2023 Hospital Quality Symposium

Presented by Partnership HealthPlan of California

Helping our members, and the communities we serve, be healthy.

8:30 a.m. – 4 p.m.

AGENDA

8:30 – 9 a.m. *Registration & Networking Breakfast*

9 – 9:10 a.m. *Welcome & Opening Remarks*

Robert Moore, MD, MPH, MBA
Chief Medical Officer,
Partnership HealthPlan of California

9:10 – 10:10 a.m. *Framework for Addressing Health Inequities in Hospitals*

Robert Moore, MD, MPH, MBA
Chief Medical Officer,
Partnership HealthPlan of California

Mohamed Jalloh, PharmD, BCPS
Director of Health Equity
(Health Equity Officer)
Health Services
Partnership HealthPlan of California

10:10 – 10:20 a.m. *Break*

10:20 – 11:20 a.m. *Improving Focused View of Health Equity Data*

Scott V. Masten, PhD
Vice President of Measurement Science and Performance Analytics,
Hospital Quality Institute

Aaron Koll, MS
Data Scientist
Hospital Quality Institute

Jeff Pratt, MBA
President & CEO
SpeedTrack, Inc.

11:20 a.m. – 12:05 p.m. *Maximizing QIP Performance: Voices from the Field - A Panel Discussion*

Mark Netherda, MD
Medical Director for Quality
Health Services
Partnership HealthPlan of California

12:05 – 12:35 p.m.. *Lunch*

AGENDA

12:35 – 1:35 p.m. *Breakout Sessions*

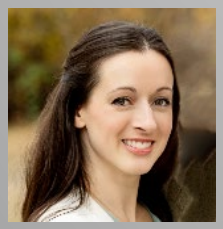
SESSION 1: *Hospital QIP Overview*

Amy McCune
Manager of Quality Incentive Program
Quality & Performance Improvement
Partnership HealthPlan of California

Troy Foster
Program Manager
Hospital Quality Improvement Program
Partnership HealthPlan of California

SESSION 2: *Exploring the New Doula Benefit, Redding*

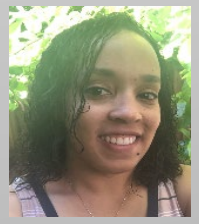
Robert Moore, MD, MPH, MBA
Chief Medical Officer
Partnership HealthPlan of California



Chelsy Marriott, BS, CD/PCD(DONA), CLC
Doula & Business Owner
Nurtured Guidance: Doula & Lactation Services

SESSION 2: *Exploring the New Doula Benefit, Fairfield*

Colleen Townsend, MD
Regional Medical Director
Health Services
Partnership HealthPlan of California



Tiffany Lacey, BS, CD (DONA)
Doula
The Mixed Doula

Eureka | Fairfield | Redding | Santa Rosa

AGENDA

1:35 – 2:35 p.m. *CalAIM & Reducing Readmission Rates, Fairfield*

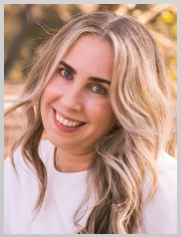
Katherine Barresi, RN, BSN, PHN, NE-BC, CCM
Senior Director, Health Services,
Partnership HealthPlan of California

1:35 – 2:35 p.m. *CalAIM & Reducing Readmission Rates, Redding*

Heather Esget, BSN
Director of Utilization Management,
Partnership HealthPlan of California

2:35 – 2:45 p.m. *Break*

2:45 – 3:45 p.m. *Risk Management in Perinatal Mental Health*



Smadar Garritson, LCSW, CLE
Huntington Hospital, Pasadena, CA
Primary Program Therapist
Maternal Mental Health Day
Treatment Program

3:45 – 4:00 p.m. *Closing Remarks*

Mark Netherda, MD
Medical Director for Quality
Health Services
Partnership HealthPlan of California

Welcome

Master of Ceremonies

Mark Netherda, MD
Medical Director for Quality,
Partnership HealthPlan of California

Housekeeping

- **Restrooms**
- **Breaks:** Two 10-minute breaks AM & PM
- **Lunch:** 30-minute lunch break
- **Evaluations:** After the Symposium, please complete your evaluation and hand to PHC staff at the doors when you leave.

Ground Rules

- Be open-minded
- Respect all ideas and opinions
- Be engaged and ask questions
- Complete the evaluation
- Share & learn

Evaluation & CE/CME Credits

EVALUATION

Your feedback is important to us!

After the Symposium:

1. Please complete the brief evaluation located in your Attendee Packet.
2. Please hand to your completed evaluation to PHC Staff at the doors when you leave.

CME/CE CREDITS

- Application for CE credit has been filed with the California Board of Registered Nursing, Provider CEP16728 for (hours TBD) contact hours. Determination of credit is pending.
- Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

Cultural & Linguistic Competency & Implicit Bias Standards for Continuing Medical Education

Event planners, faculty and speakers:

- Signed PHC's attestation to comply with California Medical Association's (CMA) Cultural & Linguistic Competency (CLC) and Implicit Bias (IB) Standards.

CME course content:

- Reviewed and approved by Partnership HealthPlan AAFP member (American Academy of Family Physicians) to ensure appropriate application of CMA standards to reduce health disparities and various components met to comply with state law.

For more information, please visit: https://www.cmadocs.org/cme-standards

Conflict of Interest

All presenters have signed a Conflict of Interest form. Although no direct conflict is evident, in the interest of full transparency, Jeff Pratt, President & CEO of Speedtrack, Inc. declared he receives subscription revenue from the HQI Platform.

Opening Remarks

Welcome & Introductions
Partnership HealthPlan of California

Robert Moore, MD, MPH, MBA
Chief Medical Officer
Partnership HealthPlan of California

About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

How We Are Organized

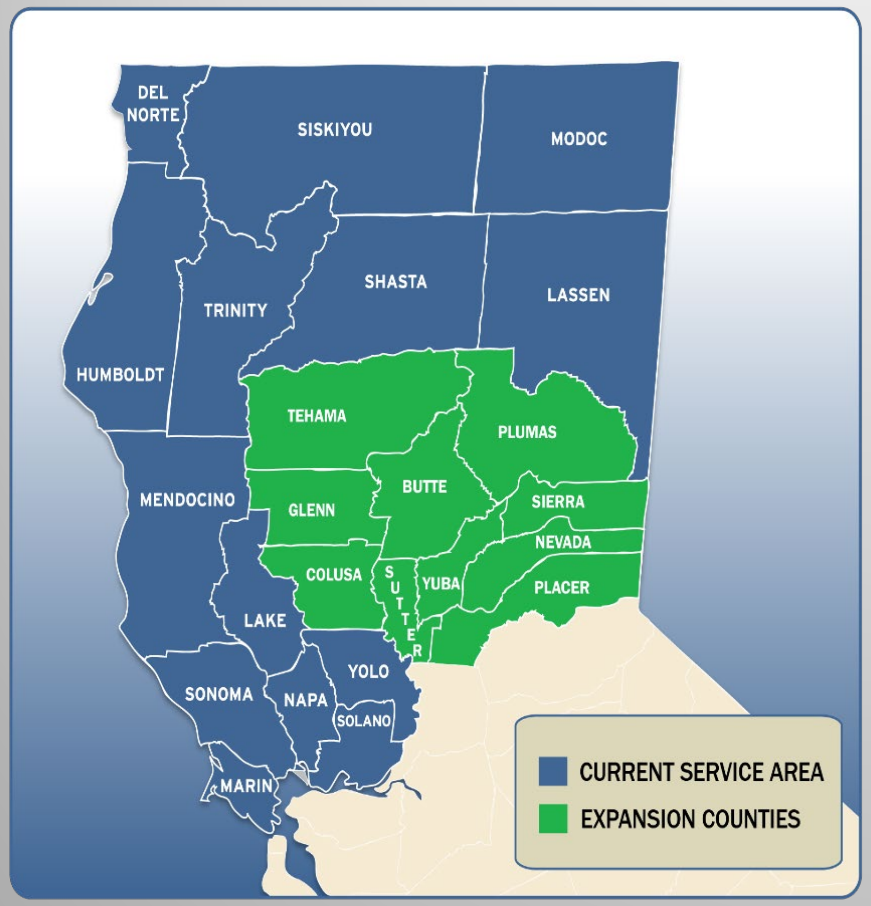
PHC is a County Organized Health Systems (COHS) Plan

Non-Profit Public Plan
Low Administrative Rate for PHC to have a higher provider reimbursement rate and support community initiatives

Local Control and Autonomy
A local governance that is sensitive and responsive to the area's healthcare needs

Community Involvement
Advisory boards that participate in collective decision making regarding the direction of the plan

Major PHC Update: County Expansion



- Partnership is expanding into 10 new counties in 2024!
- This will bring many new Hospitals & PCPs into our Provider Network.
- PHC will host Hospital QIP informational sessions for expansion county hospitals in October and November 2023

Ways PHC Supports Quality

- Incentivize participant performance on a set of meaningful measures (QIP)
- Find ways to support small and rural participants in the PHC network
- Develop platforms for collaboration among QIP participants
- Seek and disseminate new and current information

Hospital Quality Improvement Program

- Pay-for-performance program to **support hospitals** serving PHC members **to improve quality and health outcomes**.

- **Substantial financial incentives:** approximately $8.1 million awarded among 26 hospitals in the 2021-22 measurement year

- **Six domains:**
  - ✔ Readmissions
  - ✔ Advance Care Planning
  - ✔ Patient Experience
  - ✔ Patient Safety
  - ✔ Operations & Efficiency
  - ✔ Clinical Quality (OB/Newborn/Pediatrics)

Long Term Care
Quality Improvement Program

- Pay-for-performance program **supporting Long Term Care facilities** serving PHC members **to improve quality and health outcomes**.

- **Substantial Financial Incentives:**
  Over $3.4 million awarded in 2022

- **Four domains:**
  - ✔ Clinical
  - ✔ Functional
  - ✔ Resource Use
  - ✔ Operations & Satisfaction

DHCS launched the Workforce & Quality Incentive Program (WQIP) earlier this year. PHC's LTC QIP will transition to the state WQIP effective January 1, 2024.

Guiding Principles

1. Where possible, pay for outcomes instead of processes
2. Actionable measures
3. Feasible data collection
4. Collaboration with providers in measure development
5. Simplicity in the number of measures
6. Representation of different domains of care
7. Align measures that are meaningful
8. Stable measures

2023: Hospital and LTC QIPs

- 26 hospitals participate in the 2023-24 Hospital QIP.
- 54 LTC facilities/SNFs participate in the 2023 LTC QIP.

Framework for Addressing Health Inequities in Hospitals

Welcome Dr. Moore & Dr. Jalloh

Robert Moore, MD, MPH, MBA
Chief Medical Officer
Partnership HealthPlan of California

Mohamed Jalloh, Pharm D., BCPS
Director of Health Equity
(Health Equity Officer)
Health Services
Partnership HealthPlan of California

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Framework for Health Equity

Robert Moore, MD MPH MBA
Chief Medical Officer
Mohamed Jalloh, PharmD, BCPS
Health Equity Officer

Learning Objectives

- State at least three reasons that hospitals should address Health Equity.
- Describe the major categories of causes of Health Inequities.
- Describe the difference between an inequity and a disparity.
- Bring at least two new methods of addressing inequities back to your hospital quality team.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Patient
Case

Patient Case (Hospital Based)

- **KT** is 63 yo veteran male with a PMH of Diabetes, HTN, Amputated fingers, and a recent fall at home
- Presented to emergency room with **confusion, slurred speech, and constant stern look on face**
- Despite limited mobility, **he walked himself to the restroom without assistance**, and found his way back to a wheelchair where he waited to be seen

Patient Case (Hospital Based)

- KT continued to wait seated in his wheelchair
- **2.5 Hours has passed**; other patients with apparent less acute presentations were walked back
- One staff members walked by while **looking at cell-phone** during their break
- Pain in KT lower back and head begin to intensify after waiting over 2 hours, **with no water consumption**

Patient Case (Hospital Based)

- Eventually tries to get the attention of the desk nurse to determine when he will be seen, and asks for **pain medication for a growing headache**

What Happened Next?

Nurse Actions

- KT asked if he could receive "**something**" to help with the pain
- Spoke in uncaring and loud voice and telling him that the ER was too busy. Communicated that "He should wait for his turn"
- Nurse said that he didn't need any **"narcotic" pain medications** and he will be seen **"soon"**

Patient Actions

- Felt unsafe remaining in hospital and called son to pick up
- He presents to son **confused, weak, and crying**

After Leaving. . .

- **Within 12 hours of leaving the ER**, the father appeared by ambulance at the ER, once again, **after having suffered a severe stroke**!

Questions

- What **cultural factors** likely contributed to this patient's poor care?

Questions

- What **historical/systemic** factors likely contributed to this patient's poor care?

Questions

- What **interventions** could have addressed these “factors” during patient case?

Discrimination Framework

- What **metrics** could you use in your hospital to catch this? (Especially if patient left AMA)


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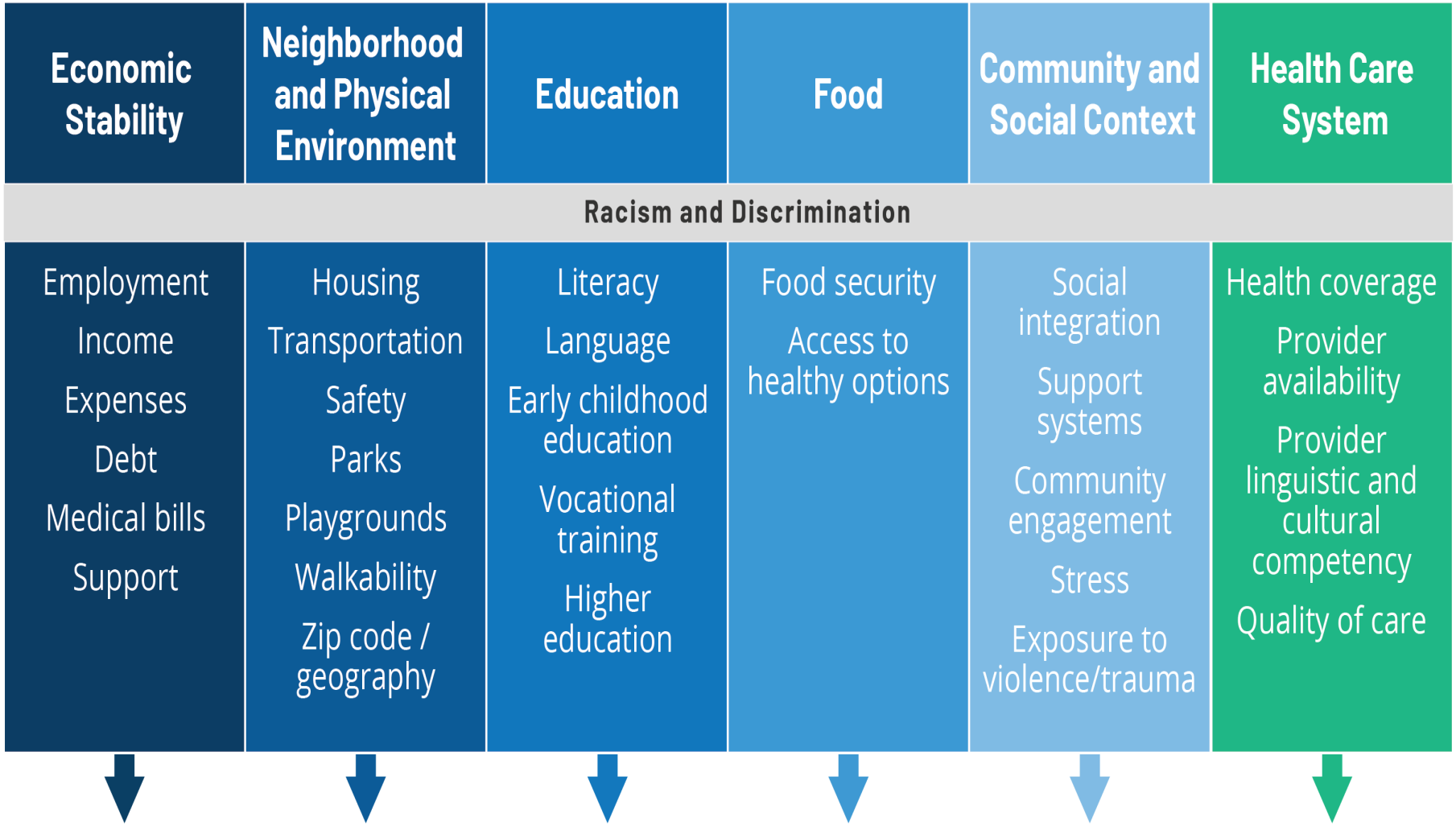
Health Equity

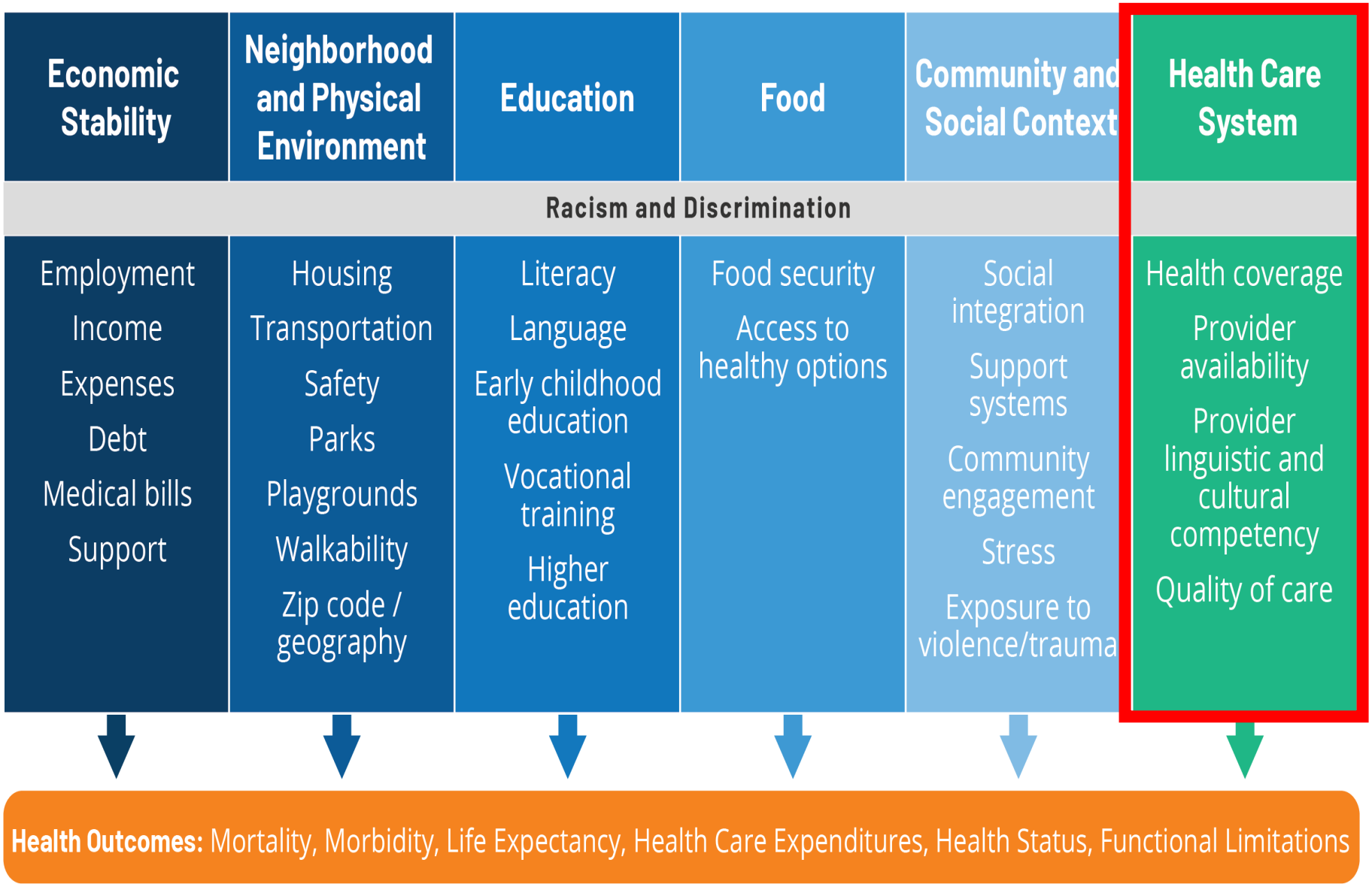
Why Hospitals Address Equity

- **Moral** Imperative
- **Public Reputation**
- Legal Risk
- Regulatory Mandate
- HQIP

Social and Economic Factors Drive Health Outcomes



Social and Economic Factors Drive Health Outcomes



Levels of Inequities

- Disability (mental and physical)
- Age
- Economic
- Environment (lived environment, neighborhood)
- Language
- Rural/Urban
- Gender identity
- Sex
- Ethnicity
- Sexual Orientation

Discrimination Framework

- What of these do you already have the data to explore?

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Major Causes of Inequities

Systematic Issues

Systemic racism (historic oppression and deprivation/social determinants)

Structure/funding/staffing of health care providers

Discrimination

- Overt discrimination
- Implicit Bias

Cultural Factors

- Relationship between health and spirituality (western medicine vs. Native American health and healing)
- Culturally influenced behaviors, like tobacco use or alcohol use.

Biological/ Genetics Factors

- Sex, Gender Identity, Age
- Genetic traits more common in some populations

"Moore-Jalloh OTIS" Method for Health Systems

- Ensure **Objective Data Stratification and Evaluation**
- **Training** to address internal learning deficiencies
- **Internal Systemic Issues** (i.e. Internal Discrimination or Bias)
- Experiment with **Solutions** in collaboration with **community champions or leaders**

"Moore-Jalloh OTIS" Method for Health Systems

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Framework for Looking for Inequities

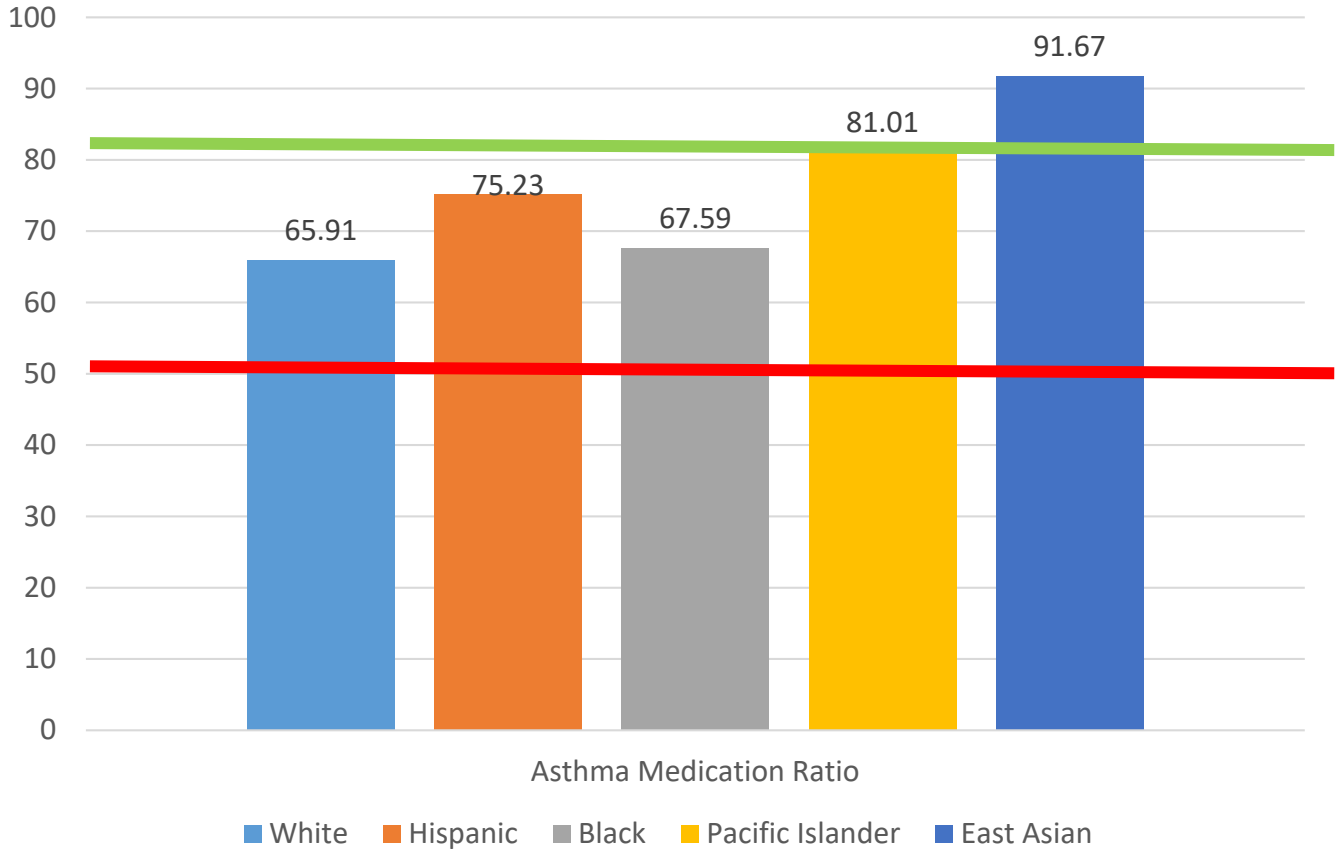
Definitions and Examples of:

- Disparities
- Inequities
- Quality issues without inequities

Definition - I

- **<u>Disparity:</u> A measured difference between one group and another group.**
  - In a disparity, a socio-economically disadvantaged group **may or may not have worse outcomes** than the dominant or historically favored group.

Example of Disparity (AMR)



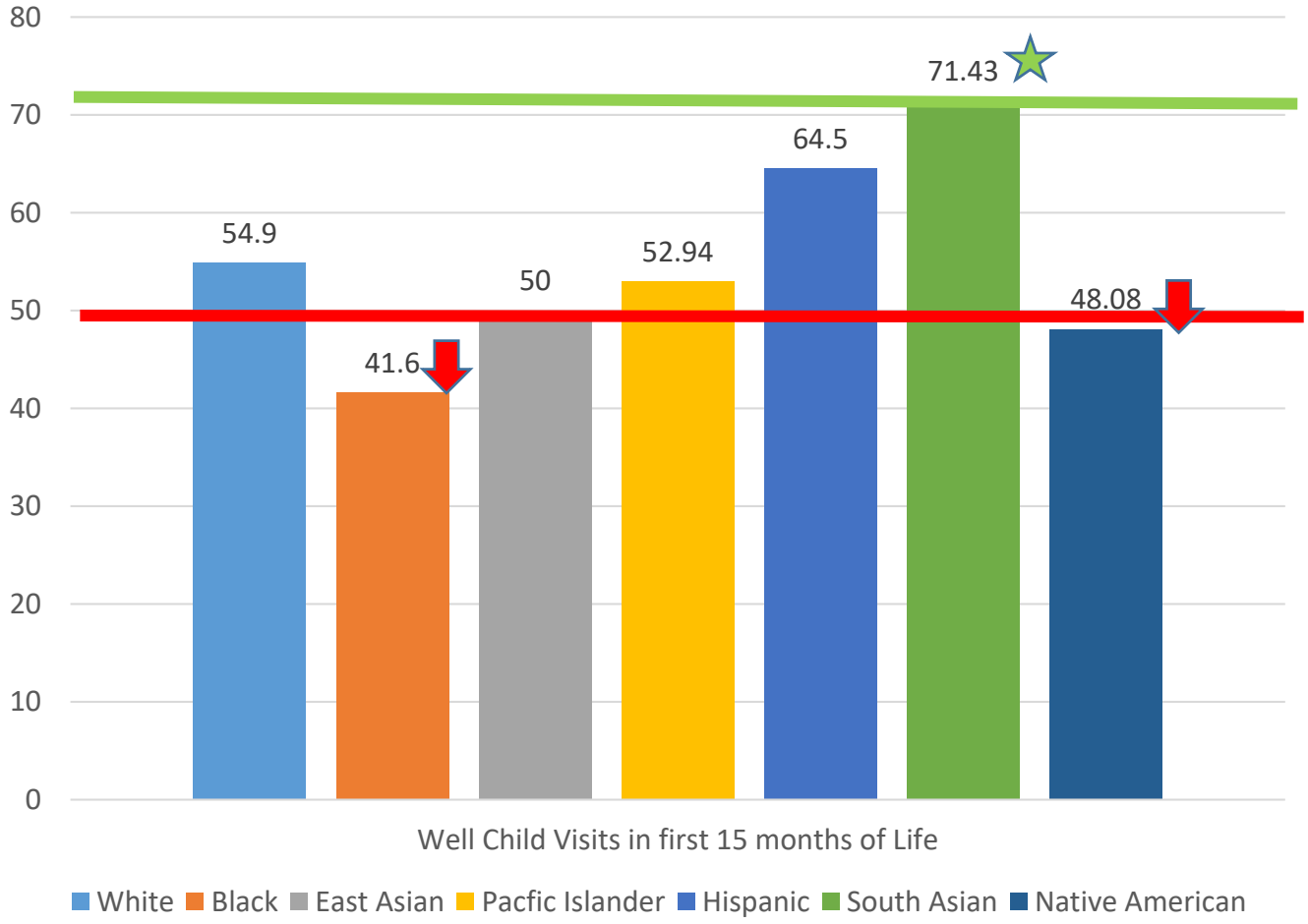
All groups below are above average (above 50th percentile)

- There are **disparities (differences)** between the groups
- None of the non-white ethnicity groups listed below performed worse than the white ethnicity group

Definition - II

- **<u>Inequity:</u> A disparity in which a socio-economically disadvantaged group has a worse outcome than the historically favored group:**
- In the case of **ethnicity**, the dominant/historically favored group is the **Caucasian race**
  - In the case of **disabilities**, dominant/historically favored group are people with **no disability**
  - In the case of language, dominant/historically favored group are **English-Speaking**
  - In the case of location, dominant/historically favored group of people are in the **Urban location**

Example of Inequity (WCV)

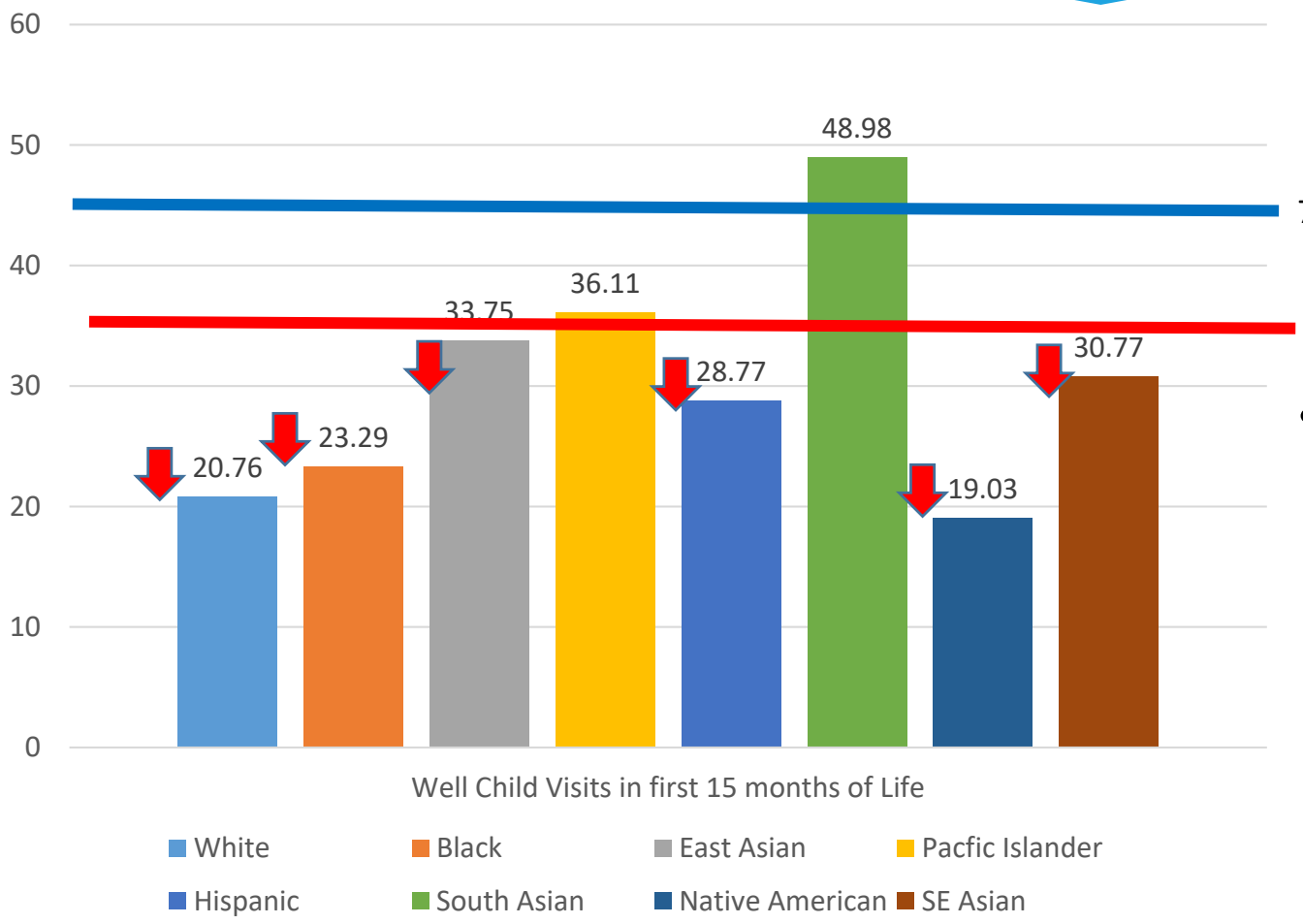


- Inequities: Statistically significantly worse than white ethnicity
- No disparity: difference from white ethnicity not statistically significant
- Disparity: Difference from other groups, but performs better than white population

Definition - III

- **<u>Low quality scores without inequities:</u>** The dominant/historically advantaged group has low performance, as do other groups.
- <u>More likely **Quality Concern**</u>

Example of Low Quality Score without Inequities



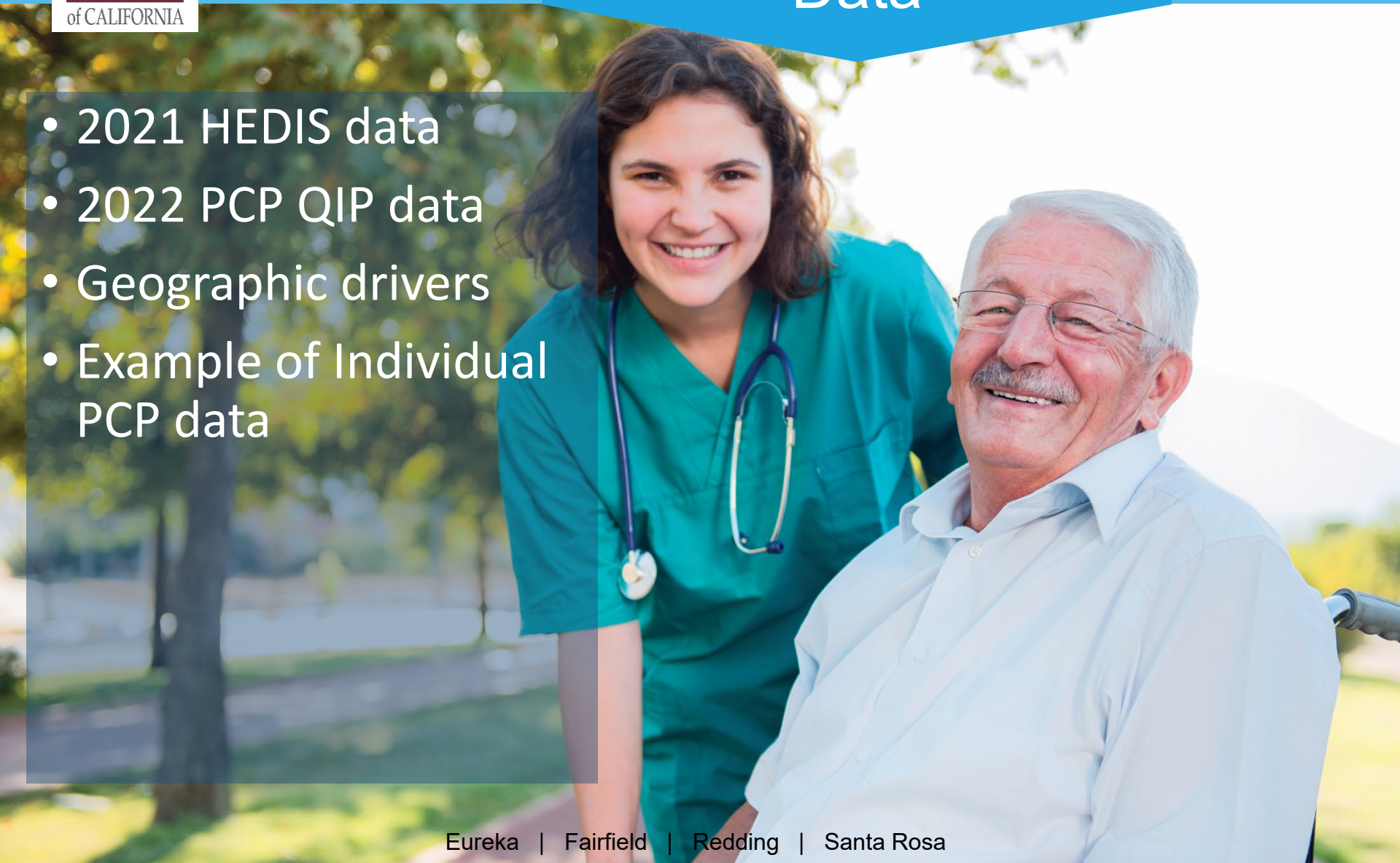
- Low performance in non-white groups is **not** an inequity, but is part of a more global quality problem, to be addressed **population-wide**.

Definitions and Examples Summary

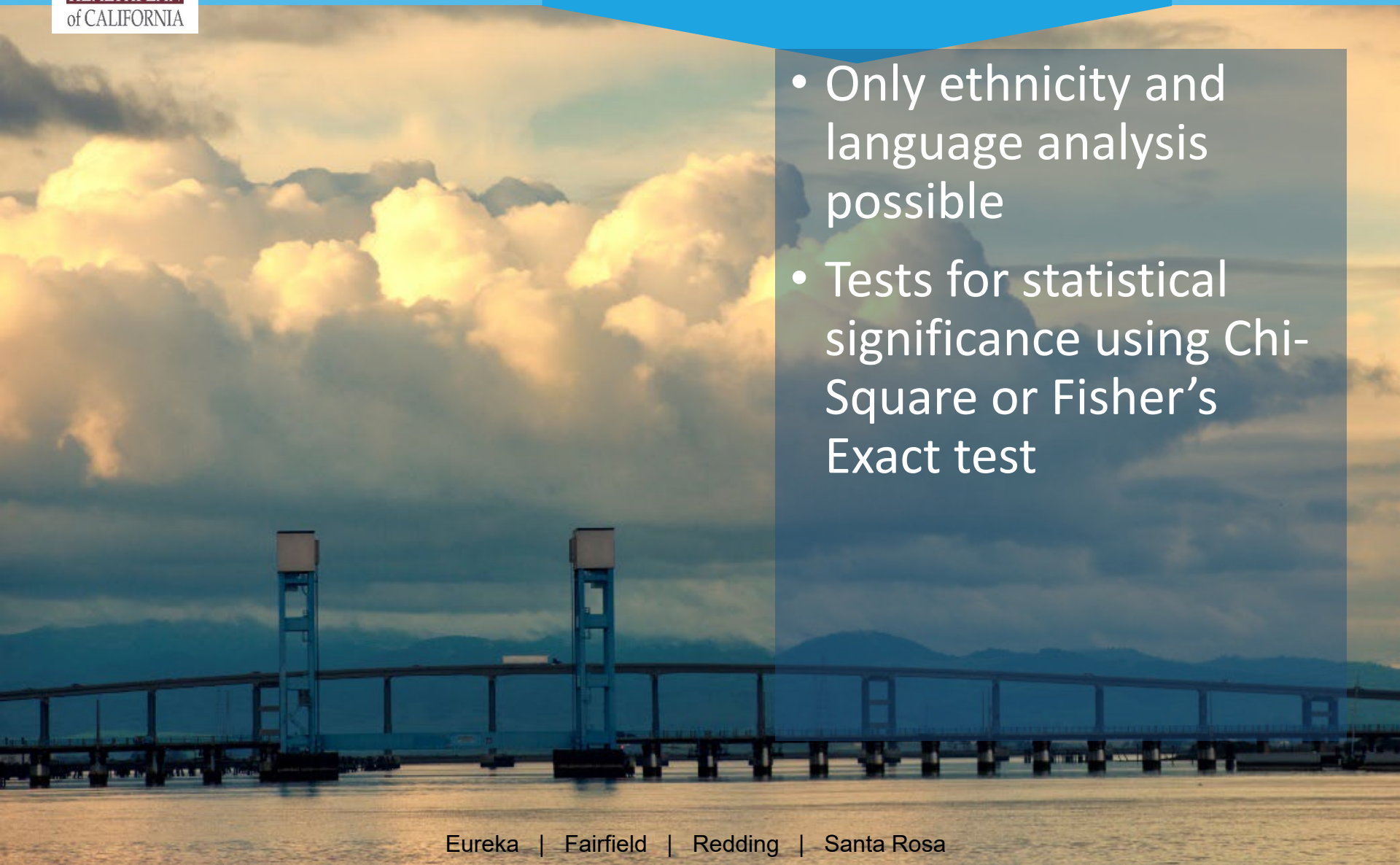
- **Disparity:** A measured difference between one group and another group.
- **Inequity:** A disparity in which a socio-economically disadvantaged group has a worse outcome than the dominant/historically favored group.
- **Low quality scores without inequities: –** The dominant/historically advantaged group has low performance, as do other groups.

Example of Reviewing Equity Data

- 2021 HEDIS data
- 2022 PCP QIP data
- Geographic drivers
- Example of Individual PCP data



2021 HEDIS Data



- Only ethnicity and language analysis possible
- Tests for statistical significance using Chi-Square or Fisher's Exact test

2021 HEDIS: Native American Inequities

Eleven measures:

1. Antidepressant medication management (AMM-A and AMM-C) follow up after initiation of medication for depression, both short term and long term (Note: very incomplete data for these ECDS measures)
2. Lower rates Breast Cancer Screening (BCS)
3. Lower rates Controlling Blood Pressure (CBP)
4. Lower rates of screening for depression (CDF-18+)
5. Lower rates of developmental screening of infants (DEV)
6. Lower rates of prenatal and postpartum visits (PPC-Pre and PPC-Post)
7. Lower rates of well child visits from 15 months of age to 21 years of age. (WCV and W30-2)
8. Lower rates of documentation of BMI in children (WCC-BMI)

2022 PCP QIP Native American Inequities

Eleven measures (out of 12) (Native American rate vs. white rate)

- Asthma Medication Ration (60% vs. 66%)
- Breast cancer screening (34.4% vs. 45.8%)
- Childhood immunization (13% vs. 20%)
- Colorectal cancer screening (27% vs. 36%)
- Blood pressure control (52% vs. 61%)
- Blood sugar control (48% vs. 62%)
- DM Retinopathy screen (30% vs. 38%)
- Adolescent immunization (19% vs. 21%)
- Nutrition counseling (35% vs. 57%)
- Physical activity counseling (41% vs. 55%)
- Well child visits (48% vs. 55%)

2022 PCP QIP Black/AA

Three measures out of 12 (African American rate vs. white rate)

- Well child visits (ages 3-20) (39% versus 42%)
- Childhood immunization (17% vs. 20%)
- Blood sugar control (59% vs. 62%)

Summary
2022 PCP QIP

- No inequities were identified in the Hispanic, Asian and Asian subgroups, and Pacific Islanders groups

Questions

- What are potential "causes" that are likely driving the inequities in the PCP QIP measures, for the Black/African American and Native American populations?

Black/AA Population

- Southern Region: 33,277
  - Solano: 24,444
  - Yolo: 2443
  - Marin: 2293
  - Sonoma: 2238
- Northern Region: 2929
  - Shasta: 1170
  - Humboldt: 1106

Which **county** is likely to be the target of the **interventions**?

March 2023 Data

Well child visits for Black Children by PCP 2022

Provider Name	Ytd Numerator	Ytd Denominator	Score
Solano County Family Health & Social Services, Vallejo (1034)	165	726	22.73
La Clinica, Vallejo (11975)	218	509	42.83
Solano County Family Health & Social Services, 2101 Courage..	147	503	29.22
La Clinica, North Vallejo (18926)	225	471	47.77
NorthBay Center for Primary Care, Hilborn Rd. (17294)	131	292	44.86
Community Medical Center, Vacaville (10992)	89	241	36.93
Ole Health, Fairfield (36802)	84	178	47.19
Solano County Family Health & Social Services, Vacaville (26..	25	168	14.88
NorthBay Center for Primary Care, Vacaville (10717)	98	163	60.12
Ole Health, East Fairfield (48514)	46	156	29.49

**This pattern was not seen for the Native American Inequities in 2021 and 2022

Discrimination Framework

- How does your hospital handle complaints of discrimination?

Complaints of Discrimination

Partnership HealthPlan Approach:

Initial review of patient grievance or complaint: nurse and physician.

If any suspicion of discrimination of a protected class, then coded as potential discrimination.

Investigation: details collected (including provider response to the complaint) .

Referred to review by senior health educator for evaluation: discrimination may be confirmed or not confirmed.

Confirmed Discrimination

Partnership HealthPlan Approach:

- All cases of confirmed discrimination (based on investigation) against a protected class:
  - Referred to the **Office of Civil Rights**; the patient and provider is notified.
  - If the discrimination involved an issue with insensitive or inappropriate communication of a support staff in the office, the **findings are referred to the office manager or supervising physician to address.**
  - If the discrimination was by a credentialed clinician, or results in a quality of care issue, a **medical director will refer the case to the peer review process.**
  - If the discriminatory behavior is related to the clinician communicating with the patient inappropriately, a **PHC medical director discusses the allegation directly with the clinician, offering advice and insight as appropriate.**

"Moore-Jalloh OTIS" Method for Health Systems

- Ensure **Objective Data Stratification and Evaluation**
- **Training** to address internal learning deficiencies
- **Internal Systemic Issues** (i.e. Internal Discrimination)
- Experiment with **Solutions** in collaboration with **community champions or leaders**

Training and Internal Systemic Issues

- Health Equity Baseline Assessment
- Implicit Bias Assessment and Culture Sensitivity Training
- Health Equity Steering Committee Formation
- Internal Metrics and Incentive Development

Health Equity Baseline Assessment

- **Improving Health Equity: Assessment Tool for Health Care Organizations created by Institute for Healthcare Improvement**
- Objective Score tool that utilizes **1-to-5 ratings** for each elements and provides overall **"score"**
- Consider having group of **3 to 7 senior leaders** to complete the assessment individually
- Use comments box to note specific examples, achievements, questions, documentation, etc.
- Provide SMART goals to clarify what would it take for us to rate yourselves as a "5"

Health Equity Baseline Assessment

Improving Health Equity: Assessment Tool for Health Care Organizations

IHI Framework Component: Make Health Equity a Strategic Priority

Element	Level of Progress Assessment scale: 1 = No work in this element. 5 = The organization consistently executes on this element.					
Health equity is articulated explicitly as a priority in key strategy documents (e.g., organizational strategic plan, fiscal plan, annual plan) and there is a clear case for how equity relates to the organization's mission, vision, and values.	1	2	3	4	5	Do not know
The organization has a plan for operationalizing the health equity strategy, tracking progress over time, and reviewing health equity data at the board, leadership, and team levels.	1	2	3	4	5	Do not know
The organization builds staff awareness, will, and skills to improve health equity.	1	2	3	4	5	Do not know
Senior leaders and the board regularly communicate the importance of health equity as a strategic priority to staff and empower staff at all levels to act on the vision.	1	2	3	4	5	Do not know
Executive compensation is tied to improving health equity processes and outcomes.	1	2	3	4	5	Do not know
Equity is a consideration in hiring decisions and improving health equity is part of senior leader job descriptions and responsibilities.	1	2	3	4	5	Do not know
Health equity is articulated as an explicit priority across business units.	1	2	3	4	5	Do not know
Comments (note examples, achievements, challenges, questions, next steps, key supporting documents, etc.)						

Health Equity Baseline Assessment

Improving Health Equity: Assessment Tool for Health Care Organizations

IHI Framework Component: Build Infrastructure to Support Health Equity

Element	**Level of Progress** Assessment scale: 1 = No work in this element. 5 = The organization consistently executes on this element.					
The organization stratifies workforce data and patient data for key outcome measures by REaL (race, ethnicity, and language) factors to identify potential inequities.	1	2	3	4	5	Do not know
Data demonstrating health equity gaps (i.e., REaL-stratified workforce, patient experience, outcomes, and quality data) are shared transparently using data dashboards and communicated broadly to key audiences.	1	2	3	4	5	Do not know
People impacted by inequities are directly engaged as key partners in work to improve equity.	1	2	3	4	5	Do not know
Staff are trained to build their capability to improve health equity and to advance equity improvement work for which they are responsible.	1	2	3	4	5	Do not know
There is a clear institutional department/office with reliable funding that is responsible for improving health equity (beyond internal diversity and inclusion of our staff).	1	2	3	4	5	Do not know
Comments (note examples, achievements, challenges, questions, next steps, key supporting documents, etc.)						

Framework for Internal Assessment

- Health Equity Baseline Assessment
- Implicit Bias Assessment and Culture Sensitivity Training
- Health Equity Steering Committee Formation
- Internal Metrics and Incentive Development

Implicit Bias Assessment and Culture Sensitivity Training

- **Core definition (Per AMA):** The attitudes, stereotypes, and feelings, either positive or negative, that affect our understanding, actions and decisions without conscious knowledge or control.
- **Implicit bias is a universal phenomenon.**
- When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability and other characteristics

Implicit Bias Example

- *"Steve is very **shy** and **withdrawn**, invariably helpful but with little interest in people or in the world of reality. A meek and **tidy** soul, he has a need for order and structure, and a passion for detail."*

Implicit Bias Example

- *Is Steve more likely to be a **librarian** or a **farmer**?*

Actual Data

- More than **20 male farmers** for each male librarian in US
- When we look at the U.S. population as a whole, the *proportion of shy librarians among all U.S. males* is in fact smaller than the *proportion of shy farmers among all U.S. males*.

Implicit Bias Training

- **Harvard Implicit Association Test— Free test that measures attitudes and beliefs that people may be unwilling or unable to report.**
- Test involves users sorting words into groups as quickly and accurately as possible
- May use as a **baseline assessment for workers** in different categories from race, disability, age, career, etc.
- Should be used for self-reflection and learning, and **NOT to fault one's presumed biases or stereotypes**

Framework for Internal Assessment

- Health Equity Baseline Assessment
- Implicit Bias Assessment and Culture Sensitivity Training
- Health Equity Steering Committee Formation
- Internal Metrics and Incentive Development

Health Equity Steering Committee Formation

Comprised of highly experienced internal leadership to ensure all patients receive equal priority and highest level of care

Develop Health Equity Strategic Plan per Health Equity Baseline Assessment

Develop internal initiatives with health analytics, community partnerships, interventions to address disparities

Should be co-chaired by Chief Medical Officer and Chief Health Equity Officer to monitor associated metrics

Key Performance Indicators (KPI) Examples

- **# of Disparities:** Absolute number of disparities per Lingual/Disability/Location/Racial Group when compared to control group
- **Rate Difference:** Absolute Difference between outcome in one group versus another group
- **Rate Ratio:** Division between outcome in one group versus another group
- **Index of Disparity:** 1 group metric is identified as the lower threshold and 1 group metric is identified as the higher target threshold

Framework for Internal Assessment

- Health Equity Baseline Assessment
- Implicit Bias Assessment and Culture Sensitivity Training
- Health Equity Steering Committee Formation
- Internal Metrics and Incentive Development

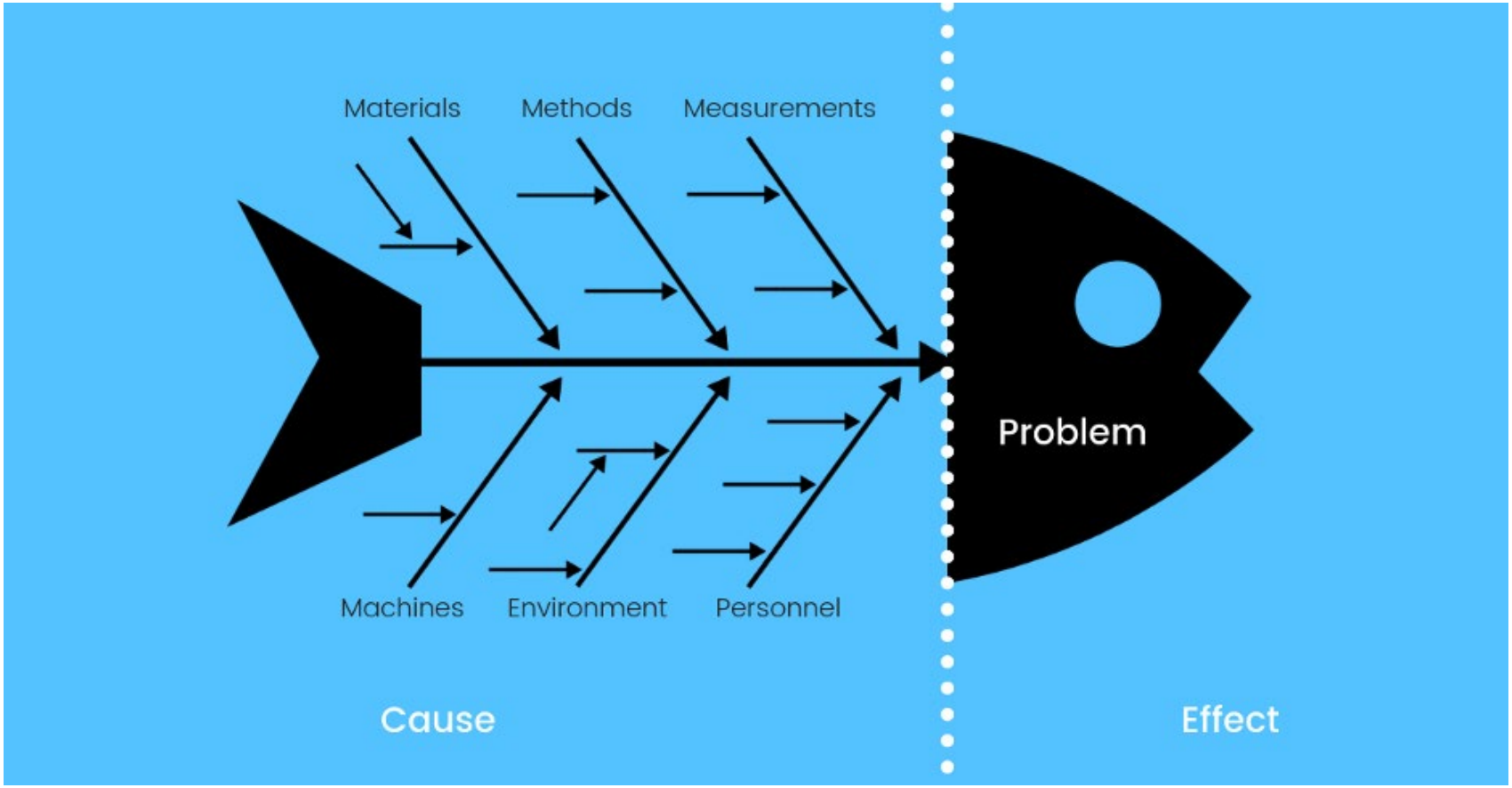
"Moore-Jalloh OTIS" Method for Health Systems

- Ensure **Objective Data Stratification and Evaluation** on potential missing info
- **Training** to address internal learning deficiencies
- **Internal Systemic Issues** (i.e. Internal Discrimination)
- Experiment with **Solutions** in collaboration with **community champions or leaders**

Framework for Addressing Inequities

- Root Cause Analysis via community group and direct patient interviews
- Identify Solutions via medical literature search and collaboration with community group
- Conduct Pilot tests using Scientific Methodology

Root Cause Analysis



Community Groups

- **Conduct community listen sessions and/or focus groups with targeted community** using open-ended questions per ideas generated from **root cause analysis**
- Goal is to **understand,** not **validate preconceived notions,** the opportunities, challenges, and ideas surrounding a disparity
- Ask questions or have representative ask questions that would promote **honest responses**

Framework for Addressing Inequities

- Root Cause Analysis via community group and direct patient interviews
- Identify Solutions via medical literature search and collaboration with community group
- Conduct Pilot tests using Scientific Methodology

Solutions

Conduct Literature
Medical Literature
Search and generate solutions (Hospital)

Provide feedback on feasibility and recommendation changes (community groups/leaders)

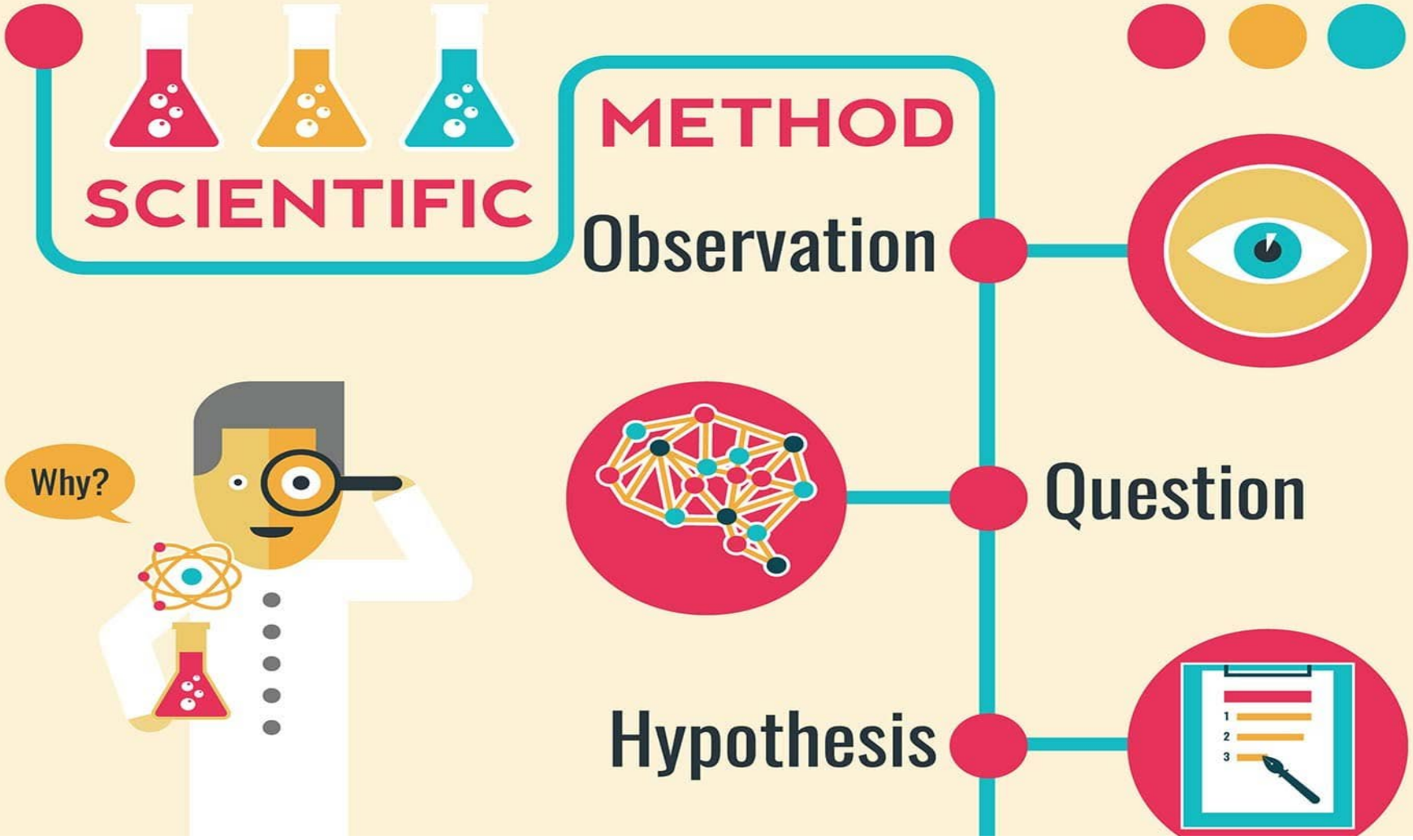
Conduct Medical Literature Search

- Conduct literature search to find published interventions versus **“re-inventing” the wheel**
- Look **for randomized controlled trials, cluster randomized trials, and pre-post analyses**
- Look for feasible interventions with comparable patient groups

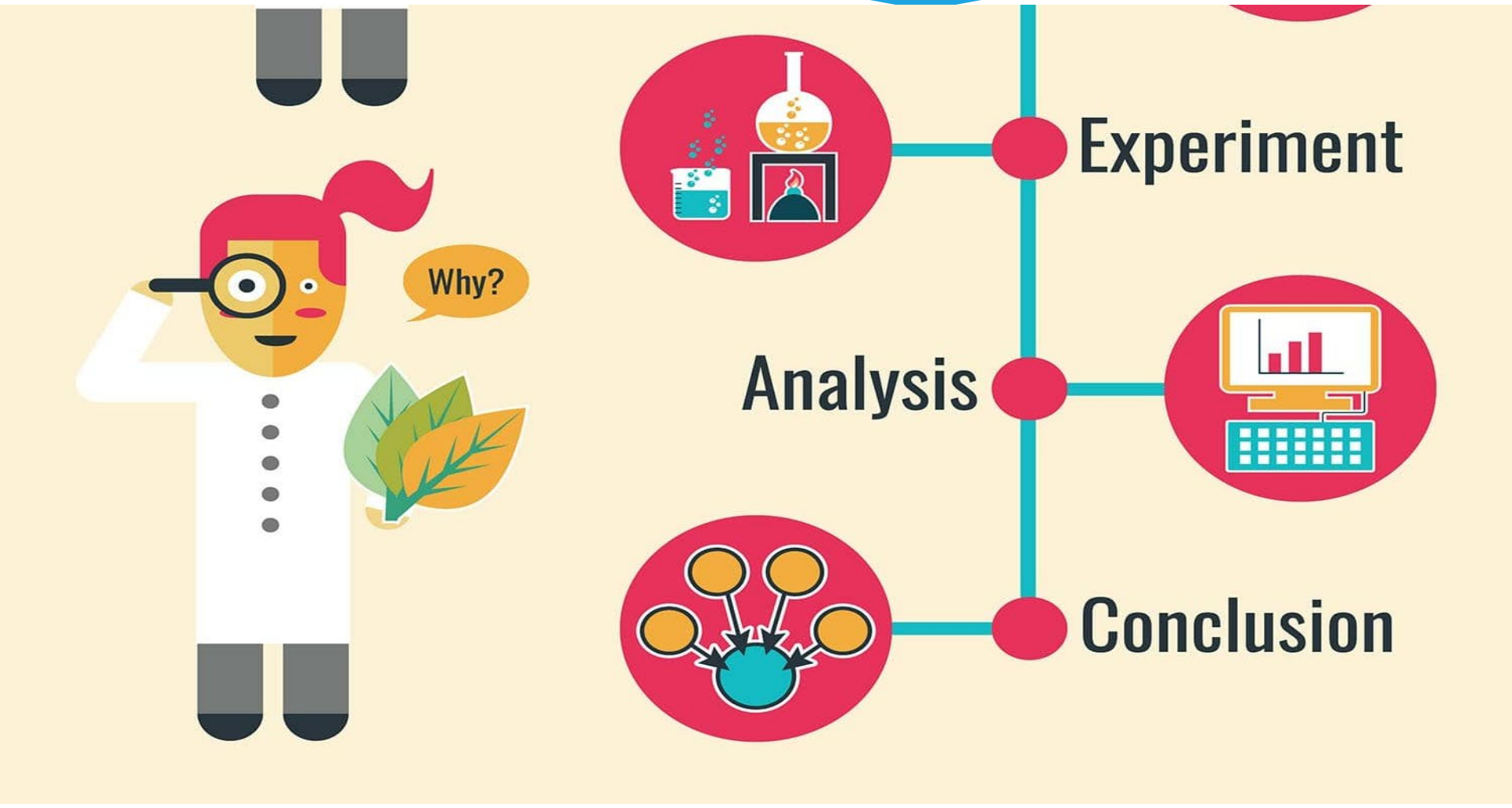
Framework for Addressing Inequities

- Root Cause Analysis via community group and direct patient interviews
- Identify Solutions via medical literature search and collaboration with community group
- Conduct “Pilot” tests using Scientific Methodology

Utilize Scientific Method



Utilize Scientific Method



Scientific Method

- Do not feel that you have to accurately identify the perfect solution → **Each "idea" is considered a hypothesis to test**
- Work with **statistician** to calculate ideal sample size of **patients** to ensure you have enough to truly validate if intervention is effective or not
- Clarify if you will have **one hospital** conduct intervention, versus **one hospital floor** or one **hospital doctor**, etc
- **Ensure you estimate time to see effect (e.g. 3 months to 3 Years)**


PARTNERSHIP
HEALTHPLAN
of CALIFORNIA
Summary

"Moore-Jalloh OTIS" Method for Health Systems

- Ensure **Objective Data Stratification and Evaluation**
- **Training** to address internal learning deficiencies
- **Internal Systemic Issues** (i.e. Internal Discrimination)
- Experiment with **Solutions** in collaboration with **community champions or leaders**

Contact Us

mjalloh@partnershiphp.org

rmoore@partnershiphp.org


Questions?

Thank You

Thank you Dr. Moore & Dr. Jalloh

Break

10 MINUTE

Welcome

Welcome Dr. Scott Masten, Aaron Koll & Jeff Pratt

Scott Masten, PhD
Vice President,
Measurement Science
and Data Analytics
Hospital Quality Institute

Aaron Koll, MS
Data Scientist
Hospital Quality Institute

Jeff Pratt, MBA
President & CEO
SpeedTrack, Inc.

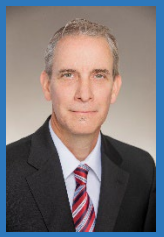
Hospital Quality Institute
Leadership in quality and patient safety

Focused View of Health Equity Data

August 8 & 10 2023

Scott Masten, VP Measurement Science & Data Analytics (HQI)
Aaron Koll, Data Scientist (HQI)
Jeff Pratt, President & CEO (SpeedTrack)

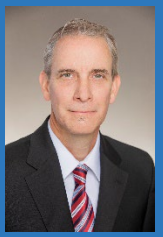
Who is HQI?



The Hospital Quality Institute (HQI)

- 501 C 3 Non-Profit Organization
- Part of California Hospital Association
- Independent Board of Directors
- 495 members (62 additional facilities in process)
- 21 states

HQI Mission



- To support members in their pursuit of safe, quality care and the attainment of zero harm
- Provide value and benefit to our members

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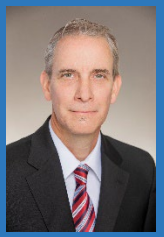
HQI Data Initiatives



- Hospital Quality Improvement Platform
  - Comparative Quality Analytics Platform
  - Patient Encounter Data
- CHPSOData
  - Reporting, Standardization, & Analytics Platform
  - Safety Event Reports
- **Quality Transparency Dashboards**
  - Dashboards of Publicly-Available Quality Data
- **Sentinel Signal Detection**
  - Artificial Intelligence to Identify Public Health Trends

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Hospital Quality Improvement Platform

HQI's Comparative Quality Analytics Platform

- **Participating California hospitals: 148 with 136 in progress**
  - 40 Rural (24 CAH)
- **No Barriers:**
  - Web-based & easy to use
  - Free for CHA members
  - Does NOT connect to EHR
  - Uses existing data – NO new data files to make
- **300+ timely quality measures & comparisons**
- **Sharing data for the greater good**

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Hospital Quality Improvement Platform

Key Progress:

- Transformed and modernized the platform with SpeedTrack
- Improved flexibility and timeliness
- Multifactor authentication
- Streamlined data uploads and quality monitoring
- Improved reports, dashboards, and analytics (ARN added)
- User-defined multi-level selections for comparisons and filters
- New Reports: Social Determinants, AHRQ Pediatric PDIs, QTD

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Hospital Quality Improvement Platform

Data Sources:

1. CDC NHSN – Healthcare-Associated Infections
2. CMQCC – Maternal Measures
3. HCAI (OSHPD) – SIERA Encounter Data

SIERA File Type	HCAI	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug†	Sep	Oct	Nov	Dec
Inpatient (IP)	Report period	Jan 1–Jun 30						Jul 1–Dec 31					
	Due date	Sep 30 of the same year						Mar 31 of the *following* year					
Emergency Department (ED)	Report period	Jan 1–Mar 31			Apr 1–Jun 30			Jul 1–Sep 30			Oct 1–Dec 31		
	Due date	May 15 of the same year			Aug 14 of the same year			Nov 14 of the same year			Feb 14 of the *following* year		
Ambulatory Surgery (AS)	Report period	Jan 1–Mar 31			Apr 1–Jun 30			Jul 1–Sep 30			Oct 1–Dec 31		
	Due date	May 15 of the same year			Aug 14 of the same year			Nov 14 of the same year			Feb 14 of the *following* year		

†HCAI aggregates SIERA files and releases statewide Limited Data Sets around August of the *following* calendar year.

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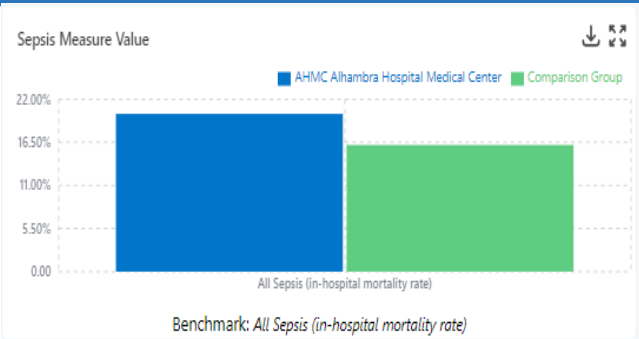

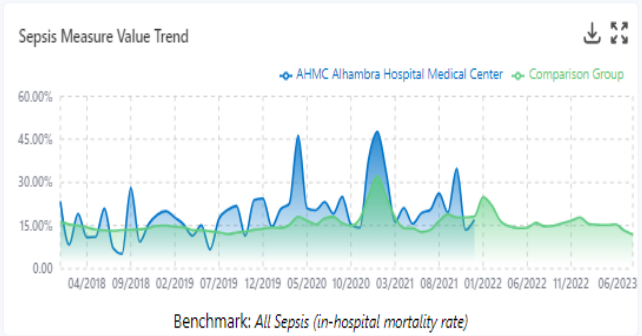

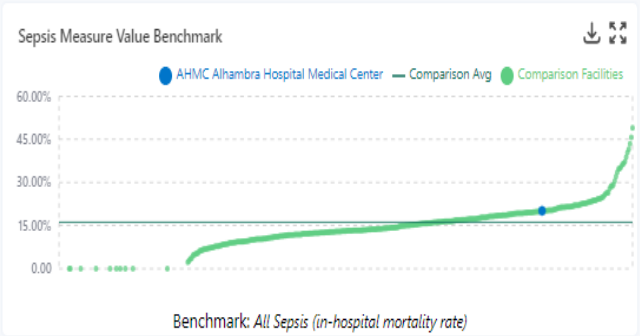

HQIP Introduction Demonstration

Presenter: Aaron Koll

Platform: https://hqipanalytics.org

Learn More: Hospital Quality Improvement Platform

Hospital Quality Institute

HCAI
Department of Health Care Access and Information

Hospital Quality Improvement Platform

Hospital Equity Reporting Program (AB 1204): Measures

1. Breastfeeding (PC-05): ALTERNATIVE: CDC/AIM SMM
2. HCAHPS Would Recommend Hospital (H-RECMND-DY): REJECT
3. HCAHPS Received Information & Education (H-COMP-6-Y-P): REJECT
4. Hospital-Wide Readmission (CMS-30d-HWR): ALTERNATIVE: HCAI-SS-HWR
5. Sepsis Management (SEP-1): ALTERNATIVE: SEP-3
6. NTSV Cesarean Birth Rate (PC-02): ALTERNATIVE: IQI 33
7. Pneumonia Death Rate (IQI 20): SUPPORT
8. Death after Serious Treatable Condition (PSI 04): SUPPORT
9. Vaginal Birth after Cesarean Delivery (IQI 22): SUPPORT
10. Time in ED Without Being Seen (ED Wait Time): REJECT
11. HCAI-SS-HWR x Behavioral Health Conditions: SUPPORT

Additional Measures:

- 9 Structural
- 8 Psychiatric
- 6 Pediatric

Learn More: HCAI Hospital Equity Reporting Program
The Medical Equity Disclosure Act (HSC §§127370-127376)

Hospital Quality Institute

HCAi
Department of Health Care Access and Information

Hospital Quality Improvement Platform

Hospital Equity Reporting Program (AB 1204): Strata

1. Age
2. Sex
3. Race
4. Ethnicity
5. Language Spoken
6. Likely Payer (SES proxy)
7. Disability Status
8. Sexual Orientation
9. Gender Identity
10. Behavioral Health Conditions

Additional Stratifiers:

- Homelessness
- California Healthy Places Index (CPI)
- Limited English Proficiency

Learn More: HCAI Hospital Equity Reporting Program
The Medical Equity Disclosure Act (HSC §§127370-127376)

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Hospital Quality Improvement Platform

Population Health Management Solutions

- Multi-Dimensional Analysis
- Integrates User Experience and Intuition
- Insightful Guided Navigation

HQIP Disparity and Equity Analytics and Reporting

- Current Measures:
  - Readmission Rates – 3, 7, 14 and 30 day (HCAI-SS-HWR)
  - In-Hospital Acute Care Sepsis Mortality Rate (SEP-3)
  - Pneumonia Death Rate (IQI 20)
  - NTSV Cesarean Birth Rate (IQI 33)
  - Vaginal Birth After Cesarean Delivery Rate (IQI 22)

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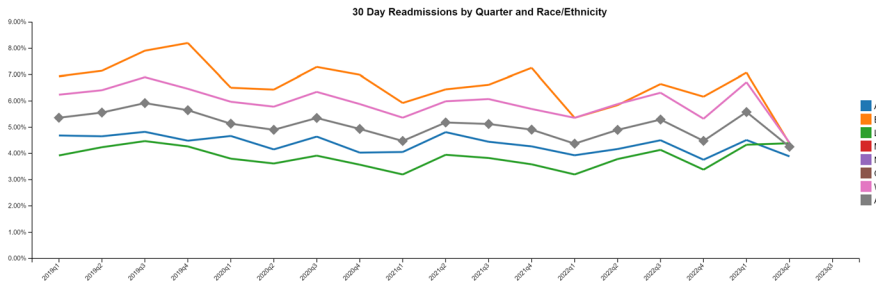

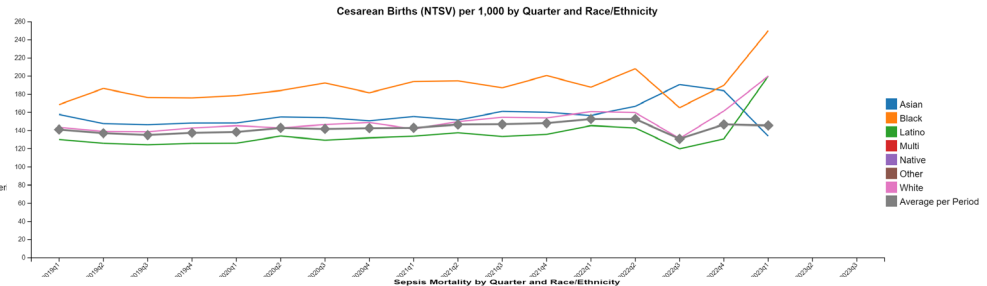

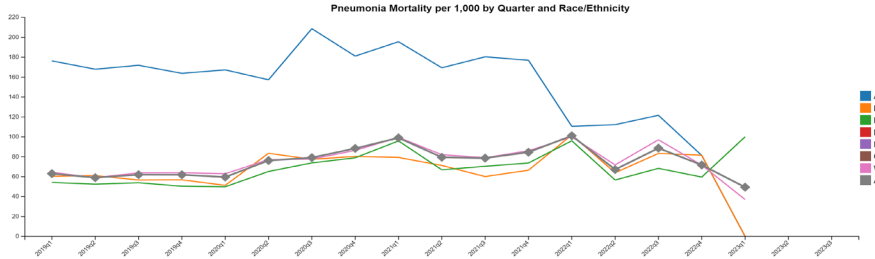

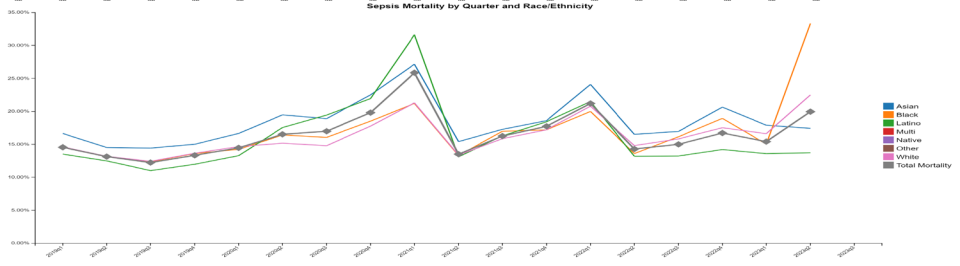

HQIP Focus on Equity Demonstration

Presenter: Jeff Pratt

Powered by SpeedTrack: https://speedtrack.com/

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Hospital Quality Improvement Platform

Future Directions & Improvements:

- Hospital-specific signal detection in platforms
- Focus on data quality & timeliness of reporting
- Improved reports, dashboards, and analytics:
  - HCAI Stratified Hospital Equity Reports (AB 1204) 2023 Q3
  - Reports for specific hospital types (child, rural, psych)
  - Readmission rates for specific (CMS) diagnoses & procedures
  - Severe Maternal Morbidity & Mortality (SMM)

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Hospital Quality Improvement Platform

Questions?

HQIP Participation is: *Free, Easy, and Important for CA*

Join HQIP or Schedule a Demo: HQIAnalytics@hqinstitute.org

Scott Masten: smasten@hqinstitute.org

Aaron Koll: akoll@hqinstitute.org

Jeff Pratt: jeff@speedtrack.com

Follow us on Twitter: @CHPSO and @HQInstitute

Hospital Quality Institute

Hospital Quality Improvement Platform

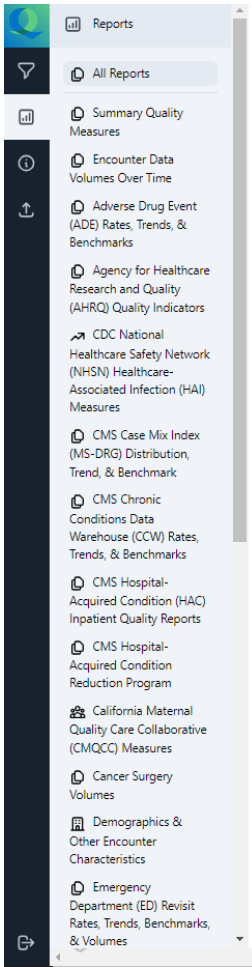
HQIP Handouts

HQIP Landing Page

Hospital Quality Improvement Platform

HQIP Handouts

HQIP Reports



Summary Quality Measures
- HQIP Landing Page

Encounter Data Volumes Over Time
- Uploaded (SIERA) Data Volumes by Encounter Type
- Uploaded (SIERA) and Historic (AB2876) Data Volumes by Encounter Type

Adverse Drug Event (ADE) Rates, Trends, & Benchmarks
- ADE Incidence for Inpatient Encounters

Agency for Healthcare Research and Quality (AHRQ) Quality Indicators
- AHRQ Patient Safety Indicators (PSI) Rates, Trends, & Benchmarks
- AHRQ Inpatient Quality Indicators (IQI) Rates, Trends, & Benchmarks
- AHRQ Pediatric Quality Indicators (PDI) Rates, Trends, & Benchmarks
- AHRQ PSI & IQI Composite Measure Rates & Trends

CDC National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) Measures
- NHSN HAI Rates, Trends, & Benchmarks

CMS Case Mix Index (MS-DRG) Distribution, Trend, & Benchmark
- Case Mix Index for Inpatient Encounters

CMS Chronic Conditions Data Warehouse (CCW) Rates, Trends, & Benchmarks
- Chronic Condition Prevalence by Encounter Type
- Other Chronic & Disabling Condition Prevalence by Encounter Type

CMS Hospital-Acquired Condition (HAC) Inpatient Quality Reports
- Deficit Reduction Act (DRA) HAC Rates, Trends, & Benchmarks

CMS Hospital-Acquired Condition Reduction Program
- CMS Hospital-Acquired Condition Reduction Program

California Maternal Quality Care Collaborative (CMQCC) Measures
- CMQCC Maternal Quality Measure Rates, Trends, & Benchmarks

Cancer Surgery Volumes
- Cancer Surgeries by Encounter Type

Demographics & Other Encounter Characteristics
- Demographic & Other Characteristic Distributions by Encounter Type

Emergency Department (ED) Revisit Rates, Trends, Benchmarks, & Volumes
- Same-Site Revisits for ED Encounters

HCUP Comorbidity (Elixhauser) Rates, Trends, & Benchmarks
- Elixhauser Comorbidity Prevalence by Encounter Type
- Elixhauser Comorbidity Composite Index Rates & Trends

Inpatient Encounter Outcome Distributions by Principal Diagnosis/Procedure
- Lengths of Stay (LOS)
- Discharge Dispositions

Inpatient Encounter Outcome Rates, Trends, & Benchmarks by Modified DRG Families
- Case Mortality
- Reoperations
- Discharges to Home
- Discharges to Skilled Nursing Facilities (SNFs)
- Lengths of Stay (LOS)
- Serious Complications

Inpatient Encounter Outcome Rates, Trends, & Benchmarks by Principal Diagnosis/Procedure
- Case Mortality
- Reoperations
- Discharges to Home
- Discharges to Skilled Nursing Facilities (SNFs)
- Lengths of Stay (LOS)
- Serious Complications

Local Health Plan Reports
- Inland Empire Health Plan - 2022 Pay for Performance (P4P) Program
- Inland Empire Health Plan - 2023 Pay for Performance (P4P) Program

Quality Transparency Dashboards
- Quality Transparency Dashboard

Readmission Rates, Distributions, & Volumes
- Readmissions for Historic (AB2876) & Recent (SIERA) Inpatient Encounters

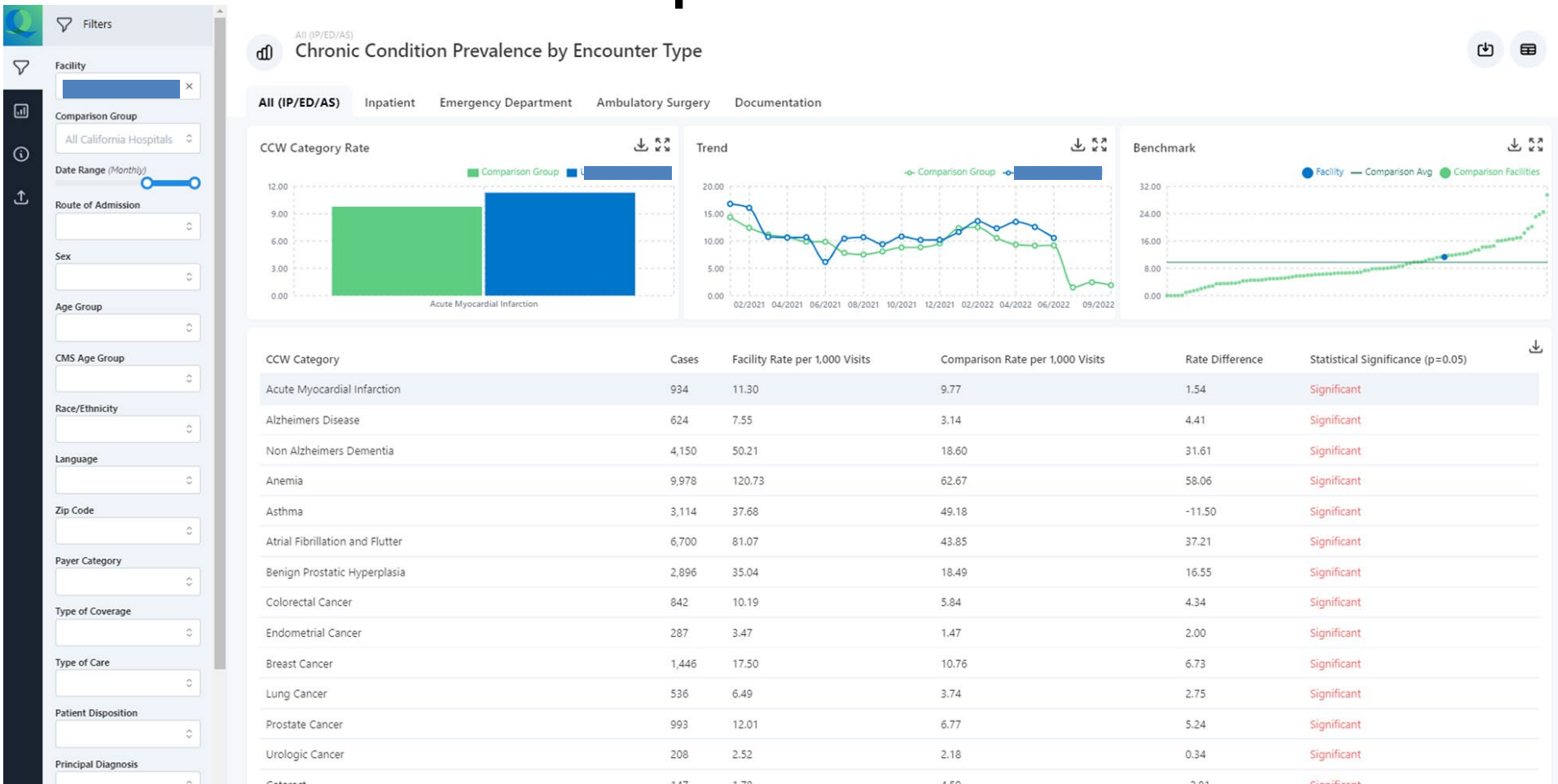
Sepsis (SEP-3) & Septic Shock Rates, Trends, Benchmarks, & Disposition Distributions
- Sepsis Incidence, Case Mortality, Length of Stay (LOS), & Admit/Discharge Dispositions for Inpatient Encounters

Social Determinants of Health (SDOH) Rates, Trends, & Benchmarks
- SDOH Prevalence by Encounter Type

Hospital Quality Improvement Platform

HQIP Handouts

HQIP Population Health



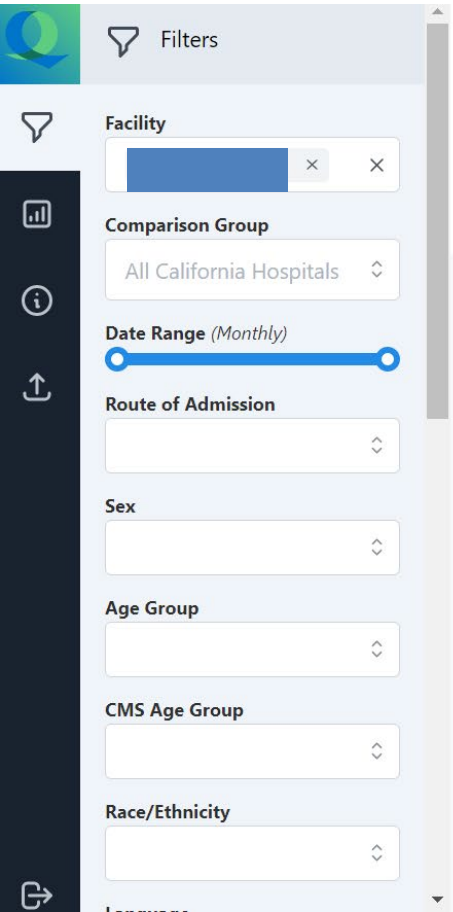
CCW Category	Cases	Facility Rate per 1,000 Visits	Comparison Rate per 1,000 Visits	Rate Difference	Statistical Significance (p=0.05)
Acute Myocardial Infarction	934	11.30	9.77	1.54	Significant
Alzheimers Disease	624	7.55	3.14	4.41	Significant
Non Alzheimers Dementia	4,150	50.21	18.60	31.61	Significant
Anemia	9,978	120.73	62.67	58.06	Significant
Asthma	3,114	37.68	49.18	-11.50	Significant
Atrial Fibrillation and Flutter	6,700	81.07	43.85	37.21	Significant
Benign Prostatic Hyperplasia	2,896	35.04	18.49	16.55	Significant
Colorectal Cancer	842	10.19	5.84	4.34	Significant
Endometrial Cancer	287	3.47	1.47	2.00	Significant
Breast Cancer	1,446	17.50	10.76	6.73	Significant
Lung Cancer	536	6.49	3.74	2.75	Significant
Prostate Cancer	993	12.01	6.77	5.24	Significant
Urologic Cancer	208	2.52	2.18	0.34	Significant

Hospital Quality Improvement Platform

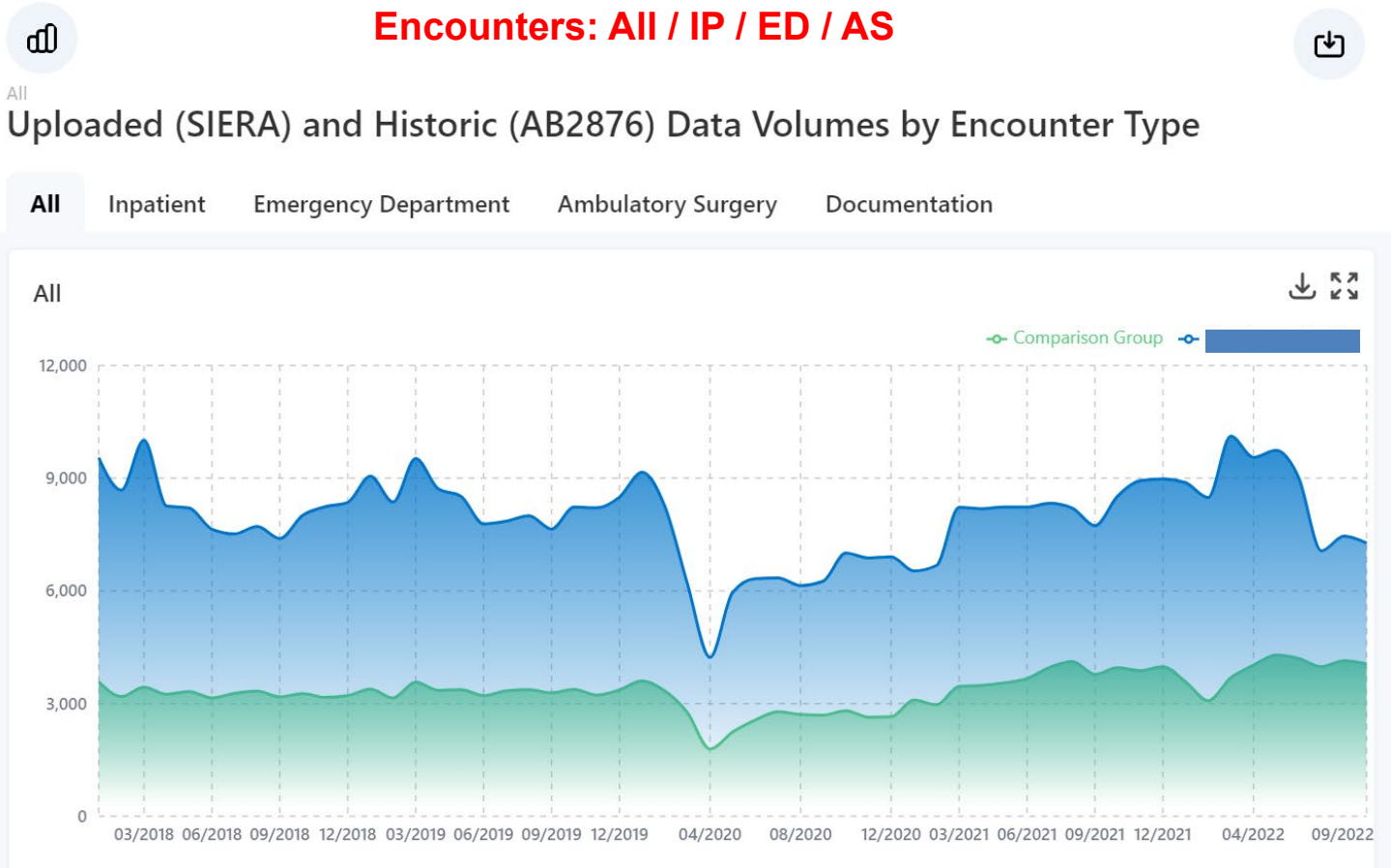
HQIP Handouts

HQIP Volume & Filters

Filter the Results



Encounters: All / IP / ED / AS

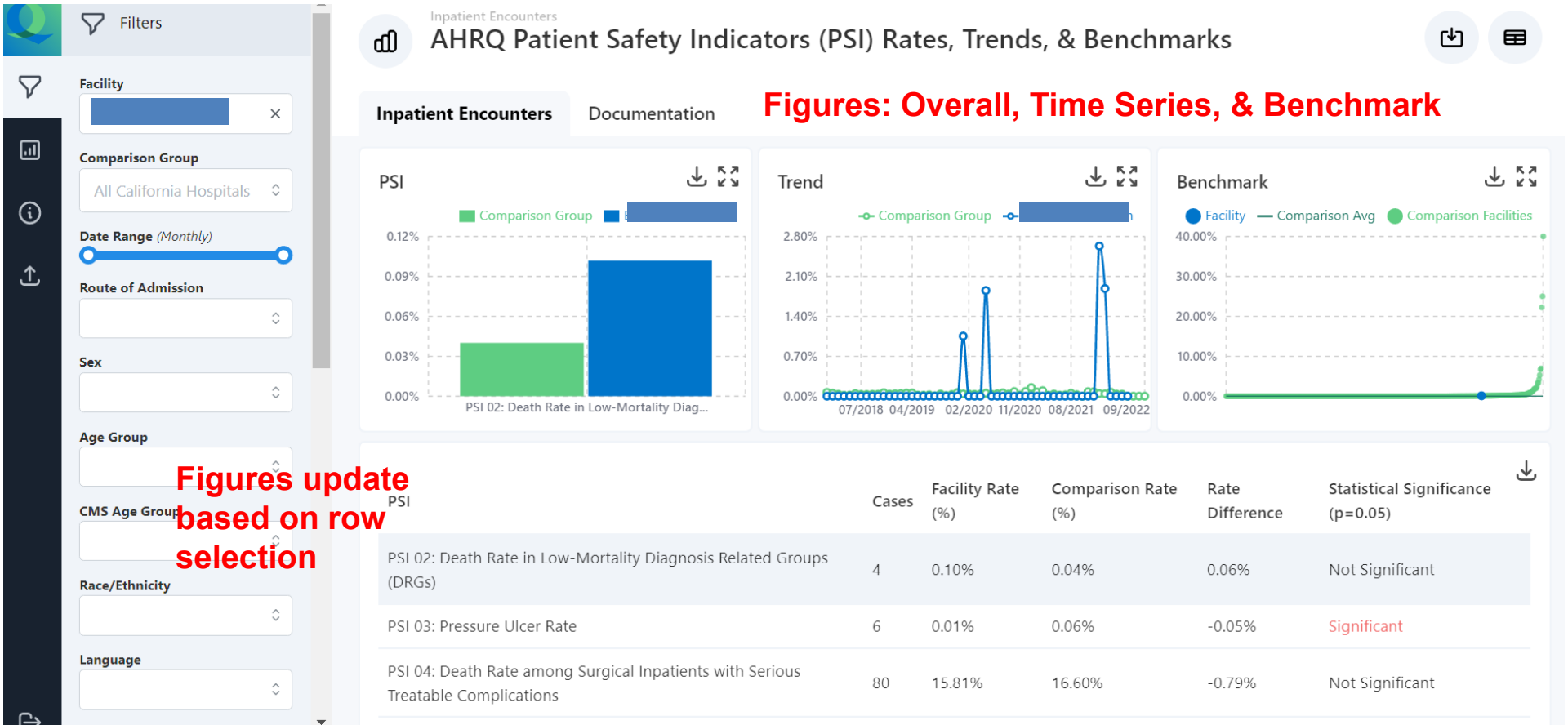


Hospital Quality Improvement Platform

HQIP Handouts

HQIP Figures

Downloadable Patient-level data

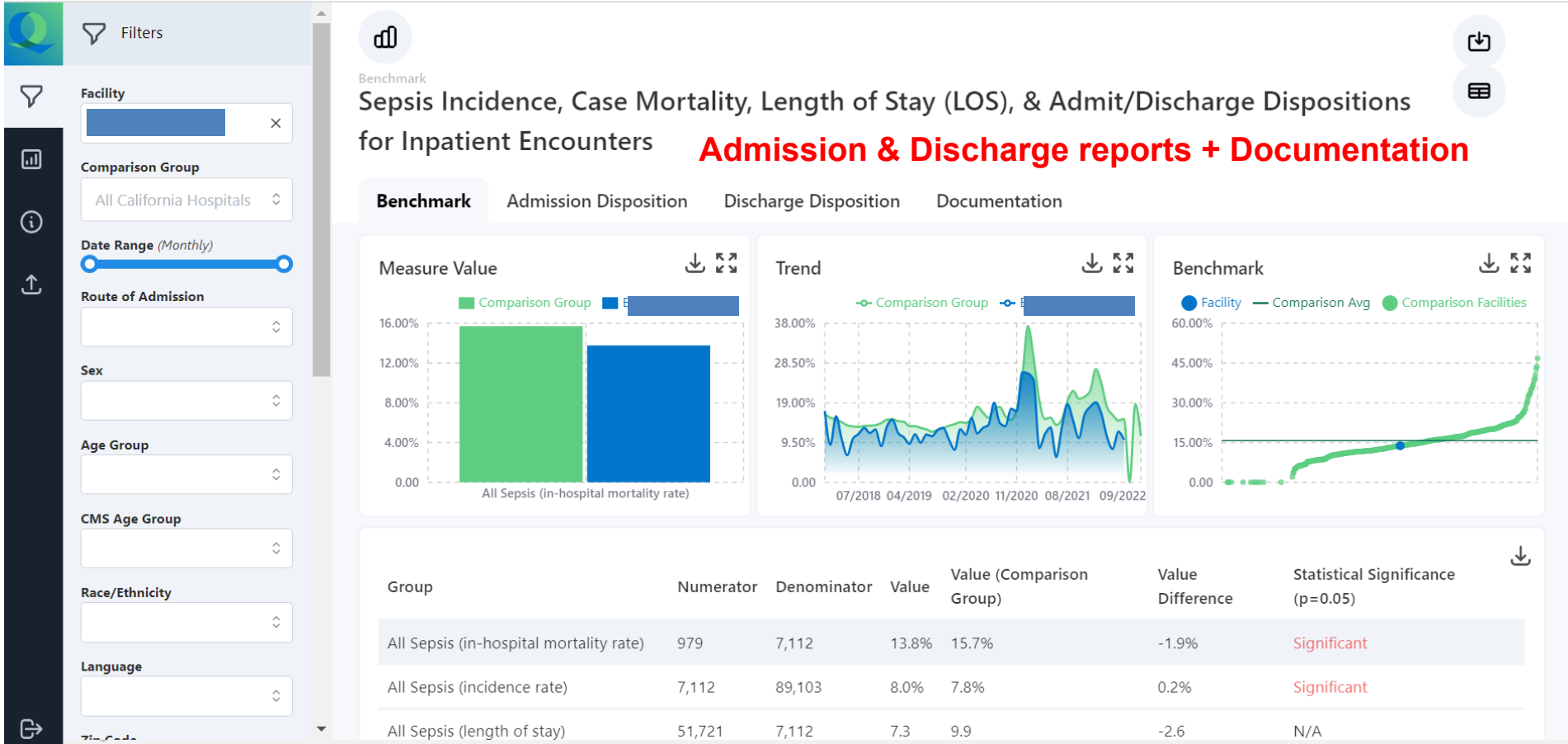


Hospital Quality Improvement Platform

HQIP Handouts

HQIP Sepsis

Select peer comparison groups



Thank You

Thank you Dr. Masten, Aaron Koll & Jeff Pratt

Maximizing QIP Performance:
Voices from the Field - A Panel Discussion

Our Moderator

Mark Netherda, MD
Medical Director for Quality, Partnership HealthPlan of California

Welcome Panel Participants

Fairfield

Christina Graves, BSN, RN - *Program Manager, Quality Outcomes - Adventist Health Ukiah Valley*

Kristy Bowen, BSN, RN, *Director, Quality/Infection Prevention, AHA Faculty - Adventist Health Howard Memorial & Ukiah Valley Hospitals*

Redding

Adrienne Tindal-Schultz, BSN, RN, *Nursing Manager; Critical Care & Medical Surgical Telemetry - Providence Redwood Memorial Hospital*

Caroline Williams, BSN, RN *Quality Improvement Coordinator - St. Joseph & Redwood Memorials Hospitals*

Tracy Norwood, *Sr. Quality Safety & Infection Prevention Program Manager - Banner Lassen Medical Center*

Thank You

Thank you Dr. Netherda & Panel Participants

LUNCH
(30 minutes)

Breakout Session 1: Hospital QIP Overview

AM

Welcome Amy McCune & Troy Foster

Amy McCune
Manager of Quality Incentive Programs
Partnership HealthPlan of California

Troy Foster
Program Manager,
Quality Improvement Programs
Partnership HealthPlan of California

NOTE: Breakout Session 2 – Exploring the Doula Benefit is located in other Conference Room

Hospital QIP Overview

Key Points for Today:

- Know your Measurement Period
- Know your Measurement Timeline
- Know your Measures
- Reach-Out/Engage Check-In

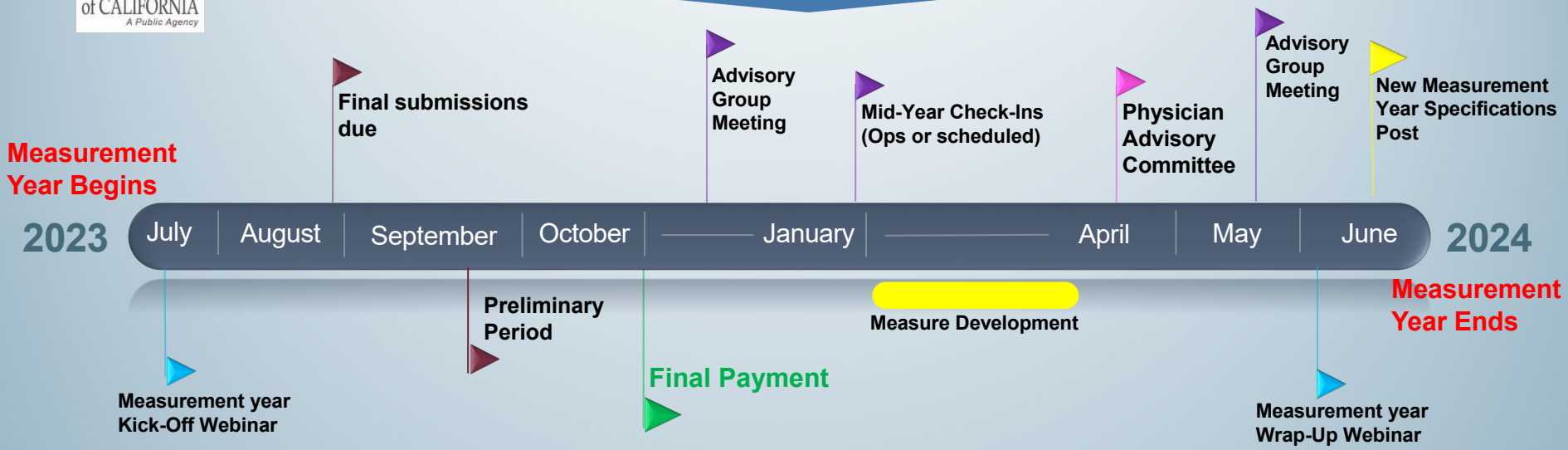
Hospital Quality Improvement Program (HQIP)

- Pay-for-performance program **supporting hospitals** serving PHC members **to improve quality and health outcomes**.

- Substantial Financial Incentives: approximately $8.1 million awarded among 26 hospitals in the 2021-22 measurement year

- 13 measures spread over Six domains: Readmissions, Advance Care Planning, Clinical Quality (OB / Newborn / Pediatrics), Patient Safety, Patient Experience, and Operations & Efficiency

Hospital QIP Timeline Overview



Measurement Year

Fiscal Year: July - June

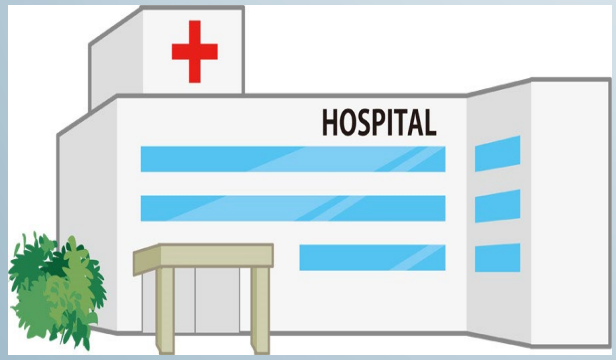
HQIP Measurement Timeline Cont.

- Regular Measurement Period:
  July 1, 2023 – June 30, 2024

- Expansion HQIP Measurement Period:
  January 1, 2024 – June 30, 2024

2023-24 Hospital QIP

HOSPITAL SIZE



Large Hospitals

≥ 50 licensed general acute beds

Small Hospitals

< 50 licensed general acute beds

Gateway Measure: HIE + EDIE Participation Requirement

- **Admissions, Discharge, Transfer (ADT)**
  plus HL7 or XDS interface with either:
  Sac Valley Med Share
  North Coast Health Information Network

- **ADT interface with EDIE**

- **Link to one of the following national HIE networks**:
  CareQuality,
  eHealth Exchange, or
  Commonwell

Capitated Hospitals: Utilization Management Delegation

- **Capitated Hospital**
  From July 1, 2023 to June 30, 2024, Hospitals must utilize **PointClickCare (formerly Collective Medical) EDIE,** for their capitated members to alert their internal Utilization Management team to out-of-network admissions.
    - PointClickCare will report usage data to Partnership HealthPlan confirming routing (month-by-month) utilization of the PointClickCare module via responsiveness to previously established alerts.

- **Delegation Reporting (not applicable for 6-month measurement set)**
  In order to receive the full Hospital QIP incentive payment, capitated hospitals must submit timely and accurate delegation deliverables to Partnership HealthPlan according to deadlines outlined in your hospital's delegation agreement.

Measure Reporting & Points

Measure/ Requirement	Hospital Reporting	PHC Reporting to Hospital (outside of final reports)	Hospital Size	Max Points
HIE and EDIE Participation	Status due June 30, 2024 to PHC	N/A	N/A	N/A
Delegation Reporting	Refer to Delegation Agreement Exhibit A	N/A	N/A	N/A
Risk Adjusted Readmissions	No reporting necessary. PHC utilizes claims data to measure performance.	Interim Reporting Available Spring of 2024	Small & Large	20
Palliative Care Capacity	August 31, 2024 to PHC	N/A	Small & Large	Large: 10 Small: 5
Hospital Quality Improvement Platform	Part I: Verification of participation in HQI Platform by 12/30/23 Part II: Timely, consistent (monthly) data submissions through June 30, 2024	N/A	Small & Large	10
Elective Delivery	Monthly reporting to CMQCC	N/A	Small & Large	5
Exclusive Breast Milk Feeding	Monthly reporting to CMQCC	N/A	Small & Large	5
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate	Monthly reporting to CMQCC	N/A	Small & Large	Large: 5 Small: 10
Vaginal Birth After Cesarean	Monthly reporting to CMQCC	N/A	Large Only	5

Measure Reporting & Points

TF

Measure/ Requirement	Hospital Reporting	PHC Reporting to Hospital (outside of final reports)	Hospital Size	Max Points
QI Capacity	Registration and attendance of PHCs 2023 Hospital Quality Symposium or other approved training.	N/A	Small & Large	5
California Hospital Patient Safety (CHPSO)	Report to CHPSO	N/A	Small & Large	Large: 5 Small: 10
Substance Use Referral	No reporting necessary. PHC utilizes claims data to measure performance.	Interim Reporting Available Spring of 2024	Small & Large	10
Hepatitis B/ CAIR Utilization	Maternity Hospitals: No reporting necessary (PHC will access CAIR data) Non Maternity Hospitals: Submit CAIR report by August 31, 2024	N/A	Small & Large	5
Cal Hospital Compare-Patient Experience	August 31, 2024 to PHC	N/A	Small & Large	10
Health Equity	Submission of HE Plan due to PHC August 31, 2024	N/A	Small & Large	5

Note: The max point value a hospital can earn may vary due to hospital size. Expansion Hospital max point value is less due to having less measures.

Risk Adjusted Readmissions
(Large and Small Hospitals)

TF

20 Points Possible

30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 1 and June 1 of the measurement year by PHC members included in the denominator.

Not applicable to the 6 month Expansion Hospital measurement set

Calculation: $\textbf{Observed 30 Day Readmissions Rate} = \frac{\textbf{Observed 30 Day } \textit{Readmissions}}{\textbf{Total Count of Index Hospital } \textit{Stays}}$

Expected 30-Day Readmission: An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

Calculation: $\textbf{Expected 30 Day Readmissions Rate} = \frac{\textbf{Expected 30 Day } \textit{Readmissions}}{\textbf{Total Count of Index Hospital } \textit{Stays}}$

Target:

Full Points = **20 Points**: Ratio < 1.0

Partial Points = **10 points**: Ratio $\leq$ 1.0-1.2

Palliative Care Capacity
(X-Large Hospitals)

TF

Hospitals ≥ 100 beds: Hospitals >100 beds are encouraged to join Palliative Care Quality Collaborative (PCQC) and use it to submit data to PHC.

Reporting:

Part 1: Hospitals must submit a report summarizing the number of palliative care consults per month for the measurement year July 1, 2023 – June 30, 2024. Hospitals using PCQC can send a report including all consults in PCQC, not just PHC members. For hospitals not participating in PCQC, these entities must submit data from an alternative reporting method to be determined by the hospital.

Part 2: Rate of consults who have completed an Advance Care Directive or have a signed POLST:
Numerator: Anyone with an Advance Directive or POLST status in PCQC or inpatient EMR and on the palliative care service at either the time of consult ***or*** the time of discharge.

Denominator: Patients with a palliative care consult recorded in PCQC or in the inpatient EMR and on the palliative care service, discharged alive from July 1, 2023 – June 30, 2024.

Targets:

Full credit: All of the following: (10 points)
Part 1: Minimum of 10 patients Part 2: > 40%

Partial credit: All of the following: (5 points)
Part 1: 5-9 patients Part 2: > 40%

Palliative Care Capacity
(Large and Small Hospitals)

Large Hospitals with 50-99 Beds:

- At least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician

Hospitals < 50 beds:

- One Physician Champion or availability of consultation, with trained clinical staff as defined by specification

Target:

Pay for reporting Palliative Care Capacity Attestation Form including the information listed under Measure Requirements.

Full points = 5 points. No partial points are available for this measure.

Maternity Measures
(Large and Small Hospitals)

TF

Data Submission Instructions
Hospitals must submit timely* data to California Maternal Quality Care Collaborative **(CMQCC)**. Hospitals must authorize PHC to receive data from CMQCC by completing the authorization form available on the Maternal Data Center.

For hospitals new to CMQCC:
- Legal agreement: due September 30
- First data submission for July - October: due December 15. Timely data submission after that, starting January.

For hospitals already participating in CMQCC: 12 months of timely data submission for each month during the measurement year.

*Per CMQCC, timely submissions are defined as those submitted within 45-60 days after the end of the month.

Effective dates for Expansion Hospitals are to be determined and will be available when Specifications are finalized in the coming months.

Elective Delivery before 39 weeks
(Large and Small Hospitals)

Description:
Percent of patients with newborn deliveries at ≥ 37 to < 39 weeks gestation completed, where the delivery was elective within the measurement year.

Numerator: The number of patients in the denominator who had elective deliveries.

Denominator: Patients delivering newborns at ≥ 37 to < 39 weeks gestation.

Target:
- Full Points: ≤ 1.0% = 5 points
- Partial Points: > 1.0% - 2.0% = 2.5 points

Exclusive Breast Milk Feeding Rate
(Large and Small Hospitals)

TF

Description:
Exclusive breast milk feeding rate for all newborns during the newborn's entire hospitalization within the measurement year

Numerator: The number of newborns in the denominator that were fed breast milk only since birth

Denominator: Single term newborns discharged alive from the hospital during the measurement year

Target:
- Full Points: ≥ 75.0% = 5 points
- Partial Points: 70.0% - < 75.0% = 2.5 points

NTSV C Section Rate
(Large and Small Hospitals)

Description:
Rate of Nulliparous, Term, Singleton, Vertex Cesarean births occurring at each hospital participating in HQIP within the measurement period.

Numerator: Patients with cesarean births.

Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation.

Large Hospital Target:
- Full Points: < 22% = 5 points
- Partial Points: ≥ 22.0% - 23.9% NTSV rate = 2.5 points

Small Hospital Target:
- Full Points: < 22.0% = 10 points
- Partial Points: > 22% - 23.9% = 5 points

Vaginal Birth After Cesarean
(VBAC – Large Hospitals Only)

Description:
For hospitals with ≥ 100 beds that offer maternity services: Percent of patients who had a previous Cesarean delivery who deliver vaginally during the Measurement Year.

Numerator: Patients who deliver vaginally that have had a previous Cesarean delivery.

Denominator: Patients with a previous Cesarean birth.

Target:
Full Points: ≥ 5.0% VBAC Uncomplicated = 5 points

CHPSO Participation
(Large and Small Hospitals)

TF

Description

Active participation in the California Hospital Patient Safety Organization (CHPSO) via data submission and participation in Safe Table Forums.

Specifications

Small Hospitals (<50 beds):

- Participation in at least 1 Safe Table Forum
- Submission of 50 patient safety events to CHPSO
- **Full Points = 10 Points**

Large Hospitals (>50 beds):

- Participation in at least 4 Safe Table Forums
- Submission of 100 patient safety events to CHPSO
- **Full Points = 5 Points**

Reporting: Hospitals report directly to CHPSO. No reporting by hospital to PHC.

Numbers of safe table forums and patient safety events to be determined for Expansion Counties

Substance Use Disorder Referrals
(Large and Small Hospitals)

TF

- **Numerator:** Any subsequent prescription of buprenorphine ***or*** any subsequent office visit with diagnosis of F11.2x (anywhere on the claim) between 1 and 60 days post discharge.
- **Denominator:** Emergency Department or inpatient admissions of PHC Members with ICD10: F11.2x diagnosis code of opioid use disorder billed in any position on the claim.
- **Data Collection:** PHC will use medical and Buprenorphine pharmacy claims data for the period 1-60 days post-discharge during the Measurement Year, as well as outpatient provider data to determine performance.
- **Target**
  - Existing Large Hospitals: ≥ 10 PHC Members = 10 points
  - Existing Small Hospitals: ≥ 3 PHC Members = 10 points

  - Expansion Large Hospitals: ≥ 5 PHC Members = 10 points
  - Expansion Small Hospitals ≥ 2 PHC Members = 10 points

Hepatitis B / CAIR
(Large and Small Hospitals)

TF

Hospitals *providing* Maternity Services

Numerator: Newborn Hepatitis B Vaccine entered in CAIR w/in first month of life

Denominator: Newborn births at the hospital between July 1, 2023 – June 30, 2024

Expansion Hospitals: January 1, 2024 – June 30, 2024

Target: Full Points > 20% = 10 Points

Partial Points 10-20% = 5 points

Hospitals *not providing* Maternity Services

Numerator: Number of vaccines recorded in CAIR

Denominator: Number of Licensed acute inpatient beds

Report August 31, 2024 with data from July 1, 2023 – June 30, 2024

Expansion Hospitals: January 1, 2024 – June 30, 2024

Target: Full Points Ratio > 1.20 = 10 Points

Partial Points Ratio 0.20 to 1.20 = 5 Points

Quality Improvement Capacity
(Large and Small Hospitals)

5 points

Description

This measure is intended to introduce resources to all PHC network hospitals, to provide hospital administrators, physicians, and staff of all levels with tools, strategies, and inspiration for improving the quality of care provided to our members

PHC encourages PHC-contracted hospitals to send staff of all levels to an informative learning session (One (1) representative per entity site location). Full credit is also available for attending the national meeting of the Institute for HealthCare Improvement.

Hospital Quality Improvement Platform (Large and Small Hospitals)

Description: This measure is designed to encourage hospitals to participate in the Hospital Quality Improvement Platform and submit timely, complete data submissions.

Two-part measure:

1. Participation in HQI Platform (proof of participation due December 30, 2023)
2. Timely, complete, and consistent submission of discharge data into HQI Platform including NHSN rights conferral (PHC will assess hospital usage June 30, 2024)

Target:

Partial Points = 5 Points: Hospitals successfully sign up, confer NHSN rights, and submit all discharge data due to HCAI into the HQI Platform by December 30, 2023 or June 30, 2024 for Expansion Hospitals.

Full Points = 10 Points: Hospitals successfully sign up, confer NHSN rights, and submit all discharge data due to HCAI into the HQI Platform by December 30, 2023 or June 30, 2024 for Expansion Hospitals **and** continued submission of all discharge data do to HCAI into the platform for the remainder of the measurement year (June 30, 2024).

Cal Hospital Compare - Patient Experience (Large and Small Hospitals)

Description

Hospital Patient Experience data collected on Cal Hospital Compare is measured as an aggregate score in comparison to the aggregate score of Patient Experience for all acute care hospitals in the State of California with publicly available information. [1]

Target

Hospital aggregate score is greater than average California hospital score *0.95

Full points = 10 points
No Partial Points

Reporting:

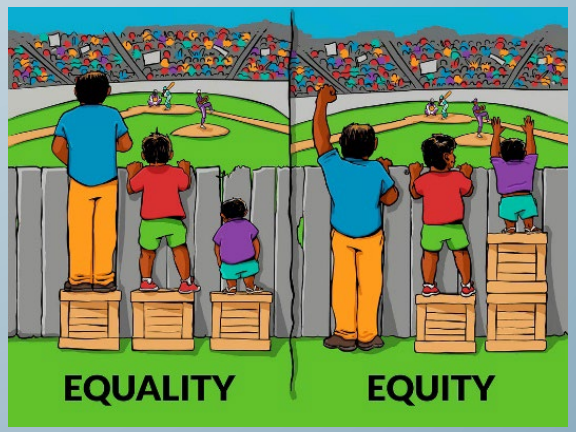
PHC will collect data that hospitals submit to Cal Hospital Compare directly from hospitals and compare aggregate score to the average California hospital score*. Hospital Patient Experience data submission due to PHC no later than August 31, 2024

Health Equity
(Large and Small Hospitals)

Description: PHC promotes Health Equity through responsive, respectful and open processes involving our internal workforce, healthcare providers, community organizations, and our members. This submission-based measure requests that hospitals submit a completed Translation and Interpretation Services Template to PHC.

Target

Submission of an HE report based on identifying health inequities as outlined in measure requirements on next slide.



Due Date: Report due by August 31, 2024

Full Points = 5 Points

No Partial Points

Health Equity - Continued
(Large and Small Hospitals)

TF

Submission shall demonstrate:

1. Using hospital data to identify at least one outcome inequity or service inequity of interest to the hospital. Any category of inequity for which the hospital has data, is acceptable. This may include: ethnicity, sex, sexual orientation, gender identity, language, residence, disability.
2. Present data analysis and any drill-down and roll-up analysis done to characterize the scope and drivers of the inequity.
3. A discussion of hypothesized drivers for the inequity.
4. Describe an intervention plan or pilot designed to address the inequity.
5. Provider data measuring the effect of this intervention or pilot
6. Summarize lessons learned from this intervention/pilot and plans for the future.

Next Steps / Reminders

- ✓ **2022-23 Preliminary Report:** Validate by Mid October
- ✓ **Staff Contact Changes:** Email HQIP@partnershiphp.org
- ✓ Keep an eye out for reports and newsletters
- ✓ Review and note measure submission dates

Contact Us

Visit our website:

www.partnershiphp.org

Email us:

HQIP@partnershiphp.org

Hospital QIP Team:

Amy McCune, Manager of Quality Improvement Programs

Troy Foster, Program Manager

Thank You

Thank you Amy McCune & Troy Foster

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Perinatal Care and Doula Services for PHC Members

August 8, 2023
Colleen Townsend, MD
Tiffany Lacey, BS, CD (DONA)

August 10, 2023

Robert Moore, MD MPH MBA
Chelsy Marriott, BS, CD/PCD (DONA), CLC

Trained, non clinical professionals who provide emotional, physical and informational support during pregnancy, delivery and after childbirth

- Provide education and emotional support to supplement and reinforce health care services
- Systems navigation – health care and social services
- Affirmation and advocacy – in situations of uncertainty or stress
- Community based practice – locally trusted and can be cultural bridges
- Access – Most doulas offer home visits, easing transportation burden for these services.

- US rates of maternal mortality and complications out pace other high income countries, and within that there are disparities based on race and income levels:
  - In 2017, a CMS panel convened to develop a strategy and action to address these issues and improve maternal care management.
- A 2020 CMS Report from a CMS Expert Panel recommends increasing access to continuous support in labor to improve maternal care management.

- Staffing models and shifting nursing responsibilities have moved nurses away from continuous labor support, leaving laboring patients without continuous support in labor.

- Studies suggest the positive effects of doula care may be even greater for women who were socially disadvantaged, low-income, unmarried, primiparous, alone, or have experienced language/cultural barriers.

Policy for Doula Services

- Doula services are considered Preventive Health Care services which, within the scope of authorized practice under State law will:
  - Prevent disease, disability, and other health conditions or their progression;
  - Prolong life; and
  - Promote physical and mental health and efficiency
- In 2019, ten doula pilots initiated by in MediCal Managed Care programs across California.
- In 2022, California submitted a State Plan Amendment to add doula services as a Medi-Cal benefit – approved in January 2023.
- In January 2023, California Medi-Cal Managed Care Plans became required to cover doula services.

Advantages of Doula Services

Doulas involved in births are associated with:

Improved Birth Outcomes

- Fewer Cesarean Sections
- Shorter labors
- Fewer forceps or vacuum assisted deliveries
- Less use of medication analgesia
- Less need for oxytocin

Improved Maternal Experience

- Increased satisfaction with birthing experience
- Improved bonding with newborn
- Higher breast feeding initiation rates and duration

The State of Doula Care in 2019
NYC Health. Retrieved from
https://www1.nyc.gov/assets/doh/downloads/pdf/csi/doula-report-2019.pdf.

Covered Doula Services

- Prenatal, Intrapartum, and Postpartum Care:
  - During pregnancy labor and delivery, miscarriage, still birth and abortion
  - Physical, emotional and non-medical care
  - Services can be provided up to 12 months from the end of pregnancy.
  - Does not require supervision of clinical provider

- Covered services Include:
  - 1 initial visit
  - 8 additional visits (pre and/or post partum)
  - Labor support
  - Up to 2 extended 3-hour postpartum visits
  - Additional visits (≤ 9) may be considered, if needed

- Partnership members who are currently pregnant, or have been pregnant in the last 365 days, are considered eligible for the doula services benefit.

- Partnership encourages doulas be integrated into member's perinatal visits and recommend doulas accompany member to one (1) prenatal visit during each trimester.

- Doulas are an important part of the perinatal care team and support the standards of care for routine perinatal services.

1) Enroll in the Medi-Cal PAVE process:
   - Documents requirement to participate
   - Establishes ability to submit claims in Medi-Cal systems

2) Contract with Partnership HealthPlan:
   - Establishes basic tenet as a service provider in the PHC Network

3) Credential with Partnership
   - Reviews the doulas training/experience background to ensure meets all requirements

4) Onboarding
   - Standard review of Partnership provider policies
   - Training in submitting claims
   - Review of Partnership Benefits and Services with emphasis on perinatal and early childhood care and resources

Training Pathway

- Minimum 16 hours of training in the following areas:
  - Lactation support
  - Childbirth education
  - Foundations of anatomy of pregnancy and childbirth
  - Non-medical comfort measures, prenatal support, and labor support
  - Developing a community resource list
- Provide support at minimum of 3 births

Experience Pathway

- At least 5 years doula experience
- Attestation to skills in prenatal, labor and postpartum care as demonstrated by the following:
  - 3 written client testimonial letters or professional letters of recommendation from a licensed provider.

Required for BOTH pathways

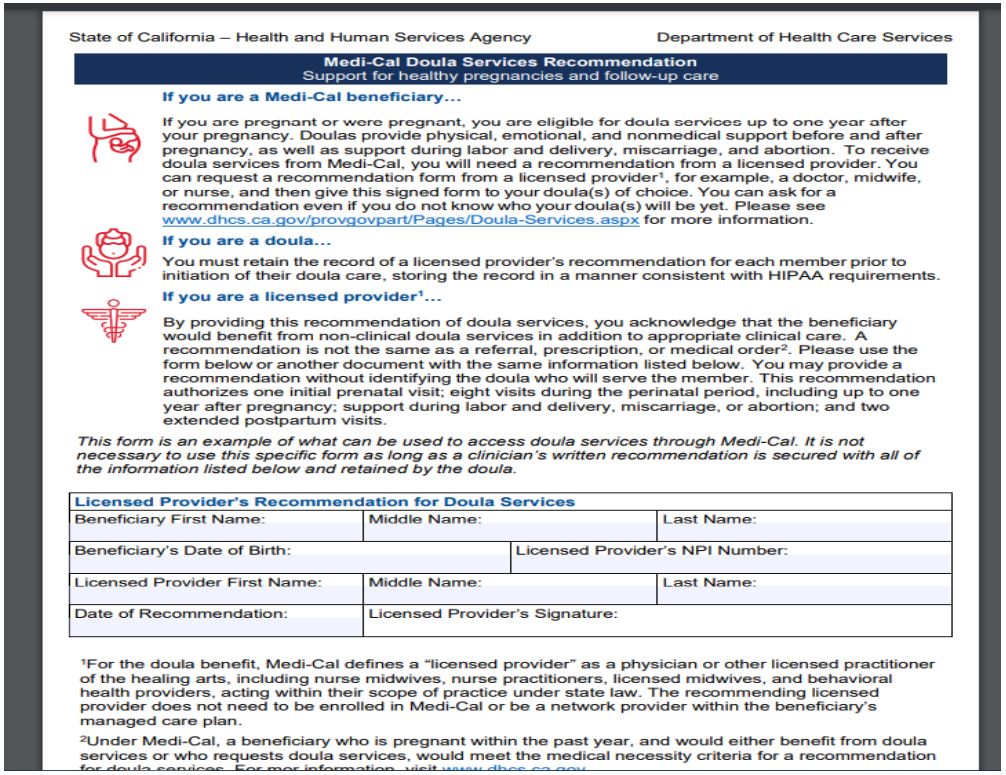
- Must be at least 18 years old
- Submit certificates of adult & infant CPR
- Submit certificate of HIPPA training or attestation
- Complete at least 3 hours of education every 3 years

Initiating Doula Services

- Referral NOT required
- Recommendation by licensed provider OR standing order by managed care plan, group or practice
  - DHCS Recommendation document:
    documenthttps://www.dhcs.ca.gov/provgovpart/Documents/DoulaREC.pdf
- Partnership HealthPlan policy allows that all pregnant members up to 365 days postpartum can access doulas services.
  - Doulas requested document the name/organization of a collaborating provider (OB/PCP, Behavioral Health Provider, Comprehensive Perinatal Services Program)

- Written recommendation in Member's record
- Standing order for doula services by MCP, physician group, or other group by a licensed Provider
- Standard DHCS form signed by licensed practitioner
  - https://www.dhcs.ca.gov/provgovpart/Documents/DoulaREC.pdf
- Additional recommendation **IS required** if > 9 visits are needed
  - Cannot be established by standing order
  - Can be from physician or licensed provider
  - The additional recommendation authorizes 9 or fewer additional postpartum visits.

DHCS Form Example



State of California – Health and Human Services Agency — Department of Health Care Services

Medi-Cal Doula Services Recommendation
Support for healthy pregnancies and follow-up care

If you are a Medi-Cal beneficiary…

If you are pregnant or were pregnant, you are eligible for doula services up to one year after your pregnancy. Doulas provide physical, emotional, and nonmedical support before and after pregnancy, as well as support during labor and delivery, miscarriage, and abortion. To receive doula services from Medi-Cal, you will need a recommendation from a licensed provider[1]. You can request a recommendation form from a licensed provider[1], for example, a doctor, midwife, or nurse, and then give this signed form to your doula(s) of choice. You can ask for a recommendation even if you do not know who your doula(s) will be yet. Please see www.dhcs.ca.gov/provgovpart/Pages/Doula-Services.aspx for more information.

If you are a doula…

You must retain the record of a licensed provider's recommendation for each member prior to initiation of their doula care, storing the record in a manner consistent with HIPAA requirements.

If you are a licensed provider[1]…

By providing this recommendation of doula services, you acknowledge that the beneficiary would benefit from non-clinical doula services in addition to appropriate clinical care. A recommendation is not the same as a referral, prescription, or medical order[2]. Please use the form below or another document with the same information listed below. You may provide a recommendation without identifying the doula who will serve the member. This recommendation authorizes one initial prenatal visit; eight visits during the perinatal period, including up to one year after pregnancy; support during labor and delivery, miscarriage, or abortion; and two extended postpartum visits.

This form is an example of what can be used to access doula services through Medi-Cal. It is not necessary to use this specific form as long as a clinician's written recommendation is secured with all of the information listed below and retained by the doula.

Licensed Provider's Recommendation for Doula Services		
Beneficiary First Name:	Middle Name:	Last Name:
Beneficiary's Date of Birth:	Licensed Provider's NPI Number:	
Licensed Provider First Name:	Middle Name:	Last Name:
Date of Recommendation:	Licensed Provider's Signature:	

[1]For the doula benefit, Medi-Cal defines a "licensed provider" as a physician or other licensed practitioner of the healing arts, including nurse midwives, nurse practitioners, licensed midwives, and behavioral health providers, acting within their scope of practice under state law. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within the beneficiary's managed care plan.

[2]Under Medi-Cal, a beneficiary who is pregnant within the past year, and would either benefit from doula services or who requests doula services, would meet the medical necessity criteria for a recommendation for doula services. For mor information, visit www.dhcs.ca.gov

- **Doulas must verify Partnership eligibility for the month which services are provided.**
- **Doulas must document each visit with the following:**
  - Doula's Name and NPI
  - Member's Name and DOB
  - Date, Time and Duration of Service
  - Visit Type *(i.e. initial, prenatal, postpartum, delivery support, miscarriage/abortion support)*
  - Document Nature of Care, Service(s) Provided, and Resources Shared
  - **Initial Visit** must document the name of the collaborating perinatal provider *(i.e. medical, Behavioral Health, CPSP, etc.)*
- Documentation **must** be shared with perinatal providers to integrate into Member's medical record.
  - Standard HIPPA authorization is required
- Records may be audited by Partnership.
  - Missing elements may impact future credentialing
- Documentation shall be accessible to DHCS upon request.

- The doula (i.e., the provider) is the one who gets reimbursed.
- In order to bill for doula care services, you must supply at least one **procedure code (CPT)** and at least one **diagnosis code (ICD-10)** when submitting a claim.

	Proc Code	Modifier	Procedure Code Description	Frequency Limit
Procedure Codes and Modifiers	Prenatal and Postpartum Visits			
	Z1032	XP	Extended initial visit 90 minutes	Limited to one per day, per member
	Z1034	XP	Prenatal visit	Limited to one per day, per member
	Z1038	XP	Postpartum visit	Limited to one per day, per member
	T1032	XP	Extended postpartum doula support, per 15 minutes	Limited up to 12 units per visit, up to two visits (24 units) per pregnancy per member provided on separate days.
	Labor and Delivery Support			
	59409	XP	Doula support during vaginal delivery only	Limited to one per pregnancy
	59612	XP	Doula support during vaginal delivery after previous caes	Limited to one per pregnancy
	59620	XP	Doula support during caesarian section	Limited to one per pregnancy
	Abortion or Miscarriage Support			
	T1033	XP	Doula support during or after miscarriage	Limited to one per pregnancy
	59840	XP	Doula support during or after abortion	Limited to one per pregnancy
DX Code	DX Codes		Diagnosis Code and Description	
	Z33.1		Pregnant state, incidental	
	Z33.2		Encounter for elective termination of pregnancy	
	Z39.2		Encounter for routine postpartum follow-up	
	O02.1		Missed abortion	
	O03.4		Incomplete spontaneous abortion without complication	

[illegible] Education that C[illegible]

- First Trimester Prenatal Care with first visit by 14 weeks Gestational Age and Postpartum Visits
- Newborn care systems navigation
- Support routine prenatal care visits and including providing education about screening complications with labs and ultrasound as recommended by prenatal provider
- Reinforce importance of screening for depression and other conditions and follow up for referrals for treatment
- Pregnancy related vaccines: Influenza and DTAP
- Preparing for the birthing process, consideration for pain management and support during labor
- Lactation and family planning education
- Navigate PHC services

Additional Services in Maternal C

References

- Department of Health Care Services All Plan Letter 22-031 (23-031) :

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-031-Doula-Services.pdf

- Centers for Medicare and Medicaid Services. Improving maternal and infant health outcomes: Crosswalk between current and planned CMCS activities and expert panel identified strategies. 2013. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-ofCare/Downloads/Crosswalk-of-Activities.pdf

- Bigby J, Anthony J, Hsu R, Fiorentini C, Rosenbach M. Recommendations for Maternal Health and Infant Health Quality Improvement in Medicaid and the Children's Health Insurance Program. December 2020. Available from: https://www.medicaid.gov/medicaid/quality-of-care/downloads/mihexpert-workgroup-recommendations.pdf

References

- Vonderheid S. C., Kishi R., Norr K. F., & Klima C. (2011). Group prenatal care and doula care for pregnant women In Handler A., Kennelly J., & Peacock N. (Eds.), *Reducing racial/ethnic disparities in reproductive and perinatal outcomes: The evidence from population-based interventions* (pp. 369–399). 10.1007/978-1-4419-1499-6_1

- CMS Code of Federal Regulation Code 430440: Preventive Health Care Services

Contact Partnership

Address: 4665 Business Center Drive Fairfield CA 94534

Business Hours: Monday – Friday (8 AM – 5 PM)

PHC Website: www.partnershiphp.org

Member Services: (707) 863-4120

Eligibility Verification: (800) 557-5471

Provider Relations: (707) 863-4100

Claims: (855) 798-8761

FIS Integrated Payables (EFT): (800) 330-4950

Carelon Behavioral Health: (855) 765-9703

Advice Nurse Line (24/7): (866) 778-8873

Transportation: (800) 828-2303

Welcome Tiffany Lacey

Tiffany Lacey, BS, CD (DONA)
Doula
The Mixed Doula

What does providing doula services look like?

Prenatal & Postpartum

- Regular visits
- Evidence based education (childbirth, infant care, breastfeeding, movement)
- Phone calls for questions that come up
- Assistance with coordination of care and resources
- Assistance with birth preferences
- Building trusting relationships

Labor & Birth

- Support while laboring at home
- Education and assistance with decision making during interventions
- Continuous support throughout labor
- Familiar Face
- Physical and emotional support for birthing person and partner

How was having a doula beneficial to you?

"The support, narrowing down the perfect birth plan and being my greatest support during labor with your knowledge and techniques. If it was not for squeezing my lower back through the contractions and suggesting different things to do to manage the pain through the contractions, I would have requested the epidural"-past client

"Tiffany not only helped us to have the most incredible and empowering physiological birth to bring [our baby] into the world, but was also there for us to help me navigate the ups and downs of pregnancy and advocate for the type care I wanted"-past client

Birth Story…

Basic Non-identifying information

- 34 Year Old Female
- Second Baby
- Previous hospital birth during pandemic with birth trauma
- Autoimmune disease
- Desired an unmedicated birth
- Wanted no interventions

Welcome Chelsy Marriott

Chelsy Marriott,
BS, CD/PCD(DONA), CLC
Doula & Business Owner
Nurtured Guidance: Doula & Lactation Services

Chelsy Marriott, BS, CD/PCD(DONA), CLC

ABOUT ME

I am the business owner of Nurtured Guidance: Doula & Lactation Services. I am a full-spectrum doula, with certifications in birth and postpartum, both through DONA International. My birth and bereavement doula certification is through StillBirthday. I am also a certified lactation counselor, certified childbirth educator, and I hold a bachelor's degree in Human and Child Development.

I provide hands-on support to mothers before, during and after birth and offer science-based education in the community on a wide variety of perinatal topics. I am a mother of four young children and value supporting new mothers and parents as they transition to life with an infant.

More about Doulas

Doulas provide support prenatally, during birth and postpartum.

During a birth, doulas work as part of the care team within the doula's scope of practice to provide continuous support during labor and birth.

Doulas can offer support at home births, at birth centers, at hospital births, and for both medicated and unmedicated vaginal births, cesareans, abortions and stillbirths.

Emotional Support

Informational Support

Physical Support

Advocacy

PRENATAL DOULA SUPPORT

During Prenatal visits- topics may include:

- Childbirth education topics
- Past birth traumas
- What to expect during pregnancy and birth
- Creating a birth plan

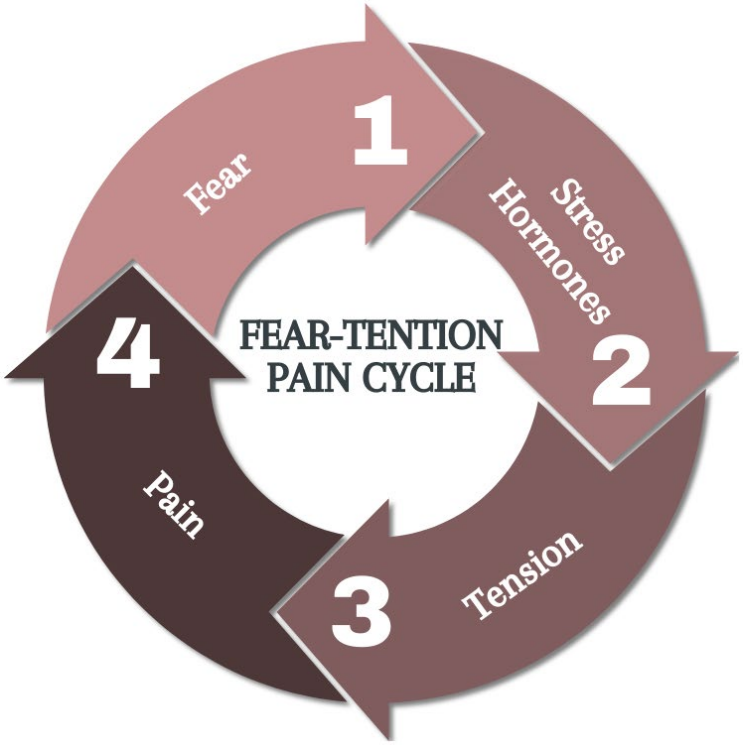
- How to communicate with healthcare providers
- Fears they have about the birth and coming up with a plan
- Comfort measures that can be used during labor
- Community resources

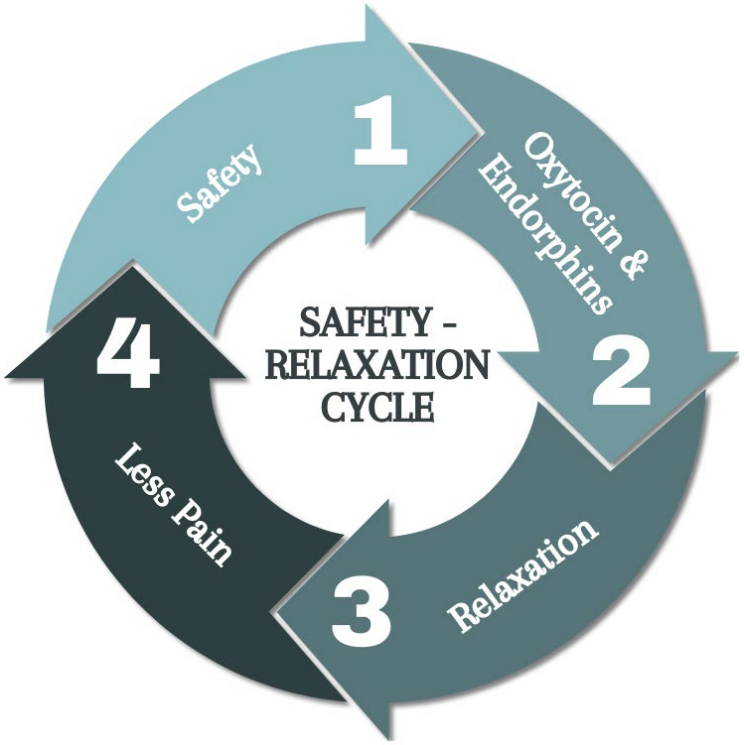
BIRTH DOULA SUPPORT

Continuous Labor Support- includes support such as:

- Provide reassurance and encouragement
- Helping the birthing person work through fears and self-doubt
- Showing compassion & empathy
- Creating a calm environment
- Use massage, touch, or counter pressure
- Guide through stages of labor
- Suggest movement and positions to do during labor
- Help the birthing person understand medical procedures that are happening
- Facilitate collaborative conversations between patient and healthcare providers

FEAR VS SAFETY CYCLES IN BIRTH





POSTPARTUM DOULA SUPPORT

Following birth and at home visits:

- Immediately supporting for the first few hours after birth. Can support during the golden hour and with the first breastfeed.

- Postpartum home visits can include things such as helping the client process the birth experience, providing emotional support, providing practical help in the home, teaching newborn basics and mother care measures, and referring to resources for more support.

HOW DO DOULAS IMPROVE BIRTH OUTCOMES?

The 2014 ACOG Consensus Statement states “Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula. A Cochrane meta-analysis of 12 trials and more than 15,000 women demonstrated that the presence of continuous one-on-one support during labor and delivery was associated with improved patient satisfaction and a statistically significant reduction in the rate of cesarean delivery. Given that there are no associated measurable harms, this resource is probably underutilized”.

Research from 2017, Bohren et al. Cochrane Review shows having a doula increases the likelihood of having a safe and satisfying childbirth experience.

39% decrease in risk of a caesarean delivery

10% decreased use of pain medications

15% increase likelihood of vaginal birth

31% less negative childbirth experience

CONTACT

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360-672-0982

nurtured guidance

DOULA & LACTATION SERVICES

Thank you Tiffany Lacey
&
Chelsy Marriott

Thank you everyone for attending this breakout session today

CalAIM & Reducing Readmission Rates

Welcome Katherine Barresi, Presenting at Fairfield Symposium

Katherine Barresi, RN, BSN, PHN, NE-BC, CCM

Senior Director, Health Services, Partnership HealthPlan of California

CalAIM & Reducing Readmission Rates

Welcome Heather Esget, Presenting at Fairfield Symposium

Heather Esget, BSN
Director of Utilization Management,
Partnership HealthPlan of California

CalAIM & Reducing Hospital Readmissions

August 8, 2023 and August 10, 2023

Katherine Barresi, RN, BSN, PHN, NE-BC, CCM
Senior Director Health Services

Heather Esget, BSN, ACM-RN
Director of Utilization Management

Agenda

- **Post-Covid: Trends in Readmission Rates**
- **What Works?**
  - Evidence Based Models & Approaches
  - *New*! Reducing Disparities in Readmissions
- **CalAIM & Innovative Approaches**
  - Enhanced Care Management
  - Community Supports
  - Transitional Care Services
- **Questions**

Trends in Hospital Readmission Rates - 2020

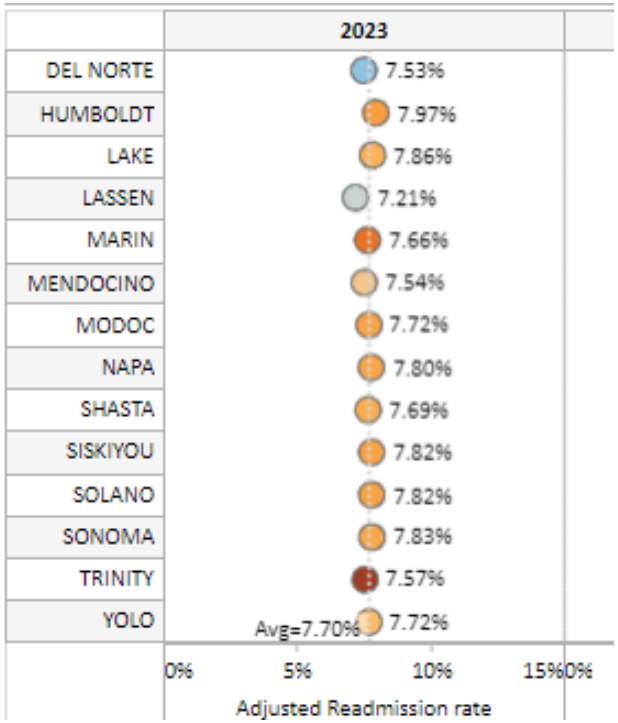
	Total # of Admits	30-Day Readmits	30-Day Readmission rate
Del Norte	1174	112	9.54%
Humboldt	5984	738	12.33%
Lake	4191	618	14.75%
Lassen	614	59	9.61%
Marin	8660	1092	12.61%
Mendocino	4856	673	13.86%
Modoc	338	45	13.31%
Napa	5168	747	14.45%
Shasta	12277	1591	12.96%
Siskiyou	1791	186	10.39%
Solano	17619	2598	14.75%
Sonoma	19924	2664	13.37%
Trinity	693	85	12.27%
Yolo	6945	976	14.05%

15.45%
Medi-Cal Average in 2020

PHC County (unadjusted) rate for all-cause, unplanted, 30 day inpatient readmissions; regardless of payor

2023 Partnership Readmission Rates – By County

Risk-adjusted hospital readmissions following HEDIS 2020 specifications.



- Risk adjustment ensures that the health conditions, health status and demographics of the members are taken into account when measuring readmission outcomes.
- **7.70%** risk-adjust hospital readmission rate

**as of April 13,2023*

Post-Covid: Trends in Readmission Rates

- Delayed care for chronic conditions = sicker patients
- Provider access and availability in outpatient settings; specialty care
- Workforce challenges in all sectors of health care delivery
- Increasing demand for mental health services and care
- Housing/Homelessness

"Additionally, studies have shown that certain patient characteristics, such as race, ethnicity, language proficiency, age, socioeconomic status, place of residence, and disability, among others—may predict readmission risk and readmissions, particularly for costly and complicated medical conditions such as heart failure, pneumonia, and acute myocardial infarction." – CMS 2018

What Works & How Can We Do Better?

Evidence-Based Models & Approaches

- Identify and understand populations at higher risk for readmissions
- Medication Reconciliation
- Improve hand off communication
- Optimize use of technology

- Use an Evidence-Based Transition of Care Model
  - BOOST – Better Outcomes for Older Adults Through Safe Transitions
  - GRACE – Geriatric Resource Assessment
  - TCM – Transitional Care Model
  - Project RED – Re-Engineered Discharge
  - Care Transitions (Coleman Model)
  - STAAR – State Action on Avoidable Re-Hospitalizations

Reducing Disparities in Readmissions

In their 2018 report, *A Guide to Reducing Disparities in Readmissions*, CMS identified the following eight (8) key issues:

1. Racial and ethnic minorities are less likely than white patients to follow up with primary care provider on an appropriate provider after discharge

2. Racial and ethnic minorities are less likely to be linked to a primary care provider or have usual source of care. Lack of this linkage leads to lower quality care

3. Limited English proficiency is associated with several factors that contribute to avoidable readmissions, including lower rates of outpatient follow-up, use of preventative services, medication adherence and understanding of discharge instructions

Reducing Disparities in Readmissions

In their 2018 report, *A Guide to Reducing Disparities in Readmissions*, CMS identified the following key issues:

4. Many factors that contribute to readmissions for racial and ethnic minority populations are associated with health literacy

5. Cultural beliefs and customs influence patients' health behaviors, perceptions of care, and interpretation of medical advice

6. Factors linked to socioeconomic resources are associated with higher readmission rates for patients at minority-serving hospitals (ex: housing and food security, transportation, employment, etc.)

Reducing Disparities in Readmissions

In their 2018 report, *A Guide to Reducing Disparities in Readmissions*, CMS identified the following key issues:

7. Anxiety and depression disproportionately impact certain minority groups (ex: Black patients with heart failure) and poor mental health has been show to affect access to services and self-care after discharge

8. Racial and ethnic minorities commonly have multiple comorbidities, resulting in higher readmission rates

Reducing Disparities in Readmissions

In their 2018 report some of the strategies CMS recommends for reducing disparities in readmissions include:

- Hospitals should systematically examine what they can do to improve care in accordance with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care by reviewing A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities (https://www.cms.gov/AboutCMS/Agency Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf).

- Provide early discharge planning and follow-up for patients at high-risk of readmission (ex: linked to primary care, assistance with scheduling appointments, addressing barriers to follow-up like transportation)

- Use common words. Avoid medical jargon. Using relatable language is vital for patients with limited English proficiency.

- Connect patients with community-based resources such as adult day health programs, and/or services that address SDOH

What is CalAIM?

CalAIM stands for ***"California Advancing and Innovating Medi-Cal."***

CalAIM is not a singular goal or program; CalAIM is a multi-year, multi-initiative framework being implemented by the Department of Health Care Services (DHCS) over the next 5 years.

All of the initiatives within CalAIM are focused on transforming the delivery of Medi-Cal services, programs and benefits with a goal of integrating services and improving outcomes.

The Centers for Medicare and Medicaid Services (CMS) approved CalAIM and the state's associated waivers on Dec. 29, 2021.

DHCS CalAIM proposal: https://www.dhcs.ca.gov/calaim

CalAIM Overview

Key CalAIM Areas of Focus

Population Health Management

Enhanced Care Management & Community Supports

Dual Eligible Special Needs Plans (D-SNP) & Integration of Long-Term Support Services

Services & Supports for Justice Involved Adults & Youth

Behavioral Health Delivery System Transformation

Standardization with Medi-Cal Enrollment

CalAIM: CS & ECM

Community Supports (CS) Services

- Not a Medi-Cal benefit; an optional service that health plans have been allowed to provide in-lieu of traditional a Medi-Cal benefit.
- The Community Support service can only be approved it demonstrates that it replaces a regular Medi-Cal benefit and is cost-effective (ex: hospital stay, ED visit, etc.)
- PHC currently offers 8 CS Services

Enhanced Care Management (ECM)

- A Medi-Cal benefit
- To qualify, members must meet DHCS criteria outlined – "*Population of Focus"*
- Goal is to provide a lead, community-based case manager to coordinate: medical, oral, behavioral health, long-term supports and community referral needs – no matter the payer.
- New Populations of Focus are being added by DHCS.

Community Supports Services

PHC currently offers the following Community Support Services in 14 counties:

1. Housing Transition & Navigation Services
2. Housing Deposits
3. Housing Tenancy
4. Short-Term Post Stabilization Housing
5. Recuperative Care (Medical Respite)
6. Medically Tailored Meals
7. Respite Services
8. Personal Care/Homemaker Services

COTS - Committee on the Shelterless: Recuperative Care Bed – Sonoma Co.

Enhanced Care Management

The following Populations of Focus have gone live. Others will go live in the near future:

1. Individuals Experiencing Homelessness
2. Individuals At Risk for Avoidable Hospital or ED Utilization
3. Individuals with Serious Mental Health and/or SUD Needs
4. Adults Living in the Community and At Risk for LTC Institutionalization
5. Adult Nursing Facility Residents Transitioning to the Community
6. Children & Youth (ex: Foster Youth, California Children's Services / Whole Child Model, etc.)

Coming Soon!

1. *Justice – 1/1/2024*
2. *Birth Equity 1/1/2024*

New! Transitional Care Services

- Partnership provides Transitional Care Services (TCS) for all high-risk members.
- Utilization Management teams: assist with difficult placements and discharge planning through concurrent review process
- Case Managers in the Care Coordination Dept. can assist members with needs pre/post discharge, such as:
  - Support with discharge planning
  - Outpatient appointments/follow-up
  - Medication reconciliation
  - DME, supplies, Home Health
  - Referrals to specialty care
  - Disease Management / Education
  - Community Resources
  - Transportation

PHC Care Coordination:
1-800-809-1350
CareCoordination@partnershiphp.org

PHC Transportation Services:
1-866-828-2303
Mon-Fri 7am-7pm

Questions

Resources

PHC CalAIM Webpage:

http://www.partnershiphp.org/Community/Pages/CalAIM.aspx

ECM Populations of Focus:

https://acrobat.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3Aea3bb6fe-76a7-3456-ab74-05e19da9c64d&viewer%21megaVerb=group-discover

PHC ECM Referral Form:

www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/ECM%20Documents/ECM%20Referral%20Form.pdf

PHC CS Referral Form:

http://www.partnershiphp.org/Community/Documents/CalAIM%20Webpage/Community%20Supports%20Documents/CS%20Referral%20Form.pdf

DHCS CalAIM Long Term Care Carve In: https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx

Thank You

Thank you Heather Esget

Break

10 MINUTE

Risk Management in Perinatal Mental Health

Welcome Smadar Garritson

Smadar Garritson, LCSW, CLE
Huntington Hospital, Pasadena, CA
Primary Program Therapist
Maternal Mental Health Day Treatment Program

MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families

A project of Community Partners,
a 501(c)3 organization.

Risk Management in Perinatal Mental Health

Smadar Garritson, LCSW, CLES

August 2023

MMH-NOW
HISTORY

- Personal story of struggle in spite of access

- Bringing together efforts to reduce barriers to screening and treatment throughout Los Angeles County and beyond

#1: Public Awareness

#2: Training Institute

#3: Policy: Advocacy & Legislation

Perinatal Mood and Anxiety Disorders:

Why does it matter?

Among pregnancy-related deaths with information on timing, *22% of deaths occurred during pregnancy*, *25% occurred on the day of delivery or within 7 days after*, and *53% occurred between 7 days to 1 year after pregnancy*.

The leading underlying causes of pregnancy-related death include:

- **Mental health conditions** (including deaths to suicide and overdose/poisoning related to substance use disorder) (23%)
- Excessive bleeding (hemorrhage) (14%)
- Cardiac and coronary conditions (relating to the heart) (13%)
- Infection (9%)
- Thrombotic embolism (a type of blood clot) (9%)
- Cardiomyopathy (a disease of the heart muscle) (9%)
- Hypertensive disorders of pregnancy (relating to high blood pressure) (7%)

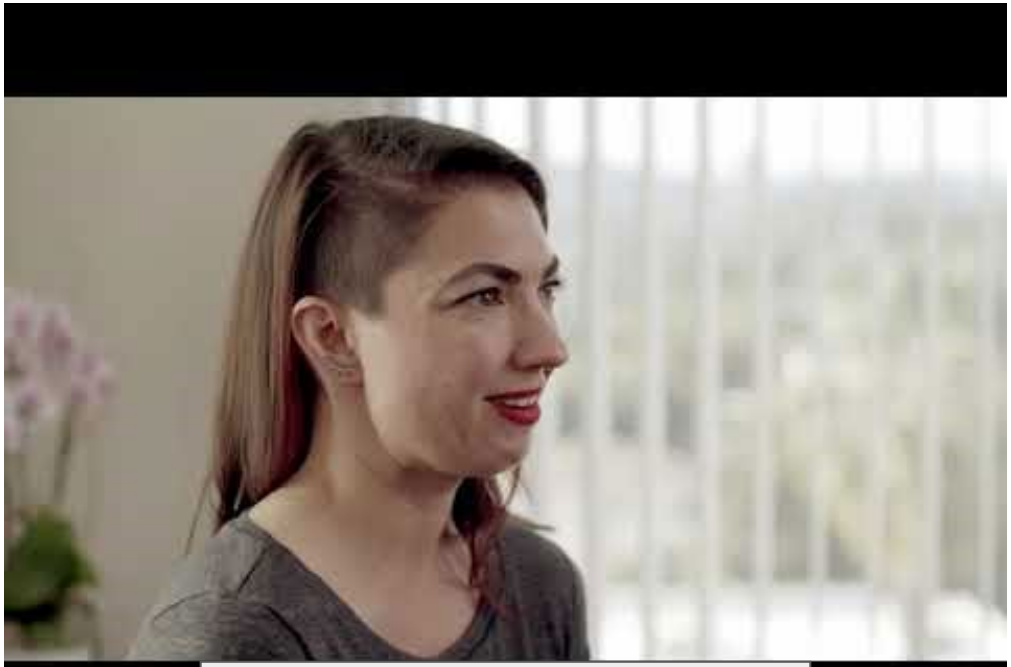
Sources: https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html

Perinatal **M**ood **and** **A**nxiety **D**isorders:

Why does it matter?

- Early experiences matter for baby's brain development in context to relationships
- Early experiences alter gene expression and shape development : "*Serve and Return*" for developing brains
- Adverse Childhood Experiences (ACEs) correlate to poor adult health

Sources: Developingchild.harvard.edu; https://www.cdc.gov/violenceprevention/aces/fastfact.html



Amber's Story

MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families

A project of Community Partners,
a 501(c)3 organization.

https://www.youtube.com/watch?v=e1_2FK0lTJg

Prevalence Rates + **Financial** Toll

- 1:4 in California with experience perinatal depression
- 50% (+) of cases go undiagnosed and untreated
- Annual cost of untreated perinatal depression = $32,000/person totalling $2.5 billion
  - Increased frequency/duration of hospital stay
  - Work productivity decrease
  - Risk of suicide/death
  - Risk of other poor health outcomes

Sources: Mathematica Policy Research, 2019. Policy Center for Maternal Mental Health

Perinatal **M**ood and **A**nxiety **D**isorders

- Depression vs. “baby blues”
- Anxiety Disorders
- Obsessive-Compulsive Disorder (OCD)
- Post Traumatic Stress Disorder (PTSD)
- Bipolar Disorder
- Psychosis

“BABY BLUES” VS. Perinatal Depression

- Very common - NOT postpartum depression
- 50-85% of all birthing people
- Result of hormone shifts, sleep deprivation, transition period
- < 2 weeks + mild symptoms
- Goes away gradually on it’s own

➔ **REST** and nutrition
➔ **Reach out** if they need help
➔ **Do not WAIT** for things to get better

Sources: Halbreich & Karkun, 2006; O’Hara & Wisner, 2014

Perinatal Depression

~ 20% prevalence

- **Often co-occurs with anxiety**
- Sleep disruption - can't sleep even when given the opportunity!
- Sadness, isolation, withdrawal, ***anger/irritability***
- **Somatic** presentation common (e.g., headaches, GI upset, fatigue)
- Can present during pregnancy, immediately after birth, and throughout postpartum period until 1 year

PERINATAL Obsessive Compulsive Disorder (P-OCD)

11% prevalence

Compulsive/repetitive behaviors (cleaning, counting, checking all about safety related to the baby)

Intrusive/repetitive thoughts/vivid images

Sometimes presents as thoughts of harm coming to child, often accompanied by anxiety-reducing behaviors

Very upsetting to birthing person; they will recognize these thoughts as "foreign" and are unlikely to act on them

Increased risk of suicide for caregiver

→ Thoughts ⇏ action

BOTTOM LINE: If ANY thoughts of harming baby, seek consultation first

Sources: Collardeau et al., 2019; Miller et al., 2013; Russel et al., 2013; Uguz et al., 2007.

POSTPARTUM
Psychosis

~1-2: 1000 births

→ 5% risk of suicide
→ 4% risk of infanticide
→ 4x higher in pandemic

Psychotic features occur alone or in combination with rapidly fluctuating depressive mood symptoms (intense highs and lows)

→ In some, this is the first manic episode of Bipolar Disorder
→ NOT a progression of PPD - different disorder entirely

Fixed delusions and paranoia focused on baby
Waxes and wanes – difficult to diagnose short-term

Full blown at 1 month PP but may be noticed within a few days of birth and in some cases, can emerge later than 1 month

DO A THOROUGH ASSESSMENT!

→ Personal or family history of Bipolar Disorder or previous psychotic episode? – up to 50% experience psychotic episode PP when untreated
→ Antipsychotic medication history?

Sources: Sharma & Sommerdyk, 2014.

POSTPARTUM
Psychosis

Postpartum psychosis is temporary and treatable with professional help, but it is an emergency and it is essential that you connect client to resources.

Occurs in
0.1-0.2% of births

Do not leave them alone with baby.

www.maternalmentalhealthnow.org

Sources: Sharma & Sommerdyk, 2014.

Perinatal Mental Health and Risk

- **Postpartum Psychosis** – high risk!
  - Infanticide, filicide, and suicide
  - Is NOT postpartum depression
  - Requires immediate intervention
  - Monitor for history of bipolar disorder or sx of mania

- **Postpartum OCD** – consult!
  - Intrusive thoughts do not equal intention
  - Not likely to cause harm to infant
  - More likely to cause harm to self

- **Postpartum Anxiety** - assess!
  - Panic disorder, PTSD, etc.
  - May experience challenges coping and functioning
  - Some risk of suicide
  - May lead to other impairments (i.e., judgment, decision-making)

Sources: Ayers et al., 2019

Other circumstances that may trigger concern

Substance misuse

- Exposure to infant
- Impulsivity
- Concerns with ability to provide care - safety in the home
  - Assess for support people who can monitor and provide supervision
  - Provide referrals EARLY

Intimate partner violence / Domestic violence

- Violence in the home
- Concerns of exposure and risk of harm
  - Safety planning
  - Educate on risk and cycle of abuse

Both are common co-occurrences with perinatal mood and anxiety disorders!

Sources: Ayers et al., 2019

Concerns About Child Abuse?

ONLY on few occasions will this be necessary

- *Most individuals struggling with perinatal mental illness do not exhibit risk factors warranting a call to CPS*

- ❑ Be well informed of your mandated reporting requirements - “reasonable suspicion”
- ❑ Consultation
  - Documentation at every stage is important
    - Document protective factors + referrals too!
  - Consult with a Children’s Social Worker
  - Even if pregnant, you can still consult
    - ❑ **Never promise a report won’t be made!**

Resources

Child Welfare Information Gateway:

https://www.childwelfare.gov/topics/can/factors/parentcaregiver/mentalhealth/

Child Abuse Mandated Reporter Training:
https://mandatedreporterca.com/

Monitor for suicidal thoughts!

The risk for postpartum suicide is highest between 6-12 months PP…

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Develo[illegible] of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthca[illegible]fessional: For interpretation o[illegible], please re[illegible] accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

	Past 1 Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Any YES indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the emergency room, call 1-800-273-8255, text 741741 or call 911. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Suicide Hotline

9-8-8

Columbia Suicide Severity Rating Scale (CSSRS)

https://www.nytimes.com/video/well/family/100000005086852/conception-mother-depression.html

Concerns About Suicide?

- ❑ Have policies in place – knowing what to do makes having difficult conversations less scary!
  - **CONSULT!**
  - Listen to your intuition
  - Practice safety planning

National Crisis Text Line:
Text HOME to 741741 from anywhere in the USA, anytime, about any type of crisis.

National Suicide Prevention Hotline 988

www.suicidepreventionlifeline.org - Call for yourself or someone you care about; free and confidential; more than 140 crisis centers nationwide; available 24/7

Language For Assessing Risk

- “It’s not uncommon for new parents to experience a range of emotions and some may even have scary or unusual thoughts. Has this ever happened to you?”
- “Sometimes it can be difficult to cope with such a huge transition. What have you turned to in order to manage during this time?”
- “Some parents may feel overwhelmed from time to time and feel there’s no help for them, or feel they need to escape. Have these feelings ever occurred for you?”
- Normalize assessment:
  “We ask all new parents these questions”

What Helps Parents **Get Better?**

- Address risk factors
- Alleviate current stressors and triggers
  - Stabilize
  - Coping strategies
  - Referrals
- Increase support and protective factors as buffer

Sources: Fonagy, et al., 1992; Misri & Kendrick, 2007; Stein, et al., 2014.

What Helps Parents **Get Better?**

Comprehensive Care/ Wellness Plan

Lifestyle shifts

- ❑ Sleep hygiene / rest
- ❑ Nutrition, hydration
- ❑ Movement

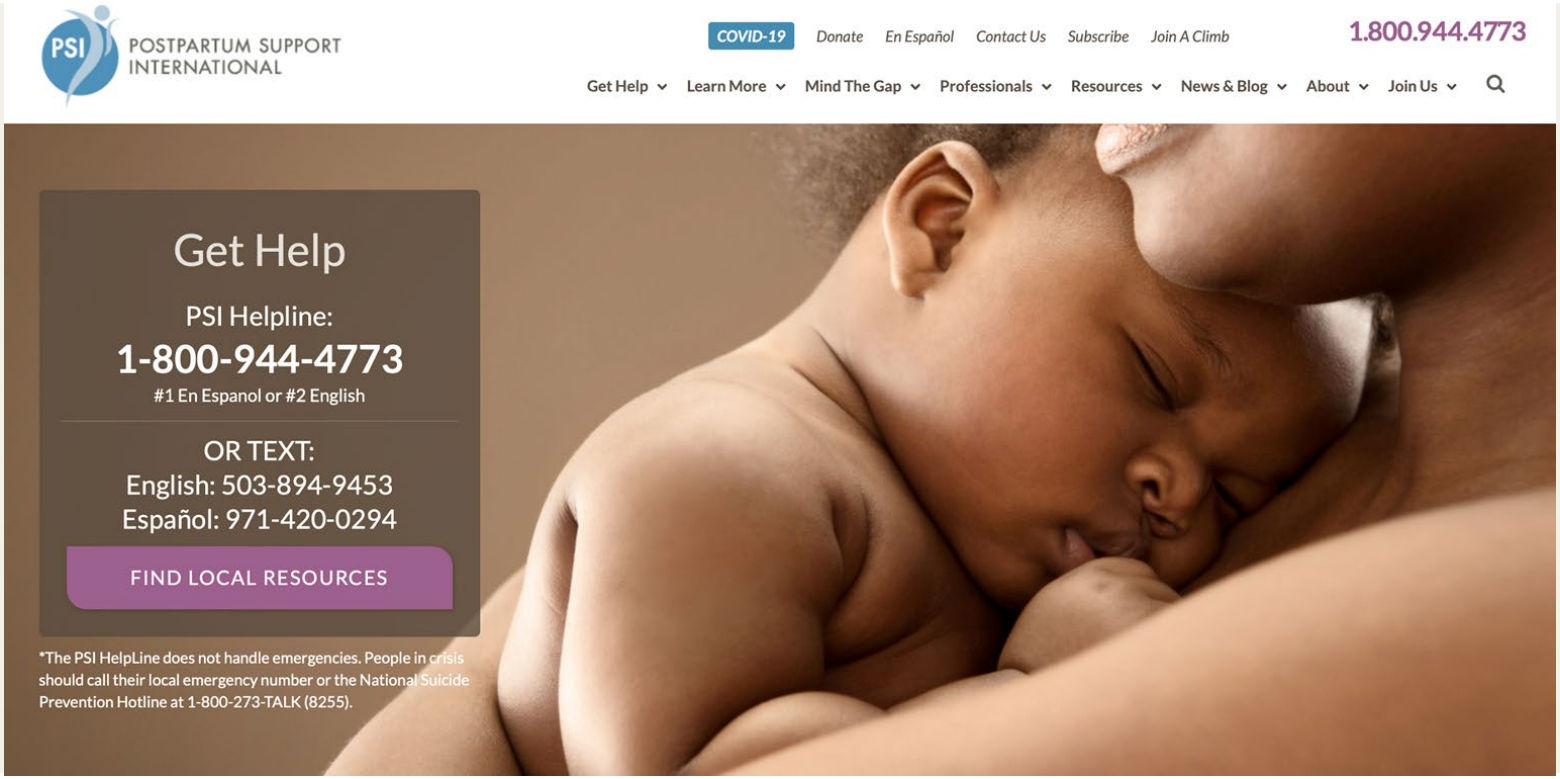
Community Support - Reduce Isolation!

- ❑ Home visitation
- ❑ School-based
- ❑ Peer support
- ❑ Faith community
- ❑ Family
- ❑ Parenting classes (dyadic, Triple P, Reflective parenting, PCIT)

Professional Mental Health Care

- ❑ Psychotherapy (CBT, IPT, Mindfulness)
- ❑ Groups
- ❑ Medication and supplements

Sources: Fonagy, et al., 1992; Misri & Kendrick, 2007; Stein, et al., 2014.



postpartum.net

MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families

A project of Community Partners,
a 501(c)3 organization.

PERINATAL PSYCHIATRIC CONSULT LINE

PSI Perinatal Psychiatric Consult Line
1-877-499-4773

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National Maternal Mental Health Hotline

Are you a new parent - or about to be - and feeling sad, worried, overwhelmed, or concerned that you aren't good enough?

For emotional support and resources

CALL OR TEXT 1-833-TLC-MAMA (1-833-852-6262)

Free – Confidential – 24/7

60+ Languages

HRSA Maternal & Child Health

PREGNANCY & OPIOIDS

What families need to know about opioid misuse and treatment during pregnancy

Partnership for Drug-Free Kids
Where families find answers

THE MEDICINE ABUSE PROJECT

PREGNANCY AND SUBSTANCE USE:

A HARM REDUCTION TOOLKIT

NATIONAL HARM REDUCTION COALITION

IN COLLABORATION WITH
Academy of Perinatal Harm Reduction

Personal Stories -

https://www.maternalmentalhealthnow.org/stories-video-library/

Stories help us learn about the emotional journey of parenting, and when and how to intervene.

Consultation Group -

First Thursday of the month 9-10amPT

info@maternalmentalhealthnow.org

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THANK YOU

www.maternalmentalhealthnow.org

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Thank You

Thank you Smadar Garritson

Closing Remarks

Mark Netherda, MD
Medical Director for Quality,
Partnership HealthPlan of California

Evaluation

WE NEED YOUR FEEDBACK

After the Symposium:

1. Please complete the brief evaluation located in your Attendee Packet.

2. Please hand your completed evaluation to PHC Staff at the doors when you leave.

Your feedback is important to us!

PHC's QIP Team

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Thank you for attending our *Hospital Quality Symposium*

Special thanks to today's guest speakers and panel participants!

Partnership HealthPlan of California

Helping our members, and the communities we serve, be healthy.