UPMC

Insurance Services Division

Supporting Health Equity

HERE'S THE PLAN

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AGENDA

01 Introduction to UPMC Health Plan

02 Broad Health Equity Strategies

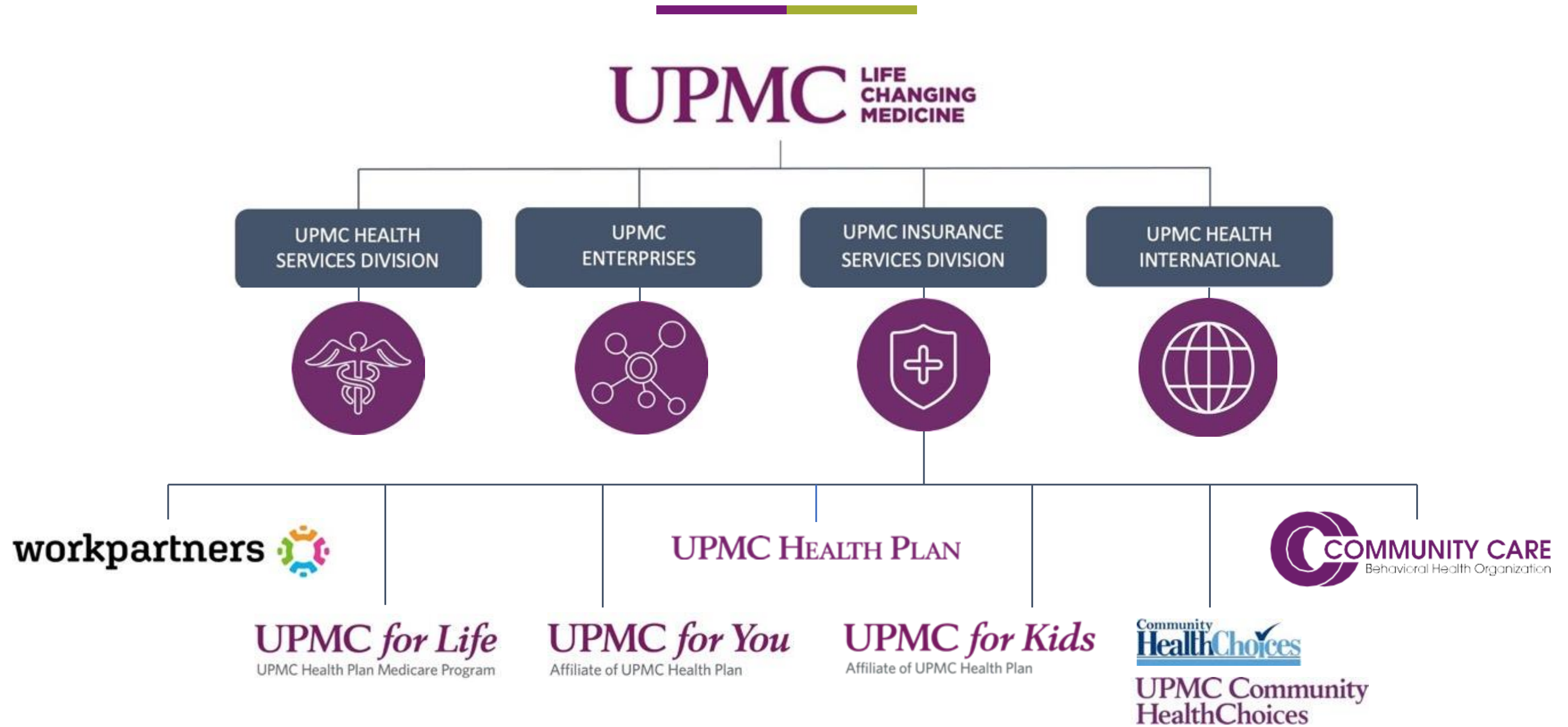
03 Examples of Health Equity Initiative in Action

04 Health Equity Approach: Data, Social Determinants, and Community-Based Organization (CBO) Partnerships

05 Promoting Equity with Value-Based Payment Programs

01 Introduction to UPMC Health Plan

Offering Insurance Within an Integrated System



Our Mission and Vision

Mission

To serve our community by providing outstanding patient care and to shape

and education.

Vision

UPMC will lead the transformation of health care. The UPMC model will be nationally recognized for redefining health care by:

- Putting our patients, health plan members, employees, and community at the center of everything we do and creating a model that ensures that every patient gets the right care, in the right way, at the right time, every time.
- Employing our partnership with the University of Pittsburgh to advance the understanding of disease, its prevention, treatment, and cure.
- Serving the underserved and disadvantaged, and advancing excellence and innovation throughout health care.
- Fueling the development of new businesses globally that are consistent with our mission as an ongoing catalyst and driver of economic development for the benefit of the residents of the region.

02 Broad Health Equity Strategies

NCQA Health Equity Accreditation for UPMC *for You*

Why Pursue Health Equity Accreditation?

- To improve health equity and address social drivers of health
- To solidify our ongoing commitment to embed health equity into standardized structures and processes
- To provide an actionable framework for improving health equity

Health Equity Accreditation and Health Equity Accreditation Plus are two separate and distinct accreditations.

Three-Year Accreditation:

Earned in September 2022

Next survey scheduled for June 2025

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Health Equity Accreditation Requirements

- Build and promote a diverse staff
- Collect and store race, ethnicity, language, gender identify, and sexual orientation data
- Use HEDIS and CAHPS data to identify disparities and act upon opportunities
- Provide translation and interpreter services
- Collect practitioner race/ethnicity and language services
- Evaluate program annually

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- **Collection, integration and analysis of community and individual data**
- **Cross-sector partnerships and engagement**
- **Data management and interoperability**
- **Program to improve social risks and address social needs**
- **Referrals, outcomes, and impact**

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The Patient-Centered Outcomes Research Institute (PCORI)

Health Systems Implementation Initiative (HSII): Systematically Focusing on Equity

Using Federal (PCORI) Funding to Support Equity-Focused Strategies

- Patient Centered Outcomes Research Institute
  — About $600M annually focused primarily on evaluation of community-based services
- Largely comparative effectiveness research (CER) though also funds stakeholder engagement and dissemination
- Generates evidence comparing benefits and harms of at least two different interventions to prevent, diagnose, treat, and monitor clinical conditions and/or improve care delivery
- Measures benefits in real-world populations and provides results in subgroups of patients/members
- Patients and other healthcare stakeholders have key roles

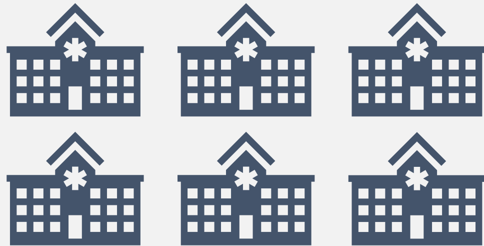
PCORI Health Systems Implementation Initiative (HSII)

Aims to promote implementation of evidence from PCORI-funded research in real-world practice

Offers a unique opportunity to provide infrastructure and financial support for UPMC to reduce health-related disparities through community-integrated, evidence-based implementation efforts

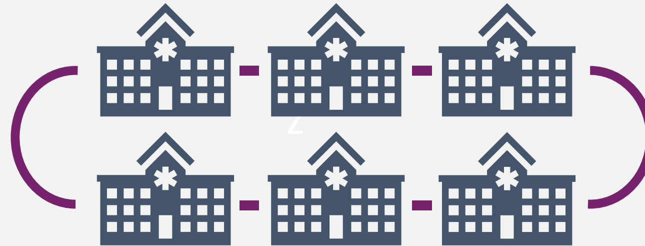
STEP 1:

Health systems apply to become HSII Participants



STEP 2:

HSII Participants propose Capacity Building Projects
(Budgets ≤ $500K)



We Are Here

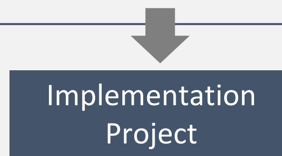
Capacity Building Project

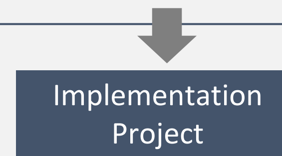
Capacity Building Project

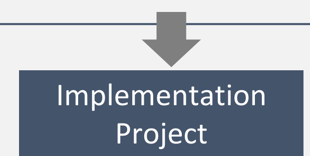
Capacity Building Project

STEP 3:

HSII Participants propose Implementation Projects
(Budgets $1–5M)







Implementation Project

Implementation Project

Implementation Project

HSII: Participating Health Systems

Collectively Reaching Nearly 80 Million Patients

42	800	145K	79M	6,400	41
Health System Participants	Hospitals	Hospital Beds	Unique Patients	Primary Care Locations	States + DC

- AdventHealth
- Advocate Aurora Health
- Ascension Health
- Atrium Health
- Children's Healthcare of Atlanta
- Cincinnati Hospital Children’s Medical Center
- Cleveland Clinic
- CommonSpirit Health
- Corewell Health
- Duke University Health System
- Geisinger Clinic
- Harris Health System
- HonorHealth
- Inova Health System
- Intermountain Health
- Iowa City VA Medical Center
- Jefferson Health
- Kaiser Permanente Southern California
- MedStar Health
- Mercy Health
- Montefiore Health System
- Northwell Health
- Northwestern Memorial HealthCare
- OSF Healthcare System
- Phoenix Children's Hospital
- Saint Luke's Health System
- San Francisco Health Network
- Stanford Medicine
- Temple University Health System
- The Children's Hospital of Philadelphia
- The Nebraska Medical Center
- The Queen's Medical Center
- The University of Chicago Medicine
- The University of Missouri Health Care System
- University Hospitals Health System
- University of California San Francisco Health
- University of Florida Health System
- **UPMC**
- UW Health (University of Wisconsin)
- Valleywise Health
- Vanderbilt University Medical Center
- WellSpan Health

Advancing Health Equity (AHE) Learning Collaborative

Leading Care, Payment, and Systems Transformation: A national program of the Robert Wood Johnson Foundation to convene multi-sector state teams to advance collective health equity goals

Overview of Opportunity

Purpose: Develop shared equity priorities, uncover drivers of disparities, address racism, and create payment models to support equity-focused care transformation

Participants: Five teams composed of Medicaid agencies, MCOs, and health care providers and/or systems

Conveners: Center for Health Care Strategies, Institute for Medicaid Innovation, University of Chicago

Timeframe: January 2023 – December 2024

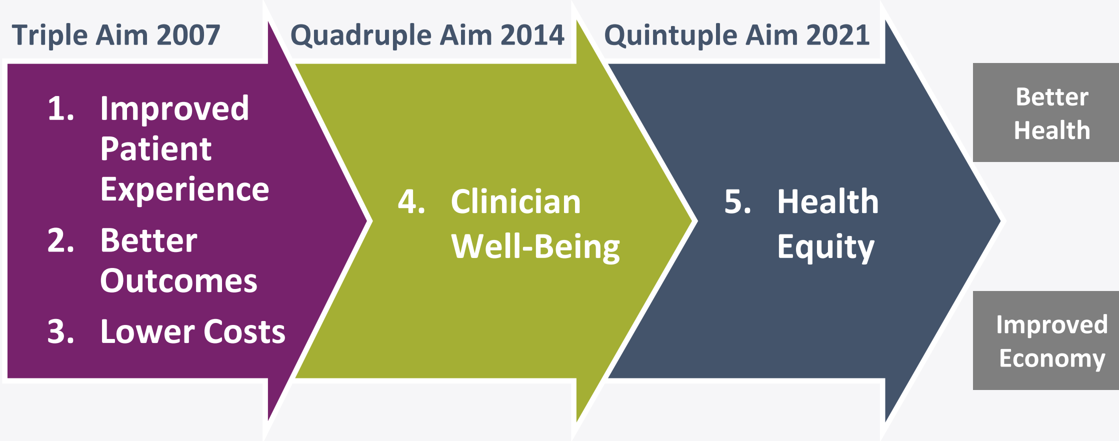
UPMC Participants: UPMC *for You*, CCBH, UPMC Magee, CHVHC

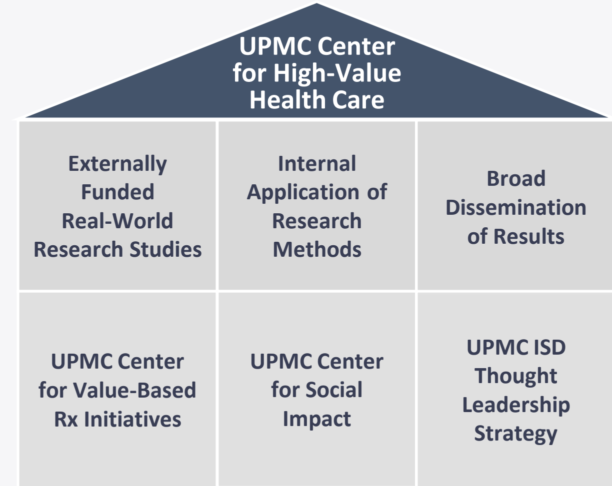
State-wide Partners: PA-DHS Office of Medical Assistance Programs, Geisinger Health Plan, Geisinger Women and Children's Institute, Healthy Start

Our Proposed Plan/Objective: Advance maternal health equity initiatives across Pennsylvania

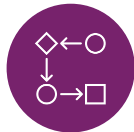
- Promote whole-person health through comprehensively identifying and addressing medical, behavioral, and social needs.
- Develop/refine/test value-based payment approaches to support patients with high-risk pregnancy-related conditions.

UPMC Center for High-Value Health Care





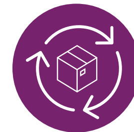
Evidence Gathering and Synthesis


Implementation Science

Rapid Learning and Improvement

Mixed Methods

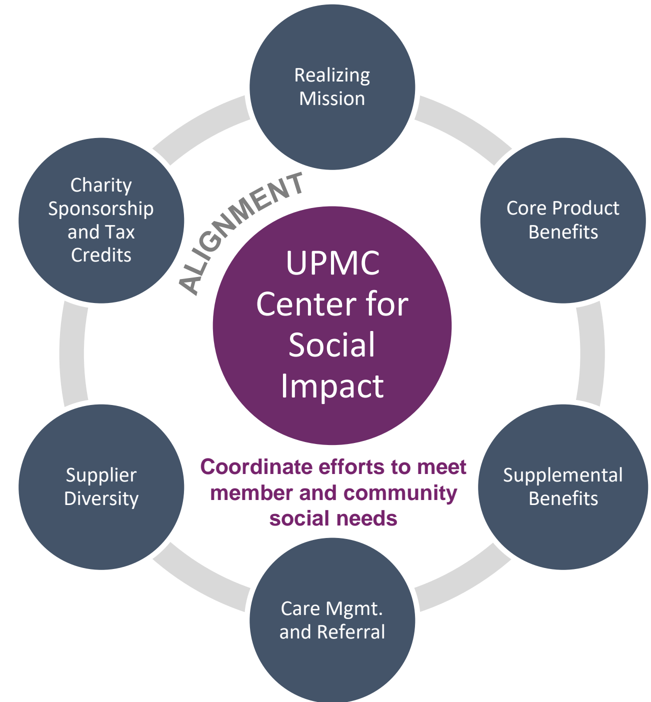
Model Scaling


Dissemination

UPMC Center for Social Impact

Established in 2019 to make UPMC a national leader in evidence-based social interventions that impact health, quality, and cost.

1. **Establish social impact strategy** to guide long-term vision for Insurance Services Division (ISD).
2. **Document and report** contributions and outcomes as a part of all ISD units impacting social determinants of health (SDOH).
3. **Coordinate SDOH programming** across the ISD with emphasis on government lines of business, collaborating closely with the Center for High Value-Health Care, the Department of Health Economics, marketing, charitable giving, and clinical programs.
4. **Develop and incubate pilots** for underserved communities using social determinants of health and identify and advocate for socially responsible investments and spending.
5. **Support evaluation and dissemination** of results impacting social needs of our members from benefits, supplemental benefits and value-added services, charitable and tax credit activity, and support from human services and government programs.

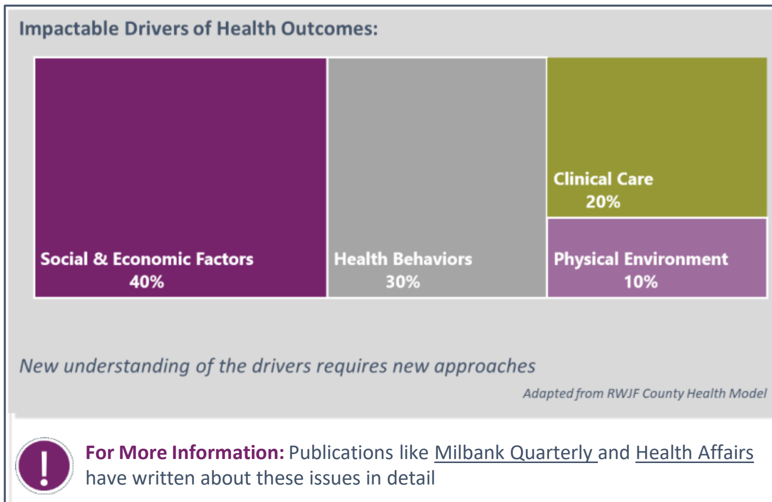


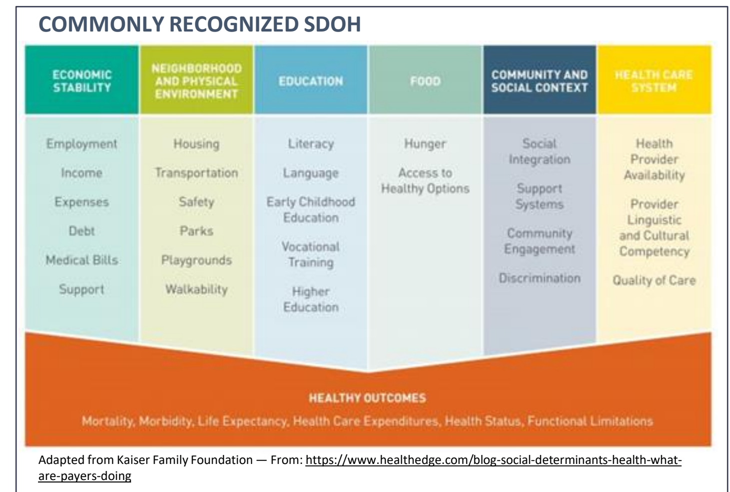
Working Upstream and Meeting Our Members' Social Needs

SDOH are structural "conditions in which people are born, grow, live, work, and age" such as macroeconomic policy or public policies on education and transportation and are not inherently negative.

Social risk factors are specific adverse social conditions associated with poor health that relate to SDOH — poverty or bus route access.

Health-related social needs refer to immediate barriers faced in accessing care they need depending on people's individual preferences and priorities, regardless of social risk factors experienced.





03 Examples of Health Equity Initiative in Action

What is Health Equity?

The state in which **everyone** has a **fair and just opportunity** to attain their **highest level of health**[1]

Inclusive of:

- Demographics
  - Race/Ethnicity
  - Gender/Gender Identity
  - Sexual Orientation
  - Age
  - Preferred Language
  - Disability Status
- Social Determinants of Health
- Geography
- Medical complexity

SDOH

- Economic stability
- Education access and quality
- Neighborhood and built environment
- Social and community context

Social needs

Health care equity[2] in:

1. Access to care
2. Care transitions
3. Quality of care
4. Post-discharge period

Behavioral health

Physical health

Socioemotional health

1. Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough A. (2017, May 17). What is health equity? And what difference does a definition make? Robert Wood Johnson Foundation.
2. Ma, S., Agrawal, S., & Salhi, R. (2023). Distinguishing Health Equity and Health Care Equity: A Framework for Measurement. *NEJM Catalyst Innovations in Care Delivery*, *4*(2).

LGBTQIA+ Affirming Provider Designation

Health Plan Find Care Directory

UPMC Provider

This provider has completed training on how to create a safe, comfortable and welcoming environment for LGBTQIA+ patients. The provider may or may not offer LGBTQIA+ specific medical or surgical care; please ask when scheduling.

LGBTQIA+ Affirming Provider

Special accessibility amenities

Available as of 11/1/22 in the Find Care directory

Health Services Find A Doctor Directory

Example Name, MD

ACCEPTING NEW PATIENTS | LGBTQIA+ AFFIRMING

Book Appointment

Specialties
Radiation Oncology

UPMC PROVIDER

Practice Locations	Phone
UPMC Hillman Cancer Center 4401 Penn Avenue, Pittsburgh, PA 15224 (Map)	412-692-9513

Available as of 8/9/22 in the Find A Doc directory

- Providers who are listed in the Find Care and/or Find A Doctor provider directories may earn the LGBTQIA+ Affirming Provider designation by completing three learning modules and an attestation
- Members and patients can **filter directory search results** for providers who have earned the LGBTQIA+ Affirming Provider designation
- **Hover text** explains that the designation is an indicator of a provider's cultural competency; the provider may or may not offer LGBTQIA+ specific medical or surgical care

Earning the LGBTQIA+ Affirming Provider Designation

Providers who are listed in the Find A Doctor and/or Find Care directories may earn the LGBTQIA+ Affirming Provider Designation by completing **three learning modules and an attestation**

Each learning module qualifies for 1.0 Continuing Medical Education (CME) credit

UPMC employed providers:

- Access the learning modules and attestation through HR Direct Learning by searching for “Affirmative Communication with LGBTQIA+ Patients & Members”

Non-UPMC employed providers:

- Access the learning modules and attestation through links on the Patient Health webpage of upmchealthplan.com

Learning Modules

1. LGBTQIA+ Patient and Colleague Awareness Training
2. Care for Transgender, Gender Diverse, and Intersex Patients
3. Sexual Orientation and Gender Identity Affirming Documentation and Systems

Attestation

I attest to:

- Adhering to the most recent version of the World Professional Association of Transgender Health Standards of Care (wpath.org/publications/soc)
- Understanding the content presented in all three learning modules
- Being confident in communicating with my patients about health needs relating to sexual orientation and gender identity
- Being an LGBTQIA+ Affirming Provider champion
- Agreeing to the LGBTQIA+ Affirming Provider Designation being displayed with my provider details in UPMC Health Plan's provider directory listing

UPMC Health Plan Neighborhood Center

UPMC Health Plan Neighborhood Center

Objective

"To provide a multi-use space to support Health Plan members — and our community – in meeting their basic needs while providing a venue for community health engagement, job training and navigation support through partnerships with community-based organizations."

Overview

Infusing 4 Pillars to engage our members, community members, and stakeholders

Education

Workforce Development

Health and Wellness

Enrichment

Addressing Equity With the UPMC Health Plan Tech Guides

- The **UPMC Health Plan Tech Guides** are a specially trained subset of our Member Services team with a mission to enhance digital equity.
- **Tech Guides** answer questions about UPMC digital assets, including UPMC AnywhereCare; the UPMC Health Plan app, RxWell; and MyUPMC.
- **Tech Guides** are also trained to assist members with basic digital activities, such as downloading an app or preparing a camera for a telehealth visit.
- Members can have their questions answered **telephonically** or at **UPMC Connect Centers.**

04 Health Equity Approach: Data, Social Determinants, and Community-Based Organization (CBO) Partnerships

UPMC Health Plan Social Determinants of Health Billing Guide

Provider screening for SDOH

- Improve provider awareness and screening for social factors that influence health outside the clinic.
- Incorporate SDOH screening and referrals to community resources into the overall care plan to provide whole-person care, improve clinical outcomes, and reduce disparities.

What's the provider's/care team's role?

When you identify SDOH upon screening, submit claims using G-codes and ICD-10 Z-codes for specific SDOH:

- **G9919—***Screening performed and positive and provision of recommendations*
- **G9920—***Screening performed and negative*

Z-code domains (69 Z-codes within 10 key domains):

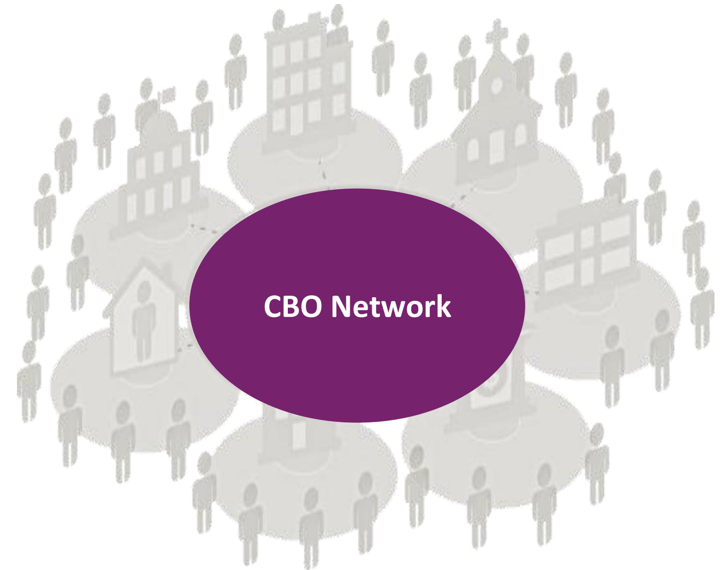
- Z55 – Education & literacy
- Z56 – Employment & unemployment
- Z57 – Occupational risk factors & exposures
- Z58 – Problems with physical environment
- Z59 – Homelessness & economic instability
- Z60 – Problems with social environment
- Z62 – Problems with upbringing
- Z63 – Family & social support
- Z64 – Psychosocial certain (e.g., unwanted pregnancy, multiparity)
- Z65 – Psychosocial other (e.g., crime, judicial system, violence)
- Z59.82 – Transportation insecurity (effective Oct. 1, 2022)

Z55 – Z65 are comprised of multiple subcategories.

Community-Based Organizations (CBOs)

Managed Care Organizations (MCOs) must develop CBO partnerships and network adequacy

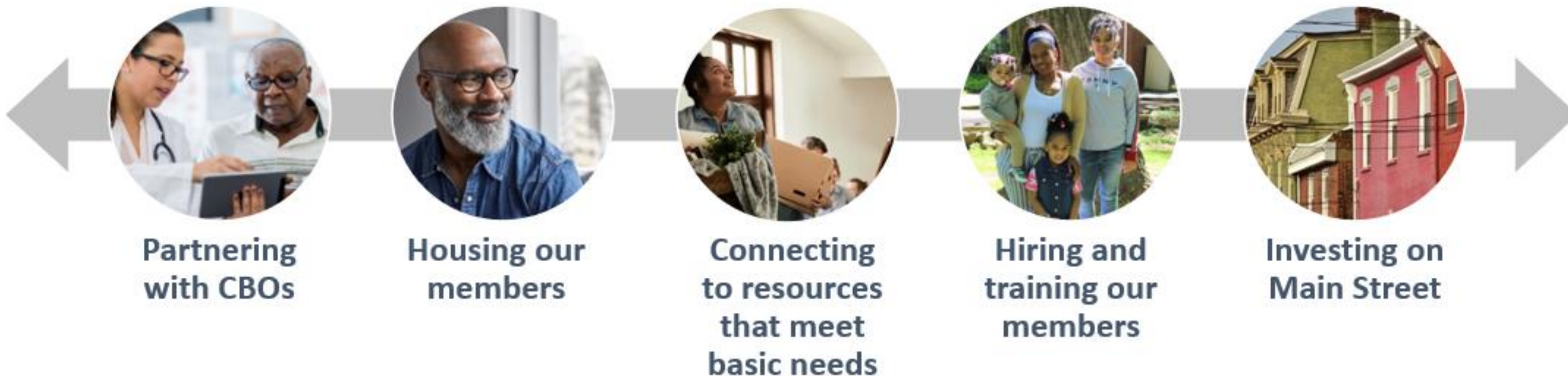
- CBOs use community health workers (CHWs) to connect and engage members and link them to resources.
- CBO partnerships are essential given the trusted, established relationships with underserved/hard-to-reach members, neighbors, and communities.
- Because social and environmental factors affect 60% of healthcare outcomes, MCOs must develop robust CBO networks.
- **Key factors for success:**
  - Innovative contracting
  - Value-based payment (VBP) arrangements linking providers and CBOs



A robust CBO network with network adequacy is essential in managing SDOH.

UPMC Health Plan Center for Social Impact

Incorporating housing, food insecurity, and employment training into VBP arrangements



VBP partnerships with CBOs to enhance community outreach and access to services

Focus on SDOH — UPMC and UPMC Health Plan Efforts to Advance Equity

- **The Food Trust**
- **Greater Pittsburgh Food Bank**
- **Cultivating Health for Success**
- **Pathways to Work**
- **Mom's Meals Diabetes Pilot**

The Food Trust Program

Integration of food insecurity into contracted VBP Primary Care practice locations

- The Food Trust (TFT) is a nonprofit located in Philadelphia, serving the SW and SE regions of Pennsylvania.
- It operates a national produce prescription program known as *Food Bucks Rx*—coupons redeemed for fresh produce.
- UPMC Health Plan partnered with TFT and four PCP practices to become Food Bucks Rx distribution sites.
- The practices perform screening for SDOH.
- Members who screen positive for food insecurity during a clinic visit receive an envelope containing:
  - Vouchers for fresh produce.
  - A map of redemption sites in their area.
  - Contact information for support.

Mom’s Meals

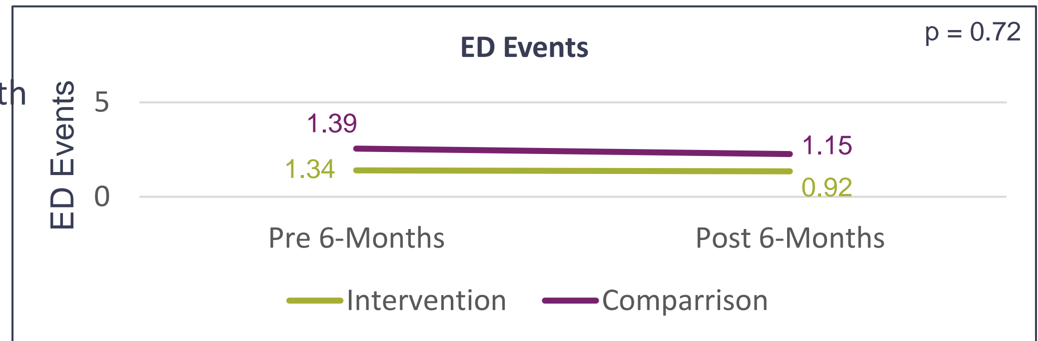
Medically tailored meals

Pilot:

- 100 UPMC *for You* members with food insecurity, and
  - Age 21 years and older
  - Diabetes or heart failure
  - High risk of avoidable admission
- Members received 3 meals per day for 13 weeks
- Ongoing engagement with Community Health Worker program
- Six-month pre/post analysis of intervention vs. comparison group
- 91% of responders rated the meals as “very good” or “good”

Individuals who received meals had a 19% total cost of care reduction, largely driven by a 14% decrease in Emergency Department (ED) utilization.

- 19% cost decrease as displayed in analysis
- The largest ED reductions were noted in members with a mental health diagnosis



Mom's Meals

What's next? The future of medically tailored meals

Expanding program to 500 members focused on A1c management, complex chronic conditions, high Area Deprivation Index, and high readmission risk

- Enrolled members will also be offered longitudinal care management support
- Use meals in conjunction with health coaching, care coordination, and connection with available community-based supports
- Identifying CBOs to facilitate member identification

Expansion Goals:

- Further demonstrate success of proof-of-concept pilot
- Increase sample size and time of post intervention measurement to achieve statistically significant results
- Focus on diabetes due to prevalence and longitudinal impact on members' lives

Overview: Cultivating Health for Success (CHFS)

Collaboration with UPMC Health Plan, Community Human Services, and Allegheny County

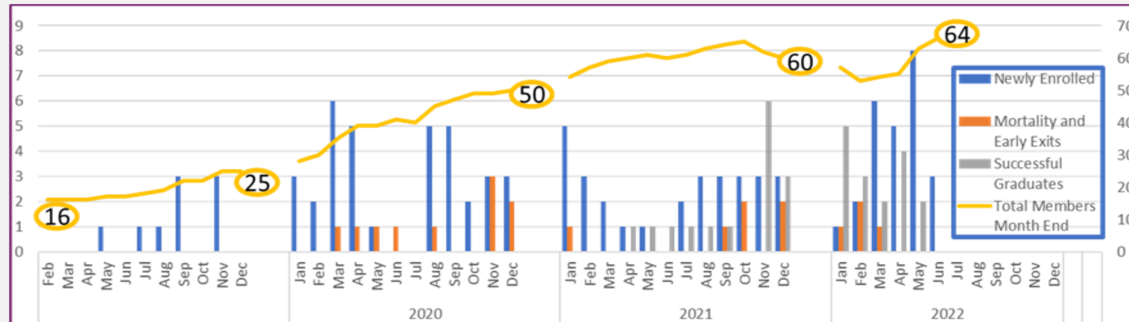
Homeward

CHFS has housed 152 members since 2010 (67% after 2019)

Originally it was a HUD initiative. Today, it is a Pay-for-Success program utilizing multiple housing subsidies.

Integrates permanent supported housing, an assigned medical home, and intensive case management/care coordination with a community nurse and social worker to provide:

- Secure living environment and social supports.
- Timely and coordinated medical care and monitoring.
- In-home assistance with activities of daily living and life skills training.



June 2022 number of members housed, exited, or graduated by month.

Pathways to Work Program

Actively train, recruit, and hire from underserved communities

- Connects Medicaid members to work who are unemployed, underemployed, or have barriers to work.
- Increases access to employment, including training, education, and support from UPMC staff.
- Assistance with job searches, creating resumes, and accommodations for disabilities
- Includes partnerships with UPMC HR and community organizations, such as ACHIEVA and Freedom House.

Two Pillars – Meeting People Where They Are:

Job Navigation

- ~200 Hires per month statewide
- 200+ people active in the pipeline
- 20+ applications per week
- 20+ new inquiries per day

Training Programs and Partners

- 15 *Freedom House 2.0* Cohorts 1/2021 – 12/2023
- 10 Workforce Investment Board training partnerships
- 50+ community partnerships for job fairs, referral pipelines
- $3 million+ in federal/state funds into communities

Connecting Medicaid members to careers!

***Freedom House 2.0** is a community-based training program—based on the 1960s model—to recruit, train, and employ first responders from economically disadvantaged communities, many of which have been impacted by COVID-19.*

***Future –** Maintain apprenticeships and pathways across the Commonwealth, including students and veterans.*

Benefits Data Trust

BDT helps members/households with getting connected to benefits

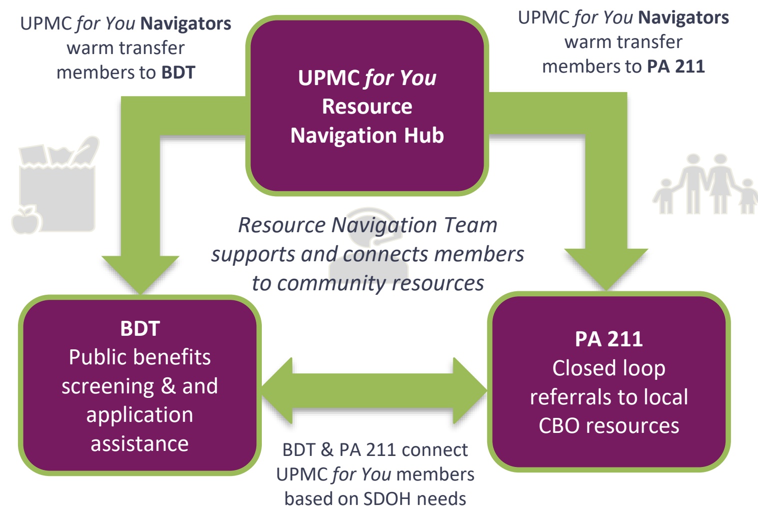
Application Assistance and Referrals for Benefits:

- Supplemental Nutrition Assistance (SNAP)
- Heating assistance (LIHEAP)
- Medicaid coverage renewal
- Property Tax/Rent Rebate (PTRR)
- Pharmaceutical Assistance for Elderly (PACE)
- Children's Health Insurance Program (CHIP)
- Women, Infants and Children (WIC)
- Unemployment insurance
- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI)
- Qualified health plan coverage (Exchange)

Reporting Period: April 5, 2021, to June 30, 2023:

- 5,480 full benefit apps submitted
- 1,140+ referrals to WIC, SSI/SSDI, etc.

UPMC *for You* Resource Navigation Hub



October 2022:

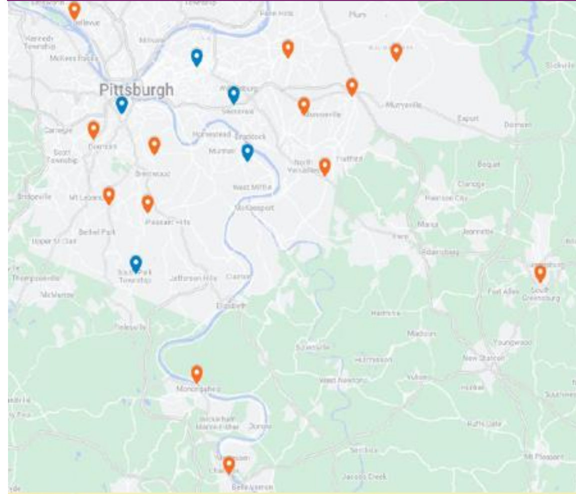
UPMC *for You* launched "Quick Screener" pilot tool with BDT

Fabric Health

Meeting members needs where they are!

UPMC members attend Fabric Health's inaugural event at Shadyside

Fabric's footprint today and where we're heading tomorrow!



Partnering Laundromats Prospective Partners

Your front door to current and future customers: Activating Laundromats for UMPC Engagement

Trusted Relationships—Not Marketing: Messaging and Staffing

Turning Skeptics into Community Ambassadors: UPMC-sponsored Quarterly Member Laundry

05 Promoting Equity with Value-Based Payment Programs

Addressing Health Disparities With Providers

Promoting effective clinical interventions with providers

The first step in addressing health disparities is to recognize them and commit to reducing them.

Step 1. Provide medical practices with race and ethnicity data for the clinical and quality measures.

Step 2. Help providers to use the data in an actionable way.

Step 3. Promote screening and referrals to overcome social barriers.

Step 4. Value-based payments, incentivizing equity performance.

- Race and ethnicity information is provided in monthly quality reports to practices engaged in UPMC Health Plan's VBP programs (shared savings, Medicaid P4P, and PCMH practices).
- Practices receive education and data on their rates of SDOH screening.

VBP Approaches at UPMC Health Plan

Quality-based reimbursement

- **UPMC *for You* Provider Pay For Performance Program**
- **UPMC *for You* Health Plan Premier Partners Shared Savings Program**
- **UPMC *for You* Value-Based Program for Community-Based Organizations**

VBP have robust reporting and collaboration from plan to provider

Ability to engage in data-based discussions at provider level

Bring awareness of health disparities to a more personal level

UPMC Premier Partners — Shared Savings Program

Value-based payment within patient-centered medical home practices

Premier Partners Program Components

- PMPM care coordination fee
- Detailed quarterly reports
- Quality first program (Quality targets must be met for eligibility for savings distribution.)
- Measure-level quality bonuses for key metrics
- MER or Total Cost of Care financial opportunity

Additional Areas of Focus

- Social determinants of health
- Patient experience
- Depression screening with follow-up for positive screens
- Transitions of care

Program Success

- Quality and equity performance is higher than for non-participating groups.

Program began in 2011

35 Current Premier Partners Program Practices

- 7 pediatric-focused
- 1 geriatric-focused
- 13 adult and pediatrics combined
- 14 adult-focused

Program participation spans across 1,800 primary care providers at more than 700 office locations.

UPMC *for You* Membership: Medicaid Data Supporting Health Equity

Moving from understanding to action

Medicaid Pay for Performance and Premier Partners Program practices receive:

- **Monthly data reports at the TIN and site levels to display performance and progress.**
- **Monthly reports include:**
  - Profile of member demographics and population health characteristics for their patient population.
  - Performance on health equity measures including open gaps by race and ethnicity.
  - Comparisons of the providers' specific rates to the peer network average.
- **Opportunities are provided for care coordinators and practices to review engagement strategies.**
- **Educational opportunities are performed with provider groups on how best to address and resource alignment to close care gaps.**

UPMC Health Plan | QP QualityPartners

Incentive Program

Health Equity Measure Performance - UPMC *for You*

Purpose: This report provides a TIN level summary of open gaps in care for Black Medical Assistance members. Membership is based on non-continuous enrollment. UPMC *for You* committed to addressing health inequities among our Black member population. To partner with our providers to improve outcomes for these members, UPMC *for You* will incentivize the Health Equity Measures listed below. TINs with 5 or more Black members in the measure denominator will be eligible for an annual payment for the measure if they perform at or above the calculated 70th percentile compared to their peers.

- Controlling High Blood Pressure
- HbA1c In Control (≤9%)
- Well Visits in the first 15 months of life-6 or more

Other measures included on the report are for display purposes only.

Disclaimer: The Open Gap reports will be produced monthly for informational purposes only and are not tied to incentive payments.

Report Date: APR 2

Membership as of 04/15/2

Incentivized Measures

Measures	Payment Timeframe	Total Eligible Gaps	Current Open Gaps	Current % Closed	Current Percentile	70th Percentile	80th Percentile	90th Percen
HbA1c Control 9.0 or lower	*Annual*	272	200	26.47%	70th	25.75%	28.57%	34.64%
High Blood Pressure Control		262	188	28.24%	50th	34.48%	38.82%	44.44%
Well Child Visits in First 15 Months of Life (6 or more)		235	176	25.11%	30th	40.00%	45.22%	52.81%

UPMC *for You* Pay for Performance (P4P) Program

Incentive included for equity measures

UPMC *for You* provider P4P Program

- Providers are incentivized to improve quality performance.
- Incentive payments are based on achieving quality performance thresholds as well as year-over-year improvement.

Health Equity Incentives are included

- Additional incentive payments can be earned by reducing the variance between white and non-white members.
- Monthly open gap rosters include data that enable providers to track their progress and actively manage quality disparities.

Current Health Equity Measures

- PCP: Controlling High Blood Pressure, HbA1c Poor Control, and Well-Child Visits in the first 15 months
- Obstetrical Providers: Prenatal Care in the First Trimester and Postpartum Care (postpartum visits)

UPMC *for You* P4P Equity Incentive for PCPs

Additional payment is achieved for closing disparity gaps

Controlling High Blood Pressure

Well-Child Visits in the first 15 months of life — 6 or more

HbA1c Poor Control (> 9%)

Providers are eligible for two types of payments:

Percentile Payments

- Practices that perform at the 70th, 80th, or 90th percentile relative to their peers will receive payments.
- Payments will be in proportion to their denominator of their Black membership for the measures, among practices in that same percentile.

Improvement Payment

- Improvement payments will be made based on year-over-year improvement in rates for Black membership in the measure denominator.
- A higher payment factor will be applied to each Black member in the measure denominator for providers in higher performance tiers.

Value-Based Purchasing Arrangements with CBOs

Incorporating CBOs into value-based purchasing arrangements

2023 VBP arrangements seek to connect CBOs and Primary Care Provider partners in ***meaningful relationships.***

A key goal is **aligning incentives** among CBO – PCP partners to achieve quality goals and reduce avoidable unplanned care.

Food Insecurity

Housing Instability, Homelessness, or Housing Inadequacy

Transportation Insecurity

Final Thoughts

Recognize and reduce health disparities

Despite health care improvements, racial and ethnic minorities continue to experience lower quality of care and worse health outcomes.

Health disparities are rooted in social, economic, environmental, and geographic conditions.

Multiple strategies, from policies to programs, are required in order to reduce or eliminate health disparities.

- Embedding equity data into all metrics and programs
- Screening, identifying, and overcoming social challenges
- Building a CBO network
- Provider – CBO – MCO partnerships
- Value-based payment incentives to promote health equity

UPMC Health Plan Can Help

UPMC can assist you in meeting members' social needs

Prescription for Wellness:

Enables providers to ***prescribe*** the following:

- Health coaching
- Lifestyle management
- Chronic condition management
- Behavioral health support
- Pharmacy consultations
- **Social services referral**

Operationally friendly for providers:

- Order entry in EpiCare or the Provider Online Portal
- Health Plan ***"fills"*** the Rx by ***engaging*** the patient
- Providers receive ***feedback*** on the patient's progress

Physician prescription of health coaching leads to a 3-fold greater engagement and improvement in outcomes*

Call UPMC Special Program Assistance Line (SPA) at **1-855-772-8762**

Email SPA at healthplanspaef@upmc.edu

Enter an order for Prescription for Wellness

Email Prescription for Wellness at RxforWellness@upmc.edu

Contact your practice-based case manager, if assigned

*Hammonds T, Keyser DJ, Parkinson MD, Peele PB, Wheeler JR. Impact of physician referral to health coaching on patient engagement and health risks An observational study of UPMC's Prescription for Wellness. Am J Health Promot. 2020 May;34(4):366-375.