QUALITY CARE QUARTERLY

Summer 2017 - Volume 2

Your Guide to Programs and Rewards

Featuring

- A Message From our Medical Director of Provider Network Innovation, Dr. David Moroney
- How CHI Memorial, Mission Health Care Network Improves Quality of Care for High-Risk Patients
- The Link Between Obesity and Antipsychotics

Inside this Issue

Innovation in Health Care Delivery Through Dedicated Clinical Teams

CHI Memorial and Mission Health Care Network Improve Quality of Care for High-Risk Patients

Health Scorecards Mailed to Your BlueCross, BlueCare℠ Patients

Quality Care Rewards Tool

Quick Tips

A Clinical Focus

The Link between Antipsychotic Medications and Obesity

Conducting Diabetic Retinopathy Scans Onsite?

Help Us Improve TennCare℠ Kids Screening Results

Recommended Blood Glucose Testing for Overweight Patients

Training Opportunities

Patient-Centered Medical Home Annual Meeting in Chattanooga

Innovation in Health Care Delivery through Dedicated Clinical Teams

The focus on innovation in health care delivery to improve outcomes, cost, and quality can be challenging for organizations of any size. But there is tremendous opportunity to improve care with projects that are modest in size, fitting somewhere between small process improvement projects and large organizational change initiatives. And they're often overlooked. These are innovations involving small dedicated full-time clinical teams that redesign and deliver care for a particular patient population.

This idea is explored by Chris Trimble, formerly an adjunct professor at Dartmouth College, in his book, How Physicians Can Fix Health Care: One Innovation at a Time. The concept is straightforward. It involves targeting a select patient population and commissioning a small, full-time clinical team to redesign care from scratch. The goal is to deliver better care through more effective care planning, care coordination, decision-making and enhanced patient availability to the clinicians.

Trimble offers actions for effective innovation:

1. Choose a patient population
2. Understand the needs of the population
3. Design and build teams from scratch
4. Invent operating solutions from scratch
5. Measure costs and outcomes

– © 2015 Chris Trimble

Even though the decision to take this path can be a difficult one, a number of providers around the country, including some in Tennessee, are demonstrating the feasibility and effectiveness of this approach to innovation in health care delivery.

We hope you find insights in this edition of the Quality Care Quarterly that can help you improve outcomes for your practice.

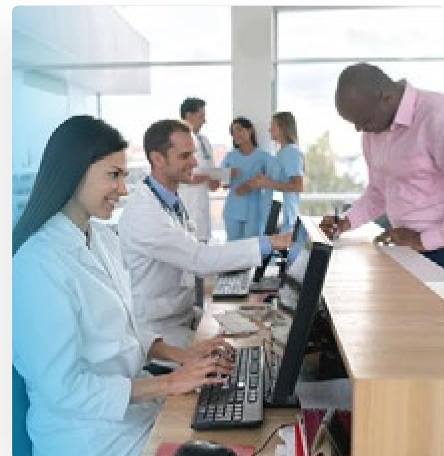
– **Dr. David Moroney**
Medical Director, Provider Network Innovation
BlueCross BlueShield of Tennessee

How CHI Memorial and Mission Health Care Network Improve Quality of Care for High-Risk Patients

Participation in Patient-Centered Medical Home Program Focuses on Care Coordination

CHI Memorial and Mission Health Care Network (MHCN) have been successful in improving the quality of health care for chronically ill patients, while achieving cost savings for their physicians and the hospital system. One step that moved them closer to their goal was to enter into an agreement with BlueCross to participate in the Patient-Centered Medical Home program.

The intent of the agreement is to help improve the quality of care for high-risk patient populations and identify and close gaps in care that exist for patients with chronic health conditions. This includes patients with uncontrolled diabetes, high blood pressure and high cholesterol, those who are overweight or obese, and those living with COPD, CHF, ESRD, and asthma.



Mission Health Care Network is a physician-led clinically integrated network governed by community physicians and Memorial Health Care System.

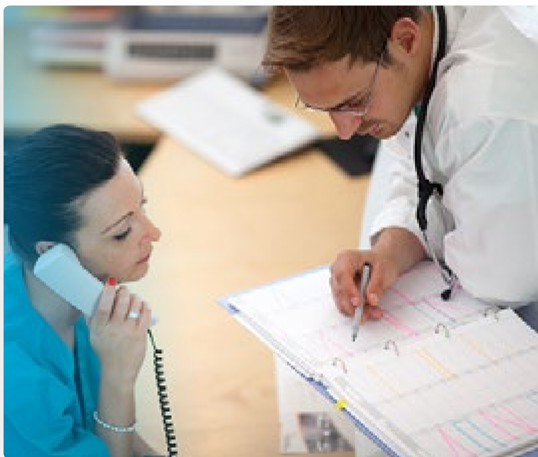
Data Access and Dedicated Staff Drive Success

BlueCross shares information through a care coordination platform that enables MHCN staff to easily identify BlueCross members who have recently visited the ER or had an inpatient admission. It also includes data on members who are high-risk, have a chronic condition, or have not received important preventive screenings.

Three staff members have been added to specifically address routine monitoring and education needs. These employees work alongside more than 20 MHCN team members, ranging in disciplines such as social work, care management and health coaching. They also work in collaboration with in- and outpatient educators and nurse navigators.

"We understand that physicians, especially primary care physicians, are dealing with a large patient base and have a limited time for extensive patient education and follow up. If we can help identify these needs and give more time to the physician to focus on pressing health concerns, we're on the right track," says Tod Erickson, vice president, Mission Health Care Network. "It takes work from many angles and persistent and consistent routine monitoring to provide the highest quality care. We want to be the resource physicians turn to when they need additional support."

Since the agreement went into effect on March 1, 2016, this new care coordination effort has not only identified opportunities for follow-ups, but has also resulted in more than 7,000 closed gaps in care.



"It takes work from many angles and persistent and consistent routine monitoring to provide the highest quality care."

– **Tod Erickson,**
Vice President,
Mission Health Care Network.

Number of Closed Gaps in Care - March 2016 through Feb. 7, 2017.

ASTHMA	CAD
2,911	3,022
CHF	**COPD**
1,208	1,799
DIABETES	**HYPERTENSION**
3,986	6,195
TOTAL CHRONIC CONDITIONS	
7,534	

*Some patients reflected in this chart have multiple chronic conditions.

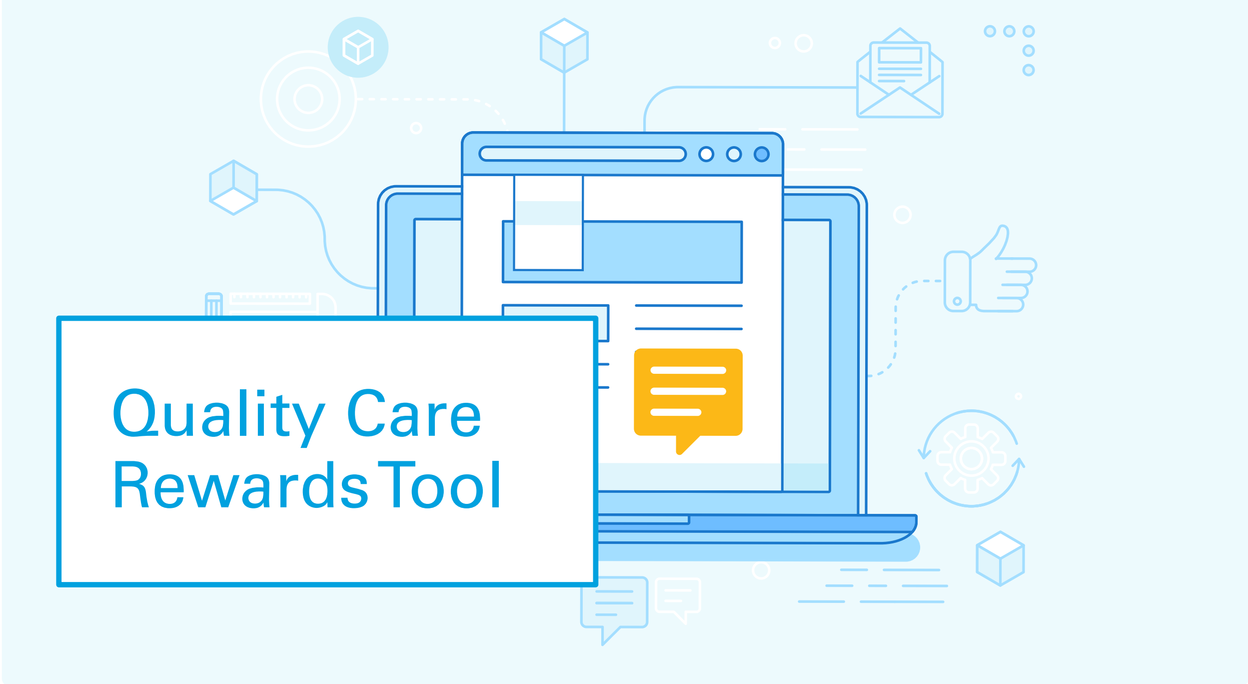
Health Scorecards Mailed to BlueCross and BlueCare Patients

In May, we sent health scorecards to our commercial, Medicare Advantage, BlueCare Plus (HMO SNP)SM, BlueCare Tennessee and CoverKids members. These scorecards alert them to screenings and care they need to get, and include customized health tips. Members are encouraged to bring their scorecard to their next office visit to discuss the recommendations with their physician.

Who Gets a Scorecard?

Scorecards are mailed only to adults, teens or children who have a gap in care, based on their gender, age and chronic conditions. These scorecards are color coded to show the status of each screening listed. Scorecards for adolescents are specific to teen health needs and immunizations and are sent to the parent or guardian three months prior to the child's birthday.

This year, a select group of members who are enrolled through their employer, will receive their health scorecards by email. This version provides links to online care management content to help them learn more about the specific gaps that are listed and detailed information about the screenings, tests and preventive care the scorecard recommends.



Quick Tips

Looking for The Quality Care Rewards tool is the best way to learn about the specific care your patients may still need, and the financial opportunities you can gain by addressing these gaps in care. We made several updates to the Quality Care Rewards tool on June 6 that will make it easier to find what you need.

Here's what's new:

Improved Navigation

At the top of the page, you'll find program view navigation at the contract and provider levels. The drop down list shows programs available to view, depending on the provider contract.

- All Programs – lists all of the quality programs aligned with your contract. Note: To view a scorecard, you must select a program from the program view drop-down list.
- All Gaps – this view includes all BlueCross members that are attributed to a provider.

Improved Reporting

We've included enhanced reporting features.

- Non-compliant gap list reports can be exported from the All Program view or from each individual quality program.
- Reports now include members who are non-compliant for a Provider Assessment Form.
- Member roster reports can be exported from the member roster tab.
- Scorecards can be exported in Excel or as a PDF.

For training assistance, please contact:

West Tennessee
Debbie Angner
(901) 544-2285
Debbie_Angner@bcbst.com

Middle Tennessee
Faye Mangold
(423) 535-2750
Faye_Mangold@bcbst.com

East Tennessee
Faith Daniel
(423) 535-6796
Faith_Daniel@bcbst.com

For technical issues or general questions about the Quality Care Rewards tool, please call the service center at (423) 535-5717 (select option 2), or email eBusiness_service@bcbst.com.

The Link between Antipsychotic Medications and Obesity

In 2015, BlueCross BlueShield of Tennessee members who were prescribed antipsychotics were almost two times more likely to be obese than the general population. And according to the American Psychological Association, patients who take these drugs and gain weight initially, are at risk to gain weight throughout treatment.

Comprehensive care and coordination between PCPs and behavioral health practitioners is important for patients taking antipsychotics. Behavioral health practitioners should confer with the patient's PCP about metabolic test results and potential side-effects. PCPs should consider working with a behavioral health practitioner who can provide a higher level of care for behavioral health issues.

There are steps you can take to reduce the likelihood of weight gain or metabolic issues.

- Use alternative first-line interventions. Consider psychological assessment and/or therapy during initial treatment, especially for patients who are under 21.
- Emphasize eating well and moving more. Refer patients to bcbst.com for information on our wellness programs.
- Ensure ongoing metabolic monitoring. Your patients should have at least one LDL-C and HbA1c test every year. When appropriate, check with your patients' other providers to ensure these screenings take place.
- PCPs should evaluate and document weight and BMI routinely for patients over 20. For patients younger than 20, document height, weight and BMI percentile.
- Call on our behavioral health team. We can schedule and make referrals. Or you can speak to one of our Behavioral Health medical directors to discuss alternative medications:

  Primary Care Physician Consultation: 1-800-367-3403

Conducting Diabetic Retinopathy Scans Onsite?

What You Need to Know to Close The Gap

More primary care offices now have the equipment to conduct onsite diabetic retinopathy scans for their diabetic patients. This is very beneficial to patients because they can get all their diabetic screenings completed at the same time, in one location. It's also a good alternative for those who may not be able to get to an ophthalmologist for a full eye exam.

Clinical quality guidelines recommend that people with diabetes between the ages of 18 and 75 have regular retinal eye screenings. However, if you are a Primary Care Physician (PCP) and are performing the retinal exam, you must have the exam read by a licensed eye care professional (optometrist or ophthalmologist).

How You Code is Important

Adding a CPT®2 code to your claim form can help ensure that the gap in care closes. The most common procedure code used with diabetic retinal screenings is 92250. But if you're performing the imaging in your office and sending the results for an eye care professional to review, you should note that only CPT®2 codes 2026F (for current year) or 3072F (which indicates a member is low risk and had negative findings in the prior year) will close the gap in care.

If you have, or are considering, an eye scan machine for your office, here's what you need to know:

- Diabetic retinal exam quality gaps in care for patients with diabetes are closed with a retinal or dilated eye exam by an eye care professional during the current year, or by documentation of a negative retinal or dilated eye exam the year prior.
- When filing a medical claim for a patient's diabetic retinal eye exam, a diabetes diagnosis must be documented on the claim form.
- An annual diabetic retinal exam is a covered medical benefit for BlueCross BlueShield of Tennessee members who have diabetes even if they do not have vision benefit coverage. Some members may be subject to cost share.

Help Us Improve TennCare Kids Screening Results

Thousands of children from low-income homes aren't getting the care they need. In fact, only 70 percent of kids enrolled in BlueCare Tennessee get their annual Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) checkups. We're asking for your help as we work to raise that rate above 80 percent.

Here's how you can help:

- Schedule appointments and provide reminders to your patients.
- Partner with BlueCare Tennessee to conduct outreach events.
- Make sure special-needs members are getting their checkups.
- Capitalize on opportunities to perform TennCare Kids screenings, when possible, during sick visits and sports physicals.

You can also help with thorough documentation and appropriate coding.

- Document all seven components of the TennCare Kids exam in the patient's medical record, including the nutritional assessment and physical activity portion of the exam.
- Bill appropriately to maximize your reimbursement.
- Bill us even if the patient has other insurance. It's important that we capture the claim information that documents an increase in overall screening rates.

Note: Infants and toddlers should have 12 well-care checkups before their third birthday. Children ages 3 through 20 should get a TennCare Kids well-care checkup every year.

Get Free EPSDT and Coding Program Training

The Tennessee Chapter of American Academy of Pediatrics (TNAAP) offers free EPSDT and Coding Program training and educational resources to help you reduce costs and improve quality.

Training is offered in each region of the state. To learn more about their many educational opportunities, please visit the TNAAP website at http://tnaap.org/coding.

Blood Glucose Testing Now Recommended for Overweight Patients

The US Preventive Services Task Force (USPSTF) has endorsed blood glucose testing as part of cardiovascular risk assessment in adults, 40 to 70, who are overweight or obese. Patients with abnormal blood glucose results should be referred for behavioral counseling to promote a healthy diet and physical activity. These interventions can help lower blood pressure, glucose and lipid levels, and weight, all of which can reduce a patient's risk for type 2 diabetes.

The CDC's National Diabetes Prevention Program website lists nationally recognized programs that have agreed to use a CDC-approved curriculum that meets established duration, intensity, and reporting requirements.

Training Opportunities

Patient-Centered Medical Home Annual Meeting in Chattanooga

Mark your calendars now for the 2017 PCMH annual meeting on Sept. 22 at The Chattanoogan Hotel from 8:00 a.m. to 3:30 p.m. A physician panel will cover best practices across the state and there will be a discussion on BlueCare Plus (HMO SNP)^{SM} chronic, complex case management.

Contacts for Quality Initiative Programs

Commercial

Patty Howard
Manager, Commercial Quality Improvement
Patty_Howard@bcbst.com
(423) 535-7865

Medicare Advantage

East
Ashley Ward
Ashley_Ward@bcbst.com
(865) 588-4628

Trey Brown
TreyB_Brown@bcbst.com
(423) 535-4366

Middle/West Region
Genaro Velasquez Rios
Genaro_VelasquezRios@bcbst.com
(615) 565-1910

Parrisha Beard
Parrisha_Beard@bcbst.com
(615) 565-1941

BlueCare Tennessee

Statewide
Sharonda Featherstone
Manager, Provider Quality
Sharonda_Featherstone@bcbst.com
(423) 535-8299

East Grand Region
Sam Hatch
Provider Quality Consultant
(423) 535-4204
Sam_Hatch@bcbst.com

West and Middle Grand Region
Tiffany Gray-Jackson
Provider Quality Consultant
Tiffany_Gray@bcbst.com
(423) 544-2595

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

BlueCross BlueShield of Tennessee complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

For TDD/TTY help call 1-800-848-0298.

BlueCross BlueShield of Tennessee, Inc. and BlueCare Tennessee, Independent Licensees of the BlueCross BlueShield Association

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CPT® is a registered trademark of the American Medical Association. This article is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card. This article may not be reproduced, printed, photocopied or distributed without prior written consent from BlueCross BlueShield of Tennessee.