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

May 18, 2022
Housekeeping

- Attendees are muted
- Be prepared to share.
- Put your questions in chat.
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

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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

<table>
<thead>
<tr>
<th>Health Equity Domain</th>
<th>Most Disparate Region</th>
<th>Median Disparate Region</th>
<th>Least Disparate Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socio-economic status</td>
<td>Northern, Interior, Southwest</td>
<td>Gulf Coast, Southeast, portions of Southwest</td>
<td>Anchorage Municipality, Matansuka-Sustitna Borough</td>
</tr>
<tr>
<td>Household composition/disability</td>
<td>Most of Interior, much of Southeast, most of Northern, Matansuka-Sustitna Borough</td>
<td>Parts of Northern, parts of Southwest, parts of Gulf Coast</td>
<td>Parts of Southwest, Anchorage</td>
</tr>
<tr>
<td>Minority status and language</td>
<td>Much of Southwest and Northern</td>
<td>Interior, much of Southeast, Gulf Coast</td>
<td>Anchorage Municipality, Matansuka-Sustitna Borough, parts of Southeast</td>
</tr>
<tr>
<td>Housing and transportation</td>
<td>Parts of Interior, parts of Southern and Gulf Coasts</td>
<td>Most of Northern, most of Southeast, most of Gulf Coast</td>
<td>Anchorage Municipality, Matansuka-Sustitna Borough</td>
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</tbody>
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*Source: healthyakaskans.org*
Evaluating Patient Visit Types

- Routine care
- Non-urgent follow-up visits
- Urgent visits
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

<table>
<thead>
<tr>
<th>Manual</th>
<th>Electronic</th>
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</thead>
<tbody>
<tr>
<td>• Log-Books</td>
<td>• Electronic health record (EHR)</td>
</tr>
<tr>
<td>• Card Files</td>
<td>• Leverage customizable functions to advance efforts</td>
</tr>
<tr>
<td>• File Folders</td>
<td>• Quality Measure Reports</td>
</tr>
<tr>
<td>• Paper Checklist</td>
<td></td>
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<tr>
<td>• Calendar Reminders</td>
<td></td>
</tr>
</tbody>
</table>
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

- Women living alone versus living with others
- Women having a spouse versus being a single woman
- Women who are post-partum
Maximizing Billing and Coding for Well-Woman Visits

- **Provide**: Provide ABN for Medicare Annual Physician Exam
- **Code**: Code the Preventive Medicine Service
- **Check**: Check for Preventive Service Documentation
- **Reserve**: Reserve the CPT Mammograms Codes for X-Ray Center
- **Instate**: Instate Strong Practice Management Policies
- **Train**: 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):
- HCPCS Code G0476:
  - Z01.411
  - Z01.419
  - Z12.4
  - Z12.72
  - Z08
  - Z11.51

#### Commercial Insurance (CPT):
- 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!