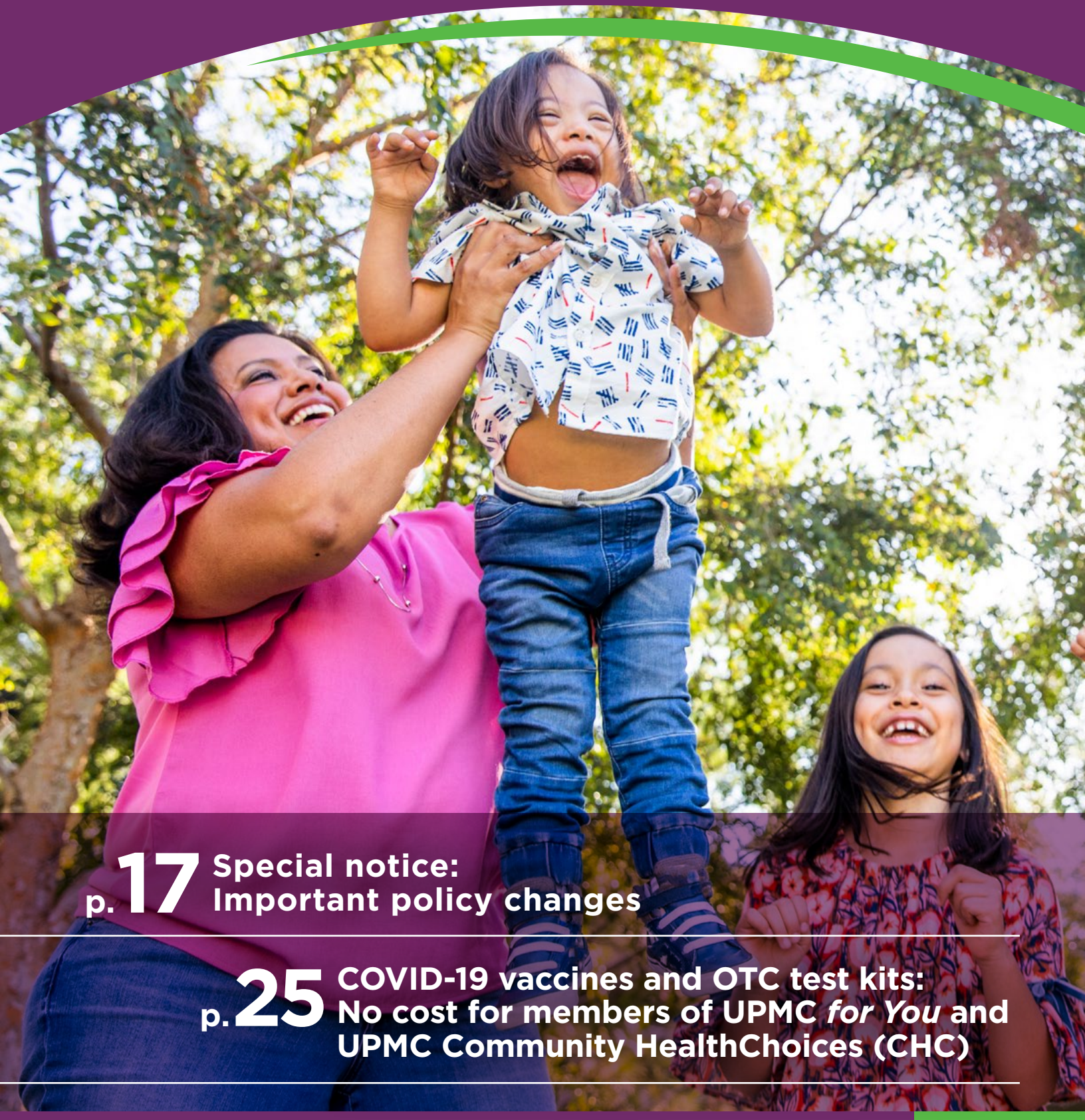
UPMC Health Plan

Provider Partner Update

April 2025



What's inside:

Provider directory updates and required attestation

As you know, UPMC Health Plan requires all providers to verify their provider directory information at least every 90 days (quarterly).

This allows us to comply with CMS/DHS/PID requirements to maintain accurate directories—as well as the federal No Surprises Act (effective Jan. 1, 2022).

Accurate directories are the primary way our members find in-network care. CMS states, "Plans may not list a provider in their directory if the enrollee cannot call the phone number listed and request an appointment with that provider at the address listed."

UPMC Health Plan quality programs also require provider directory verification as a condition of participation and payment. In addition, failure to attest every 90 days may result in further action per your participating provider agreement.

Ways to keep your information current

UPMC Health Plan utilizes CAQH for directory updates and attestation. CAQH will notify you by alerts and contact you by email or telephone outreach to verify and attest that your provider directory information is accurate. If you're already registered with CAQH, please continue to visit the CAQH Provider Data Portal at **proview.caqh.org** to update your information. If you're a new user, please create a CAQH profile at **proview.caqh.org/PR/Registration.** The CAQH Provider Data Portal will guide you through completing your information, managing your profile data and supporting documentation, and attesting your information.

You can visit the provider directory to ensure that your provider information and office details are up to date and accurate. This is the information that must be reviewed/updated/verified:

- Ability to accept new patients
- Street address
- Phone number
- Office hours
- Hospital privileges
- Telehealth availability
- Any other information that affects your availability to our members

You can view your information by searching the online directory for your name at **upmchealthplan.com/find.** You can make updates to your information at **upmchealthplan.com/providers/change.html.**

If you have any questions, need help with your updates, or need to change your contact information, please contact your physician account executive or email **providernetworkinquiries@upmc.edu.**

Thank you for your support in this ongoing effort!

CAQH cannot change your product participation or the services contracted by your practice. If you have questions or concerns regarding product participation or contracted services, contact your physician account executive.

If you have questions or concerns regarding product participation or contracted services, contact your physician account executive.

Please review your National Provider Identifier (NPI) data in the National Plan & Provider Enumeration System (NPPES) as soon as possible to ensure that accurate provider data is displayed. CMS strongly recommends that providers keep their NPPES data current.

Patient Safety and Technology Assessment chart

The Patient Safety and Technology Assessment Committee (TAC) meets regularly to review medical technology. The TAC decides which existing medical and medical prior authorization policies need to be updated or amended or if new policies need to be developed. All policies undergo an annual review.

The following chart details recent TAC decisions. Please refer to each policy (available at upmchealthplan.com/providers) for complete indications and limitations. You can view upcoming changes to medical policies at upmchp.us/ProviderRLDocs.

Title – Policy #	Products	Policy Change Description/Summary of New Policy
Brachytherapy – MP.220 This policy is effective May 1, 2025.	All	This policy is being retired and the prior authorization policy is being transitioned to MP.PA.139. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Brachytherapy – MP.PA.139 This policy is effective May 1, 2025.	All	This policy is new and will require prior authorization for the following codes: 19296, 19297, 19298, 41019, 55920, 57155, 57156, 58346, 76873, 77316, 77317, 77318, 77750, 77761, 77762, 77763, 77767, 77768, 77770, 77771, 77772, 77778, 77789, 77790, 92974, C1715, C1728, C2616, C7533, C9725, C9726, C9728, G0458, Q3001 **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Implantable Loop Recorder (Subcutaneous) Cardiac Rhythm Monitor – MP.165 This policy is effective May 1, 2025.	All	This policy is being retired and the prior authorization policy is being transitioned to MP.PA.140. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Implantable Loop Recorder (Subcutaneous) Cardiac Rhythm Monitor – MP.PA.140 This policy is effective May 1, 2025.	All	This policy is new and requires prior authorization for the following codes across all LOBs: 0650T, 33285, 33286, 93285, 93291, 93298, C1764, E0616 The following codes will be E&I for CM/CHIP; and NMN for MA, CHC, and MC/SNP: 0525T, 0526T, 0527T, 0528T, 0829T, 0530T, 0531T, 0532T **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Radiation Therapy, External Beam (EBRT) and Intensity-Modulated (IMRT) – MP.034 This policy is effective May 1, 2025.	All	This policy is being retired and the prior authorization policy is being transitioned to MP.PA.142. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs

Title – Policy #	Products	Policy Change Description/Summary of New Policy
Radiation Therapy, External Beam (EBRT) and Intensity-Modulated (IMRT) – MP.PA.142 This policy is effective May 1, 2025.	All	This policy is new and will require prior authorization for the following codes: 77301, 77338, 77385, 77386, 77387, 77401, 77402, 77407, 77412, 77423, 77424, 77425, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016 **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Radiation Therapy – SRS and SBRT – MP.060 This policy is effective May 1, 2025.	All	This policy is being retired and the prior authorization policy is being transitioned to MP.PA.143. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Radiation Therapy – SRS and SBRT – MP.PA.143 This policy is effective May 1, 2025.	All	This policy is new and will require prior authorization for the following codes: 32701, 61781, 61782, 61783, 61796, 61797, 61798, 61799, 61800, 63620, 63621, 77371, 77372, 77373, 77432, 77435, G0339, G0340 **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Sleep Medicine – Sleep Study – MP.157 This policy is effective May 1, 2025.	All	This policy is being retired and the prior authorization policy is being transitioned to MP.PA.144. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Sleep Medicine – Sleep Study – MP.PA.144 This policy is effective May 1, 2025.	All	This policy is new and will require prior authorization for the following codes: 95782, 95783, 95800, 95801, 95805, 95806, 95807, 95808, 95810, 95811, G0398, G0399, G0400 **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Pulse Oximetry, Continuous Home – MP.006 This policy is effective May 1, 2025.	All	Changes have been made to diagnosis restrictions for this policy. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Vagus Nerve Stimulators (VNS) – MP.025 This policy is effective May 1, 2025.	All	Code 0908T has been added to the policy. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs

Title – Policy #	Products	Policy Change Description/Summary of New Policy
Knee Microprocessor – MP.PA.114 This policy is effective May 1, 2025.	All	Removed billing information regarding codes L5856 and L5850. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Single gene analysis (KRAS, BRAF, NRAS) This policy is effective May 1, 2025.	All	Additional covered diagnosis codes for single gene analysis of KRAS, BRAF, and NRAS to be added. - CPT code: 81275/81276 (KRAS): Added K86.3, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9. - CPT code: 81210 (BRAF): Added C48.1, C56.3. - CPT code: 81311 (NRAS) Added C91.00, C91.01, C91.02, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12 C92.40,C92.41,C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.A0, C92.A1, C92.A2, C93.10, C93.11, C93.12, D46.0, D46.1, D46.20, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9 **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Avalon policies These policies are effective May 1, 2025.	All	Avalon policies have been implemented for the following: - MP.A077: Therapeutic Drug Monitoring for 5-Fluorouracil Avalon policies have been updated for the following: - MP.A003: Vitamin D Testing - MP.A004: Diabetes Mellitus Testing - MP.A009: Testosterone - MP.A010: Vitamin B12 and Methylmalonic Acid Testing - MP.A046: Pathogen Panel Testing - MP.A058: Coronavirus Testing in the Outpatient Setting - MP.A073: Laboratory Procedures Reimbursement Policy - MP.A023: Prenatal Testing for Fetal Aneuploidy **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs
Experimental and Investigational These policies are effective May 1, 2025.	All	**Mechanical stretch devices:** LLPS devices for management of other joints (such as shoulder or ankle) and/or the use of static progressive stretch devices (SPS), and patient-actuated serial stretch devices (PASS)remain experimental and investigational for COM/CHIP, not medically necessary for MC/SNP and allowed if on the MA/CHC fee schedule. **Laser Interstitial Thermal Therapy (LITT) for Intracranial Indications (Glioblastoma, Radiation, Necrosis, Epilepsy):** Codes 61736 and 61737 are no longer considered E&I for MC/SNP, COM, CHIP, and MA/CHC if on the fee schedule. **You can view upcoming changes to medical policies at:** upmchp.us/ProviderRLDocs

You can see details for each policy on April 1 using the link to the redline versions of the policies below.

upmchp.us/ProviderRLDocs

Providers are responsible for appropriate billing of services. These suggested codes are not meant to provide or supersede clinical judgment.

High-value health care in action

The UPMC Center for High-Value Health Care Center (Center) tackles health care's toughest challenges by uniting experts across UPMC, organizations that collaborate with us, and the communities we serve.

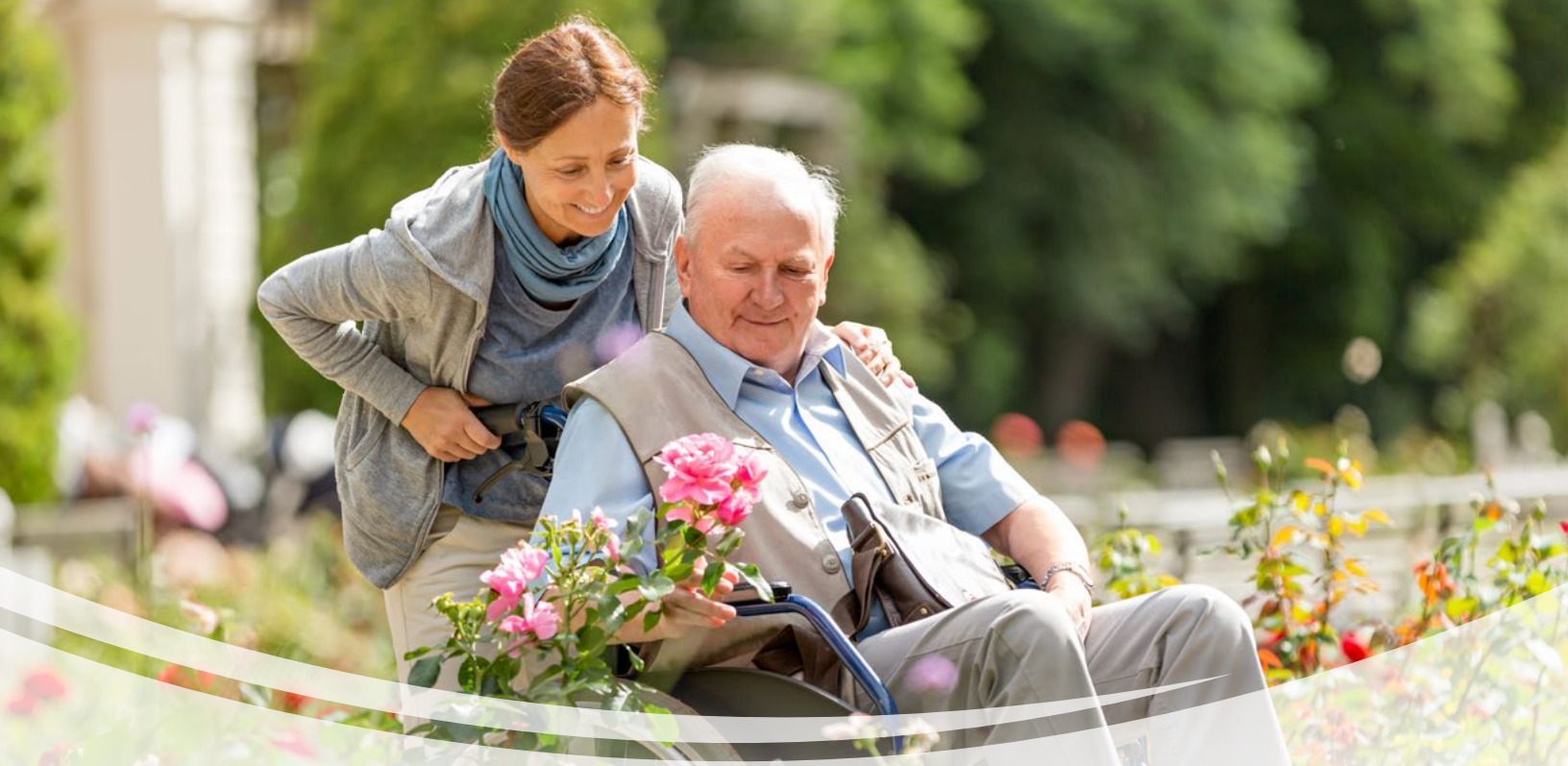
Collectively, we drive better care delivery and outcomes through research, community engagement, and service innovation.

Improving rural community access to behavioral health care is a current focus of the Center's efforts. Nationally, only 60 percent of rural residents have access to a behavioral health provider. To address this gap, the Center is spearheading two impactful projects aimed at integrating behavioral health services in rural primary care settings. The first, supported by an award from Health Services Research Administration (HRSA), uses telehealth to advance maternal health equity by bringing behavioral health services into rural health care settings within UPMC's provider network. This initiative builds on prior work with the Patient-Centered Outcomes Research Institute (PCORI), where the Center collaborated with stakeholders across Pennsylvania to develop a rural maternal health research agenda.

The second project, supported by funding from SAMHSA awarded to the PA Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS), focuses on integrating the collaborative care model in rural and underserved primary care clinics. As OMHSAS's primary subcontractor, the Center is leading the implementation, evaluation, and providing technical assistance to primary care practices that provide care across 13 Pennsylvania counties.

Want to stay updated on our latest findings and initiatives? Don't miss out on the results of our recently completed $3.8M PCORI-funded study, which revealed how high-tech, multi-modal, and resource-efficient care management approaches improve outcomes for Medicaid and dual-eligible adults with complex health needs. The study's actionable insights led to better care efficiencies, reduced medical costs, and improved patient satisfaction—providing clinical teams with valuable strategies to optimize care for individuals with multiple chronic conditions.

Collaborate with us and be part of the change driving better health care outcomes! For more information on the Center, **visit our website**.



Keeping your patients healthy and happy with their care

Each year from March through June, UPMC Health Plan Medicare Advantage members are asked about their health care experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

This anonymous survey is required for National Committee for Quality Assurance (NCQA) accreditation, NCQA ratings, and Centers for Medicare and Medicaid Services (CMS) star ratings. With our focus on quality, we believe there is always room for improvement in patient care. Remember, CAHPS surveys are not only about how well you are caring for your patients, but also your patients' perceptions of the care you provide.

We're encouraging our members to discuss these topics with you at their annual wellness visit:

- **What they are doing to stay active**
  Should they maintain or increase their current level of physical activity?
- **How they are managing current medications**
  Are they having any side effects?
- **Their energy level, sleep habits, and overall mood**
  Have they noticed changes to these?
- **Preventing falls or injuries**
  Are they losing their balance or having trouble with stairs? Are they using any tools that can help prevent falls?
- **Improving bladder control**
  What exercises can they do to help with this?

Discussing these important questions and topics can help identify barriers that may be affecting their health and allow you to build a care plan that addresses their needs.

Telehealth and access to care

Easy access to care is important. With telehealth, patients can receive care from the comfort of home. These appointments are often available sooner than in-person appointments. Plus, copays are the same as in-person appointments.

Some UPMC *for Life* patients may appreciate the convenience of telehealth but feel unsure when it is appropriate or preferred by their doctor. Talk to your patients if they could benefit from a telehealth visit based on their health needs. Check out UPMC Health Plan's Provider Telehealth Toolkit for resources that may help when discussing this type of care with your patients! Go to **our provider telehealth guidelines page.**

UPMC *for Life* community events

UPMC *for Life* members are invited to attend fun community events that can help them stay active and up to date on important health and wellness information. To see a complete schedule and list of all event dates, go to **upmchp.us/community-events.**

Zoo walks at the Pittsburgh Zoo & PPG Aquarium

Admission to the Pittsburgh Zoo & PPG Aquarium is FREE for UPMC *for Life* members on select dates. Each member can bring one guest of any age who will also get free admission. Members should arrive between 8 a.m. and 10 a.m. and show their member ID card at the admission gates.

Erie Zoo

UPMC *for Life* members and one guest of any age can get FREE admission to the Erie Zoo on select dates. Members should arrive between 10 a.m. and 5 p.m. and show their member ID card at the admission gates.

Keystone Safari

UPMC *for Life* members and one guest of any age can receive FREE admission to the park on select dates. Members should arrive between 10 a.m. and 6 p.m. and show their member ID card at the admission gates.

Garden Walks

UPMC *for Life* members and one guest of any age can receive FREE admission to the Pittsburgh Botanic Garden on select dates. Members should arrive between 9 a.m. and 11 a.m. and show their member ID card at the check-in.

Free admission applies only to UPMC for Life members on the dates listed. Other UPMC Health Plan members will not receive free admission. If the UPMC for Life member brings more than one guest, additional guests will be charged the applicable admission fee at the gate. Admission costs are subject to change by the Pittsburgh Zoo & Aquarium, Erie Zoo, and Keystone Safari.

UPMC for Life is a product of and operated by UPMC Health Plan Inc., UPMC Health Network Inc., UPMC Health Benefits Inc., UPMC for You Inc. and UPMC Health Coverage Inc.

CAHPS®
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (HRQ).

Guardians of integrity: How the SIU combats health care fraud

The Special Investigations Unit (SIU) is a specialized team of experienced Investigators, registered nurses, dental hygienists, and certified professional coders in the UPMC Insurance Services Division (ISD) dedicated to preventing, detecting, investigating, correcting, and reporting suspected fraud, waste, and abuse.

The ISD is contractually obligated to have an SIU to handle program integrity and payment integrity functions. By conducting thorough audits and investigations, the SIU helps protect the integrity of the insurance system. Additionally, the SIU conducts routine auditing and monitoring of providers and works closely with state and federal law enforcement and regulatory agencies to ensure compliance and protect the integrity of health care services.

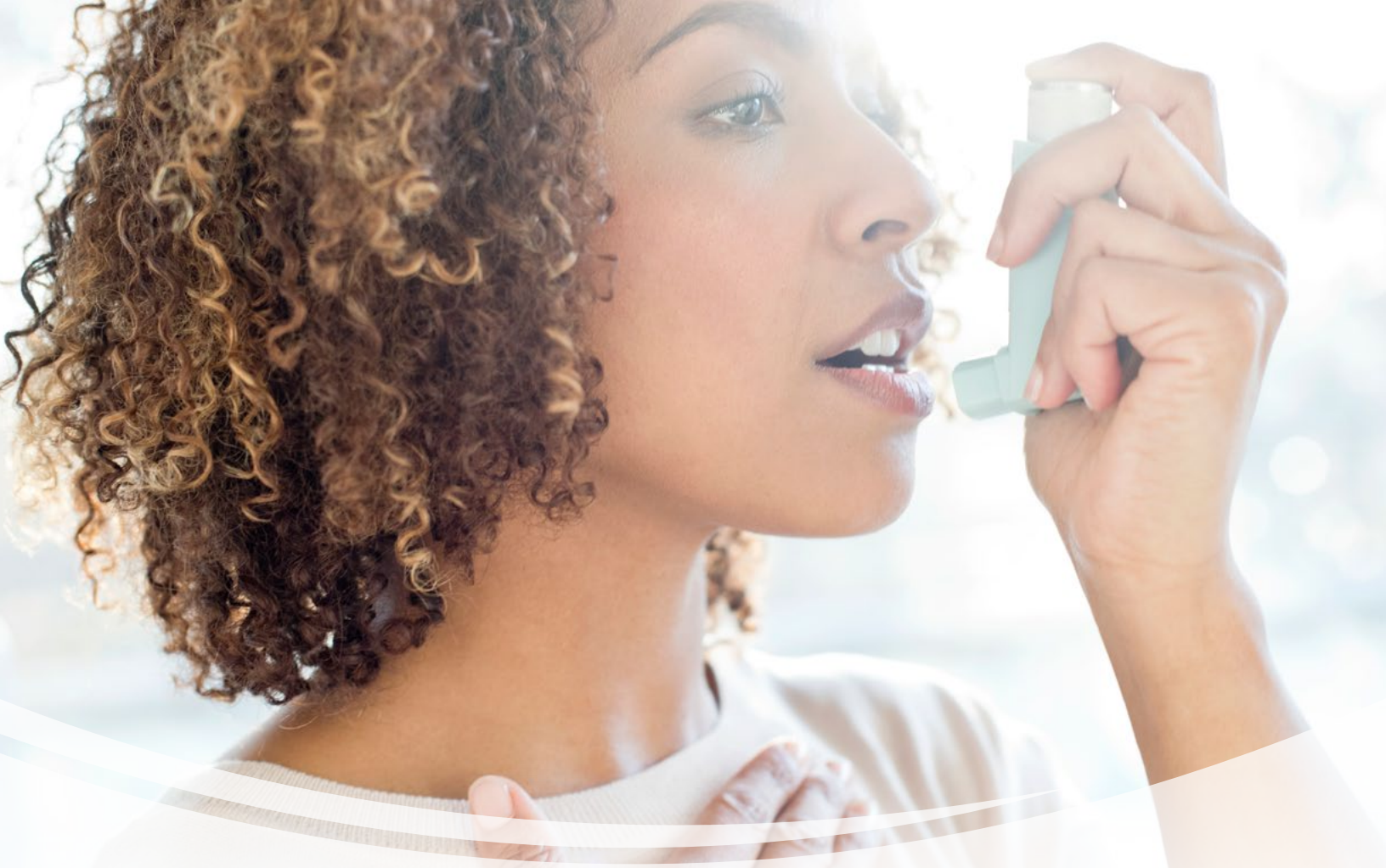
If you suspect fraud, waste, or abuse, you can report it to:

Email:
specialinvestigationsunit@upmc.edu

Fraud hotline:
1-866-FRAUD-01 (1-866-372-8301)

Fax:
412-454-0446

U.S. mail:
UPMC Health Plan
Special Investigations Unit
PO Box 2968
Pittsburgh, PA 15230



CME webinar: Asthma Clinical Guideline Updates

Please join us for a live, CME-accredited webinar on Wednesday, April 30, that will provide an overview of asthma clinical guideline updates. During this presentation, our speakers will discuss:

- The goals of therapy for asthma.
- The definitions, descriptions, and clinical usefulness of asthma severity.
- The clinical benefits of single maintenance and reliever (SMART) therapy for steps 1 and 2 of asthma management.

Speakers:

- **Nicholas DeGregorio, MD, MMM, FACP,** AVP of Medicaid Services, UPMC Health Plan
- **Lindsay Joseph, PharmD,** Clinical Pharmacy Coordinator, UPMC Health Plan
- **Rebecca Nagle, MS, BSN, RN, CPHQ,** Director of Medicaid and CHIP Quality Programs, UPMC Health Plan

Register now. This webinar will be recorded.

In support of improving patient care, the University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the health care team. The University of Pittsburgh designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. The maximum number of hours awarded for this Continuing Pharmacy Education is 1.0 contact hour. The maximum number of hours awarded for this Continuing Nursing Education activity is 1.0 contact hour. Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

Provider is responsible for verifying CME eligibility.

How PA Act 146 will change the way we submit prior authorization requests for medications

PA Act 146 is legislation that aims to streamline the prior authorization process, improving the sequence of events, with an end goal to move patient care forward.

PA Act 146 requires providers to submit all prior authorization requests electronically through a portal by Jan. 1, 2026. To ease the transition, we encourage providers to start making the switch now.

What electronic options are available to providers?

The electronic alternatives include:

- **ePA:** UPMC providers utilizing **epic** may submit prior authorization requests related to medications through the electronic **ePA system.** The **electronic prior authorization (ePA)** interfaces directly with EPIC, it is an electronic process established in the National Council for Prescription Drug Programs (NCPDP) to streamline the prior authorization process by allowing a provider the ability to proactively initiate a real-time prior authorization request. This system will be fully functional by the Jan. 1, 2026, transition deadline.
- Non-UPMC providers can also use the **ePA system through Sure Scripts, Arrive Health,** or submitting a prior authorization request through the **PromptPA portal** upmc.promptpa.com. You can upload chart documentation, lab notes, and progress reports to the prior authorization in the **PromptPA portal.** You are also able to check the status of your prior authorization request in the portal.
- A video tutorial on how to use the **PromptPA portal** is available on the UPMC website and additional training material will be made available upon request.
- ***Coming soon:*** UPMC Health Plan will accept electronic prior authorization requests for medications entered into the **CoverMyMeds** portal. With an anticipated go-live by July 2025, additional communications will be distributed to providers when the portal is available.

UPMC Cole obstetrics unit closure

Effective April 7, 2025, UPMC Cole will transition labor and delivery services away from their facility:

UPMC Cole
1001 East 2nd St.
Coudersport, PA 16915

Labor and delivery services will move from The Birthplace at UPMC Cole to The Birthplace at UPMC Wellsboro. The transition will only affect labor and delivery. UPMC Cole will still provide prenatal and postnatal care, routine gynecological care, ultrasounds and imaging, maternal fetal medicine, gynecological surgery, and women's specialty care. UPMC Health Plan sent a letter to patients affected by the unit closure.

Integrating behavioral health care and primary care: An introduction to the collaborative care model

Integrating behavioral health and physical health in the primary care setting has gained more traction within the past several decades in response to publications demonstrating the benefits of this approach for patient outcomes, provider satisfaction, and cost effectiveness.

Much of the time needed for effective care coordination and team-based care is not accounted for in evaluation and management billing codes or default practice workflows. To support practice transformation toward greater levels of integration, CMS made specific billing codes that help physical health care providers who address behavioral health conditions provide comprehensive, whole-person care and be compensated for the valuable work they do.

Across physical health care settings, there is a spectrum of how behavioral health is being addressed. While some primary care practices do not universally screen for behavioral health conditions, the percentage of primary care visits with a focus on behavioral health has increased substantially in recent years. Accordingly, many providers are incorporating measurement-based tools for common behavioral health conditions into their workflows, such as the PHQ-9 for depression and the GAD-7 for anxiety. When patients are seen in primary care for a behavioral health condition, screening is the first step to a patient receiving care. Practices must then determine care options—whether it is treating the patient with a medication prescribed by their primary care provider or referring to other behavioral health treatment services. Primary care providers may feel they do not have adequate time to address patients' behavioral needs or may not have adequate knowledge to care for all behavioral health conditions. Establishing formal relationships with behavioral health providers or having a co-located/embedded therapist in the practice are examples of options for facilitating timely referrals to behavioral health services.

The collaborative care model is an evidence-based practice for integrated, whole-person care within primary care. Unlike co-location, billing for all services related to behavioral health in the practice is through the treating primary care physician. What is unique about this model is that the primary care physician cares for their patients as part of a team that includes the patient, primary care physician, behavioral health care manager, and a psychiatric consultant.

The behavioral health care manager has experience in behavioral health. They have a bachelor's degree or (ideally) master's degree in behavioral health (social work, counseling, psychology), and can also be a nurse. The behavioral health care manager provides behavioral health treatment through brief, frequent contact with the patient rather than traditional behavioral health therapy sessions.

They use evidence-based screening tools to monitor the patient's symptoms over time, with treatment focused on symptom reduction. Using a patient registry allows the team to track progress. This is a registry is a way to evaluate all of the patients enrolled in collaborative care, identify those who are not improving, and prioritize those patients so they do not fall through the cracks. The behavioral health care manager employs evidence-based practices such as motivational interviewing, behavioral activation, and problem-solving therapy.

The patient is the integral member of the team; they decide what modalities work best for them in accomplishing their goals. The behavioral health care manager helps the patient set goals they can work toward and achieve within the next day or two, rather than over weeks or months. This approach benefits the patient, who may be feeling overwhelmed by the mental health symptoms they are experiencing. Breaking larger goals down to a more manageable level can lead to successes that increase a patient's drive toward their overall goals related to symptom reduction. The model is highly adaptable to the patient, and the care can be provided in person, by telephone, or virtually.

The behavioral health care manager's activities are tracked over a month's time and then are billed through the primary care physician, also known as "incident to" billing. This model removes the barrier of the behavioral health care manager needing to be individually credentialed to bill for traditional behavioral health services.

The other essential team member in the model is a contracted psychiatrist. The psychiatric consultant conducts routine caseload reviews with the behavioral health care manager and makes treatment recommendations, which are shared with the team. The established contracted relationship between the primary care practice and the psychiatric consultant permits for complex case consultation in a coordinated and timely manner, using one electronic health record for the patients' care.

There is a strong evidence base for the model demonstrating positive outcomes for conditions like depression, anxiety, attention deficit hyperactivity disorder, chronic pain, and substance use disorders. A recent systemic review indicates that suicidal thoughts in patients engaged in collaborative care activities were reduced by 34 percent compared to those receiving care as usual within primary care.

UPMC Health Plan is dedicated to supporting our network providers in implementing integrated care models within their practices to provide physical health and behavioral health services in a collaborative and coordinated approach to patient care. If you would like to learn more about the collaborative care model, please email our behavioral health integration team at **BHPHIntegration@upmc.edu.**

Prescription for Wellness e-learnings

The Prescription for Wellness team is excited to announce the development of several e-learnings for providers and office to access to obtain additional information regarding Prescription for Wellness, a nationally recognized, Six Sigma-developed best practice system that provides a convenient and effective way for providers to prescribe resources and support offered by UPMC Health Plan to their patients who are UPMC Health Plan members.

All e-learnings were developed using a microlearning template to afford brief learning opportunities to accommodate provider and office staff busy schedules (content for each microlearning can be viewed within five minutes or less). Current topics include Prescription for Wellness (a high-level overview); Prioritizing Patient Needs Through the Personal Health Review; UPMC Behavioral Health Coaching and Care Management; UPMC Lifestyle Health Coaching; UPMC Health Plan Pediatric Resources; and more!

The catalog can be accessed under the **Documents and Forms** section on Provider OnLine under Prescription for Wellness. The catalog includes the following:

- Title of the microlearning
- Brief content description
- Intended audience
- Hyperlink to access the microlearning

Our goal is to continue to add to our repository of microlearnings. If there is a particular topic you would like us to focus on, please feel free to email us at **RxforWellness@upmc.edu.** Our team will make every effort to accommodate requests.

Taking on tobacco cessation alongside behavioral health treatment

Use targeted tools to improve tobacco cessation success in patients with mental illness and substance use disorder

Nicholas DeGregorio, MD, FACP, MMM
Associate Vice President, Medicaid Medical Services, UPMC Health Plan

Over the years, many myths have surrounded tobacco cessation—particularly those concerning patients receiving support for behavioral health conditions.

Debunking false information and dispelling these myths is critical to helping this vulnerable population improve their overall health, as they often have higher rates of tobacco use.

According to information shared by the National Institute on Drug Abuse (NIDA), among U.S. adults in 2019, the percentage who reported past-month cigarette smoking was 1.8 times higher for those with any past-year mental illness than those without (28.2 percent versus 15.8 percent).[1] NIDA also shared information on smoking rates among people with serious mental illness and those in treatment for substance use disorder (SUD) indicating that:[2]

- As many as 70 to 85 percent of people with schizophrenia smoke.
- As many as 50 to 70 percent of people with bipolar disorder smoke.
- Between 65 and 80 percent of people in addiction treatment smoke.

The situation is dire nationally and in our backyard, according to the Pennsylvania Statewide Tobacco-Free Recovery Initiative (PA STFRI)—a five-year initiative funded by the Centers for Disease Control Prevention (CDC) that aims to advance evidence-based tobacco interventions in behavioral health settings. This initiative offers statewide consultation, training, and technical assistance to treatment providers and community partners to develop tobacco-free policies and integrate a tobacco-free recovery system of care into existing behavioral health services.

PA STFRI states that tobacco use among Pennsylvanians with mental and substance use disorders is three times higher than the general population.[3] The initiative also notes other concerns for this population:[4]

- Disproportional tobacco-related health disparities
- Inadequate access to appropriate tobacco treatment services

Myths: People with mental illness are not interested in quitting smoking. Tobacco cessation is not successful during treatment of serious mental illness, substance use treatment, or recovery; and it may lead to an exacerbation of their underlying conditions.

Facts: Most people with mental illness want to quit smoking. Randomized controlled trials show that smoking cessation in this population can be successful and does not exacerbate psychiatric symptoms or use of illicit drugs. Individuals engaged with smoking cessation during treatment for substance use disorders are 25 percent more likely to remain alcohol or drug free in the long term.

The "why" behind behavioral health and tobacco use

Many assume that people with behavioral health conditions—especially depression, anxiety, schizophrenia, and SUDs—begin smoking because nicotine can temporarily reduce symptoms such as low mood, anxiety, and stress. This is one of the many dangerous ideas promoted by tobacco companies that also billed smoking as healthy by having doctors endorse cigarettes.[5] In the past, mental health hospitals promoted smoking, gave out free cigarettes, and received tobacco donations from the tobacco companies.

While this is no longer the case, people with schizophrenia and other serious mental health conditions have a reduced life expectancy that is partly attributable to increased cardiovascular disease (CVD).[6] In most countries, people with schizophrenia have a reduced life expectancy between 15 to 20 years—with a significant contributor being CVD caused in part by lifestyle factors such as smoking.[7]

These data points and persistent myths underscore the need for health care providers to have accurate information about tobacco cessation in behavioral health settings and the tools to support patients in quitting. Success is quite possible for this population.

PA STFRI states that "… people who are provided evidence-based tobacco interventions while in behavioral health services have better overall treatment outcomes compared with those who do not."[8]

Take the initiative to help patients quit

Screen and address smoking cessation needs

Patients are twice as likely to quit smoking if advised by their physician. Remember to:

ASK patients if they smoke. Identify tobacco users at each visit.

ADVISE them to quit.

ASSESS if the patient is willing to attempt quitting in the next 30 days. If they say no, help them understand the risks of smoking and the benefits of quitting, making it personal to their lives. Consider using the five Rs:

- Relevance to their personal health and well-being
- Risks to their lives and livelihoods
- Rewards from becoming tobacco free
- Roadblocks to success; discuss how to overcome what is holding them back
- Repetition of the message

ASSIST with a plan to quit; set a quit date; and provide practical tips such as avoiding triggers, alcohol use, and being around smokers.

ARRANGE follow-up contact within a week after the quit date. You may also arrange referral to smoking cessation services.

A quicker approach is the 30-second **ASK, ADVISE, REFER** model. Ask about smoking at every visit, advise the patient to quit, and refer them to smoking cessation health coaching and/or quit lines.

Get tobacco cessation training

Physicians and other licensed health care professionals, including nurse practitioners, dentists, pharmacists, social workers, counselors, and psychologists, can take a 45-minute training course called **Every Smoker, Every Time** on the PA Department of Health website. Passing with a post-test score of 80 percent makes one eligible to be listed on the Pennsylvania State Pre-Approved Tobacco Cessation Registry. It is important to note that:

- Providers on this list can bill for 15-minute face-to-face encounters for tobacco cessation counseling using procedure code S9075.
- This code can be billed up to a maximum of 70 units per patient per year for medical assistance members.

Offer and encourage extra support

In addition to counseling, providers can improve success rates for quitting smoking and vaping by prescribing pharmacotherapy that helps patients stop smoking. First-line treatment generally includes the use of varenicline and/or nicotine replacement products, though individual clinical circumstances and preferences should be considered. The American Thoracic Society has put forward seven concise recommendations for clinicians, which are available on their website.

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There are many additional resources to help patients quit nicotine. For UPMC Health Plan members, you may use **Prescription for Wellness** to prescribe smoking cessation for your patients. A health coach will outreach and engage the member to assist in smoking cessation.

Interested members may be enrolled into the ***My*Health Ready to Quit Program,** which looks at a person's usage and guides them through the process of quitting and remaining nicotine free. UPMC Health Plan also offers an online smoking cessation tool for its members called the ***My*Health Wellness Program.** Members can log in to this program through the portal using their member ID.

Talk about tobacco cessation supports

You can also encourage patients to use these resources to help them initiate tobacco cessation and get the motivation to stay quit.

- The Pennsylvania FREE Quit Line: Telephonic health coaching service is available by calling **1-800-QUIT-NOW (1-800-784-8669).** Those who qualify can use this telephone-based tobacco cessation counseling service that offers five free coaching sessions with free nicotine replacement therapy. Text messaging is also included.
- QuitLogix: **pa.quitlogix.org/en-US**
- Tobacco Free Allegheny: Group and individual support is available by calling **412-322-TFA1 8321 ext. 8321.**
- National Cancer Institute: Clearing the Air–Quit Smoking Today at **cancer.gov/publications/patient-education/clearing-the-air**
- Online or telephone assistance is available by calling 1-877-44U-QUIT (7848) or visiting **smokefree.gov/pubs/Clearing-The-Air_acc.pdf.**
- UPMC behavioral resources: **upmchp.us/behavioralresources**
- Tobacco Free Adagio Health: Patients can call **1-800-215-7494** or text **412-253-8158** to be connected to a cessation counselor or visit **tobaccofree.adagiohealth.org.** Tobacco Free Adagio Health serves 16 counties in western Pennsylvania including Armstrong, Allegheny, Beaver, Butler, Cambria, Cameron, Elk, Fayette, Forest, Green, Indiana, McKean, Somerset, Warren, Washington, and Westmoreland.

  Programs include:
  - Cessation classes and counseling – Six- and eight-week courses are available.
  - Educational training sessions – Courses are available on behavioral health, wellness, substance abuse, prevention, LGBTQIA+, and more!
  - My Life, My Quit – This free and confidential service helps teens quit all forms of tobacco and vaping.
  - PA QuitLogix: **pa.quitlogix.org/en-US**

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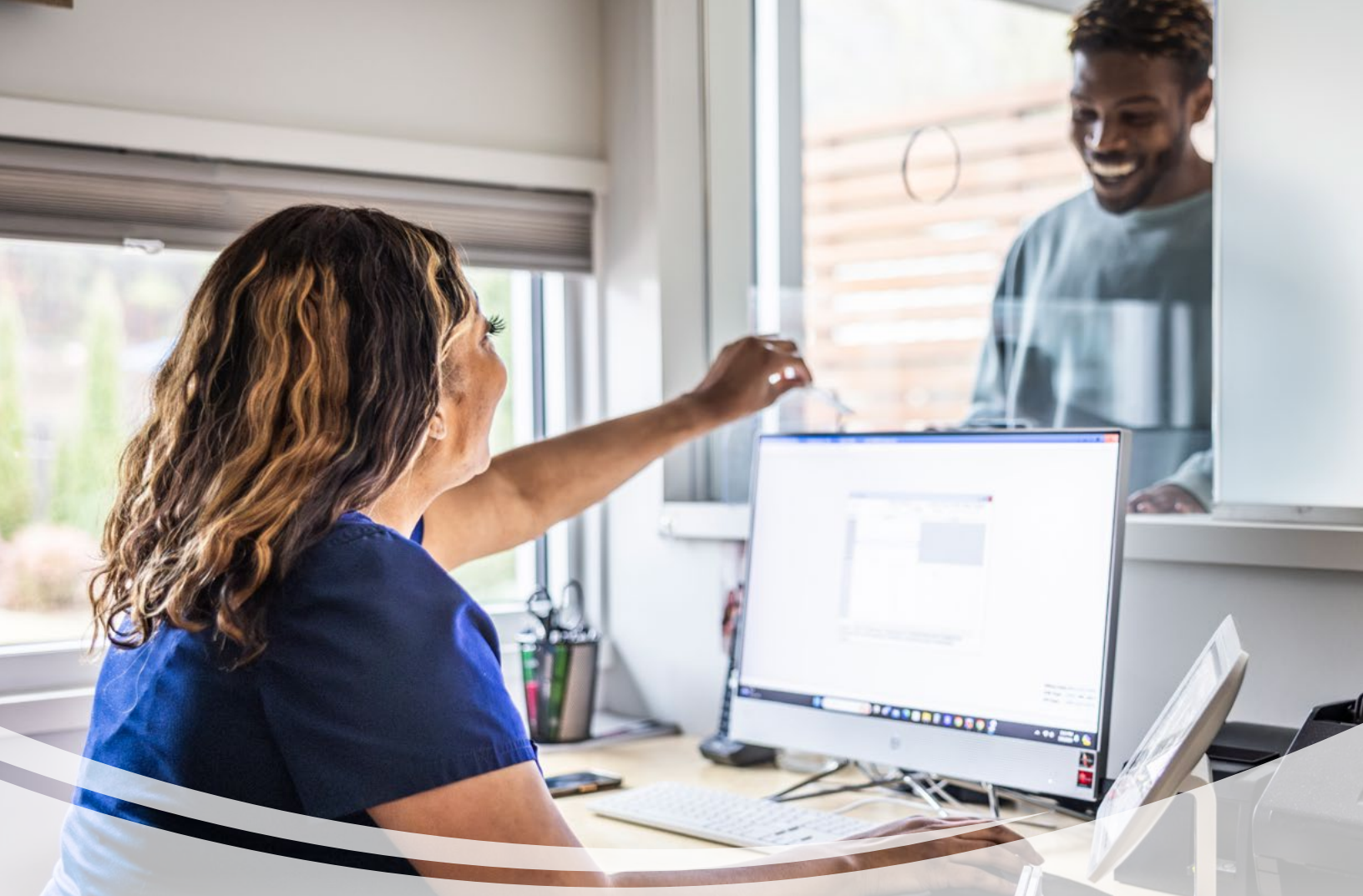

Special notice: Important policy changes

Effective May 1, 2025, the following policies will be retired and replaced with prior authorization policies. For more information, please visit **upmchp.us/policiesandprocedures.**

- **Brachytherapy – MP.220** is being retired and will be replaced by **Brachytherapy – MP.PA.139.**
- **Implantable Loop Recorder (Subcutaneous) Cardiac Rhythm Monitor – MP.165** is being retired and will be replaced by **Implantable Loop Recorder (Subcutaneous) Cardiac Rhythm Monitor – MP.PA.140.**
- **Radiation Therapy, External Beam (EBRT) and Intensity-Modulated (IMRT) – MP.034** is being retired and will be replaced with **Radiation Therapy, External Beam (EBRT) and Intensity-Modulated (IMRT) – MP.PA.142.**
- **Radiation Therapy – SRS and SBRT – MP.060** is being retired and will be replaced with **Radiation Therapy – SRS and SBRT – MP.PA.143.**
- **Sleep Medicine – Sleep Study – MP.157** is being retired and will be replaced with **Sleep Medicine – Sleep Study – MP.PA.144.**

Again, prior authorization will be required for all of the new policies beginning May 1.

If you have any questions or concerns about these policy changes, please contact your physician account executive or call Provider Services at **1-866-918-1595.**

Thank you for the excellent care and support you provide to our members.

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Quality improvement best practice insights

Topic: Chlamydia Screening (CHL)*

Measure: The percentage of members 16-24 years old who were recommended for routine chlamydia screening, were identified as sexually active, and who had at least one test for chlamydia during the measurement year.

Include members recommended for routine chlamydia screening with any of the following criteria:

- Administrative gender: Female (Administrative Gender code female) anytime in the member's history
- Sex assigned at birth: (LOINC code 76689-9) Female (LOINC codeLA3-6) anytime in the member's history.

Identify members who were recommended for routine chlamydia screening and are sexually active. Two methods identify sexually active members: pharmacy data and claim/encounter data.

Claim/encounter data. Members who had a claim or encounter indicating sexual activity during the measurement year. Any of the following meets criteria:

- Diagnoses Indicating Sexual Activity Value Set. Do not include laboratory claims (claims with POS code 81)
- Procedures Indicating Sexual Activity Value Set
- Pregnancy Tests Value Set

Pharmacy data. At least one contraceptive medication dispensing event during the measurement year (Contraceptive Medications List).

Numerator: At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year. Screening can be completed via a urine sample.

Measurement period: Jan. 1, 2025, through Dec. 31, 2025

Exclusion criteria:

- Sex assigned at birth: (LOINC code 76689-9) Male (LOINC code LA2-8) anytime in the member's history.
- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit anytime during the measurement year.
- Members who die anytime during the measurement year are excluded.
- For members identified based on a pregnancy test alone, remove members who meet either of the following:
  - A pregnancy test (Pregnancy Tests Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List) on the date of the pregnancy test through the six days after the pregnancy test

- A pregnancy test (Pregnancy Tests Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test through the six days after the pregnancy test

Best practices:

- Do a urine screen during the office visit instead of sending a script to an outpatient lab. This ensures the test will be completed.
- Educate the patient and parents/guardians (if applicable) about the effects of having an untreated chlamydia infection.
- Consider screening all members recommended for routine chlamydia screening 16–24 years old for chlamydia as a standard of care in the office.
- Obtain the patient's personal phone number to report results. If you are unable to reach school age patients, work with the school nurse to contact the patient. The school nurse can call the patient to the office and the provider can inform the patient of results over the phone in the nurse's office.
- Bill screening tests as preventive to prevent out-of-pocket costs for the patient or family.

Cervical Cancer Screening (CCS-E)*

Measure: The percentage of members 21-64 years old who were recommended for routine cervical cancer and were screened for cervical cancer using any of the following criteria:

- Members 21–64 years old who were recommended for a routine cervical cancer screening and had cervical cytology performed within the last three years
- Members 30–64 years old who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years
- Members 30–64 years old who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last five years

Denominator: Include members recommended for routine cervical cancer screening with any of the following criteria:

- Administrative gender of Female (Administrative Gender code F) anytime in the member's history.
- Sex assigned at birth (LOINC code 76689-9) of Female (LOINC code LA3-6) anytime in the member's history.

Measurement period/Intake period: Jan. 1, 2025, through Dec. 31, 2025

Exclusion criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit anytime during the measurement year.
- Members who die anytime during the measurement year are excluded.
- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) anytime during the measurement year.
- Members who had an encounter for palliative care (ICD-10-CM code Z51.5) anytime during the measurement year. Do not include laboratory claims (claims with POS code 81).
- Members with sex assigned at birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time in the patient's history.
- Hysterectomy with no residual cervix (Hysterectomy with No Residual Cervix Value Set) anytime during the member's history through Dec. 31 of the measurement year. The following examples meet criteria for documentation of hysterectomy with no residual cervix:
  - Documentation of "complete," "total," or "radical" hysterectomy
  - Documentation of "vaginal hysterectomy"
  - Note: Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.
- Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) anytime during the member's history through Dec. 31 of the measurement year. Do not include laboratory claims (claims with POS code 81).

Best practices:

- Have a provider within the PCP's office who can perform Pap testing. If this is not possible, encourage members recommended for routine chlamydia screening to follow up yearly with an ob-gyn provider.
- Ensure that office staff follow up with the ob-gyn to obtain records to close the gap in care for those patients who see an ob-gyn regularly.

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Topic: Acute Hospitalization Utilization (AHU)

Measure: For members 18 years old and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year

Denominator: Members who meet the age criteria

Numerator: An acute inpatient or observation stay discharge

Note: The goal of this measure is to avoid acute hospital utilization. Use the following steps to identify and categorize acute inpatient and observation stay discharges for the observed events:

Step 1: Identify all acute inpatient and observation discharges during the measurement year.

Step 2: *Direct transfers:* For discharges with one or more direct transfers, use the last discharge.

Measurement period: Jan. 1, 2025, through Dec. 31, 2025

Exclusion criteria:

- Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit anytime during the measurement year
- Remove discharges for outlier members:
  - Medicare members with four or more inpatient or observation stay discharges during the measurement year
  - Medicaid members with six or more inpatient or observation stay discharges during the measurement year
  - Commercial members with three or more inpatient or observation stay discharges during the measurement year
- Nonacute inpatient stays (Nonacute Inpatient Stay Value Set)
- For the remaining observation and inpatient discharges, exclude inpatient and observation discharges with any of the following on the discharge claim:
  - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set)
  - A principal diagnosis of live-born infant (Deliveries Infant Record Value Set)
  - A maternity-related principal diagnosis (Maternity Diagnosis Value Set)
  - A maternity-related stay (Maternity Value Set)
  - A planned hospital stay using any of the following:
    - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set)
    - A principal diagnosis of rehabilitation (Rehabilitation Value Set)
    - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set)
    - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set)
  - Inpatient and observation stays with a discharge for death

  Note: For hospital stays where there was a direct transfer, use the original stay and any direct transfer stays to identify exclusions.

Best practices:

- Engage patients diagnosed with chronic conditions to help prevent hospitalization.
- Provide regular wellness visits and screenings.
- Ensure coordination of care and offer support services to patients diagnosed with chronic conditions.
- Provide post-discharge follow-up for patients admitted to the hospital.

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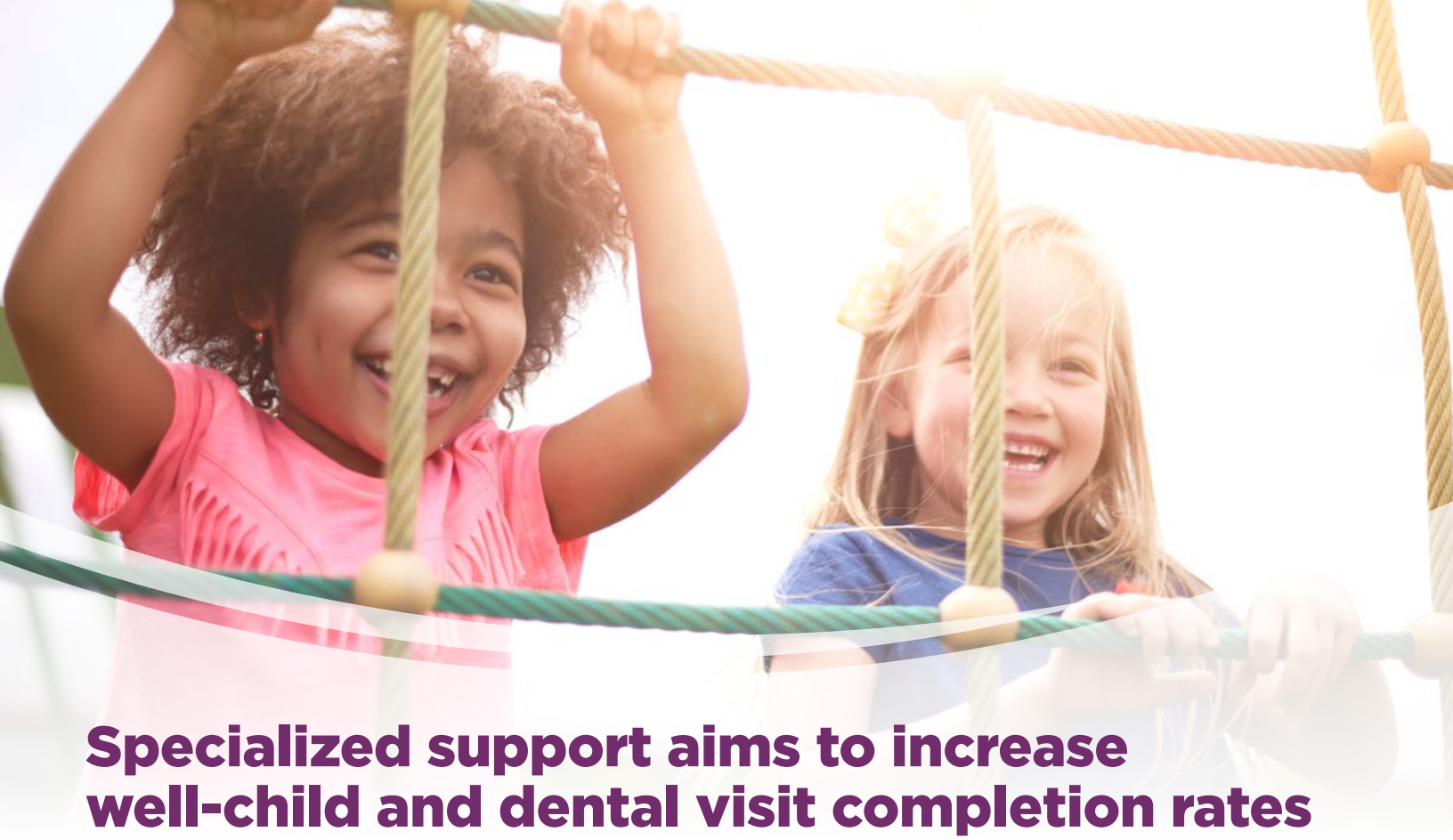

Specialized support aims to increase well-child and dental visit completion rates

Outreach efforts to continue throughout the year

Many children in the U.S. are not getting all the care they need to help them get or stay healthy—particularly preventive care that they could receive at a well-child visit.

According to a 2023 National Health Statistics Report, visits for preventive care decreased nearly 40 percent for children younger than age 18 and just over 22 percent for those in the report's next range of ages 18–64.[1]

Oral health is also an integral part of overall health for children and adolescents, yet the prevalence of dental caries remains greater than 40 percent among children 2 to 19 years old.[2] This common disease can have significant downstream health, social, emotional, and educational consequences, as untreated tooth decay:

- Causes pain and infections that may lead to problems, such as eating, speaking, and playing.[3]
- Can lead to poor attention in the classroom, poor grades, and lower academic achievement.[4]
- Can cause embarrassment, low self-esteem, and social isolation.[5]

Partners in improvement

UPMC *for You* and UPMC *for Kids* will continue to contact parents and guardians of our pediatric members using the Clark Resources outbound call center throughout 2024 to help schedule well-child and dental visits that can provide broad benefits. The calls Clark Resources agents make aim to help families stay up to date on annual preventive visits. They may also support your office in closing gaps in care for key quality and/or pay for performance measures.

All the actions agents take

Clark Resources agents will provide the following services to connect Medical Assistance and Children's Health Insurance Program (CHIP) members with providers to schedule well-child and dental visits:

- Remind the caregiver of the need for well-child and/or dental visits for all children in the household.
- Attempt to schedule needed appointments with a provider of choice via a recorded three-way call.
- Help the caregiver find a participating primary care provider (PCP) or primary dental provider (PDP) near their home address when needed.

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- Confirm with the caregiver that they do not have any concerns with transportation to and from the scheduled appointment(s). If needed, the agent will connect the member with the Medical Assistance Transportation Program (MATP) to arrange transportation to the scheduled appointment(s). (This is only offered for members enrolled in Medical Assistance, as it is not a service available from the Department of Human Services for CHIP members.)
- Note scheduled appointments in our system to help enable the member to receive reminder calls in advance of the appointment in addition to any reminders from your office.
- Assist members with updating their PCP selection and requesting new ID cards as needed.
- Remind the caregiver of any upcoming Medical Assistance renewal dates for members in the household to assist families in maintaining their coverage.
- Offer to assist families with scheduling their flu shots during flu season.

Support this essential effort

Please let your office staff know about these outreach calls. A positive experience with scheduling can build cooperation and solidarity among members, your staff, and UPMC *for You* and UPMC *for Kids* families. This collaboration between UPMC Health Plan, PCPs, and members can have a positive effect on well-child and dental visit completions for our members ages 2–21.

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CME webinar: Essential Best Practices for Newborn Care: Ensuring Healthy Beginnings Through Comprehensive Care

Please join us for a live, CME-accredited webinar on Wednesday, May 7, from noon to 1 p.m. that will provide an overview of newborn care.

- The key principles of newborn care.
- Opportunities to standardize newborn discharge practices.
- Barriers to Safe Sleep anticipatory guidance.
- Understand the newborn HEDIS® measures: Follow-Up Visit Post Discharge.

Speakers:

- **Gysella Muniz Pujalt MD, MBA FAAP,** UPMC Regional Director of Quality Newborn Care, Medical Director, MWH Newborn Nursery Services
- **Debra Zeh, RN, BSN,** Senior Director Quality Improvement, Provider Performance, UPMC Health Plan

Register now.

In support of improving patient care, the University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the health care team. The University of Pittsburgh designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. The maximum number of hours awarded for this Continuing Nursing Education activity is 1.0 contact hour. Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

Provider is responsible for verifying CME eligibility.

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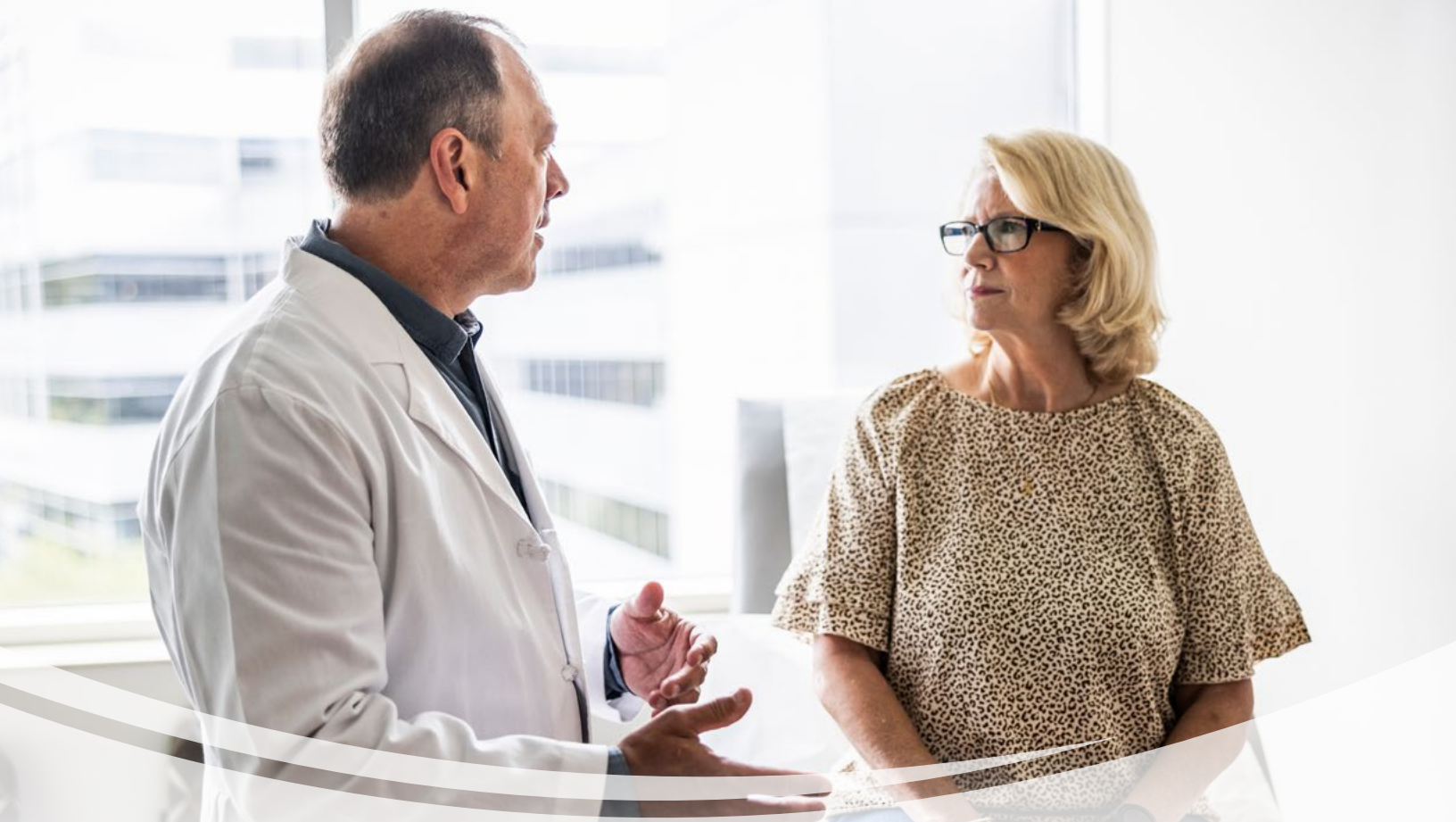


The importance of referring patients to in-network providers

As dedicated health care providers, your primary goal is to ensure the well-being of your patients.

A crucial aspect of this responsibility involves making informed referral decisions that not only deliver the best medical care but also consider the financial impact on your patients. When patients are referred to out-of-network providers, they often face significantly higher medical expenses and substantial out-of-pocket costs. Referring patients to in-network providers is a key practice that can significantly reduce health care costs and prevent unexpected bills.

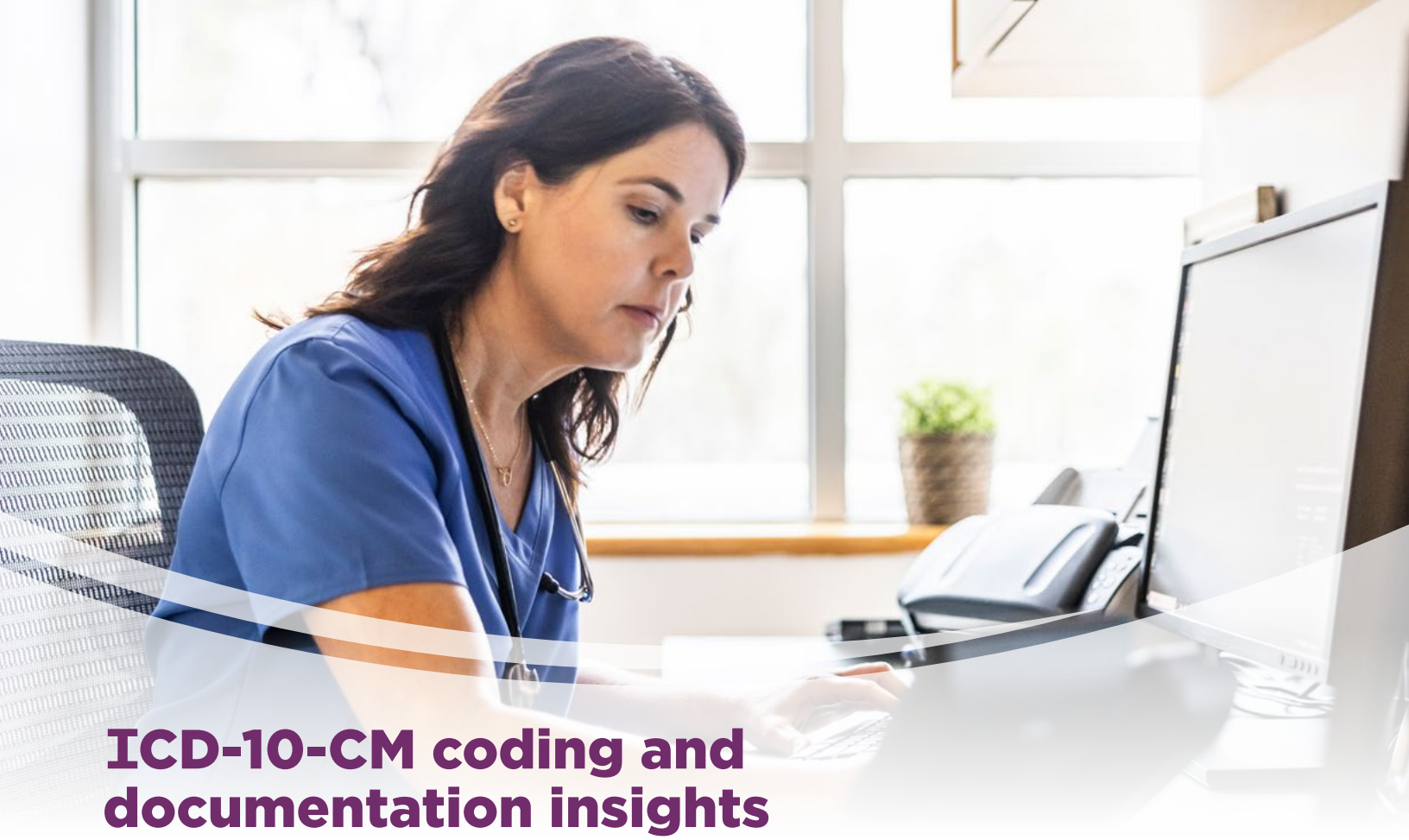
As part of your contractual agreement with UPMC Health Plan, participating providers are required to refer UPMC Health Plan members to participating laboratories, facilities, and providers. Choosing a nonparticipating facility may result in the patient being financially responsible for the services provided. Continued referrals to nonparticipating laboratories, facilities and providers may result in further administrative action by UPMC Health Plan. More details at the link below:

Provider Manual; Provider Standards and Procedures; Chapter B, page 31; Closer Look at Referrals **UPMC Provider Manual: Referrals and Coordination of Care**

As part of your contractual agreement with UPMC Health Plan:

- Providers are required to coordinate a member's care with other specialists, behavioral health providers, therapists, hospitals, laboratories, and facilities in the network appropriate to the member's benefit plan.
- Providers are required to refer members to other participating providers (including but not limited to specialists, behavioral health providers, hospitals, laboratories and facilities).
- Use of network providers helps members maximize medical benefits and reduce out-of-pocket expenses.
- Failure to comply with this requirement may lead to provider termination.

To enhance service excellence of quality coverage, UPMC Health Plan is committed to maintaining a laboratory, facility, and provider network that is reliable, affordable, and a convenient point of care system. To find an in-network provider, please visit **upmchealthplan.com** and search our provider directory, or call Provider Services at **1-866-918-1595.**



ICD-10-CM coding and documentation insights

Marlana Tice, CCS-P, CPC, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer
Program Director, Risk Adjustment/HCC Coding Education

General tips for ICD-10-CM documentation

Compliant and accurate diagnosis documentation leads to compliant and accurate ICD-10-CM diagnosis code reporting. ICD-10-CM code reporting is not just for inpatient facility (DRG) reimbursement. ICD-10-CM codes are important and utilized in all patient care settings. From an outpatient/office visit perspective, many providers think that the ICD-10-CM code is only for reporting the medical necessity of their service represented by a CPT® code. Although this is one aspect of reporting ICD-10-CM diagnosis codes, the ICD-10-CM codes are critical in determining severity of illness in risk adjustment, determining utilization for risk management, identifying resource use, determining quality of care, and supporting public health management.

The following are a few tips to help providers document support for the reporting of an ICD-10-CM code.

- **Do not use "history of" terminology for chronic or incurable conditions.** ICD-10-CM considers "history of" terminology as a resolved condition.
  - o Imagine and document conditions in terms of **active** or **resolved.**
  - o Document chronic conditions as *"controlled" or "compensated" with the named medication, "present," "active," "known problem of...," or "current problem of..."*
- **Do not use uncertain terminology.** Per ICD-10-CM guidelines, documentation of these uncertain terms to describe a diagnosis makes the diagnosis ineligible to report: *probable, suspected, questionable, rule out, consistent with, compatible with, working diagnosis, likely, or any other term conveying uncertainty.*
  - o If the provider has yet to confirm the diagnosis, it is acceptable to document a condition as uncertain (e.g., probable) while working to confirm the diagnosis. However, only report the ICD-10-CM code for the symptoms, signs, abnormal test results, or other reasons for the visit until an encounter confirms the diagnosis in the documentation.
- **Document with individual aspects of care for each diagnosis listed.**
  - o Eliminate "blanket statements" or a templated assessment and plan of care for all diagnoses.
- **Check templated documentation for consistency throughout all sections of the record.**
  - o Be sure that templated documented clinical findings (or negative findings) in the history or exam sections do not conflict with the diagnosis in the assessment and plan.

COVID-19 Vaccines and OTC Test Kits: No Cost for members of UPMC *for You* and UPMC Community HealthChoices (CHC)

COVID-19 vaccines and over-the-counter (OTC) COVID-19 test kits remain available at no cost to members of UPMC for You and UPMC CHC.

COVID-19 vaccines

- FDA-authorized COVID-19 vaccines are covered with $0 member cost-sharing for vaccine administration at all in-network licensed providers and pharmacies.

  Note: When the government provides COVID-19 vaccines at no cost, providers should bill only for vaccine administration.

COVID-19 OTC test kits

- Members of UPMC *for You* and UPMC CHC are eligible to purchase OTC COVID-19 tests for $0 through participating pharmacies or submit for reimbursement after purchasing from retailers.*

**UPMC for You and UPMC CHC coverage includes up to 8 FDA-authorized OTC rapid tests every 28 days per each covered individual when they are purchased through a participating pharmacy or directly from a retail store or retailer website. Members are eligible to purchase COVID-19 tests for $0 through participating pharmacies or submit for reimbursement after purchasing from retailers. The member will be reimbursed for the actual cost of the COVID-19 OTC test, up to a maximum amount of $12 per OTC COVID-19 test (including taxes), but will not be reimbursed for shipping. Reimbursement forms must be received by the Health Plan within 180 days of the date on the member's receipt.*

Update to the Admissions Notice Packet (MA 401) form

The purpose of this communication is to inform UPMC Health Plan providers enrolled in the UPMC *for You* and UPMC Community HealthChoices programs that **effective immediately,** there have been updates to the Admissions Notice Packet (MA 401) form because of an increase in the personal needs allowance (PNA) deduction amount listed on the form.

Applicants and residents of **nursing facilities, ICF facilities, and long-term care facilities** must receive certain information required by federal law and regulations. Funding in the 2024–2025 state bulletin has allocated the PNA deduction amount to be increased to be used on purchasing a variety of personal needs such as but not limited to personal hygiene products, toiletries, and snacks.

Effective Jan. 1, 2025, the basic PNA deduction amount increased from $45.00 to $60.00. The updated MA 401 has been changed to reflect the increased PNA deduction amount.

For additional information and location of the MA 401 form, please see bulletin 03-25-33 located on the DHS website.

If you have any questions, contact your physician account executive or call Provider Services at **1-866-918-1595.**

Quick care and clear conversations: Enhancing patient wait times and communication for health literacy

Time is of the essence for both care teams and their patients, especially when quick and efficient care can make a big difference in managing health outcomes.

There are two important areas to consider that can preserve time and improve patient satisfaction throughout the visit: 1) The waiting period prior to the appointment; and 2) the provider-patient interaction. Prior to the appointment beginning, it is important to have all patient information gathered and accessible to the care team. This allows for more coordinated and effective care, ensuring that each team member can make meaningful contributions to the patient's health care journey. As the appointment concludes, it is essential that the patient leaves with a clear understanding of what the provider communicated to them. This ensures that they can follow through on any instructions or treatments independently, leading to better health outcomes and overall satisfaction. To achieve these goals, here are some best practices to consider:

Prior to the encounter:

Seamless check-in. While UPMC offices have well-implemented seamless check-in processes, it's essential to ensure that members who do not currently use self-check-in resources receive the same level of efficient service. To manage these members effectively, ensure that there are always alternative check-in options available, such as traditional desk check-ins, to accommodate all patients' preferences and needs. Additionally, and when practical, encourage staff to walk hesitant patients through the self-check-in process in a step-by-step approach. This hands-on method can help build confidence and familiarity with the technology.

When delays are unavoidable, proactive communication is vital. Informing patients as soon as a delay is anticipated, whether through text messages or phone calls, helps manage their expectations. Being transparent about the reason for the delay and providing an estimated wait time can also alleviate frustration.

Leveraging technology can further enhance the patient experience. Offering telehealth options for follow-ups or less critical consultations can reduce the burden on in-person visits. Implementing real-time tracking systems that allow patients to monitor their appointment status, like ride-sharing apps, can also improve transparency and satisfaction.

Collecting patient feedback regularly is important for continuous improvement. This feedback can highlight areas for improvement and help refine scheduling and communication practices. Training staff on the importance of time management and effective communication is also crucial. Empowering them to handle delays gracefully and professionally can make a significant difference.

During the appointment:

Let patients assist in setting the agenda. Invite the patient to share their understanding of their health concerns. This helps to create a cohesion, bringing to light any opportunities for further education. Additionally, if this is a telehealth visit, check if the patient is in a suitable environment to start or continue the call, ensuring there are no distractions in the background that could hinder their ability to receive and understand the information being shared.

Break down complex ideas: Consider the members understanding of health-related matters to guide the conversation. Using the teach-back method to gauge the patients understanding can ensure that information has been shared and received effectively.

Cultural sensitivity: Providing culturally sensitive care is essential to ensure that all patients feel respected and understood. To enhance cultural sensitivity, ask open-ended questions, allowing the patient to share their experiences. Adopt a humble approach by acknowledging that you may not know everything about the patient's culture and showing a willingness to learn. Practice active listening by giving patients your full attention and showing empathy.

Patient education materials: To optimize time and allow providers to focus on the patient's agenda, it is beneficial to use educational handouts that may cover a range of basic questions and provide valuable information in a concise format. Additionally, consider the technical literacy of patients when distributing these materials. Visual aids can help bridge the gap for patients who struggle with reading. Ensure that these materials are available in multiple languages if needed. Incorporate diagrams, pictures, and videos to explain medical concepts when possible. To ensure visual aids are effective in a telehealth setting, it's crucial to adapt them for online use. Use digital visual aids that can be easily shared and viewed on-screen during telehealth sessions, ensuring that all information is communicated clearly to the patient.

Review treatment options: When considering follow-up care, evaluate whether virtual or in-office follow-up appointments, depending on their convenience and the nature of their condition, may be appropriate for the patient. Additionally, consider options related to specialist care, ensuring that patients receive the most appropriate and specialized treatment.

By implementing these strategies, your practice may operate more efficiently and enhance overall experience. We hope that these best practices will encourage further innovation as we continuously seek ways to improve provider-patient care and communication.

Talk to patients about organ donation through UPMC

Help us save and enhance more lives

For decades, UPMC has served as a renowned medical center revered for its transplant services. In 1964, Children's Hospital of Pittsburgh performed its first pediatric kidney transplant. Since its establishment in 1981, UPMC Transplant Services has performed more than 20,000 organ transplants, including:

- Liver transplants (living and deceased donor).
- Kidney transplants (living and deceased donor).
- Pancreas transplants.
- Small bowel transplants.
- Heart transplants.
- Lung transplants (double- and single-lung).
- Multiple-organ transplants.

Today, UPMC is one of the country's oldest and largest transplant programs. The program expanded to offer life-saving transplant care in Pittsburgh, Erie, and Harrisburg; and transplant evaluations in north central, central, south central, northwestern, and southwestern Pennsylvania.

Encourage organ donation to help us save more lives

UPMC increases access to transplant services but needs support to help those on the waiting list get life-saving organs. The need for more people to register as organ donors remains dire.

According to Health Resources & Services Administration (HRSA) data, there are more than 103,000 people on the national transplant waiting list, and every eight minutes, another person is added to the list.[1] Sadly, 17 people die each day waiting for an organ transplant.[2]

Use talking points to guide the conversation

You can help make sure that people on the waiting list get the life-saving transplants they need by talking to your patients about the importance of organ donation. These talking points can help you guide the critical conversation on organ donation.

- **It's easy.** Signing up through UPMC is quick. To register as an organ, eye, and tissue donor, visit **registerme.org/UPMC.**
- **It's selfless.** When you register to be an organ donor, you are giving those on the waiting list hope for a second chance at life.
- **It makes a difference.** One organ donor can save as many as 8 lives and enhance more than 75 others.
- **You can donate a kidney or a portion of your liver while you're still alive.** Living donation enables those with end-stage disease to receive a transplant sooner—before they become sicker. Visit **livingdonorreg.upmc.com** to register as a living donor.

Get inspired by these success stories

These stories are proof of the life-saving difference that organ donation makes. When you encourage patients to register as a donor through UPMC, you help make more of these stories possible.

Alan and Amanda

Alan was diagnosed with primary sclerosing cholangitis (PSC) in 2008 and was able to manage the disease on his own until 2020, when his disease progressed and his liver began to lose function. Alan's wife, Amanda, was a perfect match and was willing to be his living-liver donor.

Read Alan and Amanda's story

Jaxson and Kayla

Jaxson was born with cystic renal dysplasia of both kidneys that would eventually require a kidney transplant at age 2. Luckily, his mother, Kayla, was able to serve as his living donor.

Read Jaxson and Kayla's story

Alecia

After Alecia was diagnosed with pulmonary hypertension, she was determined to improve her health and live life to the fullest. She received a lung transplant at UPMC and is looking forward to more special moments and adventures with her family.

Read Alecia's story

Experience and support matter

UPMC provides patients with education, resources, and step-by-step support throughout their transplant journey.

Our program includes:

- Experienced transplant surgeons.
- Hepatologists.
- Nephrologists.
- Pulmonologists.
- Cardiologists.

Our support team includes:

- Transplant coordinators.
- Social workers.
- Financial/Insurance coordinators.
- Pharmacists.
- Nurse practitioners.
- Dietitians.
- Living Donor Ambassadors.

Complete your 2025 annual education today

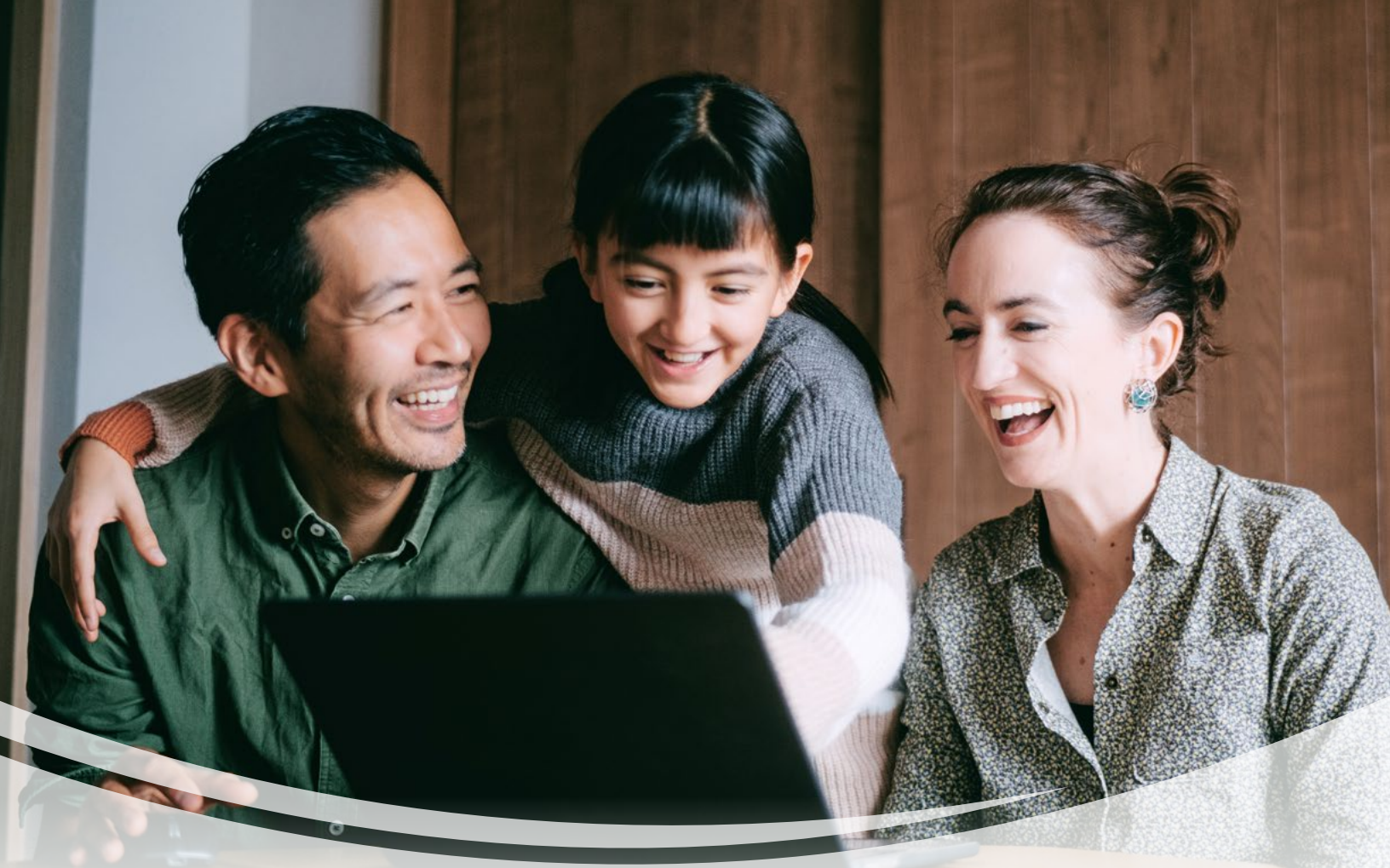
Health plans are required by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Human Services (DHS), and the Centers for Medicare & Medicaid Services (CMS) to deliver annual provider education and training.

Participation is reported to these government entities upon request. For your convenience, UPMC Health Plan's 2025 training/education module is now available online. Complete the training at **upmchp.us/annualeducationoffering.**

You will need your tax identification number to register. You can also find the training on Provider OnLine in the Documents and Forms section under Provider Training.

Please contact your network manager or physician account executive if you have questions or would like to schedule in-person or virtual training.

Thank you for your continued support and the care you provide to our members!



Improving member experience: 2024 survey results

Our goal is to provide our members with access to high-quality care. As a Partner in Care, you are key in helping us achieve this goal.

Surveys give us actionable information that can help improve our members' health care experiences and promote a high level of care.

Every year, UPMC Health Plan members provide anonymous feedback on their health care experiences in these ways:

- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey for Commercial, Medicaid, Medicare, and CHIP members
  - o MCAHPS survey administered February – May 2025
  - o HEDIS CAHPS survey administered January – May 2025
- The Qualified Health Plan Enrollee Experience survey (QHP) for Marketplace members
  - o QHP survey administered February – May 2025

Listening to and acting on feedback

The 2024 member experience survey results highlighted an opportunity to support members' access to care. Efforts are underway to increase the visibility of services that may improve members getting needed care and getting care quickly.

1. **Getting Needed Care**
   - o **Consider consulting with a specialist** versus referring a patient to see the specialist when clinically appropriate. For example, schedule an eConsult with the specialist. eConsults enable providers to request and obtain a specialist consult through systems such as EpicCare. eConsults are billable for both requesting and responding providers. Plus, they let patients avoid waiting for a visit with a specialist, improve PCP and specialist communication, and enhance care coordination.

- **Offer telehealth specialist referrals.** Many specialists now offer telehealth services, encouraging patients to request a specialist visit through audio/video calls when clinically appropriate. This may make obtaining a specialist appointment easier, faster, and more convenient with no need for travel.
- **Encourage use of care team in health discussions.** It's important to include your care team (for example, nurse practitioners and physician assistants) as options for getting care necessary care, tests, or treatments.

2. Getting Care Quickly

- **Offer telehealth services.** Telehealth allows patients to consult with doctors through audio/video calls, which can be especially helpful for routine check-ups or minor ailments and manage chronic conditions. This makes getting appointments for needed care right away easier if preferred by the patient.
- **Offer online appointment scheduling.** Using online platforms to schedule appointments can help patients find the earliest available slot that meets their needs with their health care provider.
- **Encourage patients to see other members of your care team.** Encouraging patients to obtain care from nurse practitioners, physician assistants, and other team members can help them get access right away when needed. Members can also use Health Plan services, such as UPMC AnywhereCare, to get care right away for nonemergent issues.

  Get more information on telehealth in the provider telehealth tool kit:

  upmchealthplan.com/providers/medical/resources/telehealth-guidelines.aspx

3. Consider care coordination

- Invite caregivers into exam rooms with member permission to support the patients understanding of treatment plan.
- Review and discuss care tests and treatments involving other providers. Ask and share specific details about any recent specialty care since their last visit.
- Discuss prescribed medications and listen to feedback about cost. UPMC Health Plan has medications that have a $0 copay when filled at preferred pharmacy or mail-order pharmacy.
- Make coaching part of care by offering resources to support members in healthy lifestyle changes such as UPMC Health Plan practice-based care managers and health coaches.
- Discuss digital options that are available, such as secure websites and apps like *My*UPMC or MyChart, to access test results and post-office visit summaries.

Meeting accreditation requirements

These surveys are required to maintain ratings and accreditations:

- Centers for Medicare and Medicaid Service (CMS) star ratings
- National Committee for Quality Assurance (NCQA) accreditation
- NCQA ratings

To view the CAHPS survey for each line of business[1], please visit these websites:

- Commercial: **upmchp.us/CAHPSCM**
- UPMC *for You*, adult: **upmchp.us/CAHPSMAad**
- UPMC *for You*, child: **upmchp.us/CAHPSMAchild**
- UPMC *for Kids*: **upmchp.us/CAHPSKids**
- UPMC *for Life*: **upmchp.us/CAHPSMC**
- UPMC Community HealthChoices: **upmchp.us/CAHPSCHC**
- Marketplace: **upmchp.us/CAHPSQHP**

As always, thank you for making outstanding care a priority.

[1]Please note that the CAHPS survey varies slightly depending on the member's insurance plan.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

QUALITY CORNER

Embracing collaboration and coordination to reduce hospitalizations

Strategies to prevent and manage acute conditions in outpatient settings

Mary Kelleher, MD, MPH
Senior Medical Director Medicaid, UPMC *for You*

It's no secret that emergency rooms across the U.S. are seeing an increasing volume of patients to the tune of nearly 140 million visits annually—13 percent of which result in hospital admission.[1]

Septicemia, heart failure, osteoarthritis, pneumonia, and diabetes mellitus top the list of most frequent diagnoses for hospitalizations.[2] These life-threatening conditions have other things in common. For one, they can share risk factors and complications. And importantly, interventions and access to high-quality primary care can help manage these conditions and reduce the risk of associated hospitalizations.

Take sepsis, for example. The Centers for Disease Control and Prevention (CDC) estimates that many of the at least 1.7 million adults in America who develop sepsis each year had signs and symptoms before going to the hospital—and most of them have at least one underlying medical condition, such as chronic lung disease or a weakened immune system.[3] What's more, nearly a quarter to a third of people with sepsis had a health care visit in the week before they were hospitalized.[4]

Diabetes is another disease where the primary care provider plays a vital role in reducing complications and hospitalizations. Upwards of 38 million Americans have diabetes, and there is a shortage of endocrinologists to medically manage them—a crisis that has been years in the making.[5,6]

In addition, diabetes is a major contributor to an increased risk of cardiovascular disease such as congestive heart failure and coronary artery disease.[7] Congestive heart failure treatment presents many opportunities for improving management by following evidence-based medication guidelines and optimized treatment regimens. While there are many guidelines around optimal pharmacologic and nonpharmacologic outpatient therapies that can help reduce hospitalizations and prolong survival for the 6.7 million Americans with congestive heart failure, some are not being followed, likely contributing to congestive heart failure exacerbations and inpatient admissions.[8]

Using all our tools with every patient—every time

Primary care medical home and collaboration. Primary care providers and specialists working together with the aim of optimizing chronic disease care regimens is a powerful, patient-centered way to manage chronic conditions. Providing services in a primary care medical home model can improve medical regimens by using comprehensive, coordinated care to prevent hospitalizations—and, more importantly, morbidity and mortality associated with chronic conditions. It is important to note that a

medical home, as defined by the Agency for Healthcare Research and Quality (AHRQ), is not merely a place but an organizational model of primary care that delivers the core functions of primary health care.[9] You can **access Agency for Healthcare Research and Quality resources** to learn more about implementing or improving this model.

- **Vaccination promotion and vaccination acceptance.** Increase acceptance of vaccines can aid us tremendously in reducing acute hospitalizations, given that pneumonia, influenza, respiratory syncytial virus (RSV), and COVID-19 vaccines can help prevent infections and complications associated with all the conditions that rank high on the hospitalization list.[10] Despite their initial and downstream potential for disease prevention and complications, vaccination rates are not near where they should be. For example, as of late February 2025, the percentage of people reporting receipt of the updated 2024–25 COVID-19 vaccine is hovering around 12 percent for children and just over 23 percent for adults 18+, including just under 45 percent among adults 65+.[11] You can **review CDC strategies for COVID-19, flu, and other adult vaccines** for resources that can support this important effort.
- **Appropriate antiviral treatment.** While vaccines are considered the primary preventive measure to help reduce the risk of infection and severe illness, antiviral medications can be an effective second line of defense by reducing the severity and duration of symptoms, preventing complications, and lowering the risk of hospitalization—when they are used.[12] While COVID-19 antivirals help reduce hospitalizations and deaths among people at higher risk, especially people 65 years old and older and those with certain underlying conditions, they are often underused and should be prescribed more often to people who are at risk of severe illness to reduce hospitalizations and save lives.[13]
- **Prescription for Wellness.** UPMC Health Plan's Prescription for Wellness provides a mechanism for providers to prescribe Health Plan clinical services to their patients who are UPMC Health Plan members. This best-practice system offers health coaching and care management services to support lifestyle improvement, behavioral health support, pharmacy intervention, social service intervention, and chronic disease/condition management across many areas, including:
  - **Diabetes care and condition management.** Nurses establish condition-based knowledge and address clinical needs such as symptom management, medication, and self-care. They also assist with care coordination, decision-making, and help address medication questions along with support from our pharmacy care management team comprised of registered pharmacists.
  - **Congestive heart failure.** Supports for this serious condition through Prescription for Wellness may include discussions with patients on topics, including care coordination, signs that their symptoms are worsening, self-management with daily weight monitoring, intake and output, low-salt diet, exercise, and elevation of legs, and treatment options with medications (such as diuretics) or procedures (such as AICD or pacemaker).

Providers can write a Prescription for Wellness through EpicCare, CHP Cerner, or the Health Plan's secure provider website, Provider OnLine (for practices with an alternative EMR). Learn more about Prescription for Wellness and how it can help create healthier, more engaged, and better-informed patients.

We are all in this together

Helping patients prevent and manage disease is no small task. It cannot be done alone in a silo. Rather, it requires a team approach grounded in sharing information on patients' needs and preferences. Communication across the health care delivery system serves as a conduit for safe, appropriate, evidence-based care that can help keep patients healthier longer through improved chronic condition management. There is power in pooling our talents and working together to achieve better outcomes.

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QUALITY CORNER

Use conversation and rapport to increase chlamydia and cervical cancer screenings

Combine education, empathy, and encouragement to aid in efforts

Mary Kelleher, MD, MPH
Senior Medical Director Medicaid, UPMC *for You*

As health care providers, we understand the importance of preventive screening in reducing the risk of diseases, disabilities, and death. We also understand that people don't always complete the recommended screenings, including the recommendations for chlamydia and cervical cancer.

That's not to say that patients don't value their health or the advice providers an offer in attaining their health goals. The fact is that patients may encounter barriers when it comes to these and other recommended screenings. It might take extra effort tailored to each patient—but if we can meet them where they are, we can improve screening rates.

Conversations: A way to remove screening barriers for patients

Most providers have more than enough on their plate, but we need to make more room to address barriers patients may face in accepting screening recommendations. It's safe to say that this is often a big ask because different patients have different barriers, and reasons to decline screening recommendations. The good news is that we have a tool to help us through it all: conversation. Discussing why screenings are recommended and a strong patient-provider relationship can increase acceptance. There are certain tools and approaches providers can use to increase the chance of patients following their screening recommendations.

- **Create a comfort level.** One of the biggest barriers to chlamydia screening is its link to sexual activity. Association with sexuality can hinder patients from talking honestly about their history and risk factors. Hesitance to address sensitive topics can go both ways, as providers may sometimes shy away from the discussion. No matter the reason, this hesitance may create a wall that can be difficult to break down. Making patients feel comfortable having nonjudgmental discussions related to sexual activity is an effective tool to help foster provider-patient communication.

For children and adolescents, honest disclosures can come from speaking with the patient confidentially without a parent or caregiver present. Encouraging parents or caregivers to step out of the room, though it can be difficult, is important for allowing adolescents to feel supported and heard. Stress to parents that this is not to exclude them from their children's health care but an important step in allowing their child to feel comfortable with their health care provider. Many times parents and caregivers may initially be surprised by the request. But they come to understand that it is part of adjusting to their child growing up and becoming an adolescent.

When approaching the parent, believe it or not, adding some humor can help. You can try saying something like, "This is the part where I kick you out of the room," along with a smile and a little laughter to ease the situation. Offer parents the same comfort level you are trying to create for their child or teen by recognizing it is not easy for parents to accept their children are growing up. Follow up by explaining that you want their child or teen to feel comfortable with you as a provider so they will keep you involved in their health care decisions as they reach adulthood. Let parents know that it's not about excluding them; it's about opportunity—the opportunity for their child or teen to discuss concerns confidentially.

Parents sometimes need reminding that when we create an environment where children and adolescents only feel safe saying what they believe their parents want them to say, that is what they will say. As difficult as it can be, you may need to help parents accept that many teens are sexually active. Your goal as a provider is to make sure you provide teens the tools and insight to keep themselves healthy. The confidential discussion is an opportunity for counseling and education that can help young patients protect their health—a goal shared by providers and parents.

- **Help remove perceived judgment and shame.** Many people, adults and adolescents included, feel judgment and shame around sexual and reproductive health topics and shy away from talking about them. Fear of being judged or shamed for being honest about their sexual activity can contribute to people avoiding screenings for chlamydia and cervical cancer. Education on the importance of these screenings allows providers to explain why they are important and leaves the door open for questions and concerns. Even if the patient doesn't get a screening that day, a positive discussion is still a step forward. For patients who use apps like MyUPMC to manage their health, you can send follow-up messages to provide additional screening recommendations they can read when they have time.* That way, they have an even greater frame of reference at the next visit.

Uncover unconscious bias. Nobody is immune from unconscious bias, and everyone can have different biases around who is at risk for sexually transmitted infections (STIs). Assuming that one can predict when certain patients are not at risk is a dangerous stance that is often wrong. It can lower screening prevalence for chlamydia and other STIs in some populations and put them at higher risk for complications. For example, young white patients may be screened at a lower rate than their African American peers. Data from our chlamydia task force at the Health Plan found a disparity in screening where sexually active white members were less likely to get screened than Black members. The CDC's Sexually Transmitted Infections Surveillance report from 2023 indicates that chlamydia rates are higher among Black individuals compared to white individuals, highlighting disparities in both the incidence of chlamydia and potentially in screening practices.[1] Provider bias is one possible explanation; the perception of risk may result in white people in rural communities getting screened less, increasing their risk of complications from untreated infections. All this points back to the harms of unconscious biases, as well as the importance of relevant STI screenings for sexually active patients younger than age 25 and those 26 and older who are at increased risk.

Keep co-screening top of mind

It is important to note that the U.S. Preventive Task Force (USPTF) recommends co-screening for chlamydia and gonorrhea. Specifically, its recommendations are as follows:[2]

- The USPSTF recommends screening for chlamydia in all sexually active women 24 years old and younger and in women 25 years old and older who are at increased risk for infection.
- The USPSTF recommends screening for gonorrhea in all sexually active women 24 years old and younger and in women 25 years old and older who are at increased risk for infection.

- **Break the patient bias barrier.** Bias as a barrier can go both ways. Patients often have an "it can't happen to me" stance when it comes to chlamydia and other STIs, thinking that only promiscuous people are at risk. If you ask patients who they think is at risk for chlamydia, few are likely to include themselves. But all sexually active people have some risk of chlamydia—a fact that many people either don't know or don't want to admit. Putting it out there in black and white for patients can clear up any "not me" misconceptions. The same can hold true for cervical cancer, which is related to HPV, a sexually transmitted virus.

Continued on p. 36

Continued from p. 35

- **Clearly communicate all consequences and options.** Not everyone knows how dangerous chlamydia and the risk of HPV-related cervical dysplasia can be. For example, patients may not know about asymptomatic chlamydia infections and the risk of untreated infections can cause over time. Educating about these can help patients move toward screening acceptance. You can call attention to the long-term risk of chlamydia by saying something like, "There are risks associated with untreated chlamydia infections that can increase your risk of being able to become pregnant and start a family later in life."

  Talking about cervical cancer risks alongside chlamydia can be equally advantageous in making strides toward screening acceptance. According to the Healthy People 2030 initiative, the number of women getting screened for cervical cancer has decreased in recent years.[3] Many patients do not know the relationship between HPV and cervical cancer. Here are some talking points from the CDC that can help you make the case for cervical cancer screening and HPV vaccination:[4,5]

  - HPV infections can cause certain cancers of the cervix, vagina, and vulva in women and cancer of the penis in men.
  - HPV infections can cause cancer of the anus and the cancer in the back of the throat in men and women.
  - HPV vaccination can prevent over 90 percent of cancers caused by HPV.
  - The HPV test and the Pap test can help prevent cervical cancer or find it early.
  - The HPV test looks for the virus (human papillomavirus) that can cause cell changes on the cervix.
  - The Pap test (or Pap smear) looks for precancers—that is, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
  - No special preparation is needed to have an HPV test.

We now understand that HPV testing is an important tool in addition to cytology for screening for cervical cancer. Many patients may be unwilling to get a pelvic exam, while others may be unable to get onto an exam table because of physical limitations.

Self-collection kits for HPV testing (where available), are an option recommended by the USPSTF that can help overcome this barrier for both types of patients. Since May 2024, the FDA expanded the approvals of two tests that detect HPV in the cervix. Under these expanded approvals, people can now be offered the option to collect a vaginal sample themselves for HPV testing if they cannot have or do not want a pelvic exam. However, collection, which involves a swab or brush, must be done in a health care setting, such as primary care offices.

Providers can manage this by instructing patients on how to use the HPV self-collection kit in the bathroom at the doctor visit. The provider can then send the sample to a laboratory for testing. The privacy and ease of self-collection in not having to get undressed or get up on a table for a pelvic exam has the potential to dramatically increase cervical cancer screening rates in certain populations.

USPSTF cervical cancer screening recommendations

The USPSTF recommends screening for cervical cancer as follows:[6]

- For women 21–29 years old, every three years with cervical cytology alone
- For women 30–65 years old, every three years with cervical cytology alone or every five years with high-risk human papillomavirus (hrHPV) testing alone; or every five years with hrHPV testing in combination with cytology (co-testing)

- **Standardize and normalize the screening conversation.** All these tools and steps serve to level-set upfront and helps set the stage for discussing STI and cervical cancer screenings as a vital part of women's health. Take pride in talking. In a world of AI and apps, the art of conversation is not lost. Your ability to talk with patients and guide them in making decisions is a valuable service to those who may feel overwhelmed when navigating their health and health care—especially when it comes to sensitive issues around sexual and reproductive health. Time spent with patients makes a difference in achieving good health, so keep the open and honest conversations going with your patients. In time, you may find that your efforts can help even the most hesitant patients say "yes" to screenings.

**MyUPMC is available only to UPMC patients. Health information will not appear in MyUPMC for patients who receive care from participating providers who are outside of the UPMC system. MyUPMC is not available for central Pennsylvania patients. UPMC Carlisle, UPMC Hanover, UPMC Lititz, UPMC Memorial, UPMC Harrisburg, UPMC West Shore, and UPMC Community Osteopathic patients can use the UPMC Central PA Portal for patient information.*

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CULTURAL COMPETENCY CORNER

Language assistance resources are available

Language barriers can have a significant effect on health care

Research indicates that, compared to English-speaking patients, those with limited English proficiency (LEP) have a greater chance of readmissions for certain chronic conditions because of difficulty understanding how to manage their conditions and take their medications, as well as which symptoms should prompt a return to care and when to follow up.[1]

Meeting a need

This underscores the need to consistently provide patients with materials in their preferred language at touchpoints throughout their care experience. To help meet this need, new resources are available that can help your patients feel comfortable requesting language assistance.

Interpretation services

Documents related to provision of sign and spoken language interpretation and translating patient documents can be found on Infonet: **upmchs.sharepoint.com/sites/infonet/ClinicalTools/PatientInteractions/Pages/Interpretation-Services.aspx**

Resources in the UPMC Print Shop catalog

UPMC providers can access patient-facing signage and materials that facilitate a request for language interpretation services in the UPMC Print Center catalog. These resources help inform patients and their support persons that free interpretation services are available:

- The language interpretation poster is ideal for posting at entrances and in registration, reception, and waiting areas. You can order this poster with the standard 15 languages as shown in the Print Center catalog in a laminated or wall-cling format. A companion Language Interpretation flier can be used as well.
- The "Care in Your Language" poster is simpler than the multi-language interpretation poster and is geared toward English learners.
- "I Speak" cards are available to all UPMC facilities through the Print Center. Patients can carry this small card and hand it to staff to identify the language they speak and request an interpreter. The front of the card is in English, and the back of the card is in their preferred language. The cards are available in many languages, as well as a blank version that allows one to write in the patient's preferred language.
  - o "Preferred Language" stickers and clings can be also used by patients, which enables a patient to identify their preferred language to others.
  - o Additional resources pre-translated into various languages can be found in the UPMC Print Center, such as "Same-Day Surgery Flight Plans" available in Arabic, Nepali, Spanish, and Uzbek; or "Coronavirus Vaccine Storyboard" available in Arabic, Chinese, Nepali, Russian, and Spanish.

How to order

Visit the UPMC Interpretation Resources document on Infonet for more information.* Resources can also be found in the UPMC Print Center for order.

**Access to Infonet is available to all staff with a UPMC network ID.*

References

1 The Joint Commission, Division of Health Care Improvement. Overcoming the challenges of providing care to LEP patients. Quick Safety. May 2015;[13]:1.

UPMC HEALTH PLAN

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- U.S. mail: UPMC Health Plan Special Investigations Unit, Personal and Confidential, PO Box 2968, Pittsburgh, PA 15230

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