Community HealthChoices

Women's Health Initiative

Managed Long-Term Services and Supports (MLTSS) Subcommittee Meeting
December 6, 2023

Medical Director
Office of Long-Term Living

Medical Directors from CHC Health Plans

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Women's Health Initiative

- Women’s Health Focus
- Women’s Health in Community HealthChoices (CHC)
- Approach in 2023

Community HealthChoices

Women's Health Focus in Seniors

- Of the 48 million seniors living in America in 2016, about 55 percent (27 million) were women.
- Women have a higher life expectancy (81 years) then men (76 years).
- In the CHC Program, 59.6% of participants are women.
- Women have a higher chance of developing health issues in later years.

Community HealthChoices

Approach to Data:

- Inter-Resident Assessment Instrument (inter-RAI) Homecare Assessment Tool
- HealthCare Effectiveness Data and Information Set (HEDIS) Measures
- Pennsylvania Performance Measures

Key Diseases of Focus Affecting Elderly Women

- Cardiovascular Diseases (Hypertension and Strokes)
- Osteoporosis - Fracture and Fall Prevention
- Breast Cancer

Cardiovascular Disease in Women

- Cardiovascular disease kills more women than all forms of cancer combined.
- Cardiovascular disease is the Number 1 killer of women, causing 1 in 3 deaths each year.
- Only 44% of women recognize that Cardiovascular disease is their greatest health threat.

Community HealthChoices

Cardiovascular: Hypertension

- 51.9% of high blood pressure related deaths are in women.

- Out of all women, 57.6% of Black females have hypertension — more than any other race or ethnicity.

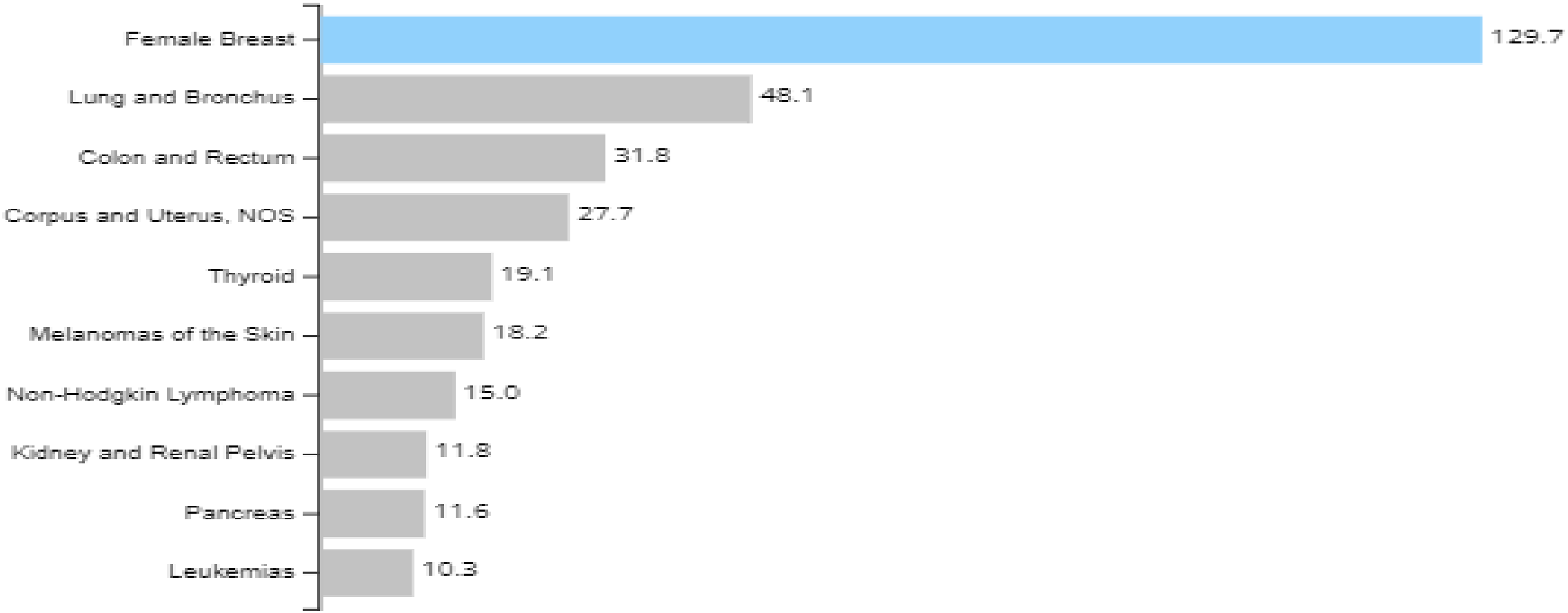
Community HealthChoices

Osteoporosis in Elderly Women

- Osteoporosis is common in the wrist and the spine. The hormone estrogen helps to make and rebuild bones. A woman's estrogen levels drop after menopause, and bone loss speeds up. That's why **osteoporosis is most common among older women**.
- Women over the age of 50 are four times more likely to suffer from osteoporosis and tend to have fractures 5-10 years earlier than men.
- In 2020 in Pennsylvania, 27.9% percent, or 616,159 of older adults fell and presented to an Emergency Room (ER).

Community HealthChoices

Top 10 Cancers by Rates of New Cancer Cases
United States, 2019, All Races and Ethnicities, Female



Community HealthChoices

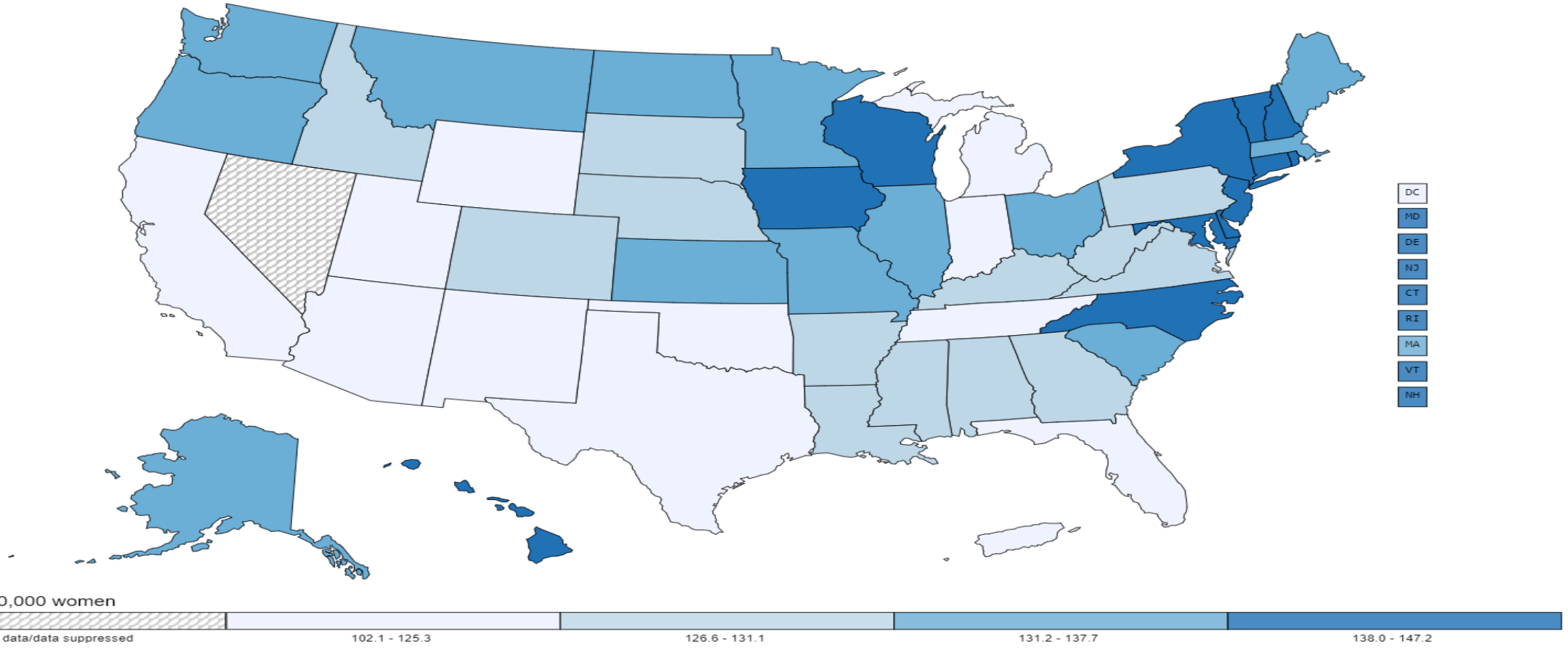
Top 10 Cancers by Rates of New Cancer Cases
United States, 2019, All Races and Ethnicities, Female

Rate per 100,000 women

Source - U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2021 submission data (1999-2019): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2022.

Rate of New Cancers in the United States, 2019

Female Breast, All Ages, All Races and Ethnicities, Female



Community HealthChoices

Rate of New Cancers in the United States, 2019

Female Breast, All Ages, All Races and Ethnicities, Female

Rate per 100,000 women

Source - U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2021 submission data (1999-2019): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; https://www.cdc.gov/cancer/dataviz, released in November 2022.

Community HealthChoices

Women's Health Initiative
Focus: Cardiovascular Disease

Managed Long-Term Services and Supports (MLTSS) Subcommittee Meeting

December 6, 2023

Presented by: Erica David-Park, MD, MBA, FAAPMR
Market Chief Medical Officer

AmeriHealth Caritas

CARE IS THE HEART OF OUR WORK℠

Delivering the Next Generation of Health Care

Our Cardiovascular Approach

- Utilizing inter-Resident Assessment Instrument (interRAI) Clinical Assessment Protocols (CAPs) for Targeted Participant Health Education
- Service Coordinator Education
- Data Analytics

interRAI CAPS Triggers

- interRAI CAPs are triggered using assessment questions.
- Responses to cardiovascular health questions are pulled into the Person-Centered Service Plan (PCSP) planning process and discussed with the Participant as a potential goal.
- The Service Coordinator discusses the importance of creating a goal regarding cardiovascular health with the Participant.
- If the Participant agrees the goal is created and Primary Care Practitioner (PCP) follow-up is encouraged to facilitate improved cardiovascular health.

interRAI CAPS Triggers, continued

Blood Pressure Measured in the Last Year:

- **1 – Yes**
- **0 – No**
- **NULL**

Stroke:

- 0 – Not present
- 1 – Primary diagnosis/diagnoses for current stay
- 2 – Diagnosis present, receiving active treatment
- 3 – Diagnosis present, monitored but no active treatment
- NULL

Action:
If 1, 2 or 3 provide educational handouts

Health Education Handouts

- Using interRAI cardiovascular CAPs responses, the Service Coordinator provides cardiovascular health education handouts.
- The cardiovascular health education handouts contain information to:
  - Promote health literacy and empowerment.
  - Encourage healthy behaviors and PCP follow-up.
- The Service Coordinator encourages the Participant to share handouts with Direct Care Workers (DCWs) and informal supports.

Health Equity – Controlling High Blood Pressure Solutions

- Recent clinical studies have documented racial and ethnic disparities in hypertension control with lower rates of control for non-Hispanic Black and Hispanic people as compared to non-Hispanic White individuals. [1,2]
- Text campaign targeting African American/Black and Hispanic/Latino Participants.
- Increase in community educational events in regions with strong African American/Black and Hispanic/Latino presence.
- Targeted culturally responsive education and awareness.
- Emphasis on hiring bilingual associates.
- Education, in-person and virtually, through the Health Plan's Participant Advisory Committee (PAC).

[1] https://link.springer.com/article/10.1007/s11886-022-01826-x
[2] https://www.ahajournals.org/doi/10.1161/HYPERTENSIONAHA.121.17570

Controlling High Blood Pressure Healthcare Effectiveness Data and Information Set (HEDIS) Initiative

- Pilot program with 77 Participants in the Southeast with the following criteria:
  - African American female
  - Non-compliant with HEDIS for multiple years
  - Vulnerable in health literacy
  - Medication non-compliance

- Targeted education to the Participants and PCPs including:
  - Blood pressure monitoring for self-checks
  - Pharmacy benefit for blood pressure monitors
  - Pillboxes for medication adherence
  - Provider toolkit developed by the Health Plan's Health Equity team
  - Culturally-specific educational documents

Questions?

UPMC
LIFE CHANGING MEDICINE

Women's Health Initiatives 2023

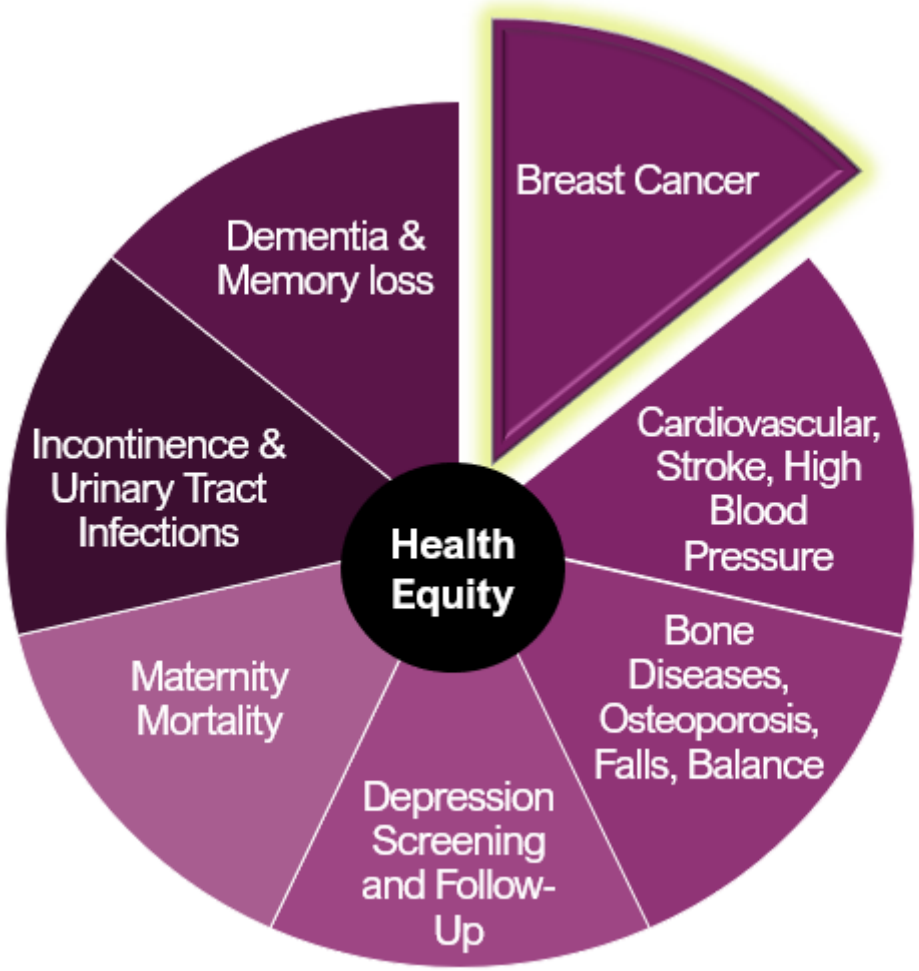
UPMC Community HealthChoices (CHC)

Managed Long-Term Services & Supports (MLTSS) Subcommittee
December 6, 2023

Crystal Clark, MD MPH
Chief Medical Officer
UPMC Community HealthChoices

UPMC Community HealthChoices

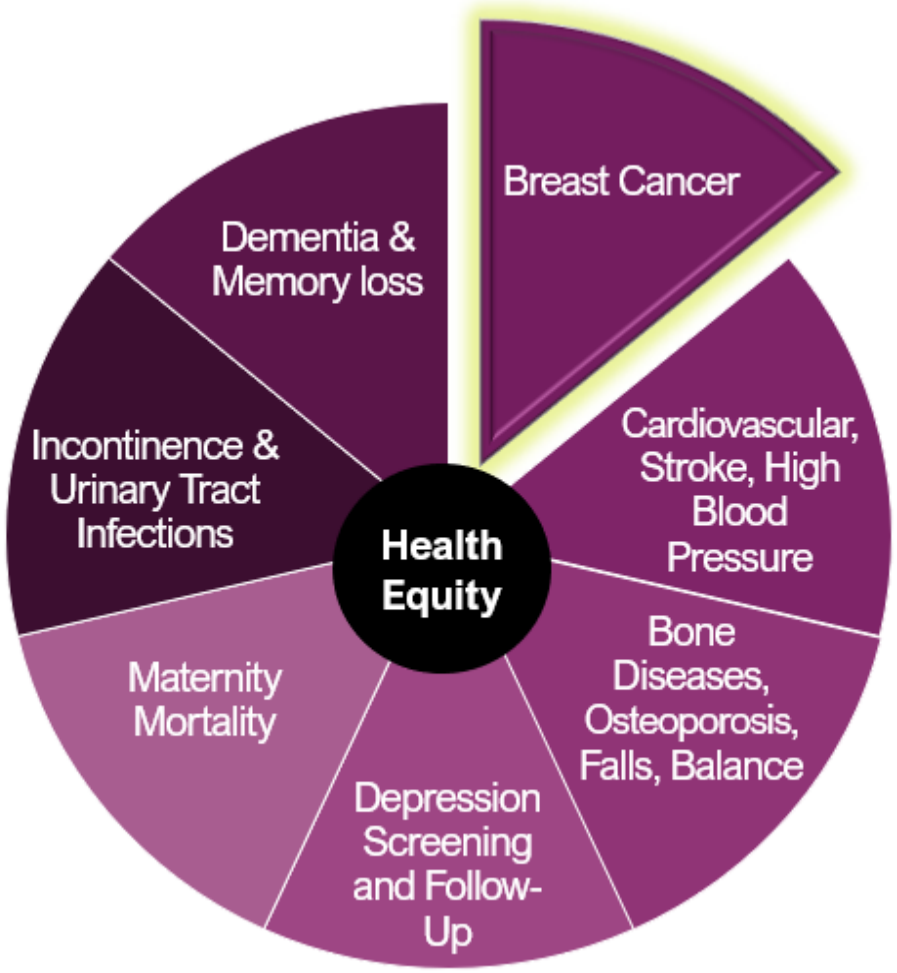
UPMC Women's Health Priority Areas 2023



Opportunities

- Nursing Facilities reported Breast Cancer Screenings (BCS) at a lower rate (38%) than both the Home and Community-Based Services (HCBS) (70%) and Nursing Facility Ineligible (NFI) (70%) populations.
- BCS rates are slightly lower in 2023 from 2022. No disparities noted by race or ethnicity.

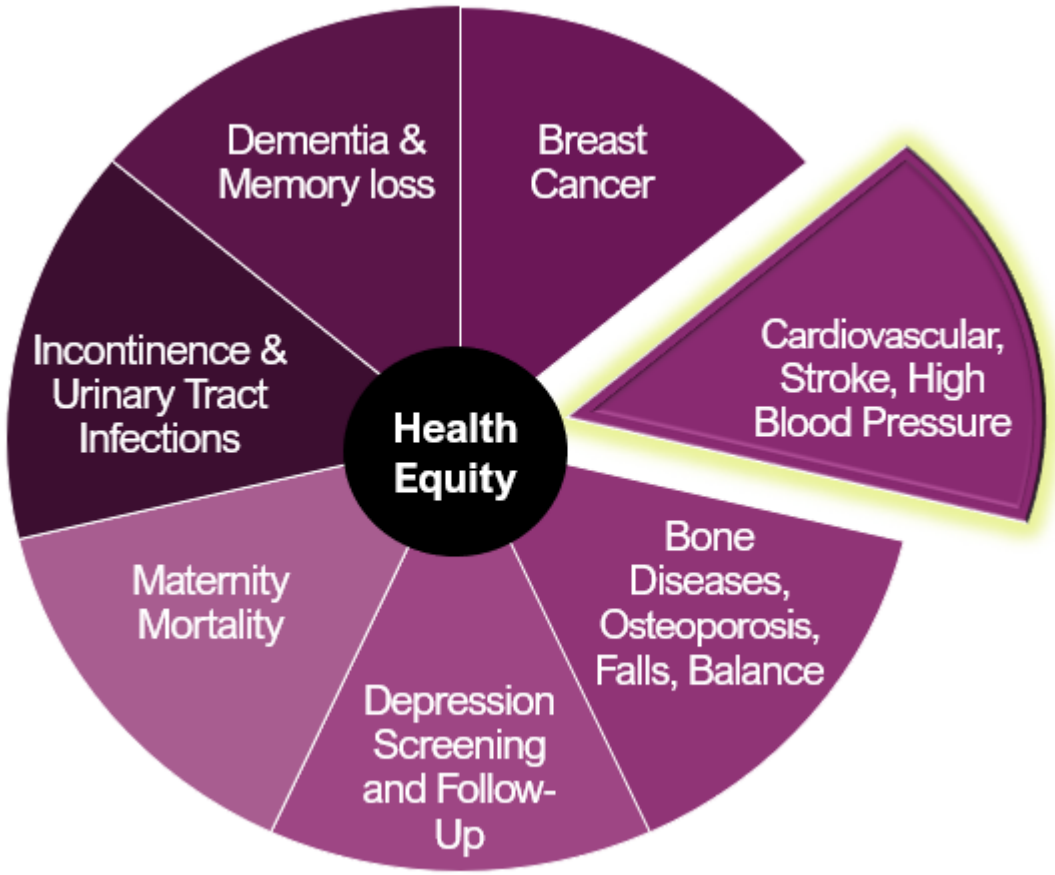
UPMC Women's Health Priority Areas 2023



Actions

- *Gap in Care Tool* used by Member services shows if the member calling in has a Breast Cancer Screening (BCS) gap (12 other gaps can be displayed as well).
- *Blaster call outreach* for BCS that prompts members to schedule by pressing 1 during an automated message.
- CHC members are also included in programs like *Medicare Faith and Wellness program,* which include mammogram outreach and their mam and glam events.
- Additional reminders to *SNP* members who meet eligibility for SNP funded incentives for completing mammograms.

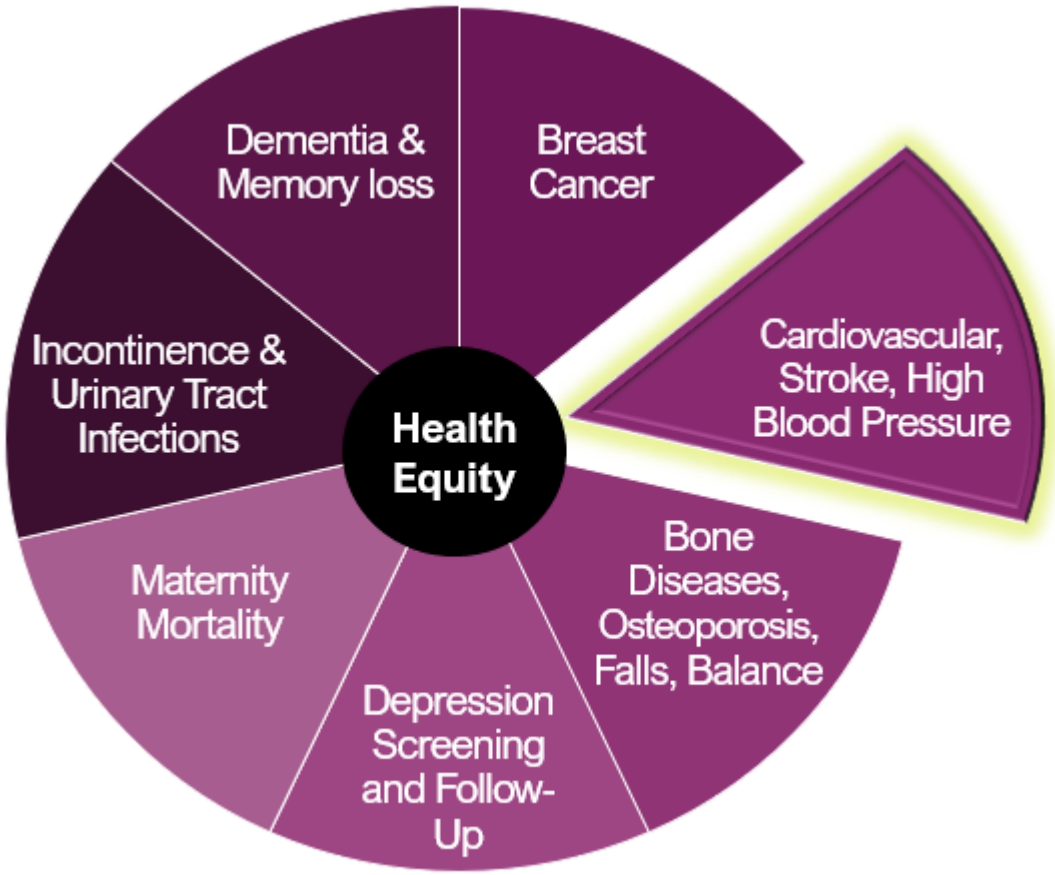
UPMC Women's Health Priority Areas 2023



Opportunities:

- For controlling high blood pressure, there is a 7% difference in reported data for African American women and Hispanic women compared to Caucasian women.
- Lower percentage of African American and Hispanic individuals reported adequate HbA1C control and high blood pressure compared to Caucasians.

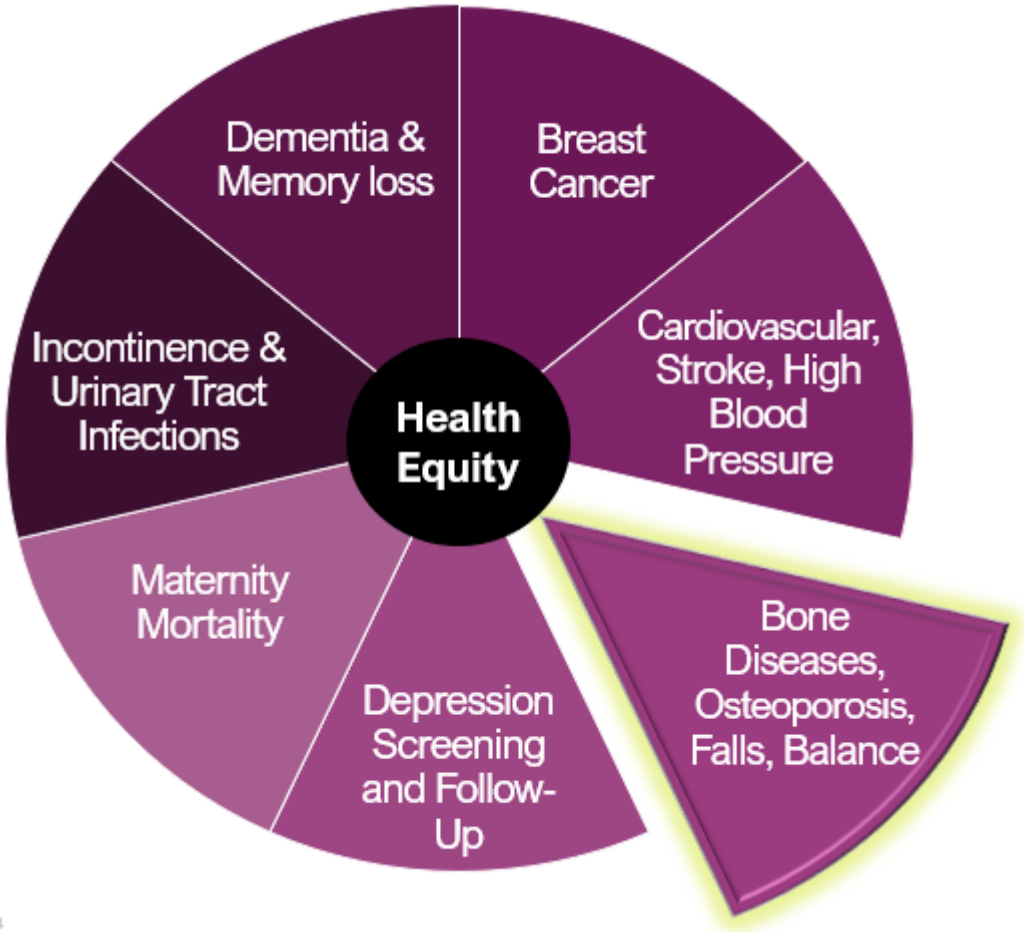
UPMC Women's Health Priority Areas 2023



Actions:

- Increased education to providers to pass on to participants regarding statin adherence and health benefits.
- Care coordination to facilitate filling statin prescriptions. Statin therapy for Cardiovascular and Statin Adherence both increased by about 2 points from 2022.
- UPMC Electronic Medical Record (EPIC) configured to accept Controlling High Blood Pressure Current Procedural Terminology (CPT) codes via telephone and MyUPMC encounters.
- Several new strategies underway using electronic health record messaging.

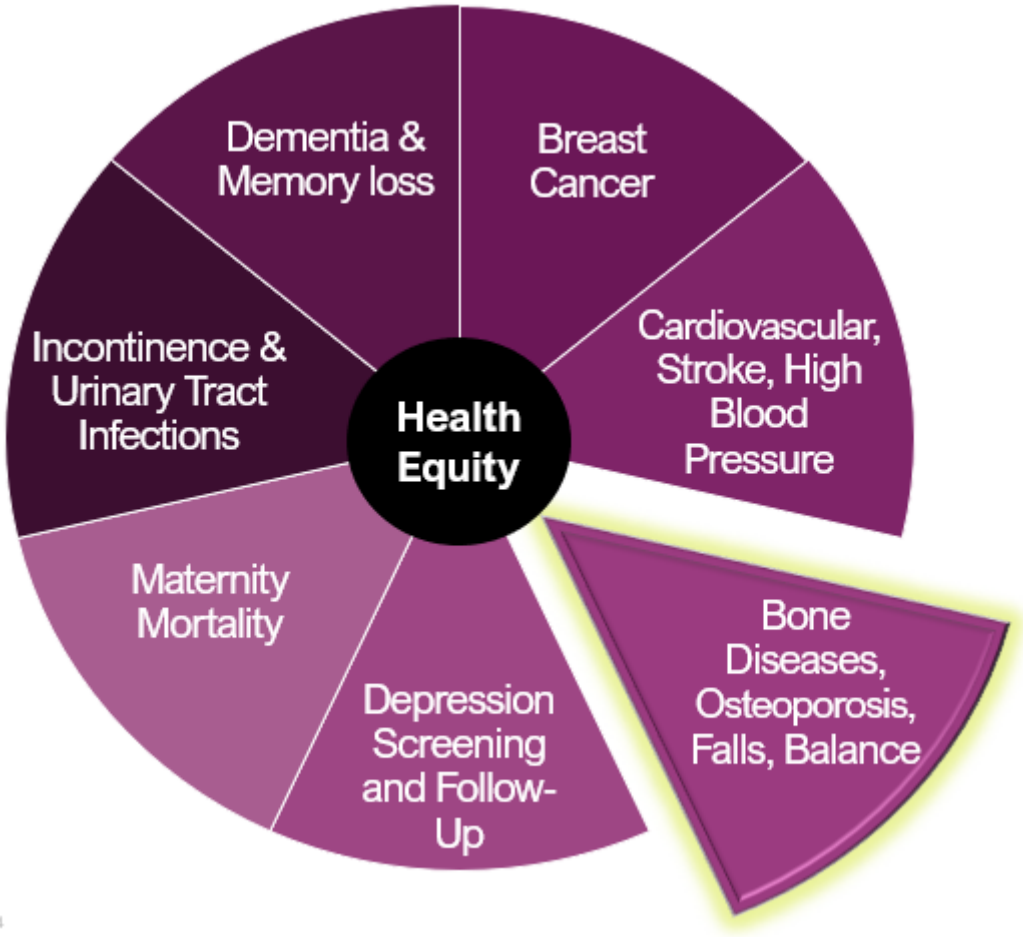
UPMC Women's Health Priority Areas 2023



Opportunities:

- We recognize that women fall more than men. Women fall at a rate of 29%, men fall at a rate of 26%.
- Participants are encouraged to follow up with their Primary Care Provider (PCP), receive a home safety evaluation, and engage in activities to improve strength and balance.
- There is a difference in interventions engaged by ethnicities. African Americans engage less interventions than any other race.

UPMC Women's Health Priority Areas 2023



Actions:

- UPMC CHC Fall Risk Initiative provides a letter to participants who have recently fallen.
- Over 15,000 participant reported having a fall and received a letter about UPMC's Fall Prevention Program.
- Almost 1000 participants were evaluated and referred for home modifications, Physical Therapy (PT)/ Occupational Therapy (OT), and a visit with their PCP – all designed to reduce the risk of future falls.
- Pharmacists have several transitions of care and clinical disease programs, including our Medication therapy management (MTM) program where we will assess medications, age, conditions, etc. for fall risk and make recommendations to the doctor on anything that could increase their risk.

UPMC Women's Health Priorities 2024

Our strategic approach for 2024 has three primary pillars:

1.Goals based on shared priorities and collaboration.

2. Improvement approach based on best evidence, best practice, and lessons learned.

3. Outcome and process measures that allow ongoing improvement of our approach to help us reach our final goals.

In preparation for 2024, we launched a *Women's Health Work Group. The functions of this work group include:*

- Sharing current opportunities, lessons learned on improving access, engagement, and outcomes for all participants.
- Researching best practices on innovation, continuous improvement, and optimizing the participant experience.
- Improving communication among all key stakeholders.

UPMC
LIFE CHANGING MEDICINE

Questions

UPMC Community HealthChoices

Women's Health Initiatives

Managed Long-Term Services and Supports (MLTSS) Subcommittee Meeting
December 6, 2023

Louis Sabater, Sr. Director, Population Health and Clinical Operations

Olivia Martin, Sr. Director, Long-Term Care & Service Coordination

Holistic Assessment

- PHW focuses on assessing and monitoring Participants through a “Health Equity Lens.” We have an awareness that systemic social and health inequalities have put some population groups at increased risk. We strive to ensure our Participants receive a fair opportunity to achieve their full health potential.
- There are some key diseases affecting women, which account for 60% of our membership. These include breast cancer, hypertension, stroke, and osteoporosis.
- PHW stratifies our population by gender, age, ethnicity, and geographic location.
- We also look at contributing factors to overall health, such as living arrangements, social isolation, fall risk, and dementia.

Care Coordination

- PHW has focused on key areas for Participant education and outreach, including breast cancer awareness, fall prevention, and care gap closures.
- PHW has partnered with HHAX leveraging Direct Care Workers to assist in assessing clinical risk for women's health concerns, such as:
  - Mammogram/breast cancer screening within the past two years
  - Increased history of falls
  - Medication adherence
  - Living environment and safety risk
- Through a consolidated data capture process, the care management team is able to address these critical areas for Participant outreach and plan activities to reduce risk and improve overall health outcomes.

Example Outreach

- PHW has gathered data on Participants in different high risk group categories. One area that we focused on involved breast cancer awareness and prevention.
- According to the Centers for Disease Control and Prevention, breast cancer is the second most common cancer among women in the U.S., with Black women dying at a higher rate than White women.
- PHW initiated a multi-prong approach to improving Participant outcomes in this area. These included:
  - A targeted referral program where care management provided outreach educating Participants on mammogram/breast cancer screening
  - An educational awareness campaign for Participants, Providers, and Service Coordinators.

Questions and Comments?

2023 Successful Focus on Women's Health in CHC

- Women’s Health Care is a key driver of Quality in the CHC Program.
- The data available on Heart Disease, Falls and Fractures, and Breast Cancer present opportunities for Prevention and Management in the CHC Population.
- There has been a tremendous amount of work on Women’s Health Initiatives in CHC. Lives are being saved and injuries are being prevented!
- Focus and innovations will yield continued success!