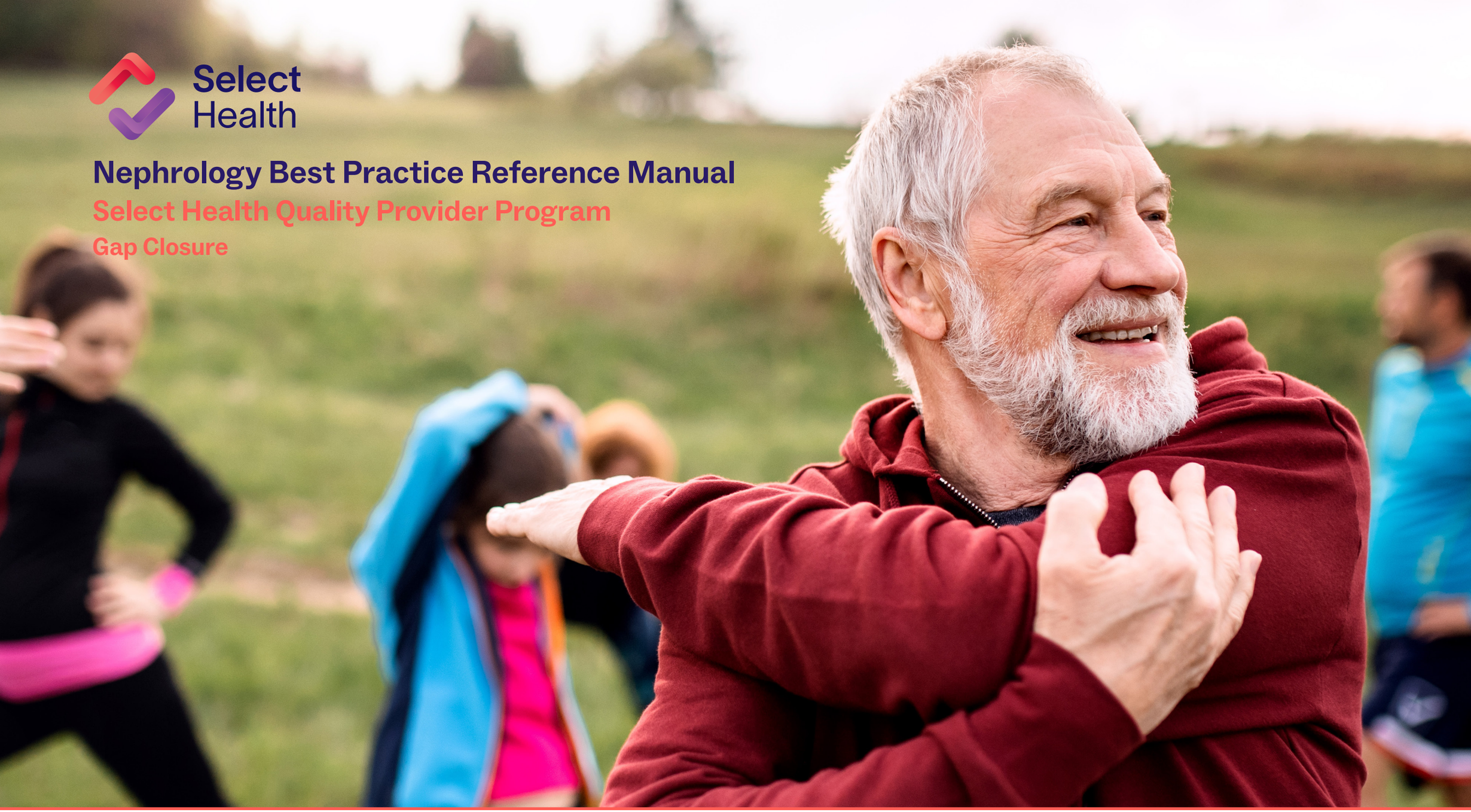
Select Health

Nephrology Best Practice Reference Manual

Select Health Quality Provider Program

Gap Closure



June 2024

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Best Practices: Care Coordination

WHAT IS CARE COORDINATION?

The Agency for Healthcare Research and Quality (AHRQ) has developed a working definition of care coordination (2014):

> "Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."[1]

This process is most successful when there is a dedicated staff, who are given dedicated time to fill this role.

WHY IS CARE COORDINATION IMPORTANT?

Care coordination is a key strategy that can improve the effectiveness, safety, and efficiency of the healthcare system, including primary care clinics. If done well, care coordination can also improve outcomes for everyone: patients, providers, and payers. Furthermore, care coordination can bring a financial return on the investment according to a study published by the American Academy of Family Physicians.[2]

From IntermountainHealthcare.org - Triple Aim presentation

WHAT ACTIVITIES ARE TYPICAL OF CARE COORDINATION?

In the literature, descriptions of care coordination activities are frequently broad and ambiguous. To help better define this work, The Agency for Healthcare Research and Quality (AHRQ) developed a framework identifying two fundamental domains of care coordination:

- Specific activities
- Broad approaches

AHRQ hypothesizes that both domains improve the delivery of healthcare through care coordination. The information that follows, at right and on the next page, provides a summary of AHRQ's findings.

SPECIFIC ACTIVITIES

- **Establish Accountability or Negotiate Responsibility.** Specify who is primarily responsible for key care coordination activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants. Accountability involves the act of answering or responding to a breakdown or failures of care coordination activities.
- **Communicate.** Share knowledge among team members involved with a patient's care, equally communicating clearly and regularly with the patient. Communication involves two separate modes:
  - — Interpersonal. Face-to-face interactions, telephone conversations, and the written word (email correspondence and letters)
  - — Information transfer. A written summary of lab results sent from provider to patient, verbal confirmation of lab value, or the transfer of radiological images and testing
- **Facilitate Transitions.** Transitions occur when care is being transferred from one healthcare provider to another. Commonly used phrases that denote the activity include:
  - — Transitions of care. Hand-off from hospital/ED to home, one provider to another, or across settings
  - — Age out of practice. Pediatric members transitioning to adult providers
  - — Transitional care management (TCM). Hand-off between any inpatient setting and a return home (Medicare only)
  - — Refer to **Transitions of Care Best Practices** for additional support and/or information.
- **Assess Needs and Goals.** Determine the patient's care needs by looking at:
  - — Physical, emotional, psychological health
  - — Functional health status
  - — Current health and health history
  - — Self-management knowledge and behaviors
  - — Current treatment recommendations, including medications
  - — Need for any support services (see "Link to Community Resources" at right)
- **Create a Proactive Plan of Care.** Work with the patient and care team to establish and maintain a plan of care. This plan should outline the patient's current and long-standing needs and goals, anticipate any routine care needs, and identify any gaps in their care.

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- **Monitor Follow-Up and Respond to Change.** Together with the patient and/or their caregivers, assess progress toward care and coordination goals, noting both successes and failures. Refine the care plan as needed, and arrange any necessary follow-up care.

  The practice of noting preventive and chronic condition gaps in care is an essential part of following up and responding to change. Once a perceived gap has been identified, the care coordinator should make a notation of the gap and engage in activities to ensure its closure. Closing care gaps will fall into a few categories:

  — Recalling patients, annually, as needed, per evidence-based preventive care and screening guidelines, or the clinic's disease specific care protocols
  — Making referrals to the primary care physician and closing the loop with them via their consult notes
  — Monitoring lab orders and closing the loop via lab results
  — Monitoring medication orders and closing the loop via medication reconciliation and adherence-related issues

  Closing gaps in care is critical for improved outcomes; comparatively, this practice reduces costs by avoiding duplication of services and errors. For more information regarding closing gaps in care strategy, please see the next two sections of this manual:

  — Best Practices: Gaps in Care (**page 7**)
  — Best Practices: Tips & Tricks for Closing Gaps in Care (**page 9**)
- **Support Self-Management Goals.** Learn about a patient's capacity and preference to be involved in their own care. Tailor education and support to align with this assessment. Education and support include:

  — Information, training, or coaching provided to patients and/or their caregivers to promote understanding and ability to carry out their self-care tasks
  — Support for navigating care transitions, self-efficacy, and behavior change
- **Link to Community Resources.** Community resources are services/programs that may support a patient's health, wellness, or care goals. In Select Health's Quality Provider Program, you may hear this resource need referred to as Social Determinants of Health (SDoH). Common resources for SDoH might include:

  — Financial resources (e.g., Medicaid, food stamps)
  — Social services
  — Educational resources
  — Support groups or programs (e.g., Meals on Wheels)

  Provide information on the availability of community resources that may help support patients' health and wellness or meet their care goals. A comprehensive resource detailing available community resources is United Way's **211.org**. Access these 2-1-1 searchable guides to community resources (in English and Spanish) for:

  — Utah: **English**, **Spanish**
  — Colorado: **English**, **Spanish**
  — Idaho: **English**, **Spanish**
  — Nevada: **English**, **Spanish**
- **Align Resources with Patient and Population Needs.** Assess the needs of patients and populations and allocate health care resources according to those needs at the:

  — Population level. Develop system-level approaches to meet patient needs.
  — Patient level. Assess the needs of individual patients to determine whether they might benefit from the system-level approach.

BROAD APPROACHES

- **Teamwork Focused on Coordination.** Integrate with other care providers participating in a patient's care (health care professionals and organizations or outside care teams) to achieve a cohesive and functioning body capable of addressing patient needs.
- **Health Care Home.** The primary care provider should be a central point for coordinating care around the patient's needs and preferences. Terms frequently used to describe this care delivery model include medical home, patient-centered medical home, and advanced primary care.

  AHRQ states that the term, "medical home," encompasses several functions and attributes as it is patient centered and provides superb access to comprehensive and coordinated care. The medical home embraces five functions and attributes:[3]

  1. **Comprehensive care.** Establish a team of providers to meet each patient's physical and mental healthcare needs.
  2. **Patient centered.** Create relationship-based care with patients and families to understand and respect each patient's unique needs, culture, values, and preferences.

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3. **Coordinated care.** Coordinate care across all elements of the broader healthcare system to address all Social Determinants of Health needs.
4. **Accessible services.** Provide shorter wait times for urgent care needs, adopt a means for electronic access to the healthcare team, and enhance office hours.
5. **Quality and safety.** Use evidence-based medicine in clinical decision making. Engage in performance measurement and quality improvement.

- **Care Management.** Care management is a process designed to assist patients and their support systems in managing their medical/social/mental health conditions more efficiently and effectively. There are two distinct functions that fall under the care management umbrella:

1. **Case management.** The Case Management Society of America defines case management as: "... healthcare professionals who serve as patient advocates to support, guide, and coordinate care for patients, families, and caregivers as they navigate their health and wellness journeys."[4]
2. **Disease management.** The Disease Management Association of America uses the definition supplied by the U.S. Congressional Budget Office to define disease management: "...a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."[5] In short, they seek to manage chronic conditions of high-risk patients.

Both concepts of care management aim to reduce associated costs from avoidable complications by identifying and addressing any barriers to healthcare and treating chronic conditions more quickly and effectively, thus slowing the progression of disease and improving the overall health of the patient.

Select Health has a care management team that is available free of charge for its members. You may send a member referral using this email: **shtoc@imail.org**. You may also call **800-442-5305** or **scan the QR code at right** to get started.

- **Medication Management.** Medication management is vital to achieving favorable health outcomes. Any management approaches implemented should involve two assessments:

1. **Medication reconciliation.** Reviewing the patient's medication regimen after admission/transfer/discharge, including assessing use of over-the-counter medications and supplements
2. **Medication adherence.** Regularly assessing patients for adherence and addressing common barriers to adherence, including:
   - Lack of knowledge about the disease state
   - Fears about the medication
   - Reliance on media or neighbors for information
   - Present lack of symptoms
   - Challenges in implementing lifestyle changes

Medication education and patient counseling are important strategies for improving patient adherence.

- **Health IT-Enabled Coordination.** Using electronic medical records, patient portals, or databases to communicate information about patients and their care between health care providers and to maintain information over time

Care coordination is no easy feat; however, the payoff—your member's health and wellness and your practice's financial health—is well worth the effort.

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Best Practices: Closing Gaps in Care

WHAT IS A GAP IN CARE?

A "gap in care" is defined as the discrepancy between recommended best practices and the care that is provided. Gaps in care can manifest in several ways:

- A member does not follow recommended screening guidelines.
  Example: The American Cancer Society recommends that women get screened for breast cancer starting at age 40 and yearly thereafter. When that mammogram is not done as recommended, it creates a "gap" in the member's care.
- A member does not follow recommended prescription guidance for a chronic condition.
  Example: The provider prescribes a statin for cholesterol management. The member does not refill the prescription because, "They feel fine."
- A member is sent to a specialist, but a report is not sent back to the provider.
  Example: The American Cancer Society recommends screening for colon cancer starting at age 45. Follow-up screening recommendations depend on the type of screening completed and the results of that screening. If the primary care provider does not receive a report back from the specialist, the follow up may not be completed as medically indicated.
- A clinic does not have a defined process to recall members for routine care.
  Example: A member comes in for a routine visit. The provider recommends coming back in a year. The provider's schedule only goes out for six months, so the next visit is not scheduled while in the office. This requires contact later, but there is not a process in place to track this need.

WHY IS THIS IMPORTANT?

When there are gaps in care, patients are more likely to experience negative health outcomes, which can result in readmission, lower quality and satisfaction scores, and increased costs for healthcare providers.

However, closing these gaps is not a simple feat! The first step to closing gaps in care is to understand why they even exist in the first place.

WHY DO GAPS IN CARE EXIST?

There are many factors that contribute to gaps in care. Two primary reasons are patient socioeconomic conditions and inconsistent care coordination. To address these challenges, clinics may want to consider implementing the following strategies:

- **Get the patient in for clinic appointments.** The best way to address gaps in care is by getting patients in for face-to-face clinic appointments. This allows medical providers to perform immunizations, order lab tests and preventive screenings, and document the completion of any tests and screenings done outside the office. However, to do this effectively, clinics must be able to identify patients who currently have gaps in care.

  Data plays a crucial role in the process. There are two ways to obtain data to be used for gaps-in-care closure:

  1. **Your electronic health record (EHR).** Providers can leverage EHR data to track preventive tests and screenings and identify patients who are at risk because of chronic conditions or healthcare disparities. Learning to use and accurately update the data fields in your EHR can also decrease unnecessary retesting.
  2. **Your healthcare insurance payers.** Your participation in Select Health's Quality Provider Program allows access to gaps-in-care lists for a select set of Healthcare Effectiveness and Data Information Sets (HEDIS) and Centers for Medicare Services (CMS) Stars measures.
- **Hire care coordinators.** Another way to ensure patients get the care they need is by hiring care coordinators—dedicated staff who are given dedicated time to fulfill specific roles. While it may be difficult for clinics to find room in their budgets to accommodate this added staffing, research has shown that care coordinators often deliver significant returns on investment. The American Academy of Family Physicians published a study conducted by Trinity Mother Frances Health System showing the value of care coordination.[1] For this study, the healthcare system hired two dedicated care coordinators charged with pre-visit planning, care gap management, and care transitions.

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Observations from the research included:[1]

- The facility's no-show rate for appointments was down to 2.8% after six months, and they were able to increase the number of primary care visits by 3% from the previous year.
- The cost of the care coordinators was $68,400 ($19/hr) for nine months; however, the organization generated an added $117,528 in net downstream revenue by closing care gaps. **Figure 1** below provides a summary of care coordinators' duties and noted results.
- This model is also scalable to fit the needs of variable clinic sizes.

- **Invest in cultural competency training.** Research shows that racial or ethnic minority groups are more likely to experience gaps in their healthcare. These gaps in care are often referred to as healthcare disparities. Organizations can help meet the needs of those with cultural barriers and/or limited English proficiency through cultural competency training. With this training, providers and clinic staff can learn about how:
  - Cultural issues may affect the way patients share medical information
  - To best treat those with limited English proficiency
  - To take cultural backgrounds into account when providing care

  According to CMS Office of Minority Health HealthPartners (a Minnesota-based care system) was able to reduce healthcare disparities through the implementation of many culturally tailored initiatives for racial and ethnic minorities and patients with limited English proficiency.[2] In summary, they were able to:
  - Successfully close the colorectal screening gap between white and racial and ethnic minority patients by one-third, from 11.5% to 7.6% in one year
  - Shrink the disparity in anti-depression medication compliance between whites and racial and ethnic minorities by one-third, from 18.7% to 12.8% over three years
  - Nearly eliminate the disparity in mental health length of stay for patients with limited English proficiency
- **Tailor patient communications.** Members have different personalities and communication styles. Case studies have found that people are more likely to engage with healthcare providers when communications are tailored to suit their preferences.

  According to Deloitte Center for Health Solutions, healthcare organizations should try to understand where patients fall on a spectrum of attitudes and preferences.[3]
  For example:
  - Why do patients choose your providers or clinic?
  - How can you develop strategies to attract AND keep patients?
  - How can you help passive consumers become more engaged in their health?

  Through their research, Deloitte has named four consumer segments (trailblazer, bystander, prospector, and homesteader); learn more about these groups in **Figure 2** on the next page.

Figure 1. Care Coordinators' Duties and Noted Results

Duties	Description	Results
Previsit Planning	Confirm visits, schedule preventive services, order all labs in advance per protocol, conduct medication reconciliation, order refills	Fewer no-shows, higher visit volume, improved staff satisfaction, increased adherence and revenue, improved outcomes
Care-gap Management	Follow up with patients who are overdue for services or whose measures are out of range, particularly for chronic illnesses	Increased adherence and revenue, improved outcomes
Transitions of Care Contacts	Call patients upon discharge	Increased follow up with primary care provider, decreased readmissions

HOW DO WE BUILD OUR CLINIC STRATEGY?

When building out a year-round strategy to close gaps in care, there are several key items to consider. According to Managed Healthcare Executive, you will need:[4]

- Senior leadership buy-in and organizational investment to create a strategy
- A continuous (not seasonal) strategy to make an impact and see financial benefit
- Prioritized quality improvements to create change

Additionally, you need an adaptive company culture that always seeks improvement. Without organizational buy-in and a sustained investment in ongoing resources, your program will not succeed in the long term.[4]

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Figure 2. Consumer Segments Identified by Deloitte[3]

NOTES:

For more information about how to implement a care coordination strategy, review "Best Practices: Care Coordination" (**page 3**).

For tips and tricks for closing gaps in care for your Quality Provider Program participation, review "Best Practices: Tips & Tricks for Closing Gaps in Care in Quality Measures" (**page 9**).

RESOURCES:

- Pre-visit planning info, tools, templates: **https://edhub.ama-assn.org/steps-forward/module/2702514**
- Building effective care teams: **https://improvingprimarycare.org/team/practice-team**
- Primary care strategies, building teams, other resources: **https://improvingprimarycare.org**

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Best Practices: Tips & Tricks for Closing Gaps in Care for Quality Measures

Adhering to recommended preventive and disease-based care, like cancer screening and diabetes testing, leads to better health outcomes due to early diagnosis or maintenance of chronic conditions. Here is a compilation of tips and tricks you may use to improve your clinic processes and optimize capturing and closing gaps in care.

GENERAL

Closing Gaps in Care in Office

- **Identify quality champions in your practice for:**
  - **Staff.** This person will set expectations, ensure staff receive adequate training, and hold the practice accountable for performance goals.
  - **Providers.** This person will set expectations, ensure providers receive adequate training, and hold the practice accountable for performance goals.
- **Develop a payer-agnostic approach to quality**, and organize your workflows to achieve operational efficiency.
- **Hold pre-clinic care team huddles** to exchange information that may be useful during the clinic day/week.
- **Use the clinical registries in your electronic medical record** (EMR) to manage populations.
- **Implement the process of ordering labs before the visit.** It is much easier, more effective, and more efficient to have a conversation about lab results while the patient is in the clinic rather than playing phone tag days later.
- **Schedule annual wellness visits** (physical, well-woman exam, well-child exam, etc.) and address, clearly document, and update the patient history to include all quality gaps in care.
- **Plan a communications strategy:** screening invitations, reminder phone calls, text messaging, social media campaigns, etc.
- **Develop clinic-wide protocols** to use standing orders for prevention testing and disease monitoring.
- **Send appointment reminders** to decrease the no-show rate.
- **Boost staff participation** by engaging your clinic staff in a friendly challenge or game (such as giving a prize to the staff member who scheduled the most AWVs in a week/month).
- **Close gaps in care with payers by:**
  - Identifying members who may have been covered by another insurer when service was rendered.
  - Talking to your Quality Provider Program representatives about submitting corrections.
  - Providing Select Health with documentation to support services being completed for your clinic in order to receive credit for the care (called a "correction"). Documentation should:
    - Always have two patient identifiers—typically patient name and date of birth
    - Reflect the latest date possible when you have an incomplete date (e.g., a month and year [03/2022] would be 3/31/2022; a year [2022] would be 12/31/2022)

    NOTE: If the health plan has a claim for a service being completed, you do not need to submit documentation to close that gap (unless it is A1c, which requires a result).
  - Implementing Current Procedural Terminology (CPT) category II coding to decrease the amount of work to close many of the gaps in care (see Select Health's **CPT Category II Coding** document for more information).

NEPHROLOGY-SPECIFIC MEASURES

Diabetes A1c in Control (< 8%) (HBD)

To help close gaps in care:

- Target your HbA1c gaps by identifying the members who have had an A1c drawn, but the health plan just needs a value.
- Implement CPT category II coding to denote A1c results.
- Determine frequency of A1c testing based on results.
- Do not underestimate the power of education because the complications from diabetes may be asymptomatic.
- Hold a daily or weekly huddle about members with upcoming diabetic gaps in care and outreach activities for those members who have missed their appointments.

Diabetes Eye Exam (EED)

To help close gaps in care:

- Offer diabetic retinal screenings in the office. If in-office screenings are not possible:

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  - — Develop a relationship with a local optometrist or ophthalmologist with whom your staff can easily make appointments.
  - — Ask to have the results shared with you so you can upload them into your EMR.
- Implement CPT category II coding to denote eye exam results (retinopathy vs. no retinopathy), and repeat exam as follows:
  - — A negative eye exam (no retinopathy) is only required every 2 years.
  - — A positive eye exam (evidence of retinopathy) is required yearly.
  - — Do not underestimate the power of education. Sometimes complications from diabetes may be asymptomatic.
- Hold a daily or weekly huddle about members with upcoming diabetic gaps in care and outreach activities for those members who have missed their appointments.

Kidney Health Evaluation (KED)

To help close gaps in care:

- Update your diabetes order sets to include both blood glomerular filtration rate (GFR) and urine albumin creatinine ratio (ACR) testing as albumin is often missed.
- If missed, urine albumin and creatinine should be reordered and retested to close this gap.
- Do not underestimate the power of education. Sometimes complications from diabetes may be asymptomatic.
- Have a daily or weekly huddle about members with upcoming diabetic gaps in care and contact those members who have missed their appointments.

Blood Pressure Control for Patients with Diabetes (BPD) & Controlling High Blood Pressure (CBP)

- Select Health will pay for adequately controlled blood pressure (<140/90 mm Hg) for diabetic patients during the measurement year (not every 365 days). This applies to diabetic patients 18-75 years of age as of December 31 of the measurement year. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year.

The member is not compliant if:

- The BP is ≥140/90 mm Hg
- There is no BP reading during the measurement year
- The reading is incomplete (e.g., the systolic or diastolic level is missing).

If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Excluded BP readings: Readings taken during an acute inpatient stay or an ED visit, taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests are excluded.
Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

Self-report readings: Members can self-report blood pressures taken by the member **using digital device**. Self-reported blood pressures cannot be taken by the patient using a manual blood pressure cuff and a stethoscope. There is no requirement that there be evidence the BP was collected by a PCP or specialist.

To help close gaps in care:

Implement CPT category II - Organizations that use CPT Category II codes to identify numerator compliance must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

CPT II CODE AND ASSOCIATED BP READING

Systolic	Diastolic
3074F Systolic less than 130	• 3078F Diastolic less than 80
3075F Systolic 130-139	• 3079F Diastolic 80–89
3077F Systolic equal to or greater than 140	• 3080F Diastolic equal to or greater than 90

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- The clinic can use the medical record of the provider who manages the member's diabetes. If that medical record does not contain a BP reading, the organization may use the medical record of another primary care physician or specialist from whom the member receives care.
- Do not underestimate the power of education because the complications from diabetes may be asymptomatic.
- Hold a daily or weekly huddle about members with upcoming diabetic gaps in care and outreach activities for members who have missed their appointments.

Frequently Asked Questions

Q: Can we use a patient's measured BP from out of the office?

A: Yes, if taken by the member using a digital device such as with a digital blood pressure cuff.

Q: Does a member who is prescribed Metformin qualify for the Blood Pressure Control for Patients with Diabetes (BPD) measure?

A: No, Glucophage/Metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

Q: If a patient forgets to take prescribed blood pressure medication on the day of the eligible blood pressure reading, is the blood pressure reading eligible for the closing the measure gap?

A: Yes, a patient forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the blood pressure reading is eligible.

Questions about the Quality Provider Program?

Contact your Quality Provider Performance representative
(qualityprovider@selecthealth.org)

Select Health