Blue Cross Complete of Michigan

CONNECTIONS

November/December 2023

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Quality Improvement program can enhance member access to care and services

Blue Cross Complete is committed to providing access to high quality health care in Michigan and has a 3.5-star rating from the National Committee for Quality Assurance. We also received the highest ranking possible, a score of four apples, in the Michigan Department of Health and Human Services 2023 Consumer Guide for the "Taking Care of Women" category.

NCQA rates health plans on the results of care people receive and what patients say about their care. These results are obtained through the NCQA Healthcare Effectiveness Data and Information Set (and the Consumer Assessment of Healthcare Providers and Systems survey.) We've maintained our accreditation with NCQA, which means we have well-established programs for service and clinical quality. These programs meet or exceed requirements for consumer protection and quality improvement.

Blue Cross Complete also continues to hold the Multicultural Health Care Distinction from NCQA. This distinction is awarded to organizations that engage in efforts to improve health care for all by making culturally and linguistically appropriate services available to members and reducing health care disparities.

Blue Cross Complete has an active community outreach program. To engage more with members, we supported more than 869 community events across Michigan in 2022. Community health navigators worked with members to screen for Social Determinants of Health needs and schedule appointments with primary care providers, specialists and dentists to make sure their health needs were addressed.

Members are also asked if Blue Cross Complete can assist with a variety of other concerns, including childcare and clothing. We ask if we can help with hygiene supplies or household items, such as furniture and appliances. Sometimes members need assistance with access to food, housing, utilities, transportation, education and literacy resources. We saw members with needs that included access to a phone and basic medical supplies. Blue Cross Complete also provided resources to members to cope with personal and household safety concerns and address social needs to help reduce isolation and loneliness.

Each year, we also send the CAHPS survey to a random group of members asking them to rate their experience with Blue Cross Complete and their health care for the previous year.

For services provided in 2022, these CAHPS categories received the highest scores from our members:

- How Well Doctors Communicate
- Coordination of Care
- Getting Needed Care

Members lowered their ratings for:

- Rating of Personal Doctor
- Rating of Specialist
- Doctors Explaining Things in a Way That Was Easy to Understand

This represents an opportunity for doctors and specialists in our network to improve their ratings with members, and for providers to explain things to their patients in a way that is easy to understand. Members also rate their doctors on advising smoking and tobacco users to quit and discussing cessation medications and strategies, which is a continuing opportunity to improve health outcomes.

Full HEDIS and CAHPS survey results are available to providers by calling Blue Cross Complete at **1-888-312-5713** from 8 a.m. to 5 p.m. Monday through Friday. We can also mail this information to providers who don't have fax, email or internet access.

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

*Our website is **mibluecrosscomplete.com**. While website addresses for other organizations are provided for reference, Blue Cross Complete does not control these sites and is not responsible for their content.

Post appointment survey gives physicians insight into patient experience

Understanding and meeting customer expectations is crucial for success in today's competitive business landscape. This is particularly true in the service-based industry, where the quality of customer experiences can advance a company's reputation and support business goals.

To effectively gauge customer satisfaction and identify areas of improvement, Blue Cross Complete provides its members with a post-appointment survey to receive timely feedback regarding their experiences with their primary care provider. The survey provides valuable insights into customer sentiments, enabling providers the opportunity to enhance their support and services to build stronger customer relationships.

Members who have had an appointment within the previous 30 days receive a four-question survey by text message after completing an outpatient visit to determine how satisfied they were with the visit.

Members are asked the following questions:

1. How satisfied were you with how carefully the doctor/care provider listened to you?
2. How satisfied were you with how much respect the doctor/care provider showed for what you had to say?
3. Overall, how satisfied were you with the doctor/care provider?
4. How long did you have to wait from the time of your appointment until the provider saw you?

Survey responses collected from January to May 2023 indicate:

- Out of 4,670 primary care provider visits, 81% of members were satisfied with how carefully their provider listened to them.
- About 81% were satisfied with how much respect the provider showed for what they had to say and,
- 80% were satisfied with their overall visit.
- Of those same survey respondents, 98% reported waiting 45 minutes or less to see their doctor.

Each question is scored based on the number of answers to the question and physicians are evaluated only on the answered questions.

Overall, these surveys have proven to be a valuable tool in helping providers maintain a high level of customer satisfaction in providing quality support and services to our members.

If you have any questions, contact your Blue Cross Complete provider account executive or the Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

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Bridging the Gap: Report Z codes to help improve patients' health outcomes

The key to addressing disparities in health outcomes lies not just in treating diseases but in understanding the factors that influence them. These factors, known as Social Determinants of Health, or SDoH, are crucial pieces of the puzzle that can't be ignored.

At Blue Cross Complete, we believe providers play a critical role in addressing SDoH by accurately reporting Z codes to help us better address issues and concerns affecting our members. Blue Cross Complete assesses, identifies, and addresses health care and Social Determinants of Health needs in the populations we serve by incentivizing our behavioral health providers with the Behavioral Health Quality Enhancement Program. The program provides a $5 incentive for each time a provider reports an SDoH code on a claim.

Understanding Social Determinants of Health

SDoH encompass a range of non-medical factors that influence a person's health. These include socioeconomic status, education level, neighborhood conditions, access to healthy food and employment status. SDoH can have a profound effect on a person's risk of developing chronic disease, their access to health care and overall well-being. These social factors can impose significant barriers to a person's health and wellness, and may affect their ability or willingness to follow a recommended treatment plan. By working together to adopt a "whole person" approach, we can help remove barriers to improve health and enhance the quality of life for members. Therefore, reporting Z codes related to SDoH can provide crucial information to Blue Cross Complete.

What are Z codes?

SDoH-related Z codes range from Z55-Z65 are the ICD-10-CM diagnosis codes used to document SDoH data (for example, housing, food insecurity and transportation). Z codes are a set of diagnostic codes used in health care to capture information about factors that may not be a primary reason for a patient's visit but still affect their health. This data helps us track and identify the unique social needs affecting our members, specific populations who have similar struggles and connect them to resources. It also allows us to form relationships with local community organizations that will assist the member with needs beyond their health concerns. Any member of a person's care team can collect SDoH data.

Use the infographic from the Centers for Medicare & Medicaid Services on page 5 to better understand collecting and reporting SDoH Z codes.

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Bridging the Gap: Report Z codes to help improve patients' health outcomes

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IMPROVING THE COLLECTION OF

Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

What Are Z Codes?

- SDOH-related Z codes range from ICD-10-CM categories Z55-Z65 and are used to document SDOH data (e.g., housing, food insecurity, lack of transportation)
- Z codes refer to factors influencing health status or reasons for contact with health services that are not classifiable elsewhere as diseases, injuries, or external causes

What Are SDOH & Why Collect Them?

- SDOH are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks[1]
- The World Health Organization (WHO) estimates that SDOH accounts for **30-55% of health outcomes**[2]

Collecting SDOH can improve equity in health care delivery and research by:

- Empowering providers to identify and address health disparities (e.g., care coordination and referrals)
- Supporting quality measurement
- Supporting planning and implementation of social needs interventions
- Identifying community and population needs
- Monitoring SDOH intervention effectiveness for patient outcomes
- Utilizing data to advocate for updating and creating new policies

Using Z Codes for SDOH

- SDOH information can be collected before, during, or after a health care encounter through structured health risk assessments and screening tools
- These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor that influences the patient's health
- Coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record
- SDOH information can be collected through person-provider interaction or self-reported, as long as it is signed-off on and incorporated into the medical record by a clinician or provider
- It is important to screen for SDOH information at each health care encounter to understand circumstances that may have changed in the patient's status

VIEW JOURNEY MAP

ICD-10-CM Z Codes Update

- New SDOH Z codes may become effective each April 1 and October 1. New codes are announced prior to their effective date on CDC website.
- Use the CDC National Center for Health Statistics ICD-10-CM Browser tool to search for all the current Z codes.
- Join the public process for SDOH code development and approval through the ICD-10-CM Coordination and Maintenance Committee

[1] Healthy People 2030 [2] World Health Organization

go.cms.gov/OMH

For Questions Contact: The CMS Health Equity Technical Assistance Program | ICD-10-CM Official Guidelines for Coding and Reporting FY 2024

IMPROVING THE COLLECTION OF

Social Determinants of Health (SDOH) data with ICD-10-CM Z Codes

Exhibit 1. Recent SDOH Z Code Categories and New Codes

Z55 – Problems related to education and literacy
- Z55.5 – Less than a high school diploma (Added, Oct. 1, 2021)
- NEW Z55.6 – Problems related to health literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment (Added, Oct. 1, 2021)
- Z58.6 – Inadequate drinking-water supply (Added, Oct. 1, 2021)
- NEW Z58.8 – Other problems related to physical environment
  - NEW Z58.81 – Basic services unavailable in physical environment
  - NEW Z58.89 – Other problems related to physical environment

Z59 – Problems related to housing and economic circumstances
- Z59.0 – Homelessness (Updated)
  - Z59.00 – Homelessness unspecified (Added, Oct. 1, 2021)
  - Z59.01 – Sheltered homelessness (Added, Oct. 1, 2021)
  - Z59.02 – Unsheltered homelessness (Added, Oct. 1, 2021)
- Z59.1 – Inadequate Housing (Updated)
  - NEW Z59.10 – Inadequate housing, unspecified
  - NEW Z59.11 – Inadequate housing environmental temperature
  - NEW Z59.12 – Inadequate housing utilities
  - NEW Z59.19 – Other inadequate housing
- Z59.4 – Lack of adequate food (Updated)
  - Z59.41 – Food insecurity (Added, Oct. 1, 2021)
  - Z59.48 – Other specified lack of adequate food (Added, Oct. 1, 2021)
- Z59.8 – Other problems related to housing and economic circumstances (Updated)
  - Z59.81 – Housing instability, housed (Added, Oct. 1, 2021)
    - Z59.811 – Housing instability, housed, with risk of homelessness (Added, Oct. 1, 2021)
    - Z59.812 – Housing instability, housed, homelessness in past 12 months (Added, Oct. 1, 2021)
    - Z59.819 – Housing instability, housed unspecified (Added, Oct. 1, 2021)
  - Z59.82 – Transportation insecurity (Added, Oct. 1, 2022)
  - Z59.86 – Financial insecurity (Added, Oct. 1, 2022)
  - Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (Added, Oct. 1, 2022; Revised, April 1, 2023)
  - Z59.89 – Other problems related to housing and economic circumstances (Added, Oct. 1, 2021)

Z60 – Problems related to social environment

Z62 – Problems related to upbringing
- Z62.2 – Upbringing away from parents
  - NEW Z62.23 – Child in custody of non-parental relative (Added, Oct. 1, 2023)
  - NEW Z62.24 – Child in custody of non-relative guardian (Added, Oct. 1, 2023)
- Z62.8 – Other specified problems related to upbringing (Updated)
  - Z62.81 – Personal history of abuse in childhood
    - NEW Z62.814 – Personal history of child financial abuse
    - NEW Z62.815 – Personal history of intimate partner abuse in childhood
  - Z62.82 – Parent-child conflict
    - NEW Z62.823 – Parent-step child conflict (Added, Oct. 1, 2023)
  - Z62.83 – Non-parental relative or guardian-child conflict (Added Oct. 1, 2023)
    - NEW Z62.831 – Non-parental relative-child conflict (Added Oct. 1, 2023)
    - NEW Z62.832 – Non-relative guardian-child conflict (Added Oct. 1, 2023)
    - NEW Z62.833 – Group home staff-child conflict (Added Oct. 1, 2023)
  - Z62.89 – Other specified problems related to upbringing
    - NEW Z62.892 – Runaway [from current living environment] (Added Oct. 1, 2023)

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstance

Z65 – Problems related to other psychosocial circumstances

go.cms.gov/OMH

Sickle cell disease can present oral health challenges

Sickle cell disease has long been associated with a range of health challenges, from severe pain to organ damage. However, a lesser known aspect of sickle cell disease is its effect on oral health.

Those living with sickle cell disease, especially children, are often unaware of the unique oral health challenges they may face. There are several ways in which the disease can affect oral health. These include oral infections, delayed dental development and acute pain crises, which can manifest in the jaw and oral cavity. Poor oral care can lead to gingivitis or periodontal disease, which may result in loss of teeth, infection and other complications.

For individuals with sickle cell disease, oral health is even more important to make sure it doesn't further complicate an already challenging disease state. Treatments, such as hydroxyurea, can increase the risk of oral sores, which can worsen symptoms and make it difficult to brush and floss. Therefore, it's important to encourage patients to make oral health a vital part of their daily routine.

The **Sickle Cell Disease Association of America** estimates that 100,000 Americans have sickle cell disease and that cases in the U.S. are highest among African Americans, affecting one in every 365 births. Every baby born in the U.S. is tested for sickle cell disease.* The Centers for Disease Control and Prevention **provides additional information about sickle cell disease**.*

By educating patients about the connection between sickle cell disease and oral health, providers can empower patients to take proactive measures to decrease and mitigate complications resulting from the genetic disorder.

As a reminder, Blue Cross Complete coverage includes dental benefits, including exams, cleanings and extractions for members. Additional dental benefits include:

- Four bitewing X-rays every year.
- Full-mouth X-rays once every five years.
- One filling per tooth every two years.
- Emergency exams, no more than twice a month.
- Sealants, once every three years.
- Topical fluoride up to age 21, twice per year.
- Fluoride varnish up to age 21, twice per year.
- Crowns, once every five years on the same tooth.
- Root canal therapy.
- Retreatment of previous root canal, once per tooth per lifetime.
- Periodontal evaluation, once every 12 months.*
- Periodontal maintenance, once every six months.*
- Complete and partial dentures, once every five years per arch.

Eligible members can locate a dentist by visiting mibluecrosscomplete.com and selecting Find a doctor, and then Find a dentist. Members may also call Blue Cross Complete's Dental Customer Service at **1-844-320-8465**.

While sickle cell disease poses various health challenges, its impact on oral health shouldn't be overlooked. Together, we can continue to educate our members, while promoting better health.

If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

*Periodontal services, including scaling and root planning requires prior authorization.

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The HEDIS Corner: Diabetic care tips

Hemoglobin A1c Control for Patients with Diabetes

- Performed at least once a year
- Chart necessities:
  - Log the A1c result and the specific date, even if test is in-house or from specialists or consulting providers.
  - Note a distinct numeric result. Ranges and thresholds don't meet criteria.
  - Document treatment, follow-up and progress of diabetes along with diabetes diagnosis and medications.
  - Add patient name and date of birth to flowsheets.

Eye Exam for Patients with Diabetes

- Retinal eye exam required yearly by an eye care professional (ophthalmologist or optometrist).
- Blindness isn't an exclusion for a diabetic eye exam.
- Chart necessities:
  - Include the date of service, results and the full name and credentials of the provider conducting the eye exam. Name of a vision care center alone is not acceptable for compliancy.
  - Note clearly if the patient had a dilated or retinal exam.
  - Make note if retinopathy is present or of any eye enucleations
  - Documentation of "diabetes without complications" doesn't meet criteria.

Blood Pressure Control for Patients with Diabetes

- Blood pressure test is required at least once a year.
- Member-reported data is acceptable if BP is captured with a digital device.
- If no BP is recorded in the record, the member's BP is reported as "not controlled."
- Chart necessities:
  - Record all BPs performed during each visit as a distinct numeric result. Ranges and thresholds don't meet criteria.
  - List sufficient details for member-reported BPs. Example: type of BP device used, date of test, etc.
- Don't round up BP before documenting it in medical record.

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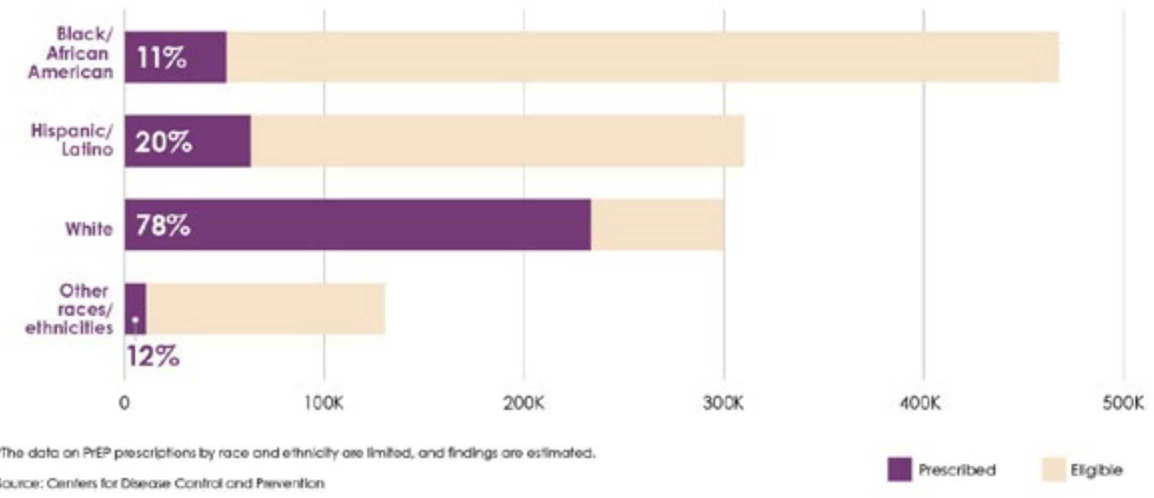
PrEP: A game-changer in HIV prevention

In the ongoing battle against HIV, the introduction of preexposure prophylaxis, or PrEP, has emerged as a transformative medication that can help reduce the risk of infection, particularly for high-risk individuals.

High-risk populations for HIV infections include men who have sex with men, transgender individuals, people who engage in unprotected sex, individuals with multiple sexual partners, and those who inject drugs. According to the Centers for Disease Control and Prevention, these groups often face elevated rates of HIV transmission due to various factors, including limited access to health care, stigma and socioeconomic disparities.

The CDC recommends that physicians offer PrEP to patients who are HIV negative but at high risk of getting the infection. PrEP can be taken in the form of pills or shots. The medication contains a combination of two antiretroviral drugs — tenofovir and emtricitabine. Injectable PrEP with Cabotegravir is recommended to prevent HIV among all people at risk through sex. Cabotegravir is given as an intramuscular injection. These drugs work by inhibiting the virus's ability to establish a foothold in the body, thereby preventing infections if exposure occurs.

The CDC estimates that 1.2 million people could benefit from PrEP in the United States, yet only about one-quarter of them received the medication in 2020. Although most people who could benefit from PrEP are Black or Latino, CDC data suggest very few Black or Latino people have been prescribed it. In 2021, less than one-quarter of Black and Latino people who were eligible for PrEP were prescribed the medication compared to three-quarters of white people. Rates of new HIV infections are almost eight times higher among Black people, and almost four times higher among Latino people than among white people.



How you can help

According to the CDC, you don't have to specialize in infectious diseases or HIV medicine to prescribe PrEP. The medication should be offered by any prescriber.

Successful PrEP usage often involves close collaboration between health care providers and patients. Regular checkups, HIV testing and counseling are essential components of a comprehensive PrEP program. These services can help sexually active individuals remain HIV negative while also offering valuable support and information.

(continued on page 9)

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PrEP: A game-changer in HIV prevention (continued from page 8)

Increasing awareness, reducing stigma and improving access to health care are essential steps in making PrEP more widely prescribed. It's important to inform all sexually active patients about PrEP and its ability to protect them from getting HIV. By doing so, we can increase awareness of PrEP and help patients overcome any embarrassment or stigma that might prevent them from discussing their HIV risk factors with their health care provider.

Who's eligible for PrEP?

Those who test negative for HIV and:

- Patients who engage in infrequent or inconsistent condom use during sex with partners.
- Those who have unprotected sex with someone whose HIV status is unknown.
- Anyone diagnosed with a sexually transmitted disease in the past six months.
- Patients who share needles or other equipment to inject drugs.
- Individuals with an HIV positive sexual partner (especially if the partner has an unknown or detectable viral status).

Current guidelines recommend anyone who has had sex get tested at least once. People at high risk for HIV are those with more than one sex partner (especially men who have sex with men), those who trade sex for money, housing or drugs or use IV drugs. Partners of those with HIV should be tested at least once a year. All pregnant women should be screened to protect their baby and anyone who has a sexually transmitted disease, such as chlamydia or gonorrhea, should be tested (including their partner).

For more information, visit **Michigan.gov/MIPrEP** and **cdc.gov/HIV/PrEP**.

If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

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Early detection of chronic kidney disease crucial for diabetic and hypertensive patients

Chronic kidney disease is a silent epidemic affecting 37 million adults in America, and its prevalence is on the rise, especially among those with diabetes and hypertension, according to the **National Kidney Foundation.***

CKD often develops silently over many years, progressing to advanced stages before symptoms become apparent. Uncontrolled diabetes and high blood pressure put tremendous stress of the kidneys. Patients with both conditions are at an even greater risk of developing CKD, which makes regular monitoring and early intervention crucial. Other risk factors include obesity, family history of CKD, history of acute kidney injury, patients over the age of 60 and being a member of a minority race or ethnicity.

There is no cure for CKD, but providers can help make a significant impact in the lives of patients with the disease. Early detection in at-risk patients creates the opportunity to slow or prevent the progression of this disease. Even more, understanding who has or is at-risk of getting CKD will allow you to provide education, develop treatment plans or refer outside your practice to help facilitate better outcomes for these patients.

The **National Kidney Foundation** recommends health care providers prioritize annual screening for patients with diabetes using both the eGFR and uACR lab tests.* Patients with diabetes can have changes in either test, so it's important to track both assessments. These tests provide key information about kidney health, including determining CKD stage and risk of progression.

Blue Cross Complete emphasizes the importance of patient education, as well as the need for regular follow-up appointments. Patients should feel empowered to take an active role in managing their health. The National Kidney Foundation provides health care providers with various resources to help education patients about CKD.

The National Kidney Foundation of Michigan and the Michigan Department of Health & Human services presented the **Michigan Chronic Kidney Disease Prevention Strategy 2021-2026**.* This plan focuses on kidney disease prevention, early detection and control efforts across Michigan. It's a great resource for patients and medical professionals.

Blue Cross Complete offers new program for patients with CKD

Blue Cross Complete is working with Somatus*, a value-based kidney care organization, to offer an integrated care delivery program to support eligible members with or at risk of developing chronic kidney disease or end stage kidney disease. This program is designed to help improve our members' quality measures and clinical outcomes.

The Somatus program will work alongside health care providers to provide members with additional support to help manage their kidney disease and actively follow their treatment plan. The program will be part of all eligible members' coverage and is available at no extra cost.

The Somatus team can support your patients through:

- One-on-one care to help manage their kidney disease and comorbidities, and address social determinants of health.
- Personal health coaching based on their condition, treatment options, and diet
- Assistance to transition safely from hospital to home.
- Guidance exploring transplant options, if appropriate.
- A 24/7 Somatus Care Hotline: **1-855-851-8354, ext. 9**.

Together, let's help make a difference in the lives of our members by striving for a future where CKD is no longer a silent threat but a preventable and manageable condition. By prioritizing routine testing, collaborative care and patient education, we can work together to help combat this growing public health challenge.

If you have questions, call Somatus at **1-855-851-8354** from 8 a.m. to 8 p.m. Monday through Friday or email **provider@somatus.com.** Or contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

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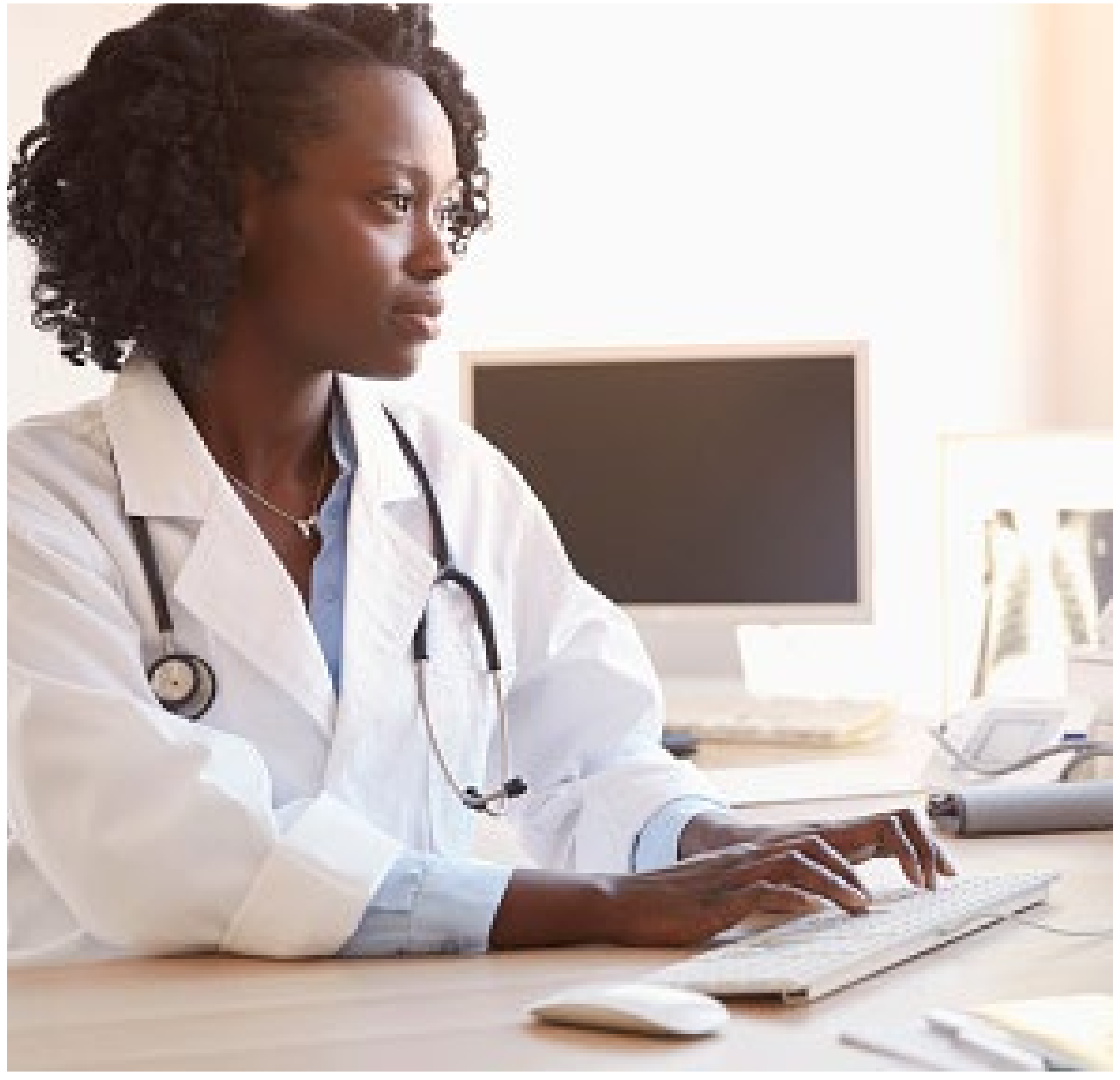
Blue Cross Complete enhances its provider website

Blue Cross Complete is excited to announce enhancements to the provider section of our website, located at **mibluecrosscomplete.com**.

These updates are designed to provide ease of navigation through our comprehensive administrative supports and programs. You will note one key update to the website is that our self-service tools page has been renamed to prior authorization resources. Providers can search for prior authorization requirements and access our prior authorization provider portal, **navinet.net**, directly from the same page. Make sure you update your bookmarks.

Blue Cross Complete is committed to ensuring our providers have the support they need to provide high-quality services to our members. If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.



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Promoting health equity and cultural competency

The goal of culturally competent health care is to provide the highest quality care to every patient, regardless of race, ethnicity, cultural background, sexual orientation, gender identity, English language proficiency or level of literacy. At Blue Cross Complete, health equity and cultural competency is a company-wide priority.

We work to monitor, evaluate and improve processes and activities to help ensure members receive high-quality culturally and linguistically appropriate services. This work enables us to define and structure member and provider outreach, collect consistent data, develop policies and set program goals. Poor health outcomes disproportionately affect racial and ethnic minority communities far worse than other communities, not only in the context of race and ethnicity, but also in language; religion; socioeconomic status; mental health; cognitive, sensory and physical disability; gender; age; sexual orientation; gender identity; geographic location and other characteristics historically linked to exclusion or discrimination.

Blue Cross Complete recognizes diversity in both our providers and members. We're committed to promoting effective, equitable, understandable and respectful quality services that are responsive to our members' diverse cultural health beliefs, practices, preferred languages, health literacy and other communication needs. Blue Cross Complete uses the National CLAS Standards and the NCQA Health Equity Standards as a blueprint to advance health equity, improve quality and help eliminate health care disparities. We foster cultural awareness both in our staff and in our provider communities by encouraging everyone to report race, ethnicity and language data to help ensure that the cultures prevalent in our membership are reflected to the greatest extent possible in our provider network. The race and ethnicity of our providers is confidential; however, the languages reported by providers are published in the Blue Cross Complete Provider Directory so members can easily find doctors who speak their preferred language.

Helping ensure that members have access to services and information in the appropriate and preferred language is a priority of our health plan. Blue Cross Complete routinely examines the access to care standards for both the general population and the populations who speak a threshold language. A threshold language is a language spoken by at least 5% or 1,000 members of Blue Cross Complete's member population, whichever is less. Interpretation and written translation services are available upon request to our members.

We recognize that it's our responsibility, as well as the responsibility of our participating providers, to meet the unique needs of our diverse membership through customized health-related information and services. Blue Cross Complete offers a multifaceted and comprehensive CLAS training program, and ongoing educational opportunities about cultural competency online, and during site visits and orientations. We also reinforce key concepts through our online provider newsletter and provider manual. Our **provider web page** offers resources and educational tools that can assist your practice with questions about delivering effective health services to diverse populations.

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Diabetes care for minorities: Recommendations and resources for providers

Research shows that racial and ethnic minorities disproportionately suffer from Type 2 diabetes, complications from Type 2 diabetes, and Type 2 diabetes-related mortality.[1, 2, 3, 4] Black people have the highest rates of diabetes-related mortality nationally.[5]

Additionally, new studies indicate that all non-white racial and ethnic groups have slightly higher "normal" A1c levels than white people. Compared to white individuals with prediabetes, who have an average A1c of 5.78%:

- Black individuals with prediabetes have an average A1c of 6.18%
- Indigenous individuals with prediabetes have an average A1c of 6.12%
- Asian individuals with prediabetes have an average A1c of 6%
- Hispanic individuals have an average A1c of 5.93%.

Time in range, the percentage of time someone spends in their target glucose range, can be used as an additional measure. TIR is a valuable and person-specific tool to assess diabetes health and works for people of all races and ethnicities.[6]

In response to the upward trend of diabetes-related morbidity and mortality in Black communities, the Centers for Disease Control and Prevention has proposed ongoing advocacy and education initiatives, along with intervention-based initiatives, to reduce diabetes-related disparities.[7, 8, 9]

This article will explore recommendations and offer practical tips and resources to providers on how to better serve Black patients with diabetes and diabetes-related symptoms.

General recommendations to address and support prediabetes and diabetes patients[7, 8]

- Counsel patients on healthy behaviors to reduce their risk of diabetes, including increasing physical activity and avoiding sugar-sweetened beverages and snack foods that are high in sugar and unhealthy fats.
- Offer testing for diabetes to high-risk patients, including adults ages 45 and older, and adults and children of any age who are overweight or obese and have one or more additional risk factors for diabetes:
- Having a first-degree relative with diabetes
  - Being of a high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, or Pacific Islander)
  - Having a history of cardiovascular disease
  - Being diagnosed with hypertension
  - Having an HDL cholesterol level < 35 mg/dL and/or a triglyceride level > 250 mg/dL
  - Being diagnosed with polycystic ovarian syndrome
  - Being routinely physically inactive
  - Having other clinical conditions associated with insulin resistance (e.g., severe obesity)
- Refer patients with prediabetes to diabetes-prevention programs, intensive lifestyle-change programs that have been shown to decrease the risk of diabetes.
- Follow the American Diabetes Association's guidelines for management of patients with diabetes.

(continued on page 14)

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Diabetes care for minorities: Recommendations and resources for providers
(continued from page 13)

Specific recommendations to address diabetes in Black patients[8]

- Work with communities and health care professional organizations to eliminate cultural barriers to care.
- Connect patients with community resources that can help people remember to take their medicine as prescribed, get prescription refills on time, and get to follow-up visits.
- Learn about social and economic conditions that may put some patients at higher risk than others for having a health problem. Including addressing issues of unconscious bias and institutional racism.
- Collaborate with primary care providers to create a comprehensive and coordinated approach to patient care.
- Promote a trusting relationship by encouraging patients to ask questions.

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Helping patients make sense of asthma

Asthma is a treatable, manageable condition that affects more than 25 million people in the United States, according to the National Committee for Quality Assurance. The prevalence and costs of this lifelong, or chronic, breathing problem have increased over the past decade, demonstrating a need for better access to care and medications. Appropriate medication management for patients with asthma may reduce the need for rescue medication — as well as the costs associated with emergency room visits, inpatient admissions and missed days of work or school.

Caused by swelling (inflammation) of the airways in the lungs, asthma can't be cured but symptoms can be prevented and controlled. All members should have an initial severity assessment based on measures of current impairment and future risk to determine type and level of initial therapy, if needed.

At planned follow-up visits, patients diagnosed with asthma should review control levels with their provider and develop a mutually agreed upon asthma action plan designed to guide decisions on maintaining or adjusting therapy. Every patient who has asthma should be taught to recognize unique symptom patterns that indicate inadequate asthma control and identify the need for treatment changes.

Patients should be routinely monitored to assess whether the goals of therapy are being met and assess whether impairments and risks are being reduced. Routine monitoring of the patient's level of asthma control also helps indicate whether any therapy adjustments may be needed.

All people who have asthma should receive a written action plan to guide their self-management efforts. The asthma action plan helps spell out which asthma medicines are needed and when. Each action plan should include instructions for daily treatment (including medications and environmental controls), and how to recognize and handle worsening asthma. For more information on the diagnosis, treatment, management, and other patient resources for asthma, visit **getasthmahelp.org**.

Although there are many types of medications used to treat asthma, there are two main types. When used effectively, they can help your patient live a healthy, active life with few symptoms.

1. Long-term controllers used daily to help keep asthma under control, even when there are no symptoms. The most common long-term control medicines are inhaled corticosteroids, which reduce swelling in the airways.
2. Quick-relief medicines, also called "rescue" medicines, are often used when asthma symptoms are present, and relieve them quickly when they flare up. Patients who use this type of medication too often may not have their asthma under control. The most common types of these medicines are short-acting beta2-agonists, or SABAs. Taken by inhaler, SABAs rapidly relax tight muscles around the airways so more air can get through, making it easier to breathe.

NCQA supports the broad use of HEDIS® measure specifications to evaluate and drive health care quality. The HEDIS measure for asthma, also known as the Asthma Medication Ratio or AMR, assesses adults and children ages 5 to 64 identified as having persistent asthma and the ratio of rescue inhaler use versus long-term controller inhaler use.

Blue Cross Complete covers inhalers and spacers for members. We appreciate the quality care and access you provide to our members. To discuss additional strategies for asthma management or if you have questions about this benefit, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**. HEDIS® is a registered trademark of the National Committee for Quality Assurance.

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MDHHS urges Michiganders to continue routine screenings

Cancer is the second leading cause of death in Michigan and heart disease remains the leader, according to the Michigan Department of Health and Human Services.

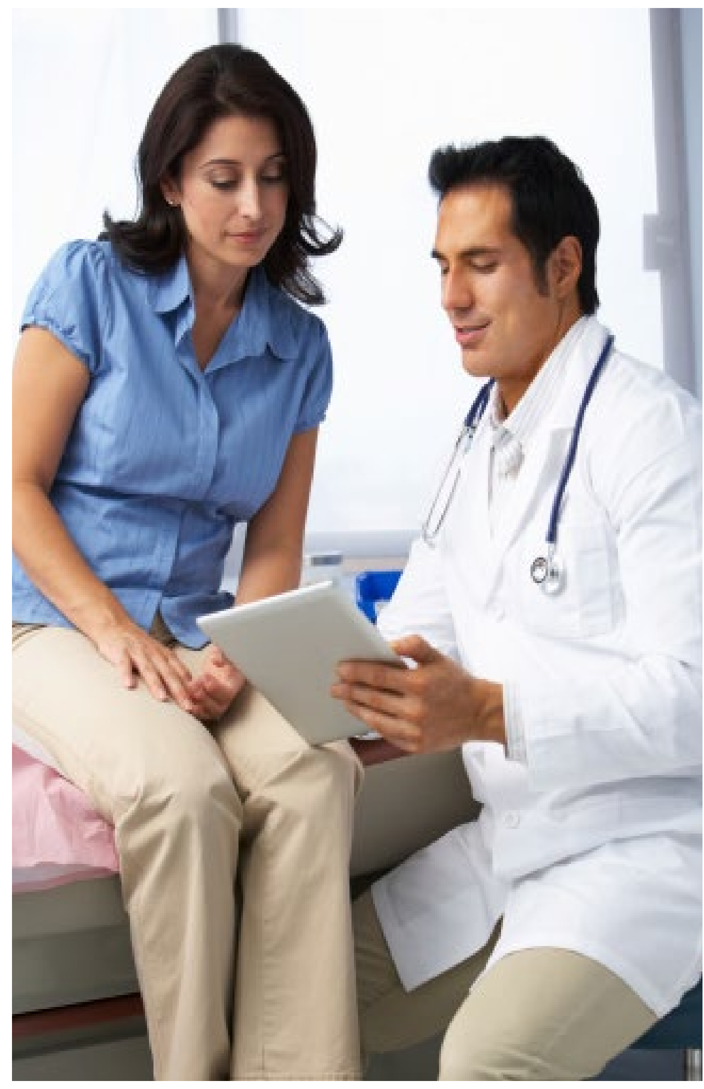
Screening tests are proactive measures that can detect cancer at an early stage before symptoms appear. When found earlier, it's typically easier to treat. Health screenings are also important in identifying risk factors a person may have for chronic conditions such as heart disease or sexually transmitted infections, including gonorrhea, chlamydia and syphilis.

Screening disparities among low-income minority women were evident prior to 2019. However, the COVID-19 pandemic has only intensified this issue. MDHHS is urging Michigan women to resume these routine screenings. Patients in need of screenings can call MDHHS at **1-844-446-8727** to speak with a program specialist.

Women in Michigan can take charge of their health by working with a health coach and making healthy lifestyle choices. They can also take advantage of free support services to maintain their health. MDHHS has openings for program-eligible women to receive free cancer and health screenings through these resources and programs:

- The **Breast and Cervical Cancer Control Navigation Program*** provides free breast and cervical cancer screening services, statewide, to low-income women.
- The **WISEWOMAN Program***, available in select areas, helps participants understand chronic disease risk factors and make healthy lifestyle choices.
- The **Michigan STI Clinical Services Locations*** Directory provides information on local health departments that offer STI screening, clinical services, as well as organizations that offer STI specialty services.
- **CDC 2021 Sexually transmitted infections treatment guidelines***.

To learn more about these MDHHS programs, call **1-844-446-8727** or visit **Michigan.gov/cancer***. Providers are encouraged to utilize **Navi Net*** to determine which Blue Cross Complete members are due for routine screenings and conduct outreach to schedule any appointments for services they may need. We appreciate the care and access you provide to our members. If you have any questions, contact your Blue Cross Complete provider account executive or call Provider Inquiry at **1-888-312-5713**.



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Recommendations for well-child visits and developmental screening

The Centers for Medicare & Medicaid Services and Bright Futures/American Academy of Pediatrics recommend that children be screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second or third birthday to assess how a child is developing in key areas.

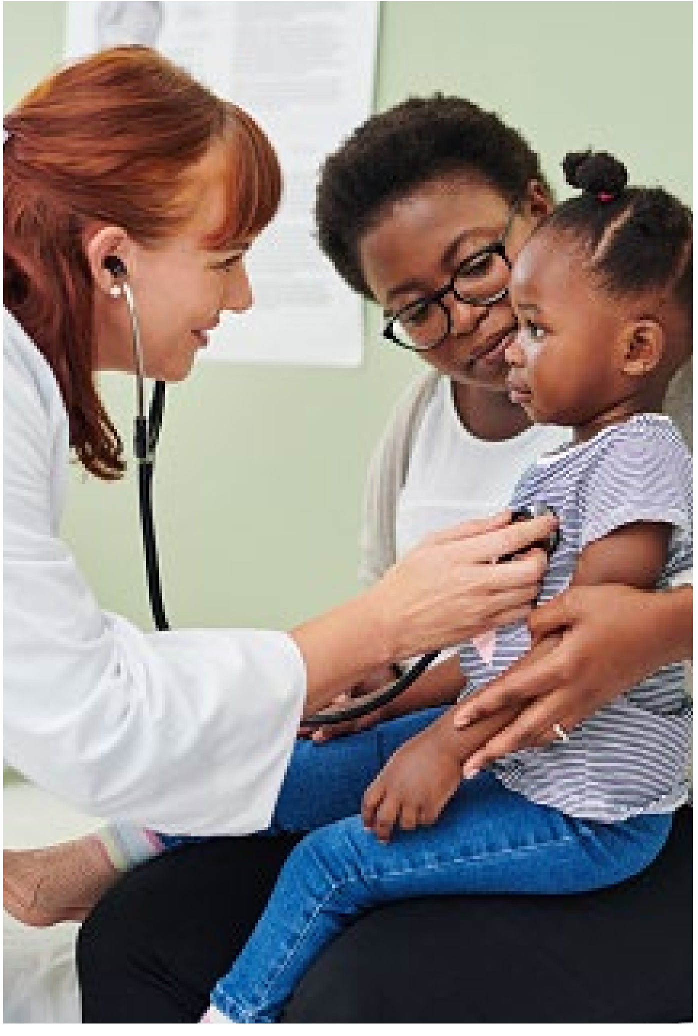
The Michigan Department of Health and Human Services requires Blue Cross Complete to report on developmental screenings during the first three years of a child's life, with the minimum standard of:

- First year of life — at or above 31%
- Second year of life — at or above 40%
- Third year of life — at or above 31%

Example of developmental screening tools that meet criteria for the measure

The following tools meet the above criteria and are included in the Bright Futures/AAP 2022 Recommendations for Preventive Pediatric Health Care at **aap.org***:

- Ages and Stages Questionnaire — 3rd Edition
- Parents' Evaluation of Developmental Status) — Birth to age 8
- Parent's Evaluation of Developmental Status — Developmental Milestones
- Survey of Well-Being in Young Children



As a reminder, Blue Cross Complete reimburses developmental screenings separately from early and periodic screening, diagnostic and treatment or EPSDT visits. Blue Cross Complete **Claims filing instructions** are at **mibluecrosscomplete.com** on the provider **Resources** page.

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MDHHS unveil new website to help reduce pregnancy-related deaths

In a step toward improving maternal health outcomes, the Michigan Department of Health and Human Service, Maternal Mortality Surveillance program launched a new website in September 2023 to help reduce pregnancy-related deaths. The **Hear Her Michigan*** website provides potentially life-saving information about urgent maternal health warning signs.

In addition, the Hear Her campaign aims to promote awareness and encourage everyone, including health care providers, to listen and act when pregnant and postpartum women express that something doesn't feel right.

According to the **MDHHS***, more than 700 women in the United States die each year due to pregnancy-related complications within one year after giving birth. In Michigan, about 25 cases of pregnancy-related deaths are reported each year. Of these deaths, approximately six out of every 10 are preventable.

To learn more about important maternal warning signs and discover how you can help, go to **www.michigan.gov/HearHer**.*

In addition, Blue Cross Completes provides new or soon-to-be parents, with resources, support and information they will need during pregnancy and after a baby is born under the **Bright Start program**®. This maternity care program is for pregnant members. Bright Start teaches new parents about their baby and helps moms with self-care and eating right.

When patients join Bright Start, a case manager will call the expectant mom to help make sure she is aware of all program services. If the pregnancy is high risk, a team of nurses and care connectors will check in regularly to help the patient stay connected to care during the pregnancy. This includes notifying the doctor that they are enrolled in the program.

If you have any questions, contact your Blue Cross Complete provider account executive or call Blue Cross Complete Provider Inquiry at **1-888-312-5713**.

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Developmental screenings are vital to early childhood health

The early years of a child's life are a period of rapid growth and development. During this critical time, it's essential to monitor if children are reaching key development milestones.

Development screenings play a pivotal role in identifying and addressing potential development delays. It's important to identify development delays early so that families can receive early intervention services and support. Detecting and addressing delays in children at an early age can offer many benefits.

Health care providers play a critical role in monitoring children's growth and development and identifying problems as early as possible. Developmental screening examines how a child is developing in certain areas such as language, movement, thinking, behavior and emotions.

The American Academy of Pediatrics recommends all children complete developmental screenings even if there isn't a known concern. Developmental and behavioral screening for all children should be completed during regular well-child visits at ages: 9 months, 18 months and 30 months. Health care providers are encouraged to do the following:

- Monitor the child's development during regular well-child visits.
- Periodically screen children with validated tools at recommended ages to identify any areas of concern that may require a further examination or evaluation.
- Ensure that more comprehensive developmental evaluations are completed if risks are identified.

Developmental monitoring and screening can be done by a number of professionals in health care, community and school settings in collaboration with parents and caregivers. It provides early detection if a child needs additional help developing language, movement, thinking, behavior and emotions. Early intervention programs, such as speech therapy, occupational or physical therapy can help children with development delays. Pediatric primary care providers are in a unique position to promote children's healthy development due to regular contact with them before they reach school age.

The AAP encourages pediatric care providers to offer **family-centered**, comprehensive and coordinated care. Remind your patients to schedule an appointment to address any questions or concerns about developmental screenings.

Source: **https://ww.cdc.gov/ncbddd/childdevelopment/screeninghcp.html**

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Help us keep the Blue Cross Complete provider directory up to date

Accurate provider directory information is critical to help ensure members can easily access their health care services. Confirm the accuracy of your information in our online provider directory so our members have the most up-to-date resources. Key items in the directory are:

- Provider name
- Phone number
- Office hours
- Hospital affiliations
- Address
- Fax number
- Open status
- Multiple locations

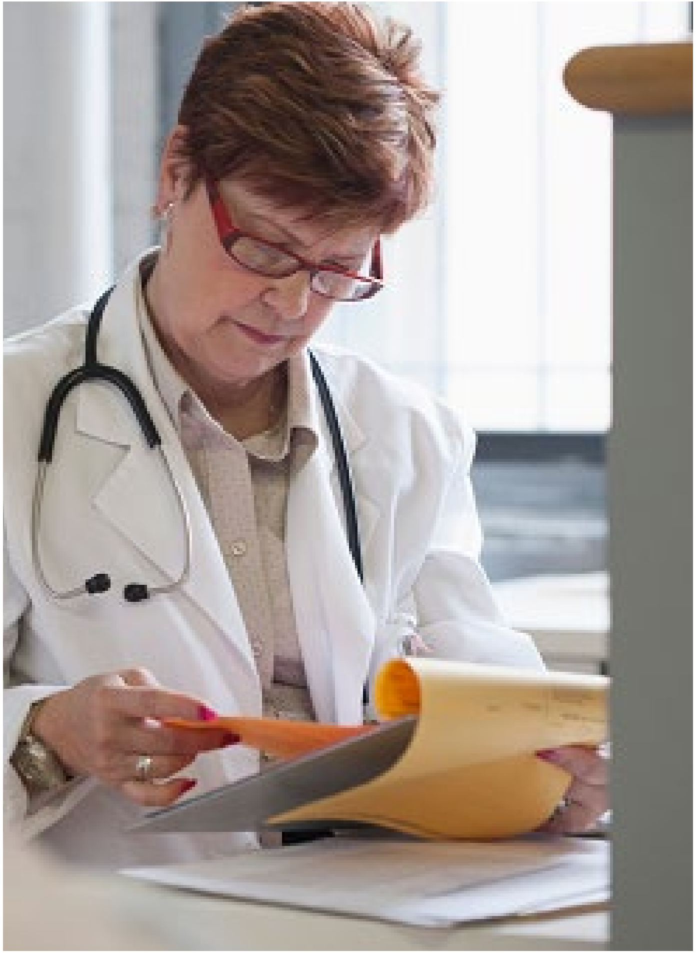
To view your provider information, visit **mibluecrosscomplete.com**, then click the *Find a doctor* tab and search your provider name. If any changes are necessary, you must submit them in writing using Blue Cross Complete's *Provider Change Form* also at **mibluecrosscomplete.com**. Go to the Providers tab, click Forms and then click Provider Change Form.

Send completed forms by:

Email: **bccproviderdata@mibluecrosscomplete.com**

Fax: **1-855-306-9762**

Mail: Blue Cross Complete of Michigan
Provider Network Operations
Suite 1300
4000 Town Center
Southfield, MI 48075



You must also make these changes with **NaviNet**.* Call NaviNet at **1-888-482-8057** or email **support@navinet.net.** If you have any questions, contact your Blue Cross Complete provider account executive.

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Reporting suspected fraud to Blue Cross Complete

Health care fraud affects everyone. It significantly affects the Medicaid program by squandering valuable public funds needed to help vulnerable children and adults access health care.

If you or any entity with which you contract to provide health care services suspect another Blue Cross Complete provider, employee or member is committing fraud, notify Blue Cross Complete's Special Investigations Unit:

Phone: **1-855-232-7640 (TTY 711)**

Fax: **1-215-937-5303**

Email: **fraudtip@mibluecrosscomplete.com**

Mail: Blue Cross Complete
Special Investigations Unit
P.O. Box 018
Essington, PA 19029

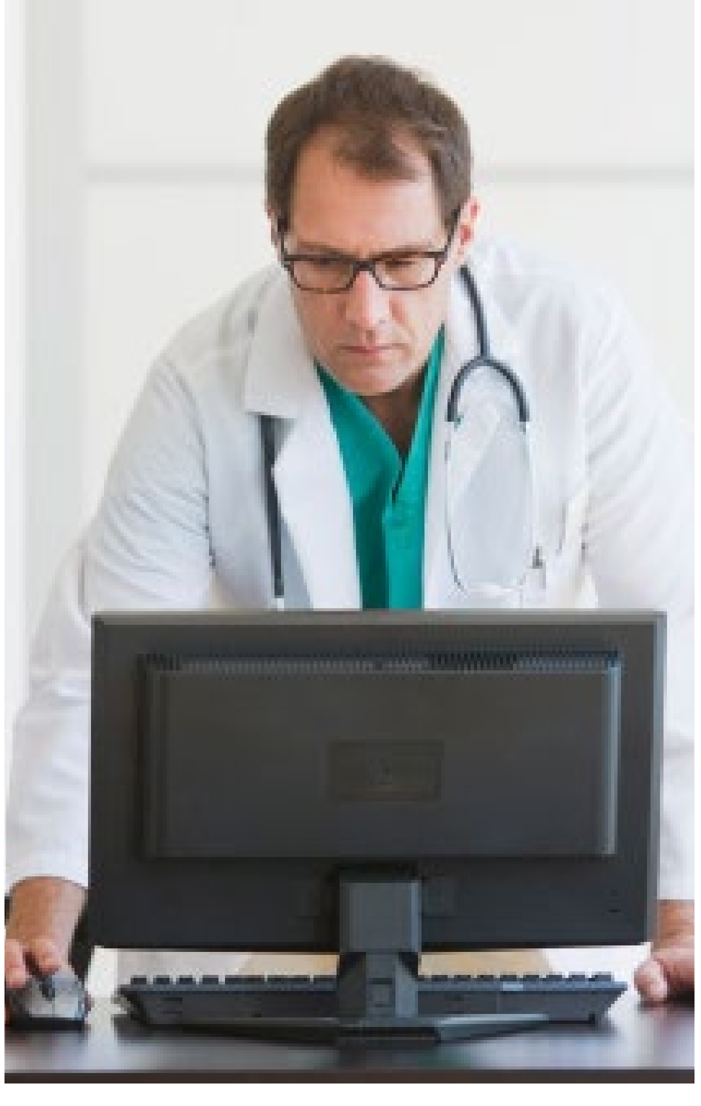
Blue Cross Complete's Special Investigations Unit supports local and state authorities in investigating and prosecuting fraud. You can also report suspected fraud related to Blue Cross Complete to the Michigan Department of Health and Human Services Office of Inspector General in one of the following ways:

Website: **michigan.gov/fraud***

Phone: **1-855-643-7283**

Mail: Office of Inspector General
P.O. Box 30062
Lansing, MI 48909

Reports can be made anonymously.



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