FBP Women's Health

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Agenda

- Healthy Beginnings Program
  - Shauri Kagie
- Best Practice: Screenings
  - Paulette Hadley
- 2023 Program Updates
  - Kari Hardy
- Q & A

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WH Medical Home

Healthy Beginnings

Shauri Kagie, MSN, RN
Healthy Connections Director,
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Healthy Beginnings

A prenatal education and high-risk identification program

The goal of this program is to increase the potential for healthy pregnancies and full-term births while lowering overall medical expenses

Cash incentives offered for pre and postnatal care (per plan)

Other perks: prenatal booklet, 3 new burp clothes and a breast pump

Depression screenings and ongoing care management for post partum depression

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Pregnant Member Identification

REFERRALS, Claims data and iCentra

Consider Referring for High-Risk Maternity Care Management

First time pregnancy	Short cervix	Preeclampsia	History of pre-term labor (37 weeks)
Gestational Diabetes and Diabetes	Multiples	History of miscarriage	Mental health history
Medical or medication history	Social Determinants of Health	Bleeding in any trimester	Uterine issues
Fetal anomaly	Hyperemesis	Post delivery complication	

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Healthy Beginnings Rack Card

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HEALTHY BEGINNINGS℠

HOW WE CAN HELP

Our Healthy Beginnings℠ program is designed to help you have the healthiest pregnancy possible. This prenatal program is available to you at **no extra cost,** and nurse care managers can offer:

- Support and education during your pregnancy
- Help with claims and benefit questions
- Community resources, such as Women, Infants, and Children (WIC) and food and transportation programs, etc.
- Education about childbirth, breastfeeding, and more
- Access to needed care

EXTRA PERKS

- Cash incentives for prenatal and postnatal care*
- Free online education through Intermountain Healthcare*
- A set of three burp cloths
- Help getting a breast pump after delivery

HOW TO ENROLL

Call us at **866-442-5052**, option 1 for Medicaid, option 2 for Commercial Monday through Friday, from 8:00 a.m. to 5:00 p.m. If calling after hours, please leave a message with a phone number and best time to reach you.

*based on plan type

SelectHealth obeys federal civil rights laws. We do not treat you differently because of your race, color, ethnic background or where you come from, age, disability, sex, religion, creed, language, social class, sexual orientation, gender identity or expression, and/or veteran status.

This information is available for free in other languages and alternate formats.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電

SelectHealth Advantage: **855-442-9900** (TTY: 711) / SelectHealth: **800-538-5038**

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Behavioral Health Support

Behavioral Resources

- Help facilitate connection with appropriate levels of care
- Provide Behavioral Health Care Management
- Help build healthy support systems
- Learn healthy coping skills (mindfulness, DBT, grounding, deep breathing, mindful journaling)

Substance Use

- **SuperRad** is specialty clinic that integrates MFM, addition specialists and resource management
- University of Utah Website, but is partnership that includes Intermountain Providers
- To enroll: call 801-581-8425

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Medicaid Differences

Incentives

- Gift Card Kohls $10, not cash

Social Determinants of Health

- Transportation
- WIC/Food Banks
- Community Health Workers

Behavioral Health Carved Out

- County Mental Health Providers

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County Mental Health Providers

Morgan	
Davis	**Davis BH 801-773-7060**
Salt Lake	**Optum/SL Co Div. of BH Svcs 385-468-4707**
Tooele	**Optum Tooele 800-640-5349**
Utah	**Wasatch BH 801-373-4760**
Summit	**Healthy U Behavioral 801-213-4104**
Wasatch	**Wasatch BH 435-654-3003/Any Med provider**
Duchesne Daggett Uintah San Juan	**Northeastern Counseling Ctr 844-824-6776** **-Vernal 435-789-6300** **-Roosevelt 435-725-6300** **-San Juan Counseling 435-678-2992**
Carbon Emery Grand	**Four Corners Community BH 435-637-7200**
Juab Millard Sanpete Sevier	**Central Utah Counseling Ctr 435-283-8400**

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Healthy Beginnings Program Outcomes

ER visits for pregnant members 26% lower

NICU stays 28% lower

Average costs for NICU stays 35% lower

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Healthy Beginnings Contact/Referral Information

Email:

- Commercial and Individual plans email: commercialumintake@imail.org
- Medicaid email: medicaidumintake@imail.org

- **Phone: 801-442-5052**
- **Fax: 801-442-0825**
- **SelectHealth Care Management Referral Form**

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Screening Best Practice

Wasatch OBGYN 4Ps and Depression Screening Process

Paulette Hadley, BSN,
Senior Practice
Manager

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Starting Out

Overview

- History of Participation in Medical Home
  - Test clinic
  - Reason for choosing current screening tools
- Clinic Process for Substance Use and Depression Screenings
  - Caregiver Roles & Responsibility
  - Use of EMR, charting
  - Scrubbing charts for missed screenings
- Barriers
  - Identify Biggest Barrier to implementation of screenings
  - Discuss effective solution to the barrier

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History of Participation in Medical Home

Starting out as a Test Clinic

What would be best possible flow for screening patients?

A. Started with when would be the best time to screen.

B. What will be the verbiage we use.

C. What screening tools will we use.

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Caregiver Roles & Responsibilities

MA/RN	Provider	RN
MA will screen for substance and depression at NOB appts, our 24-26 weeks (about 6 months) GA appt (GDM) and or 36-38 weeks (about 8 and a half months) GA appt(GBS) Enter in EMR ad hoc form in Ambulatory intakes.	Review screening has been done at these appt times. Send any referral needs to our RN's	Place referral to needed programs, MFM, Opioid Community Collaborative through Davis Behavioral Health or Weber Human Services. We have a MHI partner based in our office 3 days a week. Ensure screening is in EMR RN's do a 2–3 week post partum call and screen for social determinates of health along with the EPDS tool.

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Screening Champion

- Person caregivers can go to for any questions or concerns.
- Able to help with training staff on what changes come up.
- Attend MH Women's Health Meeting Scrub chart for missing screenings.

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Barriers with Screening

Remember to do the screenings.

**Caregivers comfort level asking the questions and following the process.*

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2023 Program Updates

Kari Hardy, RN,
Medical Home Coordinator,
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Overview

- Substance Use Disorder Screening Change
- Prenatal & Postpartum Depression Screening Changes
- New Measures
  - Chlamydia Screening
  - Social Determinants of Health (SDoH)
  - Appropriate Ultrasound
- New Requirement: QI Projects
  - Exclusive Breastfeeding Education
  - Intimate Partner Violence Screening

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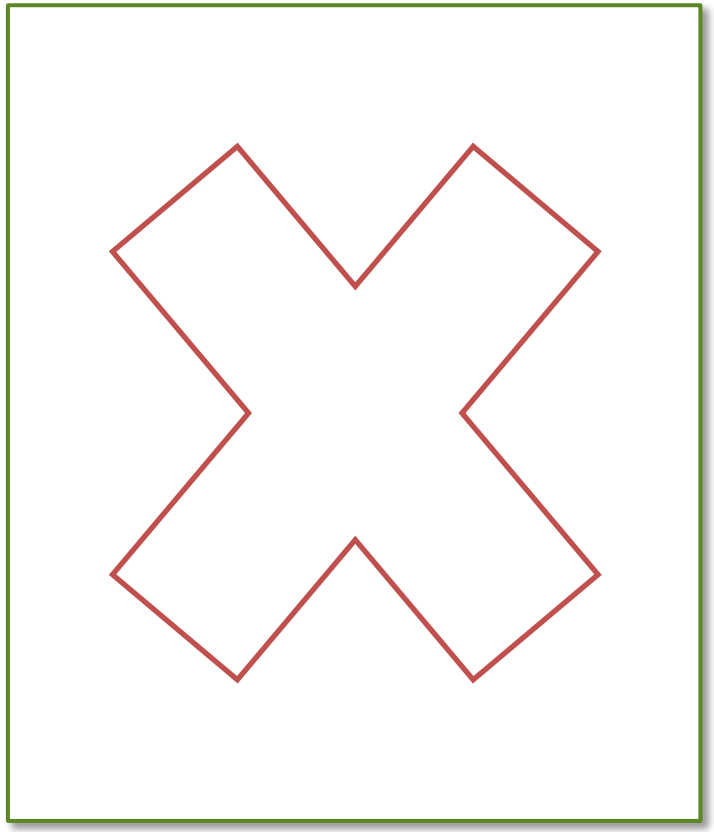
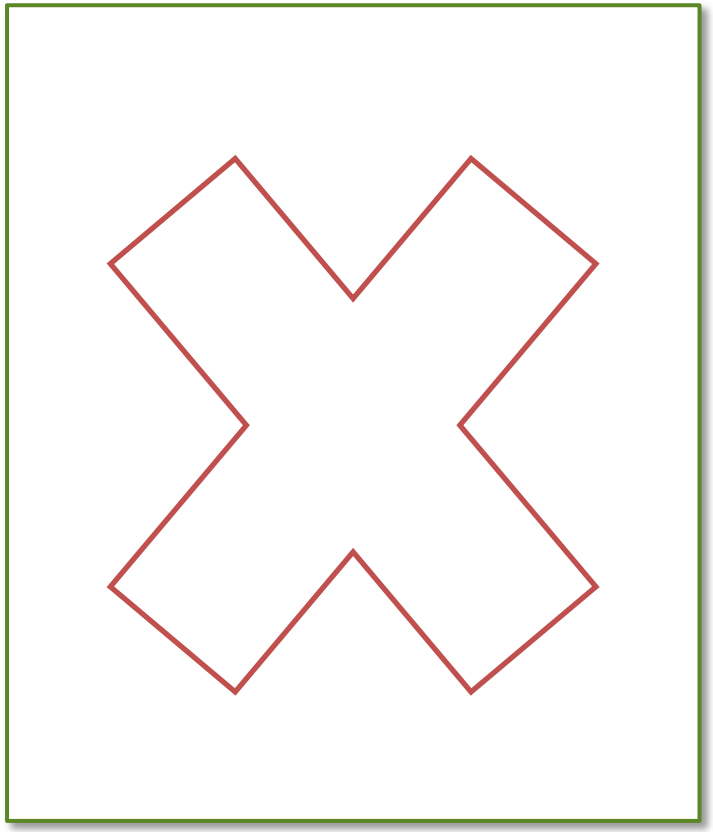
Substance Use Disorder (SUD) Screening Measure Change

- Only 1 SUD Screening per pregnancy will be required.
- Priority to obtain before 30 weeks' gestation.

SUD Screening #1



~~SUD Screening #2~~



~~SUD Screening #3~~

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Prenatal Depression Screening to be completed x1 during pregnancy:

- Credit for screening any time during pregnancy prior to delivery
- **Priority to obtain before 30 weeks' gestation**
- Emphasis on positive screening referral
  - Healthy Beginnings
  - Other Community Resources

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Postpartum Depression (PPD)Screening Changes:

- Screening range extended from 6 weeks to 12 weeks postpartum
- Aligns with ACOG & HEDIS
- Remove barriers to timely screenings:
  - Weekend Deliveries
  - Appointment Availability

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New Measure: Chlamydia Screening in Women (CHL)

1. The percentage of women 16-24 years of age who were identified as sexually active who had at least one test for chlamydia during the measurement year.
2. Two methods used to identify sexually active women are claim/encounter data and pharmacy data
3. Pregnancy test + a prescription for isotretinoin meets exclusion criteria.
4. An x-ray on the same day (or the 6 days following) a pregnancy test meets exclusion criteria

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New Measure: Social Determinants of Health (SDoH) Assessment

1. Complete an SDoH assessment on **all members** once in the calendar year.
    1. Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences tool (PRAPARE)
    2. American Academy of Family Physicians Short Form
    3. Health-Related Social Needs Screening Tool (AHC-HRSN)
2. These tests may be administered by clinical & nonclinical staff or self administered by the member.
3. For one or more positive screenings, bill using Z Codes Z55 – Z65
4. Refer members with positive screenings
    1. SelectHealth Healthy Beginnings for Pregnant Members
    2. SelectHealth Care Management
    3. Community Resources
5. Z Code Infographic: https://www.cms.gov/files/document/zcodes-infographic.pdf

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USING Z CODES:

The **Social Determinants of Health (SDOH)** Data Journey to Better Outcomes

What are Z codes

SDOH-related Z codes ranging from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.).

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship and age.

Step 1 Collect SDOH Data

Any member of a person's care team can collect SDOH data during any encounter.

- Includes providers, social workers, community health workers, case managers, patient navigators, and nurses.
- Can be collected at intake through health risk assessments, screening tools, person-provider interaction, and individual self-reporting.

Step 2 Document SDOH Data

Data are recorded in a person's paper or electronic health record (EHR).

- SDOH data may be documented in the problem or diagnosis list, patient or client history, or provider notes.
- Care teams may collect more detailed SDOH data than current Z codes allow. These data should be retained.
- Efforts are ongoing to close Z code gaps and standardize SDOH data.

Step 3 Map SDOH Data to Z Codes

Assistance is available from the ICD-10-CM Official Guidelines for Coding and Reporting.[1]

- Coding, billing, and EHR systems help coders assign standardized codes (e.g., Z codes).
- Coders can assign SDOH Z codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record.[2]

Step 4 Use SDOH Z Code Data

Data analysis can help improve quality, care coordination, and experience of care.

- Identify individuals' social risk factors and unmet needs.
- Inform health care and services, follow-up, and discharge planning.
- Trigger referrals to social services that meet individuals' needs.
- Track referrals between providers and social service organizations.

Step 5 Report SDOH Z Code Data Findings

SDOH data can be added to key reports for executive leadership and Boards of Directors to inform value-based care opportunities.

- Findings can be shared with social service organizations, providers, health plans, and consumer/patient advisory boards to identify unmet needs.
- A Disparities Impact Statement can be used to identify opportunities for advancing health equity.

CMS

For Questions: Contact the **CMS Health Equity Technical Assistance Program**

[1] https://www.cms.gov/medicare/icd-10/2022-icd-10-cm
[2] aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf

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USING SDOH Z CODES

Can Enhance Your Quality Improvement Initiatives

Health Care Administrators

Understand how SDOH data can be gathered and tracked using Z codes.

- Select an SDOH screening tool.
- Identify workflows that minimize staff burden.
- Provide training to support data collection.
- Invest in EHRs that facilitate data collection and coding.
- Decide what Z code data to use and monitor.

Develop a plan to use SDOH Z code data to:

- Enhance patient care.
- Improve care coordination and referrals.
- Support quality measurement.
- Identify community/population needs.
- Support planning and implementation of social needs interventions.
- Monitor SDOH intervention effectiveness.

Health Care Team

Use a SDOH screening tool.

- Follow best practices for collecting SDOH data in a sensitive and HIPAA-compliant manner.
- Consistently document standardized SDOH data in the EHR.
- Refer individuals to social service organizations and appropriate support services through local, state, and national resources.

Coding Professionals

Follow the ICD-10-CM coding guidelines.[3]

- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for ICD-10-CM codes and information on code usage.[4]
- Coding team managers should review codes for consistency and quality.
- Assign all relevant SDOH Z codes to support quality improvement initiatives.

Z code 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 physical environment
- **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

This list is subject to revisions and additions to improve alignment with SDOH data elements.

[3] https://www.cms.gov/medicare/icd-10/2022-icd-10-cm
[4] https://www.cdc.gov/nchs/icd/icd-10-cm.htm

Revision Date: June 2022

go.cms.gov/omh

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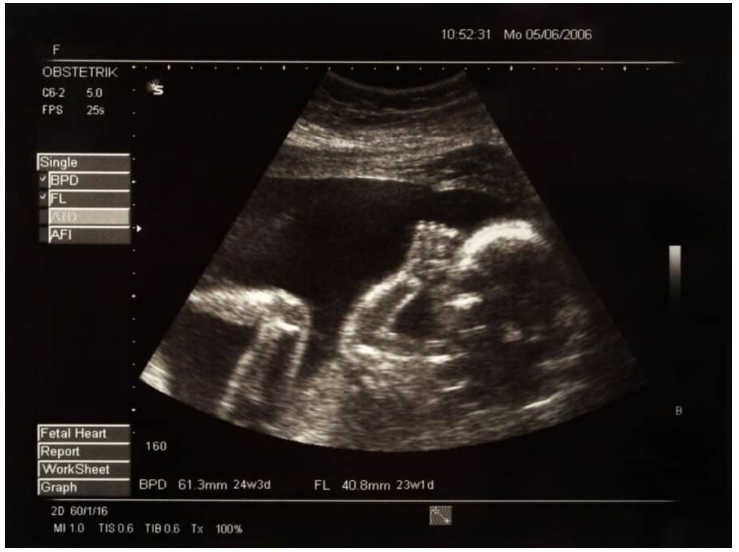
Appropriate Ultrasound During Normal Pregnancy:

- No more than 1 ultrasound after the first trimester (14 weeks).



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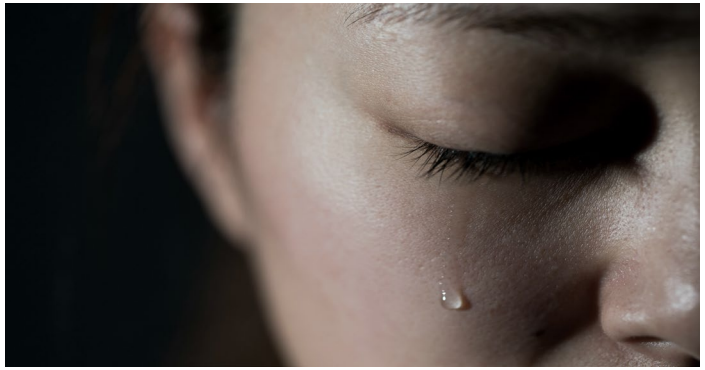
NEW REQUIREMENT

Complete 2 Quality Improvement Projects during 2023:

- Exclusivity of Breastfeeding Education
- Intimate Partner Violence (IPV) Screening

Exclusive Breastfeeding Education

Q1 & Q2



Intimate Partner Violence Screen

Q3 & Q4

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Thank You

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THANK YOU!

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