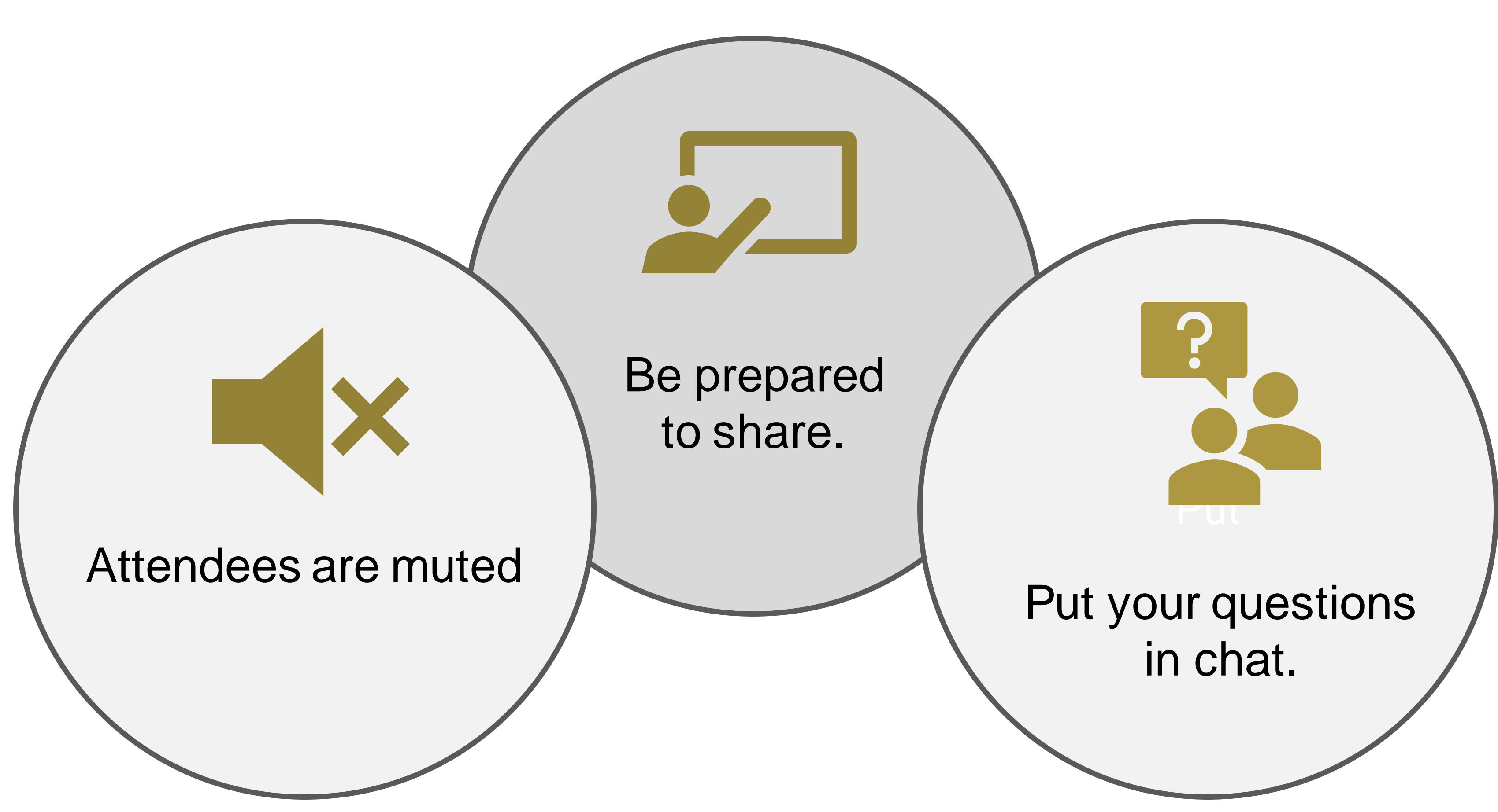
Session Two: Using Data to Bring Hard-to Reach Women in for Care

May 18, 2022

Housekeeping



Today's Agenda

- Overview of patient visit types, protocols and data to identify new opportunities for women to receive timely care.
- Discuss designing workflows to flag patients needing preventative health visits.
- Examine examples of using practice-level data to seek out patients for care.

Today's Presenters

Erin Aklestad
Mountain-Pacific Quality Health
Account Manager
eaklestad@mpqhf.org

Jeff Redekopp
Quality Health Associates of North Dakota
Quality Improvement Specialist
jredekopp@qualityhealthnd.org

Key Alaska Health Equity Facts

- 88% of boroughs are at least 25% white
- In 92% of boroughs, life expectancy is less than the U.S. average
- In 80% of boroughs, median household income less than the U.S. average
- In 92% of boroughs, at least half of residents lack broadband access
- 72% of boroughs have mental health professional shortages

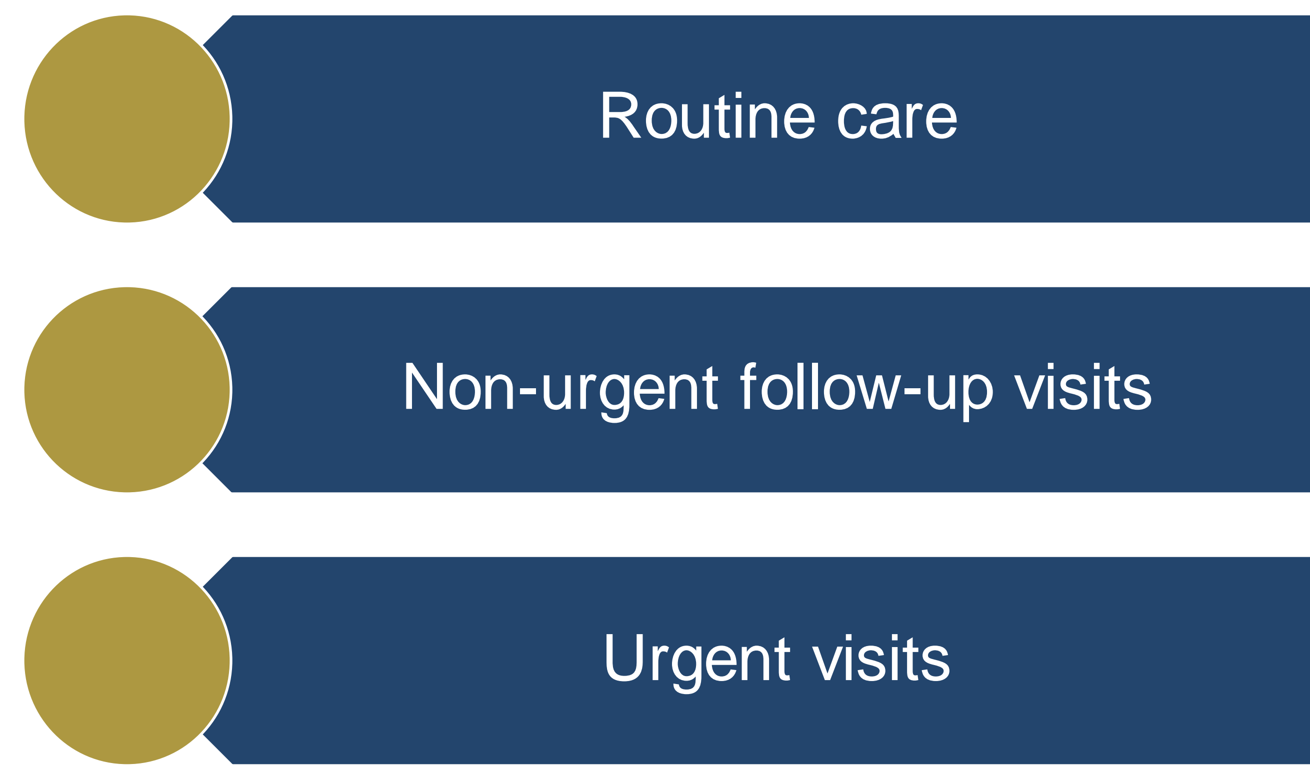
Source: Alaska Health Equity Facts

2019 Alaska Health Equity Index

Health Equity Domain	Most Disparate Region	Median Disparate Region	Least Disparate Region
Socio-economic status	Northern, Interior, Southwest	Gulf Coast, Southeast, portions of Southwest	Anchorage Municipality, Matansuka-Sustitna Borough
Household composition/disability	Most of Interior, much of Southeast, most of Northern, Matansuka-Sustitna Borough	Parts of Northern, parts of Southwest, parts of Gulf Coast	Parts of Southwest, Anchorage
Minority status and language	Much of Southwest and Northern	Interior, much of Southeast, Gulf Coast	Anchorage Municipality, Matansuka-Sustitna Borough, parts of Southeast
Housing and transportation	Parts of Interior, parts of Northern, parts of Southwestern and Gulf Coasts	Most of Northern, most of Southwest, most of Southeast	Anchorage Municipality, Matansuka-Sustitna Borough

Source: healthyakaskans.org

Evaluating Patient Visit Types



Factors Affecting Women's Preventative Care Visit Frequency

- Race/ethnicity
- High needs populations
- Uninsured/ underinsured
- Geography (remote locations)
- Areas with small clinics

Identifying Patients Due/Overdue for Well-Woman Visits and Cervical Cancer Screenings

Develop workflows to flag these patients:

1. No well-woman since first visit to the clinic:
   - Well-woman visit <12 months ago
   - Well-woman visit due <3 months

2. No cervical cancer screening first visit at the clinic
   - Last cervical cancer screening < 3 years ago
   - Cervical Cancer screening due <3 months

Tracking Systems

Manual	Electronic

• Log-Books
• Card Files
• File Folders
• Paper Checklist
• Calendar Reminders
	• Electronic health record (EHR)
	  • Leverage customizable functions to advance efforts
	  • Quality Measure Reports

Polling Question #1:

What method does your clinic use to determine when a patient is due for a well-woman visit or cervical cancer screening?

Clinical Functions

- Empanelment
- Risk Stratification
- Social Determinants Of Health (SDOH) screening
- Team-Based Care

What is Empanelment?

Enhances patient centeredness

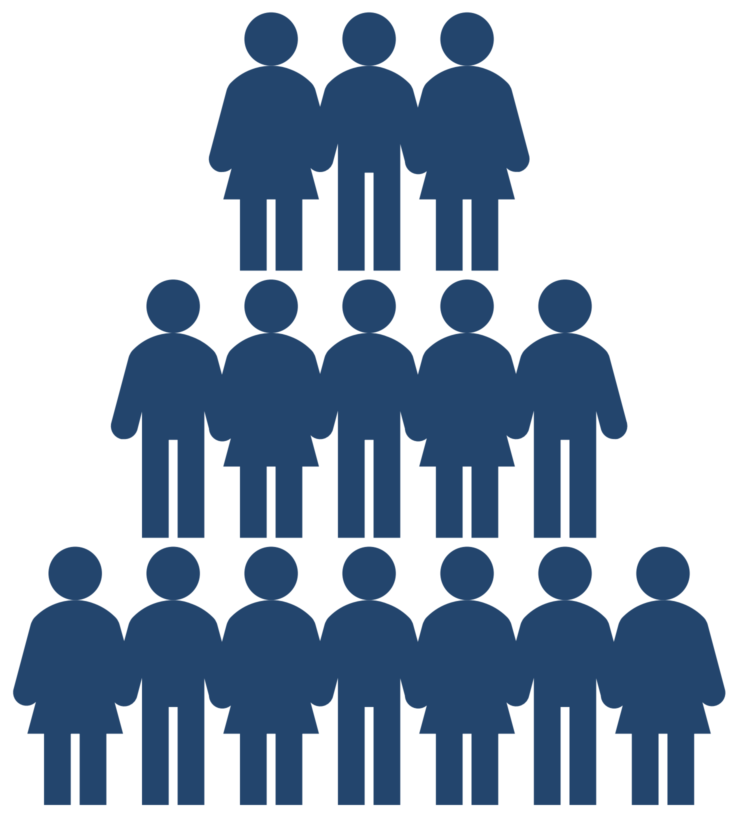
Better care for patients even when not seen often

Builds a lasting relationship

Improve continuity of care

Foster communication

Empower the patient/family in their care



What is risk stratification?

Use data analytics to determine risk

Identify patients needing higher level of care

Identify patients at lower risk needing preventative care

Adjust follow-up and assess need for care coordination

What is SDOH screening?

- Assessing patients for non-medical needs
- Understanding social factors impacting health
- Choosing a reliable and accurate tool
- Establishing a workflow for screening
- Implementing a process to address these needs

What is team-based care (TBC)?

- A group of health care professionals coordinating actions for a common purpose
- Collaboration to prevent and/or treat disease and promote health
- Actively engaging patients as full participants in their care
- Encouraging all team members to work to the full extent of their education, knowledge, skills and abilities

Polling Question #2:

What electronic health record (EHR) data are you currently using to identify gaps in care?

Practice Specific Data to Assess

Electronic Clinical Quality Measures:

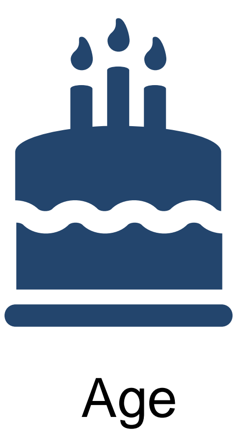
- CMS 124 – Cervical Cancer Screening
  - Percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:
    - Women aged 21-64 who had cervical cytology performed within the last three years
    - Women aged 30-64 who had cervical human papillomavirus (HPV) testing performed within the last five years

Practice Specific Data to Assess

Timely Lab Results

- Automate cervical cancer screening results so they flow directly from Lab into EHR
    - Implement an auto flag or reminder system
    - Work with EHR and lab vendors to design

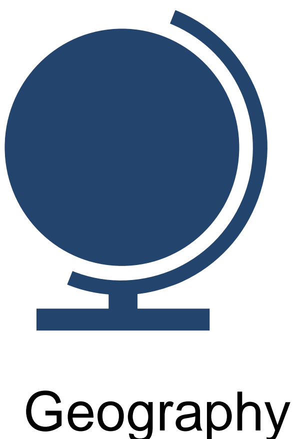
Practice Specific Data to Assess



Age

Ethnicity

Insurance Coverage



Geography

Demographic Data to Assess: Age

Target group: Ages 18-44

Lowest Well-Woman Attendance Rate: Ages 35-44

Lowest Cervical Cancer Screening Rate: Ages 18-24

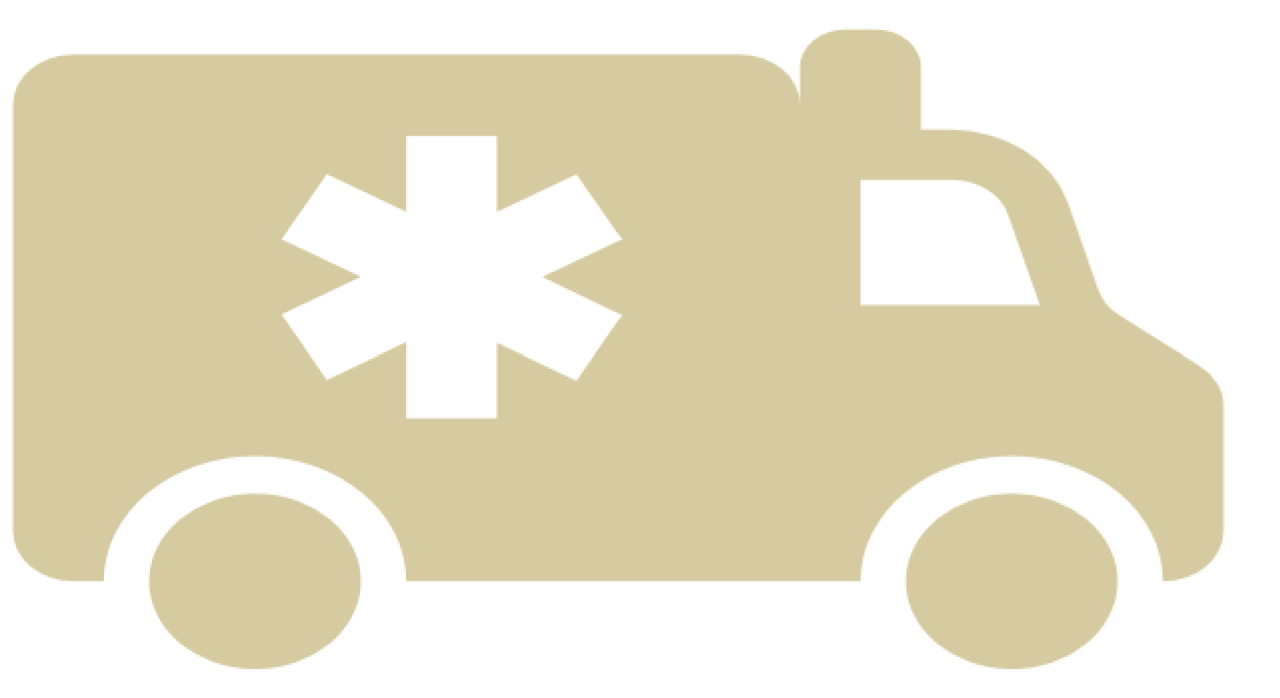
Demographic Data to Assess: Ethnicity

Target group: White Women

Lowest Well-Woman Attendance Rate: White Women

Lowest Cancer Screening Attendance Rate : White Women

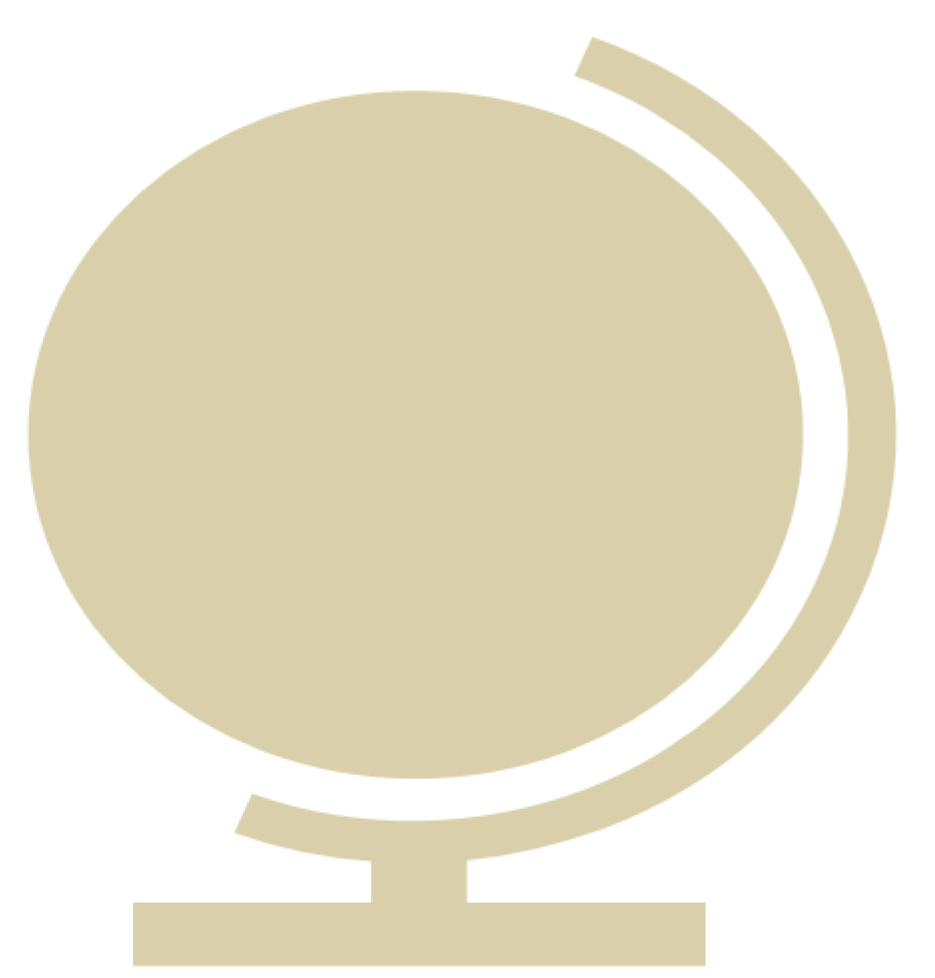
Demographic Data to Access: Insurance Coverage



Target Groups:

- Underinsured
- Uninsured
- Medicaid

Demographic Data to Access: Geography

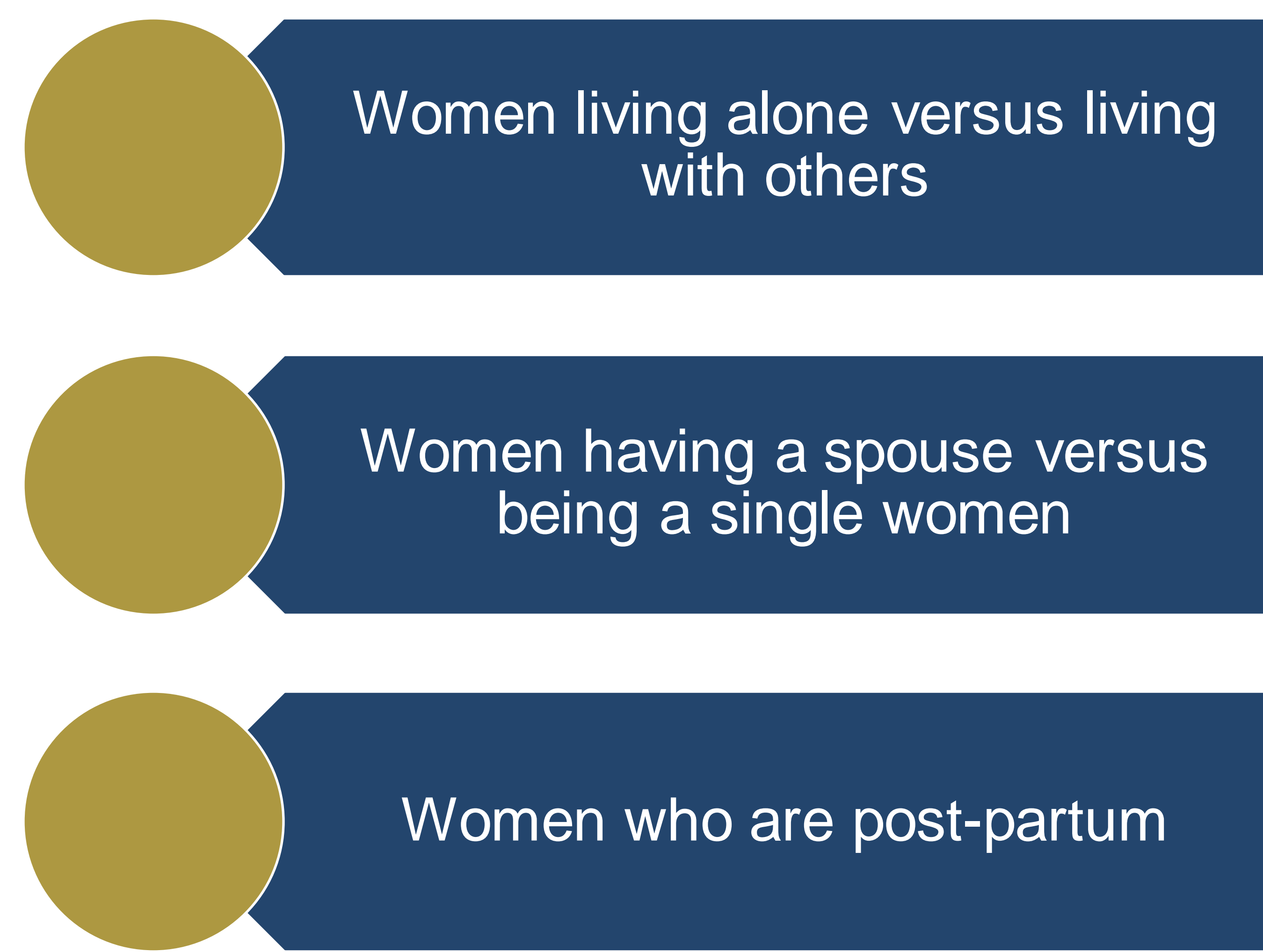


Target Regions:

Frontier Regions

Underserved Areas: Lacking enough well-trained women's health providers

Demographic Data to Access: Additional Factors



Maximizing Billing and Coding for Well-Woman Visits

Provide	Code	Check	Reserve	Instate	Train
Provide ABN for Medicare Annual Physician Exam	Code the Preventive Medicine Service	Check for Preventive Service Documentation	Reserve the CPT Mammograms Codes for X-Ray Center	Instate Strong Practice Management Policies	Train to Overcome Coding Challenges for Combined Visits

Source: Healthcare Training Leader

Maximizing Billing and Coding for Cervical Cancer Screenings

Coding Options:

Medicare (ICD-10-CM):	Commercial Insurance (CPT):
• HCPCS Code G0476: • Z01.411 • Z01.419 • Z12.4 • Z12.72 • Z08 • Z11.51	• If using CPT® preventive medicine services, and also performing a ***screening*** pap smear, report a code in 99381-99397 series and Q0091. • If using E/M codes for a symptom or condition and practitioner also obtains a pap smear, report only the E/M service.

Sources: Final WPSI Coding Guide 2021; CodingIntel,com

Polling Question #3:

Would you be interested in working on a quality improvement project to improve health outcomes for Alaskan women?

Participant Q & A

Resources:

- AAFP: Guide to Social Needs Screening
- America's Health Rankings: Health of Women and Children
- Kaiser Family Foundation: Women's Healthcare Utilization and Costs
- AAFP: How to Use Scheduling Data to Improve Efficiency
- NCBI: The Well-Woman Project: Listening to Women's Voices
- Medical Group Management Association: Measures Medical Practices Can Take to Improve Patient Access

Thank you for your attendance and participation!