



**SCHOOL WELLNESS PROGRAM (SWP)
Quarterly Reporting Data Elements: Definitions
Effective October 1, 2022**

Content Relevant to SWP and Flint Nursing Models

Number of Unduplicated Users (clients) by Demographic Designation per quarter

Definition of an Unduplicated User:

An unduplicated user is an individual who has presented themselves to the health center (SWP) for service with the main medical provider (licensed registered nurse) or the main mental health provider (minimum Master's prepared and licensed mental health provider), and for whom a record has been opened. Opening a record includes documenting an assessment, developing a treatment plan/plan of care, follow-up/evaluation as appropriate to visit; and, for mental health only, also includes making a diagnosis. Once per year, the user is counted to generate the number of unduplicated clients utilizing the health center (SWP) services for that year.

<u>Age Range</u>	Female	Male	Total Clients
0-4 years			
5-9 years			
10-17 years			
18-21 years			

Number of Unduplicated Users (clients) by Race per quarter

White
Black or African-American
Asian
Native Hawaiian or Pacific Islander
American Indian or Alaskan Native
More than One Race

Number of Unduplicated Users (clients) by Ethnicity per quarter

Arab/Chaldean
Hispanic or Latino

Total Visits by Provider Type per quarter

***Nurse Provider** includes the licensed registered nurse (RN)

***Mental Health Provider** must be minimum Master's prepared and licensed

***Other Providers** may include nurse practitioner (NP), physician assistant (PA), physician, registered dietician (RD)/nutritionist, health educator, oral health provider or another provider. Visits with other providers can only be counted after the client has been established as an SWP user per the definition.

***Telehealth Visits** include when the SWP provides this service and user is established per definition, this definition applies to telehealth visits with both the nurse provider and the mental health provider.

Definition of a Visit:

A visit is a significant encounter between an SWP provider and a new (unduplicated) user or established (duplicated) user. Each visit should be documented as appropriate to the visit and provider. Opening a record includes documenting an assessment, developing a treatment plan/plan of care, follow-up/evaluation as appropriate to visit; and, for mental health only, also includes making a diagnosis. A user will likely have multiple visits per year.

Specified Number of Tests and Positives: Medical Tests

Reported on a quarterly basis:

***Pregnancy Tests** – Overall number of pregnancy tests conducted during the quarter due to possible pregnancies; number of positive pregnancy tests during the quarter

***Chlamydia and Gonorrhea** – Overall number of Chlamydia and Gonorrhea tests conducted during the quarter; number of positive Chlamydia and Gonorrhea diagnoses during the quarter

***HIV Tests** – Overall number of anonymous and confidential HIV tests conducted during the quarter; number of positive HIV tests during the quarter

Immunizations

Reported on a quarterly basis:

***Immunizations** – Number of immunizations (shots) billed to Medicaid Health Plans (MHPs) per quarter

***Immunizations** – Overall number of immunizations (shots) provided during the quarter, regardless of payor

RN Services

Types of Nursing Services per quarter

Definition of Nursing Contact: Nursing contact includes services that occur within a visit (including telehealth/telemedicine) that is documented in the client's record.

- **Care Coordination:** The number of nursing contacts with parent(s)/guardian(s), primary care providers, social services, local health departments, community agencies, school staff and specialty care providers (including but not limited to cardiologists, pulmonologists, otolaryngologists, optometrists, etc.) for facilitating client care coordination. Examples of health issues benefiting from care coordination include communicable disease management, medication management, immunizations, chronic condition management (e.g., asthma, diabetes, epilepsy, allergies, and other non-listed chronic conditions).
- **Client Education/Guidance and Counseling:** The number of nursing contacts with a client to share information in a one-on-one setting about a specific disease process, medications, prevention, health promotion, etc. AND/OR the number of nursing contacts that provide advice or information, direction, or something that instructs a client with the purpose of resolving a problem or helping in decision making (one contact can include multiple topics but should only be reported as one contact).
- **Communicable Disease Management:** The number of nursing contacts (community, local health department, primary care provider, school staff, parent/guardian) to decrease and manage the incidence and prevalence of contagious disease (according to the [MDHHS](#) Reportable Diseases in Michigan by Condition) and other contagious diseases/conditions such as lice, scabies, bed bugs, tinea that have been seen by the SWP nurse provider or verified by lab testing/reporting.
- **Crisis Intervention:** The number of nursing contacts with a client for short-term counseling to help the client cope with a crisis and resume a state of functioning comparable to or better than the pre-crisis state (i.e., death affecting client, family crisis, school emergency).
- **Medication Administration:** The number of nursing contacts with clients for the administration of prescription and non-prescription drugs.

Note: Some of the SWP sites have indicated they provide care coordination for clients outside of the client visit. For example, contacting the parent or primary care provider. If your site would like to try and capture this type of data, consider using the GAS to report these numbers under optional – Objective 6 and/or 7 described below.

Optional ~ Objective #6: Identify the number of coordination of care visits with the parent/guardian that occur outside of a visit.

Definition: The number of nursing contacts with parent(s)/guardian(s) to obtain health information and/or coordinate care. This could include medication management, initiating a health care plan/emergency care plan for chronic conditions, wellness checks (following up with parent/guardian about a student's physical exam status), communicable disease follow-up and immunization education.

Optional ~ Objective #7: Identify the number of coordination of care visits with outside providers that occur outside of a visit.

Definition: The number of nursing contacts with (primary care providers, social services, local health departments, and/or other community agencies, school staff and, specialty care providers including but not limited to cardiologists, pulmonologists, otolaryngologists, optometrists, etc.) for facilitating client care coordination. Examples of health issues benefiting from care coordination include communicable disease management, medication management, immunizations, chronic condition management (e.g., asthma, diabetes, epilepsy, allergies, and other non-listed chronic conditions).

Chronic Condition Management

For this measure, report the YTD NUMBER each quarter. Each quarter, your data should be at least equal to, but likely greater than, the previous quarter. Note that this is different than the quarterly reporting elements, where data is reported by quarter for that specific quarter only.

***Number of Unduplicated Clients Seen with a Diagnosis of a Chronic Condition(s):**

Report the unduplicated number of clients seen at the SWP who have a diagnosis of a chronic disease, including allergies, asthma, diabetes, epilepsy, and/or obesity

***Number of Unduplicated Clients Seen with a Diagnosis of a Chronic Condition(s) who have Documented Evidence of a Case Management Plan(s):** Report the number of clients seen with a diagnosis of a chronic disease who have an individualized care plan(s) and/or action plan(s) which may include annual medication monitoring.

QUALITY INDICATORS REPORT DEFINITIONS

For each of the following Quality Measures, report the YTD NUMBER each quarter. Each quarter, your data should be at least equal to, but likely greater than, the previous quarter (with the exception of immunizations, which may fluctuate depending on client age and where clients are in a series). Note that this is different than the quarterly reporting elements, where data is reported by quarter for that specific quarter only.

Number of Unduplicated Clients with an Up-to-Date Risk Assessment /

Anticipatory Guidance – Report the number of clients that are complete with an annual risk assessment or anticipatory guidance (elementary age clients). This may include clients that are UTD because they completed the risk assessment/anticipatory guidance in a previous fiscal year but are being seen in the SWP in the current fiscal year.

Number of Unduplicated Clients Ages 10 – 21 Years with an Up-to-Date Depression Screen Using Either Risk Assessment or a Specific Depression Screening Tool

Report the number of unduplicated clients up to date with depression screening. This information could come directly from a risk assessment, so the number screened (flagged) for depression may equal or be very close to the number of risk assessments. (Note this is not the same as a depression **assessment** conducted by a provider.) Do not double count clients who were screened (flagged) for depression using a risk assessment, and who also completed a specific depression screening tool (e.g., Beck's, PHQ-9, etc).

Number of Clients Age 12 and Up with a Positive Depression Assessment (Diagnosis of Depression)

Report the number of clients (age 12 and older) with a diagnosis of depression according to the score on the depression screening tool **and** psychosocial assessment by the provider. Exclude the following: a) those who are already receiving documented care elsewhere, and b) those who are referred out of the CAHC for treatment.

Number of Clients Age 12 and Up with a Diagnosis of Depression who have Documented, Appropriate Follow-Up

Report the number of clients from the denominator who receive treatment at the CAHC who have all of elements of an appropriate follow-up plan: a) had a psycho-social assessment completed by 3rd visit (includes suicide risk assessment/safety plan), b) had a treatment plan developed by 3rd visit, c) treatment plan reviewed @ 90 days (for those on caseload for 90+ days), and d) screener re-administered at appropriate interval to determine change in score.

MEDICAID OUTREACH REPORT DEFINITIONS

Area 1: Medicaid Outreach and Public Awareness – Outreach activities include: 1) informing eligible or potentially eligible individuals about Medicaid and how to access Medicaid services; or 2) describing the services covered under a Medicaid program as part of a broader presentation e.g., within the context of a health education program. Examples include Medicaid literature distribution; using print or electronic media, school announcements to promote Medicaid covered services; and participating in health fairs where such literature is distributed.

Area 2: Facilitating Medicaid Eligibility Determination - activities that demonstrate facilitating Medicaid eligibility are those where the SWP staff assists in the Medicaid enrollment process by enrolling uninsured clients onsite at the SWP. **Report the following:** 1) unduplicated number of uninsured clients who access the SWP during the year, broken down by quarter; 2) unduplicated number of uninsured clients assisted onsite with completion of the Medicaid application; and 3) unduplicated number of uninsured clients that your SWP assisted onsite with enrollment that were successfully enrolled.

Note: The number of uninsured clients assisted onsite with completion of the Medicaid application, should not be greater than the number of uninsured clients who access the SWP during the year. The number of clients that your health center assisted onsite with enrollment that were successfully enrolled, should not be greater than the number of clients that were assisted onsite with completion of the Medicaid application.

HEALTH EDUCATION REPORT DEFINITIONS

Health education includes group education experiences – not individual education, individual therapy or group therapy – delivered by the SWP in any setting (classroom, health center, after school, assemblies, etc.). Health education programming is designed to help children and youth improve their health by increasing knowledge, influencing attitudes, and changing behaviors.

Report the duplicated number of participants in group health education.

The number of participants reported here are separate from those that participated in evidence-based programs included in the Goal Attainment Scaling report.

Health education categories include:

***General Medical/Chronic Disease** includes health education that focuses on the increased knowledge and management of chronic conditions (e.g., asthma, diabetes, food allergies, etc.) as well as general education around the management of acute illnesses, injuries, flu, infection and other medical conditions or diagnoses. Examples include education on asthma management, vaccine-preventable disease, oral health, sports injuries, etc. Report the number of participants per quarter that received general medical/chronic disease health education.

***Health Promotion and Risk Reduction** includes health education and behavior modification education for the purpose of promoting health and/or reducing risk behavior that is not specifically addressed in another area. This includes topics like smoking cessation, alcohol, tobacco and other drug prevention, stress management, personal hygiene, healthy diet (if not related to a chronic medical condition), etc. Report the number of participants per quarter that received health promotion and risk reduction health education.

***Mental Health/Social-Emotional Health** includes health education designed to facilitate the best possible social and emotional well-being of youth, including topics such as suicide prevention and bullying. Report the number of participants per quarter that received mental/social-emotional health education.

***Sexual/Reproductive Health** includes health education about sexual and reproductive health including sexually transmitted infections (including HIV), pregnancy prevention, reduction of sexual risk-taking behavior and healthy relationships. Report the number of participants per quarter that received sexual/reproductive health education.

SWP NETWORK REFERRALS

Referrals Received and Referrals Provided - Referrals are duplicated, meaning that a single client may be referred for services in multiple categories e.g., one client may be referred to a general medical provider and to school staff for support services. Non-SWP services/providers are counted as referral sources. Parents or patients are not considered to be referrals. SWP staff (nurse and mental health provider) are not considered to be referral sources for each other, though they can refer clients to the Network HUB.

General Medical – referrals provided to/received from a medical provider for reasons other than reproductive health.

Oral Health - referrals provided to/received from an oral health provider.

Psychiatric/Intensive Mental Health – referrals provided to/received from a psychiatrist or other mental health specialist.

Reproductive Health - referrals provided to/received from reproductive health services/reproductive health service provider.

Other – referrals provided to/received from other services or service providers that do not fall into the above categories e.g., support services, etc. Includes referrals provided to school staff for purposes other than mental health services (i.e. school counselor, school social worker, etc.).

If referrals are received from outside sources (including the sponsoring agency), please track the name of referral source and the number of referrals from each source. Report this information in narrative format so that determinations can be made regarding any future referral reporting categories.

SWP ANNUAL REPORTS

Diagnoses and Procedure Codes and Frequency

Reported on annual basis only, as requested:

**Mental Health Problem Diagnoses* - Top 5 diagnoses from the mental health provider

**CPT codes* – Top 5 CPT codes from the mental health provider - both the code and the name of procedure

Billing Report Definitions

Reported on annual basis only by those SWPs that are billing for services AND only as requested:

Enter the **dollar amount in claims submitted for services** provided during the current fiscal year (October 1- September 30), regardless of whether or not the claims were paid during the fiscal year.

Enter the **dollar amount received in revenue** during the current fiscal year (October 1- September 30), regardless of whether or not revenue resulted from claims filed during the fiscal year.

For each of these entries, you will be entering data by:

Medicaid Health Plan/Medicaid (from a drop-down menu)
Commercial
Self-Pay
Other

Note that the Estimated Percent of Claims Paid and Unpaid (based on dollar amount, not on number of claims) and Payor Mix will be auto-totaled.

5 Most Common Reasons for Rejection of Submitted Claims

Select the five most common reasons for rejection of submitted claims from the dropdown menu according to best-fit category.