Adirondack Health Institute

Lead • Empower • Innovate

Practice Transformation Workgroup March 2021

PRESENTED BY:

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Brenda Stiles, RN, Adirondacks ACO

March 18, 2021

Agenda

I.	Opening/Welcome – LVillani	
II.	PCMH: Update – LVillani	5 mins
III.	Hixny and HTN and A1C metrics -RACraven	15 mins
IV.	Quality Metrics and eCQM Planning Grid– BStiles, LVillani	15 mins
V.	Practice Input and Feedback	15 mins
VI.	Open Forum	5 mins

PCMH Update

- Have you started the Tracker Grid ?
- New year – Forever Coding and Annual Wellness Visits
- Any questions?

eCQMs – Controlling Hypertension & Blood Sugar (A1c) Poor Control

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

Hixny®

Objectives

- eCQM Measure Specification
- Share Practical Tools To Address Hypertension and Blood Sugar Control
- Documentation & Health Information Sharing
- Pro Tips to Improve Performance

e-CQM Measure Specification

CMS 165v9

- Controlling High Blood Pressure
- Percentage of patients 18-85 years of age
- Who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and
- Whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period

Exclusions

- Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant
- Patients with a diagnosis of pregnancy
- Patients in hospice care
- Patients 66 years of age and older who are living long term in an institution for more than 90 consecutive days
- Patients 66 years of age and older with advanced illness and frailty

Numerator Compliance

- Blood pressure readings performed by a clinician or a remote monitoring device are acceptable.

- Do not include BP readings:
  - Taken during an acute inpatient stay or an ED visit
  - Taken on the same day as a diagnostic test or therapeutic procedure requiring a change in diet or change in medication on or one day before the day of the test, with the exception of fasting blood tests
  - Reported by or taken by the member.

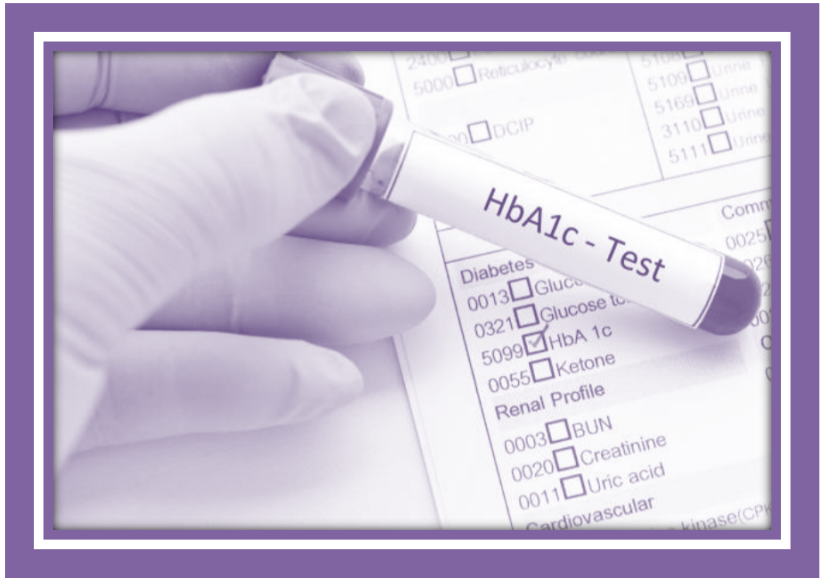
Numerator Compliance (continued)

- If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled".
- If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

CMS 122v9

- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
- Percentage of patients 18-75 years of age
- With diabetes
- Who had hemoglobin A1c > 9.0% during the measurement period

- *** lower score is better



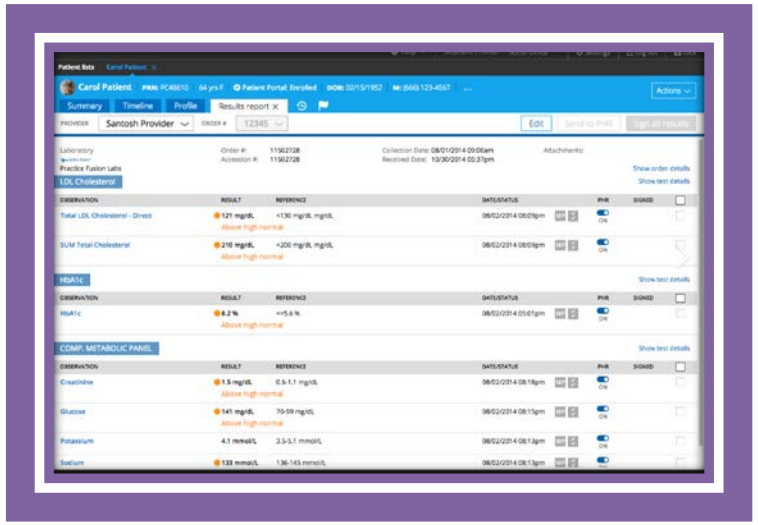
Exclusions

- Patients in hospice care
- Patients 66 years of age and older who are living long term in an institution for more than 90 consecutive days
- Patients 66 years of age and older with advanced illness and frailty

Numerator Compliance

- If most recent HbA1c level >9%, is missing or if there are no HbA1c tests performed and results documented during the measurement period.
- If the HbA1c test results is in the medical record, the test can be used.
- Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included for this measure.
- Patients with a diagnosis of secondary diabetes due to another condition should not be included.

- ***** lower score is better**



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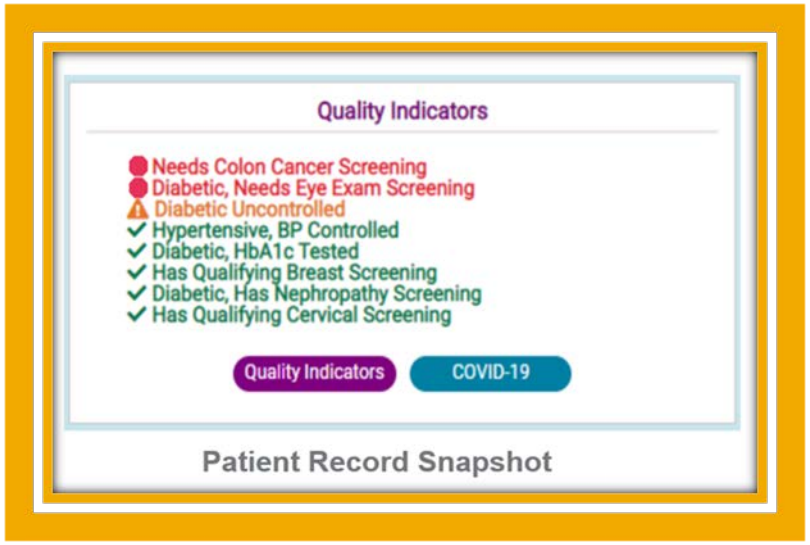
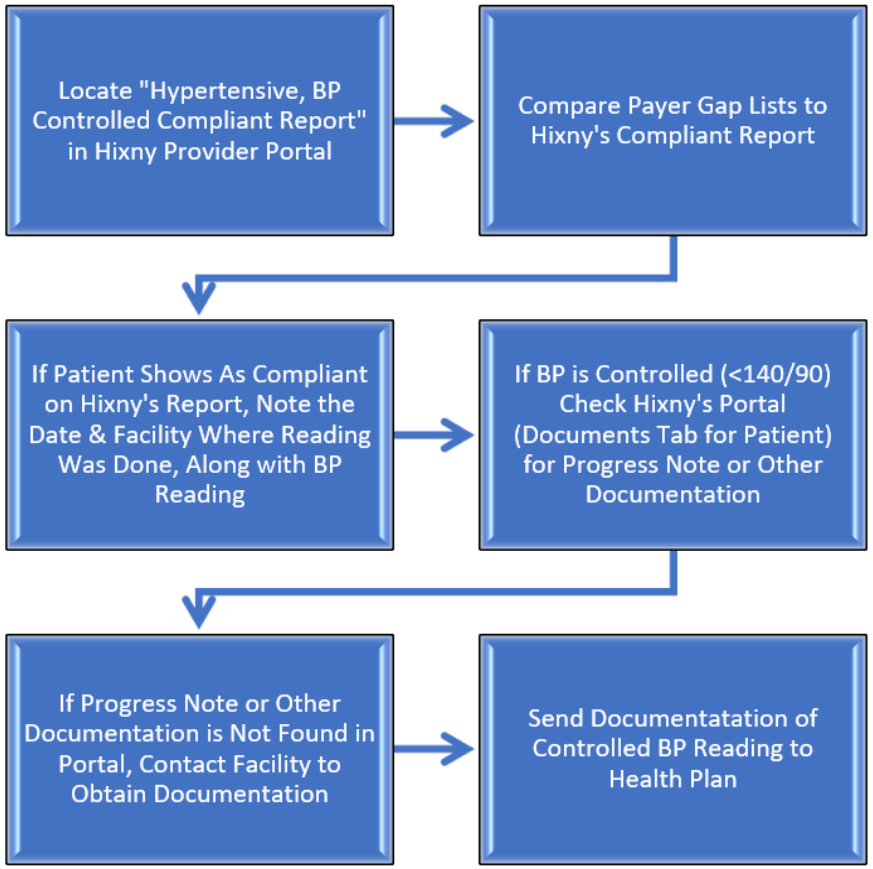
Tools for Controlling Hypertension and Blood Sugar in Primary Care



Hixny's "Hypertensive, Needs BP Gap List" Workflow for Care Coordinators

1. Locate "Hypertensive, Needs BP Gap List" in Hixny Provider Portal
2. For Each Patient On List - Call Patient
3. Schedule Office Visit Prior to 12/31
4. Inquire About Barriers That May Prevent Patient from Keeping Appointment, And Resolve
5. During Patient's Visit, Document Blood Pressure Reading
6. If Blood Pressure is Controlled (< 140/90) Send Documentation to Health Plan
7. If Blood Pressure is Not Controlled, Schedule Follow Up Visit for Patient
8. Contact No Shows to Reschedule, If Applicable

Hixny's Hypertensive, BP Controlled Compliant Report Workflow for Care Coordinators



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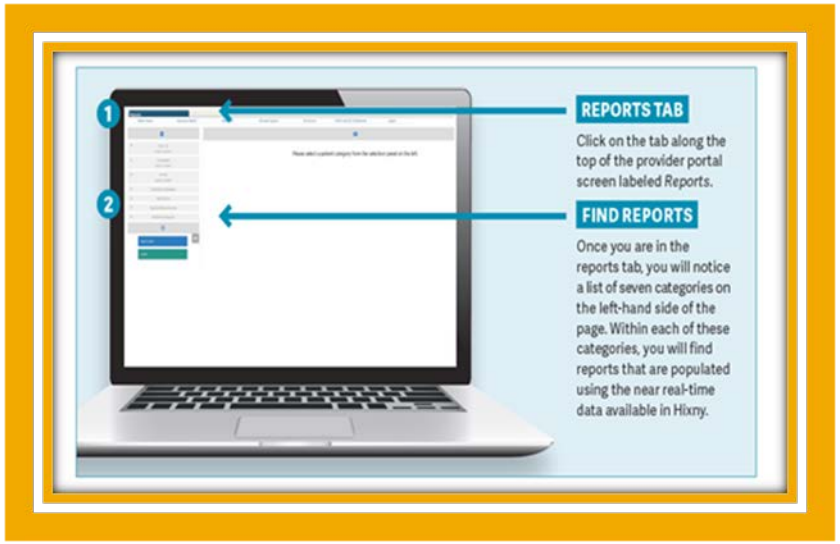
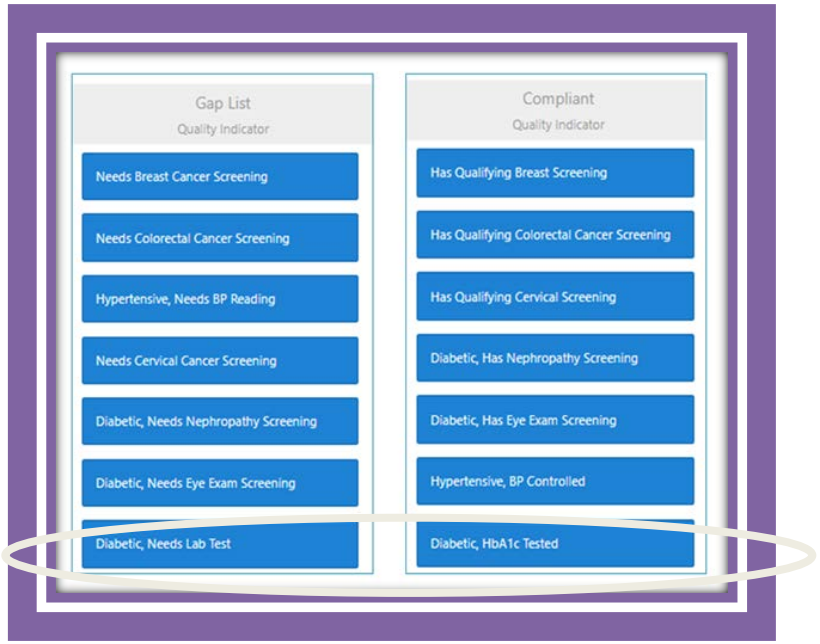
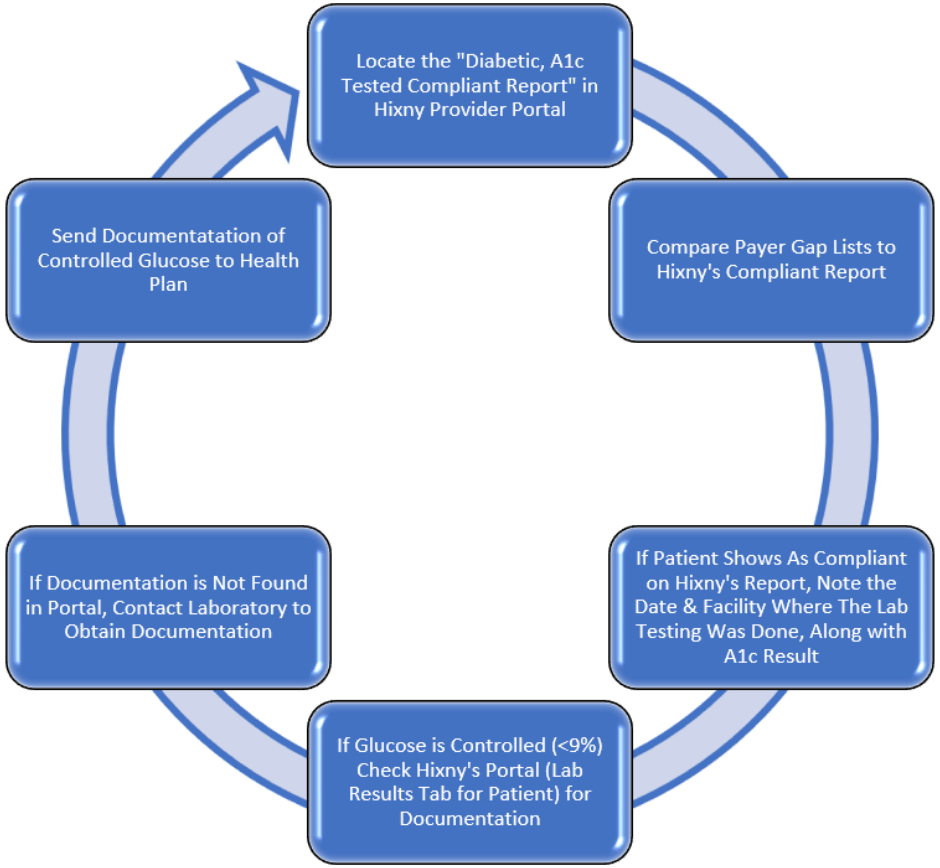


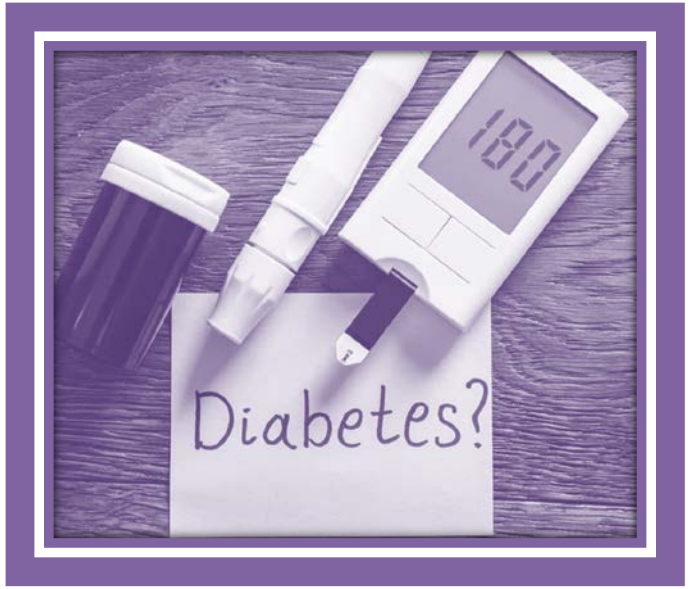


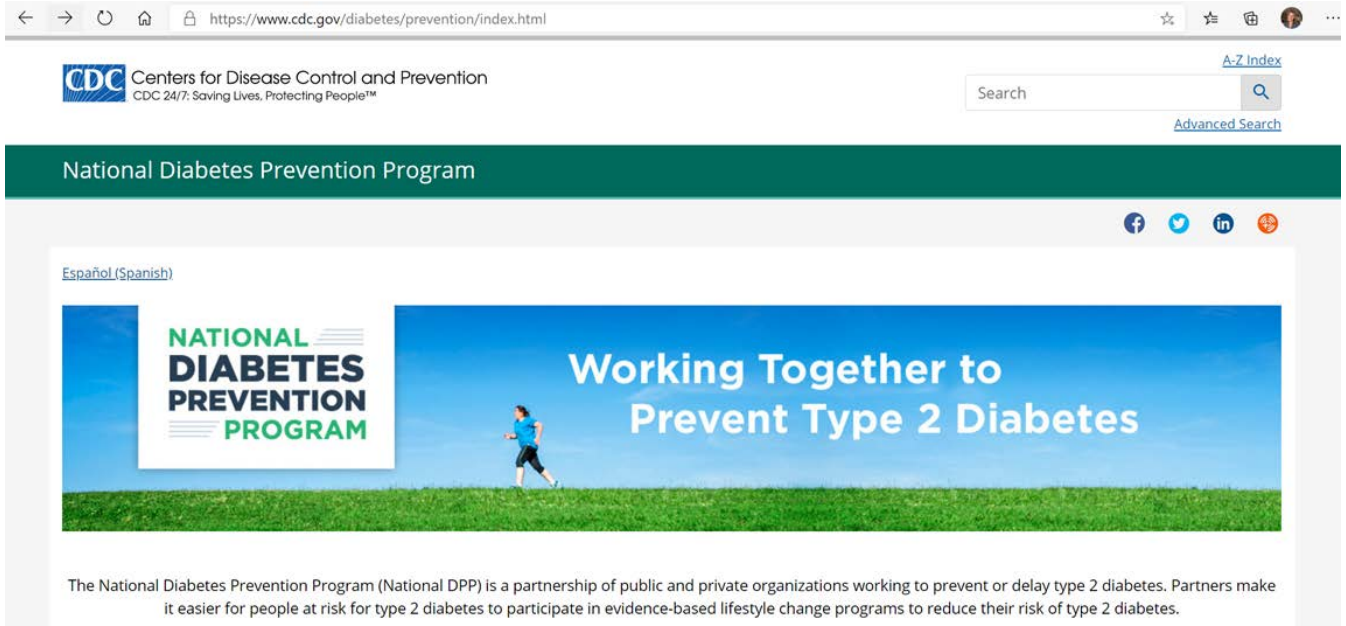
Hixny's "Diabetes, Needs Lab Test Gap List" Workflow for Care Coordinators

- Locate the "Diabetes, Needs Lab Test Gap List" in Hixny Provider Portal
- For Each Patient On List - Call Patient
- Send the Patient an Order for Bloodwork and/or Schedule Office Visit Prior
- Inquire About Barriers That May Prevent Patient from Keeping Appointment (if applicable), And Resolve
- During Patient's Visit, Review the HbA1c Result
- If Glucose Level is Controlled (< 9%) Maintain Documentation to Send to Health Plan
- If Glucose is Not Controlled, Educate on Lifestyle Changes & Schedule Another Test in 3 Months
- Contact No Shows to Reschedule, If Applicable

Hixny's "Diabetic, A1c Tested Compliant Report "Workflow for Care Coordinators







Documentation and Health Information Sharing

EHR Documentation Basics

Structured Data Fields

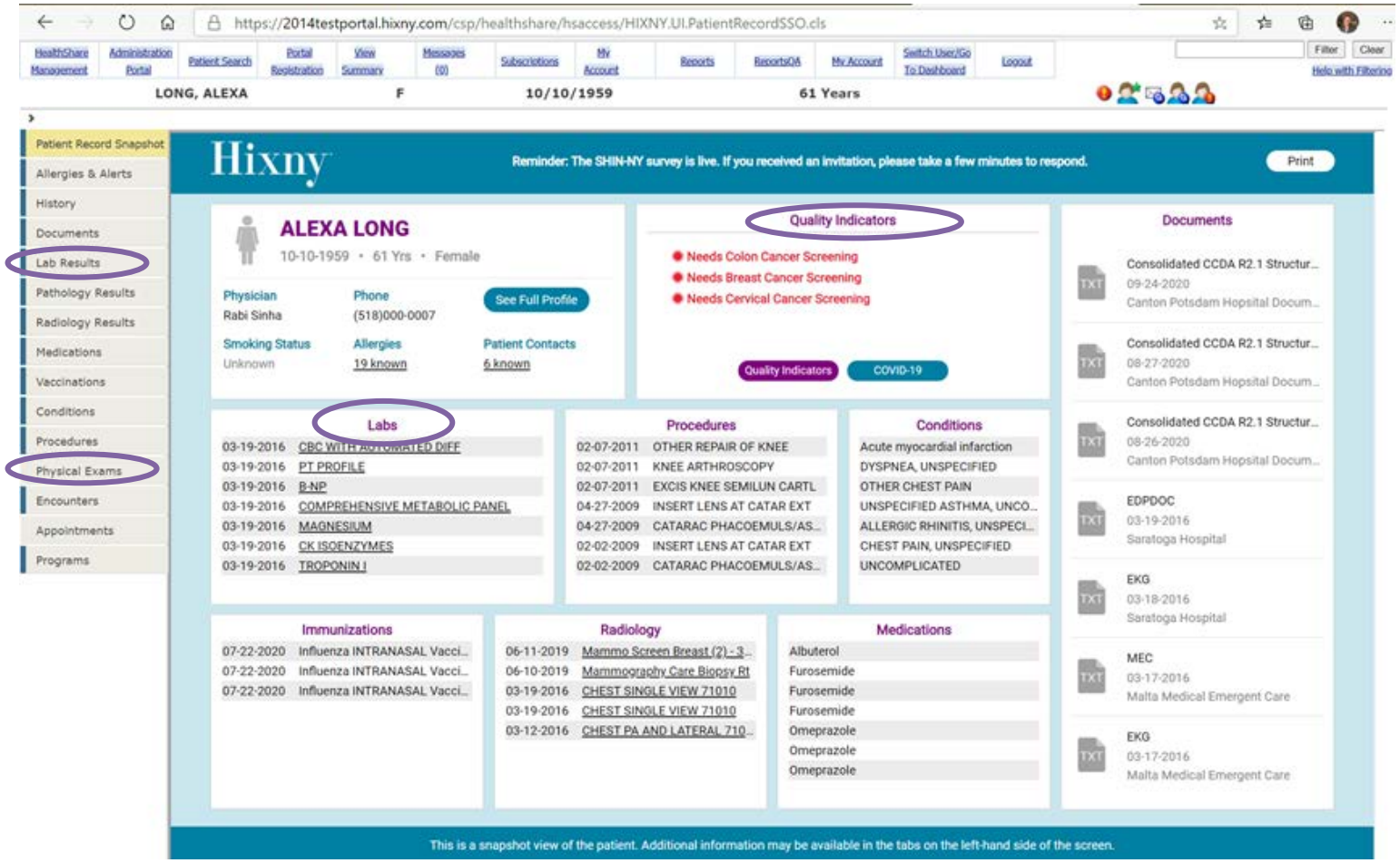
- Check with your EHR vendor regarding how to document to ensure the screening and results is shared with the health information network

Standard Codes

- Level 2 CPT - Procedures section of Portal
- LOINC codes - History section of Portal
- SNOMED codes - Conditions section of Portal

Provider Portal

- Allows extended care team to quickly view depression screening results, to inform



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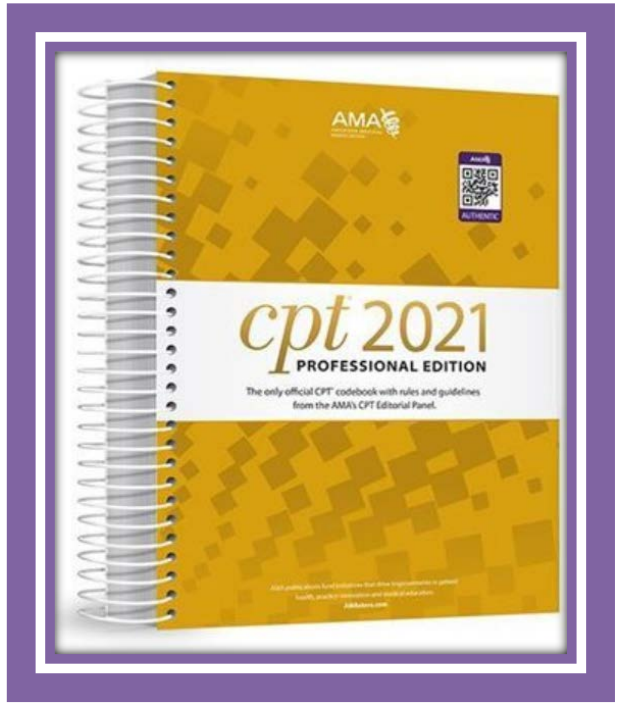
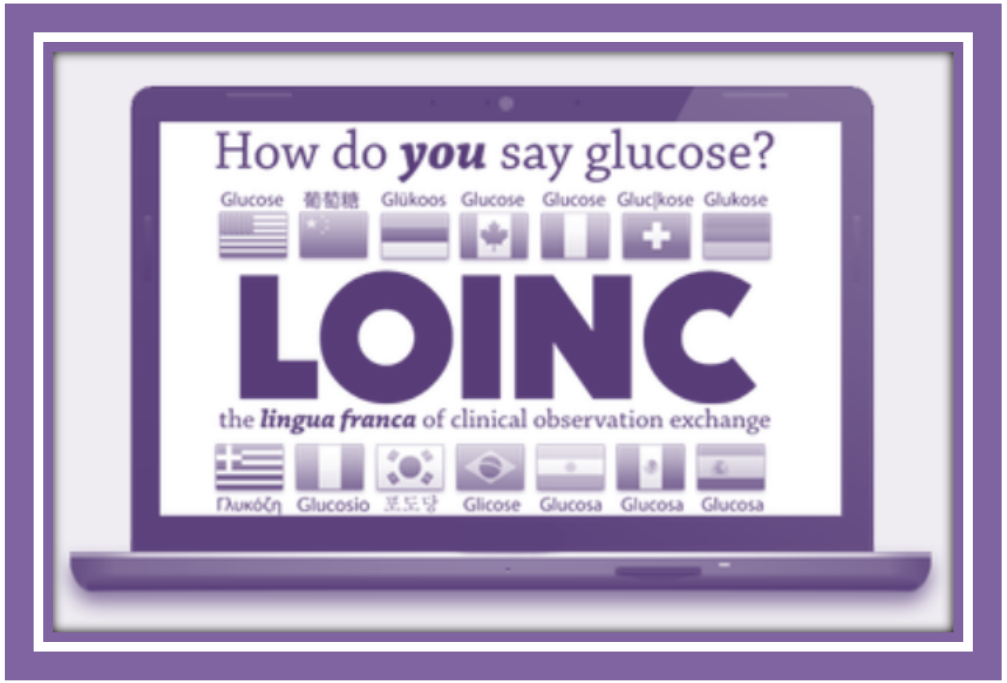
Coding – CPT II

- Systolic Blood Pressure
- 3077F – greater than or equal to 140
- 3074F – less than 130
- 3075F – between 130 and 139
- Diastolic Blood Pressure
- 3080F – greater than or equal to 90
- 3078F – less than 80
- 3079F between 80 and 89
- HbA1c Level
- 3044F – less than 7%
- 3051F – 7% to 8%
- 3052F 8% to 9%



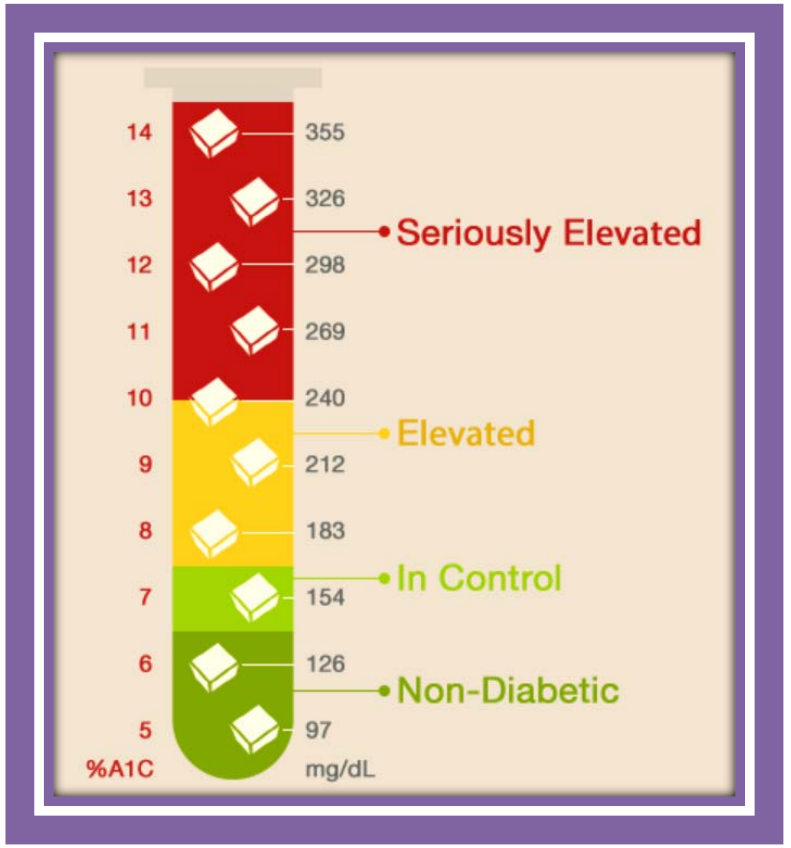
Coding – LOINC

- Systolic Blood Pressure
- 8480-6
- Diastolic Blood Pressure
- 8462-4
- HbA1c Lab Test
- 17856-6
- 4548-4
- 4549-2



Coding – SNOMED

- Systolic Blood Pressure
- 271649006
- Diastolic Blood Pressure
- 271650006
- HbA1c Lab Test
- 43396009
- 313835008
- HbA1c Lab Test Not Done
- 4501000175108



Pro Tips

PRO TIPS

- Only those patients who have provided Consent for you to view their healthcare information through Hixny will appear on Hixny's Quality Reports. Consider a waiting room display or exam room signage explaining to patients how "**Consenting to Hixny allows your Team to be aware of the care they receive in other settings – resulting in more comprehensive, better coordinated care"**.

- Complete **pre-visit planning** to identify all gaps – at every visit. Periodically review **Hixny's Quality Reports** and call patients with care gaps and work with them to get the care needed.

- Consider how **telehealth visits** can close gaps for these measures. Refer to the most recent guidance regarding use of telehealth for eCQMs.

- Coordinate **lab testing prior to the office visit** so that results can be reviewed and treatment plans adjusted as needed.

- **Repeat abnormal lab tests** later in the year to assess for improvement (is A1c at goal?)
- **Repeat BP readings** during an office visit if initial readings are high; monitor BP status at each visit and adjust medications as needed for control.
- Communicate with patients **throughout the year** to ensure all tests are completed. During monthly or quarterly care manager calls, review recommended care and determine what measures are met – and develop a plan to ensure remaining measures are completed by year end.
- **Problem solve** to resolve barriers to getting care (eg, difficulty getting to laboratory, no access to healthy food).

PRO TIPS (CONTINUED)

- **Educate patients** on evidence-based standards of care, as well as lifestyle changes to manage their conditions. Offer handouts and tools on self-management support; consider entering into a patient compact with treatment goals. Provide tangible reminders of care needed.
- The American Diabetes Association offers free **resources**.
- The Centers for Disease Control's National Diabetes Prevention Program has free curriculum and **resources** to share with patients.
- Promote the use of the **patient portal**, so patients can be messaged frequent reminders about overdue care or sent disease-specific newsletters about evidence-based care recommend

Questions?

Thank You

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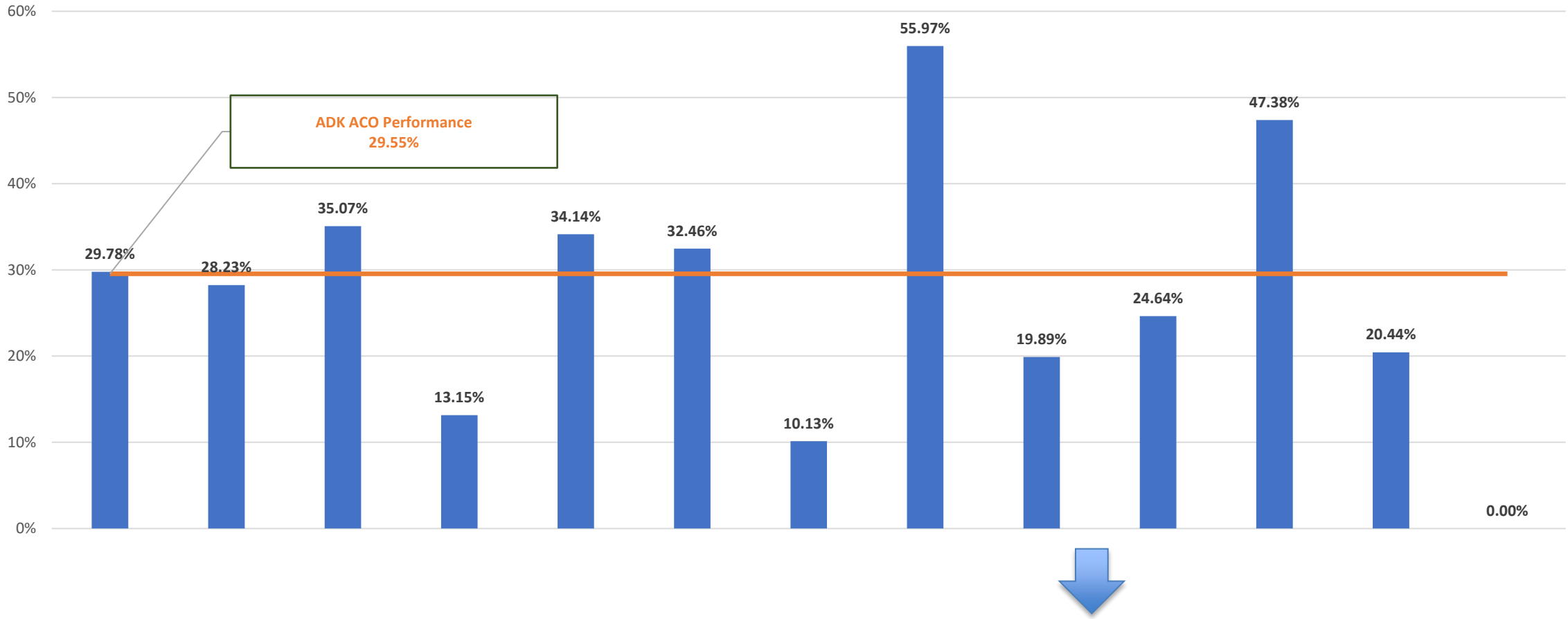
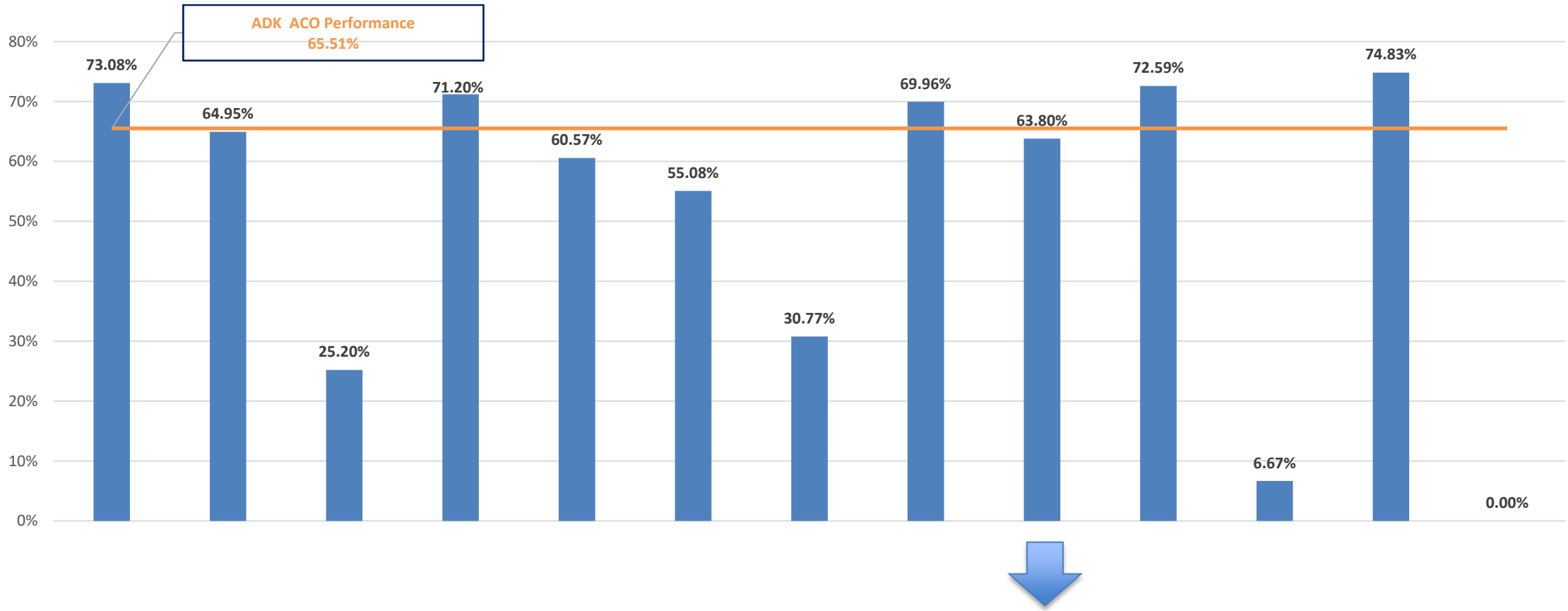
Diabetes Poor A1C Control



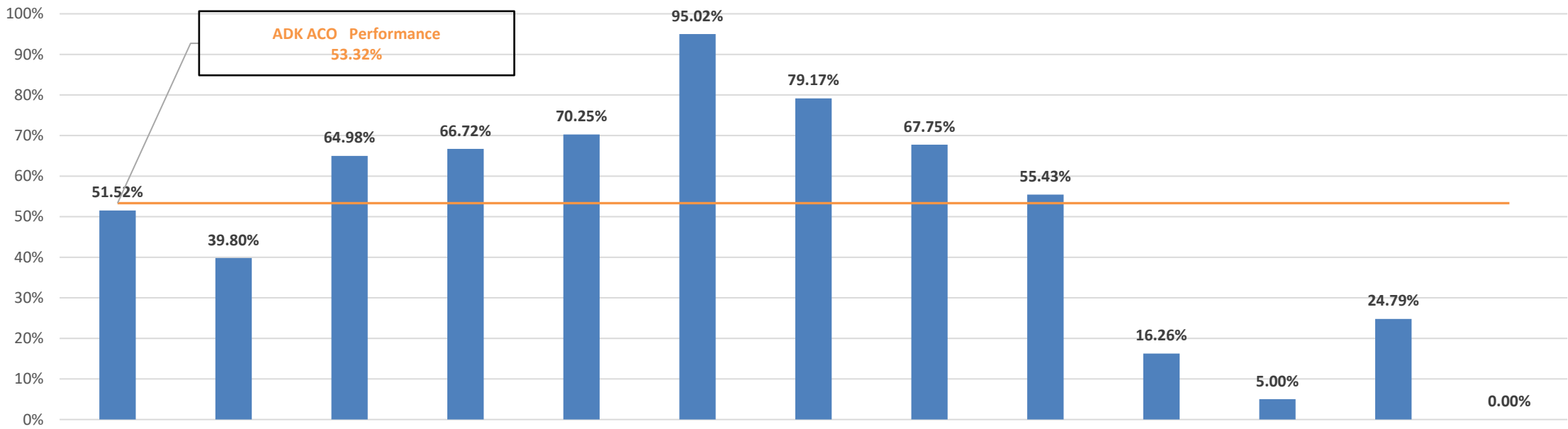
Measure Title	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	69.42 - 53.59	53.6 - 42.1	53.6 - 42.1	42.11 - 34.05	34.06 - 28.31	28.32 - 23.55	23.56 - 19.09	<=19.1

Controlling Hypertension



Measure Title	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	0.07 - 51.68	51.69 - 57.07	57.08 - 61.32	61.33 - 64.79	64.8 - 68.44	68.45 - 72.03	72.04 - 76.35	>= 76.36

Depression Screening



Measure Title	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	0.01 - 7.67	7.68 - 14.62	14.63 - 23.48	23.49 - 33.97	33.98 - 45.63	45.64 - 59.83	59.84 - 73.85	>= 73.86

eCQM Planning Tracker

eCQM Timeline Implementation
Define Team
a.) Identify the primary Lead for the organization/practice
b.) Define Steering Committee/team (stakeholders, IT, staff)
Download eCQM measures guidance and supporting documentation
Diabetes Poor Control
Controlling HTN
Depression Screening
Review of each measure to ensure appropriate capture of data and barriers
a.) Structured data fields to capture clinical data required for measure
b.) Identify workflows and potential impact
c.) Verify appropriate codes are being utilized to capture and report appropriate population and data points
d.) Identify and define reports that are being pulled
Design and develop process
a.) Design "best practice workflow" for capturing data and accurate codes
b.) Assure required reports are defined and process is mapped out
c.) Define monitoring process and timelines
d.) Work with EMR vendor to ensure that appropriate measure specification are being utilized for 2021 eCQM
Education and Communication
a.) All Staff: 3 main metrics, documentation changes and opportunities, coding requirements and workflows
b.) Attend Practice Transformation Workgroup, Quality Workgroup, ACO Webinars
c.) Review ACO Newletter and Website
Implementation & Evaluation Process - Continuous Monthly Monitoring
a.) Incorporate into NCQA and quality initiatives b.) Monitor monthly performance c.) Validate reports meeting compliance
Provide measure reports files to the ACO team for aggregation
a.) Send 2020 aggregate data by provider for each of the 3 measures
b.) Send 2021 quarterly aggregate data by provider
RESOURCES
eCQI Resouce Center - sign up for updates to measures being monitored and built in your system.
Articles for reference:

Practice Representatives Input and Feedback

- Are you currently using any electronic submission of data?
- Are you working on any electronic submission?
- What are your thoughts on this?

2021 Topics: Looking Ahead

- Potential EHR vendor
- 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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