Adirondack Health Institute

Lead • Empower • Innovate

Practice Transformation Workgroup
December 2020

PRESENTED BY:

Louann Villani, RN, AHI

Brenda Stiles, RN, Adirondacks ACO

Dec. 17, 2020

Agenda

I. Opening/Welcome – Louann Villani;

II. PCMH: 2021 criteria, QPASS opportunities, Tracker Grid Updates;

III. Hixny: Data Aggregator Update/Documentation Opportunities – RuthAnn Craven;

IV. Future Topics:

Risk Coding;

I. Open Forum (10 minutes).

Reminders and Updates

- Most NYS practices submitting for this year were due to submit 12/1/20;
- Practices may have less than a year to submit for 2021 due to the 2020 submission extension;
- Anyone with a reporting date in 2021 should be reviewing the v6 and 2021 annual reporting standards and guidelines publications;
- Major changes include the ability to use telehealth to meet certain requirements and an updated QI worksheet for annual reporting.

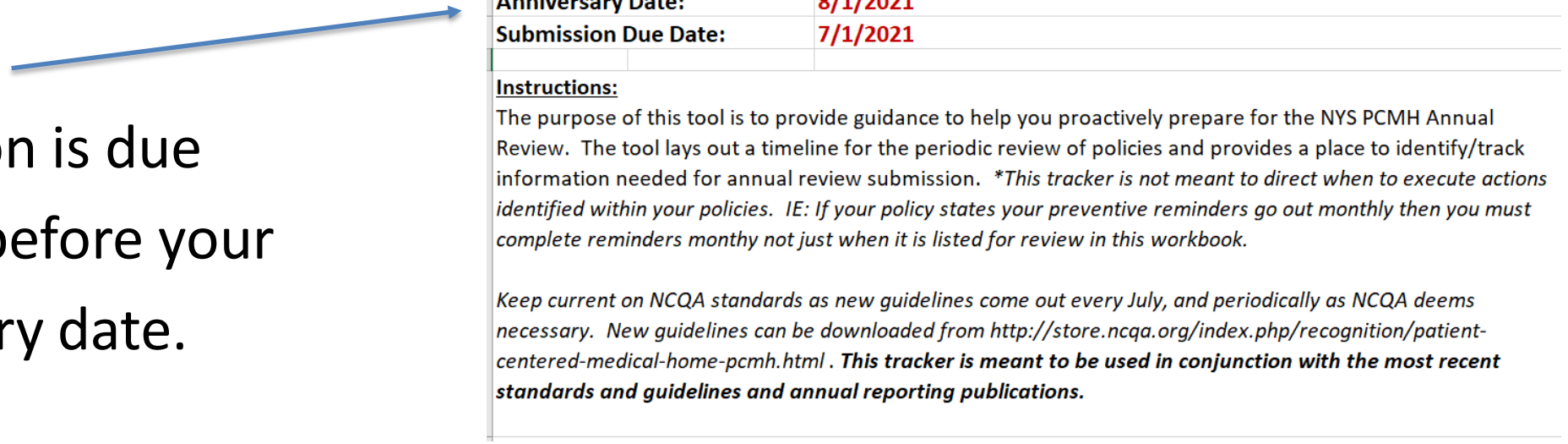
Evidence Reminders

- Should be from within the past 12 months and after your last submission;
- Should be redacted so that it does not include PHI;
- Should follow the rules for site-specific vs. shared.

PCMH Tracker Updates

In response to questions regarding what to do during annual reporting, the tracker has been updated to help guide the process.

Submission is due a month before your anniversary date.



2021 PCMH Annual Review Monthly Tracker

Practice Name:	**Sample Practice**
Electronic Medical Record:	**EMR**
Anniversary Date:	**8/1/2021**
Submission Due Date:	**7/1/2021**

Instructions:

The purpose of this tool is to provide guidance to help you proactively prepare for the NYS PCMH Annual Review. The tool lays out a timeline for the periodic review of policies and provides a place to identify/track information needed for annual review submission. **This tracker is not meant to direct when to execute actions identified within your policies. IE: If your policy states your preventive reminders go out monthly then you must complete reminders monthy not just when it is listed for review in this workbook.*

Keep current on NCQA standards as new guidelines come out every July, and periodically as NCQA deems necessary. New guidelines can be downloaded from http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh.html . ***This tracker is meant to be used in conjunction with the most recent standards and guidelines and annual reporting publications.***

PCMH Tracker Updates

A new column has been added to help practices keep track of what to do once they have obtained or updated their evidence.

Core/ NYS/ Elective	AR	Concept	Can Combine with	Description	Documented Process/ Evidence	What to do with the Documented Processs/Evidence	Shared/ Site-Specific	Person Responsible
Core		**TC 01**		**PCMH Transformation Leads**	☐ Detail about Clinician Lead ☐ Detail about PCMH Manager	Transforming Practices: Upload to QPASS or share during virtual review Annual Reporting: Review, update if needed, and save with audit files	Shared	

What you do with your evidence may be different for each criteria. For example, some NYS criteria will be awarded as transfer credit after you submit them for the first time, and you will simply need to save the evidence in your own files thereafter. Others, like CC21A and QI19, will need to be **submitted each year**.

PCMH Tracker Updates

Core/ NYS/ Elective	AR	Concept	Can Combine with	Description	Documented Process/ Evidence	What to do with the Documented Processs/Evidence	Shared/ Site-Specific
Core	**AR-CM 1** **AR-SD 1 (D only)**	CM 01		**Identifying Patients for Care Management**	☐ Documented Process OR CM 03	Transforming Practices: Upload to QPASS or share during virtual review Annual Reporting: Review, update, and save with audit files. Answer questions in QPASS.	Shared
Core	**AR-CM 1: Data**	CM 02*		**Monitoring Patients for Care Management**	☐ Report	Transforming Practices: Upload to QPASS or share during virtual review Annual Reporting: Review, update, and save with audit files. Answer questions in QPASS and provide report numbers.	Site-Specific
NYS (2)	**AR-CM 1**	CM 03*		**Comprehensive Risk-Stratification Process**	☐ Evidence of Implementation	Transforming Practices and NYS year 1: Upload to QPASS or share during virtual review (Transforming only) Annual Reporting: Review, update, and save with audit files	Shared
Core	**AR-CM 2**	CM 04*		**Person-Centered Care Plans**	☐ RRW or ☐ Report AND ☐ Patient Examples	Transforming Practices: Upload to QPASS or share during virtual review Annual Reporting: Review, update, and save with audit files. Answer questions in QPASS.	Shared-Patient Examples Only

QPASS Resources

- NCQA has some resources to help you navigate QPASS
  - What's new with the Q:
    - Free;
    - ~1.5 hours;
    - Upgrades to the system have occurred since the webinar/course was first developed, but much of the functionality remains the same.
  - Ask a question feature within QPASS:
    - Use if you are experiencing technical problems;
    - Can also be used for general program and content questions.
  - QPASS Q&A sessions:
    - Held periodically by NCQA via zoom when there are updates;
    - Come prepared with questions and a basic familiarity with the system.

https://www.ncqa.org/education-training/webinars-and-seminars/patient-centered-medical-home-pcmh/?pg=2

Improving Quality Scores
(EHR Documentation Tips)

RUTHANN CRAVEN, MS, PCMH CCE
Manager of Programs and Outreach

Hixny®

NCQA DAV
“Lessons Learned”

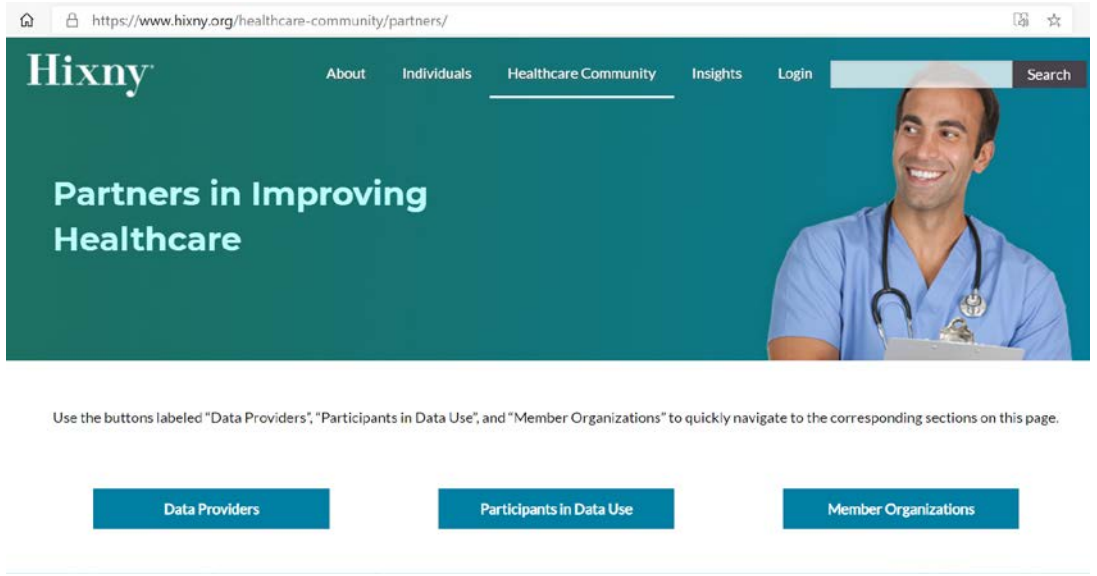
NCQA PSV Opportunities

Data Sources

- 118 Pass
- 102 Pass – Omission
- 8 Pass – Minor Error
- 14 Not Approved
- 31 Could Not Be Submitted
- 25 New Integrations (Since Validation)

Data Contribution

- Must to connected to, and contributing data to Hixny
  - Data Contributors
  - Participants in Data Use
- CCD in C-CDA version R2.1 preferred
  - eCW upgrade
  - Athenahealth C-CDA version 1.1
  - C32 format cannot be validated



EHR Documentation Basics

Structured Data Fields

Standard Codes

PSV Validated Data

Critical Data Elements – Always Reconciled

- Procedure, Assessment and / or Encounter section completed, depending on EMR and visit type
  - Procedure Code (Px) / Diagnosis Code (Dx)
  - Procedure Code (Px) / Diagnosis Code (Dx) Description
- Patient Name
- Patient DOB
- Provider Name
- Facility Name / OID
- Date of Service (DOS)

NOTE: All other data elements are considered non-critical

Critical Data Elements – Reconciled When Applicable (depends on visit type)

- Admit Date
- Discharge Date
- Immunization Code / Description
- Lab Test
- Lab Results
- Blood Pressure
- Height
- Weight
- BMI

Some Examples of Non-Critical Data Elements

- Smoking status
- Social History
- Allergies
- Medication list (not part of DAV program)

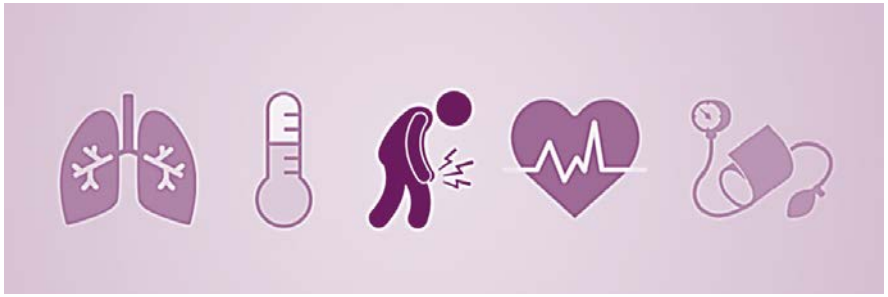
EHR Documentation

Lab Results

- LOINC® codes rather than “local” codes
  - LOINC® (Logical Observation Identifiers Names and Codes) is a set of universal names and ID codes for identifying laboratory tests in electronic laboratory report messages.
  - It was designed to facilitate the exchange and correlation of results for clinical care, outcomes management, and research.
- Medent “Laboratory test code finding” not specific enough
- For medical record documentation submitted for PSV, include lab results if discussed with the patient on the date of service
  - if not in progress note, include screenshots from EHR – CCDs are NOT accepted as medical record documentation

Vital Signs

- LOINC® codes rather than “local” codes
- Pull vitals into the CCD (for example, if a nurse rooms the patient and records vitals – how do they get into the CCD?)
  - Medent – pull nurse note into the progress note
- For medical record requests for PSV, provide documentation for ALL vital signs for the date(s) of the encounter



Diagnoses

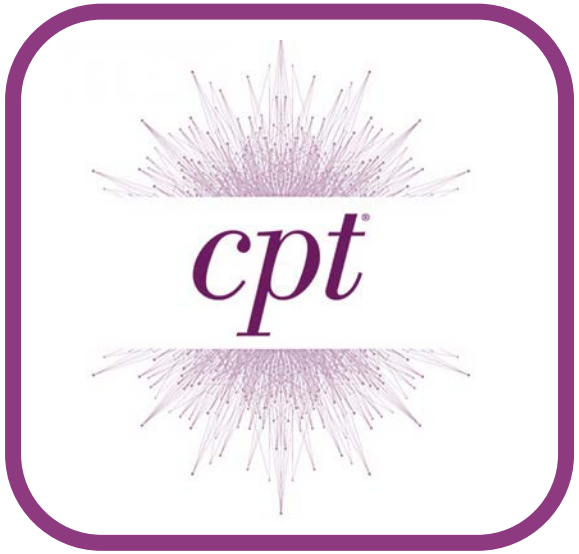
- ICD10 (or SNOMED) codes and descriptions
- Diagnoses must be included in the CCD as either a) encounter diagnoses or b) problems
    - Medent assessments should be added to problem list

Acute conditions should be marked as "resolved" at a subsequent visit

    - past illness vs. present illness; acute vs. chronic conditions
- All diagnoses included on CCD must also appear on progress note provided as medical record documentation for PSV
- Looking ahead: consider use of Z-codes for **social determinants of health**
    - Z59.0 Homelessness
    - Z59.4 Lack of food & safe drinking water

Procedures

- CPT codes and descriptions
- Looking ahead: consider documenting **psycho social screenings** as procedures
  - AIMS Center Basic Coding for Integrated Behavioral Health Care
  - CDPHP's 2020 Effectiveness Tool for Providers



Smoking Status

What should be included in a tobacco cessation EHR template?

Including tobacco use status as a vital sign provides an opportunity for office staff to begin the process. Status can be documented as:

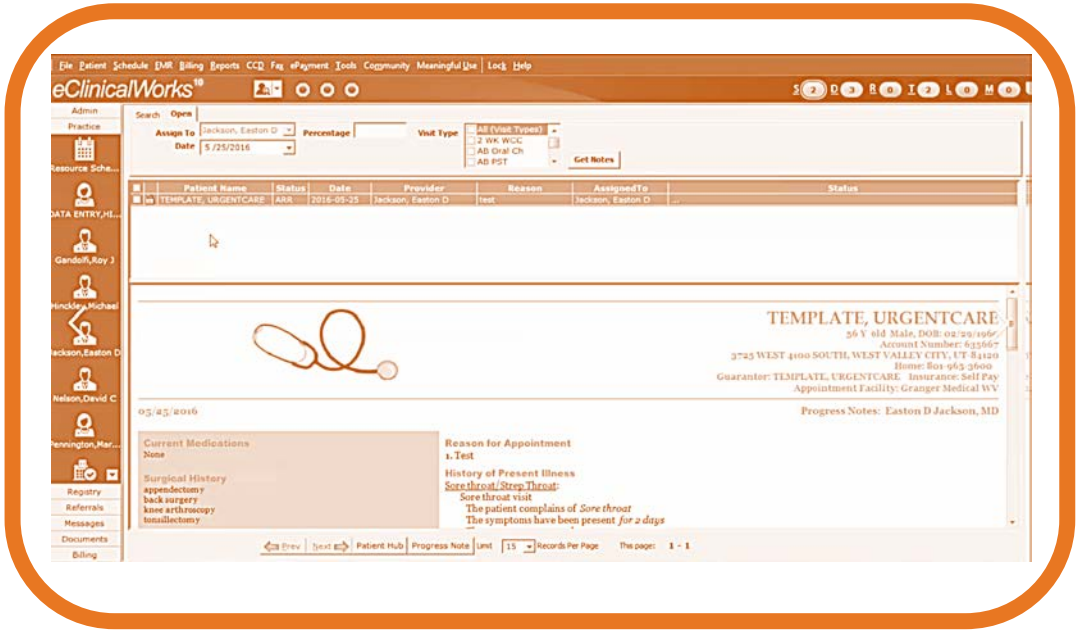
- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Unknown if ever smoked

A complementary field can document secondhand smoke exposure: current, former, or never, and work, home, or social.

- Do not use default of "Unknown" (PointClickCare)
- Update status in progress note as applicable
- Record one status at a time (Medent – multiple statuses appearing)

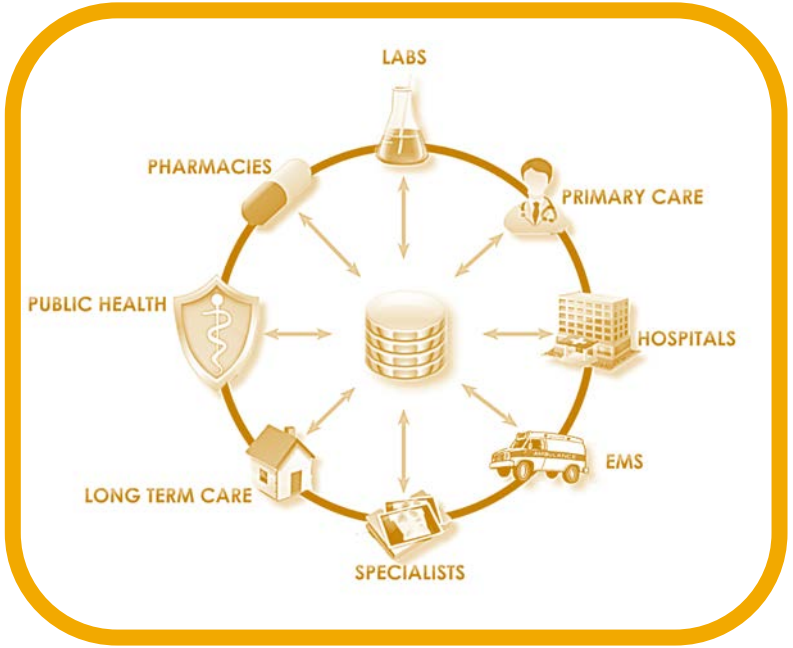
Medical Record Documentation

Progress Notes



- Practice name & address on progress note
- Provider e-signature matches CCD
- Medent family accounts
- Telehealth
  - Telehealth visits require both audio and visual
  - If vitals are self-reported by patient, progress note must indicate that
  - Rx renewal requires documentation, including appropriate diagnosis

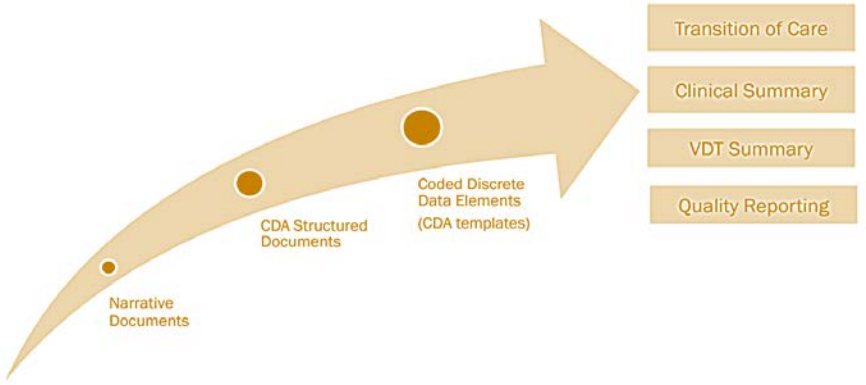
Sharing Care Plans



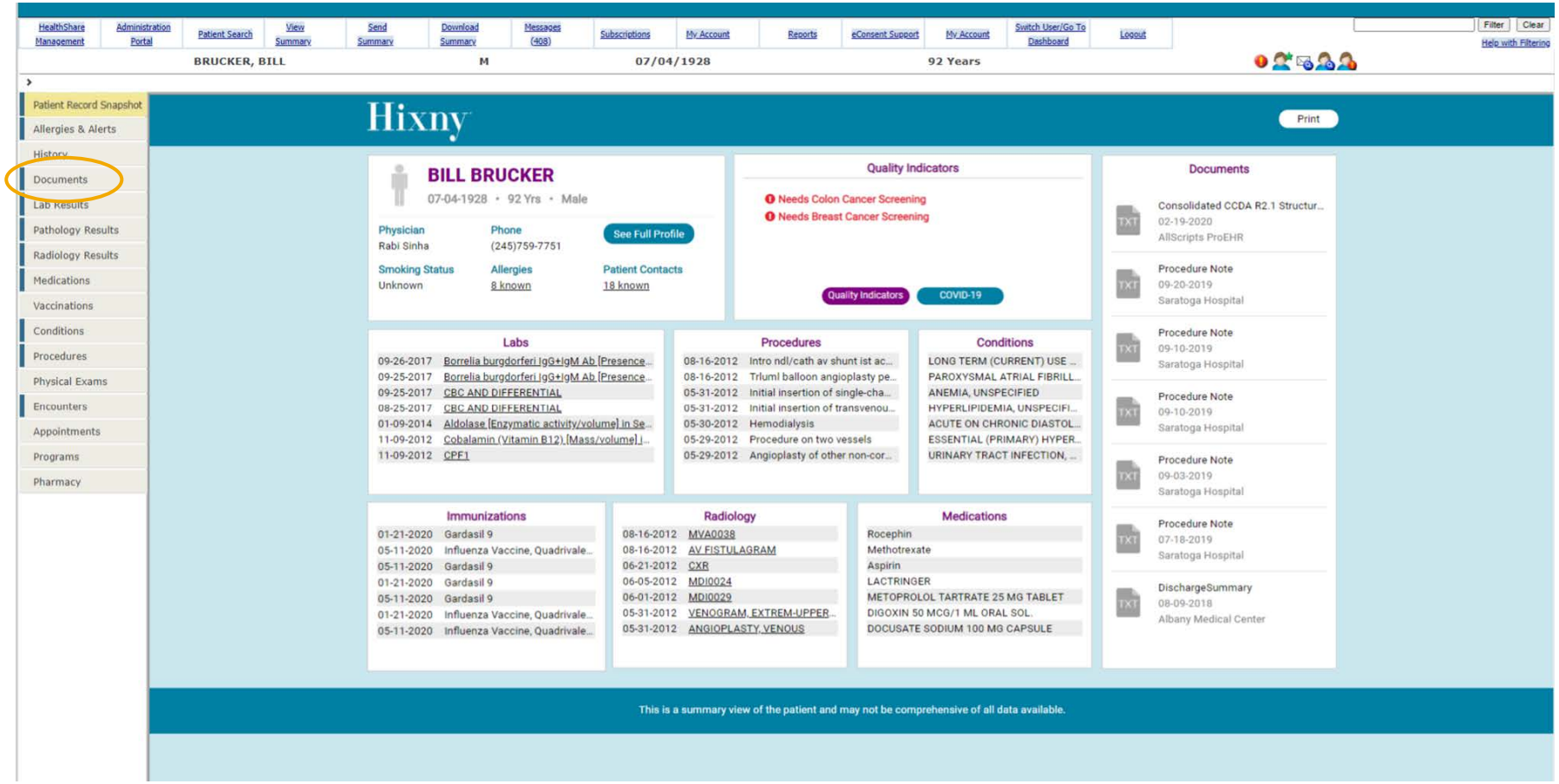
Practices Send Data to Hixny Two Ways

- Continuity of Care Document (CCD)
  - HL7 Clinical Document Architecture (C-CDA) standard
  - Core data set of the most relevant information for one healthcare practitioner to forward to another practitioner to support continuity of care
  - Provides a “snapshot in time” containing clinical and demographic data for a specific patient

- Unstructured Documents
  - Progress notes
  - Nurse notes
  - Clinical visit summaries
  - Care plans

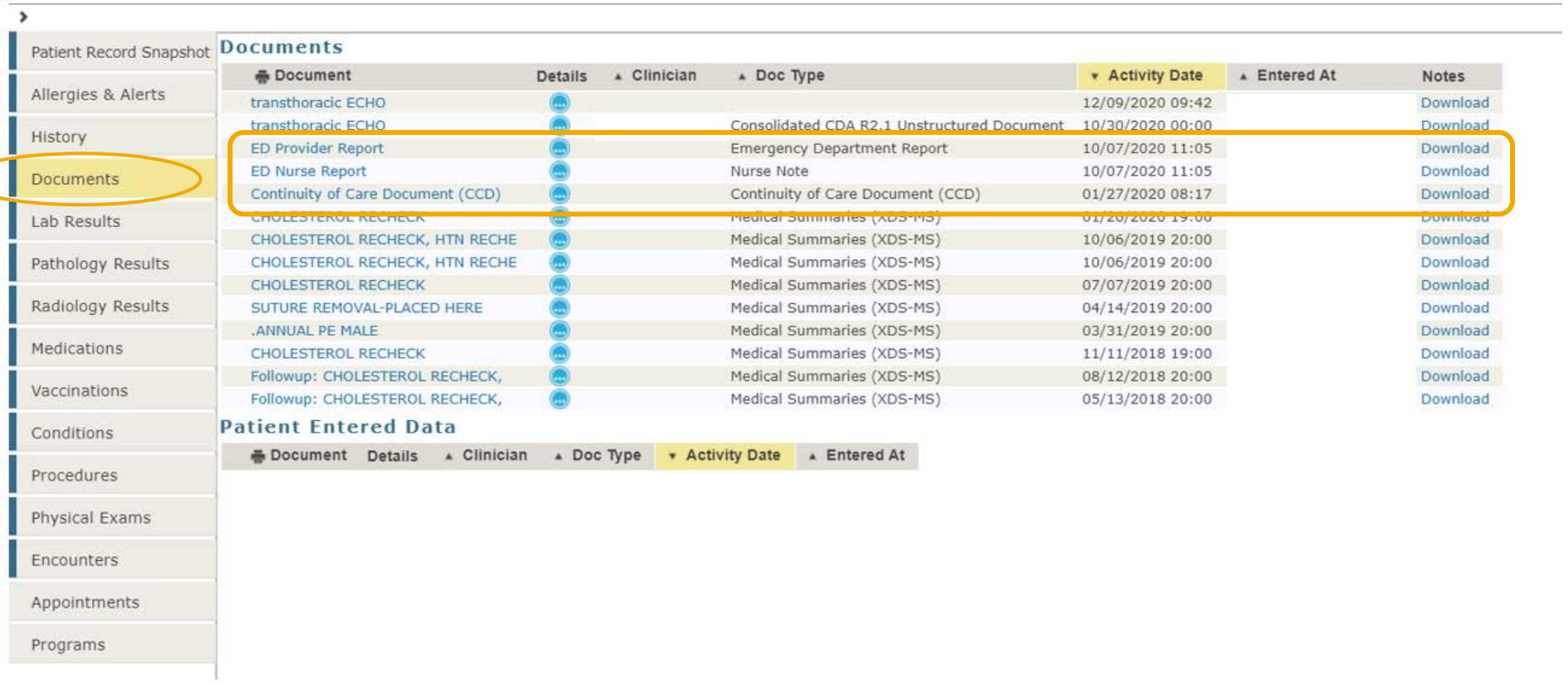


Practices Send Data to Hixny Two Ways



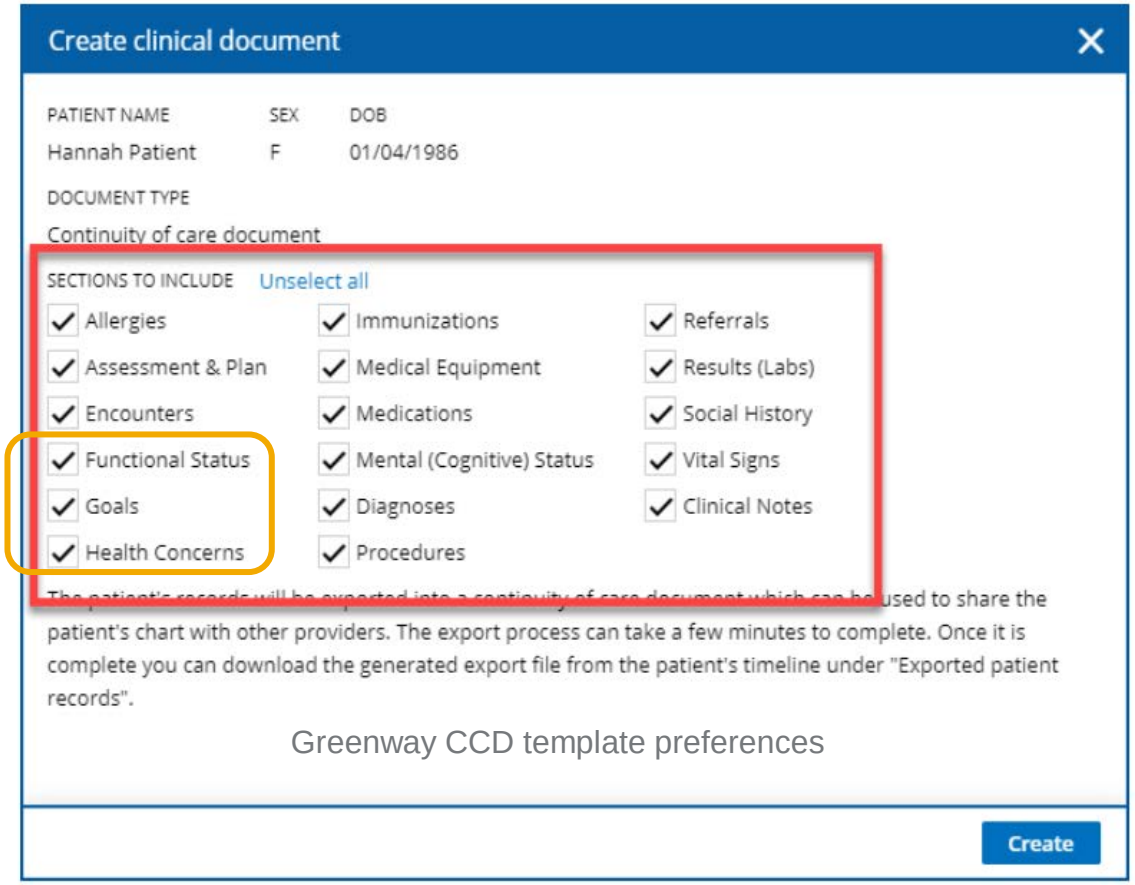
- Some structured data from the CCD parses to various tabs of the portal (eg, problems, diagnoses, medications, lab results, etc.) or is integrated into your practice EHR.
- Care plans are unstructured and only available as documents – either the CCD or a separate unstructured document.

CCDs and Unstructured Documents

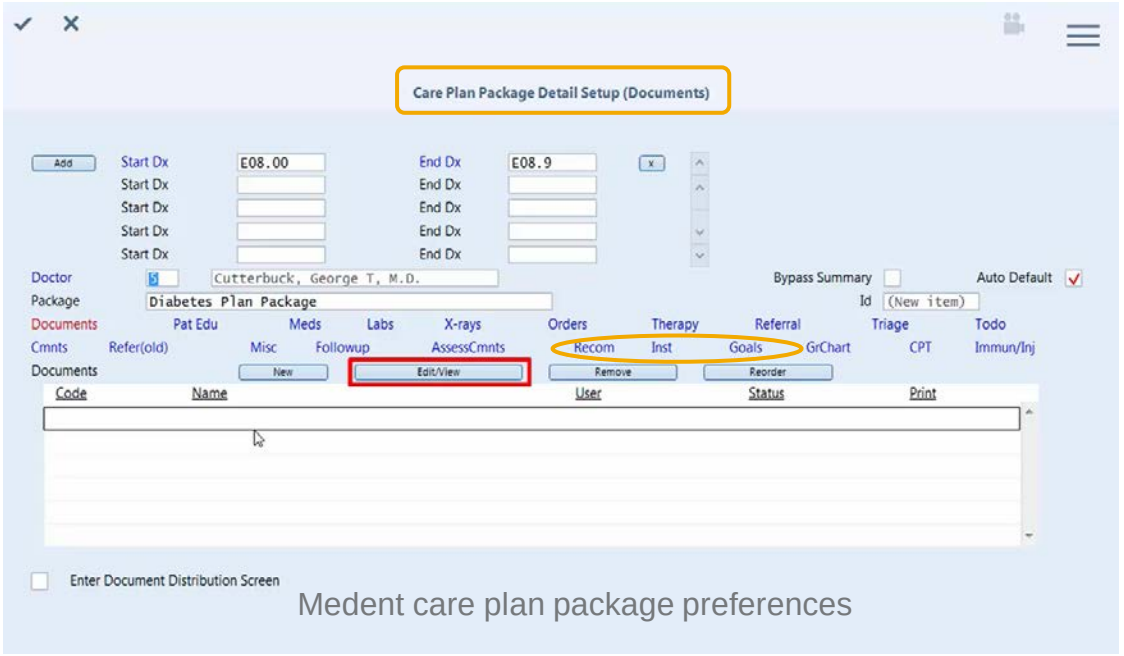


Care Plans in CCDs

- Update template & set preferences - contact your EHR vendor



Greenway CCD template preferences



Medent care plan package preferences

Example: Care Plan in CCD

Goals Section

Goal	Start Date
Move out of the city of Albany	November 08, 2019
Support member in achieving the goals and objectives to reach overall health	September 05, 2019
Attend scheduled medical appointments	September 05, 2019
Take medications as prescribed	September 05, 2019
Keep chemical dependency service appointments/attend program as scheduled	June 25, 2019
Take medications as prescribed	June 25, 2019
Call doctor or care coordinator when symptoms return, flare up, or I feel worse	June 25, 2019
Keep mental health appointments/attend program as scheduled	June 25, 2019
Care Coordinator will provide assistance to member around identified needs	June 25, 2019

Interventions Section

Planned Intervention	Status	Date
Work with HATAS to find new apartment	Active	November 08, 2019
Update CC on status of applications for apartments	Active	September 30, 2020
Request assistance from CC as needed with apartment applications	Active	September 30, 2020
identify resources and link member with community supports	Active	September 05, 2019
assist and coordinate with any discharge planning	Active	September 05, 2019
coordinate and collaborate with care team and providers, as needed	Active	September 05, 2019
assist member in meeting needs that are unmet	Active	September 05, 2019
Request assistance from Care Coordinator if needed to schedule appointments	Active	September 05, 2019
Be sure to get all testing done prior to next appointment	Active	September 05, 2019
Prepare a list of questions and concerns prior to your appointment.	Active	September 05, 2019
Notify your Care Coordinator on the outcome of your appointment and when a follow up is scheduled .	Active	September 05, 2019
Be sure to get all ordered labs done prior to your next appointment.	Active	September 05, 2019
Request automatic refills from pharmacy	Active	September 05, 2019
Know your triggers	Active	June 25, 2019
Request assistance from Care Coordinator if needed to schedule appointments	Active	June 25, 2019
Arrange transportation in advance, if you need assistance contact your Care Coordinator	Active	June 25, 2019
Prepare a list of questions and concerns prior to your appointment.	Active	June 25, 2019
Review medications with Care Manager. (ask about medication reconciliation)	Active	June 25, 2019
Request refill reminders form pharmacy.	Active	June 25, 2019
Know signs and symptoms of your chronic condition.	Active	June 25, 2019
Prepare a list of concerns and questions for provider		
Carry a list of contact numbers with you to include after hour crisis lines.		
Keep medication in a lockbox, out of sight		
Establish relationship with Parsons		
Request assistance from Care Coordinator if needed to schedule appointments		
Attend appointments as scheduled		
If an attendant is needed notify your coordinator as soon as possible.		
Prepare a list of questions and concerns prior to your appointment.		
Look into CDL classes for training		
complete plan of care		
Member will reach out to CC to request assistance with making appointments with providers		
Care Coor will arrange transport		

Completed Intervention	Status	Date
Arrange transportation in advance, if you need assistance contact your Care Coordinator	Completed	March 27, 2020
Review medications with Care Manager. (ask about medication reconciliation)	Completed	March 27, 2020
Request refill reminders form pharmacy.	Completed	March 27, 2020
complete plan of care	Completed	February 07, 2020
Care Coor will arrange transport	Completed	February 07, 2020

Health Status Evaluations/Outcomes Section

Item	Outcome	Date
Take medications as prescribed	Completed	March 27, 2020

Examples: Care Plan in Progress Note

Assessment #1: I25.10 Atherosclerotic heart disease of native coronary artery with
Care Plan:

Comments : Right now he appears to be stable he follows up with Dr. will be seeing him in September will be having blood work at that time as well.

Follow Up : 6 months.

Assessment #2: E78.5 Hyperlipidemia, unspecified
Care Plan:

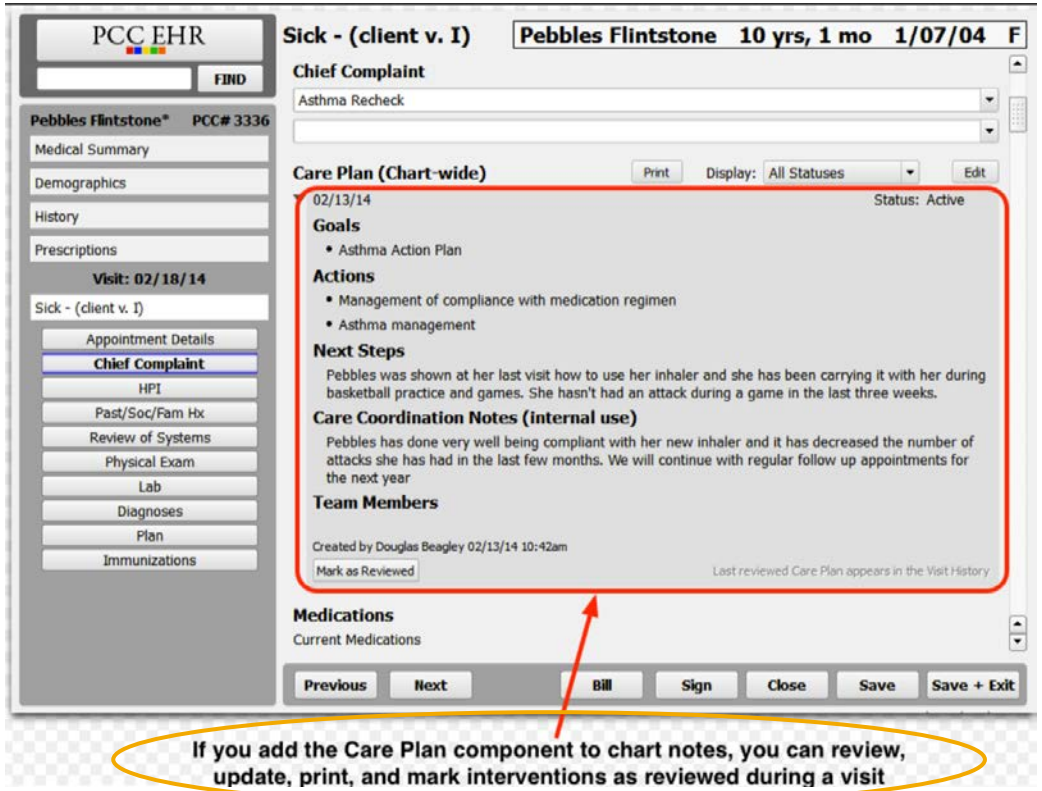
Comments : Pt is going to get blood work for Dr ınd continue on his atorvistatin 80 mg per day

Assessment #3: N40.0 Benign prostatic hyperplasia without lower urinary tract sym
Care Plan:

Comments : Patient has annual visits with his urologist, but he is not currently taking any medication for it at this time. He seems to avoid adequately.

Assessment #4: M48.00 Spinal stenosis, site unspecified
Care Plan:

Comments : Patient no longer is followed by Dr. ıd he would not continue to prescribe the diclofenac for him so I did order it for him, 75 mg once a day but he only takes it on occasion when he gets a flare and doesn't use it on any routine basis.



Example: Care Plan in Nurse Note

Forest Family Practice – Nurse Note

Patient: **Samson Smith** Gender: **M** DOB: **11/14/1954** Acct. # **8765**

PCP: **Doctor Primary, MD**

Nurse Note: **3 Month Follow Up Call w Patient in Care Management**

AAFP Risk: **5**

Hospital Utilization in Past 6 Months: **No admissions; 2 ED visits**

Do you have any issues with getting to and from your doctor's appointments? ☑ No ☐ Yes
If "Yes" was selected, please select this button and check all that apply:
Date: 02/19/2020
Was the patient queried about smoking behavior? ☑ Yes ☐ No

Does the patient currently smoke? **Smoking**: Patient is a current smoker, smokes some days.

Nurse note completed by: **Jane Nurse, RN, CCM**

Chronic conditions: coronary artery disease & hypercholesterolemia

Progress on Goals:

- Patient following low fat/low sodium diet, and walking routinely (joined a mall walking group 2x/week in winter; discussed this is only 120 min/week whereas goal is 150 min/week).
- Patient reports weight of 194 lbs. (up 2 lbs.)
- Patient not willing to consider smoking cessation at this time.
- Continuing to take statins; has adequate refills and no problem affording medication. Rx are delivered to home due to COVID pandemic.
- Lab results from 01/15/20 at Community Hospital: Total cholesterol 257 mg/dl (down from 263 mg/dl); LDL 143 mg/dl; HDL 38 mg/dl; Triglycerides 163 mg/dl
- Schedule next follow up call for 05/19/20.

QUESTIONS

Thank You

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2021 Topics: Looking Ahead

- Risk coding
- Suggestions ????

Additional Resources

- AHI website: https://ahihealth.org/
  - *Recordings and slides from meeting are posted on the site.
- AHI COVID newsletter – Mondays
- AHInformer newsletter – every other Thursday
- ADK ACO website: https://www.adirondacksaco.com/
- Adirondacks ACO newsletter - monthly

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