PROVIDER REFERENCE GUIDE

2022 Care Gap Closure Guide

St. Luke's Health Partners

A Guide to Knowing Your Population & Closing Care Gaps

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KNOW THE POPULATION AND THEIR NEEDS

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CLOSE GAPS IN THEIR CARE

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ENSURE APPROPRIATE UTILIZATION

St. Luke's Health Partners is teaming up with healthcare providers across the state to provide exceptional patient-centered care at the best value. This guide is designed to provide activities, and descriptions of quality measures, that if deployed in the primary care setting, will improve the health and wellness of patients in our communities.

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Comprehensive Wellness Visits & Empanelment

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A comprehensive wellness visit, performed annually, provides an opportunity to strengthen the provider and patient relationship, complete preventive screening, care gap closure, and address chronic conditions. The comprehensive assessment performed at these visits results in early identification of potential health problems leading to early intervention, improved patient outcomes resulting in a reduced need for the patient to utilize the ED or urgent care settings, creates a comprehensive record of the patient's medical history, and ensures that the complexity of the provider's panel is accurately reflected.

To be successful, empanelment and proactive outreach to schedule patients for a wellness visit are two important steps in getting to know the population of patients for which you are accountable. Patients attributed to your practice group can be found by accessing the SLHP performance dashboard. Unless payer contracts require a particular attribution assignment, patients are attributed based on plurality of claims within the last 18 months, following the hierarchical algorithm below:

1. Medical Claims, performed by MD/DO/NP/PA, prioritized by taxonomy of Family Practice, General Practice, Internal Medicine, and Pediatrics.
2. Prescription claims based on the prescribing Provider and their identified taxonomy (excluding emergency department).
3. Member selection that is not required by the Payer.
4. Medical claims performed by specialists (excluding claims related to emergency department visits or inpatient services).

The process of empanelment is important. It refers to a process developed within a clinical group to take the list of attributed patients and compare that to what is reflected in the EMR or clinical record. Optimally, that process should also include looking for patients that have switched PCPs, moved, and passed away. This work will impact registry accuracy when clinics begin work on chronic disease management. It can also impact how templates are developed for provider schedules in a way that maximizes patient access to care. All of this in turn, increases clinical efficiency.

If access is a challenge, patients should be prioritized for outreach based on their complexity and overall health status. SLHP tools are available to help you with this process. The work may seem overwhelming at first but the population health team at SLHP is here to help.

Introduction

Complete & Accurate Diagnosis, Documentation & Coding

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To fully depict the patient's health status, it is essential to ensure that all chronic conditions are addressed, documented, and accurately coded at the time of the patient's visit. Based on provider documentation, clinical resources are deployed to care for the patient. This connects patients with tools and resources to mitigate risks related to social determinants of health. Complete and accurate documentation also facilitates improved communication of care to other providers along the care continuum. Clear and concise provider documentation is necessary to ensure that appropriate financial resources for the care of the population are appropriately allocated. Poor documentation and non-specific diagnoses will result an inaccurate reflection of the illness burden of the patient and an inaccurate allocation of resources for the care of the population.

Calculating the allocation of resources for the care of a population is based on the CMS-HCC (Medicare) or HHS-HCC (Commercial) risk adjustment models. The calculations predict the cost of medical care that a patient might incur. A risk adjustment factor (RAF) or risk score is generated by utilizing patient demographics and the patient's health status or reflected illness burden (chronic conditions documented yearly), during a face-to-face visit with a qualifying provider.

Premium/Bid x Illness Burden = Financial Support

Individual risk scores are assigned based on:

- Enrollee Demographics (age, gender)
- Patient's Residence (community or institution)
- Medicaid Dual Eligibility & Disability Status
- Certain Disease & Disease-Disability Interactions
- Composite of Major Chronic Conditions (HCC - ICD-10 Diagnoses)

If a patient's risk score is low, it indicates to CMS that the patient is healthy and will require fewer clinical resources. For this reason, CMS allocates fewer financial resources for the care of that patient. If the patient's risk score is high, based on clinical documentation of chronic conditions, the patient will likely need more clinical resources which requires more financial resources. For this reason, CMS allocates more financial resources for the care of the patient.

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The patient example below demonstrates how complete and accurate documentation has significant clinical and financial impact. As you can see the funding that corresponds to the full complexity of a patient that is captured in a more complete and accurate diagnosis is significant. The clinical care for that patient should be more complex as well. That funding, in turn, supports work like care management and pharmacy services that are made available to providers to maximize care for patients.

The funding listed in the example is not applied by CMS at the individual level, it is a portion of the funding for the total population for which SLHP has assumed accountability. It also directly impacts the financial accountability providers in the network have assumed for that population.

No Conditions (Documented or submitted on a claim)	**Some Conditions** (Documented and submitted on a claim but non-specific)	**All Conditions** (Documented, accurately coded and submitted on a claim)
70 years old (Community, Full Benefit, Aged) 0.600	70 years old (Community, Full Benefit, Aged) 0.600	70 years old (Community, Full Benefit, Aged) 0.600
	Type 2 Diabetes (w/out Complications) 0.107	Type 2 Diabetes (w/Complications; Peripheral Neuropathy) 0.340
	Depression (unspecified) 0.000	Major Depression 0.299
	COPD 0.430	COPD 0.430
		(R) Great Toe Amputation 0.795
		Respiratory Failure/O2 0.492
		COPD/Respiratory Failure Disease Interaction 0.528
Total RAF 0.600 **$5,600** (≈ Support)	**Total RAF** 1.137 **$10,600** (≈ Support)	**Total RAF** 3.484 **$32,600** (≈ Support)

- Poor patient care: Patient likely not engaged with PCP, utilizing urgent care and ED resources
- Under documented and under managed chronic conditions,
- No allocation of clinical resources
- Poor communication along the continuum of care
- Incomplete or non-specific documentation of chronic conditions; Under-represented illness burden
- Inaccurate allocation of financial resources for the care of the patient

- Risk interventions (care management, fall, socio-economic etc.) in place
- Engaged patient, excellent quality of care
- Managed chronic conditions
- Accurate representation of the illness burden
- Accurate allocation of financial resources for care of the patient

Critical Elements to Achieve Complete & Accurate Documentation

Document and code conditions to the highest level of specificity. (e.g., acute, or chronic, severity, stage of condition, location)

Document the relationship of complications or conditions secondary to the underlying condition. Use terms like "from", "related to" "secondary to", or "with" to link diagnoses and a causal relationship (e.g., Type 2 Diabetes with Nephropathy).

Avoid "history of" if the patient is receiving ongoing treatment, medication, or intervention and if discontinuation of medication would raise a clinical concern of recurrence. "History of" means patient no longer has the condition. "History of" the condition cannot be coded as an active disease.

If a diagnosis is certain, avoid terms such as: "Consistent with", "probable", "possible" or "likely". Document and code the signs and symptoms if no definitive diagnosis can be made.

Review and update problem lists. Lists should reflect active medical problems.

Review and update medication lists. Lists should reflect currently prescribed medications and the condition it was prescribed for.

Identify any complications and document what caused the complication. (e.g., Chronic kidney disease, stage 4 due to type 2 diabetes mellitus)

Use linking language for related conditions. (e.g., Aphagia due to CVA rather than Aphagia and CVA)

Acknowledge pertinent laboratory or radiology results in the body of the documentation. (e.g., Chronic kidney disease (CKD) stage 3, GFR of 48)

Always code status conditions when present. Amputation, dialysis, ostomy, transplant, etc.

Document chronic conditions at least once per year, document that each condition was Monitored, Evaluated, Assessed and/or Treated (MEAT). A chronic condition may be documented and coded when stable with treatment (e.g., amputation, transplant, alcoholism).

MEAT	Support	Disease Example	Documentation Example
Monitor	Signs, symptoms, disease progression or regression	Congestive heart failure	Congestive heart failure is stable. Will continue same dose of Lasix.
Evaluate	Test results, medication effectiveness, response to treatment	Type 2 diabetes mellitus	Blood sugar log and A1C results reviewed with the patient.
Assess/Address	Order and discuss tests, review records, counseling, status/level of condition	Peripheral Neuropathy	Decreased sensation of BLE by monofilament test.
Treat	Prescribe medications/therapies, surgical/ therapeutic interventions, specialist referrals	Chronic kidney disease, Stage 3 (new diagnosis)	Referred to nephrology clinic.

Quality Care Gap Closure

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A quality care gap is a recommended preventive screening or evidence-based practice in the care of a condition for a patient that has not been completed per defined requirements in a specified time period.

Key Activities to Close Adult Gaps in Care

Access SLHP data and information platform to identify patients with care gaps.

Provide access for sick and well care.

Proactively reach out to patients and schedule a wellness visit.

- Complete pre-visit planning: pre-populate actionable information for provider to utilize at the time of the visit.
- Update EHR documentation template to support closure of gaps and preventive screening.

Remove barriers to testing/screening (e.g., location, demographics)

Educate and close care gaps at every touch point.

- Develop protocols for staff to provide order recommendations.
- Provide automatic reminder for testing/screening via the electronic medical record.

Ensure that testing/preventive screening was scheduled and completed.

- Educate patient on the importance of screenings and adherence.
- Provide appointment reminders.
- Dispense test kit and send reminders via mail or text to submit the kit.

Refer for home visit if patient does not or is unable to present in person.

Document testing or prior testing. Consider using CPT II codes for completed screenings.

Document and code exclusions to testing (e.g., mammograms and mastectomy patients)

Team-Based Care: Coordinated, high-quality care team that includes a combination of providers, nurses, pharmacists, social workers, case managers and other health care professionals all using their unique skills to provide the safest, best possible care to patients. Key activities include pre-visit planning, registry management, care management, diabetes education, health coaching, nutrition counseling, behavioral health care.

Note: Non-adherence does not close a care gap unless exclusions apply. Exclusions need to be accurately documented and coded.

Quality Care Gap Closure in Adults

Measure	Measure Description	Tips for Gap Closure
Annual Wellness Visit	The percentage of patients that receive their Annual Wellness Visit during the measurement year.	• Pre-Visit planning optimizes nursing, provider, and patient time. • Ensure care gaps, preventive screening, and chronic conditions to re-assess are available to the provider at the time of the visit.
Breast Cancer Screening	The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer	• If documenting a mammogram reported by a patient, include the date of service. • If the patient qualifies for exclusion, submit the appropriate diagnosis code.
Cervical Cancer Screening (CCS)	The percentage of women 21-64 years of age who were screened for cervical cancer: • Women 21-64 years of age who had cervical cytology performed within the last 3 years. • Women 30-64 years of age who had cervical high-risk human papillomavirus testing performed within the last 5 years. • Women 30-64 years of age who had cervical cytology/high risk human papillomavirus co-testing within the last 5 years.	• Documentation of a hysterectomy alone will NOT meet exclusion criteria. Include description, and or documentation that the patient no longer needs testing/cervical cancer screening. • Biopsies are not valid for primary cervical cancer screening
Colorectal Cancer Screening (CRCS)	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	Appropriate screenings are: • Fecal occult blood test during the measurement year. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior. • CT colonography during the measurement year or the four years prior.
Chlamydia Screening in Women (CHL)	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	Billing Chlamydia screening under prenatal or postpartum global billing may not be captured in claims.
Care for Older Adults (COA)	The percentage of adults 66 years and older who had each of the following during the measurement year: • Medication Review • Functional Status Assessment • Pain Assessment	• Always clearly document the occurrence of advanced care planning and the date of the service. • A provider asking a patient if advanced care plan is in place and the patient states "no" does not count as advanced care planning. • Advanced care planning, functional status, and pain assessment can be conducted over the phone by any care provider type. Documentation of the service in the medical record must be completed. • A medication review over the phone must be completed by a prescriber of clinical pharmacist. • The medication review must include prescription, over-the-counter meds, herbal or supplemental therapies and signed by the practitioner. • Use of a functional status assessment tool will improve efficiency and ensure criteria compliance. • Pain scales – numbers or faces – are an acceptable form of pain assessment.

Quality Care Gap Closure in Adults

Measure	Measure Description	Tips for Gap Closure
Controlling High Blood Pressure (CBP)	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.	• The BP reading must occur on or after the date of the second diagnosis of hypertension. • The date of service and BP reading must be recorded together. • BP must be taken during an outpatient visit or a non-acute inpatient visit.
HbA1c in Control	The percent of members 18 to 75 years of age whose hemoglobin A1c was at the following levels during the measurement year: • HbA1c control (<8.0%) • HbA1c poor control (>9.0%)	Utilization of CPT II codes to indicate control will improve outcomes: • HbA1c test <7% use code 3044F • HbA1c test ≥7% and <8% use code 3051F • HbA1c test ≥8% and ≤9 % use code 3052F • HbA1c test >9% use code 3046F
Kidney Health Evaluation	The percentage of members 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement year.	Both of the following during the measurement year on the same or different dates of service will result in compliance: • At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set) • At least one uACR identified by either of the following: - BOTH a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) *and* a urine creatinine test (Urine Creatinine Lab Test Value Set) *with* service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year. - A uACR (Urine Albumin Creatinine Ratio Lab Test Value Set).
Diabetic Eye Exam	The percent of members 18 to 75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	At a minimum, documentation in the medical record must include one of the following: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results. • A chart or photograph indicating the date when the fundus photography was performed and one of the following: - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Closing Gaps in Care in Pediatrics

Key Activities to Close Pediatric Gaps in Care

Give immunizations at any visit in addition to well-child visits.

Provide access for sick and well care.

Proactively reach out to patients and schedule a wellness visit.

- Complete pre-visit planning: pre-populate actionable information for provider to utilize at the time of the visit.
- Update EHR documentation template to support closure of gaps and preventive screening.

Send reminders to parents (texts, postcards, letters).

Participate in the state's immunization registry (IRIS).

Measure	Measure Description
Immunizations for Adolescents (IMA)	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids, acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Childhood Immunization Status (CIS)	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polio; one measles, mumps and rubella; three haemophiles influenza type B; three hepatitis B, one chicken pox; four pneumococcal conjugate; one hepatitis A; and two or three rotavirus; and two influenza vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
Child & Adolescent Well-Care Visits	The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN practitioner during the measurement year.
Well Child Visits in the First 30 Months of Life	The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months—30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Medication Adherence

Key Activities to Support Medication Adherence

When access to a pharmacy is a concern try mail order or home delivery options offered by the patient's insurance.

Try at least 90-day supply of medications, many MA plans allow for 100-day fills.

Encourage patients to work with their pharmacy on medication synchronization to allow all the patient's medications to be filled at the same time of the month.

Inquire about pill box use, if patient is using ask "how many doses have you missed in the past week?"

If the patient is not using a pill box, encourage use to help remember doses.

Update the prescription with dosing changes to reflect accurate adherence.

Note: Non-adherence does not close a care gap unless exclusions apply. Exclusions need to be accurately documented and coded.

Measure	Measure Description	Tips for Gap Closure
Medication Adherence for Hypertension	The percentage of members 18 years of age and older with a prescription for a hypertension medication who fill their prescription 80% or more of the time they are supposed to be taking the medication.	• This measure only applies to ACE inhibitors, ARBs, and Aliskiren. • Update the prescription with dosing changes to reflect accurate adherence.
Medication Adherence for Cholesterol	The percentage of members 18 years of age and older with a prescription for a cholesterol medication (statin drug) who fill their prescription 80% or more of the time they are supposed to be taking the medication.	• This measure only applies to statins. • For patients who have had muscle pain with a statin try a more hydrophilic statin such as rosuvastatin or pravastatin. Consider lower or less-frequent dosing and slowly up titrate the dose. • For patients who prefer red yeast rice, inform them the supplement may contain a chemical that is identical to lovastatin and the FDA has issued warnings about taking this supplement due to lack of standardized preparation. • When patients are concerned about reports of increased risk of dementia, remind them there is no data to support this claim. • If cost is a concern, use a generic statin. Most generic statins are very low cost, sometimes $0 co-pay.

Medication Adherence

Measure	Measure Description	Tips for Gap Closure
Medication Adherence for Diabetes Medications	The percentage of members 18 years and older with a prescription for diabetes medication who fill their prescription 80% or more of the time they are supposed to be taking the medication.	If cost is a concern, refer to the following ADA Standards of Medical Care page S116 for pharmacological approaches when cost is a major issue: https://care.diabetesjournals.org/content/44/Supplement_1/S111.full-text.pdf
Statin Therapy for Patients with Diabetes	The percentage of members 40 to 75 years of age during the measurement year with diabetes, who do not have clinical atherosclerotic cardiovascular disease (ASCVD), who met the following criteria: • Received Satin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. • Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	• If a patient is unable to take a statin due to muscle pain or another contraindication, submit associated diagnosis code at least annually and it may exclude the patient from the measure. • If a patient's chart states they are intolerant to statins, consider a rechallenge with a reduced dose of a different statin. • For patients who have had muscle pain with a statin try a more hydrophilic statin such as rosuvastatin or pravastatin. Consider lower or less-frequent dosing and slowly up titrate the dose. • For patients who prefer red yeast rice, inform them the supplement may contain a chemical that is identical to lovastatin and the FDA has issued warnings about taking this supplement due to lack of standardized preparation. • When patients are concerned about reports of increased risk of dementia, remind them there is no data to support this claim. • If cost is a concern, use a generic statin. Most generic statins are very low cost, sometimes $0 co-pay. • When a patient is taking amlodipine, remember the drug interaction with simvastatin and prescribe a statin that does not interact such as atorvastatin or rosuvastatin.

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