CIPA newsletter

FALL 2018 CONSORTIUM OF INDEPENDENT PHYSICIAN ASSOCIATIONS

DOMAIN 9: Preventive Services

What if we spent most of our time each day working on prevention vs. disease management? What would our quality look like? What would our cost and utilization reports look like?

Disease prevention is the focus of Domain 9. It is critical to the work we do in the Patient Centered Medical Home (PCMH) and population health. The goal of this domain is to screen, educate, and counsel patients on preventive care and positive health behaviors. There are nine capabilities in the domain and all apply to adults and children. Physicians spend most of their time on screening and meeting gaps in care, but maybe they should refocus their approach towards education and patient engagement in their care.

Although the internet and media are filled with information on how individuals can best manage their health, we continue to see an increase in chronic conditions. Here are some recent statistics:

- Michigan's adult obesity rate is currently **32.5%** up from **22.1**% in 2000 and from **13.2%** in 1990. (1)
- Obesity rates have more than doubled in children and quadrupled in adolescents in the past 30 years. In **Michigan**, 32.6% of children ages 0 to 17 are **overweight** or **obese**, compared to a national average of 31.3% (2)
- Approximately 1,055,253 people in Michigan, or 12.4% of the adult population, have diabetes. Of that population,
  - An estimated 259,000 have diabetes but don't know it, greatly increasing their health risk.

- Thirty-seven percent of the adult population, or 2,741,000 people in Michigan, have prediabetes with blood glucose levels higher than normal, but not yet high enough to be diagnosed as diabetes.
- Every year an estimated 50,000 people in Michigan are diagnosed with diabetes.
- Diabetes and prediabetes cost an estimated $10.5 billion in Michigan each year. This includes complications such as heart disease, stroke, amputation, end-stage kidney disease, blindness and death. (3)

As health care providers, we have work to do. The preventive services domain provides practices the small steps to get there. First, it is important that you have a comprehensive primary prevention program in place at the practice and the team knows their role to ensure it is followed. Primary prevention is defined as inhibiting the development of disease before it occurs and is typically performed on the general patient population. Individuals can receive screenings and other prevention services through their physicians, participation in health fairs, from their local health departments or pharmacies, and/or self-referral. With that, it is important to inquire at each visit whether they have received services elsewhere since their last appointment. This will ensure your records are kept up-to-date. *continued on page 2*

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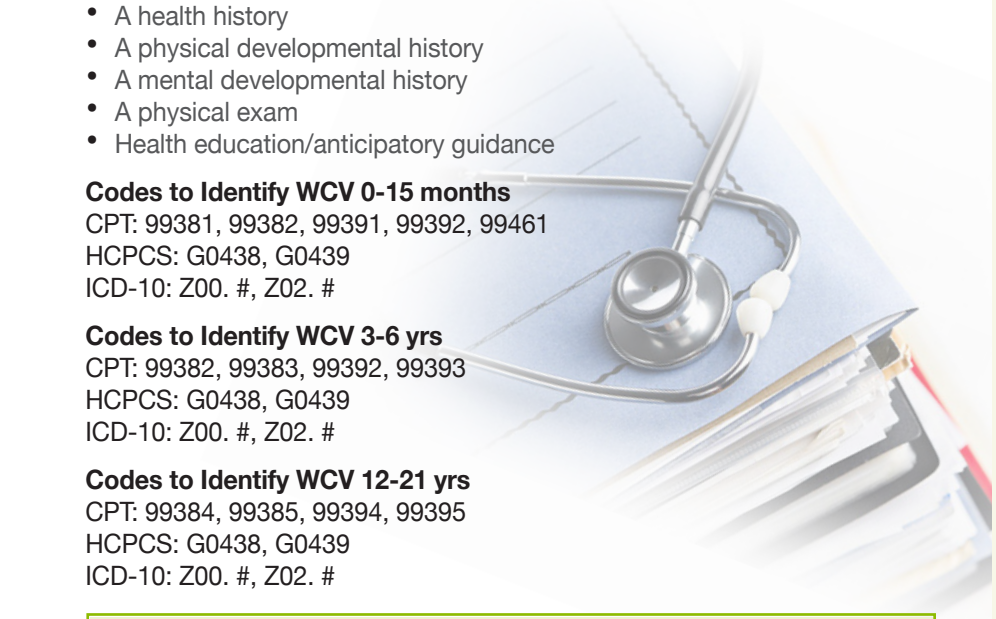
Coding Corner

Components of a WCV 0-15 months, WCV 3-6 years, AWC 12-21 years

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance



Codes to Identify WCV 0-15 months
CPT: 99381, 99382, 99391, 99392, 99461
HCPCS: G0438, G0439
ICD-10: Z00. #, Z02. #

Codes to Identify WCV 3-6 yrs
CPT: 99382, 99383, 99392, 99393
HCPCS: G0438, G0439
ICD-10: Z00. #, Z02. #

Codes to Identify WCV 12-21 yrs
CPT: 99384, 99385, 99394, 99395
HCPCS: G0438, G0439
ICD-10: Z00. #, Z02. #

On October 1st the Centers for Medicare & Medicaid Services released 247 new codes, deleted 51 codes, and revised 143 diagnosis codes in the final 2019 ICD-10-CM updates on June 11, 2018. Review the code changes at https://www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html and be sure to update your systems appropriately.

Medicare Advantage Diagnosis Incentive

Have you reviewed your Health e-Blue Diagnosis Closure patient list? If not, do so now before the incentive goes away.

Providers with one or more attributed Medicare Advantage patients that have at least one (1) open diagnosis gap identified by September 30, 2018 are eligible for the incentive.

You must have a face-to-face visit with the patient by the end of the year (December 31, 2018) and address each suspected or previously reported diagnosis. Documentation in the medical record must support Centers for Disease Control & Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS) requirements. Providers can also report that the patient does not have the suspected diagnosis. Closing gaps not only provides additional incentive dollars, but improves the accuracy of patient's risk scores, which also impacts payer reimbursement. The Diagnosis Closure Incentive booklet is available on the Health e-Blue website, CIPA's Carespective Learning Center, or contact your practice consultant for more information.

Domain 9, continued from page 1
Secondary prevention refers to measures that detect disease before it is symptomatic. It is at this point that changes in health behaviors may prevent the development of disease or if a condition is found early there can be more successful intervention and treatment. Screenings include laboratory tests, pap tests, mammograms and colorectal cancer screening. Secondary prevention guidelines may be adjusted based on the patient's family history and personal habits like smoking.

Another layer to a strong prevention program is tertiary prevention. Its focus is on people already affected by disease and through close monitoring and intervention, attempt to reduce resultant disability and restore functionality.

For any of these prevention efforts to be successful, you need to have an informed, activated team following well established evidence-based guidelines in a proactive planned fashion.

Other Resources:
The Healthcare Effectiveness Data and Information Set (HEDIS) www.ncqa.org/hedis-quality-measurement

Michigan Quality Improvement Consortium (MQIC) www.mqic.org

Sources:

1 https://stateofobesity.org/states/mi
2 https://www.nihcm.org/preventing-childhood-obesity-in-michigan-s-classrooms
3 http://main.diabetes.org/dorg/PDFs/Advocacy/burden-of-diabetes/michigan.pdf

CIPA Fall Webinar Schedule

October 18
Transitional Care Management

November 14
Telemedicine and Telehealth 101

Watch your email for more information.
All webinars are from 12-12:45 p.m.

Interested in PDCM?

Every month, BCBSM conducts a question and answer session via Cisco WebEx relating to the Provider Delivered Care Management (PDCM) program. They are scheduled on the first Thursday of the month from 12-1 p.m. The calls are a forum for providing information and discussing issues with other practices about PDCM. It is not the place to ask about patient-specific claims. Patient-specific issues should be addressed with your BCBSM provider consultant.

Contact your practice coach for the webinar information.

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Consortium of Independent Physician Associations

HEALTH ISSUE OF THE MONTH: Well Care Visits for Children, Adolescents and Young Adults

The American Academy of Pediatrics (AAP) recommends well-child visits (WCV) and adolescent well care visits (AWC) as a way for pediatricians and parents/guardians to address a child's physical, mental and social health. At each well visit, focus should be placed on developmental milestones, nutrition, safety, a child and family's emotional well-being and recommendations from the AAP. The AAP developed the health guidelines, Bright Futures, for providers to use with patients that are from newborn to 21 years of age. Regular preventive care provides opportunities for early identification and management of conditions and behaviors that, if not addressed, can become serious and extend into adulthood.

Strategies to Help Improve WCV

- Schedule well visits for school age children during winter/spring/summer school breaks
- Embed the Bright Futures guidelines into your EMR or use a hardcopy flow sheet that alerts the staff and/or physician of what service is due based on age at the point-of-care
- Ask parents/guardians to fill out a pre-visit Bright Futures questionnaire and bring to the well visit: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx
- Complete the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents ages 3-17 years of age during episodic and acute care
- Use social media or a patient portal to help promote well visits
- Offer an incentive by holding a contest of all patients that complete a well visit during the year
- Send birthday reminders for wellness visits and immunizations
- Schedule a day with extended hours that is dedicated to well visits for children and adolescents

PHYSICIAN SPOTLIGHT:
Dr. John Kalenkewicz

Dr. John Kalenkiewicz is an internal medicine primary care physician in Monroe, Michigan, where he has been practicing since graduating from the University of Michigan over 30 years ago. Since 2015, he has been a PCMH designated physician and achieved the highest quality score in CIPA in 2017. In addition to running his practice, he is also the medical director for Monroe Allied Physicians (MAP) and participates in the Medicare CPC+ program. Here's what he has to say about primary care and how he works with his patients.

How long have you been practicing at this clinic?
I grew up in Warren, Michigan, and after my residency came to Monroe. I have been here since then and will have been practicing 30 years this fall.

What do you like best about being in family medicine?
Needing to stay current in every subspecialty to provide the most comprehensive care for my patients. Our patients range in age from 18 to 102, so it's important to know how to care for the entire lifespan.

What would you say are your biggest struggles? Your victories?
There are many demands on primary care and there is never enough time to meet them. The workday is very long. We participate in quality programs with CIPA, BCBSM's PGIP, CPC+ and other payers, and have made significant improvements in our quality scores; I consider it a great accomplishment the last couple years.

Your practice has achieved very high HEDIS quality scores in CIPA and MAP. How did you accomplish this?
Longevity with our patient population has helped us to build rapport and trust which helps tremendously when we ask them to get needed tests and preventative screenings. We remind our patients that this is a partnership, so they do it because of this partnership and trust, and that we know what they need. Staff retention helps with patient retention. Patients see the same faces. We have had the same receptionist for 20 years and our patients trust and depend on her. They ask for her when she is on vacation. Because of staff retention, when we call our long-term patients, we are perceived as part of their family. We achieve staff retention by making sure we understand that they have lives outside the office and paying a competitive wage. We also have a lot of staff to make sure patient gaps in care get closed.

What three things would you tell other practices that are struggling with low quality and want to improve?

1. Choose one thing to focus on first and build from there.
2. Patient outreach – personal calls and persistence make a difference.
3. Perform pre-visit prep work to see what patients are due for and remind them during the visit.

What do you find the most challenging about patients today compared to 10 years ago? Most rewarding?
We find our patients less challenging today because we have developed long-standing relationships that foster improved quality, lower cost, and higher satisfaction. The only thing more challenging today is the out-of-pocket cost for patients, making it much harder to find affordable treatment.