Value Driven. Health Care. Solutions.

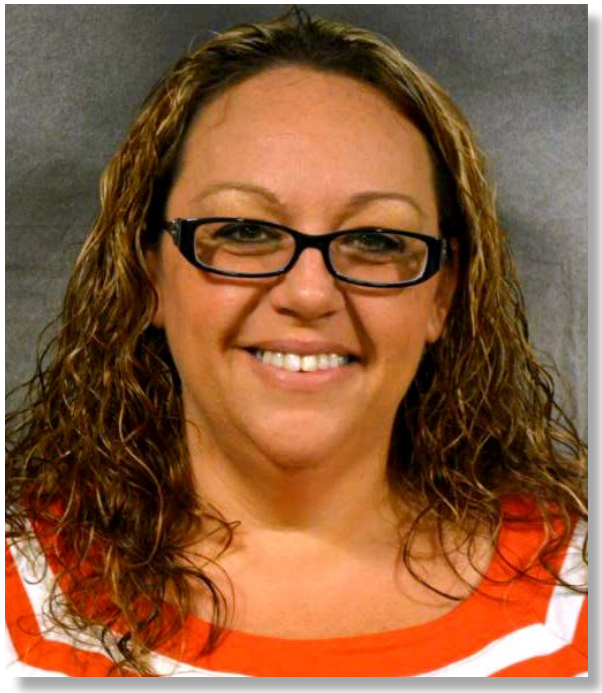
Improving Quality & Increasing Revenue

Jamie Conklin, CMC
RHC Quarterly Meeting
11/1/2018

Medical Advantage Group℠

Jamie Conklin, CMC

- >> 15 years experience
- >> Certified medical coder
- >> PCMH implementation
- >> Education and training
- >> Data capture
- >> Practice transformation



Objectives

- Define HEDIS and how it can be used to optimize quality
- Comprehend the financial aspect of population management
- Describe resources available to enhance accurate coding and documentation
- Learn to perform point of care gap closure
- Understand the data capture process and its impact to your practice

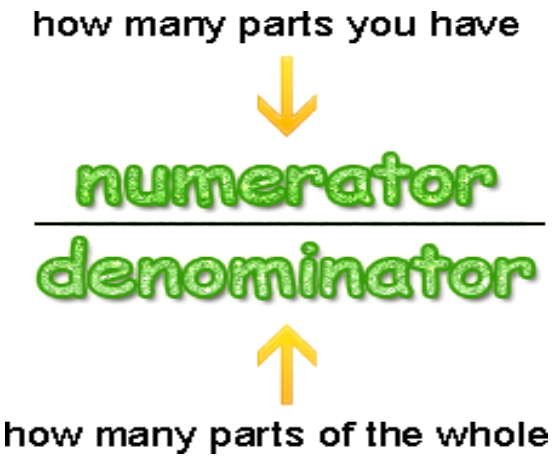
HEDIS is Key to Improving Quality Scores & Maximizing Revenue

HEDIS

- **H**ealthcare
- **E**ffectiveness
- **D**ata and
- **I**nformation
- **S**et

HEDIS Construct

– Numerator
– Denominator
– Exclusion criteria



Where Does HEDIS® Data Come From?

Standard Supplemental Data	Nonstandard Supplemental Data
Data received directly from: • Claims • EMR - EMR interface - Registry (only if data is fed from an EMR) • Labs • State or county immunization registries	Data collected from an intermediate source: • Provider portal • Verbal notification • Registry (unless data is fed from an EMR) • Provider abstraction forms • Member self-reported data

Coding and Documentation

Maintain Accuracy

Each individual encounter must be able to stand on it's own

Code to the highest level of specificity

Review coding guidelines on a regular basis to ensure guidelines are being followed

Code All Diagnoses That Have MEAT

Monitor
signs, symptoms, progression / regression

Evaluate
test results, and response to treatment

Address
order tests, referrals, and review records

Treat
scripts and therapies

Best Practices in Diagnosis Coding

A. Coding Updates and Tools

B. Proper Documentation for Accurate Data Capture

C. Training and Education

A. Coding Updates & Tools

- ICD – 10
- System Updates
- Data Search Programs

B. Proper Documentation for Accurate Data Capture

Always Code to the Highest Specificity

Audit Routinely

Diagnosis Closure

C. Training & Education

- Code Changes
  - Added
  - Deleted
  - Revised
- Electronic Health Record
- Resources - http://www.icd10data.com/

Population Health Management

What is Population Health Management?

- Aggregation of patient data across multiple health IT systems
- Analysis of that data into a single, actionable patient record
- Actions through which care providers can improve both clinical and financial outcomes

Goals of Population Health Management

- Improve health of an entire population
- Improve quality of care and decrease costs by closely attending to patients and coordinating their care
- Population health can be effectively managed with a patient registry

Clinical Aspect of Population Health

- **Coordinate Care** for High-Risk Patients
- Manage **Transitions of Care**
- Close Patient Gaps in Care
- Implement **Team-Based Approach to Patient Care**
- Implement **Patient-Centered Capabilities**
- Address **Patient Socio-Economic Barriers**
- **Address Variability in Care Delivery**

Point-of-Care Gaps Closure

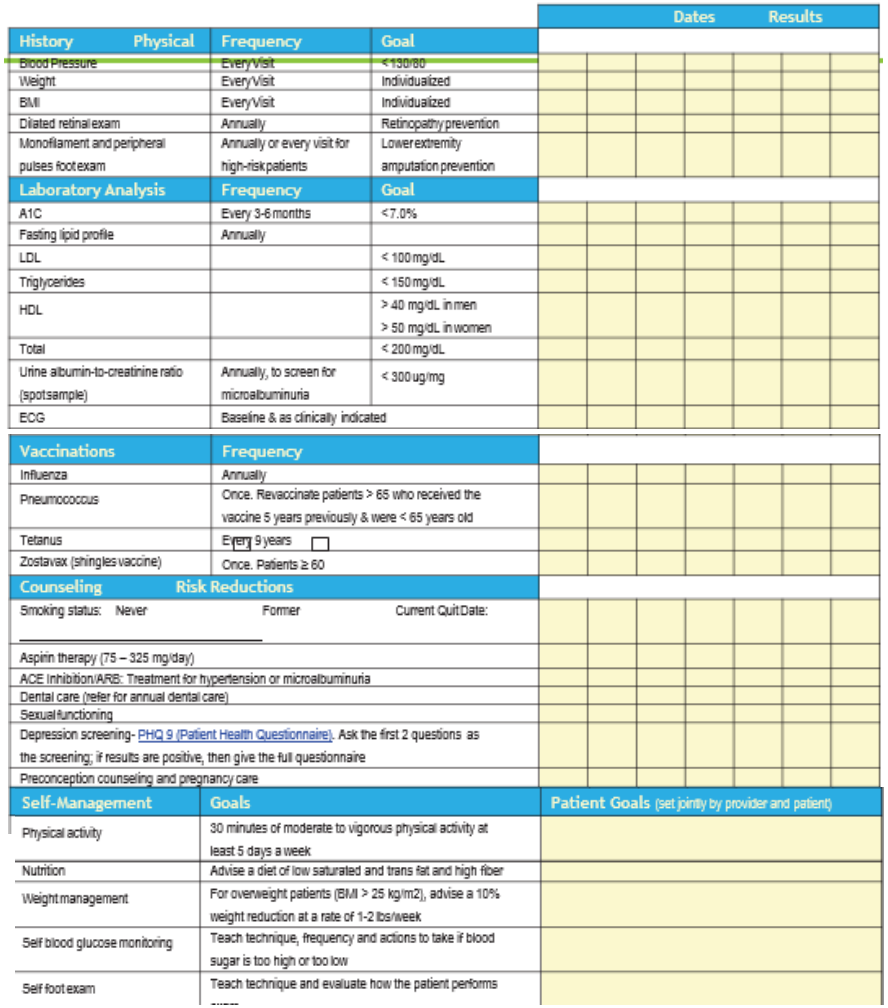
Leverage EHR as a Point-of-Care Tool

- EHR's are typically built to have patient alerts based on evidence-based care guidelines such as HEDIS and USPSTF
- Alerts tell what care items are currently outstanding- preventive and condition specific
- Be cautious – Must be built in or activated or they won't assist you

I Don’t Have an EHR…Now What?

- Evidence-based care checklists can be added to the paper record
- Health plan alert sheets
- Other resources:
  - Iowa Diabetes Care Flowsheet
  - AAFP

Iowa Diabetes Care Flowsheet



History Physical	Frequency	Goal	Dates / Results
Blood Pressure	Every Visit	< 130/80	
Weight	Every Visit	Individualized	
BMI	Every Visit	Individualized	
Dilated retinal exam	Annually	Retinopathy prevention	
Monofilament and peripheral pulses foot exam	Annually or every visit for high-risk patients	Lower extremity amputation prevention	
Laboratory Analysis	**Frequency**	**Goal**	
A1C	Every 3-6 months	< 7.0%	
Fasting lipid profile	Annually		
LDL		< 100 mg/dL	
Triglycerides		< 150 mg/dL	
HDL		> 40 mg/dL in men > 50 mg/dL in women	
Total		< 200 mg/dL	
Urine albumin-to-creatinine ratio (spot sample)	Annually, to screen for microalbuminuria	< 300 ug/mg	
ECG	Baseline & as clinically indicated		
Vaccinations	**Frequency**		
Influenza	Annually		
Pneumococcus	Once. Revaccinate patients > 65 who received the vaccine 5 years previously & were < 65 years old		
Tetanus	Every 9 years ☐		
Zostavax (shingles vaccine)	Once. Patients ≥ 60		
Counseling Risk Reductions			
Smoking status: Never Former Current Quit Date:			
Aspirin therapy (75 – 325 mg/day)			
ACE Inhibition/ARB: Treatment for hypertension or microalbuminuria			
Dental care (refer for annual dental care)			
Sexual functioning			
Depression screening- PHQ 9 (Patient Health Questionnaire). Ask the first 2 questions as the screening; if results are positive, then give the full questionnaire			
Preconception counseling and pregnancy care			

Self-Management	Goals	Patient Goals (set jointly by provider and patient)
Physical activity	30 minutes of moderate to vigorous physical activity at least 5 days a week	
Nutrition	Advise a diet of low saturated and trans fat and high fiber	
Weight management	For overweight patients (BMI > 25 kg/m2), advise a 10% weight reduction at a rate of 1-2 lbs/week	
Self blood glucose monitoring	Teach technique, frequency and actions to take if blood sugar is too high or too low	
Self foot exam	Teach technique and evaluate how the patient performs	

Iowa Collaborative Safety Net Provider Network

IOWA DIABETES PREVENTION & CONTROL PROGRAM

IDPH Iowa Department of Public Health

Supported by CDC Cooperative Agreement #5U58DP001967-03. Contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

Closing the Gap

>> Measure the Gaps

- Run a regular report that shows what quality measures are missing
- Look at your patient panel
- Identify services or gaps in services
- Reach out to patient to notify them of gap and need for services (letter, patient portal, phone call, etc.)
- Continuous process
  - Set a schedule or calendar for how you will “work” your gaps

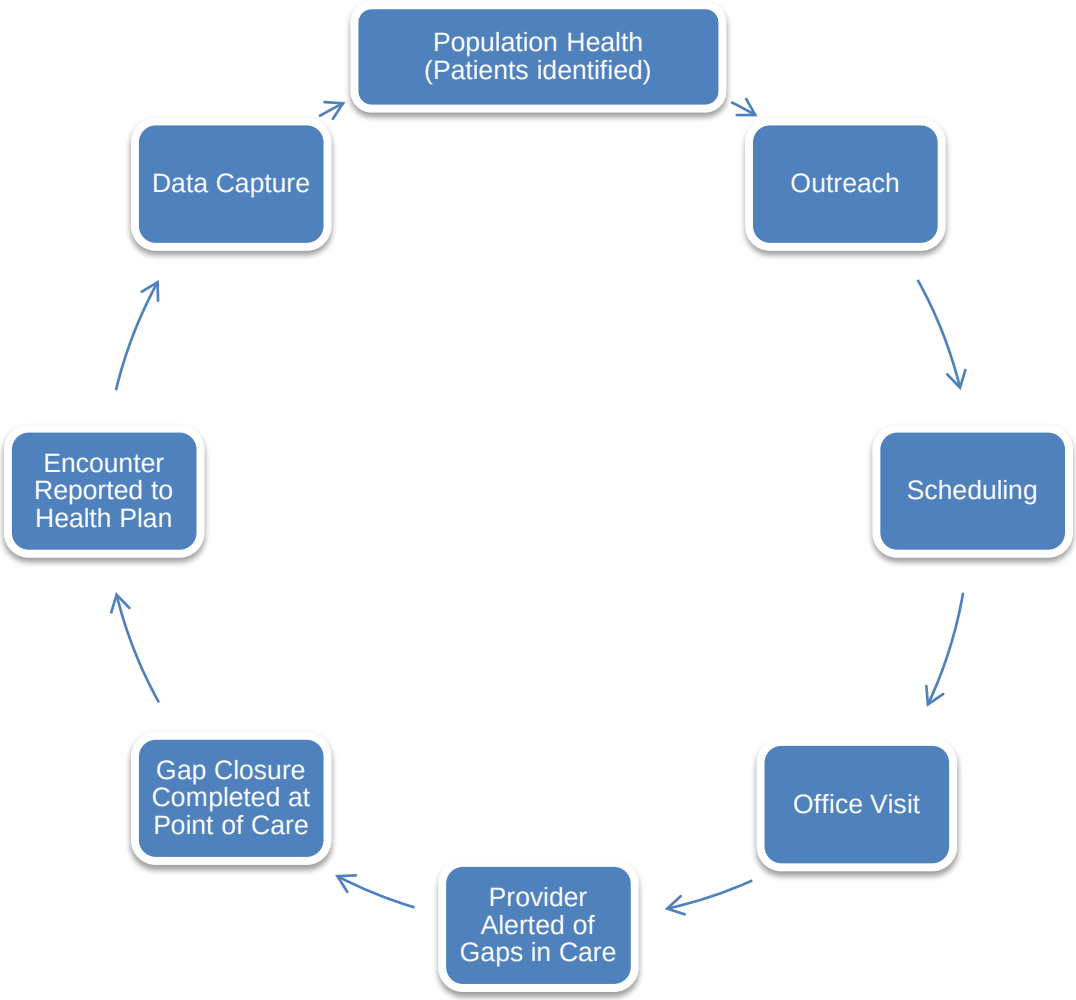
Transition Care Management

Transition Care Management (TCM)

- 30 Day period from discharge date and continues for the next 29 days
- 99495 – TCM, **moderate complexity**, visit within **14** calendar days of discharge
- 99496 – TCM, **high complexity**, visit within 7 calendar days of discharge
- Payable to all MD/DO, qualified non-physician practitioner (mid-levels)
- Treat as office visit, with cost share applied

Data Capture Process

Data Capture



Where Do You Begin?

- >> Assess tools available such as EHR or registry…
- >> Start with one condition or measure
- >> Identify evidence-based guidelines & educate team
- >> Identify your patient population
  - Relevant chronic conditions, payer mix, age, gender
- >> Conduct outreach
- >> Point of care (before or during visit)
  - EHR/registry alerts
  - Planned visit approach
  - Standing orders
- >> Accurate coding/billing

Summary

- Understand HEDIS and how to optimize quality within your practice
- Accurately code and document to support what you are reporting
  - Always code to the highest specificity
- Use point of care gap closure
- Capture all data and be sure to report everything from the encounter to the health plan
- Continual education
  - Quality measures
  - Billing and coding
  - Documentation
  - Data capture

Value Driven. Health Care. Solutions.

Jamie Conklin, CMC
Healthcare Transformation Consultant
jconklin@medadvgrp.com
517.999.8057

Medical Advantage Group℠