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PRACTICE TRANSFORMATION

Risk Assessment Can Help Determine Possibility of Opioid Abuse in Patients

The escalating public health crisis, opioid addiction, is now the leading cause of death among Americans under 50. According to data compiled by The New York Times, drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States.

Although the data is preliminary, the Times' best estimate is that deaths rose 19 percent over the 52,404 recorded in 2015. Also, all evidence suggests the problem has continued to worsen in 2017.

The problem defined

For the past several decades, medically prescribed opioid analgesics have been included as part of a comprehensive treatment program for patients with chronic pain. The ongoing debate is whether treatment for chronic noncancer pain (CNCP), especially when used long-term and at high doses, is the best choice of treatment.

According to the Surgeon General's Turn the Tide campaign created to reduce opioid abuse, experts agree although higher dosages of opioids have *not* been shown to reduce pain over the long-term, higher dosages *are* associated with higher risk of overdose and death.

Risk assessment

In an effort to balance effective pain management and safety when prescribing opioids, a number of expert-consensus guidelines for opioid prescribing in patients with CNCP were developed, including the Centers for Disease Control and Prevention (CDC) guidelines. These guidelines advise clinicians who prescribe opioids to patients with CNCP to use risk assessment instruments before and during use of opioid medication.

Based on several studies and papers focused on identifying and preventing opioid abuse, three types of risk assessment instruments were developed to detect the possibility of misuse, including: opioid misuse prior to initiating long-term opioid therapy; signs of misuse in patients currently using opioids; and non opioid general substance abuse(1).

One frequently recommended instrument for assessing the risk of opioid misuse *before* initiating long-term opioid therapy is the Diagnosis, Intractability, Risk, and Efficacy (DIRE) score. DIRE is a clinician-rated tool for primary care physicians to use to predict the effectiveness of pain reduction and compliance with long-term opioid therapy.



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Improving the way opioids are prescribed through a clinical practice guideline helps health care providers offer safer, more effective treatment while reducing opioid-related abuse and overdose. The CDC offers these guidelines to reducing exposure to opioids and preventing abuse.

- Prescription drug monitoring programs
- State prescription drug laws
- Insurance strategies such as prior authorization, quantity limits, and drug utilization review
- Quality improvement programs in health care systems to increase implementation of recommended prescribing practices
- Youth substance abuse prevention, such as intensive family or school-based programs
- Patient education on the safe storage and disposal of prescription opioids

Providers talking with patients about the risks and treatment options before taking opioid medication is good practice. One of the first steps a provider can take when beginning the conversation with a patient about treatment for CNCP is to use a risk assessment instrument to gather important information. This combined with a monitoring and mitigation process can help to make sure the patient is receiving the most appropriate care.

Sources

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COMPLIANCE CONNECTION

Choosing the Right Envelope Can Prevent a HIPAA Violation

If your office sends frequent mailings to patients, you'll want to know about this HIPAA privacy violation caused by an envelope malfunction.

In recent HIPAA news, Aetna, a major national health insurer, reportedly violated HIPAA laws by exposing confidential patient information through a transparent window of an envelope mailed to its members. The letter was sent to about 12,000 members regarding a change in pharmacy benefits.

Members received the letters advising them about options Aetna's health plan offers when filling prescriptions for HIV medicine. The envelope window contained the patient's name, address and the first few lines of the letter, which referred to the patient's use of HIV medicine. Individuals receiving the letter complained to Aetna that anyone could view this confidential information.

This is a reminder to be vigilant when mailing any type of patient confidential data. While window envelopes are a cost-effective and convenient way to get mailings out by eliminating the need for mailing labels, there is also a risk that the letter can shift in the envelope and reveal at least some of the contents, as happened in the Aetna case. If you decide to use window envelopes for your mailings, here are a few simple tips to make sure you do not accidentally reveal any confidential data:

- Do not try to adjust the margins to 'squeeze' information onto one page. Leave lots of white space on the page, especially between the patient's address and the body of the letter.
- Avoid putting detailed health information in the first paragraph of the letter.
- Make sure that only the patient's name and address appear 'above the fold.' That means when you fold the letter into thirds, you should not see any of the contents of the letter below the patient's name and address.

Some offices might also consider switching to non-window style envelopes which have two pieces of information needing to be matched up for every mailing: the letter and the address label. If you decide to go with the non-window style envelope, be sure to carefully audit your mailing before it goes out to make sure the letter and the address labels match. Many organizations using a non-window style envelope have had incidental HIPAA violations because they sent a letter containing confidential information to the wrong patient

No matter what type of envelope you choose, it is important to be aware of the potential risks of revealing patient confidential data through the mail. Take some time to discuss this with your administrative support staff or mailing vendor and make sure they are taking the proper steps to protect patient information.

Sources: <http://www.healthcarefinancenews.com/news/aetna-violated-hipaa-when-envelope-windows-exposed-hiv-medication-use-attorneys-say>



Provider Directory Data Quality Compliance Program

Update Your Information by September 30th

In 2016, CMS mandated Medicare Advantage (MA) health plans provide complete and accurate information regarding physicians who are available to new patients/enrollees in online and printed directories. Medicare Advantage plans must verify, at least quarterly, a physician's location and availability information are accurate.

As a result, BCBSM Physician Group Incentive Program (PGIP) is launching a program to collect complete and accurate demographic information on all PGIP participating providers – The Provider Directory Data Compliance Program.

What is provider “demographic data?”

Demographic data is displayed in the provider directory on bcbsm.com. It includes:

- Practice name
- Practice NPI
- Physician name
- Physician NPI
- Practice location address
- Primary or secondary location type
- Phone number (where patients call to make appointments)
- Whether the practice is accepting new patients

Which system should practitioners update – Council for Affordable Quality Healthcare (CAQH), Atlas PRIME-Hub, Provider Self- Service?

Individual physicians should continue to use provider self-service to update information as a normal course of business.

The attestation process does not replace normal provider demographic maintenance activities. Council for Affordable Quality Healthcare (CAQH) is a source of information for both credentialing and some demographic information. It is critical that physicians continue to keep their ProView application current. They should continue to update CAQH as normal for both demographic and credentialing related updates. For the quarterly attestation, physicians should continue to use the Atlas PRIME-Hub system as well as CAQH.



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How does an individual practitioner comply?

Individual physicians can become compliant by attesting his or her demographic data is accurate and up-to-date. To become compliant, the physician will need to attest for each of his or her locations. Blue Cross and Blue Care Network have a contract with a vendor, Atlas Systems, to support this attestation process.

Atlas Systems has an online portal called PRIME-Hub, which lets individual physicians log in to confirm his or her information and send it directly to Blue Cross and BCN.

The PRIME-Hub portal can be found at: www.primeatlas.com

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REGISTRATION & LOGIN

I am a first-time user. How do I register for the new self-service validation?

- To get started, go to <http://www.primeatlas.com> and click on “Provider Login” first time user on our site, you will get the opportunity to register by creating a & password for yourself. You can register by providing your name, email id, a phone number, Tax ID Number (TIN) on file.

Atlas Systems has an online chat, or you can call **1-844-334-9694** if you have questions or need to speak with a PRIME-Hub customer service representative.

Physicians will use PRIME-Hub only to confirm the accuracy of their current information. It doesn't replace the usual enrollment and change procedures practitioners follow with Blue Cross and BCN.

Enrollment and change procedures can be found on the Blue Cross website at: <http://www.bcbsm.com/providers/join-the-blues-network/enrollment.html>



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Practitioner compliance

The CMS mandate focuses on physician demographic data. All Blue Cross and BCN participating physicians need to comply. Physician compliance is determined through a quarterly attestation process. Each quarter, practice groups must attest to Blue Cross through PRIME-Hub the accuracy of the physician's demographic data. September 30th is the next due date for attestation.

Penalties for non-compliance

Consistent non-compliance by individual physicians will result in successive sanctions by Blue Cross and BCN, including suppression from the bcbsm.com provider directory, suppression of value-based reimbursement (VBR) or PGIP physician, and ultimately, termination from Blue Cross and BCN networks.

If you have any questions please contact your Provider Consultant or your Practice Transformation Coach at CIPA.



CODING CORNER

Five Myths about Childhood Obesity and How to Discuss Them with Your Patients

Over the past three decades, childhood obesity has more than doubled in the U.S. For adolescents, it has tripled. Children facing this issue have higher risks for chronic health conditions and may also suffer from social isolation, depression and low self-esteem.

Is it overweight or obese?

There is sometimes confusion between the terms obese and overweight. Obesity is defined as having excess body fat. Overweight is defined as having excess body weight relative to height. The excess weight may come from fat, muscle, bone, water or any combination of these elements. Many factors contribute to childhood obesity, including genetics, metabolism, eating habits, level of physical activity, environmental factors and psychological well-being.

For some parents, misconceptions about childhood obesity can impact their ability to help their child maintain a healthy weight. Physician offices can play an important role in educating their patients about the causes and treatments of obesity. Here are five common myths about childhood obesity and suggestions for how to address them.

Myth #1: My child and I deserve the blame for his or her weight problem.

Many parents believe obesity occurs in people who are self-indulgent or weak-willed. The fact is children gain excess weight for a variety of reasons, including genetics, lack of healthy food options, portion sizes and other factors. Help parents objectively assess the reasons for their child's weight gain, steering them toward realistic solutions and removing feelings of self-blame.

Myth #2: My child's weight problem needs a quick fix.

This belief can lead to crash diets and potentially harmful results. There are no easy answers to weight problems; encourage parents to implement simple and sustainable changes to their child's diet and lifestyle for long-term results.

Myth #3: My overweight child will grow into the excess pounds that he or she has.

Weight gain throughout childhood is a necessary part of the growth process. However, parents should not use routine growth spurts as a reason for their child's weight problem. Adjusting their child's eating habits and activity level can keep their child at a healthy weight.



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Myth #4: Our entire family is big-boned, so I don't think my child has a weight problem at all.

This is a common misconception in families, especially when the parents and other family members are also obese or overweight. In this instance, focus on the numbers. Demonstrating how the child's weight exceeds the normal range for his or her age and height can make the issue become a fact parents cannot rationalize away.

Myth #5: Because my child is heavy, he or she needs to eat more food to stay healthy.

Based on this belief, many families may give bigger meal portions to a heavier child. Redirect parents toward increasing the child's activity level and providing appropriate portion sizes.

How to determine if a child is obese

The most accurate way to determine if a child is obese is with a body mass index (BMI) screening tool. The National Committee for Quality Assurance HEDIS guidelines assess the percentage of children and adolescents, ages three to 17, who had an outpatient visit with a primary care practitioner or OB/GYN during the measurement year and had evidence of:

- Body mass index (BMI) percentile. The documentation must include height and weight.
- Counseling for nutrition, including providing written educational materials. The documentation must include a note indicating the date, and at least one of the following:
 - Discussion of current nutrition behaviors (e.g., eating habits, dieting)
 - Receipt of a nutrition checklist
 - Counseling or referral for nutrition education
 - Receipt of educational materials on nutrition during a face-to-face visit
 - Anticipatory guidance for nutrition
 - Weight or obesity counseling
- Counseling for physical activity, including providing written educational materials. The documentation must include a note indicating the date, and at least one of the following:
 - Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
 - Receipt of a physical activity checklist
 - Counseling or referral for physical activity
 - Receipt of educational materials on physical activity during a face-to-face visit
 - Anticipatory guidance specific to the child's physical activity
 - Weight or obesity counseling

Providers must show documentation of all three elements described above to receive full credit for this HEDIS measure. Because BMI norms for children and adolescents vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

How to ensure payment for services

To ensure payment for services and maximize revenue for pay-for-performance contracts, it is important to bill with the appropriate codes. The following codes are considered compliant with the HEDIS specifications for weight assessment and counseling for nutrition and physical activity for children and adolescents. Because coding guidelines change frequently, please check with your billing and coding staff for the most current requirements.

Health care providers play a key role in educating parents and reinforcing the importance of adopting healthy behaviors during routine visits. Early intervention with children and adolescents can create healthy habits lasting into adulthood. By making a few simple changes, including healthy eating and physical activity, parents can have a positive impact on their child's weight and overall health.

Codes to Identify BMI Percentile

- ICD-10: Z68.51 through Z68.54

Codes to Identify Physical Activity Counseling

- HCPCS: G0447
- S9451 (Non-physician provider)
- ICD-10: Z02.5 (Examination to participate in sports)

Codes to Identify Nutrition Counseling

- CPT: 97802 through 97804 (Registered dietician services)
- HCPCS: G0270, G0271, G0447, S9449 and S9452 (Non-physician provider)
- S9470 (Registered dietician services)
- ICD-10: Z71.3 (Dietary counseling and surveillance)

Sources:

- <https://www.cdc.gov/healthyschools/obesity/facts.htm>
- <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2016-table-of-contents/weight-assessment>
- <https://www.healthychildren.org/English/health-issues/conditions/obesity/Pages/Childhood-Obesity-Common-Misconceptions.aspx>

TECHNOLOGY

Ten Challenges in Health Care Big Data Analytics

Providers must show documentation of all three elements described above to receive full credit for this HEDIS measure. Because BMI norms for children and adolescents vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

Huge rewards await health care organizations who have successfully integrated data-driven insights into clinical and operational processes. The task remains daunting, however, for those who have just completed putting data into their electronic health records (EHR) and are now being asked to pull actionable insights out of it and create initiatives to impact reimbursement rates.

Turning data assets into data insights leads to healthier patients, lower care costs, more visibility into performance, and higher staff and consumer satisfaction rates. However, the road to meaningful health care analytics is a tough one filled with challenges to solve.

Here are 10 challenges organizations may face when starting a big data analytics program:

1. Capture data

To improve data capture routines by prioritizing valuable data types for specific projects, health care organizations can reach out to health information management professionals. Many vendors exist, but it is wise to take time to conduct due diligence and obtain references.

2. Cleaning data

Ensure datasets are accurate, correct, consistent, relevant, and not corrupted in any way through data cleaning – also known as cleansing or scrubbing. Automated scrubbing tools that use logic rules to compare, contrast, and correct large datasets are offered by some IT vendors.

3. Storing data

Nearly 90 percent of health care organizations use some sort of cloud-based health IT infrastructure, according to a 2016 survey. The cloud option offers nimble disaster recovery, lower up-front costs, and easier expansion – although make sure the business partner understands the importance of HIPAA and other health care-specific compliance and security issues.

4. Securing data

Using up-to-date anti-virus software, setting up firewalls, encrypting sensitive data, and using multi-factor authentication are recommended. Health care organizations should also frequently remind staff of the critical

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nature of data security protocols and often review who has access to high-value data assets to prevent malicious parties from causing damage.

5. Stewardship of data

Assign a data steward to handle the development and curation of meaningful metadata, and ensure all elements have standard definitions and formats and are documented appropriately from creation to deletion.

6. Querying of data

Before meaningful analysis of big data assets can happen, issues such as data siloes, interoperability problems, standardization, quality and coding issues must be overcome. Vendors are available to help solve this problem.

7. Reporting data

Options for meeting regulatory and quality assessment program requirements for reporting include qualified registries, reporting tools built into EHRs, and web portals hosted by CMS and other groups.

8. Visualization of data

Color-coding is one data visualization technique using charts with proper proportions to illustrate contrasting figures and include heat maps, bar charts, pie charts, scatterplots, and histograms.

9. Updating data

Understand which datasets need to be manually updated, which can be automated, how to complete this process without downtime for end-users, and how to ensure updates can be conducted without damaging the quality or integrity of the dataset.

10. Sharing data

Sharing data with external partners is essential, especially as the industry moves towards population health management and value-based care. Fundamental differences in the way EHRs are designed and implemented can severely curtail the ability to move data between disparate organizations, often leaving clinicians without information they need.

The ability to make informed health care decisions will turn the health care industry into a much more efficient and productive system. While many vendors offer solutions, Medical Advantage Group provides experts in *both* analytical insights and understanding of how health care providers work.

With more than 20 years of experience in the delivery of efficient, high-quality health care for medical practices, health centers, physician organizations, hospitals, and health systems, the company helps providers navigate the shifting health care landscape by providing resources needed to improve quality of care and decrease the cost of care in the new value-based health care economy.



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New PCMH Toolkit Resources in Carespective™

Physician Access Only – Secure Carespective™ Learning Center

We hope you have had the opportunity to check out the newly updated Carespective™ Learning Center! We have updated the billing and coding resource center, PCMH toolkit, PGIP clinical quality corners, and included more webinars and presentations on MACRA, EHRs, HIPAA, care management, and behavioral health in primary care.

The toolkit houses hundreds of tools and resources that correspond to each PCMH Initiative. The gaps in care tab allows you to monitor your HEDIS clinical measures performance on a monthly basis for your commercial and MA PPO patients, and BCN patients if contracted with CIPA. The admissions and discharges tab is real time data uploaded throughout the day from the Michigan Health Information Network so you can know when your patients are admitted to the hospital or ER. These tools are best used in conjunction with your Practice Transformation Coach, but check them out today and touch base with your coach to work towards PCMH designation, or to make the re-designation process easier this year!

How To Access Carespective™ Learning Center

Once you login to the secure site, click on the folder marked “Learning Center” on the right – you’ll find these new practice tools and resources there. Contact your Practice Transformation Coach for an overview of all the resources available.



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Reduce Inpatient Readmissions and ER Utilization

Reduce Inpatient Readmissions:

We are asking that you work into your daily workflow a process to ensure that your patients are seen within three-14 days of being discharged from the hospital. There are many different ways to do this, please work with your Practice Transformation Coach to find the best way to fit this into your daily routine. Here are some examples to get you started: Example #1) If your physician does rounds at the hospitals, please make sure he/she lets you know who was discharged daily, then call the patients to schedule a follow-up appointment. Example #2) Use the ADT information in Carespective™ your health information exchange server to ensure all the patients assigned to your physicians are seen in a timely manner after being discharged. Example #3) If you have Care Managers, utilize their services on this topic. Example #4) Gain access to the area hospital's records that your patients frequent and check them daily for discharges.

Reduce ER Utilization:

We have a lot of CIPA patients that are going to the ER repeatedly for non-life-threatening reasons. Please make sure the patients are educated on when the ER is and is not appropriate. Please see your Practice Transformation Coach for ideas on best practices to reduce your ER Utilization.