



Adirondack Health Institute

Lead • Empower • Innovate

---

# Practice Transformation Workgroup

## March 2021

PRESENTED BY:

*Louann Villani, RN, AHI*

*Brenda Stiles, RN, Adirondacks ACO*

March 18, 2021



- |      |   |         |
|------|---|---------|
| 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  |



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

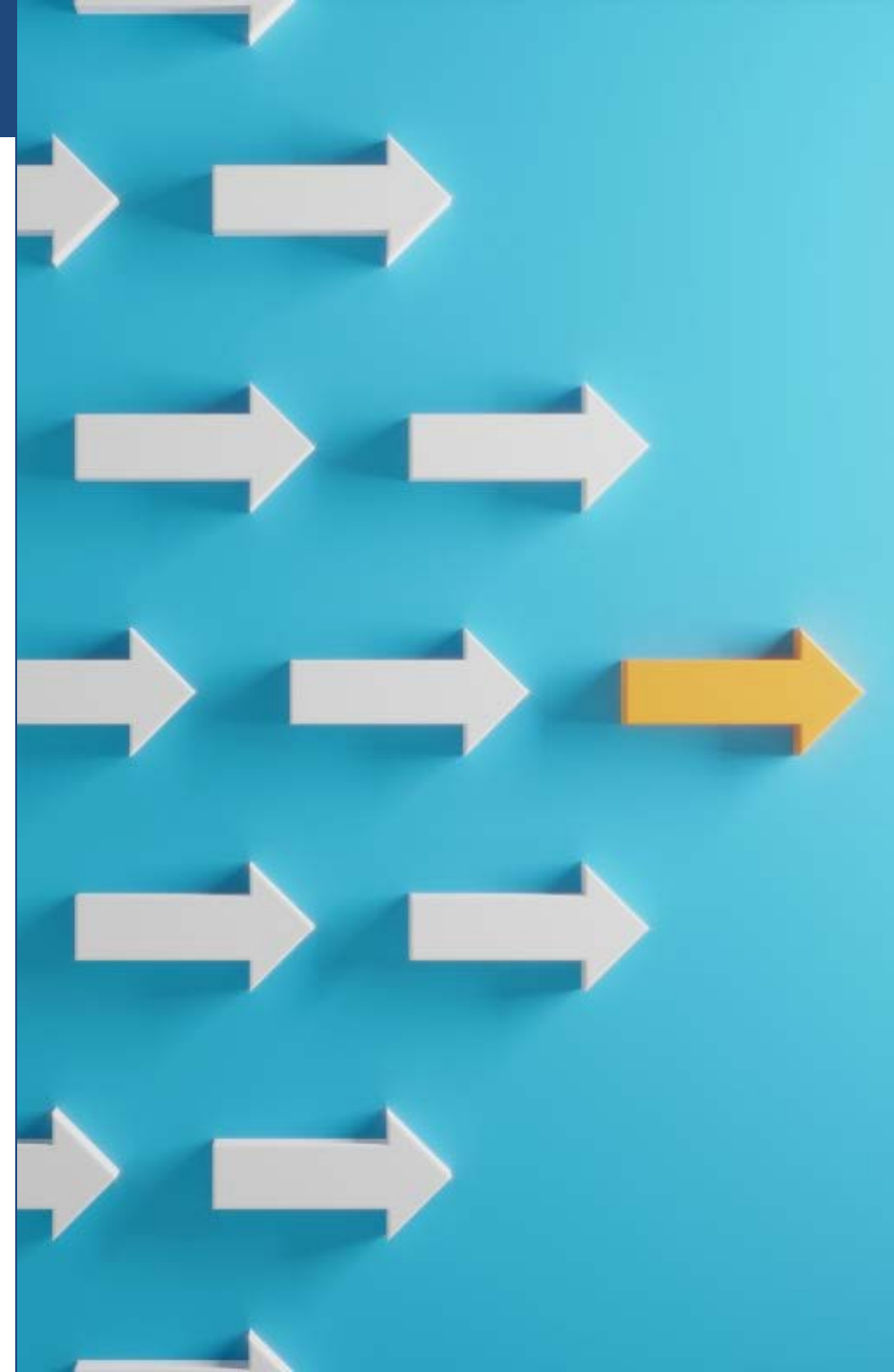
# eCQMs – Controlling Hypertension & Blood Sugar (A1c) Poor Control

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 ( $<140/90$ mmHg) 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

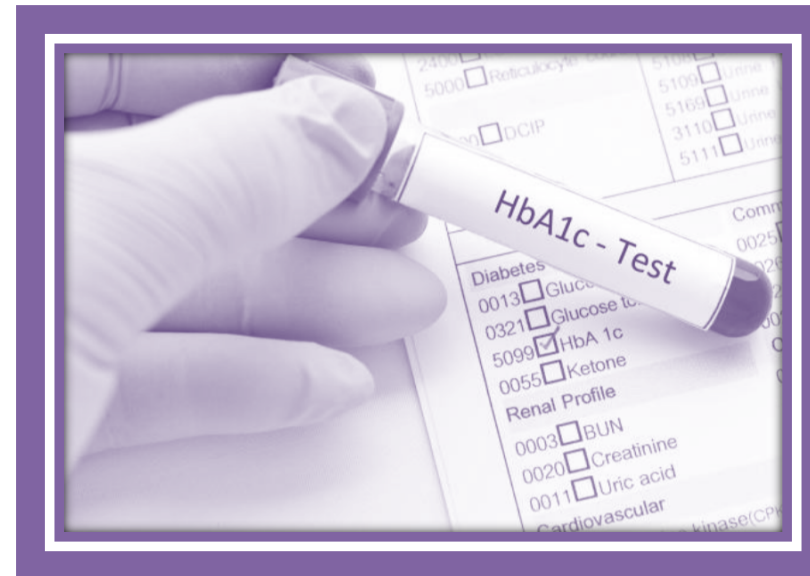
- Blood pressure readings performed by a clinician or a remote monitoring device are acceptable.
- Do not include BP readings:
  - Taken during an acute inpatient stay or an ED visit
  - Taken on the same day as a diagnostic test or therapeutic procedure requiring a change in diet or change in medication 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

Lab Results for Carol Patient (DOB: 10/15/1973, M, 3555 123-4567)

Order # 11902728, Collection Date 08/01/2014 09:06am, Received Date 10/30/2014 03:27pm

LDL Cholesterol

OBSERVATION	RESULT	REFERENCE	DATE/TIME	PHI	STATUS
Total LDL Cholesterol - Direct	121 mg/dL Above high normal	<130 mg/dL mg/dL	08/01/2014 09:06pm	ON	
SUM Total Cholesterol	210 mg/dL Above high normal	<200 mg/dL mg/dL	08/01/2014 09:06pm	ON	

HbA1c

OBSERVATION	RESULT	REFERENCE	DATE/TIME	PHI	STATUS
HbA1c	8.2 % Above high normal	<5.6 %	08/01/2014 03:27pm	ON	

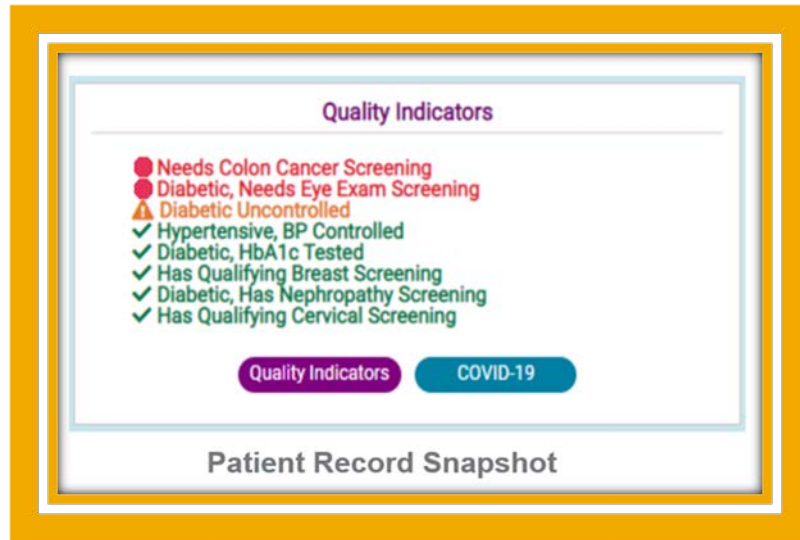
COMP. METABOLIC PANEL

OBSERVATION	RESULT	REFERENCE	DATE/TIME	PHI	STATUS
Creatinine	1.5 mg/dL Above high normal	0.5-1.1 mg/dL	08/01/2014 08:18pm	ON	
Glucose	141 mg/dL Above high normal	70-99 mg/dL	08/01/2014 08:15pm	ON	
Potassium	4.1 mmol/L	3.5-5.1 mmol/L	08/01/2014 08:13pm	ON	
Sodium	133 mmol/L	136-145 mmol/L	08/01/2014 08:13pm	ON	

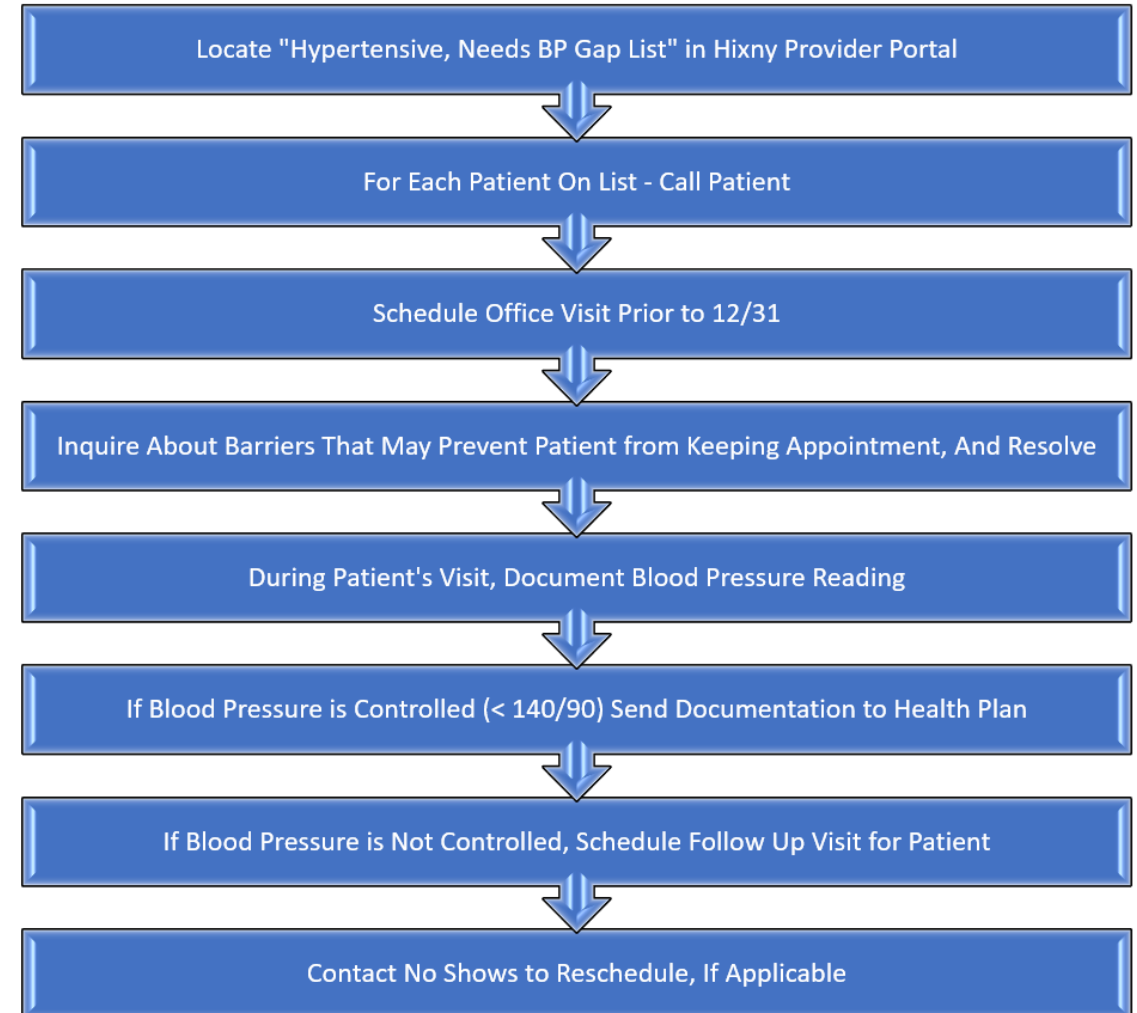
# Tools for Controlling Hypertension and Blood Sugar in Primary Care



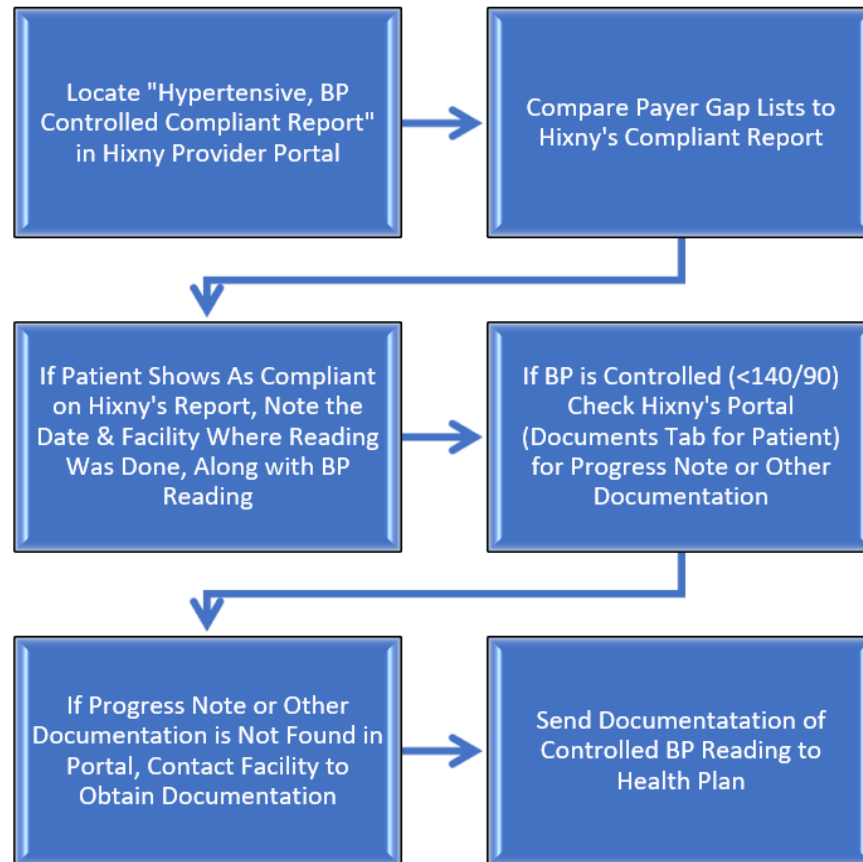
## PRACTICAL TOOLS



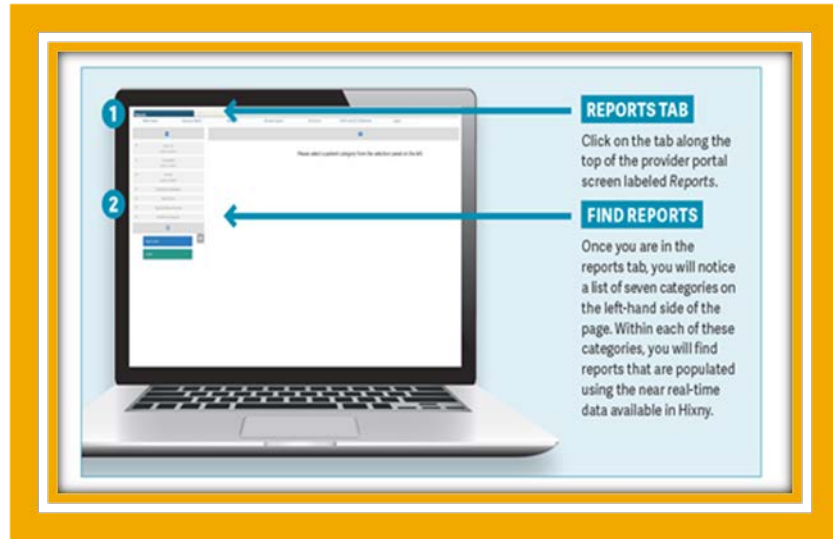
## Hixny's "Hypertensive, Needs BP Gap List" Workflow for Care Coordinators



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





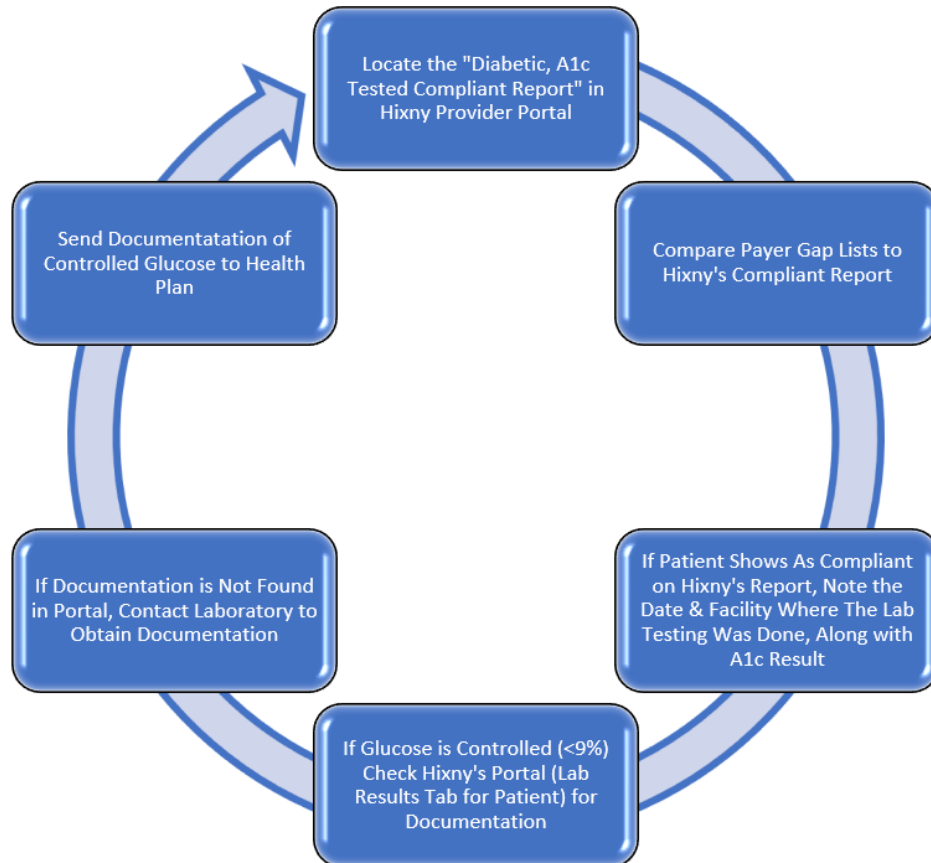


Gap List Quality Indicator	Compliant Quality Indicator
Needs Breast Cancer Screening	Has Qualifying Breast Screening
Needs Colorectal Cancer Screening	Has Qualifying Colorectal Cancer Screening
Hypertensive, Needs BP Reading	Has Qualifying Cervical Screening
Needs Cervical Cancer Screening	Diabetic, Has Nephropathy Screening
Diabetic, Needs Nephropathy Screening	Diabetic, Has Eye Exam Screening
Diabetic, Needs Eye Exam Screening	Hypertensive, BP Controlled
Diabetic, Needs Lab Test	Diabetic, HbA1c Tested

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



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





← → ↻ 🏠 🔒 <https://www.cdc.gov/diabetes/prevention/index.html> ☆ ☆ 📄 ⓘ

**CDC** Centers for Disease Control and Prevention  
CDC 24/7. Saving Lives. Protecting People™

[A-Z Index](#)  
Search  🔍  
[Advanced Search](#)

### National Diabetes Prevention Program

[Español \(Spanish\)](#)



**Working Together to  
Prevent Type 2 Diabetes**

The National Diabetes Prevention Program (National DPP) is a partnership of public and private organizations working to prevent or delay type 2 diabetes. Partners make it easier for people at risk for type 2 diabetes to participate in evidence-based lifestyle change programs to reduce their risk of type 2 diabetes.

# 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

HealthShare Administration Patient Search Portal View Messages Subscriptions My Account Reports Records My Account Switch User/Go To Dashboard Logout

LONG, ALEXA F 10/10/1959 61 Years

Patient Record Snapshot

Allergies & Alerts  
History  
Documents  
Lab Results  
Pathology Results  
Radiology Results  
Medications  
Vaccinations  
Conditions  
Procedures  
Physical Exams  
Encounters  
Appointments  
Programs

Hixny

Reminder: The SHIN-NY survey is live. If you received an invitation, please take a few minutes to respond. Print

**ALEXA LONG**  
10-10-1959 • 61 Yrs • Female

Physician: Rabi Sinha Phone: (518)000-0007 See Full Profile  
Smoking Status: Unknown Allergies: 19 known Patient Contacts: 6 known

**Quality Indicators**

- Needs Colon Cancer Screening
- Needs Breast Cancer Screening
- Needs Cervical Cancer Screening

**Quality Indicators** COVID-19

**Labs**

03-19-2016	CBC WITH AGGLOMERATED DIFF
03-19-2016	PT PROFILE
03-19-2016	BNP
03-19-2016	COMPREHENSIVE METABOLIC PANEL
03-19-2016	MAGNESIUM
03-19-2016	CK ISOENZYMES
03-19-2016	TROPONIN I

**Procedures**

02-07-2011	OTHER REPAIR OF KNEE
02-07-2011	KNEE ARTHROSCOPY
02-07-2011	EXCISE KNEE SEMILUN CARTL
04-27-2009	INSERT LENS AT CATAR EXT
04-27-2009	CATARAC PHACOEMULS/AS...
02-02-2009	INSERT LENS AT CATAR EXT
02-02-2009	CATARAC PHACOEMULS/AS...

**Conditions**

Acute myocardial infarction
DYSPNEA, UNSPECIFIED
OTHER CHEST PAIN
UNSPECIFIED ASTHMA, UNCO...
ALLERGIC RHINITIS, UNSPECI...
CHEST PAIN, UNSPECIFIED
UNCOMPLICATED

**Immunizations**

07-22-2020	Influenza INTRANASAL Vacci...
07-22-2020	Influenza INTRANASAL Vacci...
07-22-2020	Influenza INTRANASAL Vacci...

**Radiology**

06-11-2019	Mammo Screen Breast (2) - 3...
06-10-2019	Mammography Care Biopsy Rt
03-19-2016	CHEST SINGLE VIEW 71010
03-19-2016	CHEST SINGLE VIEW 71010
03-12-2016	CHEST PA AND LATERAL 710...

**Medications**

Albuterol
Furosemide
Furosemide
Furosemide
Omeprazole
Omeprazole
Omeprazole

**Documents**

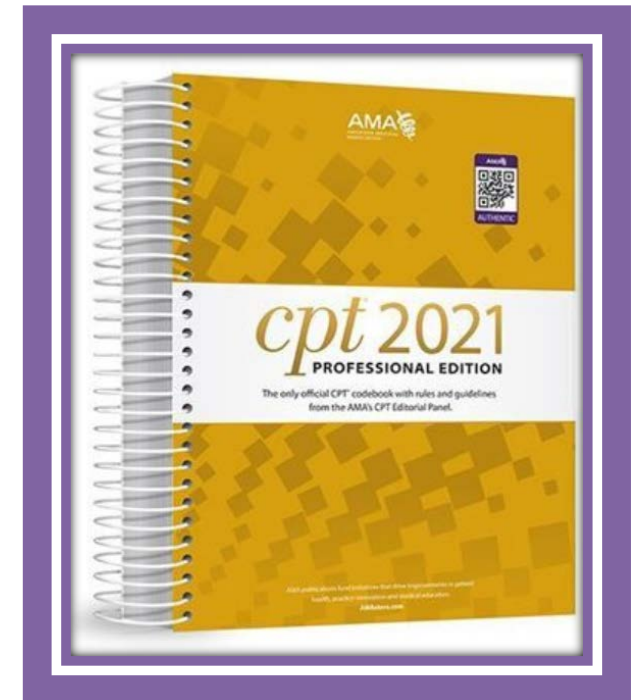
Consolidated CCDA R2.1 Structur...	09-24-2020	Canton Potsdam Hospital Docum...
Consolidated CCDA R2.1 Structur...	08-27-2020	Canton Potsdam Hospital Docum...
Consolidated CCDA R2.1 Structur...	08-26-2020	Canton Potsdam Hospital Docum...
EDPDOC	03-19-2016	Saratoga Hospital
EKG	03-18-2016	Saratoga Hospital
MEC	03-17-2016	Malta Medical Emergent Care
EKG	03-17-2016	Malta Medical Emergent Care

This is a snapshot view of the patient. Additional information may be available in the tabs on the left-hand side of the screen.



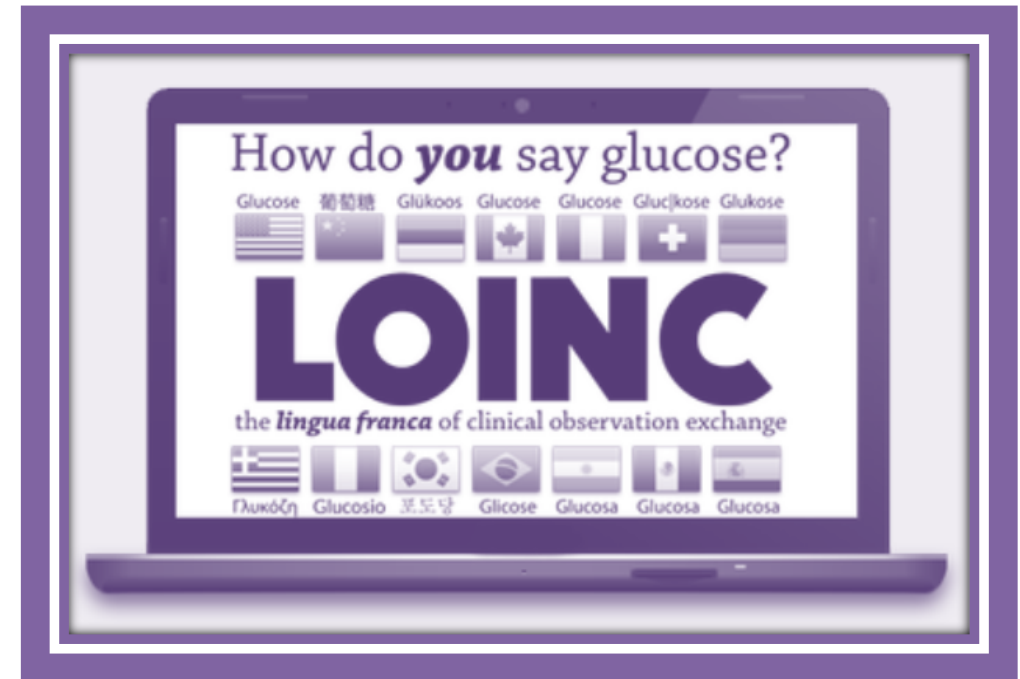
# Coding – CPT II

- 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%



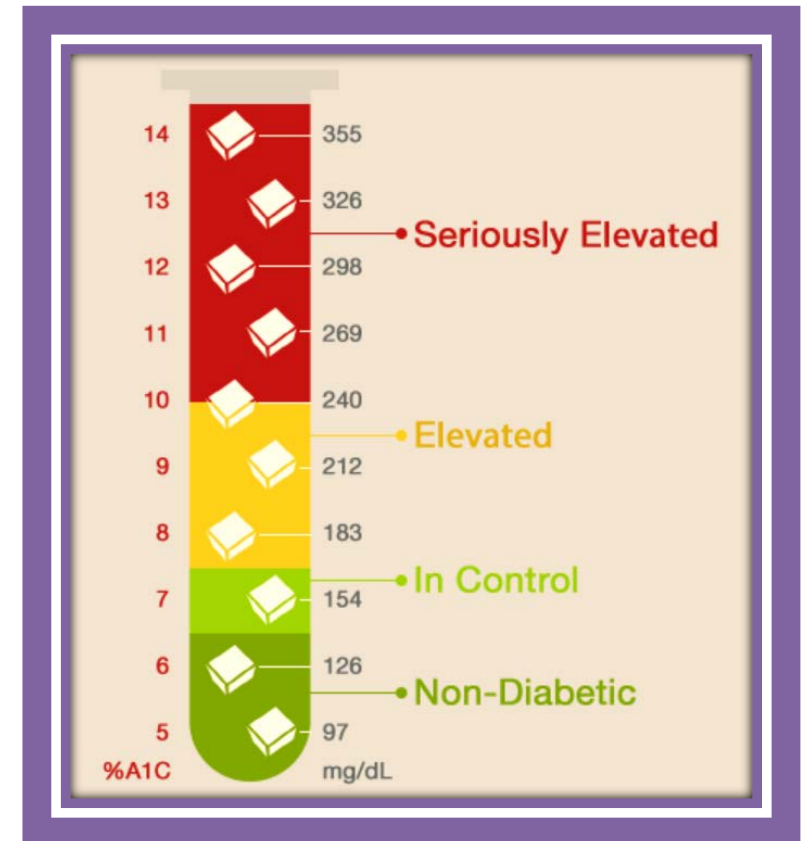
# Coding – LOINC

- 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



- 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**

Hixny®

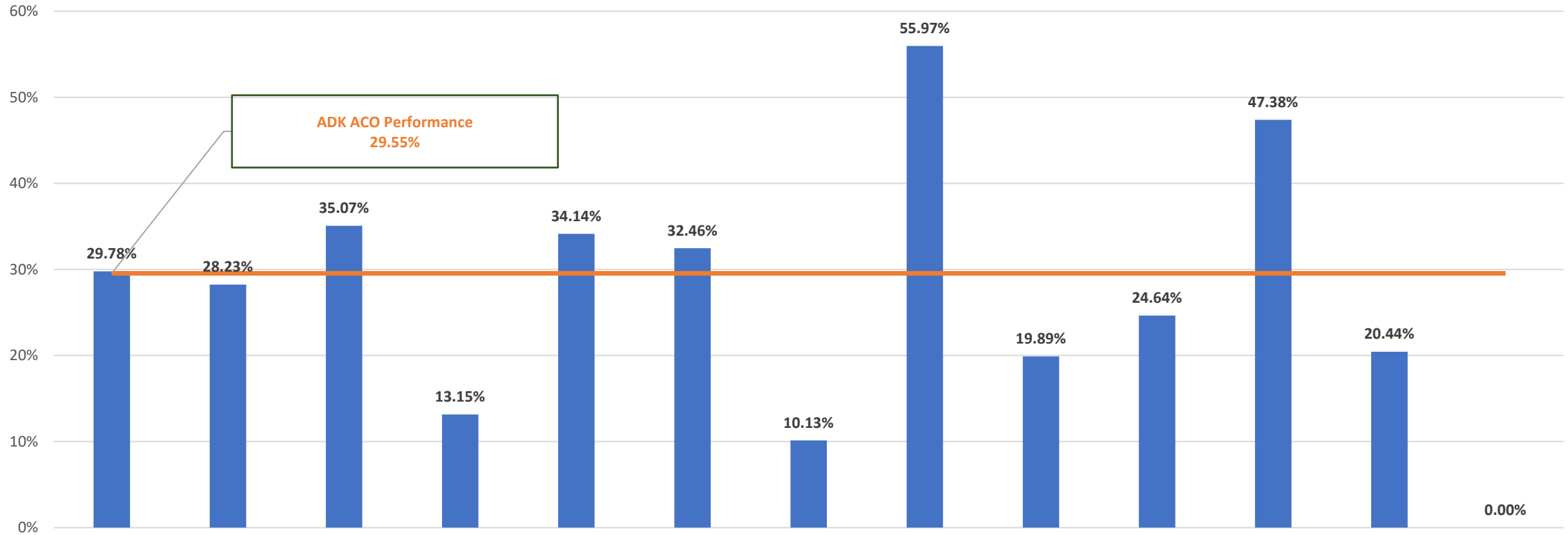


## Quality Metrics and eCQM Planning Grid

**Brenda Stiles, RN**  
**Louann Villani, RN**



# Diabetes Poor A1C Control

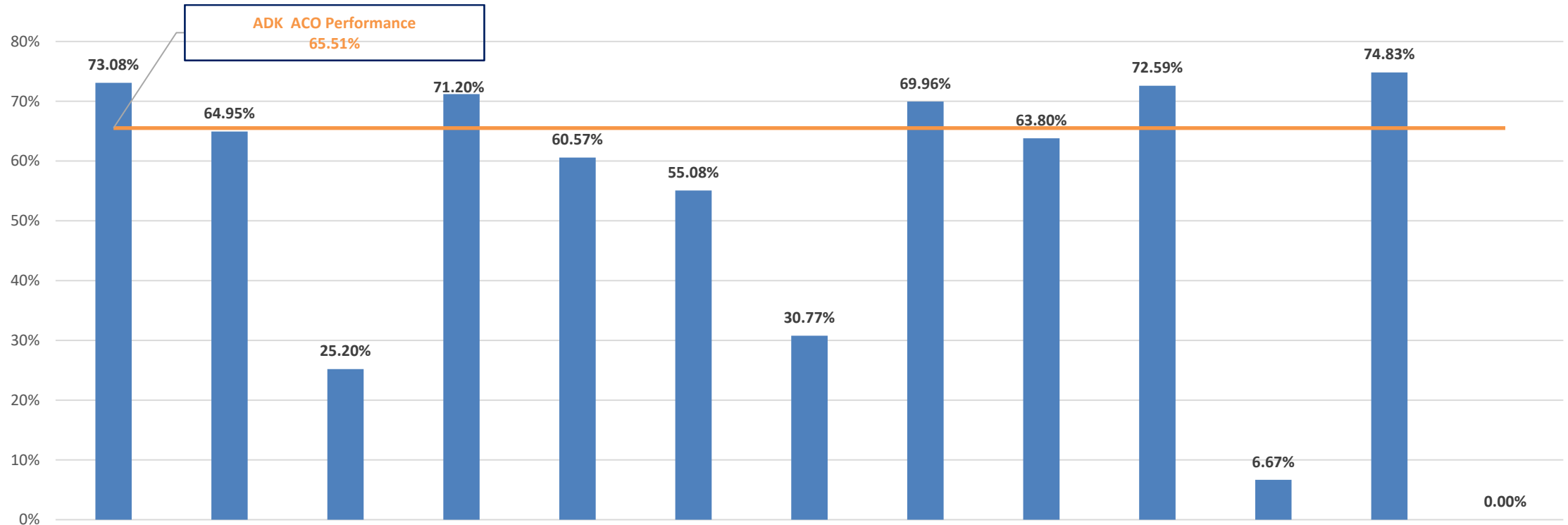


Measure Title	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	69.42 - 53.59	53.6 - 42.1	53.6 - 42.1	42.11 - 34.05	34.06 - 28.31	28.32 - 23.55	23.56 - 19.09	<=19.1





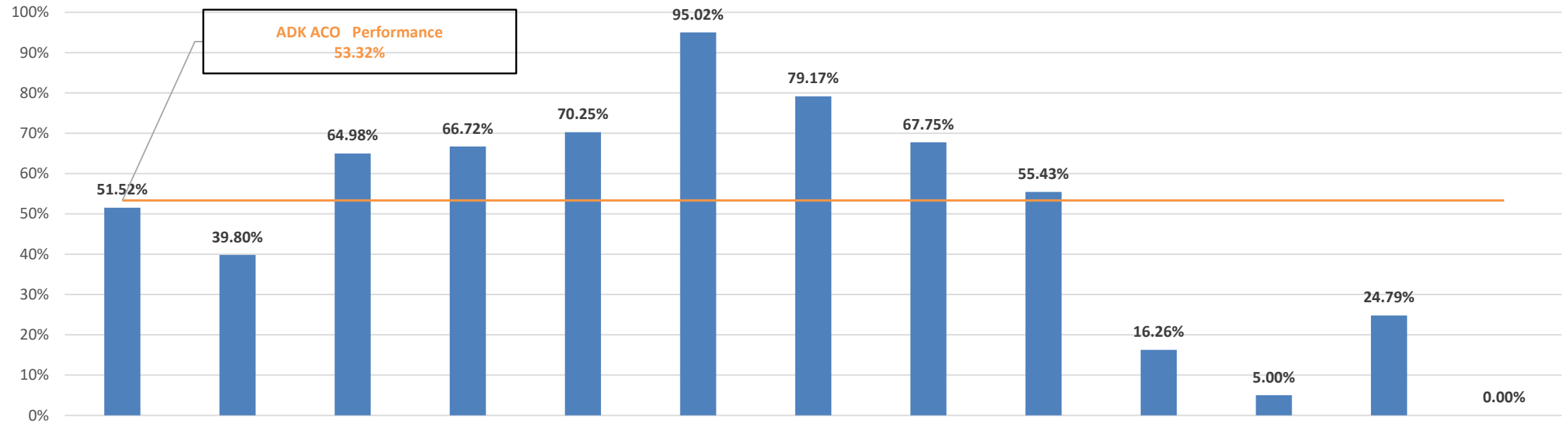
# Controlling Hypertension



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 Newsletter 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

# Louann Villani, RN

[lvillani@ahihealth.org](mailto:lvillani@ahihealth.org)

# Brenda Stiles, RN

[bstiles@cvph.org](mailto:bstiles@cvph.org)



a·H·I

Adirondack Health Institute

