Faculty Disclosure

A Community Approach to Women's Health



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Learning Objectives

- 1. Identify strategies for creating an infrastructure of community support for Women's Health
- Implement enhanced psychosocial and pregnancy intention screenings for women in both Primary Care and Women's Health Clinics
- 3. Create a network of support for women to promote individual and family wellness



Learning Objectives

Brattleboro Memorial Hospital

Brattleboro Memorial Hospital





Brattleboro Memorial Hospital



- Emergency Services
- Surgical Services
- Oncology Care
- Inpatient
- Birthing Center
- Community Health Team



- 61 bed community hospital located in Brattleboro, VT
- Serves a rural population of approximately 60,000 people in twenty-two towns in Vermont, New Hampshire, and Massachusetts
- Rapid expansion of BMH Medical Group

BMH Medical Group

- 12 Medical Group Practices
 - 7 primary care
 - 5 specialty
 - Share one EMR-Cerner
 - Care for the greater
 Windham County
 area in VT



- 55 Clinicians
- 88,000 visits in CY2017
- Total panel of 13,000 patients
- 10 RN Care Coordinators
- Support by Community Health Team



Vermont





Health Care Reform





VT Blueprint for Health

State-led initiative transforming the way primary care and comprehensive health services are delivered and paid for. Key components:

Administrative Entity:

- Coordinates efforts throughout entire Health Service Area (HSA), Grant Funding for Project Management, Quality Improvement, and Self Management Programs
- · Patient Centered Medical Homes (PCMH):
 - Foundation of the Blueprint, supported by Per Member Per Month (PMPM) payments from insurers
- Community Health Teams (CHT):
 - Interdisciplinary teams that support PCMH's. Funding is based on the number of patients served by the PCMH's in the HSA.



VT Blueprint for Health





Brattleboro Health Service Area

- Administrative Entity: Brattleboro Memorial Hospital
- Population:
 - Windham County population of 43,386
 - Blueprint attributed lives: 23,653
 - Nine PCMH's (7 BMH)

· CHT:

- Centrally located,
- Interdisciplinary team
- Care Coordinators, Social Workers, Registered Dieticians, Diabetes Educators,
 Self Management Coordinator





Blueprint Initiatives

- Patient Centered Medical Home
- Community Health Teams
- Accountable Communities for Health
- Hub and Spoke
- Support and Services at Home
- Self-Management and Healthy Living Workshops
- Women's Health Initiative



Women's Health Initiative

Healthier Women, Children, and Families





Women's Health Initiative



Background

- · In Vermont, 50% of all pregnancies are unintended
- Unintended pregnancies = increased risk, including:
 - Poor health outcomes for mothers and babies
 - Long-term negative consequences for health and well-being of children, including adverse childhood experiences (ACEs)
- · Counseling and health interventions for women who intend to become pregnant can help lower risks, such as through smoking cessation counseling and treatment for alcohol and substance misuse
- Healthy Vermonters 2020 goal for pregnancy intention is



Program Overview

The Women's Health Initiative (WHI) helps ensure that women's health providers, primary care practices, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families



Program Overview

Three forms of payment (two additional payments for

Women's Health and Patient Centered Medical Homes - WHI Capacity Payment - one time initial funding to help practices cover

- WHI Practice Per Person Per Month - an ongoing payment to support

the costs of initially implementing the program including stocking LARC



Practice Support

PCMHs):

- Learning Collaboratives

Program Overview

- · In Vermont, many women receive majority of their health care at OB-GYN and women's health clinics
- Women also access family planning and contraception through Patient Centered Medical Homes
- - Increase comprehensive family planning counseling
 - Provide timely access to long-acting reversible contraception (LARC)
 - Enhance psychosocial screening

In both of these settings, WHI allows for:

Women's Health Practice Only

enhanced care and screening

- Project Management/QI Facilitation

- CHT Staff- WHI supports 1 FTE Social Worker per every 1200 attributed beneficiary for brief intervention and referral.





WHI Strategies

Psychosocial Screening and Brief Intervention in WHI Women's Health and PCMH Clinics

- Depression
- Current intimate partner violence and adverse childhood experience
- Substance use
- Access to primary care/patient centered medical home (PCMH)
- Food insecurity
- Housing stability



WHI Strategies

Family Planning

- Efficacy-based, comprehensive family planning counseling in WHI Women's Health and PCMH practices and Community Organizations
- Onsite availability of the full spectrum of LARC
- Same-day insertion of LARC for women who choose LARC as their birth control method

Enhance System of Care and Support

- WHI Women's Health and PCMH Practices work to see clients of community based organizations within 1 week of referral
- PCMHs to accept patients who are identified without a primary care
- Community based organizations provide timely access to services such as mental health and substance use counseling, domestic and sexual violence support, housing and food



Practices and Communities

The initiative is dependent on participation of both women's health practices and community organizations

- Practice
 - medical practices work to implement psychosocial screening, offer same day access to LARC, strengthen referral networks, and see clients within one week who are referred from community organizations for family planning.
- Community
 - Local organizations who serve women with a particular focus on organizations who work with underserved populations (for example, medical practices, parent child centers, mental health providers, home health providers, etc.) work to building skills and referral pathways for family planning, psychosocial wellbeing, and primary care.



Enhanced Screenings for Women

- Comprehensive family planning counseling and services:
 - "One key question" screening
 - Timely access to LARC and other forms of contraception
 - Pre-conception counseling and services for women intending to become pregnant within a year such as tobacco cessation, mental health counseling, and treatment for substance abuse/use
- Enhanced health and psychosocial screening assesses:
 - Mental health, substance abuse, and current or past trauma
 - Partner violence
 - Access to food and housing
- Dedicated CHT social workers for women who screen positive for one or more risk factors and further connections to community services and treatment



Payment

- Payments to women's health providers
- · Payment tied to implementing screening and referrals
- Medicaid payments only to start, but other insurers/payers invited to join
- Use a 24-month lookback period for the claims-based attribution
- De-duplicated by WHI practices with patients attributed to the practice that has provided the majority of services during the 24 month look back, with attribution going toward the most recent provider if there is the same number of visits to two or more providers

Statewide Implementation

- Nineteen Women's Health Clinics in VT signed on immediately
- Statewide Learning Collaborative
 - Goals: Establish the necessary workflows, processes, and supports for participants to implement models for screening, brief intervention, and treatment; referrals, and comprehensive family planning
 - Providing expert faculty, skilled facilitators, and a comprehensive curriculum
 - Creating a statewide "Learning Community" that includes peer-to-peer learning
 - Administrative training and facilitation support addressing billing and coding, scheduling, clinical efficiency or workflow, and establishing clear referral pathways
 - In session learning sessions, webinars





Local Implementation

- · Brattleboro HSA:
 - Brattleboro OBGYN (BMH Medical Group) engagement delayed due to new EHR
 - Team formed and engagement in Learning Collaborative prior to go-live
 - Social Worker hired
 - Met every two weeks (now monthly), utilized PDSA model
 - Brattleboro OBGYN (BOG)
 - Vermont Department of Health
 - Community Health Team



Enhanced Psychosocial Screening

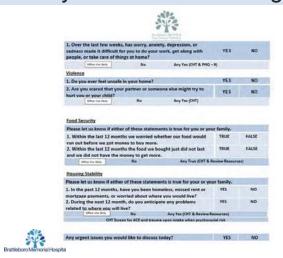
- Population: All Pregnant Women (later added postpartum and well visits)
- Created BOG-specific screening tool
- Workflow
 - RN Care Coordinator screens all women
 - Utilizes EHR and instant messaging to refer to SW
 - Warm handoffs
 - Data tracking by Social Worker



Psychosocial Screening Tool

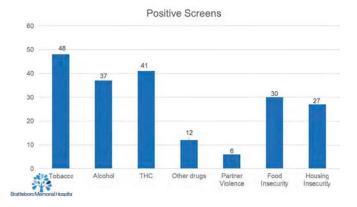


Psychosocial Screening tool



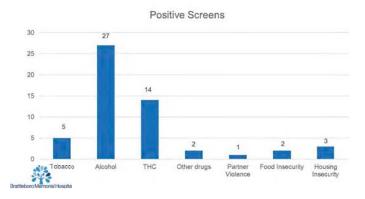
Pre/Post Partum screens

- 9/2017-8/2018
- 430 screens
- 128 referrals to Social Worker



Annual Well visit screens

- 11/2017-8/2018
- 98 Screens
- · 13 Referrals to Social Worker



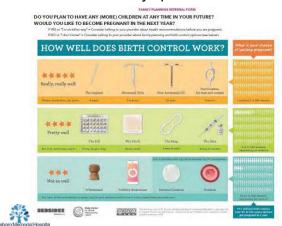
Pregnancy Intention Screening

- · Engagement of community partners
 - Housing
 - Medication Assisted Treatment (Spoke)
 - Children's Integrated Services
 - BMH Primary Care and Pediatrics
- "One Key Question"
- Referral to BOG for family planning or contraception, including LARC



Pregnancy intention screening

"one key question"



Same Day Insertion Referrals

- · Partners:
 - Groundworks
 - Children's Integrated Services
 - Primary Care (informal)
- Nov 2017-June =14
- Barriers:
 - Time
 - Lack of standard tracking form
 - Process already efficient in Brattleboro HSA



Birthing Center





BMH Birthing Center

- ~325 Births per year
- · Recent remodel
- Highly trained Physicians, Certified Nurse Midwives, and Registered Nurses
- Doula Program
- · Birthing Tubs
- Pharmaceutical and Alternative options for pain
- Classes for entire family
- · New moms group





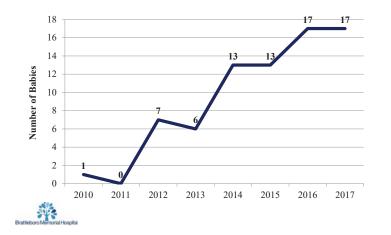
Recent Changes

- Increases in families with complex social issues
- Increase in babies born with Neonatal Abstinence Syndrome
- Department of Children and Families (DCF) involvement





Babies with Neonatal Abstinence Syndrome



Response

- · Utilize community Infrastructure
 - Maternal Child Health Coalition
 - Perinatal Wellness Initiative
 - Substance Use, Recovery, & Perinatal Health (SURPH) Coalition
- · Early outreach
 - Connection with services via WHI/SURPH
 - Initial meeting/tour of Birthing Center prior to birth
- · Cuddler Program
 - Trained volunteers cuddle and sooth medically stable babies
 - Program allows Nursing staff to focus on more complex tasks
- · Education for staff and patients



Next Steps



Focus on Women's Health

- Enhancing BMH Women's Health service line
- Utilization of Care Coordination tools for families at risk
- Consider sharing staff across continuum of care
- Marketing efforts
- Ongoing competency training (low volume/high risk)





Healthier Women, Children, and Families





How is this work replicated?

- Enhanced Screening in Primary Care (including Women's Health Clinics)
- · Fee for service
 - https://www.integration.samhsa.gov/sbirt/reimbursement_for_sbirt.pdf
- Shared care plans via EMR
- Invest in community relationships
- Set metrics, collect data and track success
- SBIRT now SBINS- expanding the WHI model to primary care and the ED with embedded LICSW and screenings
- · Administrative and clinical support



A few good...WOMEN

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Thank You!
Any Questions?



