MISSOURI PQC

Perinatal Quality Collaborative

Cardiac Conditions in Obstetric Care (CCOC)

Bridging the Gap Between Social Determinants/Drivers of Health (SDOH) Screening and Z Codes

January 28, 2025

IN PARTNERSHIP WITH THE MHA MISSOURI HOSPITAL ASSOCIATION

MO PQC Team for CCOC Collaborative and Dr. Karen Florio

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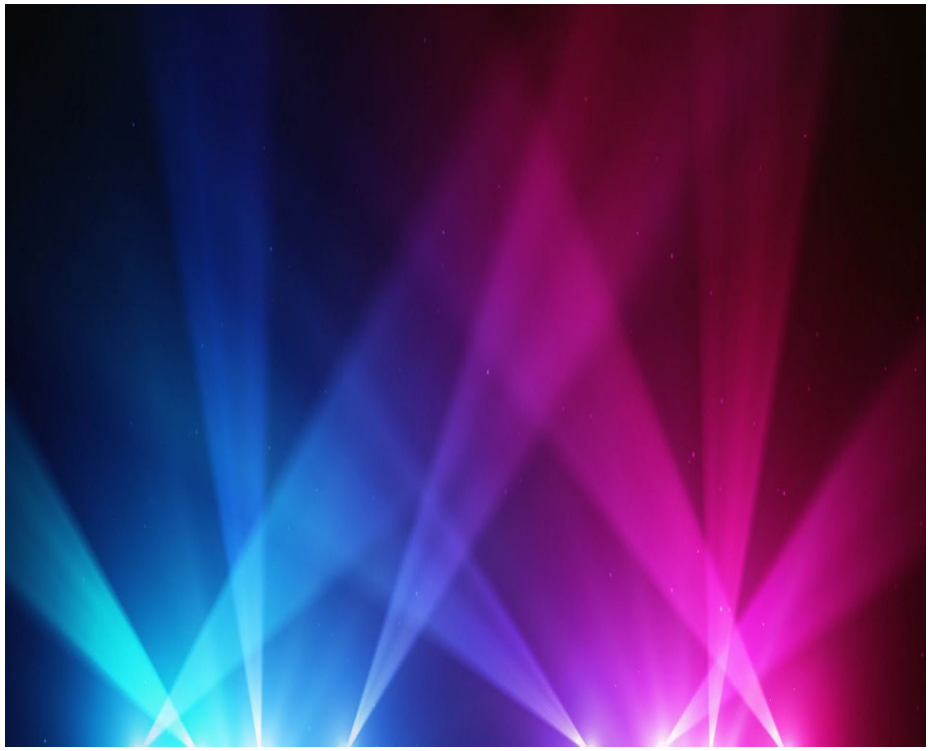
Housekeeping

- We have over 500 participants registered for today's webinar, please take a moment to put your name, title and organization in the chat.
- Please mute your audio.
- You are encouraged to be on camera if comfortable to do so.
- Today's webinar will be recorded, and the resources and slides will be shared with all of those that registered.
- The resources will also be available on the MO PQC Website under the Cardiac Conditions in Obstetric Care Initiative.
- Pre and post poll questions.
- Please take the time to complete the survey when leaving the webinar to give us feedback on today's education.

Pre - Poll Questions

Overview

- SDOH screening
  - Case Study
    - Standardized tools
    - Staff training
    - Closing the feedback loop
- Coding process
  - Guidelines
- Innovative HE dashboard
- Maternal health resources
  - Missouri Perinatal Collaborative dashboard



SDOH and ICD-10 z codes

- These include the non-clinical factors that impact people's health.
- They range from Z55 to Z65 in the ICD-10 Code.
- Documentation is often collected by care team members.
- This must be included in the official medical record.
- Coding professionals use information documented in the medical records to assign z codes.

ICD-10-CM Code Categories

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z55 — Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment and discord with teachers and classmates.
Z56 — Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 — Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z59 — Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support.
Z60 — Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.
Z62 — Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility towards and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, Z62.819 Personal history of unspecified abuse in childhood, Parent-child conflict, and sibling rivalry.
Z63 — Other problems related to primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family.
Z64 — Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors.
Z65 — Problems related to other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities.

Coding and Reporting Guidelines

Refer to the Official Guidelines for Coding and Reporting for more information.

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Manager of Patient Advocacy and Engagement Officer, University Health

Rachel Johnson

Director of Professional Revenue Cycles, University Health

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Social Determinants of Health Screening and Assistance at University Health, Kansas City, MO

Deborah L. Sisco, Rachael Johnson
University Health

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Who We Are

- Kansas City's Safety Net Hospital
- Level 1 Trauma Center
- 48% Medicaid or Self-Pay
- Over 100 languages spoken
- 91,347 patients have at least one chronic disease
- Teaching hospital for University of Missouri, Kansas City
- 2 hospital campuses, 1 behavior health campus, hospital and community outpatient clinics

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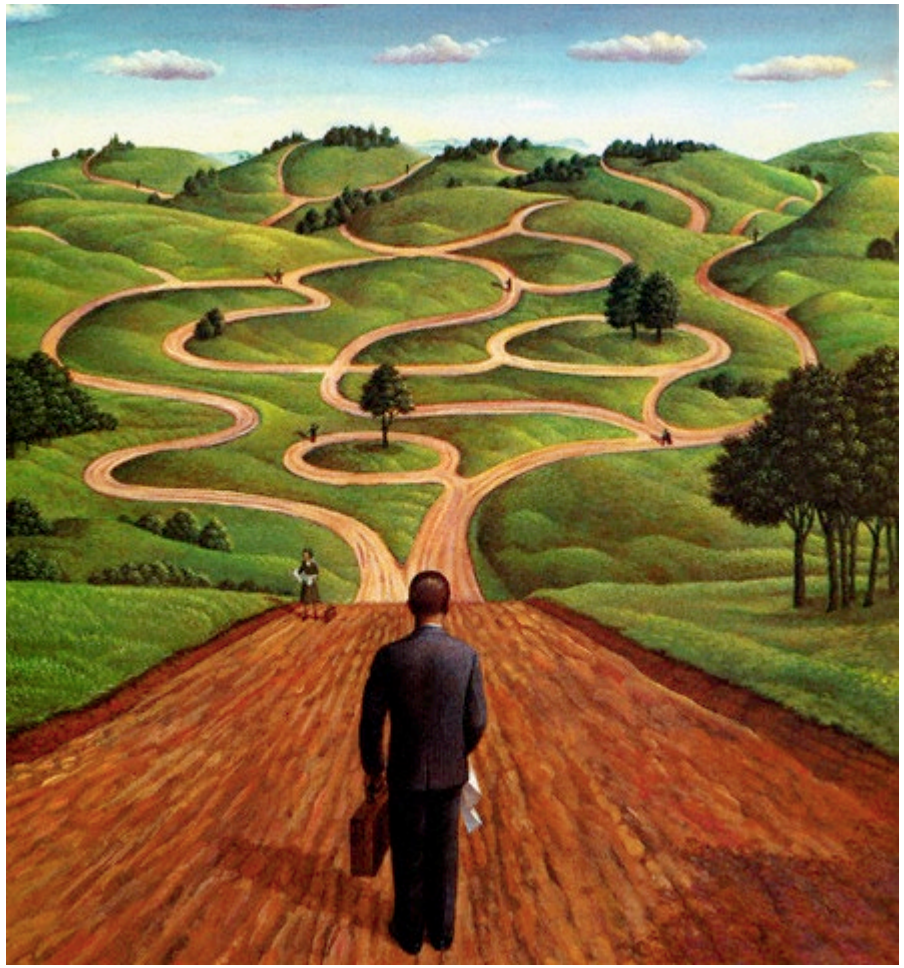
The SDOH Journey



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Collaborative Decision Making

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Our SDOH Journey

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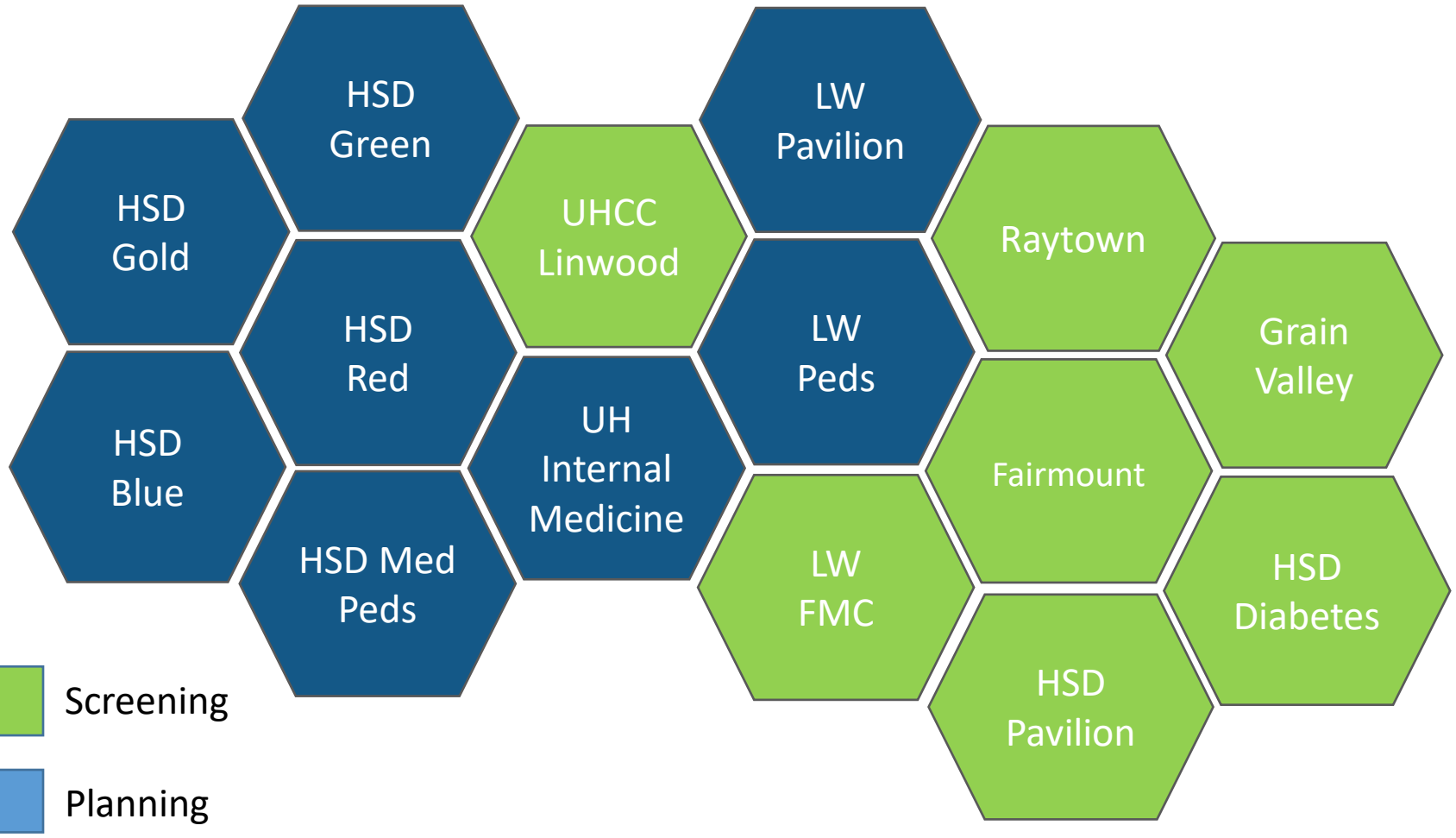
Screening


HSD Green
HSD Gold
UHCC Linwood
LW Pavilion
Raytown
HSD Red
LW Peds
Grain Valley
HSD Blue
UH Internal Medicine
Fairmount
HSD Med Peds
LW FMC
HSD Diabetes
HSD Pavilion
Screening
Planning

2022 SDOH Screenings

Month	Total Screened	Transportation	Food Insecurity	Skipped Meds due to Money
Jan-22	3711	74	45	74
Feb-22	3910	85	88	56
Mar-22	5399	126	87	78
Apr-22	4860	103	98	58
May-22	5076	66	77	79
Jun-22	5051	98	72	70
Jul-22	4653	74	72	42
Aug-22	7155	187	537	141
Sep-22	6178	177	458	128
Oct-22	6357	148	478	90
Nov-22	6875	177	459	139
Dec-22	9566	222	743	182
Total 2022	68791	1537	3214	1137
			Total All Domains: **5888**	

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2023 SDOH Screenings

Month	Total Screened	Transportation	Food Insecurity	Skipped Meds due to Money
Jan-23	8798	204	771	170
Feb-23	8740	240	892	164
Mar-23	11035	151	1060	83
Apr-23	9502	145	996	102
May-23	10174	143	1107	99
Jun-23	10229	148	1137	94
Jul-23	9575	118	1099	101
Aug-23	12433	151	1152	94
Sep-23	11183	188	1158	122
Oct-23	11900	171	1268	135
Nov-23	16045	363	1373	287
Dec-23	24982	436	1500	357
Total 2023	144596	2458	13513	1808
			Total All Domains **17,779**	

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Social Determinants of Health – 2024

- Required by both TJC and CMS in 2024
- Expanded screening to all clinics and inpatient settings
- Increased screening categories – now screening for food insecurity, ability to afford medications, transportation, utilities, housing, interpersonal safety, internet access
- Provision of resource information
  1. QR code card
  2. QR code on depart paperwork

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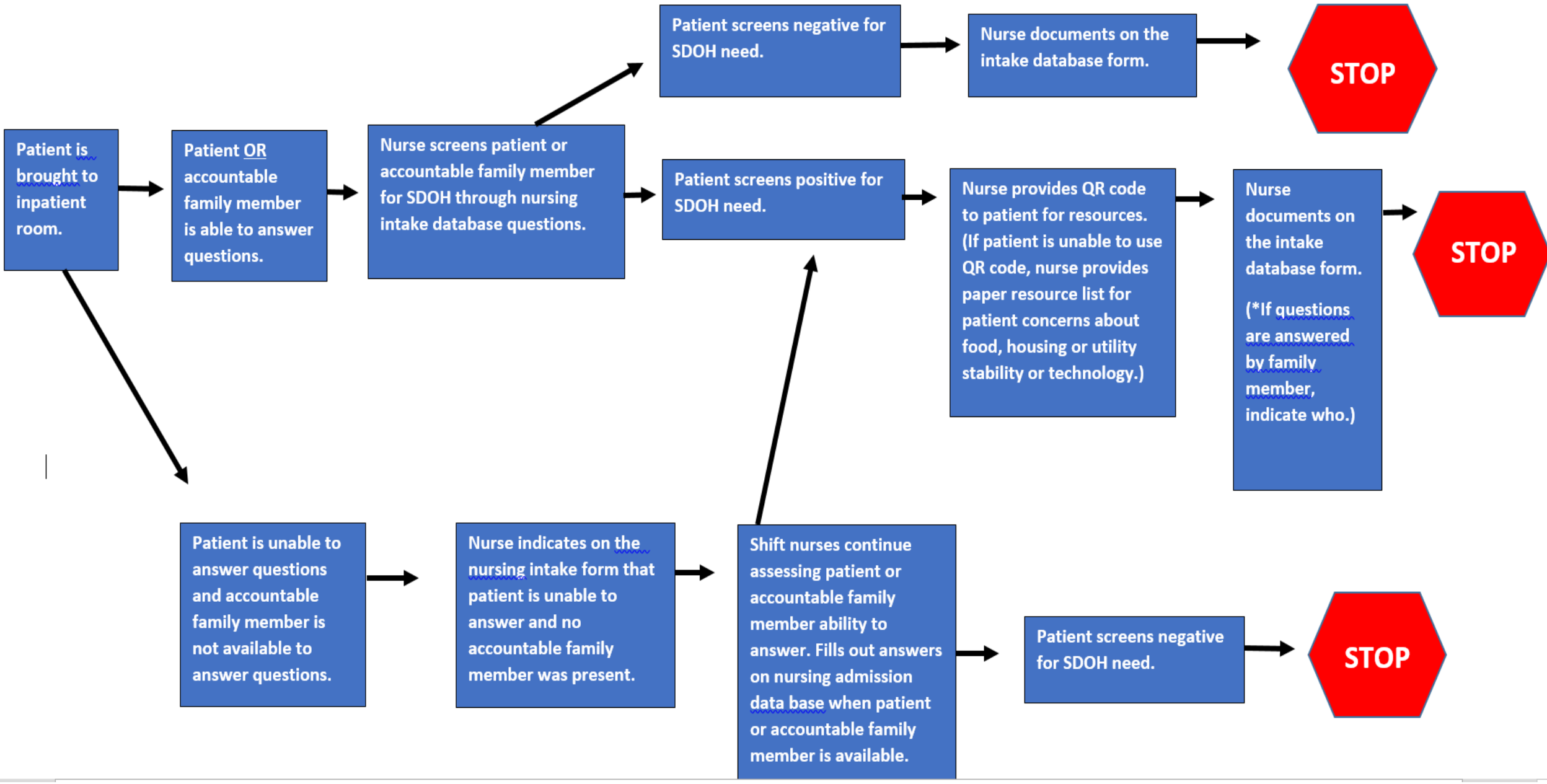
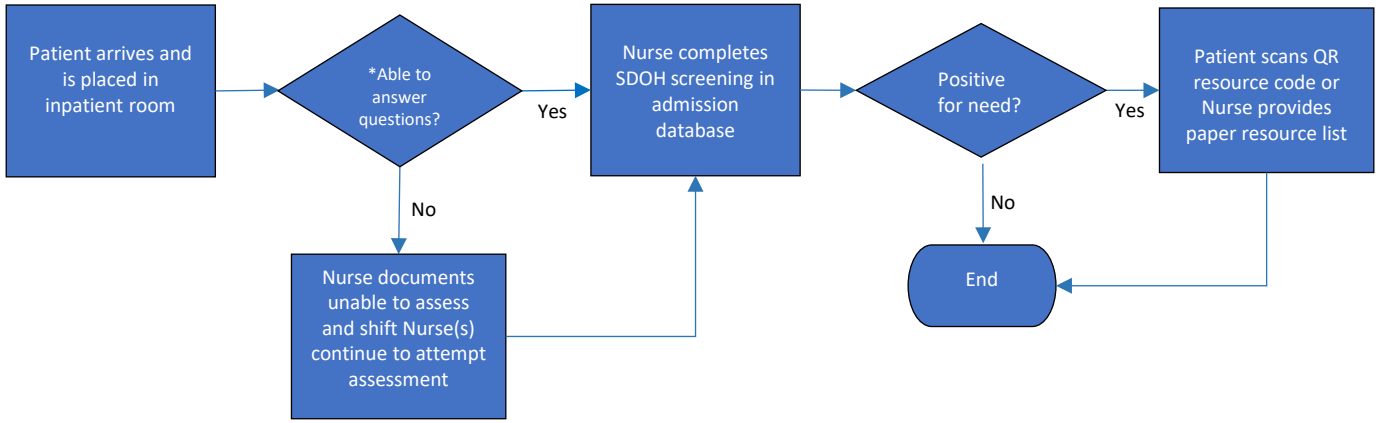

Patient is brought to inpatient room.
Patient OR accountable family member is able to answer questions.
Nurse screens patient or accountable family member for SDOH through nursing intake database questions.
Patient screens negative for SDOH need.
Nurse documents on the intake database form.
STOP
Patient screens positive for SDOH need.
Nurse provides QR code to patient for resources. (If patient is unable to use QR code, nurse provides paper resource list for patient concerns about food, housing or utility stability or technology.)
Nurse documents on the intake database form.
(*If questions are answered by family member, indicate who.)
STOP
Patient is unable to answer questions and accountable family member is not available to answer questions.
Nurse indicates on the nursing intake form that patient is unable to answer and no accountable family member was present.
Shift nurses continue assessing patient or accountable family member ability to answer. Fills out answers on nursing admission data base when patient or accountable family member is available.
Patient screens negative for SDOH need.
STOP

Inpatient Process for SDOH Screening



*Patient or designated accountable representative can answer questions. Document who answered questions if done by patient representative.

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Inpatient Screening – Positive Triggers to Whom or Other Possible Response (Suggested)

Question Category	Trigger to
Financial (Afford Medication)	Trigger to Inpatient Case Management
Food Insecurity	Use QR Code Card
Housing	Facility or houseless triggers to Social Work Worried next 2 months – resource in packet
Transportation	Triggers to Social Work
Utilities	1st Question positive – QR Code Card 2nd Question triggers to Social Work
Interpersonal Safety	Trigger to Social Work
Technology	QR Code Card

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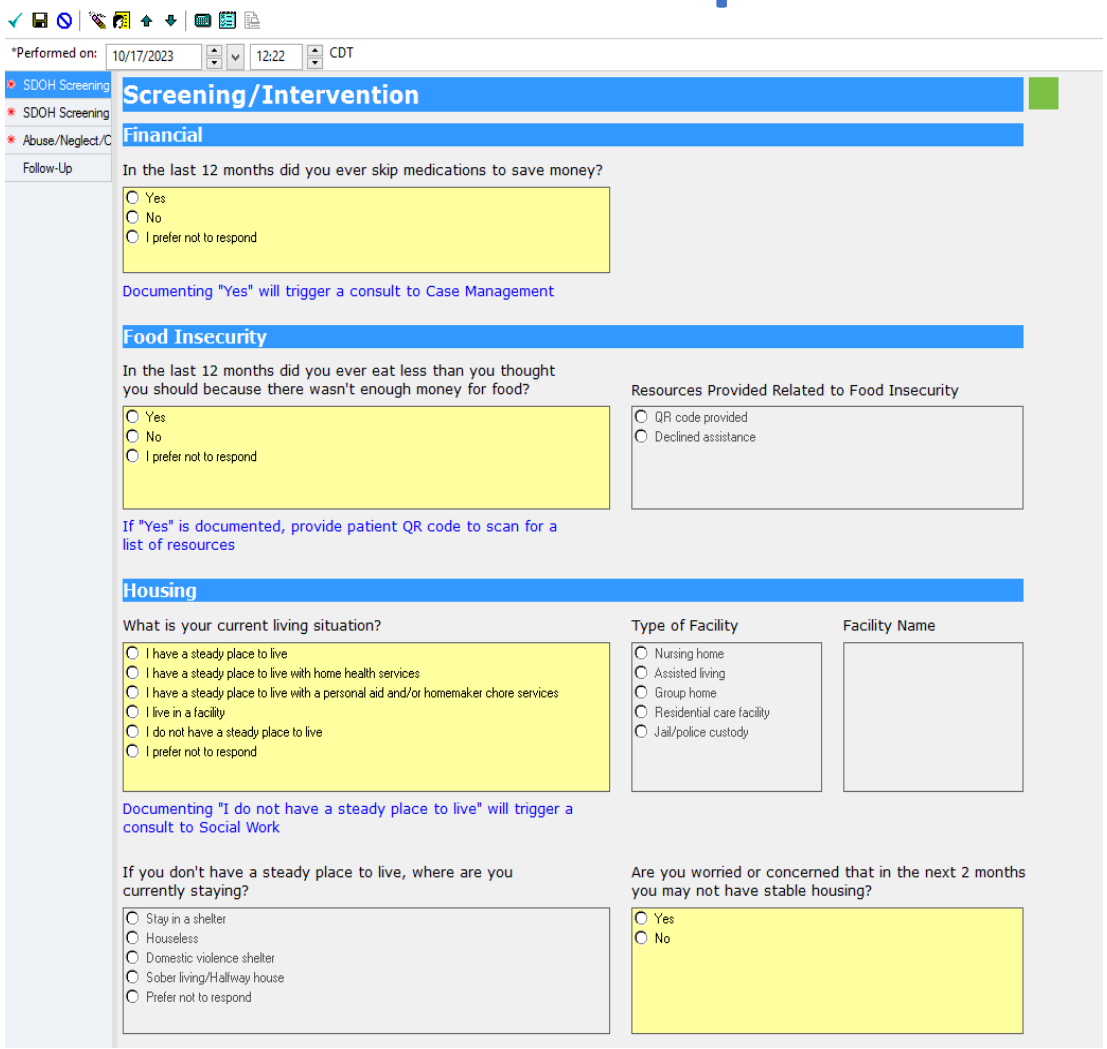
Inpatient Screening Form



*Performed on: 10/17/2023 12:22 CDT

SDOH Screening
SDOH Screening
Abuse/Neglect/C
Follow-Up

Screening/Intervention

Financial

In the last 12 months did you ever skip medications to save money?

- Yes
- No
- I prefer not to respond

Documenting "Yes" will trigger a consult to Case Management

Food Insecurity

In the last 12 months did you ever eat less than you thought you should because there wasn't enough money for food?

- Yes
- No
- I prefer not to respond

Resources Provided Related to Food Insecurity

- QR code provided
- Declined assistance

If "Yes" is documented, provide patient QR code to scan for a list of resources

Housing

What is your current living situation?

- I have a steady place to live
- I have a steady place to live with home health services
- I have a steady place to live with a personal aid and/or homemaker chore services
- I live in a facility
- I do not have a steady place to live
- I prefer not to respond

Type of Facility

- Nursing home
- Assisted living
- Group home
- Residential care facility
- Jail/police custody

Facility Name

Documenting "I do not have a steady place to live" will trigger a consult to Social Work

If you don't have a steady place to live, where are you currently staying?

- Stay in a shelter
- Houseless
- Domestic violence shelter
- Sober living/Halfway house
- Prefer not to respond

Are you worried or concerned that in the next 2 months you may not have stable housing?

- Yes
- No

Transportation

In the last 12 months have you missed a doctor's appointment or going to the pharmacy because of transportation?

- Yes
- No
- I prefer not to respond

Documenting "Yes" will trigger a consult to Social Work

Utilities

In the past 12 months has the electric, gas, oil or water company threatened to shut off services to your home?

- Yes
- No
- I prefer not to respond

Resources Provided For Utility Assistance

- QR code provided
- Declined assistance

Documenting "Yes" will trigger a consult to Social Work.
Provide patient a QR code to scan for list of resources

Technology

Do you have internet access?

- Yes
- No
- I prefer not to respond

Type of Internet Access

- Computer
- Tablet
- Smart phone

Resources Provided For Technology Assistance

- QR code provided
- Paper resources provided
- Declined assistance

If "No" is documented, provide patient QR code to scan for a list of resources

Additional Information

Additional social determinants of health reported during screening:

- Childcare
- Education
- Employment
- Health behaviors
- Social isolation and support
- Behavioral/mental health
- Medical Legal

Additional Comments:

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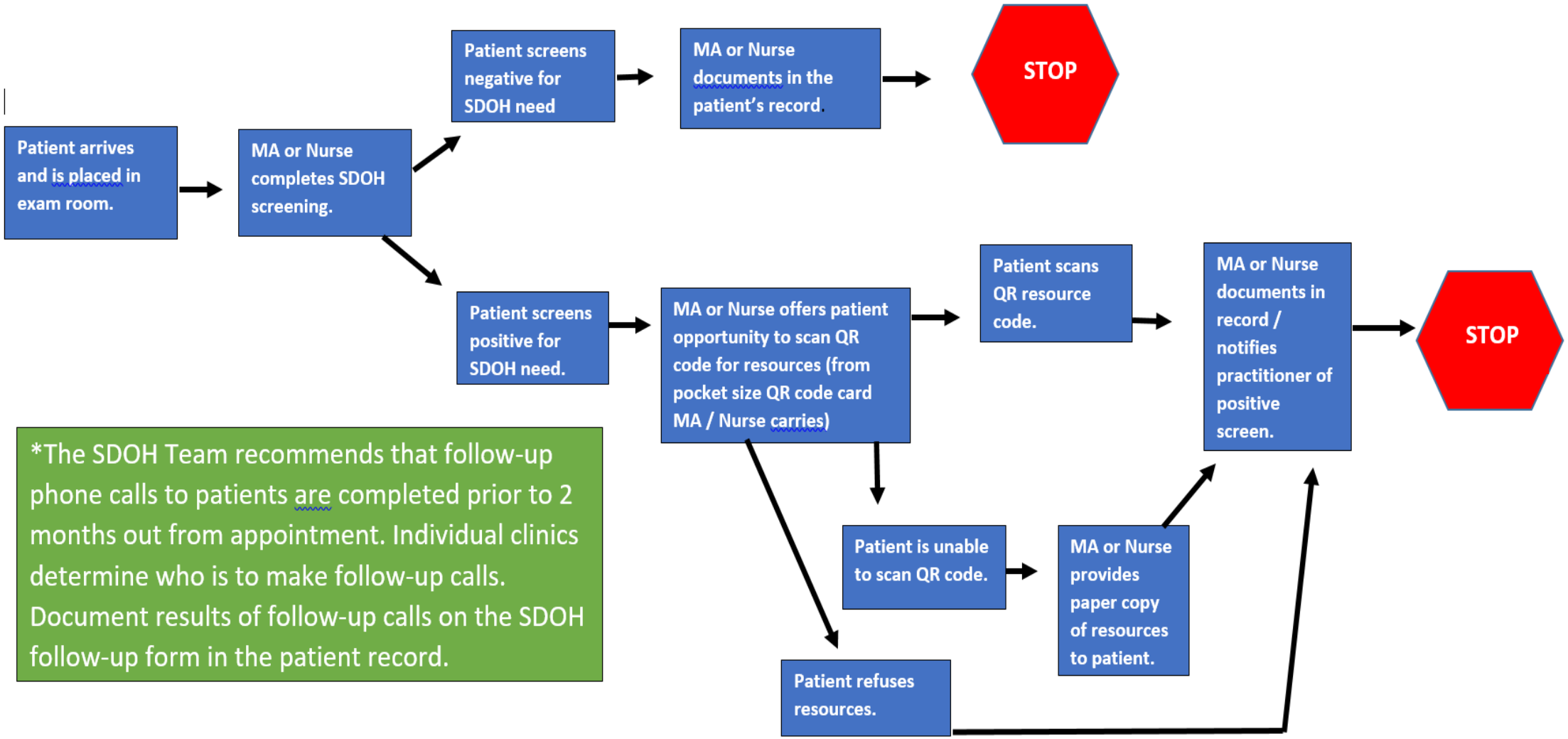
Clinic Process for SDOH Screening Beginning Fall, 2023



*The SDOH Team recommends that follow-up phone calls to patients are completed prior to 2 months out from appointment. Individual clinics determine who is to make follow-up calls. Document results of follow-up calls on the SDOH follow-up form in the patient record.

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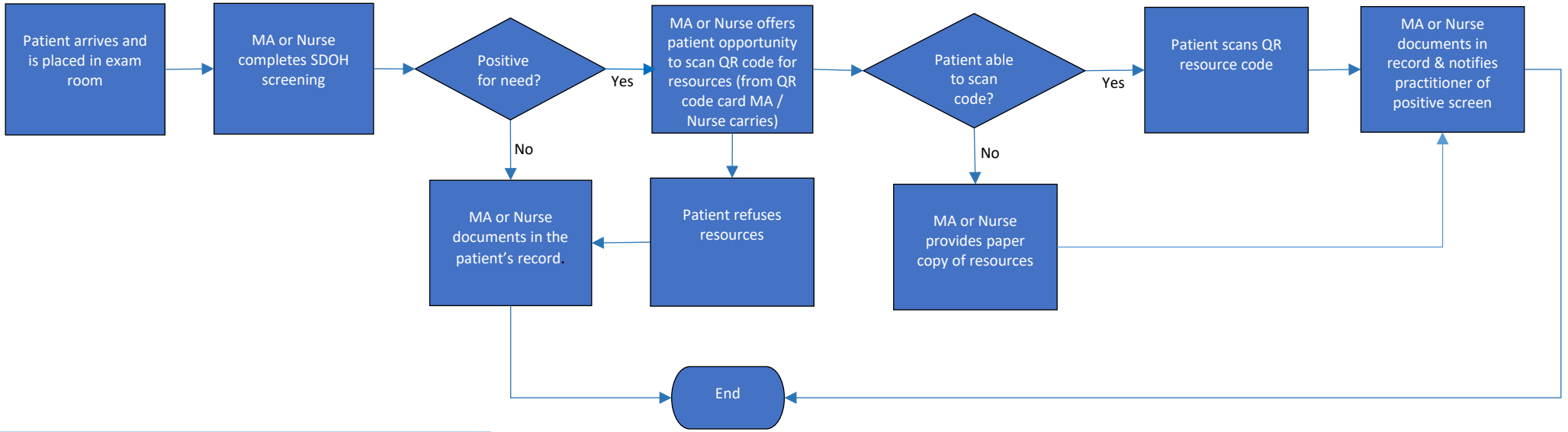
Clinic Process for SDOH Screening



SDOH Team recommends follow-up phone calls to patients are completed 2 months after appointment. Individual clinics determine who will make the phone call. Document results of the call on the SDOH follow-up form in the patient record.

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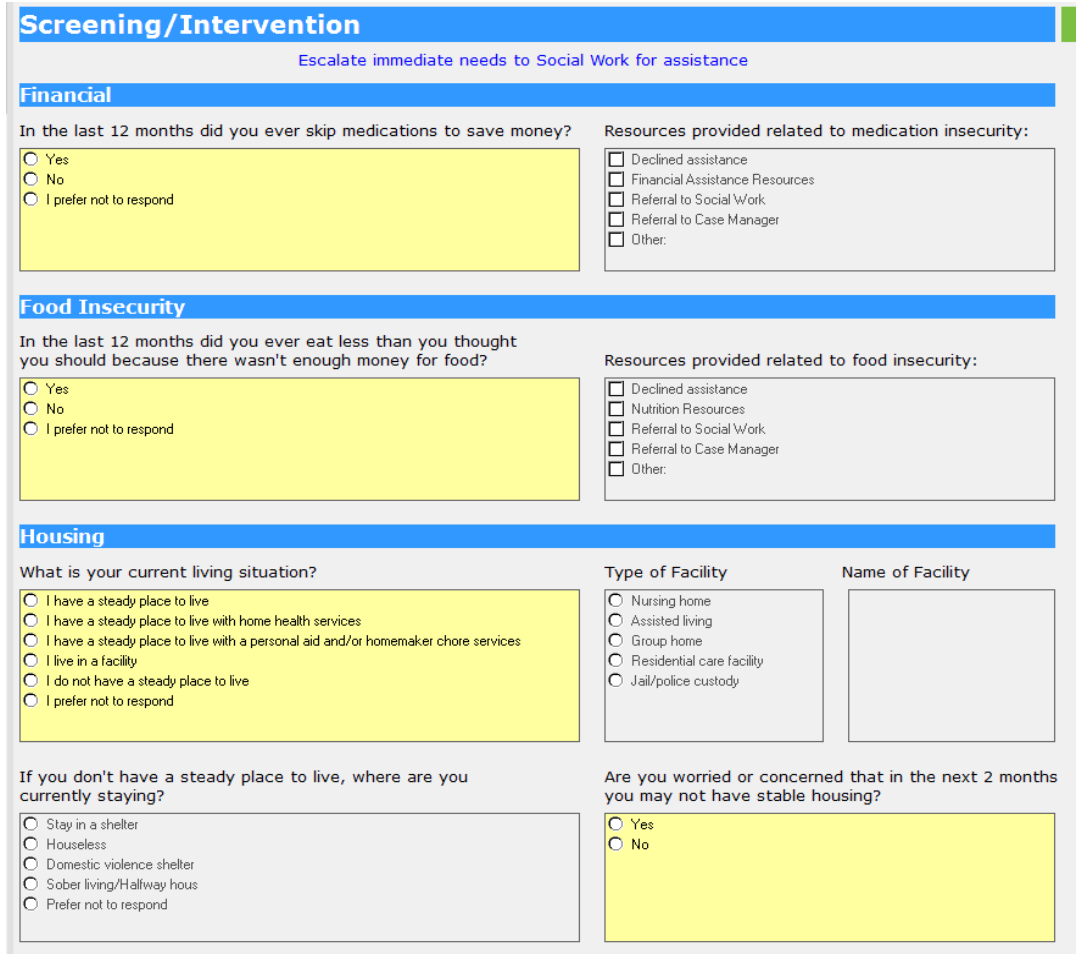
SDOH Screening Form – Outpatient Clinics



Screening/Intervention

Escalate immediate needs to Social Work for assistance

Financial

In the last 12 months did you ever skip medications to save money?

- ○ Yes
- ○ No
- ○ I prefer not to respond

Resources provided related to medication insecurity:

- ☐ Declined assistance
- ☐ Financial Assistance Resources
- ☐ Referral to Social Work
- ☐ Referral to Case Manager
- ☐ Other:

Food Insecurity

In the last 12 months did you ever eat less than you thought you should because there wasn't enough money for food?

- ○ Yes
- ○ No
- ○ I prefer not to respond

Resources provided related to food insecurity:

- ☐ Declined assistance
- ☐ Nutrition Resources
- ☐ Referral to Social Work
- ☐ Referral to Case Manager
- ☐ Other:

Housing

What is your current living situation?

- ○ I have a steady place to live
- ○ I have a steady place to live with home health services
- ○ I have a steady place to live with a personal aid and/or homemaker chore services
- ○ I live in a facility
- ○ I do not have a steady place to live
- ○ I prefer not to respond

Type of Facility

- ○ Nursing home
- ○ Assisted living
- ○ Group home
- ○ Residential care facility
- ○ Jail/police custody

Name of Facility

If you don't have a steady place to live, where are you currently staying?

- ○ Stay in a shelter
- ○ Houseless
- ○ Domestic violence shelter
- ○ Sober living/Halfway hous
- ○ Prefer not to respond

Are you worried or concerned that in the next 2 months you may not have stable housing?

- ○ Yes
- ○ No

Transportation

In the last 12 months have you missed a doctor's appointment or going to the pharmacy because of transportation?

- ○ Yes
- ○ No
- ○ I prefer not to respond

Resources provided related to transportation:

- ☐ Declined assistance
- ☐ Transportation resources
- ☐ Referral to Social Work
- ☐ Referral to Case Manager
- ☐ Other:

Utilities

In the past 12 months has the electric, gas, oil or water company threatened to shut off services to your home?

- ○ Yes
- ○ No
- ○ I prefer not to respond

Resources Provided For Utility Assistance

- ☐ Declined assistance
- ☐ Utility resources
- ☐ Referral to Social Work
- ☐ Referral to Case Manager
- ☐ Other:

Technology

Do you have internet access?

- ○ Yes
- ○ No
- ○ I prefer not to respond

Type of Internet Access

- ☐ Computer
- ☐ Tablet
- ☐ Smart phone

Resources Provided For Technology Assistance

- ☐ Declined assistance
- ☐ Technology resources
- ☐ Referral to Social Work
- ☐ Referral to Case Manager
- ☐ Other:

Additional Information

Additional social determinants of health reported during screening:

- ☐ Childcare
- ☐ Education
- ☐ Employment
- ☐ Health behaviors
- ☐ Social isolation and support
- ☐ Behavioral/mental health
- ☐ Medical Legal

Additional Comments:

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Clinic Screening Escalation to Social Work

- Abuse or Neglect Concerns
- Intimate Partner Violence/ Domestic Violence
- Suicidal Ideation/ Homicidal Ideation
- Homelessness
- Immediate Transportation Needs
- DPOA
- Complicated Resource Needs

CMS

- All inpatient 18 years or older (Unless unable to answer or have no family / designated individual to answer for them
- Must screen for specific areas including food, housing, transportation, utilities and interpersonal safety

The Joint Commission

- We may choose the population we are screening (must be a representative sample of the population)
- Designate an individual responsible for health care disparities
- Screen the population and offer community resources for those who are positive
- Stratify quality and safety data by demographics to identify disparities
- Develop a written action plan for at least one disparity
- Hospital acts when it does not achieve or sustain its goal
- At least annually report to leadership

Our Reports – What We Follow

- Clinic or inpatient area
- Patient name, MRN, phone
- Patient demographics (race, ethnicity, age, sex, insurance)
- Screener
- Date of screening
- Screening results for each area of screening
- MHA SDOH dashboard

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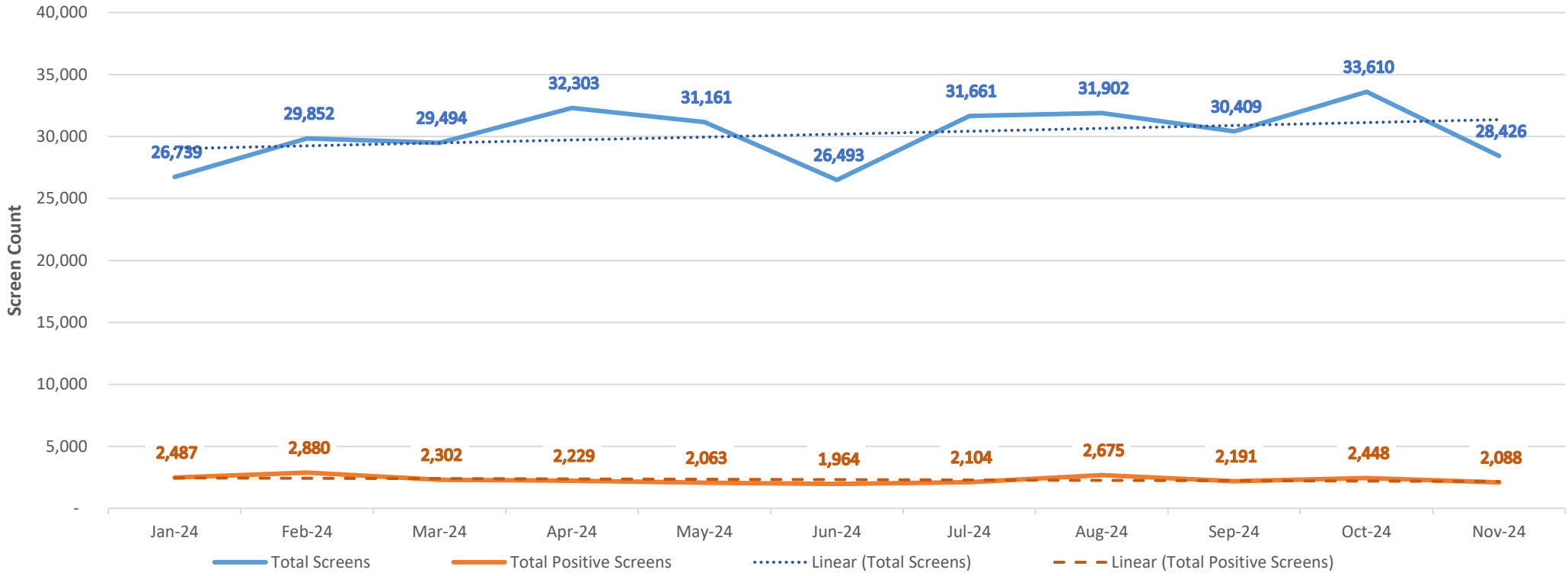
Jan – Nov 2024 Outpatient Total Screens Vs Total Positive Screen Trends



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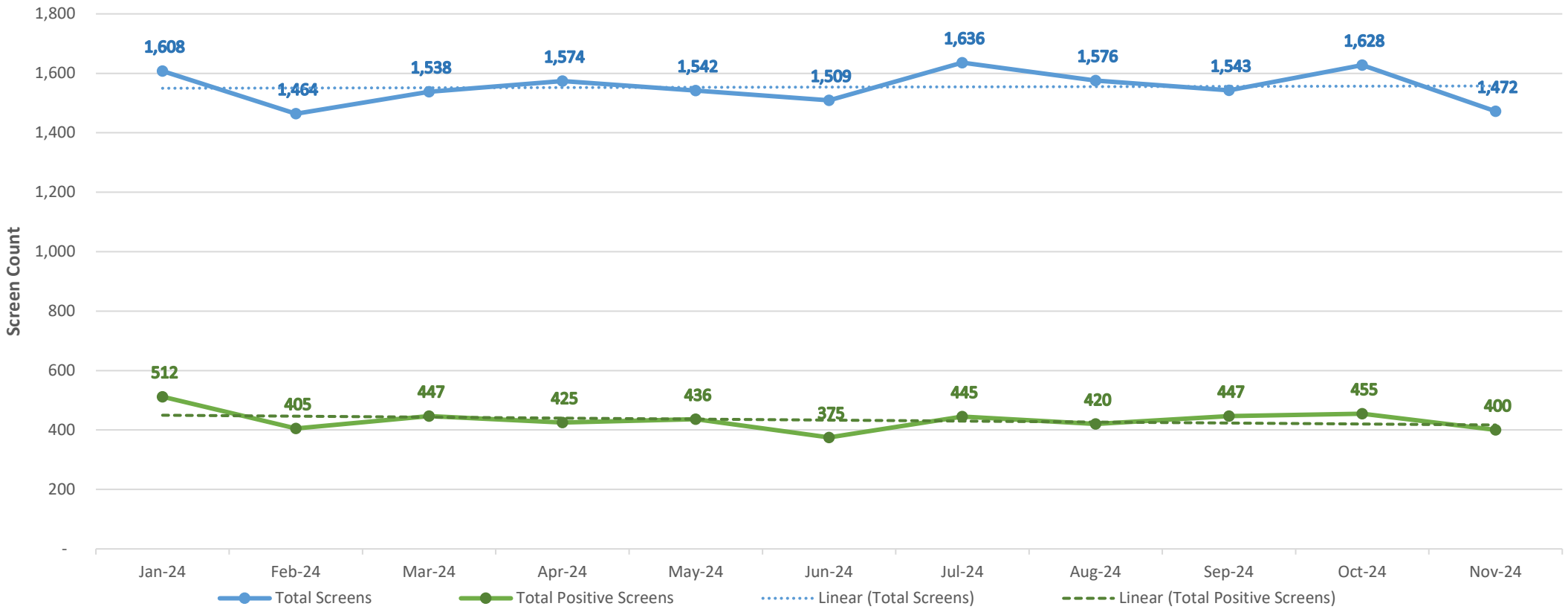
Jan – Nov 2024 Inpatient Total Screens Vs Total Positive Screen Trends



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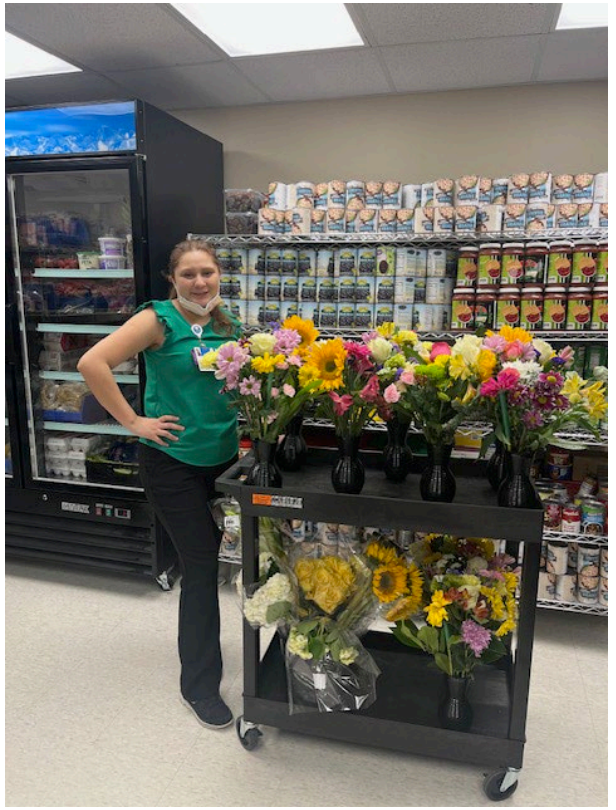
What We Do With the Information

- Provide monthly reports to managers/directors
- Provide resources
- Food pantry
- Partnerships with others (Examples: Bike Walk KC, Northland Coalition, United Way)



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University Health SDOH Training Toolkit

- Defining the social drivers of health
- Why screening and assistance matters
- The vision for SDOH at University Health
- SDOH implementation journey and timeline
- Workflow and processes (clinic and inpatient
- QR code resource card
- Screening form
- Follow-up script
- Standardizing the process
- Plan/Do/Study/Act
- Trauma Informed Care
- Empathetic listening
- Working with people who are upset
- Resource handouts

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Previous vs. Current State

Previous State

Current State

We use Cerner EHR to generate our SDOH codes to bill electronically to the payers

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How the Automation (Magic) Happens

When the SDOH screening form is completed, a rule evaluates the responses. If anything is "yes" then it adds the relevant Z-code diagnosis. Then when certain professional E&M charges are entered by a provider, another rule looks for that SDOH screening form and the Z codes.

If the form is found but there are no Z-code diagnoses, then it adds G9920 and uses the same ordering physician and diagnoses from the E&M charge. If any of the Z-code diagnoses are found, then it adds G9919 and uses the same ordering physician but attaches the Z-codes as the diagnoses for that charge.

Questionnaire is KEY

Incorporating a questionnaire that patients can complete in the waiting room, online prior to their visit, or when being roomed by the nurse or medical assistant allows providers to learn of and address any external factors that may impede their patients' health outcomes. Currently, we screen patients while in the waiting room or when they are roomed by the medical assistant or nurse. There are an infinite number of SDOH questionnaires available online or you may concoct your own.

This documentation does not need to be established by a physician or other provider type since this data represents social information rather than medical diagnoses.

New SDOH Z codes may become effective each April and October New codes are announced prior to their effective date on the CMS website:

https://www.cms.gov/files/document/cms-2023-omh-z-code-resource.pdf

Z62 – Problems related to upbringing

- Z62.2 – Upbringing away from parents
  - NEW • Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW • Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW • Z62.814 – Personal history of child financial abuse
    - NEW • Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW • Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW • Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW • Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

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When should I report an SDOH code on a CMS-1500 claim?

Medical coders should report SDOH if they are:

- Documented by medical assistants, social workers, case managers, or nurses, and the SDOH information is included in the official medical record; or
- SDOH are documented by the patient and this self-reported information is signed off on and incorporated into the medical record by either a clinician or the patient's provider
- If a questionnaire is not being used, often coders will look to nursing notes to find if there are any SDOH factors

Missouri Medicaid
Notification of Pregnancy and Risk Screening

Billing for Prenatal Screening
The above codes are reimbursed at $50.00 for completion and entry into the state's new NOP and Risk Screening Portal. Ensure the TH modifier is used for the code submitted.

For prenatal billing:

- Always include a diagnosis code that represents gestational age in weeks (of the form Z3Axx, where xx is weeks of gestational age)
- Always use the TH modifier
- If billing G9919-TH, at least one SDOH Z-code must be included (all relevant SDOH Z-codes to document the screening should be included)
- If billing G9920-TH, no SDOH Z-codes should be included (as this case corresponds to no concerns being identified)

https://mydss.mo.gov/media/pdf/notification-pregnancy-revised

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Missouri Medicaid
Notification of Pregnancy and Risk Screening

Billing for Postpartum Screening
The codes above are reimbursed an additional $50.00 for completion during a postpartum screening; however, the information gathered during this screening should not be entered into the NOP and Risk Screening Portal. Ensure the TH modifier is used for the code submitted.

For postpartum billing:

- Always include a diagnosis code that indicates postpartum (Z39.2)
- Always use the TH modifier
- If billing G9919-TH, at least one SDOH Z-code must be included (all relevant SDOH Z-codes to document the screening should be included)
- If billing G9920-TH, no SDOH Z-codes should be included (as this case corresponds to no concerns being identified)

https://mydss.mo.gov/media/pdf/notification-pregnancy-revised

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Questions?

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Post Poll Questions

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MHA Health Equity Dashboards

Data Visualization

The **Hospital Industry Data Institute** has developed various data visualizations for stakeholders to learn more about the health in their communities and Missouri.

MHA's public-facing Health Equity dashboards offer granularity in health outcomes, health factors and social determinants of health for finite population segments and geographic areas in Missouri. Hospital-specific Determinants of Health dashboards — **available to HIDI-participating hospitals at no cost** — provide hospitals with specific insights into the care they provide to patient populations through a sociodemographic lens.

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MHA Health Equity Dashboards

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

— Robert Wood Johnson Foundation

EXPLORE THE DASHBOARDS

View the steps

1. Get started with the Priority Guide
2. Take a deeper dive with the Disparity Explorer
3. Evaluate risk-adjusted differences in health outcomes
4. Understand diversity in your community's composition
5. Analyze Social Vulnerability data at the county and census tract levels

The **Hospital Industry Data Institute** provides a series of hospital-specific **Determinants of Health Dashboards** to enable hospitals to better understand and manage health disparities and service delivery across diverse patient demographics.

In January 2023, the dashboard series introduced explorers for Hospital, Social Determinants of Health and optional Risk-adjusted outcomes, which aligned with **The Joint Commission** and **Centers for Medicare & Medicaid Services** integration of health care equity standards into their health care accreditation and payment programs. May 1, 2024, HIDI will launch enhancements to the dashboards that offer in-depth, stratified analyses of hospital utilization, geographical disparities, maternal and child health, and the impacts of specific conditions on patient readmissions and mortality. These resources are known as the **Determinants of Health Dashboards** suite in Care Optics.

Developed in collaboration with stakeholders from MHA's Strategic Quality and **Health Equity** committees and HIDI's Strategic Advisory Committee, the suite of dashboards — **available to HIDI-participating MHA and SLMHC members at no cost** — offers hospital-specific insight into the care provided to patient populations through a sociodemographic lens.

Stratifying the administrative claims data already collected by HIDI in this way provides **unprecedented value** by illuminating precisely where finite resources should be allocated to make the most impact. Hospitals also gain the added benefits of peer benchmarking and visibility into potential data collection gaps.

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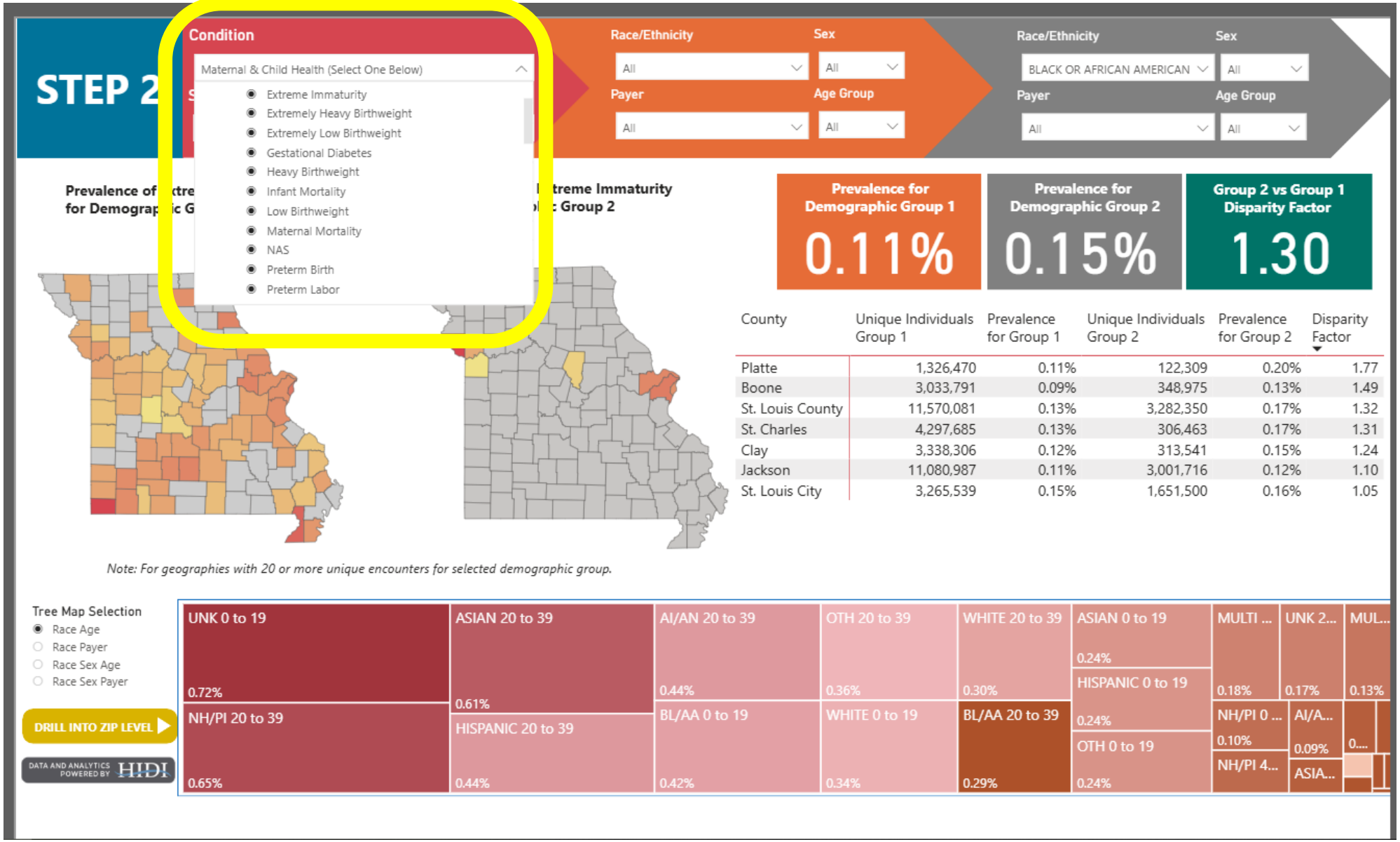

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Overview of MO PQC Dashboards and Scorecards

Overview

- MO PQC collaborated with HIDI to design and develop a suite of dashboards and scorecards related to perinatal quality
- Designed to assist hospitals in identifying and addressing variations in maternal outcomes, patient safety, and health and social risks; an infant-focused module is planned for future development
- Hospitals can gain insights to drive targeted QI initiatives, support implementation progression and overall strategic quality objectives – this is not a punitive or marketing tool
- Includes peer benchmarking capabilities and provider trends and comparatives
- Enables team members to support community health-related needs and address equity
- Hospitals have access to patient-level detail to complete case reviews
- Involves redacted transparency

Release Timeline

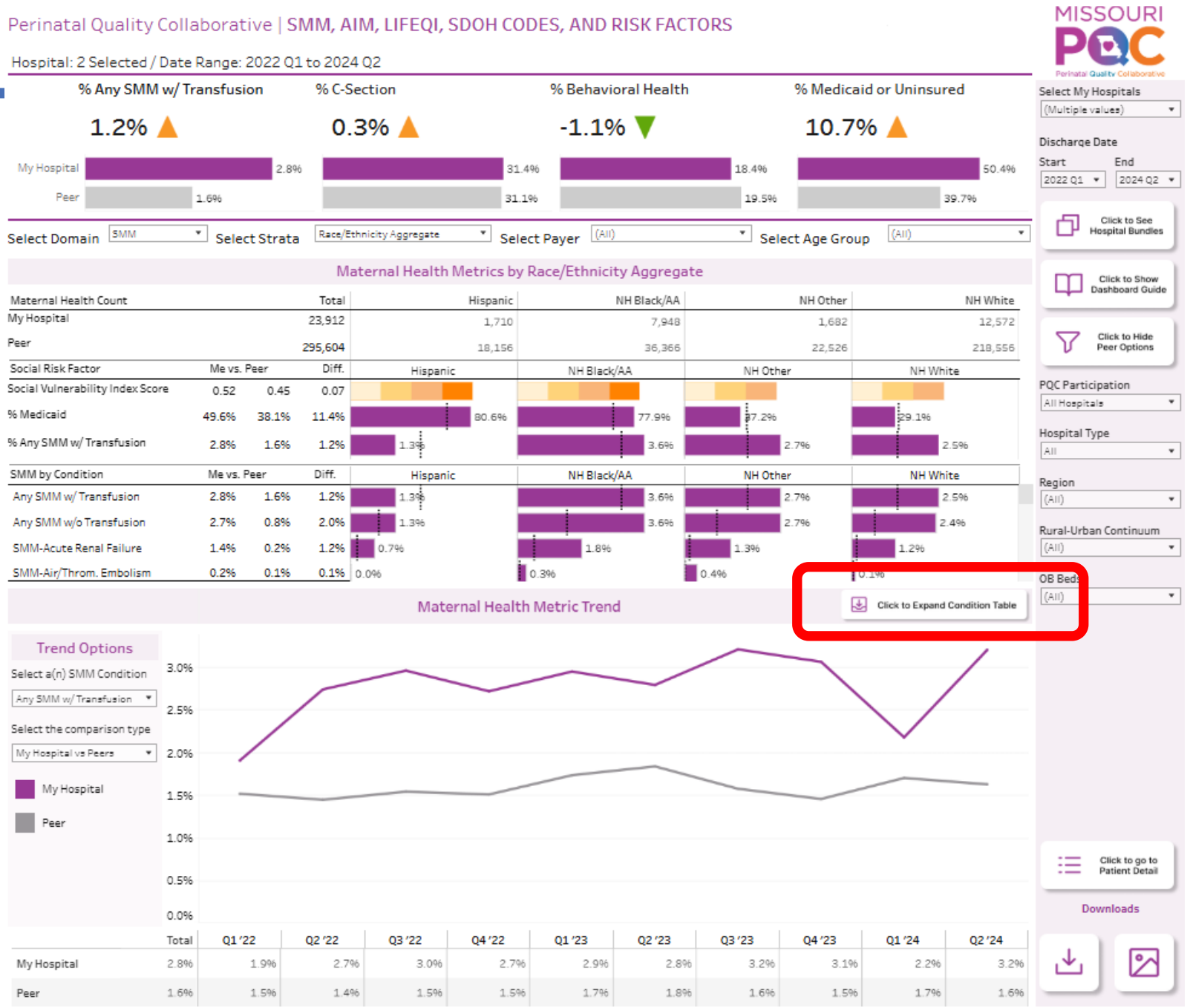
- December 2024 – PQC Dashboards released to hospital birth units (AIM Bundle Project Leads and Leadership)
- January 31, 2025 – Risk Adjustment enhancement launch
- February/March 2025 – Scorecards launched with further education
- Through April 2026 – further dashboard and scorecard enhancements will be in development

Domains for Dashboard

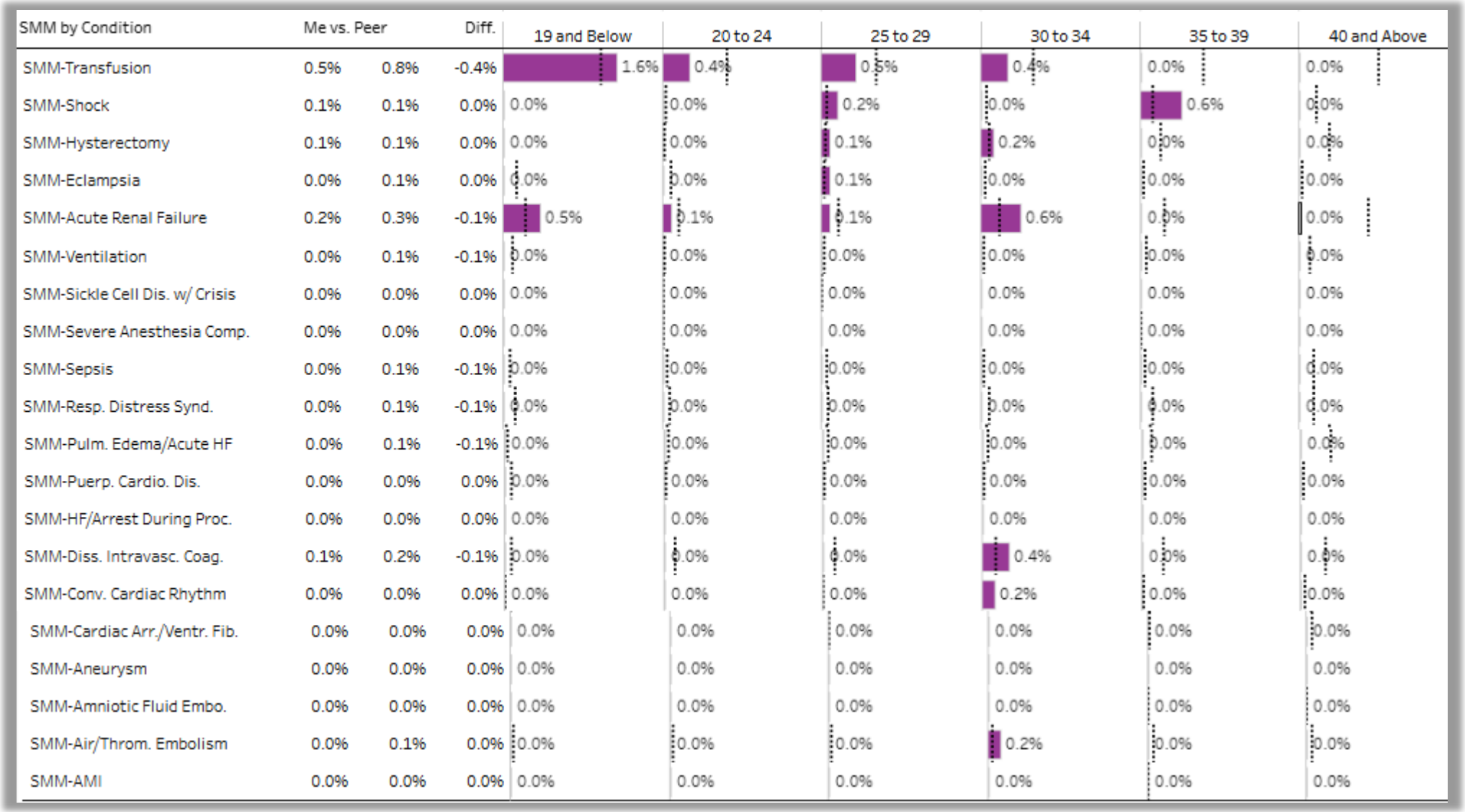
- **Severe Maternal Morbidity:** measures 21 diagnosis and procedure-based measures, stratified by patient characteristics with peer grouping available
- **AIM SMM Measures:** includes 13 additional SMMs, across three patient safety bundles (PSBs) with two global SMMs
  - Hypertension (2)
  - Hemorrhage (3)
  - Substance Use Disorder (6)
- **Life QI Bundles:** seven measures, across two patient safety bundles to complement AIM measures
  - Hypertension (4)
  - Hemorrhage (3)
  - SUD, CCOC, and PMH being added soon
- **Risk Factors by Condition**: 16 MHA-identified risk factors support risk adjustment
- **SDOH Z-Code Risk Factors:** includes 8 Z-code measures and 1 global measure

Main PQC Data Visualization Dashboard

- Measure Domains:
  - CDC SMMs
  - AIM SMMs
  - Maternal Risk Factors
  - SDOH Risk Factors
  - Life QI AIM Bundles
- Stratifiers:
  - Age
  - Payer
  - Race Ethnicity (aggregate and detailed)
  - SSM model-based risk categories (forthcoming)
- Peer Comparatives:
  - PQC participation status
  - Hospital type (PPS, CAH, Children's)
  - Region
  - Rural-urban continua
  - Staffed OB bed size categories
- Patient-Level Drill Through:
  - Demographic information and diagnosis codes on labor and delivery claims

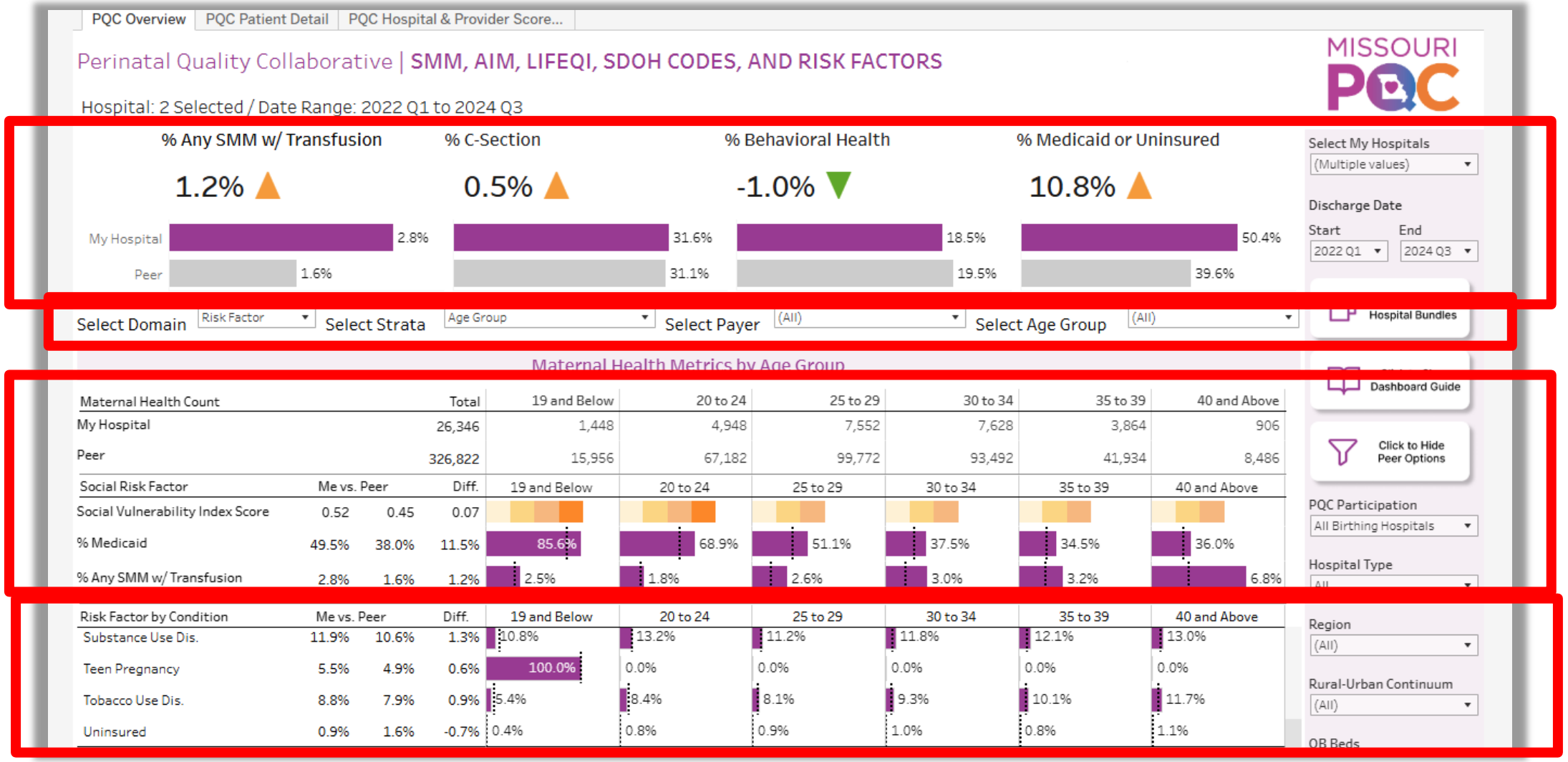


SMM Domain

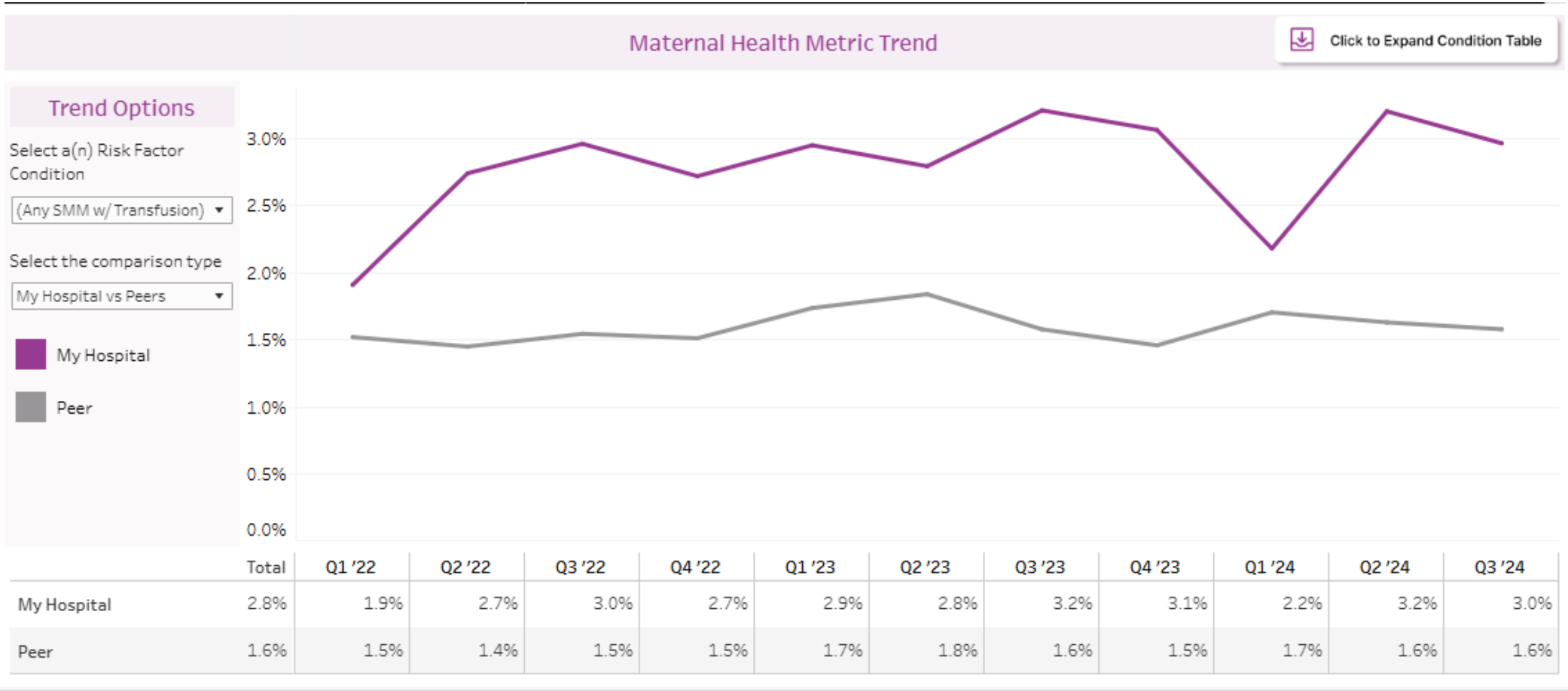


SMM by Condition	Me	vs. Peer	Diff.	19 and Below	20 to 24	25 to 29	30 to 34	35 to 39	40 and Above
SMM-Transfusion	0.5%	0.8%	-0.4%	1.6%	0.4%	0.5%	0.4%	0.0%	0.0%
SMM-Shock	0.1%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	0.6%	0.0%
SMM-Hysterectomy	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.2%	0.0%	0.0%
SMM-Eclampsia	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
SMM-Acute Renal Failure	0.2%	0.3%	-0.1%	0.5%	0.1%	0.1%	0.6%	0.0%	0.0%
SMM-Ventilation	0.0%	0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Sickle Cell Dis. w/ Crisis	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Severe Anesthesia Comp.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Sepsis	0.0%	0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Resp. Distress Synd.	0.0%	0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Pulm. Edema/Acute HF	0.0%	0.1%	-0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Puerp. Cardio. Dis.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-HF/Arrest During Proc.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Diss. Intravasc. Coag.	0.1%	0.2%	-0.1%	0.0%	0.0%	0.0%	0.4%	0.0%	0.0%
SMM-Conv. Cardiac Rhythm	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%
SMM-Cardiac Arr./Ventr. Fib.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Aneurysm	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Amniotic Fluid Embo.	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
SMM-Air/Throm. Embolism	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%
SMM-AMI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Top Section

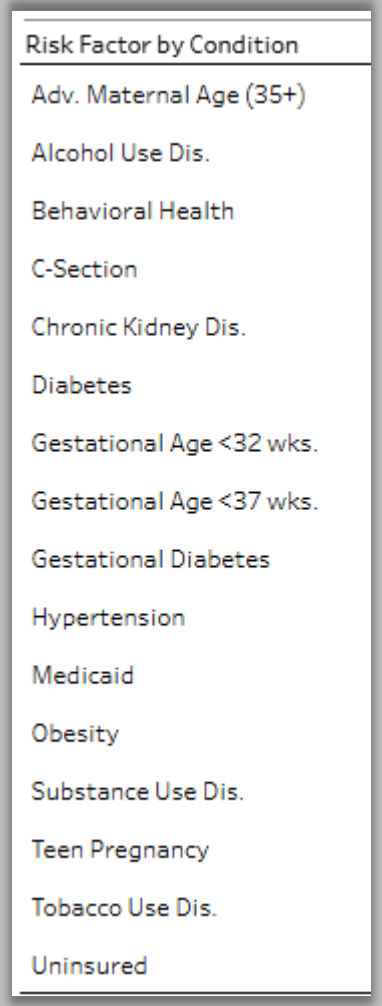


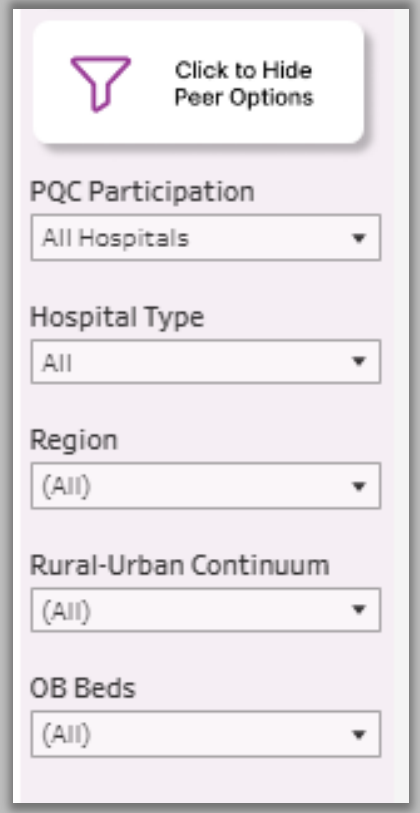
Bottom Graph Section

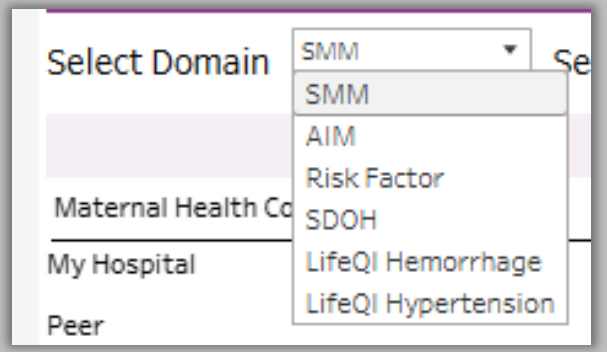


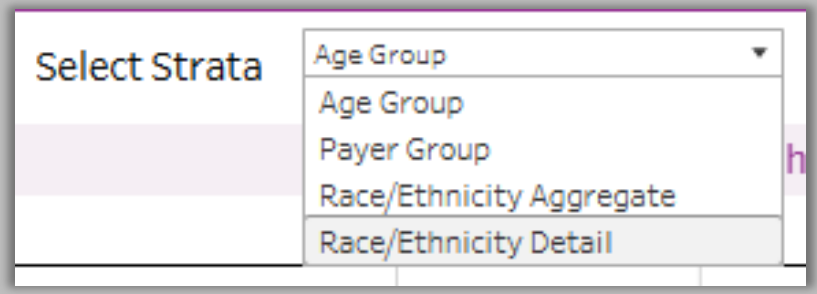
	Total	Q1 '22	Q2 '22	Q3 '22	Q4 '22	Q1 '23	Q2 '23	Q3 '23	Q4 '23	Q1 '24	Q2 '24	Q3 '24
My Hospital	2.8%	1.9%	2.7%	3.0%	2.7%	2.9%	2.8%	3.2%	3.1%	2.2%	3.2%	3.0%
Peer	1.6%	1.5%	1.4%	1.5%	1.5%	1.7%	1.8%	1.6%	1.5%	1.7%	1.6%	1.6%

PEERING, DOMAINS AND STRATA









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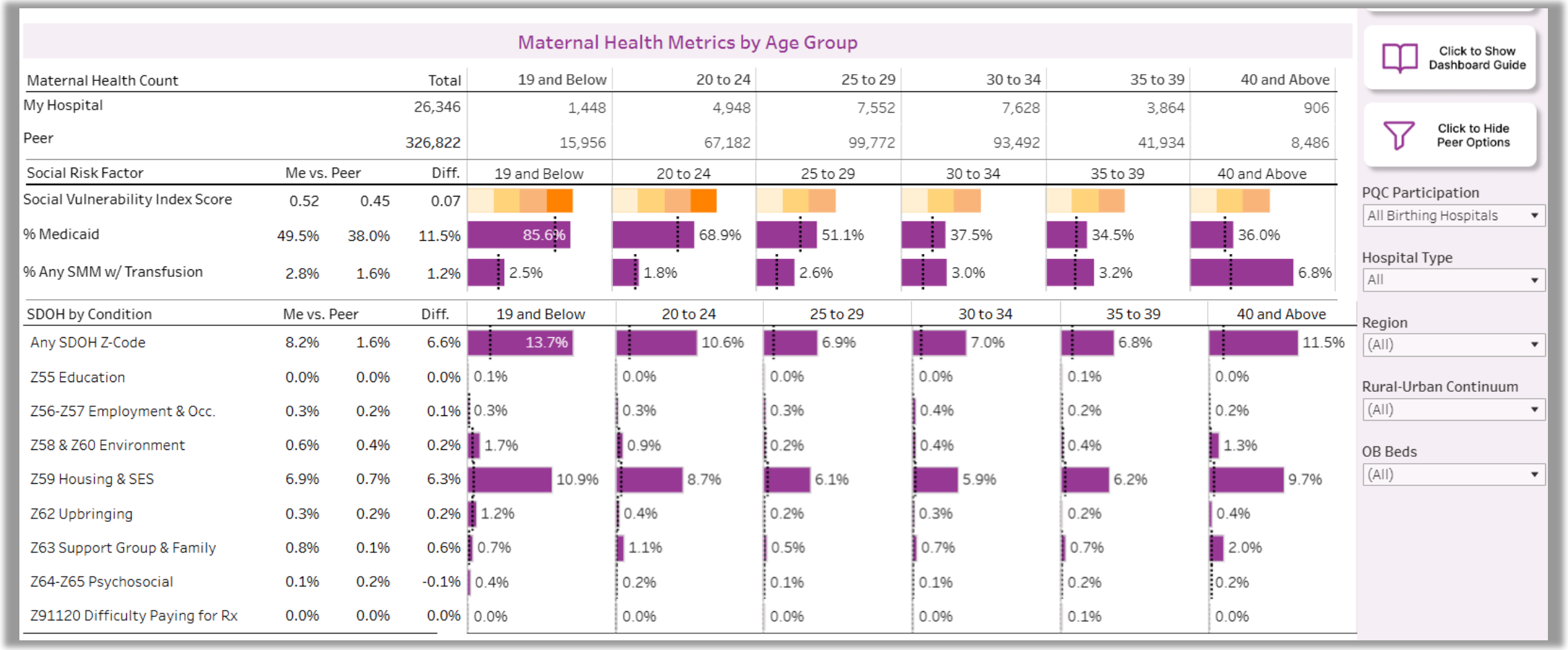
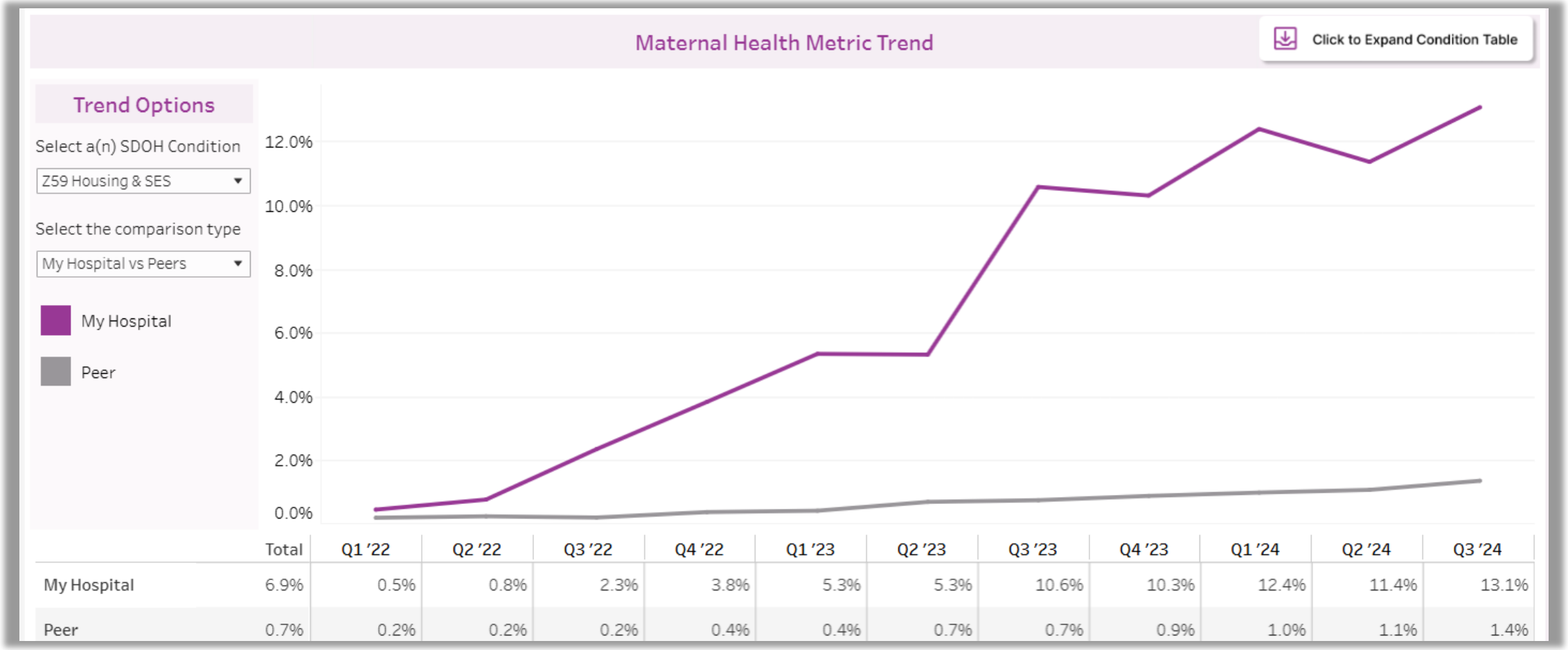
SDOH



SDOH Trend



	Total	Q1 '22	Q2 '22	Q3 '22	Q4 '22	Q1 '23	Q2 '23	Q3 '23	Q4 '23	Q1 '24	Q2 '24	Q3 '24
My Hospital	6.9%	0.5%	0.8%	2.3%	3.8%	5.3%	5.3%	10.6%	10.3%	12.4%	11.4%	13.1%
Peer	0.7%	0.2%	0.2%	0.2%	0.4%	0.4%	0.7%	0.7%	0.9%	1.0%	1.1%	1.4%

Risk Tier	
High	ARF, PEAHF, SHK
Mid-High	ARDS, ARF, PEAHF, VENT
Mid-Low	DIC
Mid-High	ARF
Mid-Low	ARF
High	PEAHF
Mid-Low	AFE, ARDS, ARF, ATE, CAVF, CCR, DIC, HFADSP, SHK
Mid-High	DIC
High	ARF, PCD
Mid-Low	ARF
Mid-Low	ARDS, VENT
Mid-High	ARF, DIC
Mid-Low	ARF
Low	DIC
Mid-High	HYST
Mid-High	SEPS
Mid-Low	ARF
High	ARDS, PCD, SHK, VENT
High	ARDS, ARF, PEAHF
High	ARDS, SHK
Mid-Low	SHK
Mid-Low	ARF
Mid-Low	ARF
Low	ARF
Mid-Low	SHK
Mid-Low	DIC
Mid-High	PEAHF
Mid-High	HYST
High	ARF
Mid-Low	ARF
High	ARF
Mid-Low	HYST
Low	ARF
High	ARF, ATE, HFADSP
Mid-High	HYST

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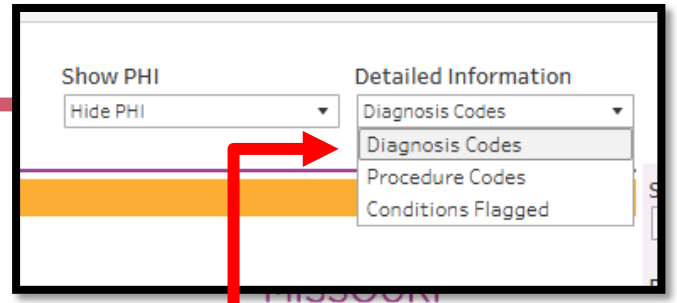

Show PHI
Show PHI
Detailed Information
Procedure Codes

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in an encrypted location.

ate	Discharge Date	
		10D07Z6,0KQM0ZZ,4A1HXCZ,10907ZC,3E033VJ,0UQG7ZZ,3E0S3BZ,00HU33Z,3..
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		10E0XZZ,4A1HXCZ,10907ZC,3E0DXGC,3E033VJ,3E0S3BZ,00HU33Z,30233N1
		10E0XZZ,0W3R7ZZ,10D17Z9,4A1HXCZ,3E0DXGC,10907ZC,30233N1,3E0S3BZ,0..
		10E0XZZ,10907ZC,4A1HXCZ,30233N1,3E0S3BZ,00HU33Z
		10E0XZZ,30233N1,4A1HXCZ,3E0DXGC,0HQ9XZZ
		10D00Z1
		10D00Z1,04QE0ZZ
		10D00Z1,0UT90ZZ,0DNU0ZZ,0DNW0ZZ,0TNB0ZZ
		10E0XZZ,0UQMXZZ,3E0P7VZ,3E033VJ
		10D00Z1
		10D00Z1,0UN90ZZ
		10D00Z1,4A1HXCZ,3E0S3BZ,00HU33Z,10907ZC,10H07YZ,3E033VJ
		10D00Z1,0UB70ZZ
		10D00Z1,30233N1,0U7C7ZZ,10H07YZ
		10D00Z1
		10D00Z1,30233N1,4A1HXCZ,3E0DXGC,10907ZC,3E0S3BZ,00HU33Z,10H07YZ
		10D00Z1,30233N1
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		10D00Z1,30233N1
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		10E0XZZ,10907ZC
		3E0P7VZ,10907ZC,0UQC7ZZ,10E0XZZ,0UQMXZZ,30233N1
		10D00Z1,0UB70ZZ,0UT90ZL,0W3R7ZZ,0W3R0ZZ,3E033VJ,05HM33Z,B543ZZA,..

Select My Hospitals
(Multiple values)

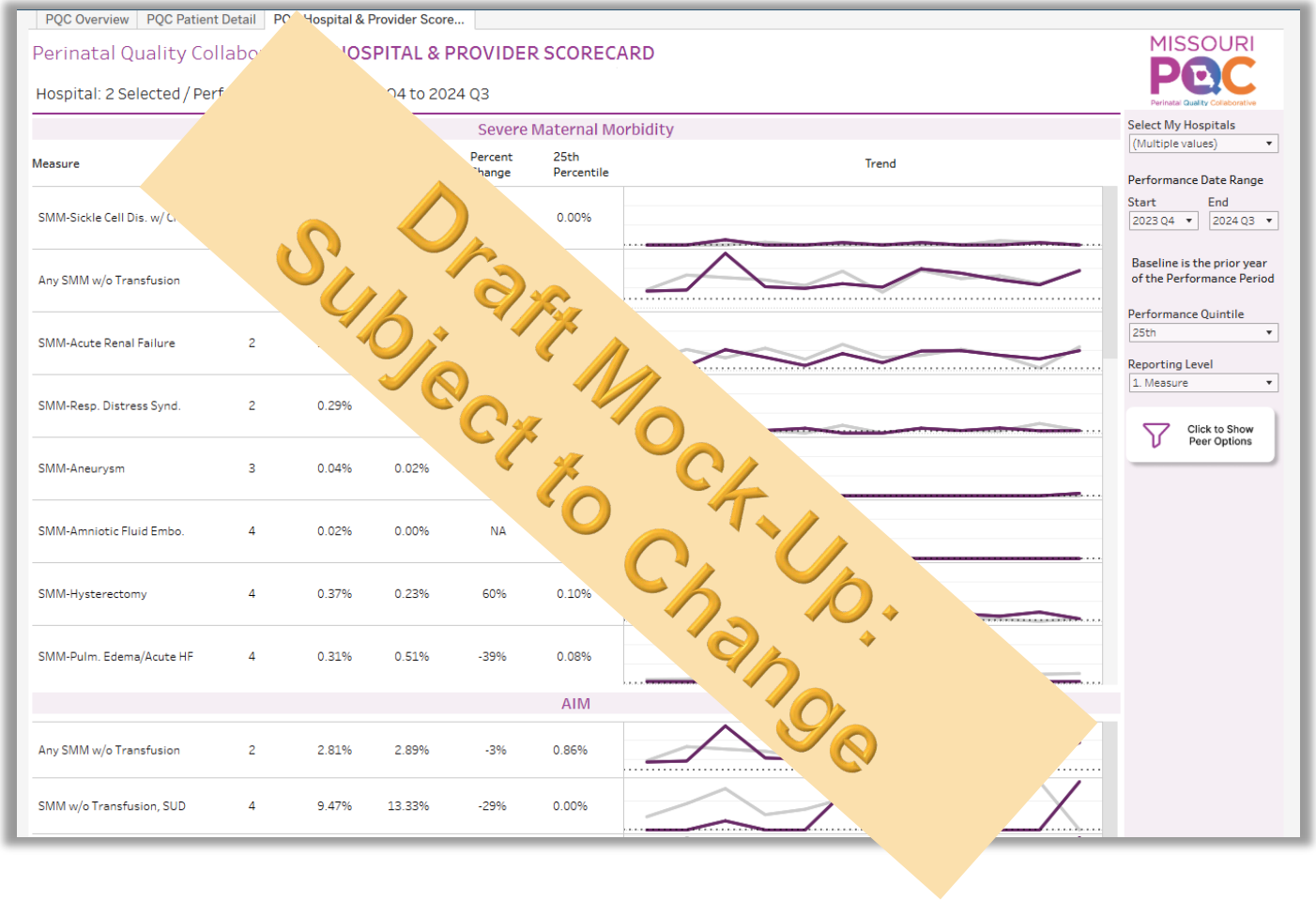
Discharge Date Range
Start: 2022 Q1
End: 2024 Q2

Patient Domain
SMM

Patient Conditions
Any SMM

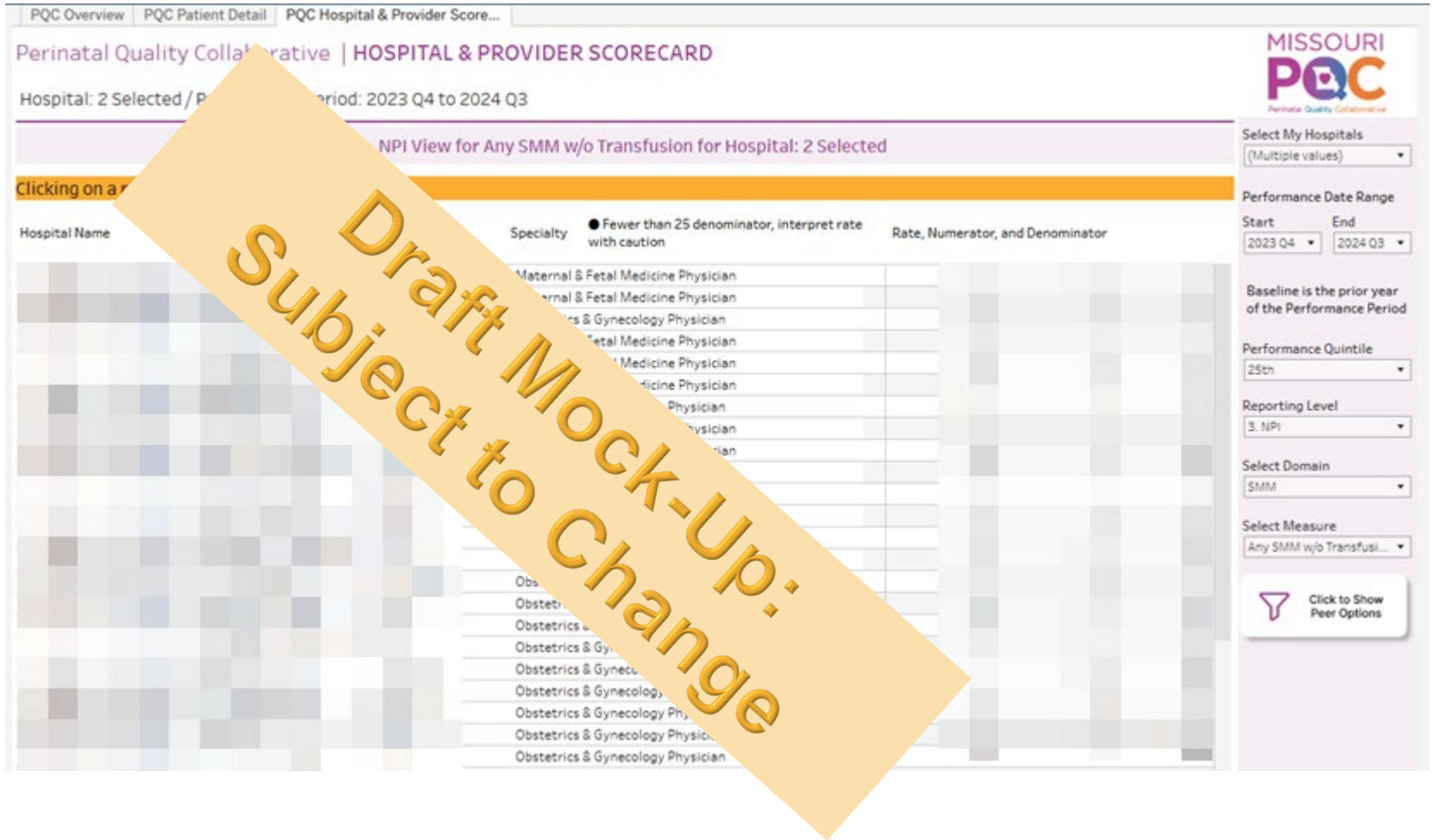
Comparative Scorecard Landing Page: All-Measure View

- Measure Domains:
  - CDC SMMs
  - AIM SMMs
- Performance Comparatives:
  - Measure ranks
  - Configurable performance vs. baseline periods (percent change and trendlines)
  - Configurable percentiles (e.g. 25th, 50th, 75th)
  - Customized peer benchmarks
- Drill Through Functionality:
  - Double clicking any measure advances user to scorecard drill level 1, displaying the hospital's rank view on individual selected measure.



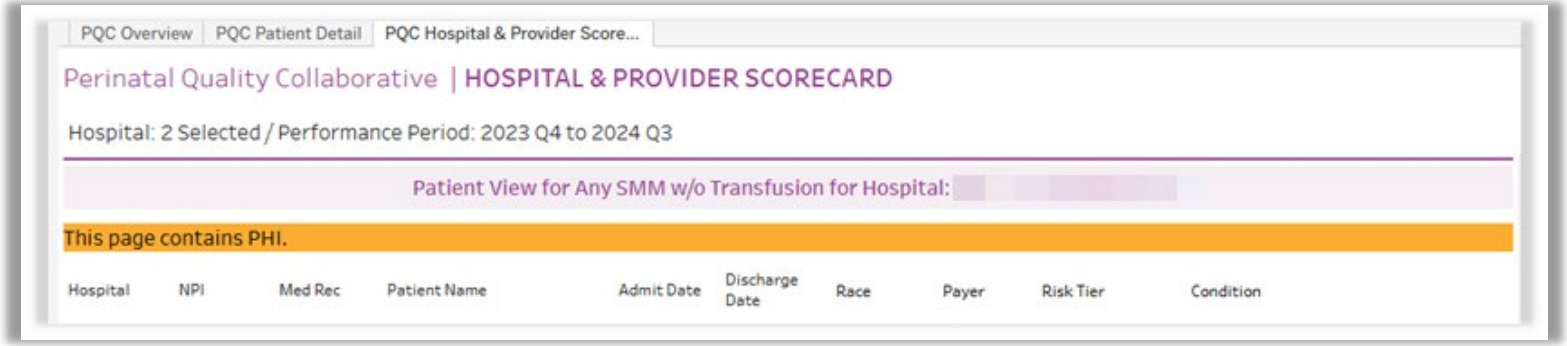
Comparative Scorecard Drill Level 3: Hospital Physician View

- Measure Domains:
  - CDC SMMs
  - AIM SMMs
- Performance Comparatives:
  - Physician hospital, name, NPI & NPI taxonomy (e.g., Obstetrics & Gynecology)
  - Ranked descending by selected measure rate for attendings with > 24 cases
  - Measure rate, numerator and denominator
  - Unreliable flag for attendings with < 25 cases
  - Mean predicted risk for the Attending Provider's patients for risk-adjusted context (forthcoming)
- Drill Through Functionality:
  - Double-clicking any physician advances the user to scorecard drill level 3, displaying the physician's specific patient list for event positives.



Comparative Scorecard Drill Level 4: Physician-Specific Patient List for Event Positives

- Measure Domains:
  - CDC SMMs
  - AIM SMMs
- Content:
  - Hospital
  - Attending NPI #
  - Patient name & medical record number
  - Labor & Delivery service dates
  - Race
  - Primary expected payer
  - Patient's predicted risk for risk-adjusted context Condition(s) patient experienced
- Key Functionality:
  - Provides visibility into which patients experienced which adverse outcome.
  - Work with OB-GYNs on the SMM predictive modeling team illuminated the disconnect they have in understanding when SMMs occur due to opaque chart-to-billing code abstraction processes.



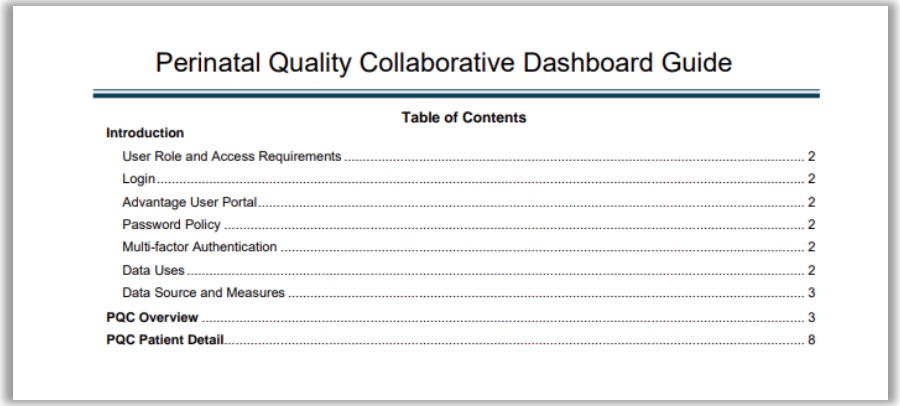
Draft Mock-Up: Subject to Change

First Year Goals

- Engaging use
- Supporting building competency in using the dashboards and scorecards
- Supporting stronger, accurate data submission – especially process measures to tie to outcomes
- Building capacity to code SDOH codes and modifiers
- Supporting SSM case reviews for QI learning purposes

Helpful Resources

- Technical specifications manual
- In-dashboard accessible guide
- MO PQC and HIDI team members
- Informational webinar – on-demand recording forthcoming
- Dashboard scenarios worksheet



Perinatal Quality Collaborative Dashboard Guide

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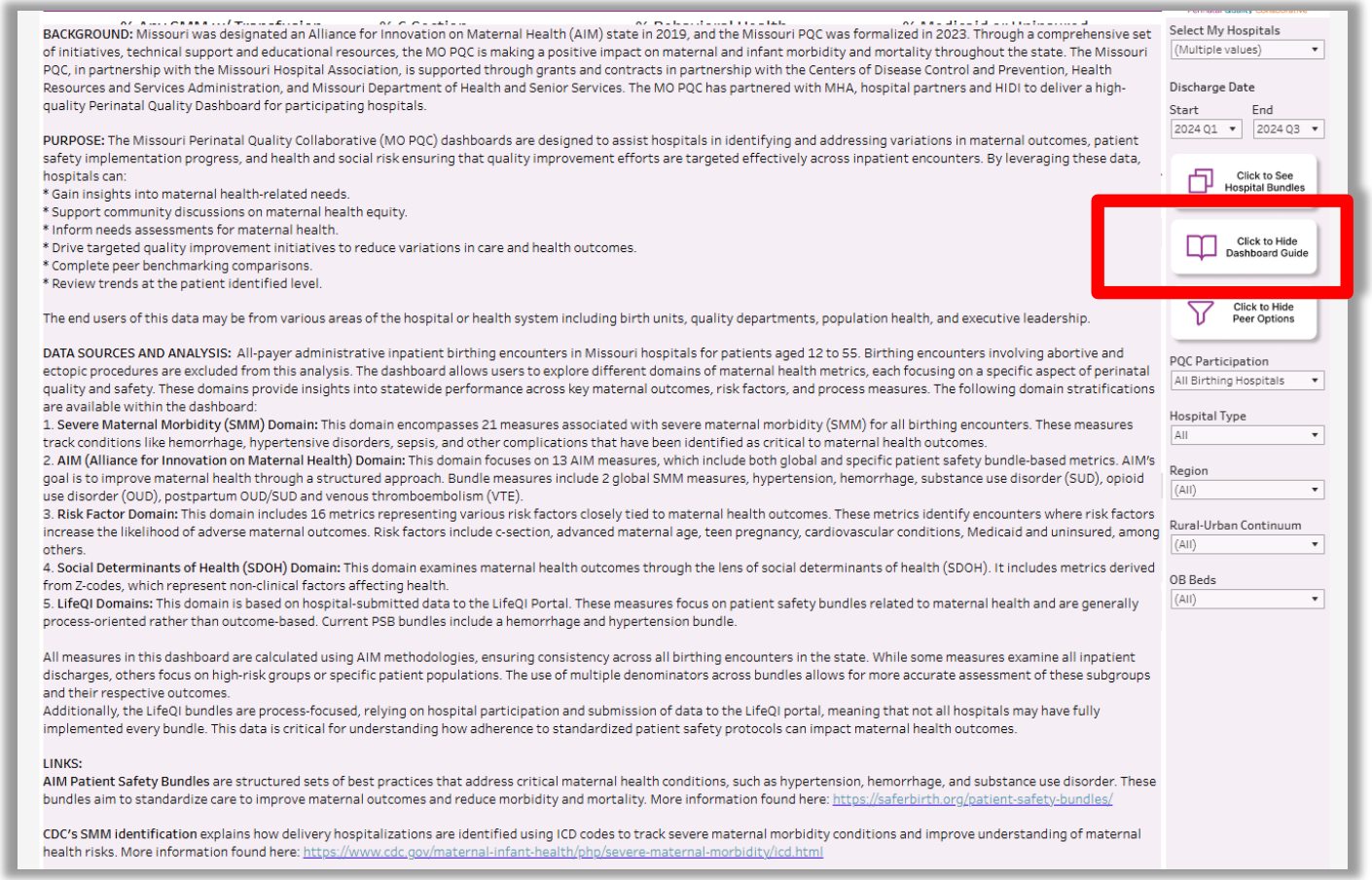

BACKGROUND: Missouri was designated an Alliance for Innovation on Maternal Health (AIM) state in 2019, and the Missouri PQC was formalized in 2023. Through a comprehensive set of initiatives, technical support and educational resources, the MO PQC is making a positive impact on maternal and infant morbidity and mortality throughout the state. The Missouri PQC, in partnership with the Missouri Hospital Association, is supported through grants and contracts in partnership with the Centers of Disease Control and Prevention, Health Resources and Services Administration, and Missouri Department of Health and Senior Services. The MO PQC has partnered with MHA, hospital partners and HIDI to deliver a high-quality Perinatal Quality Dashboard for participating hospitals.

PURPOSE: The Missouri Perinatal Quality Collaborative (MO PQC) dashboards are designed to assist hospitals in identifying and addressing variations in maternal outcomes, patient safety implementation progress, and health and social risk ensuring that quality improvement efforts are targeted effectively across inpatient encounters. By leveraging these data, hospitals can:
* Gain insights into maternal health-related needs.
* Support community discussions on maternal health equity.
* Inform needs assessments for maternal health.
* Drive targeted quality improvement initiatives to reduce variations in care and health outcomes.
* Complete peer benchmarking comparisons.
* Review trends at the patient identified level.

The end users of this data may be from various areas of the hospital or health system including birth units, quality departments, population health, and executive leadership.

DATA SOURCES AND ANALYSIS: All-payer administrative inpatient birthing encounters in Missouri hospitals for patients aged 12 to 55. Birthing encounters involving abortive and ectopic procedures are excluded from this analysis. The dashboard allows users to explore different domains of maternal health metrics, each focusing on a specific aspect of perinatal quality and safety. These domains provide insights into statewide performance across key maternal outcomes, risk factors, and process measures. The following domain stratifications are available within the dashboard:
1. **Severe Maternal Morbidity (SMM) Domain:** This domain encompasses 21 measures associated with severe maternal morbidity (SMM) for all birthing encounters. These measures track conditions like hemorrhage, hypertensive disorders, sepsis, and other complications that have been identified as critical to maternal health outcomes.
2. **AIM (Alliance for Innovation on Maternal Health) Domain:** This domain focuses on 13 AIM measures, which include both global and specific patient safety bundle-based metrics. AIM's goal is to improve maternal health through a structured approach. Bundle measures include 2 global SMM measures, hypertension, hemorrhage, substance use disorder (SUD), opioid use disorder (OUD), postpartum OUD/SUD and venous thromboembolism (VTE).
3. **Risk Factor Domain:** This domain includes 16 metrics representing various risk factors closely tied to maternal health outcomes. These metrics identify encounters where risk factors increase the likelihood of adverse maternal outcomes. Risk factors include c-section, advanced maternal age, teen pregnancy, cardiovascular conditions, Medicaid and uninsured, among others.
4. **Social Determinants of Health (SDOH) Domain:** This domain examines maternal health outcomes through the lens of social determinants of health (SDOH). It includes metrics derived from Z-codes, which represent non-clinical factors affecting health.
5. **LifeQI Domains:** This domain is based on hospital-submitted data to the LifeQI Portal. These measures focus on patient safety bundles related to maternal health and are generally process-oriented rather than outcome-based. Current PSB bundles include a hemorrhage and hypertension bundle.

All measures in this dashboard are calculated using AIM methodologies, ensuring consistency across all birthing encounters in the state. While some measures examine all inpatient discharges, others focus on high-risk groups or specific patient populations. The use of multiple denominators across bundles allows for more accurate assessment of these subgroups and their respective outcomes.
Additionally, the LifeQI bundles are process-focused, relying on hospital participation and submission of data to the LifeQI portal, meaning that not all hospitals may have fully implemented every bundle. This data is critical for understanding how adherence to standardized patient safety protocols can impact maternal health outcomes.

LINKS:
AIM Patient Safety Bundles are structured sets of best practices that address critical maternal health conditions, such as hypertension, hemorrhage, and substance use disorder. These bundles aim to standardize care to improve maternal outcomes and reduce morbidity and mortality. More information found here: https://saferbirth.org/patient-safety-bundles/

CDC's SMM identification explains how delivery hospitalizations are identified using ICD codes to track severe maternal morbidity conditions and improve understanding of maternal health risks. More information found here: https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/icd.html

Select My Hospitals
(Multiple values)
Discharge Date
Start 2024 Q1
End 2024 Q3
Click to See Hospital Bundles
Click to Hide Dashboard Guide
Click to Hide Peer Options
PQC Participation
All Birthing Hospitals
Hospital Type
All
Region
(All)
Rural-Urban Continuum
(All)
OB Beds
(All)

Access & Future Learning Options

- MO PQC Dashboards: Technical Review and Data Use Scenarios webinar
  - March 13, 2025, noon to 1:00 p.m.
  - Register here
- Please contact Mary Conley at mconley@mhanet.com to receive the HIDI Dashboards access form – requires CEO signature

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Cardiac Conditions in Obstetric Care Project

CCOC Project Updates

- Data
- Mentors
- Key Project Implementations
  - Screenings
  - Pregnancy heart teams
  - Emergency Department engagement
  - Transition of care and referrals
  - Education on cardiac conditions and respectful and equitable care

Sample Collection

- Hospitals report process measures using a random sampling method.
- From the list of patients with an ICD-10 diagnosis code(s) discharged for birth in each month, the organization should randomly sample **10 ten charts**.
- If less than 10 birth discharges have an ICD-10 code, then 100% of birth discharges with a code for cardiovascular diagnosis should be abstracted for the project's outcome and process measures.
- To meet MO AIM Stars criteria, organizations must submit a minimum of 85% of the total eligible data points in the project data capture period, including baseline and sustainability phase data capture.

Data – Baseline Processes Measures

- Baseline period timeframe is Q4 2024
- Intervention period begins January 2025
- October data was due Dec 1
  - P1: 6 hospitals reported data
  - P2: 5 hospitals reported data
- November data was due Jan 1
  - P1: 4 hospitals reported data
  - P2: 2 hospitals reported data
- December data is due Feb 1
- P1: Risk Assessment data for Oct – Dec = 36/41
- P2: Multi-D care plan data for Oct – Dec = 25/28

Measure Name	Measure Definition	Measure Source	Report As/Frequency
CCOC P1: Standardized Pregnancy Risk Assessments for People with Cardiac Conditions	*Denominator:* Patients diagnosed with cardiac conditions by birth discharge. *Numerator:* Among the denominator, those who received a pregnancy risk classification using a standardized cardiac risk assessment tool. **Inclusion criteria:** Organizations should count any cardiac screening completed from first prenatal appointment through birth discharge. Screening can occur in any health care setting. Examples of standardized pregnancy risk assessment tools include mWHO, CARPREG I, CARPREG II, ZAHARA. ➢ Risk comparison ➢ Risk comparison and prediction ***Note:** ACOG recommends universal screening of every patient upon initial prenatal visit and as needed throughout the prenatal/postpartum phase. Universal screening supports health equity constructs.	Hospital Chart Abstraction – The prenatal record and hospital admission record should be abstracted	Stratified by race and ethnicity in the Life QI portal: Non-Hispanic Black, Non-Hispanic White, Hispanic, Mixed Race, Other, Declined Monthly Oct. data due Dec 1 Nov. data due Jan 1; ongoing
CCOC P2: Multidisciplinary Care Plan for Pregnant People with Cardiac Conditions	*Denominator:* Patients diagnosed with cardiac conditions by birth discharge. *Numerator:* Among the denominator, those who had a multidisciplinary care plan for birth established by time of their birth discharge. **Inclusion criteria:** Counseling should have occurred at least once prenatally or during a patient's hospitalization for birth.	Hospital Chart Abstraction – The prenatal record and hospital admission record should be abstracted	Stratified by race and ethnicity in the Life QI portal: Non-Hispanic Black, Non-Hispanic White, Hispanic, Mixed Race, Other, Declined Monthly Oct. data due Dec 1 Nov. data due Jan 1; ongoing

Data – Baseline Outcome Measures

- Baseline period timeframe is Q4 2024
- Intervention period begins Q1 2025
- Outcome Measures
  - Q4 2024 data due February 1

Measure Name	Measure Definition	Measure Source	Report As/Frequency
CCOC O1: NTSV Cesarean Birth Rate Among People with Cardiac Conditions	*Denominator:* Among People with Cardiac Conditions, those with live births who have their first birth ≥ 37 completed weeks gestation and have a singleton in vertex (Cephalic) position. *Numerator:* Among the denominator, those with Cesarean Birth	Hospital Chart Abstraction	Quarterly Oct. – Dec. 2024 due Feb. 1 Jan. – Mar. 2025 due May 1; ongoing
CCOC O2: Preterm Birth Rate Among People with Cardiac Conditions	*Denominator:* Singleton live births among people with known cardiac conditions *Numerator:* Among the denominator, preterm live births (<37 completed weeks gestation)	Hospital Chart Abstraction	Quarterly Oct. – Dec. 2024 due Feb. 1 Jan. – Mar. 2025 due May 1; ongoing

Upcoming Events

EDUCATIONAL WEBINARS

- Wed, Feb 5, 12-12:30 p.m., webinar, CCOC Toolkit Webinar
- Tues, Feb 11, 10-11:00 a.m., webinar, Data Assistance and Support Call
- Wed, Mar 19, 10:00 a.m.-12:00 p.m., webinar, Spring 2025 Diabetes Shared Learning Network Meeting
- Wed, Mar 26, 10-11:30 a.m., webinar, CCOC - Elevating Patient Involvement and Experience in Healthcare

MISSOURI PQC
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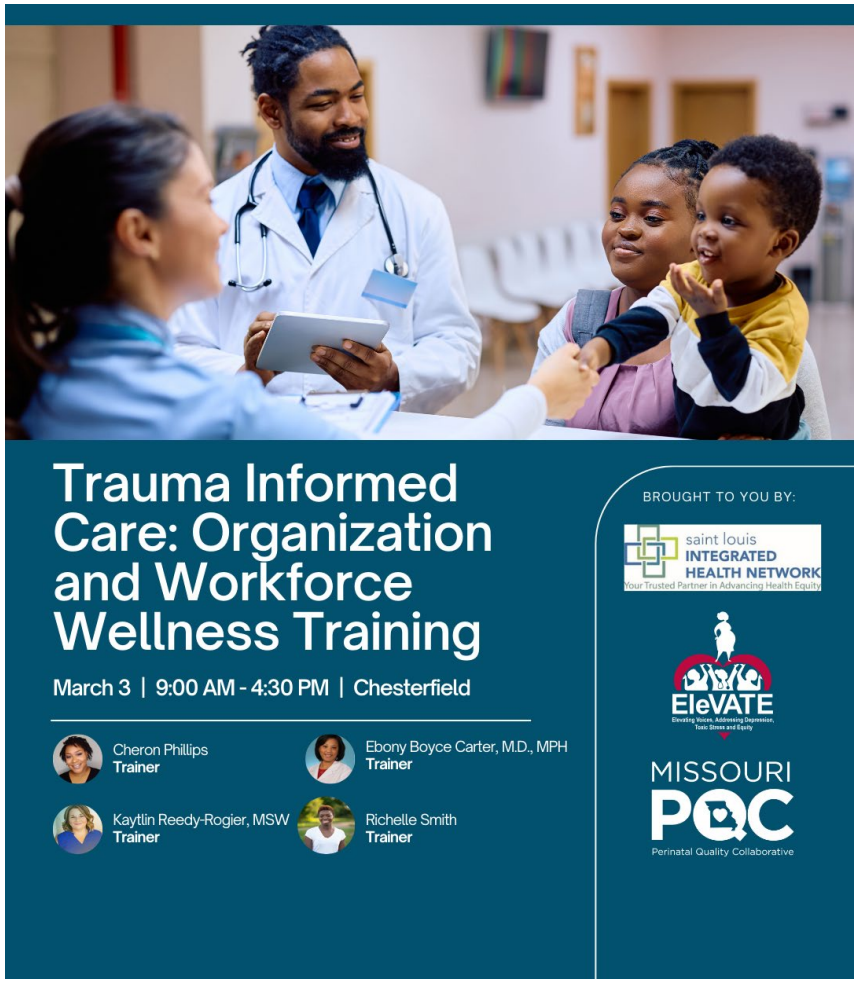
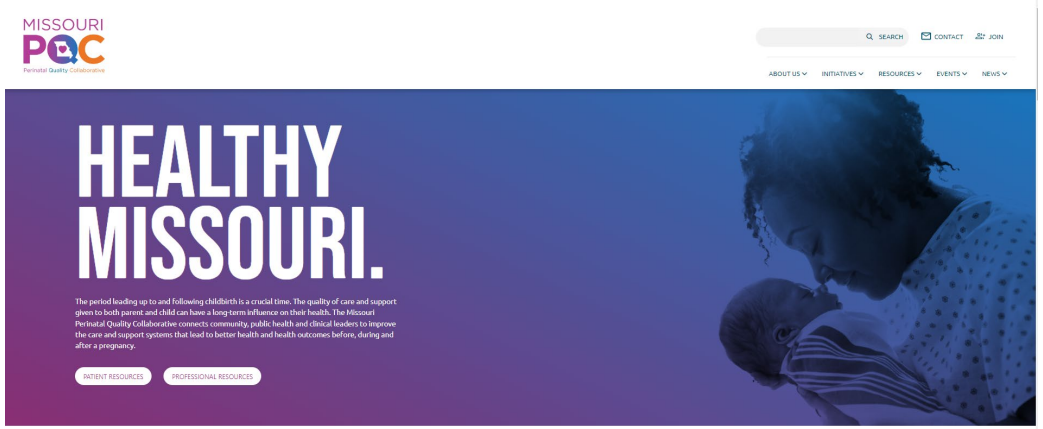
March 3: Trauma Informed Care: Organization and Workforce Wellness Training



March 4-5: Changing Missouri's Birth Story: 2025 Maternal & Infant Health Convening

MO PQC Website - Resources

MISSOURI PQC
Perinatal Quality Collaborative



Our website is live!

www.mopqc.org

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Questions?