

QUALITY CARE QUARTERLY

Spring 2017 - Volume 1

Your Guide
to Programs
and Rewards



of Tennessee

Featuring

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- Readmission and Patients with Behavioral Health Needs
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A portrait of Dr. Andrea Willis, a Black woman with short dark hair, smiling. She is wearing a white collared shirt under a dark blazer. The background is a solid blue color.

Every Day Is an Opportunity to Serve

In the changing health care landscape, there is an increased awareness of health outcomes and performance based on key quality measures and scores. But some things can't be measured. What we do is about serving our members – our mothers, fathers, sisters, brothers, children, neighbors, friends – every day. It is about cultivating meaningful partnerships with you, the health care providers who help guide our members to better health and to better lives.

We are committed to offering quality care strategies that focus on our members and provide the right care at the right time. And we are dedicated to providing support that

empowers the health care team to improve when, why and how care is delivered, and target healthy outcomes with personal, affordable care.

In this first edition of our Quality Care Quarterly newsletter, we share stories and information from your peers, and from our quality teams at BlueCross BlueShield of Tennessee. We hope that you find this new resource to be beneficial to your practice.

– **Dr. Andrea Willis**
Chief Medical Officer
BlueCross BlueShield of Tennessee

Holston Medical Group Lowers Inpatient Readmission, ER Utilization Rates

Between 2014 and 2015, Holston Medical Group (HMG) had a 77 percent improvement on 30-day hospital readmissions. By introducing new programs and procedures, and adding a clinic that serves their chronically ill population, HMG has improved care and lowered costs for patients. And in the process, they improved their own quality scores.

“HMG is continually looking for innovative ways to meet the needs of our patients,” HMG Chief Medical Officer Samuel Breeding, M.D. said. “We know that

patients with three or more chronic conditions require a more proactive, hands-on approach. We are committed to developing programs and implementing operational efficiencies which address their unique needs.”

HMG is a multi-specialty, physician-owned practice with approximately 180 providers, including both physicians and mid-level practitioners. Seventy-eight of the group’s practitioners are primary care providers. The group has 14 primary care offices, two urgent care locations and a number of locations for specialists.



Best Practice Tips from HMG

- Call any patient who has been to the ER within 48 hours of the visit.
- Follow up with a Transition of Care call and schedule a PCP appointment as soon as possible, but no later than 14 days.
- Offer same day access and ensure that patients are aware of this practice.
- Educate patients about use of Urgent Care and about access and hours of their primary care offices.
- Offer educational materials on what is considered appropriate use of the ER versus an office visit or urgent care clinic visit.



When patients are able to get same-day appointments or to get seen at the Extensivist Clinic, it keeps them out of the ER.

Impact to Patients

The changes that HMG has put in place help lower the patients' out-of-pocket costs. The cost of a PCP visit or urgent care clinic is much lower than co-insurance for hospital stays or co-pays for ER visits.

Amy Honeycutt, Operations Project Manager and Care Coordinator Manager for HMG, says that patients are often surprised at this level of outreach and feel it is a great benefit from their primary care office.

Improving Quality Scores

The outreach efforts of the Care Coordination nurses and Patient Navigators have helped to improve the quality scores by reducing the number of ER visits and in-patient admissions. When patients are able to get same-day appointments or to get seen at the Extensivist Clinic, it keeps them out of the ER. HMG knows that when a patient visits the ER, the chance of them being admitted is high.

HMG also works closely with patients who have congestive heart failure or COPD to ensure they have the needed "rescue kit" medications and know the appropriate actions to follow to minimize the risk of hospital admission during exacerbation of symptoms.

HMG keeps track of their gainful improvements through careful review of the quarterly reports from BlueCross.



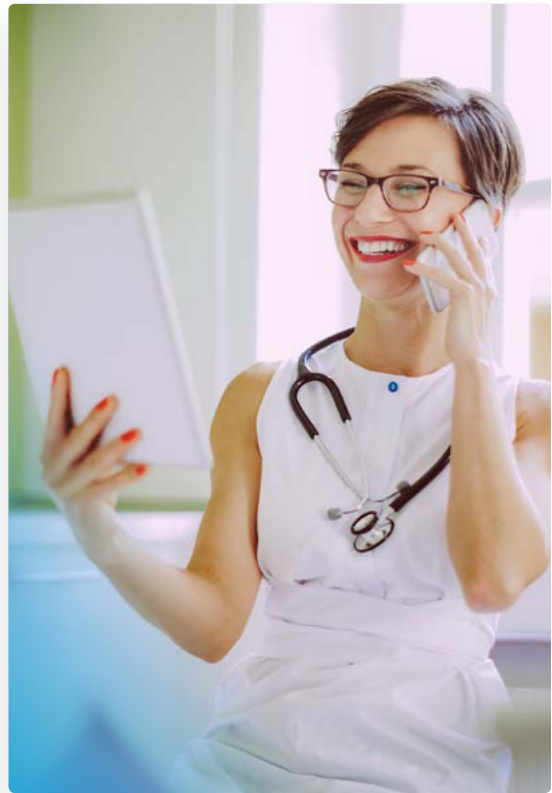
"This level of effort is unheard of. And patients cannot believe that their provider's staff cares enough to contact them to see if they are doing well after an inpatient admission or ER visit."

Patient Navigators Help Reduce Recurring ER Visits

Patient Navigators call HMG patients that have been seen in local emergency rooms to determine if they understand the diagnosis and/or test results they may have received.

During the calls, these staff members also:

- Check to see if prescriptions have been filled, and if not, why.
- Schedule a follow-up appointment with the (PCP).
- Recommend the use of an HMG urgent care facility in the future for non-life threatening illnesses, and provide hours of operation. Navigators also educate patients on potential cost savings in using urgent care versus the emergency room.



When Patient Navigators are unable to reach a patient by phone, they mail a letter requesting a return call with a flier on the appropriate use of urgent care.

Care Coordination Key to Lowering Readmission Rates

As part of HMG's Care Coordination Team, nurses call any patient who has been discharged from the hospital to review diagnoses and treatment options. They also go over care plans that were developed during the hospital stay. Based on their level of illness and need, nurses follow up with these patients weekly, monthly or bimonthly.

Transition of Care calls are made within 48 hours of discharge to ensure the patient is stable and to schedule a follow up with the PCP. The goal is for the patient to be seen five to seven days following discharge.



Tackling Unnecessary Admissions

HMG administration and hospitalists realized that their chronically ill patients sometimes needed a higher level of care for acute illnesses that often led to an emergency room visit for admission to the hospital. To

address this need, they established the HMG Extensivist Clinic where patients could receive treatments such as IV fluids or IV antibiotics, as well as extensive care for a medical condition that typically indicates a need for hospitalization.

The clinic is staffed by HMG hospitalists and a team of RNs that provide a level of critical care in an outpatient setting.

The cost to the patient is comparable to the cost of an urgent care clinic visit. And when the staff determines that a patient must be admitted for extended care, he or she is admitted directly from the clinic. This process eliminates the use of an emergency room visit for hospital admission – reducing the cost and the often lengthy wait for the patient.



Readmission: A Focus on Patients with Behavioral Health Needs

High readmission rates understandably have a financial impact on all aspects of health care, but most importantly, inpatient readmission impacts the well-being of your patients. And certain groups of patients – some of the more vulnerable – are at a greater risk.

Your BlueCareSM patients with behavioral health needs are among the most vulnerable when they are discharged from an inpatient facility. Many face obstacles that make it difficult to keep follow-up appointments or to obtain medications and take them properly.

Our Behavioral Health team has developed an initiative to address these barriers to wellness that can lead to readmissions. Field Case Managers (FCM), located across the state, engage with members and facilities to bridge the gap and make the transition home or to an outpatient facility successful. The goal is to ensure each member's physical, behavioral (including substance use disorder), and social needs are met. FCMs target individuals identified on daily census reports that meet certain criteria.

Their goals are to:

- Coordinate with other key programs within behavioral health, including Tennessee Health Link and System of Support to ensure all providers are aligned.
- Work directly with the member and providers to develop a person-centered plan incorporating physical, behavioral and social care.
- Meet with inpatient facilities to give them a more holistic view of the patient.
- Work closely with Peer Support Specialists (PSS) to add more support. The PSS work within the community in various locations to ensure members have the appropriate recovery tools to avoid readmission.



What You Can Do To Help

As a provider, you may get questions from your patients, or their families, who have been included in this initiative. Patients may be confused about the intentions of their FCM. You can help your patient get the most from the program by encouraging their participation.



Quality Care Partnership Initiative (QCPI)

Looking for information on specific clinical quality guidelines included in the Quality Care Partnership Initiative program? Check the [provider section of bcbst.com](https://www.bcbst.com/provider) for helpful resources.

You'll find a comprehensive guide that includes information on all the measures. Or if you're looking for more specific information you can access fliers that cover a wide range of health and wellness measures for adults, women, children and adolescents.

Our fliers include tips to help with gap closures, a description of the quality measure and steps you can take to improve results.

– Commercial, BlueCare Tennessee

Schedule a Well-Child On-Site Screening at Your Location

BlueCare Tennessee's Community Care Partner staff travel across the state, working with local providers like you, to host and participate in hundreds of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening events. You can call us to set up a well-child screening at your office any time. We require only a two-month advance notice.

Our team can provide a list of the members with well-child gaps in care for your office. When providers call their patients to schedule appointments, the attendance is much higher. But if you need support, our member education staff is available to help schedule appointments for these events. We can also help get your patients in the door by:

- Mailing postcards or invitations to your patients (with a month's notice).
- Sending automated voice mail messages (with three months' notice).
- Offering giveaways and educational preventive care literature onsite.

– BlueCare Tennessee



Call us at 1-800-771-0217 to schedule an EPSDT screening event at your office.



Helpful online Resources:

- The Tennessee Chapter of the American Academy of Pediatrics offers an extensive EPSDT and Coding Program. [Visit the website for additional information.](#)
- [Bright Futures Guidelines](#) for Health Supervision of Infants, Children and Adolescents – Third Edition, and Periodicity Schedule.





2017 BlueCare Member Incentives

BlueCare provides incentives to members to encourage certain preventive screenings. These campaigns run throughout the entire year. Gift cards are distributed once the claims are submitted. See the chart below for the list of measures, outreach method and gift card amount for 2017.

Incentive Measure	Outreach Method	Dollar Amount
Breast Cancer Screening	Outbound Call	\$50
Cervical Cancer Screening	Outbound Call, Member Scorecard	\$50
Well Child Checkup	Outbound Call, Outreach Event, Member Scorecard Mailing	\$20
Postpartum Checkup	Outbound Call, Mailing	\$50
Diabetic Retinal Eye Exam	Outreach Event, Home Visits, Member Scorecard Mailing	\$50
Chlamydia	Member Scorecard Mailing	\$25

– [BlueCare Tennessee](#)



Medicare Advantage Stars

Member Wellness Incentive Information now Available

BlueCross offers incentives to our Medicare Advantage members for completing various health screenings. Our wellness and reward program, My Healthpath®, is designed to encourage our BlueAdvantage (PPO)SM and BlueChoice (HMO)SM members to get their annual wellness exam.

For 2017, members earn initial wellness points when they complete their wellness exam. Once the claim has been processed, they may be eligible to earn additional points for completing other preventive screenings. Each wellness point is valued at \$1. Points can be accumulated and redeemed for gift cards. Members receive an introductory letter to encourage participation in the program.

You can learn more about how the program works, what measures are included, and which screenings are accepted in the [2017 Member Wellness Incentive FAQ](#) located on the Quality Care Rewards section of our website.



Quick Tips

Create Easy-to-Use Reports from the Quality Care Rewards Tool

Looking for a way to streamline your quality focus? Try creating pivot tables from your Quality Care Rewards Member Aggregate Reports. A pivot table can display all open gaps for each of your patients – or you can create a list based on one particular measure to achieve faster results.

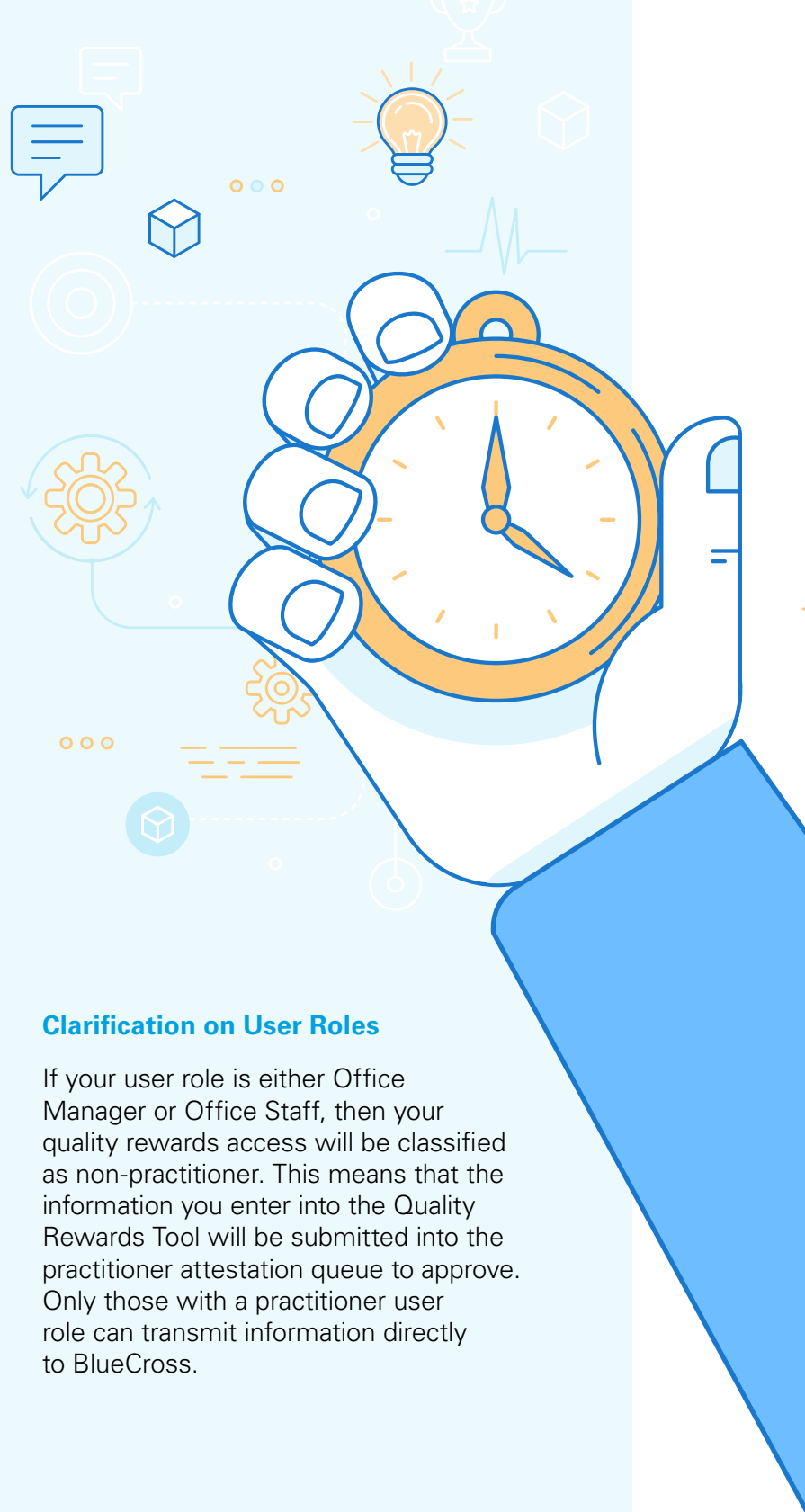
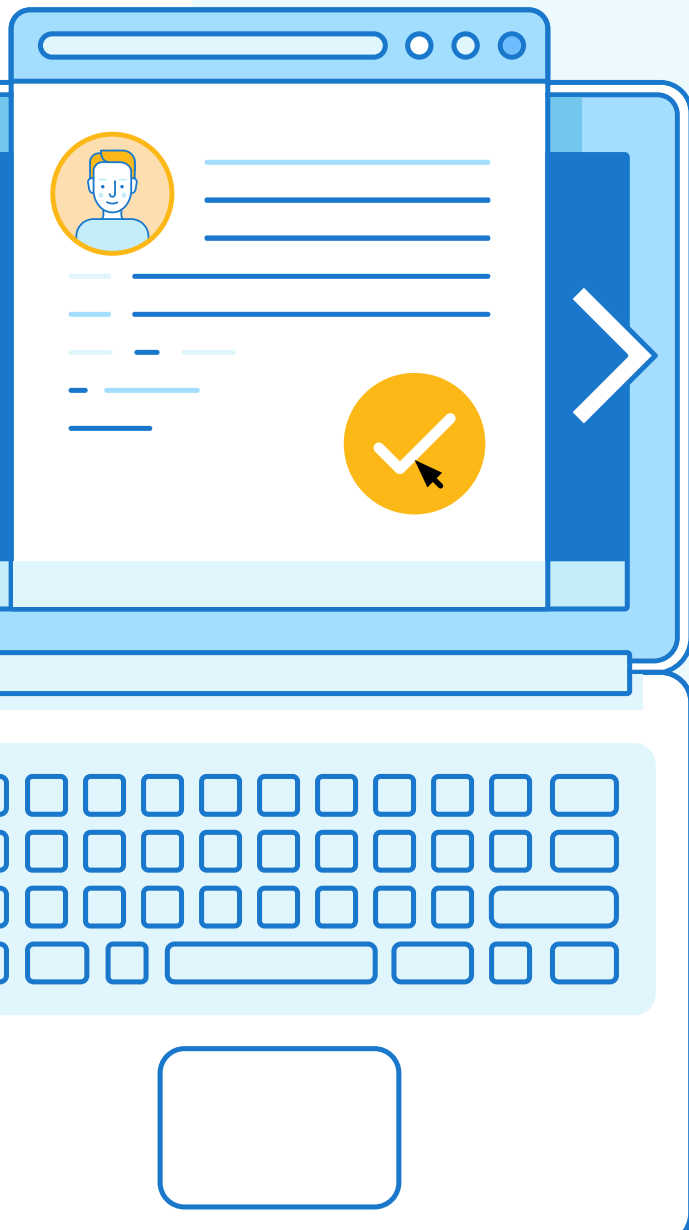
Follow these five easy steps to create your pivot tables:

1. Export the Member Aggregate report by clicking the Member Aggregate button on your contract page.
2. The worksheet will be labeled Contract Master noncompliant. Note: Some members will be listed on multiple rows to show each open measure.
3. Click Insert on the Excel menu, and then select Pivot Table.
4. When the Create Pivot Table dialogue box appears, click OK.
5. The pivot table fields will appear on the far right corner of your screen. Use these to select the level of detail you want. For instance, if you click the field Measure Name, you can pull in a specific measure – such as BMI – that the provider would like to focus on at this time.

More Tips

Working Through Daily Interruptions

A Provider or Member favorite list, on the Main Navigation Menu, is created when you click on either a provider or member name. If you're distracted and return to your work later, the favorite list will show the name of the record you were reviewing the last time you were in the application.



Clarification on User Roles

If your user role is either Office Manager or Office Staff, then your quality rewards access will be classified as non-practitioner. This means that the information you enter into the Quality Rewards Tool will be submitted into the practitioner attestation queue to approve. Only those with a practitioner user role can transmit information directly to BlueCross.



A Clinical Focus

Update:

Additional Tests Accepted for Colorectal Screening Measure

There are now two additional tests that can be used to close a Colorectal Cancer Screening (COL) gap in care. FIT-DNA tests (every three years) and CT Colonography (every five years) are now accepted, as well as the following:

- Colonoscopy – during the current measurement year or nine years prior (considered the Gold Standard)

- Flexible Sigmoidoscopy – during the current measurement year or the four years prior
- Fecal occult blood test (FOBT) - annually

Important Reminder

Neither digital rectal exams, nor FOBT tests performed in the office or performed on a sample collected from a digital rectal exam can be used to close the colorectal cancer gap in care.

– Commercial, Medicare Advantage and BlueCare Plus (HMO SNP)SM



Reducing the Use of Imaging for Low Back Pain

While low back pain is one of the most common reasons for an inpatient visit, it is a self-limiting condition that does not, in most cases, warrant the use of imaging studies, according to the American College of Radiology. In fact, the majority of patients with uncomplicated low back pain are back to their usual activities in about 30 days.

The use of imaging studies for low back pain (LBP) is a measure included in the commercial Quality Care Partnership Initiative (QCPI) program. It is based on the percentage of patients, 18-50 years old, with a primary diagnosis of low back pain that did not have an imaging study within 28 days of the diagnosis. This includes a plain X-ray, MRI or CT scan.

Of course, there are situations in which imaging is clinically appropriate, including:

- Cancer
- Recent trauma
- IV drug abuse
- Neurologic impairment
- Prolonged corticosteroid use
- HIV
- Spinal infection
- Major organ transplant

– Commercial, Medicare Advantage and BlueCare Plus (HMO SNP)SM



How to Document Weight Assessment and Counseling for Children and Adolescents

Childhood obesity is on an upward trend. As a provider, you play an important role in educating patients through weight assessments and counseling.

In addition to the date of the counseling session, there are three components to the Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) quality measure. Here's what you need to know about documenting these components:

Body Mass Index (BMI)

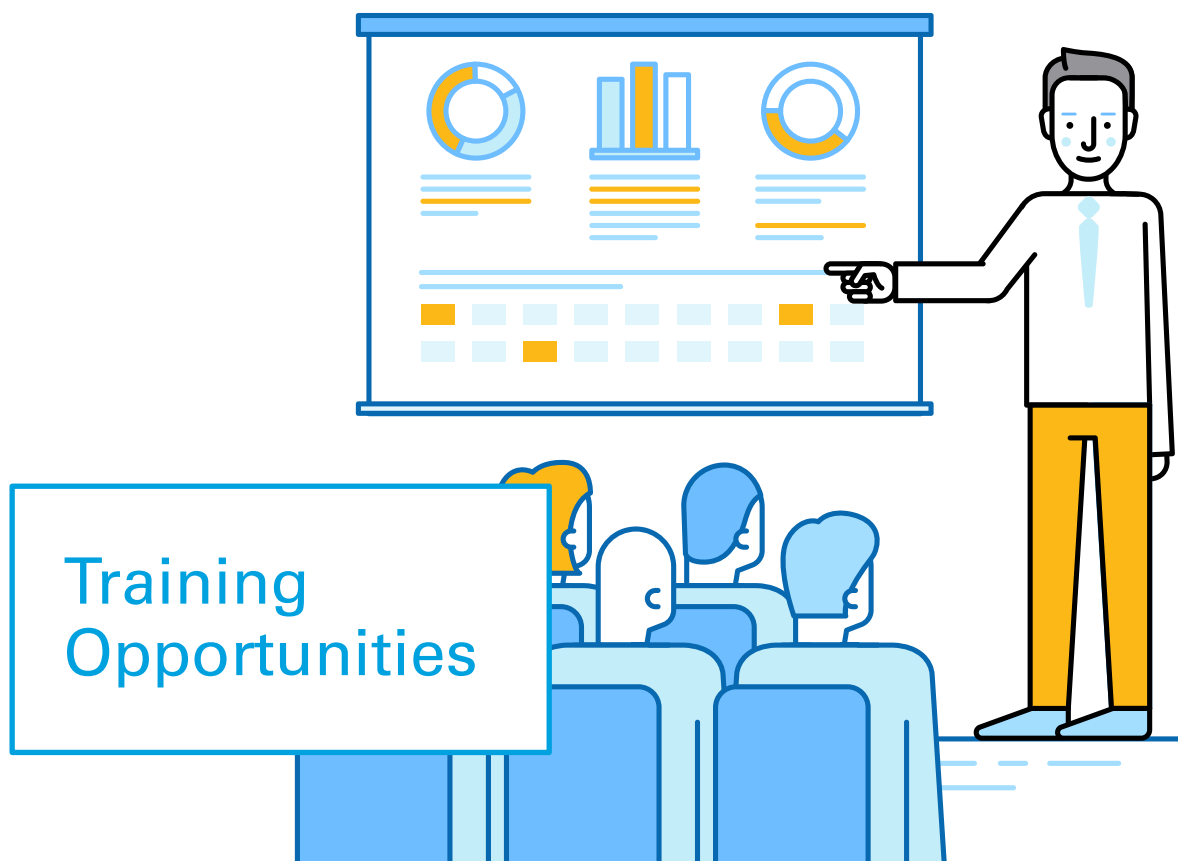
- Use specific BMI percentiles that account for age and gender rather than absolute BMI. A range of BMI percentiles is not specific enough (e.g. <85 percent).
- Include the percentile in the physical or electronic medical record, or plot the percentile on an age-growth chart that's specific to BMI.

Nutrition Counseling

- Document the assessment of current eating habits and dieting behaviors.
- Document counseling on diet or eating habits, any educational resources provided, or nutrition referrals made.

Physical Activity Counseling

- Document any assessment and counseling related to current physical activity, educational resources provided, or referrals made.
- Guidance should include recommendations on types and amounts of physical activity – not counseling solely related to safety during physical activity.



Calendar of NCQA Training

The NCQA Recognition Program hosts monthly customer education sessions for each program. You can attend audio workshops or WebEx training sessions that combine audio and Internet-accessible video presentations.

You don't need to make a reservation. [Visit the NCQA website](#) for the current calendar and course descriptions.

To participate:

Call 1-866-505-4013

Participant Code: 7023159766#
(You must enter the # after the code)

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-565-9140-1 (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)。