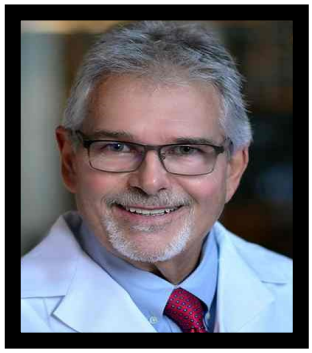
CHI Texas Division

ConnectCIN

www.chitxcin.org

April 20, 2018

From the CMO *Jeff Steinbauer, MD*



Special points of interest:

- From the CMO
- From the Director of Analytics
- From the Director of Quality
- What's New in the Network?
- Ask the CIN

In this issue of ConnectCIN, you will learn more about our data systems and our efforts to help you improve quality. These efforts include:

- Doing your quality reporting for you (if you are also a member of our ACO) so you are complete for that portion of MIPS/QPP
- Providing quarterly scorecards reflecting your performance in the key metrics our contracts require
- Understanding how our RN Care Managers and other CIN staff work *with your office* to improve coordination of care and timely completion of visits after hospitalization, and getting recommended preventive services.

Please note that the following have been identified as key areas on which we, as physicians and providers, should focus:

- Please refer patients to CHI facilities for testing, ER visits and admissions whenever possible
- Please refer patients needing consultation to other Texas Division CIN providers
- Be sure to see patients after hospital stays within seven days whenever possible
- Be sure to review all medications at every visit, especially on post hospital visits
- For diabetic patients
  - ◊ Remember to get annual nephropathy screening
  - ◊ Remember to refer for annual retinal exams
- For young women, age 18-25, be sure to check for chlamydia infection (urine screening is OK)

These are the metrics for our MIPS reporting and our CIGNA commercial contracts where we have the greatest opportunity for improvement. If you have suggestions for ways our nurses might help you achieve better scores in these areas, please let me know. Thanks!

CHI Texas Division

From the Director of Analytics—Provider Scorecards

Royd Hernandez, MHA

Many of you have received a Texas Health Network Provider Scorecard with information on quality and utilization performance for a number of metrics that align with our CIN objectives. Below are the answers to some of the common questions that we received in recent weeks:

1. ***How are patients attributed to my practice?***

   Answer: Patient attribution is reviewed based on the following criteria:

   a. 2 years of retrospective claims data is used to evaluate attribution.

   b. Patient and provider records are selected based on a specific market. For example, an individual in the St. Luke's Memorial market can only be assigned to a provider in the same market.

   c. Evaluation and management (E&M) codes are used for alignment. They include:
      - Office visits: 99201-99205 and 99211-99215
      - Preventive checkups: 99381-99387 and 99391-99397
      - Office consults: 99241-99245

   d. Provider type:
      - Commercial patients: PCP specialties including Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine, Geriatric Medicine and Obstetrics and Gynecology.
      - Medicare/ACO patients: PCP specialties considered first. If no services found by a PCP, then patients are attributed to the provider listed on the CMS ACO attribution files.

   e. Patients are assigned to the provider with the most visits

2. ***Do services performed by other providers count towards my quality score?***

   Answer: Yes, all eligible services are included.

3. ***Is there a way to receive the member detail associated with my scores?***

   Answer: Yes, please send an email to TexasDivisionClinical@StlukesHealth.org to request additional information.

4. ***Some of the patients listed as non-compliant for a wellness check-up have recently been seen by me. Why are they on the list?***

   Answer: Please be sure an eligible claim has been submitted with the appropriate codes:

   a. CPT: 99381-99385, 99391-99395, 99461

   b. HCPCS: G0438, G0439

   c. ICD10: Z00.8, Z02.0-Z02.6, Z02.71, Z02.79, Z02.81-Z02.83, Z02.89, Z02.9

The second edition of the scorecards will be available in March 2018. We value your continued support and partnership as we work toward improving the quality of care of the population we serve.

From the Director of Quality—Diabetic Management

Tracy Maddox, JD, MSN, RN

Research shows that best in class population health networks have care management programs that foster a multidisciplinary management approach to specific groups of patients with predictable clinical courses. Success depends upon well defined goals for the professionals involved in patient care. The goal is to identify patients with diabetes early by periodically screening those at risk:

Diabetes Screening Recommendations

⇒ **Fasting plasma glucose every 3 years:** Patients age 45 or older, or patient with BMI > 25

⇒ **Fasting plasma glucose and/or HgbA1C every year:** All patients at high risk

- BMI >30
- CHD risk factors
  - ◊ HTN
  - ◊ Elevated lipids,
  - ◊ Family history of cardiovascular risk) first degree family history of type II diabetes
  - ◊ Polycystic ovary syndrome
  - ◊ Personal history of diagnosed gestational diabetes
  - ◊ Delivering a baby greater than 9 lbs

For patients with a diagnosis of diabetes, work toward full control:

⇒ A1C less than population-specific goal (7%)

⇒ LDL less than 100 mg/dL (statins not appropriate for frail elderly)

⇒ Blood Pressure less than 130/80 mmHg

⇒ Urine microalbumin/creatinine ratio < 30 mg/g

⇒ Patient is a documented daily aspirin user

⇒ Patient is a documented non-smoker

⇒ GFR ≥ 60 cc/min

Exams:

⇒ Chronic Disease Management (CDM) visit every 6 months

⇒ Annual diabetic eye exam

⇒ Annual foot exam

Labs and Imaging:

⇒ A1C at least 1 time annually

⇒ Fasting lipids annually

⇒ Urine albumin/creatinine ratio annually (optional for patients > 75 years of age)

Patient Engagement:

⇒ Offer diabetic education annually

⇒ Offer reconciled medication list and after visit summary at the conclusion of each visit

From the Director of Quality (Continued)

For Patients with Diabetes Out of Control and/or with Complications

⇒ A1C greater than population-specific goal (8%)
⇒ LDL greater than 100 mg/dL (statins not appropriate for frail elderly)
⇒ Blood Pressure greater than 130/80 mmHg
⇒ Urine microalbumin/creatinine ratios greater than 30mg/g
⇒ GFR less than 60 cc/min

Exams:

⇒ Chronic Disease Management (CDM) visit **3 times every year**
⇒ Annual diabetic eye exam
⇒ Annual foot exam

Labs and Imaging:

⇒ **A1C: 3 times per year** or as needed to gain and/or maintain control
⇒ Fasting Lipids at least annually and as needed to maintain control
⇒ Urine microalbumin/creatinine ratio annually or repeat first positive (optional for patients > 75 years of age)

Patient Engagement:

⇒ Medication Therapy Management (MTM) Pharmacist – Medication review or visit with pharmacist for patients who have intensive insulin needs, whose medication costs exceed established limits, or who are prescribed a highly complex regimen and difficulty with side effects.
⇒ Communication with CIN Care Management team on selected high risk patients for patient centered assistance with treatment goals

For All Patients:

Immunizations

⇒ Annual influenza vaccination
⇒ Pneumococcal vaccination (at least one After age 65)

When to Refer to a Specialist:

⇒ Proteinuria uncontrolled after 6 months of treatment with ACE/ARB
⇒ Any Proteinuria with GFR < 45
⇒ Any Proteinuria with Rapid decline of GFR (> 4mL/min/yr.)
⇒ Uncontrolled DM with multi target organ damage with GFR < 60

Patient Engagement:

Communicate with the CIN Care Management team on selected high risk patients for patient centered assistance with your treatment goals. Care Coordination can extend your practice, promote a patient-centered focus and enhance your services through increased continuity, comprehensiveness and – most importantly – **coordination.**

Educating your patients about Care Coordination and what they can expect from it is crucial to having Collaborative Care work well. We are with your patients every step of the way. Think of us as personal healthcare guides. We are nurses and medical assistants who take the time to get to know your patient's unique health and treatment needs and promote the best possible self-management.

What's New in the Network?

Contributed by Jodi Vella, Physician Relations Coordinator

Hello, I'm Jodi Vella, one of your Provider Relations staff members, working to improve your CIN, inform on recent updates, answer questions, expand the network, and learn what we can do to support and enhance your practice.

On March 7, 2018, the CHI St. Joseph Medical Group (Bryan/College Station) Family Medicine meeting was held in the MatureWell Lifestyle Club. The MatureWell Lifestyle Club is a beautiful two-story 23,000 square-foot building encompassing a state-of-the-art gym with modern exercise equipment, a variety of fitness classes, personalized trainers and an indoor pool. It provides health and wellness services to adults 55 and older in the Bryan/ College Station communities. The MatureWell Lifestyle Club has been specifically designed to create a place where seniors can access Board Certified Geriatrician Primary Care Physicians, Rehabilitation Services, and information about nutrition, disease management and lifestyle recommendations.

Dr. Garth Morgan, CMO for the St. Joseph Medical group, engaged fellow physicians, network staff, and CHI St. Joseph Health employees regarding relevant topics including MSSP Strategies & Initiatives, Scorecards, Depression screening, Diabetes care, Nephropathy, and Ambetter insurance. Sarah Hilton and Reyann Davis updated the group on the success of home health utilization, and increases in annual wellness visits, risk scores, and quality measures. Moving forward, the 2018 initiatives will focus on home health, risk scores, readmissions and provider scorecards.

Lisa Cochran, Division Director of Network Development, explained our CIN Provider Performance Scorecard., a copy of which follows. The scorecards reflect success rates of provider performance based on attributed Cigna lives. The scorecards contain Cigna quality measures, preferred utilization and CHI/CIN utilization. The performance success rate is based on the quality score which compares the provider to the current market benchmark and current national benchmark.

A key to learning, supporting and enhancing your practice is by distributing such scorecards. Royd Hernandez, Director of the Director of Analytics, discusses some of the methodologies of the scorecards in this newsletter. Scorecards were distributed mid-April via email. **Please let us know if your email preferences have changed so we are sure you receive your Scorecard.**

Should you have any questions or comments, please do not hesitate to let our department or me know texasdivisionclinical@stlukeshealth.org, jvella@stlukeshealth.org.

We now have over 2000 providers in the CHI Texas Health Network CIN, including 297 in the Bryan/College Station market. If you have any providers you work with who are not in our CIN, please let us know so we can reach out to them. Please email any recommendations to texasdivisionclinical@stlukeshealth.org.

For more information on MatureWell Club, please visit http://www.chistjoseph.org/maturewell-lifestyle-club. For more information on the CHI Texas Health Network CIN, please visit www.chitxcin.org.

CIN PROVIDER PERFORMANCE SCORECARD

CHI Texas Division

Practice Name:				
Provider Name:				
Provider TIN:				
Attributed Patients:	ACO/MSSP	125	Commercial:	116

HCC	
Commercial	MSSP
1.01	0.8

QUALITY PERFORMANCE

COMMERCIAL PRODUCT MEASURES — **Commercial Quality Score:**

Condition	Quality Measure	Current Market Benchmark Success Rate (%)	Current National Benchmark Success Rate (%)	Your Performance Success Rate (%)	Quality Comparison
CAD	Patient(s) currently taking a statin. All males or females that are 18 years or older at end of reporting period. At least 12 months medical benefit and 4 months pharmacy benefit	69.9%	71.6%	50.00%	
Diabetes Care	Patient(s) 18 - 75 years of age that had an annual screening test for diabetic retinopathy.	27.9%	32.5%	12.50%	
	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	75.0%	71.7%	75.00%	
	Patient(s) 18 - 75 years of age with lab results that have evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	82.3%	83.6%	100.00%	
	Patient(s) 18-75 years of age with lab results with most recent HbA1c result value less than 8.0%.	69.7%	70.7%	83.33%	
Diabetes Mellitus	Patient(s) compliant with prescribed statin-containing medication (minimum compliance 80%). All males or females that are 18 years or older at end of reporting period. At least 12 months medical benefit and 6 months pharmacy benefit	76.7%	79.7%	100.00%	
Depression Med Mgmt.	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 6 months of continuation phase treatment.	34.9%	39.1%	N/A	
Adolescent Well-Care	Patient(s) 12 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN in the last 12 reported months.	54.2%	58.1%	80.00%	
Pharyngitis	All children who are 2 to 18 years treated with an antibiotic for pharyngitis that had a Group A streptococcus test.	85.4%	86.5%	N/A	
URI	All children who are 3 months to 18 years with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.	86.4%	88.7%	N/A	
Well-Child 15 Mo	Patient(s) that had six or more well-child visit with a PCP during the first 15 months of life.	64.7%	71.7%	N/A	
Bronchitis, Acute	Patient(s) with a diagnosis of acute bronchitis that did not have a prescription for an antibiotic on or three days after the initiating visit.	23.1%	28.4%	N/A	
GDR	Generic Dispensing Rate (GDR) represents the rate at which generic pharmaceutical medications were utilized in place of brand name medications.	81.8%	83.4%	91.53%	
LBP Imaging	Patient(s) with uncomplicated low back pain that did not have imaging studies.	69.9%	73.1%	100.00%	
Breast CA Scrn	Patient(s) 52-74 years of age that had a screening mammogram in last 27 reported months.	72.0%	77.6%	28.57%	
Chlamydia Scrn	Patient(s) 16- 20 years of age that had a chlamydia screening test in last 12 reported months.	48.0%	46.7%	N/A	
PREV- CHI	Colorectal cancer screening	52.0%	60.2%	42.50%	
	Preventive care care and screening: Annual Wellness Visit Adults	35.0%	35.0%	38.50%	
	Preventive care care and screening: Pap/HPV Screening	22.5%	22.5%	15.60%	

MEDICARE ACO MEASURES — **ACO/MSSP Quality Score:**

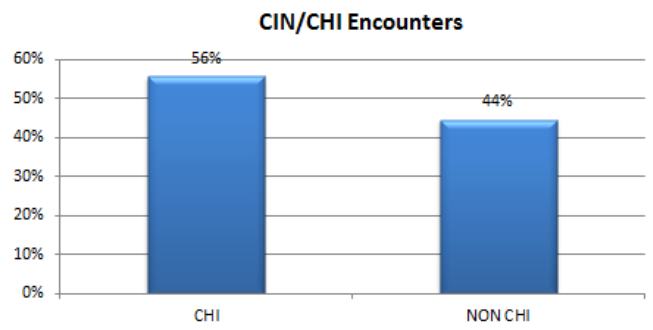
PREV-6	Colorectal cancer screening	52.0%	60.2%	26.72%	
PREV-7	Preventive care care and screening: Influenza immunization	65.0%	62.0%	33.62%	
Well-Care	Annual well visit	63.6%	63.7%	15.52%	
Breast CA Scrn	Patient(s) 52-74 years of age that had a screening mammogram in last 27 reported months.	35.0%	35.0%	30.80%	
			Your Quality Score:		

UTILIZATION

II. Preferred Utilization

#	Initiative	Expected Performance	Your Score	Indicator
I	Inpatient Admissions at Preferred Facilities	75%	100.00%	
II.	Outpatient Services at Preferred Facilities	75%	35.53%	
III.	Lab Referred at a Preferred Provider	75%	97.60%	
			Your Preferred Utilization Score:	

III. CHI/CIN Utilization



Category	Rate
Admissions at CHI Facilities	50.00%

Top Hospital Systems Utilized

Hospital System	% Encounters
CHI	50.00%
HCA	23.56%
MHHS	15.50%
OTHER	10.94%

CHI Texas Division

Ask the CIN

Questions? Comments? Concerns?

Please refer to the staff directory below and send us your feedback. We look forward to hearing from you and assisting in any way we can. General questions can be sent through the website at www.chitxcin.org or via email to texasdivisionclinical@stlukeshealth.org.

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