Trinity Health
Mid-Atlantic

# All-CIN Physician WebEx

## Quality Health Alliance

## Mercy Accountable Care

## Delaware Care Collaboration

**November 11, 2020**
6:00pm - 7:30pm

 

# Reflection

# Trinity Health Mid-Atlantic (THMA) Clinically Integrated Network (CIN)

## Regional News

Quality Health Alliance – St. Mary Medical Center

Mercy Accountable Care – Legacy Mercy Health System

Delaware Care Collaboration – St. Francis Hospital

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# THMA CIN Physician / Executive Leadership Team

**Dan Bair**
**Regional Executive Director**
**THMA CIN**

**Dr. Sharon Carney**
**Regional Chief Clinical Officer**
**THMA**

**Dr. Benjamin Chack**
**President**
**Quality Health Alliance**

**Dr. Robert Monteleone**
**Medical Director**
**Delaware Care Collaboration**

**Dr. Wayne Miller**
**Medical Director**
**Mercy Accountable Care**

**Dr. Naomi McMackin**
**Medical Director**
**Quality Health Alliance**

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# Welcome New THMA CIN Regional Directors

**Brittany Danoski**

**Regional Director for Population Health**

**Mark Lewis**

**Regional Director for Data/Analytics**

# New THMA Regional Newsletter Publication


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Quality Health Alliance

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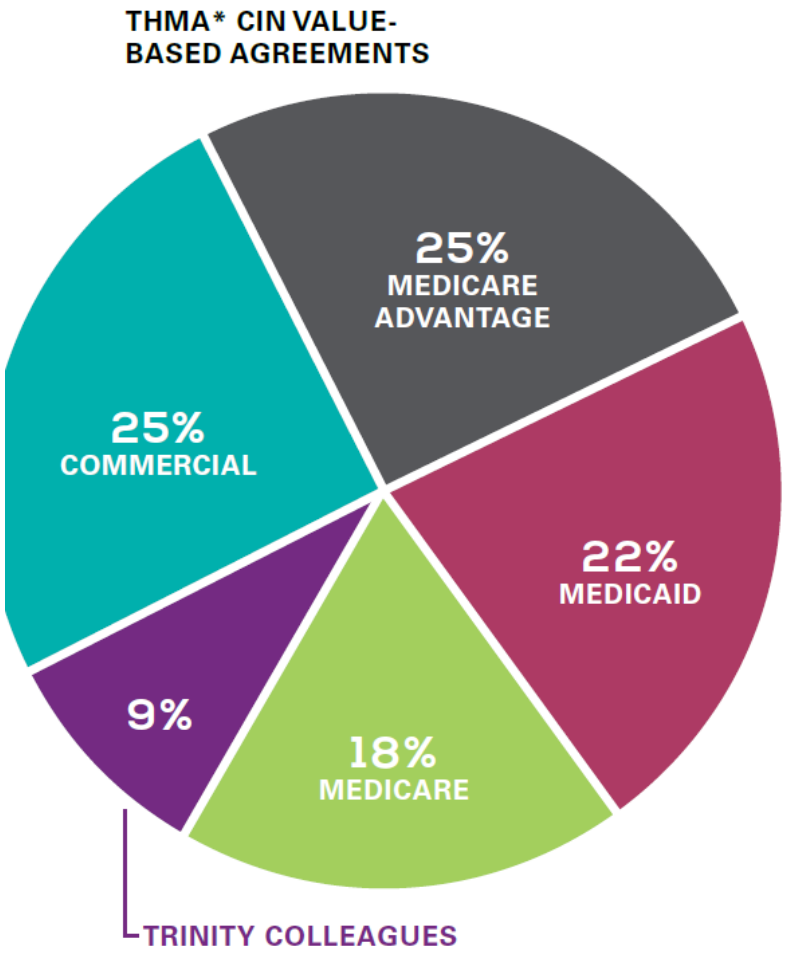
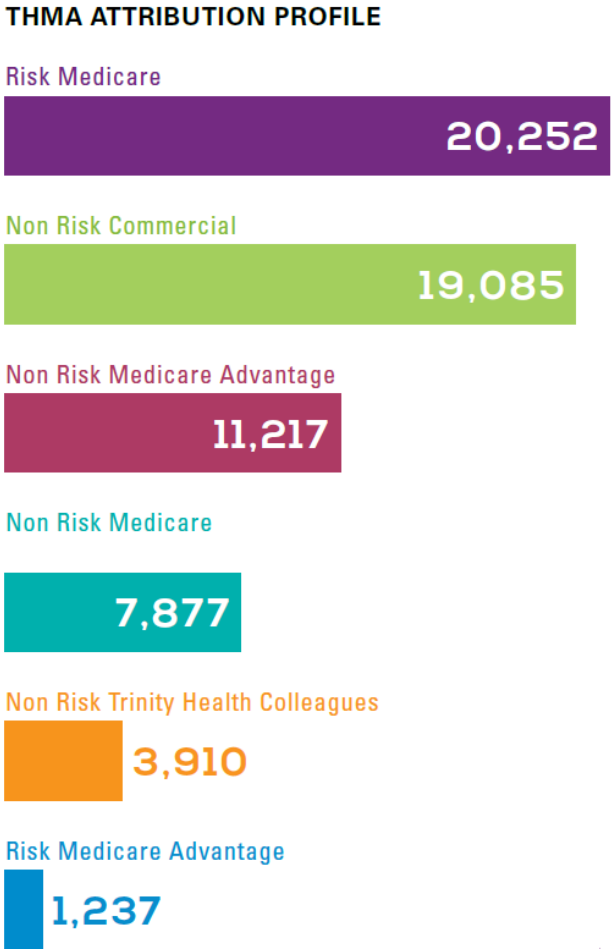
# THMA CIN Value-Based Agreements 2020




*represents QHA, MAC, and DCC as of June 2020

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# Medicare Shared Savings Program (MSSP)
# 2019 Participation Year Results

## Trinity Health Integrated Care
## Delaware Care Collaboration

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# Medicare Shared Savings Program (MSSP) PY 2019 Results

- **Trinity Health Integrated Care (THIC)**

**Savings Generated = $19.8 M**

**Savings Earned = $13.7 M**

**Quality Score = 92%**
**Savings Rate = 2.9%**

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# Medicare Shared Savings Program (MSSP) PY 2019 Results

- **Delaware Care Collaboration (DCC)**

**Savings Generated = $4.9 M**

**Savings Earned = 0$**

**Quality Score = 92%**
**Savings Rate = 2.2%**

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# MSSP 2020 – COVID-19 Implications

- CMS Public Health Emergency (PHE) extended through January 20, 2021;

- MSSP 2020 Quality Metrics:
  - ACOs are accountable to participate in a CMS ACO Quality Measures Audit (GPRO) for the 2020 participation year;
  - CMS preliminary rule indicates ACOs can use the better of the 2019 or 2020 score for the 2020 participation year – NOT FINAL;

- What does this mean for Trinity Health Integrated Care (QHA & MAC) and Delaware Care Collaboration?

# MSSP 2020 – COVID-19 Implications

- **Trinity Health Integrated Care (THIC)**
  - NO downside financial risk for 2020 participation year;
  - Entitlement to all shared savings earned in 2020 participation year;

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- **Delaware Care Collaboration (DCC)**
  - NO progression to downside risk for 2021 participation year;
  - Entitlement to all share savings earned in 2020 participation year;

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# Quality, Practice Transformation, and Care Management Updates

Presented by Dr. Naomi McMackin
Chief Medical Officer of Quality Health Alliance

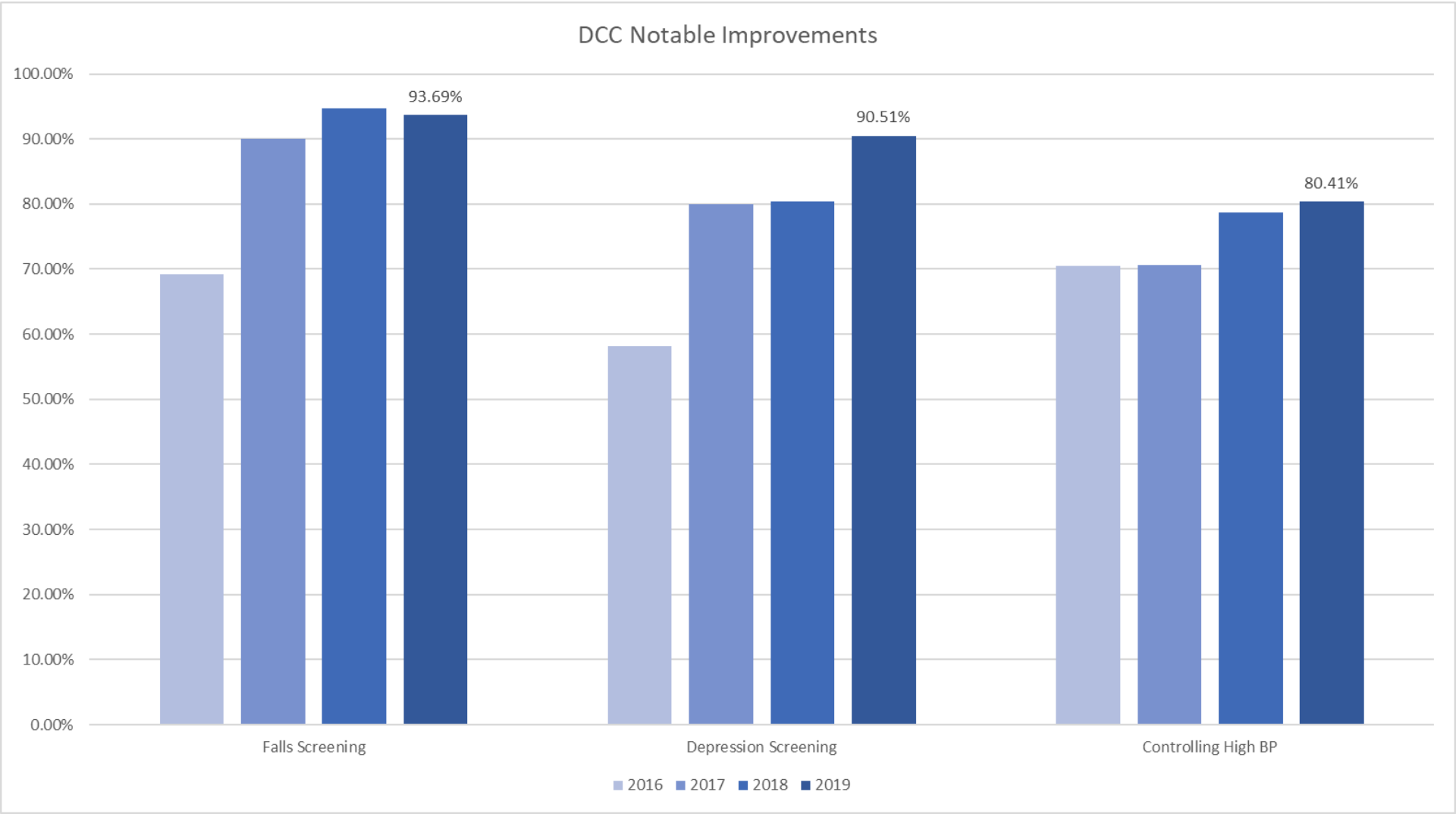
# THMA CIN Quality and Care Coordination Updates

- Quality
  - 2019 GPRO Performance
  - 2021 ACO Proposed Quality Measures
- Practice Transformation
  - COVID19 & Flu
- Care Coordination
  - Advanced Care Planning COVID19

# GPRO Results 2019- DCC

| 2019 Quality Performance Report (includes 2019 and 2019-A) | | | | | | |
|---|---|---|---|---|---|---|
| DELAWARE CARE COLLABORATION DCC LLC | | | | | | |
| ACO | Measure | Measure Name | Numerator | Denominator | DCC 2019 %Rate | ACO National Mean %Rate |
| DCC | CARE-2 | Falls Screening | 282 | 301 | 93.69% | 84.04% |
| DCC | DM-2 | HbA1c Poor Control | 40 | 296 | 13.51% | 13.88% |
| DCC | HTN-2 | Controlling High BP | 242 | 300 | 80.67% | 75.04% |
| DCC | MH-1 | Depression Remission 12m | 5 | 64 | 7.81% | 13.58% |
| DCC | PREV-10 | Tobacco Use (Screen/Cessation) | 21 | 25 | 84.00% | 78.04% |
| DCC | PREV-12 | Depression Screening | 267 | 295 | 90.51% | 70.40% |
| DCC | PREV-13 | Statin Therapy CVD | 263 | 294 | 89.46% | 82.17% |
| DCC | PREV-5 | BrCa Screening | 233 | 298 | 78.19% | 73.84% |
| DCC | PREV-6 | CRC Screening | 232 | 300 | 77.33% | 70.76% |
| DCC | PREV-7 | Flu Immunization | 222 | 250 | 88.80% | 74.77% |

# GPRO Results 2019- DCC Improvements

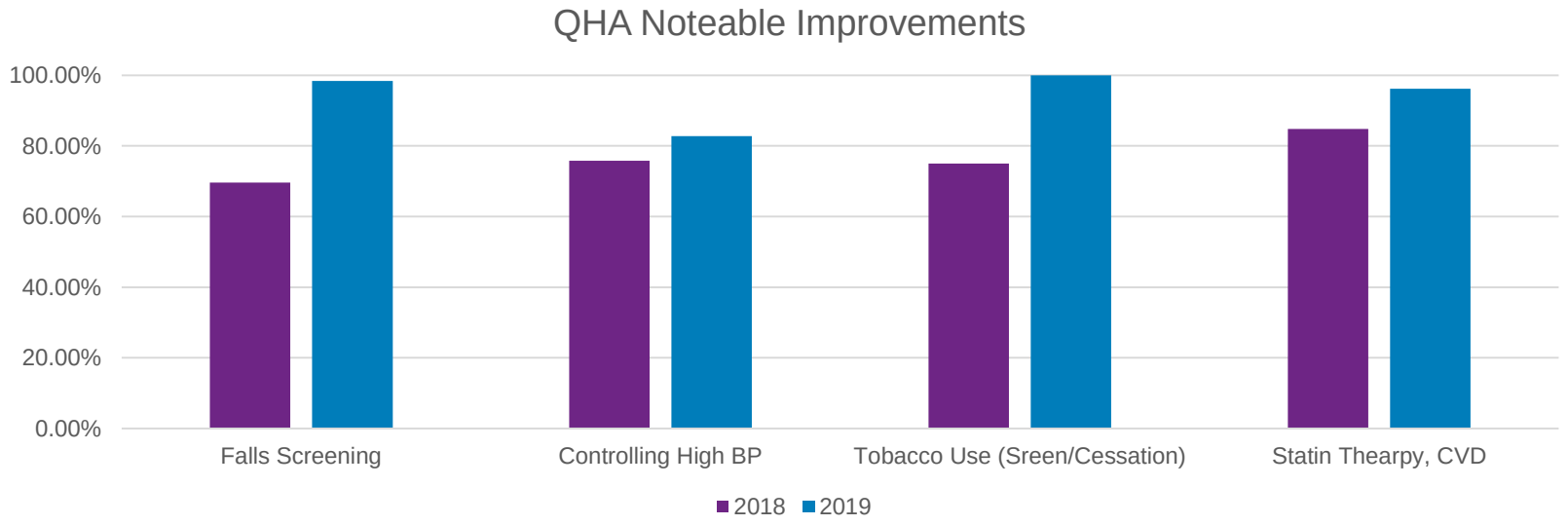


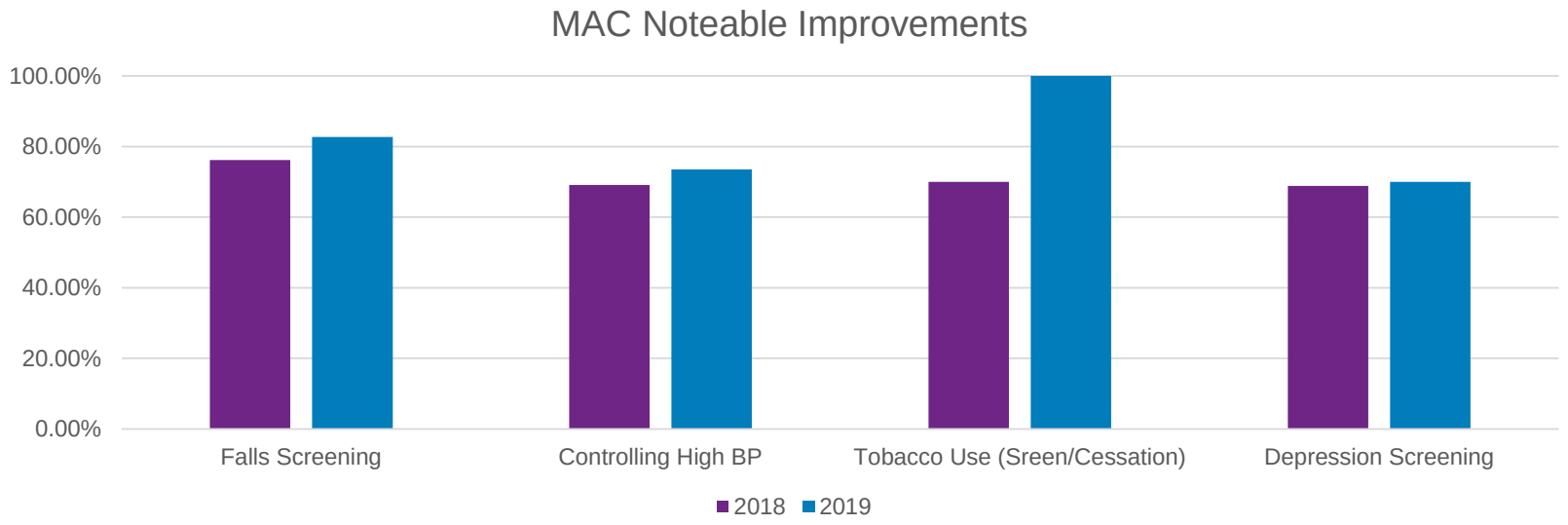
# GPRO Results 2019- QHA & MAC

| ACO | Chapter | Measure | Measure Name | Numerator | Denominator | Score |
|---|---|---|---|---|---|---|
| THIC | Langhorne | CARE-2 | Falls Screening | 120 | 122 | 98.36% |
| THIC | Langhorne | DM-2 | HbA1c Poor Control | 22 | 125 | 17.60% |
| THIC | Langhorne | HTN-2 | Controlling High BP | 106 | 128 | 82.81% |
| THIC | Langhorne | MH-1 | Depression Remission | 1 | 13 | 7.69% |
| THIC | Langhorne | PREV-10 | Tobacco Use (Screen/Cessation) | 7 | 7 | 100.00% |
| THIC | Langhorne | PREV-12 | Depression Screening | 97 | 120 | 80.83% |
| THIC | Langhorne | PREV-13 | Statin Thearpy, CVD | 153 | 159 | 96.23% |
| THIC | Langhorne | PREV-5 | BrCa Screening | 123 | 145 | 84.83% |
| THIC | Langhorne | PREV-6 | CRC Screening | 123 | 145 | 84.83% |
| THIC | Langhorne | PREV-7 | Flu Immunization | 96 | 119 | 80.67% |

| ACO | Chapter | Measure | Measure Name | Numerator | Denominator | Score |
|---|---|---|---|---|---|---|
| THIC | SEPA | CARE-2 | Falls Screening | 43 | 52 | 82.69% |
| THIC | SEPA | DM-2 | HbA1c Poor Control | 19 | 65 | 29.23% |
| THIC | SEPA | HTN-2 | Controlling High BP | 50 | 68 | 73.53% |
| THIC | SEPA | MH-1 | Depression Remission | 0 | 4 | 0.00% |
| THIC | SEPA | PREV-10 | Tobacco Use (Screen/Cessation) | 7 | 7 | 100.00% |
| THIC | SEPA | PREV-12 | Depression Screening | 42 | 60 | 70.00% |
| THIC | SEPA | PREV-13 | Statin Thearpy, CVD | 66 | 79 | 83.54% |
| THIC | SEPA | PREV-5 | BrCa Screening | 47 | 70 | 67.14% |
| THIC | SEPA | PREV-6 | CRC Screening | 30 | 56 | 53.57% |
| THIC | SEPA | PREV-7 | Flu Immunization | 39 | 54 | 72.22% |

# GPRO Results 2019- QHA & MAC Improvements

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# Proposed Quality Changes for PY2021

| Measure # | Measure Title | Collection Type | Submitter Type | Meaningful Measure Area |
|---|---|---|---|---|
| Quality ID # 321 | CAHPS for MIPS | CAHPS for MIPS Survey | Third Party Intermediary | Patient's Experience |
| Quality ID # 001 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control | eCQM/MIPS CQM | APM Entity/Third Party Intermediary | Mgt. of Chronic Conditions |
| Quality ID # 134 | Preventive Care and Screening: Screening for Depression and Follow-up Plan | eCQM/MIPS CQM | APM Entity/Third Party Intermediary | Treatment of Mental Health |
| Quality ID # 236 | Controlling High Blood Pressure | eCQM/MIPS CQM | APM Entity/Third Party Intermediary | Mgt. of Chronic Conditions |
| Measure # TBD | Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups | Administrative Claims | N/A | Admissions & Readmissions |
| Measure # TBD | Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs | Administrative Claims | N/A | Admissions & Readmissions |

# CPT II Codes for CMS 2021 Quality Measures

## Diabetes Hemoglobin A1c

| | | | |
|---|---|---|---|
| HbA1c level < 7.0% | 3044F | HbA1c level 8 – 9 | 3052F |
| HbA1c level ≥ but < 8 | 3051F | HbA1c level > 9 | 3046F |

## Screening for Depression

3725F

## Controlling High Blood Pressure

| | | | |
|---|---|---|---|
| Systolic < 130 | - 3074F | Diastolic < 80 | - 3078F |
| Systolic between 130-139 | - 3075F | Diastolic between 80-89 | - 3079F |
| Systolic ≥ 140 | - 3077F | Diastolic ≥ 90 | - 3080F |

# COVID19 + Flu

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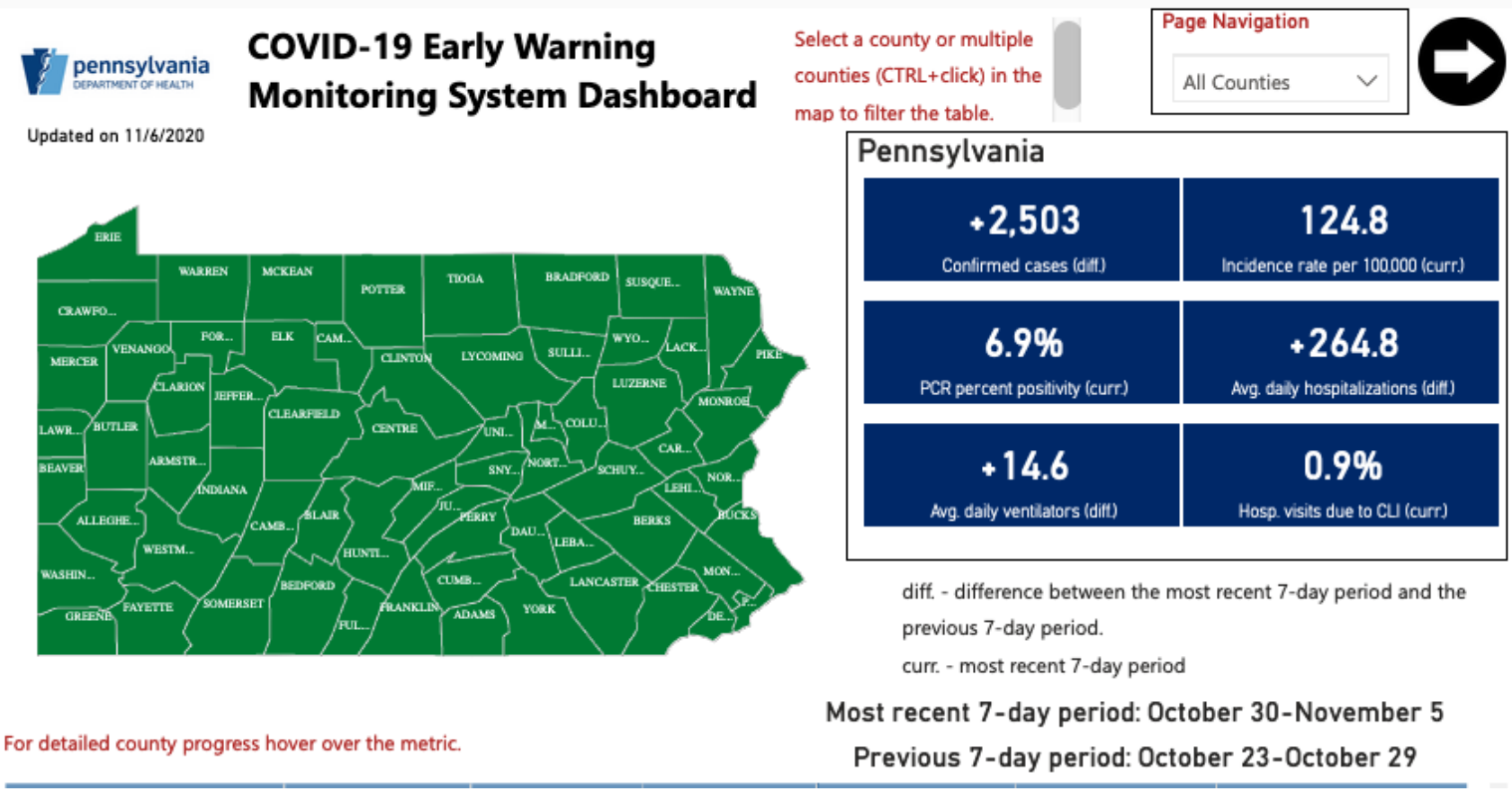
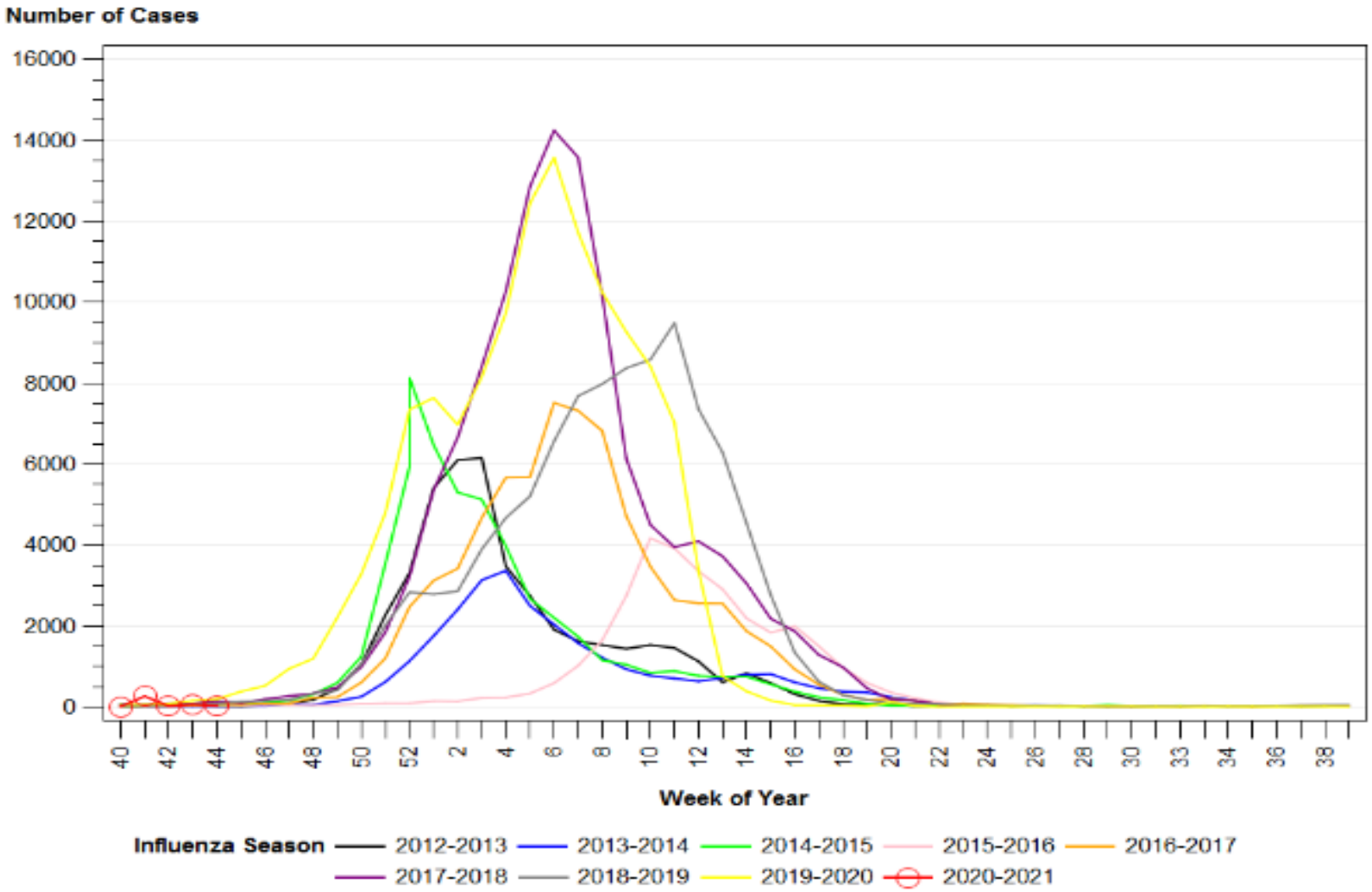



[1]https://www.health.pa.gov/topics/disease/coronavirus/Pages/Monitoring-Dashboard.aspx

# Comparison of PA Influenza Cases in Current Season to the Eight Previous Seasons




[1]https://www.health.pa.gov/topics/disease/Flu/Pages/2020-21-Flu.aspx

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# COVID19 vs Flu

| Symptoms | Coronavirus (COVID-19) Symptoms range from mild to severe | Influenza (FLU) Abrupt onset of symptoms | Cold Gradual onset of symptoms | Seasonal Allergies Symptoms improve or worsen depending on environment |
|---|---|---|---|---|
| Fever | Often | Often | Rare | Sometimes |
| Fatigue | Sometimes | Sometimes | Sometimes | Often |
| Cough | Often (usually dry) | Often (usually dry) | Mild | Often |
| Sneezing | No | No | Often | Often |
| Aches & Pains | Sometimes | Often | Often | No |
| Runny or Stuffy Nose | Rare | Sometimes | Often | Often |
| Sore throat | Sometimes | Sometimes | Often | No |
| Diarrhea | Rare | Sometimes in Children | No | No |
| Headaches | Sometimes | Often | Rare | Sometimes |
| Shortness of breath/ Difficulty breathing | Often | Rare | Rare | Rare |
| Loss of taste and smell | Often | Rare | Rare | Rare |

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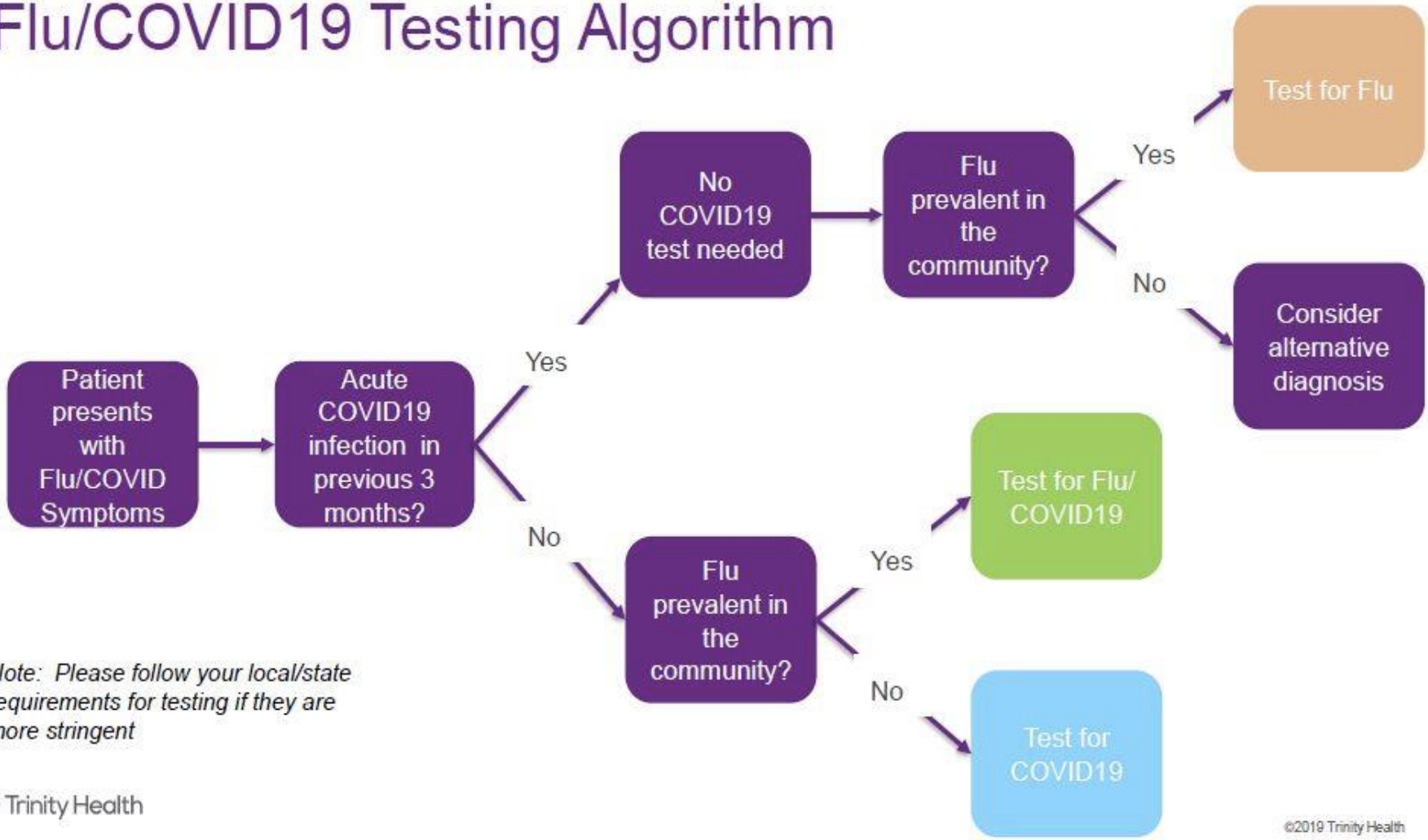
# Flu/COVID19 Testing Algorithm




*Note: Please follow your local/state requirements for testing if they are more stringent*

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# Partnering to Keep Patients Safe During COVID-19

- **Patient Collateral** developed to help patients seek care in appropriate setting based off symptoms (→)
- Partner with your patients to **mitigate** community spread
- Focus on inappropriate ED visits for **ambulatory conditions** & **chronic disease management** to prevent future inpatient admissions
- Ensure office access for same day/next day visits and education to patients to **call your office** for help deciding where to seek care.


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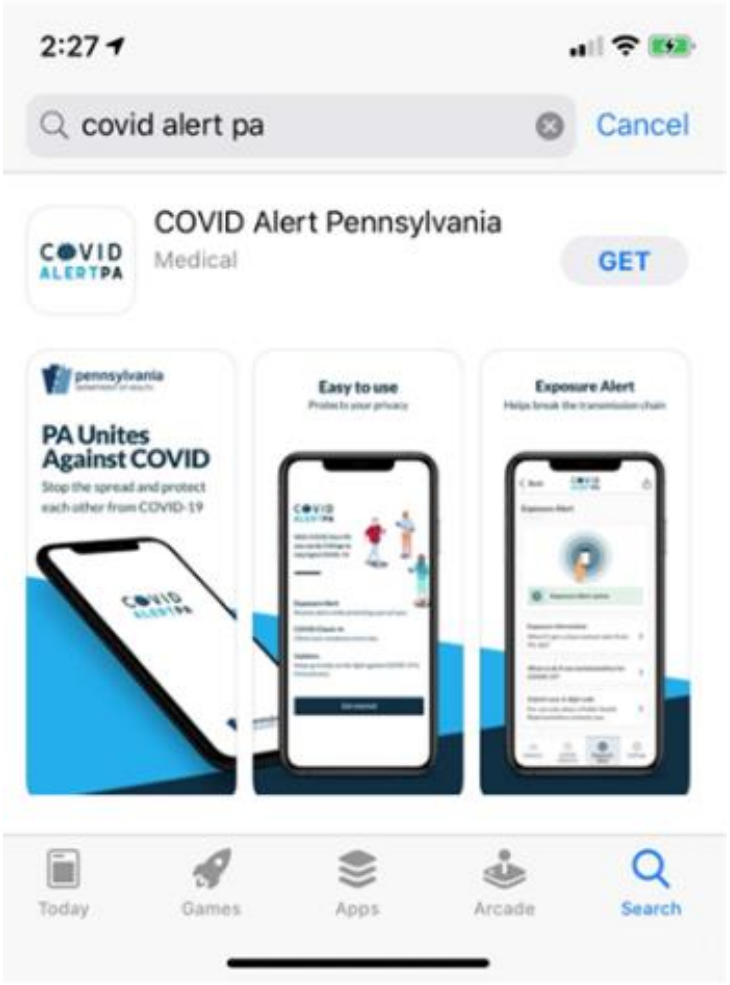
# COVID Alert PA app

- App uses anonymous Bluetooth low technology to know when your phone is within 6 feet of another phone with the app for 15 minutes or more.
- When an app user confirms a positive COVID-19 test result in the app, it will check to see if it matches any of the anonymous Bluetooth close contact interactions your phone has had over the last 14 days.
- If there is a match, COVID Alert PA may send an alert after taking into account the date, duration of exposure, and the Bluetooth signal strength



# THMA CIN Regional Care Coordination Leadership Team

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# THMA CIN Care Coordination Leadership Team

**Christine Falcone, MHA, BSN, RN, CPHQ**

**Vice President of Quality, Safety, and Care Transformation**

**Rhonda Meredith, BSN, RN, CCM, Director of ACO Care Coordination, Delaware Care Collaboration**

**Allison Patzek, MSN, RN, CCRN-K Director of Ambulatory Care Coordination, North Region**

**Tanya Vogel, MSN, RN Director of Acute and Ambulatory Care Integration**

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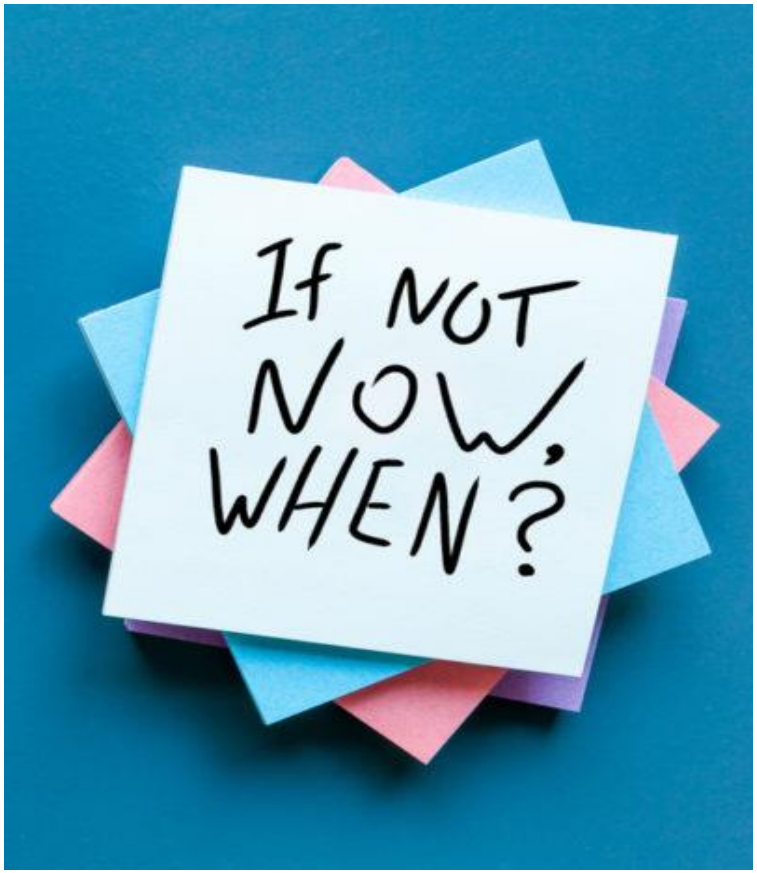
# Advance Care Planning During COVID 19 – Role of Primary Care Provider

- Ensure patients receive the care they want, aligning the care that is delivered with patients' values and goals.
- Know that patients most likely to develop severe illness will be older and have greater burden of chronic illness.
- Have the relationships with patients and families while hospitalist/intensivists are tasked with urgent decisions in a crisis.
- Best understand how visitor restrictions create communication challenges with patients and their loved ones.

[1]The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19)
J. Randall Curtis, MD, MPH, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Washington, Seattle; and Cambia Palliative Care Center of Excellence, University of Washington, Seattle
Erin K. Kross, MD, Division of Pulmonary, Critical Care, and Sleep Medicine, University of Washington, Seattle; and Cambia Palliative Care Center of Excellence, University of Washington, Seattle
Renee D. Stapleton, MD, PhD
Larner College of Medicine, Division of Pulmonary and Critical Care Medicine, University of Vermont, Burlington

# Advance Care Planning During COVID 19

- Ambulatory Care Managers have been trained in ACP and Serious Illness conversation
- ACP quality measure for BPCI-A
- Newsletter contains education on documentation and coding opportunities

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Renee D. Stapleton, MD, PhD
Larner College of Medicine, Division of Pulmonary and Critical Care Medicine, University of Vermont, Burlington

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# Guidance Regarding Best Practices for Prescription Medication and Refill Requests and Prescribing of Chronic Regimens of Controlled Substances

Presented by Dr. Robert Monteleone
Medical Director of Delaware Care
Collaboration

Development of Guidance in part by:
Kristina Mazzie, PharmD
Population Health Pharmacist
Mercy Accountable Care

# Summary of Guidance for Refill and Prescription Requests

**Education**

- Informing and educating staff and patients of the refill policy should be a priority

**Process of Patient Prescription and Refill Requests**

- Refills should be requested at patient's office visit or via office refill line during normal business hours
- Ninety-day supplies should be prescribed whenever possible
- Prescribing should primarily be performed electronically
- Requests should be checked at least twice a day

**Denial of Patient Prescription and Refill Requests***

- Reasons would include:
    1. not being seen by provider in last 6 months
    2. if request is for a medication not previously prescribed by provider
- If an appointment is needed, it should be scheduled for patient within 72hrs of request

** Exceptions to this policy are allowable per provider on a case by case basis.*

# Summary of Guidance for Prescribing of Chronic Regimens of Controlled Substances

**New Patients, Initiation of Therapy and Controlled Substance Agreements**

- New patients are required to give informed consent and submit their prior health records
- Opioid Risk Assessment and urine drug screen should be performed
- Controlled substance agreements are required for regimens >7 days

**Usage of Prescription Drug Monitoring Program (PDMP)**

- Prescribers must continue to query the PDMP before therapy initiation and for every therapy renewal
- Prescribers must be registered with the PDMP in each state they are licensed to practice

**Clinician Guided Monitoring for Continuation of Therapy**

- Periodic fluid drug screens should be completed at least every 12 months in PA and every 6 months in DE
- Patients should be available for monitoring requests within 24hrs

# Summary of Guidance for Prescribing of Chronic Regimens of Controlled Substances

**Procedure for Handling of Prescription Refills and/or Renewal Requests**

- Patients should be seen once every 3 months by telehealth or in-person visit before renewal is approved.
- At the patient's office visit, a prescription for CII medications can only be written for a thirty-day supply.
- CIII-CV prescriptions can be written for up to a ninety-day supply
- Prescription renewal requests for CII medications should be requested by the patient for the 2nd and 3rd prescriptions by phone to the office staff or via refill phone extension.

**Discontinuation and Tapering of Ongoing Therapy**

- Tapering should not occur at a rate greater than 25% per week, in order to minimize serious risk of withdrawal.

**Monitoring of Clinician Compliance with Prescribing, and Patient Surveillance**

- Random audits of compliance should be performed by the compliance department or the network's corporate staff.

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# Clinical Condition Documentation/ Hierarchical Condition Category (HCC) Coding

Wayne G. Miller, D.O., M.P.H.
Medical Director
Mercy Accountable Care

# Importance of Focusing on Clinical Condition Documentation (CCD) Education

- *The move from FFS to Value-Based Care makes it increasingly important for providers to properly document the disease burden of their patients*

- *CCD educational efforts are geared toward helping assure that the codes being used on claims help payers accurately risk adjust patients*

- *This will result in both more accurate forecasting of benchmarks in CMS shared savings programs and more accurate reimbursement in Medicare Advantage and other commercial programs*

# What do you see?


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# How many lives are we talking about for our Clinically Integrated Network?

Approximately 28,000 Attributed Medicare Patients

40

# Risk Adjustment Factor (RAF) and Methodologies

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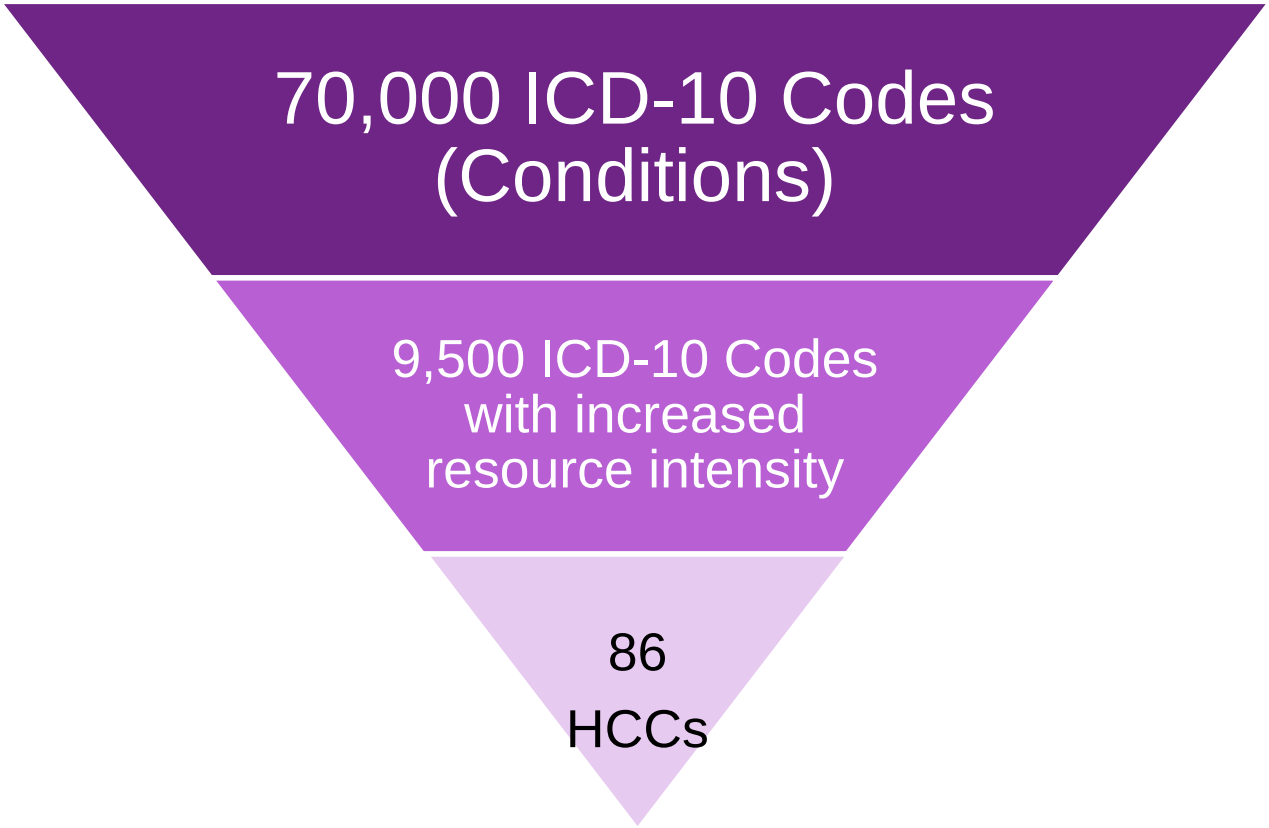
# CMS-HCC model

- 70,000 ICD-10 Codes (Conditions)
- 9,500 ICD-10 codes require increased costs to manage
- Conditions grouped into Hierarchical Condition Categories **(HCC)**
  - Similar conditions
  - Similar resource needs

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# CMS-HCC model

| ICD-10-CM codes | HCC category description | HCC | Disease Hierarchy |
|---|---|---|---|
| E08.0-, E08.1-, E08.641, E09.0-, E09.1-, E09.641, E10.1-, E10.641, E11.0-, E11.1- , E11.641, E13.0-, E13.1-, E13.641 | Diabetes with acute complications | 17 | 18, 19 |
| E08.21-E08.638, E08.649-E08.8, E09.21-E09.638, E09.649-E09.8, E10.21-E10.638, E10.649-E10.8, E11.21-E11.638, E11.649-E11.8, E13.21-E13.638, E13.649-E13.8 | Diabetes with chronic complications | 18 | 19 |
| E08.9, E09.9, E10.9, E11.9, E13.9, Z79.4 | Diabetes without complication | 19 | |
| I85.-, K70.41, K71.11, K72.01-K72.91, K76.6, K76.7, K76.81 | End-stage liver disease | 27 | 28, 29, 80 |
| K70.30-K70.9, K74.3-K74.69 | Cirrhosis of liver | 28 | 29 |
| B18.-, K73.-, K75.4 | Chronic hepatitis | 29 | |

# How is risk score (RAF) calculated?


*RAF: Risk Adjustment Factor;  HCC: Hierarchical Condition Categories*

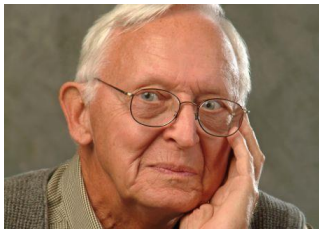
# Where does each patient stand?


***Important to note that CMS rebases what "1" is every year based on all Medicare beneficiaries and their risk score***

# Patient Comparison

- 66 Years Old
- Female
- HTN

Below Average RAF



- 87 Years Old
- Male
- CHF + DM

Above Average RAF

# Provider concerns

Providers want to provide the best care for their patients.

Providers want to properly document the disease burden of their patients.

Providers are not specifically trained in diagnostic coding.

# Documentation Elements

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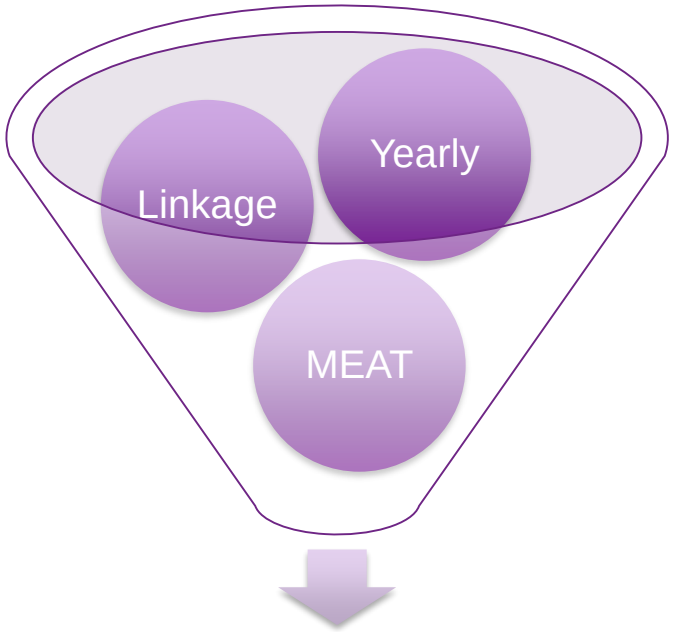
# The sooner, the better

**Yearly-** Document chronic conditions at least once annually

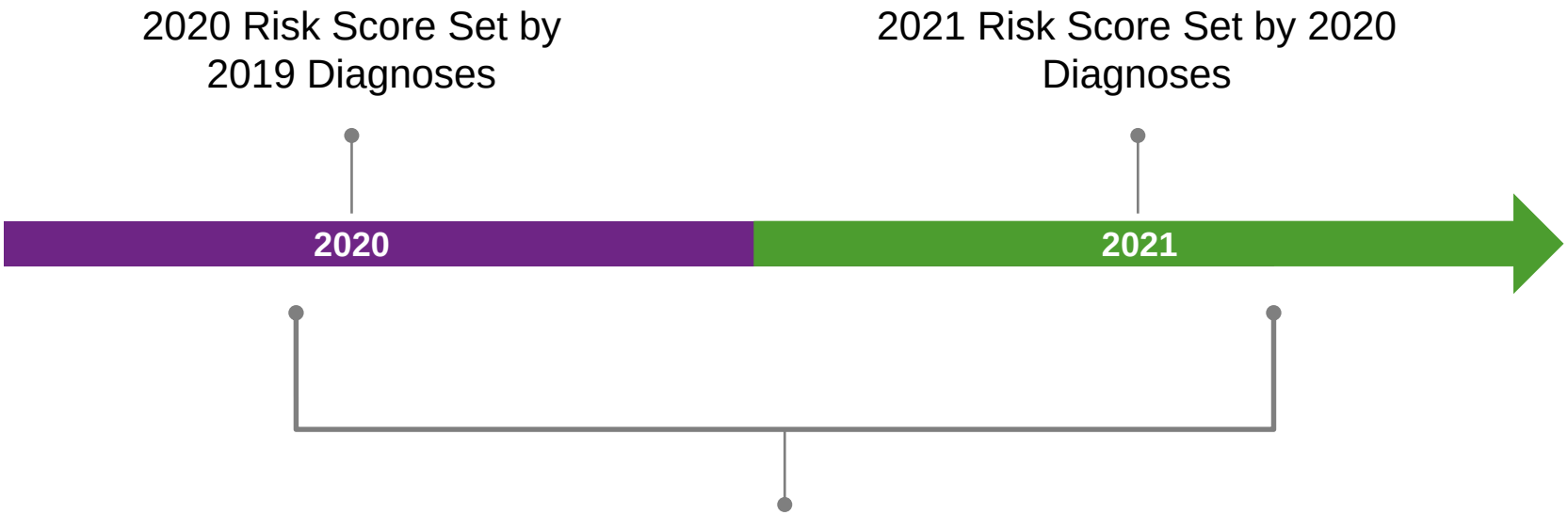
**Linkage-** clarify any complications that relate to chronic conditions

**MEAT-** add supporting documentation for each chronic condition assessed




**Excellent Documentation**

# The documentation done in 2020 directly impacts 2021




## HCCs must be reconfirmed on an annual basis

# Linkage

Medical complications can result from a long-standing, under-controlled primary condition. In these cases, the complication is *assumed* to have resulted from the primary condition. The patient's encounter diagnosis should reflect the connection between the primary and secondary conditions

<u>The most common assumed relationship are:</u>

- Diabetes with complications
- Hypertension with heart failure or kidney failure

# Remember this acronym

***M***onitor

***E***valuate

***A***ssess/Address

***T***reat

MEAT is an easy acronym for remembering what suffices as supporting documentation.

Only **one** of the elements needs to be present for a coded condition.

# Essential Concepts
# What is MEAT?

**Monitor**
- How is the individual doing?
- Are there any signs or symptoms?
- Conceptually represents ongoing surveillance of the condition(s)

**Evaluate**
- What is the current state of the condition?
- What is the provider's judgement of the condition currently?
- For example: *the review of results or the treatment outcomes*.

**Access**
- How will the conditions(s) be evaluated or estimated?
- For example: *documentation of prior records review, counseling, or ordering further studies*

**Treat**
- What care is being offered or what is being done to help the patient with the condition(s)?
- For example: *medication, diagnostic study, or therapeutic service.*

# What are acceptable locations for MEAT documentation?

| YES | | NO | |
|---|---|---|---|
| √ | History of present illness | X | Past medical history |
| √ | Review of symptoms | X | Surgical history |
| √ | Physical exam | X | Problem list |
| √ | Assessment | X | Medication list |
| √ | Plan | | |
| √ | Treatment | | |

# Assessment and Plan with Opportunities

- Type 2 Diabetes **with retinopathy**- refill meds and continue follow up with Ophthalmologist, Dr. Smith. Diabetic **retinopathy** education is provided.
- Hypertension- controlled, continue meds
- **Recurrent** depression, **mild**- Stable on citalopram, symptoms are improving
- Morbid obesity- Diet and exercise information given and discussed

# Assessment and Plan with Opportunities

- Congestive heart failure, **diastolic, chronic**- this is **not due to hypertension**. Patient is tracking salt intake and has quit smoking.
- **Hypertensive chronic kidney disease**-patient is compliant with ACE inhibitor and has been referred to nephrology with new diagnosis of stage 5 CKD.
- History of breast cancer-patient had a double mastectomy and is currently **completed** all treatment. Originally diagnosed in **1995.**

# It all boils down to this!

| No Conditions Coded | |
|---|---|
| **Clinical Factor** | **Weight** |
| 76 year old female | 0.468 |
| Medicaid Eligible | 0.177 |
| DM not coded | 0 |
| CKD not coded | 0 |
| Use of insulin not coded | 0 |
| COPD not coded | 0 |
| Interaction of COPD + DM | 0 |
| Total Risk Adjustment Factor | 0.645 |
| PMPM Spending Budget | $484 |
| Annual Expected Cost of Care | ~$6K |

| Only Some Conditions Coded and with Poor Specificity | |
|---|---|
| **Clinical Factor** | **Weight** |
| 76 year old female | 0.468 |
| Medicaid Eligible | 0.177 |
| DM, type 2 | 0.121 |
| CKD, stage 4 | 0.23 |
| Use of insulin not coded | 0 |
| COPD not coded | 0 |
| Interaction of COPD + DM | 0 |
| Total Risk Adjustment Factor | 0.996 |
| PMPM Spending Budget | $747 |
| Annual Expected Cost of Care | ~$9K |

| All Conditions Coded Accurately | |
|---|---|
| **Clinical Factor** | **Weight** |
| 76 year old female | 0.468 |
| Medicaid Eligible | 0.177 |
| DM with CKD | 0.667 |
| CKD, stage 4 | 0.23 |
| Long term use of insulin | 0.121 |
| COPD | 0.355 |
| Interaction of COPD + DM | 0.204 |
| Total Risk Adjustment Factor | 2.222 |
| PMPM Spending Budget | $1,667 |
| Annual Expected Cost of Care | ~$20K |

**This is what the payer believes it should cost annually to care for a patient with a score of 2.2 compared to a patient with a score of 0.64. Same patient, $14,000 difference based on accurate and complete coding**

# The Essential Eight

- Diabetes
- Chronic Kidney Disease
- Depression
- Neoplasms
- BMI and Nutritional Status
- Obstructive Pulmonary Disease
- Congestive Heart Failure Chronic
- Vascular Disease

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# BMI & Nutritional Status

***BMI Status***

- You can diagnose Obesity based upon BMI
- You can diagnose Cachexia based upon BMI

***Nutritional Status***

- You can diagnose morbid obesity related to excessive calorie intake
- You can diagnose protein-calorie malnutrition

| Code | Description | HCC |
|---|---|---|
| E66.01 | Morbid (severe) obesity due to excess calories | 22 |
| Z68.41-Z69.45 | BMI > 40 | 22 |
| R64 | Cachexia | 21 |
| E43-E46 | Protein-calorie malnutrition | 21 |

*not all-inclusive list

59

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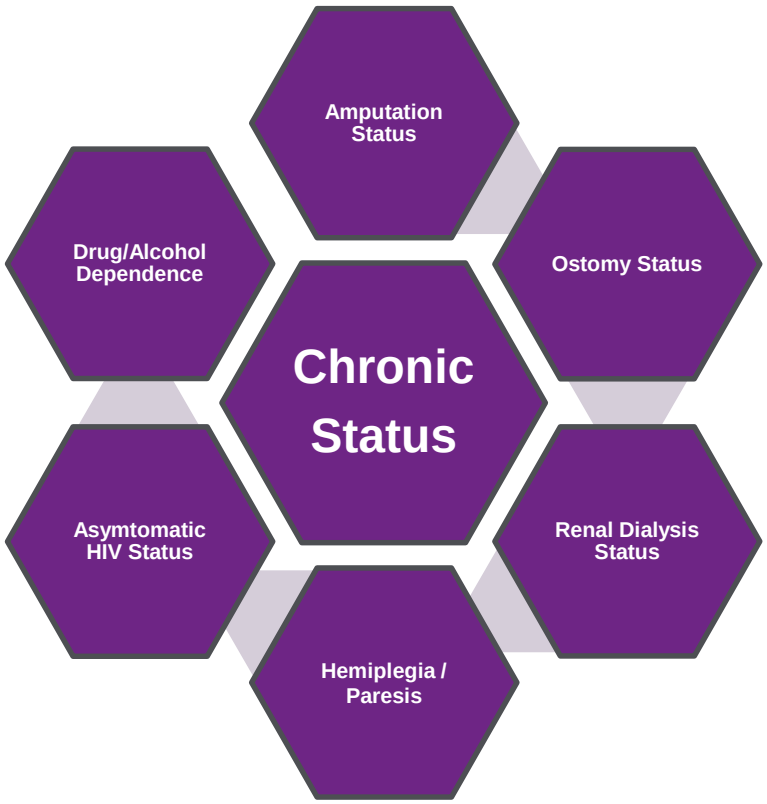
# Chronic Statuses Illustrate Full Picture




***If these conditions are still present they need to be coded at least once EVERY year.***

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# Use of Comprehensive Care Visit (CCV) forms

- CCVs assist in achieving an accurate risk score by listing opportunities to :
  - Revalidate chronic active conditions for the current year
  - Reject resolved conditions or incorrect diagnoses
  - Document conditions with status codes for the current year
  - Use more specific language for certain diagnoses and/or link to other conditions by, e.g., “due to”
  - Add new chronic active conditions diagnosed in other settings

# Keys to Success

- Address Chronic Conditions **once a year**
- Better to see patients sooner in the year
- Give a full picture of patient


62

# Adjournment

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