

Adirondack Health Institute

Lead • Empower • Innovate

Practice Transformation Workgroup November 2020

PRESENTED BY: Louann Villani, RN, AHI Brenda Stiles, RN, Adirondacks ACO

Nov. 19, 2020





- I. Opening/Welcome Louann Villani
- II. PCMH: Have you submitted?
- III. SDoH coding initiatives Ann Hutchison
- IV. Coding: "Painting the Patient Picture" Brenda Stiles
- V. Future topics
- VI. Open forum



NCQA PCMH and QPASS Updates



- How many have submitted?
- Any questions?
- QPASS still has issues
- Zoom accounts



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NYS Health Homes SDoH Screening Process

PRESENTED BY:

Ann Hutchison

Director, Health Home and Care Management

Nov. 19, 2020



Health Home Overview

- ✓ Medicaid Eligible
- ✓ Chronic Conditions
- ✓ Behavioral Health
- ✓ Social Problems
- ✓ High Utilizers





Health Home Overview

Health Home Network

- ✓ Clinical Providers
- Behavioral Health
 Providers
- ✓ Social Services Agencies and CBOs





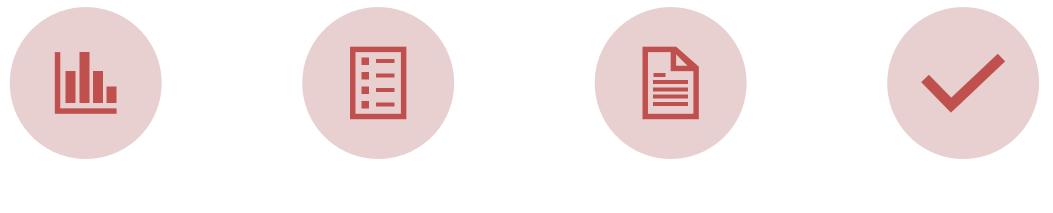
AHI Health Home Network

- AHI's Community Access Team
- Alliance for Positive Health
- Behavioral Health Services North
- Capital District Psychiatric Center
- Catholic Charities Care Coordination
- Champlain Valley Family Center
- Citizen Advocates
- Community Connections of Franklin Co.
- Essex County Mental Health Services
- Families First in Essex
- Fort Hudson Care Management
- Glens Falls Hospital
- Hamilton County Community Services
- HCR Care Management
- Hudson Headwaters Health Network

- Mental Health Association in Essex County
- Salvation Army
- St. Anne Institute
- St. Lawrence Psychiatric Center
- Transitional Services Association
- United Helpers Mosaic
- University of Vermont Health Network - CVPH
- Warren-Washington Association for Mental Health
- Lakeside House (onboarding)
- People, Inc. (onboarding)



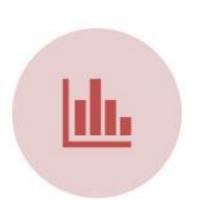
Care Coordination Process



ASSESS DOCUMENT REFER CLOSE LOOP







- Comprehensive Assessment is completed for every patient/member;
- Identifies clinical, behavioral and social problems;
- ASSESS Assessment includes 10 SDoH questions;
 - Subset of CMS tool.





5 Core SDoH Domains

Housing instability;

Food insecurity;

Transportation problems;

Utility help needs; and

Interpersonal safety.





Care Coordination Process



- Problems are documented;
- ICD10 and Snomed Codes used;

DOCUMENT

• Tied to member/patient care plan.



Examples of Codes



Housing Instability (ICD 10 Code)

- Homeless (Z59.0)
- Inadequate housing (Z59.1)
- Food Insecurity (SNOMED Code)
 - Food insecurity (733423003)
- Transportation Problems (SNOMED Code)
 - Lack of access to transportation (713458007)
- Utility Help Needs (ICD 10 Code)
 - Problem related to housing and economic circumstances unspecified (Z59.9)
- Interpersonal Safety (SNOMED Code)
 - Victim of physical abuse (225824003)
 - Victim of emotional abuse (419916003)







- Problems are referred to a service provider;
- Service providers are inventoried in care management record system;

REFER

• Care Manager tracks the status of the problem and the referral.









- Both the status of the problem and the referral are followed until closed;
- Contact is monthly (at minimum);

CLOSE LOOP

 Member discharges with connections to needed services. For more information about the Health Home program, or to learn how to make a referral, please contact:

ahutchison@ahihealth.org or healthhome@ahihealth.org



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Painting the Patient Picture

November 2020



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Why Focus on Risk Coding Opportunities?

- Risk Coding allows you to 'Paint' a complete "Patient Picture"
 - Present the complexity of the patient
 - Identifies gaps in care providing a comprehensive view of a patient's health
- Coding determines the complexity of the patients that you are serving:
 - Severity of illness
 - Family history of
 - Past medical history
 - Social Determinants of Health
- Risk Coding is not a one-time process:
 - Patient conditions change annually therefore capturing new conditions or those that have ceased must be done annually.
 - Each year is a clean slate must recode conditions you know have existed for years
 - Diagnosis codes impacting a particular visit but also any diagnosis code associated with the person (chronic conditions, permanent conditions)



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Z-Codes

- Z-Codes represent factors influencing health status and contact with health services.
- Z-Codes may be assigned as appropriate to further explain the reason for presenting for healthcare services.
- Z-Codes commonly used:
 - Contact/Exposures
 - Status
 - History (of)
 - Breast Cancer Z85.3
 - Screenings
 - Screening for depression Z13.89 (encounter for screening for other disorder)
 - Newborns and infants
 - Social Determinants of Health (Z55-Z65)
 - Z55-Problems related to education and literacy
 - Z56-Problems related to employment and unemployment
 - Z57-Occupational exposure risk factors
 - Z59-Problems related to housing and economic circumstances
 - Z60-Problmes related to social environment



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Case Study #1

- 65-year-old male in for a routine visit
- History of diabetes, retinopathy, hyperlipidemia
- BP 120/75, Ht. 67 in., Wt. 280, BMI 43.9
- Labs: A1C 6.5
- Social history recently retired from his 40-year career as an accountant for a manufacturing company, states difficulty with the change.





Case Study # 1 Coding Scenarios

Scenario # 1

Diagnosis	ICD-10 Code	HCC	HCC Weight
Type 2 diabetes, uncomplicated	E11.9	18	0.104
Obesity	E66.0		0
Retinopathy	H35.109		0
Hyperlipidemia	E78.5		0
Total			0.104

Scenario # 2

Diagnosis	ICD-10 Code	HCC	HCC Weight
Type 2 Diabetes, with unspecified retinopathy	E11.329	18	0.318
Morbid Obesity	E66.01	22	0.273
BMI 40 - 44.9	Z68.41	22	0
Hyperlipidemia	E78.5		0
Problems with adjustment to life cycle transitions	Z60.0		0
Total			0.591



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Case Study #2

68-year-old female with Type 2 Diabetes and polyneuropathy. She expresses how expensive her medications are and difficulty meeting monthly expenses. History of great toe amputation 5 years ago and personal history of uterine cancer with complete hysterectomy as well. Patient continues to smoke ½ pack per day. She has a history of depression. Screened with PHQ-9 and the score was 12. Complaints of increased fatigue, lacking desire to participate in family events and activities since the loss of her sister.





Case Study # 2 Coding Scenarios

Scenario # 1

Diagnosis	ICD-10 Code	HCC	HCC Weight
Type 2 Diabetes, uncomplicated	E11.9	18	0.104
Nicotine Dependent	F17.209		0
Major Depressive Disorder, recurrent episode unspecified	F32.9		0
Total			0.104

Diagnosis	ICD-10 Code	нсс	HCC Weight
Type 2 Diabetes, with polyneuropathy	E11.42	18	0.318
Nicotine Dependent	F17.209		0
Acquired loss of unspecified great toe	Z89.419	189	0.588
Major Depressive Disorder, recurrent, moderate	F33.1	58, 59	0.395
Disappearance and death of family member	Z63.4		0
Personal History of malignant neoplasm of uterus	Z85.42		0
Total Hysterectomy	Z90.710		0
Low Income	Z59.6		0
Total			1.301

Scenario # 2



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Case Study 3

- 45-year-old male in for annual wellness visit.
- Hypertension monitors several times a week and takes medication.
- History of alcoholism reports he remains abstinent; continues counseling to address issues regarding past childhood abuse -which led to removal from parent's home because of alcohol/drug addiction of the parents.





Case Study # 3 Coding Scenarios

Scenario # 1

Scenario # 2

Diagnosis	ICD-10 Code	HCC	HCC Weight
Hypertension	110	0	0
Total			0

Diagnosis	ICD-10 Code	HCC	HCC Weight
Hypertension	110	0	0
Alcoholism, remission in	F10.21	55	0.383
Personal history of unspecified abuse in childhood	Z62.819		0
Alcoholism and drug addiction in family	Z63.72		0
Total			0.383



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December Topic: Looking Ahead

➢ 2021 PCMH updates

- ➤ Tracker grid updates
- ≥ 2020 metrics
- ➢ Risk coding







• AHI Website: <u>https://ahihealth.org/</u>

*Recordings and slides from meeting are posted on the site.

- AHI COVID newsletter Monday afternoons
- AHInformer Every other Thursday newsletter
- ADK ACO website: https://www.adirondacksaco.com/
- Adirondacks ACO monthly newsletter

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