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Quality Training Manual 2020


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Principles of Value Based Healthcare Delivery

- Early detection
- Right diagnosis
- Slower disease progressions
- Early treatment in causal chain of diseases Appropriate treatment plan
- Reduced need for ER visits
- Prevention of illness
- Fewer complications
- Fewer mistakes and repeats in treatments Faster recovery
- More complete recovery
- Fewer recurrences, relapses, and flare-ups

"Quality drives better health outcomes"

"Shift from volume-based to value-based healthcare"

Medicare Risk Adjustment

Risk adjustment is the methodology used by the Centers for Medicare and Medicaid Services (CMS) to understand the health status, clinical risk, and expected medical costs of Members enrolled in health plans. This method ensures accurate, timely, consistent, and complete documentation.

The goal of the Medicare Risk Adjustment model is to allow physicians to effectively manage their patients' healthcare needs by allowing for appropriate resources and responses. Capturing risk posed by chronic conditions and coexisting medical conditions allows physicians to encourage members to participate in disease and care management programs.

Hierarchical Condition Category (HCC)

70000
+ ICD10s

All ICD- 10 Codes

14000
+ Risk Adjusted

Map to 1 of 86 categories

Each Code AKA an HCC

86
HCC Categories

Clinically related conditions

Each category is technically an HCC

Each category has a RAF (Risk Adjustment Factor)

Most Categories (RAFs) are Additive and some can Hierarch others

Here are a few HCC categories

Category	ICD - 10	Description
18	E11.638	Type 2 diabetes mellitus with other oral complications
	E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
	E11.36	Type 2 diabetes mellitus with diabetic cataract
	E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
22	E66.01	Morbid (severe) obesity due to excess calories
	E66.2	Morbid (severe) obesity with alveolar hypoventilation
111	J41.0	Simple chronic bronchitis
	J43.9	Emphysema, unspecified
	J44.9	Chronic obstructive pulmonary disease, unspecified

Medical Record Documentation Guidelines and Checklist

Medical Record Documentation Guidelines and Checklist

PATIENT INFORMATION	Initials
❑ Every page of the medical record must have:	
❑ Patients First and Last Name	
❑ Date of Birth	
❑ Date of Service	
PROVIDER INFORMATION	**Initials**
❑ Every note must have rendering provider's full name and credentials (MD / DO / NP / PA)	
❑ If handwritten, full name and credentials MUST be legible	
TIMELINESS, SIGNATURE, AND LOCKING	**Initials**
❑ All Progress Notes MUST be signed and locked within 48-72 hours (no more than 30 days)	
❑ Date of service and date signature MUST be shown on the notes	
❑ DO NOT bill without completing, signing, and locking the note	
❑ DO NOT unlock the note to make changes to the documentation	
ADDENDUMS	**Initials**
❑ Addendums should be done minimally (no more than 30 days)	
❑ Date of addendum and reason for addendum MUST be shown on the addendum	
❑ DO NOT unlock a note to add information	
SUPPORTING EVIDENCE	**Initials**
❑ Every note MUST include vitals and physical exam	
❑ Every diagnosis code listed on the note MUST have ALL of the below ❑ Monitor - Signs, Symptoms, Disease progression, Disease regression ❑ Evaluate - Test Results, Medication effectiveness, Response to treatment ❑ Assess - Ordering tests, Discussion, Review of records, Counseling ❑ Treat - Medications, Therapies, Other modalities	
COPYING OR CLONING	**Initials**
❑ Every note MUST be unique and MUST show only the items addressed during that visit	
❑ DO NOT clone or copy / paste any part of the progress note from previous visits	
❑ IF ROS or Physical Exam unchanged from previous visit, make a notation on your notes	
ADDITIONAL GUIDELINES	**Initials**
❑ Include only the ACTIVE conditions that were addressed during that visit	
❑ DO NOT include rule out, resolved, past history conditions as active conditions	
❑ Include ROS, Physical exam, and other references (labs, imaging etc) pertinent to every addressed condition, and ensure that the details in all sections are consistent	
❑ DO NOT include ROS, Physical exam sections that were not completed during that visit	
❑ Ensure that codes on notes match with billed claims	
❑ If preparing notes prior to visit, every pre-prepared item MUST be thoroughly reviewed and edited accordingly during the visit	
❑ DO NOT leave open notes for no show or cancelled or rescheduled visits	

I understand the above documentation guidelines and agree to comply with CMS standards of medical record documentation.

Provider Signature: _____ Date:_____

Provider Name: _____

Provider Credentials: MD / DO / NP / PA

MEAT Vs. SOAP

Clear and concise medical record documentation is critical to providing patients with quality care, helping healthcare providers evaluate and plan the patient's treatment and maintain the continuum of care.

M — MONITOR

- Signs
- Symptoms
- Disease progression
- Disease regression

E — EVALUATE

- Test results
- Response to treatment
- Medication responsiveness

A — ASSESS / ADDRESS

- Ordering tests
- Record review
- Counseling
- Discussion

T — TREAT

- Medications
- Treatment
- Other modalities
- Therapy

Vs.

S — SUBJECTIVE

- Chief Complaint
- HPI, PMH, ROS, PE
- Co morbidities
- Standard Abbreviations

O — OBJECTIVE

- Documentation must support the Dx reported
- Document cause/effect relationship

A — ASSESSMENT

- Document condition assessed and what is being done for that conditions (Rx, labs, referrals etc)

P — PLAN

- CMS acceptable signature followed by credentials
- Authenticate EMR note

Quality Program

Physician Partners initiates the Quality Program at the beginning of each year. The aim of this program is to ensure every patient is seen as early as possible and a comprehensive assessment of the patient's chronic care gaps is completed. To assist with this initiative Physician Partners provides various tools such as the 5 Star Checklist, 5 Star PCP Portal, training manuals, etc.

The main objective of this program is for the providers to use our 5 Star Checklist at the time of the comprehensive assessment and address all the chronic care gaps listed in the checklist with thorough documentation and appropriate coding.

Office Champions (Office Managers or other Team Members within the office) and Primary Care Physicians play a very important role in the success of this program. Below are some key roles and responsibilities of the Office Champion and the PCP.

Office Champion's Responsibilities

1. Review the member list on the 5 Star PCP Portal Quality Program Dashboard and schedule patients for a comprehensive appointment.
2. Log into the 5 Star PCP Portal and populate the scheduled appointment dates for each patient.
3. As each patient's appointment date approaches, log back into the 5 Star PCP Portal to download the 5 Star Checklist for the Provider to use during the encounter with the patient.
   - DO NOT bulk print all 5 Star Checklists in advance.
4. Once the encounter is complete, ensure that both the 5 Star Checklist and progress notes are properly completed.
5. Upload the completed 5 Star Checklist and completed progress note onto the 5 Star PCP Portal.
   - If you are unable to upload, please contact your Quality Analyst for alternative ways of submitting the completed documents.

Provider's Responsibilities

1. During the patient's encounter use the 5 Star Checklist provided to you by your Office Champion and complete a comprehensive visit with the patient.
2. Properly document any active conditions that exist on the progress note.
3. Any conditions that do not exist, please comment on the 5 Star Checklist and DO NOT include on your progress note.
4. Provide the date of service and sign the 5 Star Checklist.
5. Complete your progress note per documentation guidelines.

Introduction to Chronic Conditions

A chronic condition is a physical or mental health condition that lasts more than one year and causes functional restrictions or requires ongoing monitoring or treatment. Chronic diseases are the most prevalent in the United States. Nearly half (approximately 45%, or 133 million) of all Americans suffer from at least one chronic disease, and the number is growing. Chronic diseases—including cancer, diabetes, hypertension, stroke, heart disease, respiratory diseases, arthritis, obesity, and oral diseases—can lead to hospitalization, long-term disability, reduced quality of life, and death. In fact, persistent conditions are the nation's leading cause of death and disability.

According to the CDC more than two thirds of all deaths are caused by one or more of these five chronic diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes. Additional statistics are quite stark: chronic diseases are responsible for seven out of 10 deaths in the U.S., killing more than 1.7 million Americans each year.

What makes treating chronic conditions (and efforts to manage population health) particularly challenging is that chronic conditions often do not exist in isolation. In fact, one in four adults in the United States have two or more chronic conditions, while more than half of older adults have three or more chronic conditions. The likelihood of these types of comorbidities occurring goes up as we age. Given United States' current demographics (10,000 Americans will turn 65 each day from now through the end of 2029), it is reasonable to expect that the overall number of patients with comorbidities will increase greatly.

In this manual you will find information on 30 common chronic conditions including prevalence, symptoms, risk factors, diagnostic tests, treatment protocols, coding guidelines and ICD-10 diagnostic codes. As you continue to see your patients, work to identify conditions early and work to prevent disease from getting worse. We must remember to document our findings and what we did in the room with the patient with as much detail as possible.

We hope these tools and resources will help you continue on this path with us to better health!

Abdominal Aortic Aneurysm

Abdominal Aortic Aneurysm

Abdominal aortic aneurysm (AAA) is defined as a segmental, full-thickness dilatation of a blood vessel that is 50 percent greater than the normal aortic diameter.

Prevalence

- Aortic aneurysm is the 13th leading cause of death in the United States.
- Approximately 4500 people die secondary to AAA rupture per year.
  - According to the NCBI, two-thirds of acute AAA events occurred at age 75 years and above.

Risk factors

» **Tobacco use**
- Strongest risk factor for developing AAA

» **Advanced age**
- Peak incidence between ages 70-80 years

» **Family history**
- 15-25% prevalence in those who have a family history of aortic aneurysm

» **Ethnicity**
- More common in caucasians

» **Gender**
- More common in males

» **Atherosclerosis**
- Damage due to plaque formation and rupture can weaken the vessel wall

» **Hypertension**
- Increased pressure causes abnormal ballooning of the vessel wall causing aneurysm

Diagnostic Test or Physical Examination Findings

Symptoms

» **Asymptomatic**
- According to the U.S. preventive services task force, men over the age of 65 who have smoked even once should get a screening for AAA

» **Back pain**
- Pain is due to the aneurysm pushing and creating pressure on adjacent viscera

» **Abnormal pulsation**
- Patients may experience abdominal pulsations if they have a hyposthenic or sthenic body habitus

Signs

» **Visible pulsation**

- Pulsation is seen in about 40% of patients

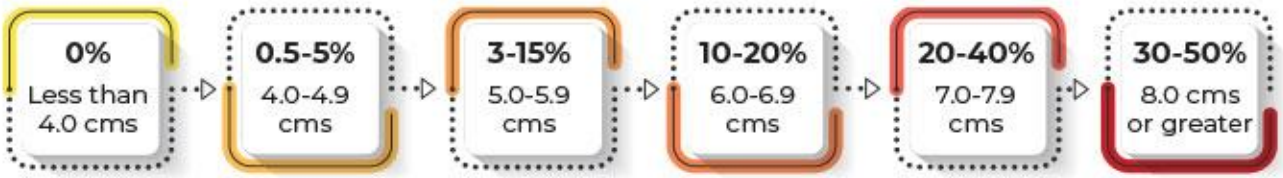
» **Abdominal bruit**

- Can be heard upon auscultation

Complications

» **Rupture**

- Acute AAA rupture is a life threatening event that occurs when the dilated portion of the vessel becomes extensively weak and causes massive hemorrhage into the abdominal cavity leading to hypovolemic shock
- Risk of rupture depends on the size:



Diagnostic Tests

» **Ultrasound**

- Doppler ultrasound
  - Shows the perfusion of the vasculature in the human body. Through ultrasound, the aortic distension can be visualized. Using ultrasound has a 95% sensitivity and 100% specificity

» **Computed tomography**

- CT scan will show the dilatation as well as give the provider an estimated size of the aneurysm

Care and Treatment Protocols

» **Observation and follow-up**

- Asymptomatic patients may not need any additional treatment but should be continuously monitored and evaluated for the progression of the aneurysm

» **Medical management**

- Cessation of smoking
  - Smoking contributes to the weakening of the vessel wall, accelerating the growth rate of the AAA
- Beta blockers
  - Significantly reduce the expansion rate of AAA when monitored by serial USG examination
- Risk factor reduction
  - Treating concomitant conditions such as hypertension and dyslipidemia helps to reduce morbidity and mortality in patients who are diagnosed with AAA

» **Surgical management**

- Transabdominal repair
- Retroperitoneal repair
- Endovascular repair

Documentation Guidelines

» **History of present illness**
- Document any risk factors that the patient may have including tobacco use and family history

» **Review of systems**
- Review cardiac risk
- Evaluate for Abdominal Pain, Back Pain, or Groin Pain

» **Physical examination**
- Abdominal bruit
- Visible pulsation

» **Plan**
- Document observation and follow-up if the patient does not need any medical intervention
- Document size of the aneurysm and the medical treatment for the patient
  - Medications may include but are not limited to:
    - Beta blockers
    - Statin therapy
- If surgery is indicated, document referral to cardiovascular surgeon
  - Post-surgery, consider diagnosis of Z95.828, Presence of other vascular implants and grafts, stating that the patient had endovascular repair.

ICD - 10 and HCC

Abdominal Aortic Aneurysm is in the vascular category which falls in HCC 108.
Here are some of the other care gaps in that category.

ICD	ICD Description	HCC
I70.0	Atherosclerosis of aorta	108
I70.1	Atherosclerosis of renal artery	108
I71.4	Abdominal aortic aneurysm, without rupture	108
I71.9	Aortic aneurysm of unspecified site, without rupture	108

Reference Resources

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4687424/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3076160/
- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/abdominal-aortic-aneurysm-screening

Alcohol Dependence

Alcohol Dependence

According to the NCBI, alcohol dependence occurs when there is continued excessive alcohol consumption leading to development of dependency. Dependency is associated with a withdrawal syndrome when alcohol consumption is ceased or substantially reduced. The syndrome has both physical and psychological manifestations that contribute to distress and psychological discomfort.

Prevalence

- Over 76 million people have alcohol use disorder consisting of dependence, abuse, and harmful drinking.
- Between 30-50% of the geriatric population who are hospitalized in divisions of general medicine and psychiatric medicine present with concomitant alcohol use disorders.
- In the general population approximately 2.3 million geriatric adults present with alcohol use disorders.

Risk factors and Complications

» **Psychiatric conditions**
- Schizophrenia
- Depressive disorders
- Personality disorders

» **Social history**
- Personal choice of drinking

» **Family history**
- Constant exposure to alcoholism making it "acceptable" for the patient

Complications

» **Complications from alcohol**
- Acute intoxication
- Harmful use
- Psychosis
- Alcohol poisoning

» **Neuropathy**

» **Myopathy**

» **Cardiomyopathy**

» **Gastritis**

» **Liver disease**
- Hepatitis
- Cirrhosis

» **Pancreatitis**
- Trauma/Personal injury

Diagnostic Test or Physical Examination Findings

The diagnosis of alcohol dependence is defined by DSM-V as a score of 6 or above for the following criteria:

1. Use of alcohol in larger amounts or for a longer period of time than intended
2. Persistent desire or failed efforts to control use
3. Much time spent obtaining, using, or recovering from the effects
4. Craving, strong desire, or urge to use
5. Failure to fulfill major roles at home, work, or school
6. Continued use despite social or interpersonal problems related to use
7. Giving up or reducing important social, occupational, or recreational activities due to use
8. Recurrent use in physically hazardous situations
9. Continued use despite awareness of a physical or psychological problem due to alcohol
10. Tolerance: need for a larger amount to achieve the desired effect or diminished effect with the same amount
11. Withdrawal: occurrence of a withdrawal syndrome or continued use of alcohol (or benzodiazepines) to avoid withdrawal symptoms

The DSM-V allows providers to specify how severe or how much of a problem the substance use disorder is, depending on how many symptoms are identified. Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder

Tools to help diagnose dependence

- CAGE questionnaire
- AUDIT-C screening tool
- DSM-V screening tool

Care and Treatment Protocols

» **Brief Intervention**

- 5-10 minute conversation with a counselor or certified professional which covers risks associated with pattern of drinking, reducing the amount you drink, alcohol support networks such as Alcoholics Anonymous, and any emotional issues surrounding your alcohol abuse

» **Moderation vs. Abstinence**

- Quitting "cold turkey" is associated with side-effects, thus cutting down and drinking in moderation is always a better treatment plan as it reduces the withdrawal symptoms a patient may have

» **Detoxification**

- Mild dependence may be treated with simple detoxification done at home by avoiding alcohol
- Moderate or severe dependence will require medical attention and medication to help prevent withdrawal symptoms
  - Withdrawal symptoms may last anywhere from 24 hours to 7 days

» **Medications**

- Acamprosate
- Naltrexone
- Disulfiram

» **Therapy**

- Self help group
- Cognitive behavioral therapy
- Family therapy
- Drinking diary