

NYC REACH Newsletter

January 2019

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Welcome to the January 2019 NYC REACH Newsletter.

In this issue, we share opportunities to improve asthma severity documentation, highlights from the 2018 PCMH Congress, and tips and tricks (for providers, from providers) for operating as a patient-centered medical home.



We also review the goals and structure of value-based payment arrangements. The healthcare industry shift from fee-for-service payment to value-based payment has significant implications for New York City providers and patients, and NYC REACH will continue to guide providers through this change.

Enjoy the newsletter!

Sincerely,
The NYC REACH Team

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Using ICD-10 Asthma Severity Codes

New York City is one of the top twenty “Asthma Capitals” in the United States, a designation based on asthma prevalence, asthma-related emergency visits, and asthma-related fatalities.ⁱ The City also has the third highest rate of asthma-related deaths in the country.ⁱⁱ

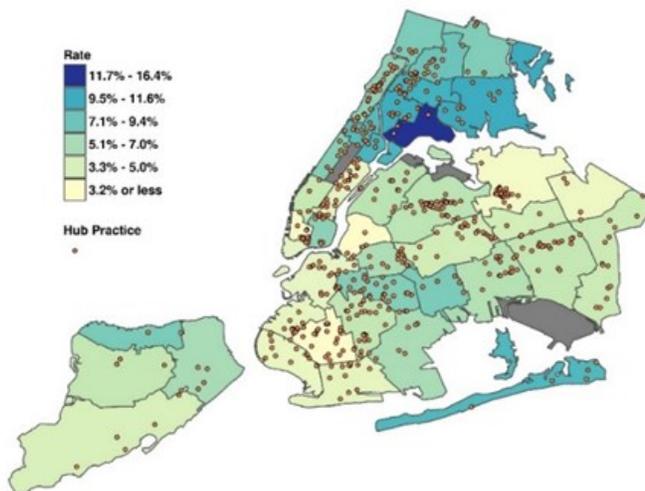
Data on provider documentation practices can inform new population health and clinical approaches to improving patient outcomes. The Evaluation, Research and Analysis team at the Primary Care Information Project (PCIP) reviewed the documentation of asthma severity in pediatric and adult patients. The findings present an opportunity to improve asthma severity documentation, which is important for patient treatment, targeted interventions, and claims reporting.

Reviewing Asthma Severity Documentation

Using data from aggregate electronic health records (EHR), the team reviewed the use of ICD-10 codes to document the specificity of a patient’s asthma condition. Under the expanded ICD-10, coding allows for asthma diagnoses to be classified by severity with greater specificity. Aggregated data were limited to the number of patients who visited a provider in 2016 and had an ICD-10 asthma code in their problem list or assessment. A total of 619 practices, accounting for 1.7 million patients, contributed data.

Findings

The most commonly selected asthma diagnosis codes were “unspecified” and “other.” These two codes were used twice as often as any of the more specific ICD-10 severity codes. Of the patients, 7.2 percent had an asthma diagnosis, but only half of those patients had a diagnosis that specified the severity of their condition. The findings show that severity codes were used less for adult patients than for pediatric patients, even though asthma is typically more severe in adults (adults are four times more likely than children to die from asthmaⁱⁱⁱ). “Mild intermittent” was the most commonly used severity code across all practice types and patient demographics. Pediatric practices were more likely to use severity codes than other practice types.



Asthma Diagnosis by UHF neighborhood

The data show a similar pattern to previous findings on the distribution of asthma in New York City: the South Bronx (16.4%) and East Harlem (10.8%) are asthma hotspots, and children aged 5 to 11 had the highest prevalence of any age group (12.8%).

Importance of Using ICD-10 Severity Codes

Detailed documentation of asthma severity may lead to improved patient outcomes. Knowing the severity of asthma is an important indicator for treatment and management. Using ICD-10 severity codes can help better manage patients' asthma and prevent avoidable hospitalizations and emergency room visits.^{iv} Communicating this information to patients helps them understand their own condition, and documenting severity is useful to other care providers who may be unfamiliar with a patient's medical history. The use of severity codes can also help identify patients with severe or poorly managed asthma and, in turn, public health or health systems can develop more targeted, effective population-based interventions.

The codes used in documentation for disease severity impact provider's evaluation of care and related reimbursements. The use of unspecified codes may result in payment delays and unnecessary claim denials by the Centers for Medicare & Medicaid Services (CMS) and other payers. CMS requires the use of 5th or 6th character placement to report the highest level of specificity (for asthma and for other conditions).^v

Guidance on Using ICD-10 Severity Codes

Aggregated information from over 600 practices suggests that the low usage of ICD-10 severity codes may be the result of issues accessing codes in EHR systems. For example, several providers did not know to use the severity codes because their EHR system was not fully updated.

The table to the right lists ICD-10 codes available for specifying asthma severity. Providers should be able to see all of these codes and select any of them in their EHR. If not, providers should contact their EHR vendor.

Consider taking a few minutes to review clinical documentation and ensure codes align with the severity documented in the patient's health record.

For a step-by-step guide to updating and mapping ICD, CPT, and LOINC codes in eClinicalWorks, watch the Electronic Health Record Tips & Tricks webinar on the NYC REACH resource library at www.nycreach.org (Electronic Health Record Assistance folder).

ICD-10	Definition
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma with acute exacerbation
J45.22	Mild intermittent asthma with status asthmaticus
J45.30	Mild persistent asthma, uncomplicated
J45.31	Mild persistent asthma with acute exacerbation
J45.32	Mild persistent asthma with status asthmaticus
J45.40	Moderate persistent asthma , uncomplicated
J45.41	Moderate persistent asthma with acute exacerbation
J45.42	Moderate persistent asthma with status asthmaticus
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with acute exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma

Codes follow the National Asthma Education and Prevention Program guidelines.^{vi}

Please contact pcip@health.nyc.gov for further assistance. See [page 5](#) for contributing researchers and references.

PCMH Congress 2018 Highlights

PCMH Congress is an annual conference hosted by the National Committee for Quality Assurance (NCQA) where healthcare providers and program experts share successes, challenges, and innovations in patient-centered medical home (PCMH) model implementation. This year, NCQA invited NYC REACH to share its expertise with attendees. NYC REACH program experts shared best practices and lessons learned from working with New York City providers to adopt and sustain the PCMH model.

The PCMH program supports practices with providing patient-centric care, improving quality outcomes, and succeeding under value-based payment (VBP) arrangements. Practices that transform into patient-centered medical homes strengthen their population health capabilities, simplify practice workflows, and improve performance in other programs. New York providers adopt the New York State PCMH model, a framework designed exclusively for New York providers.

Presentations and case studies of PCMH practices largely focused on how providers can:

- Ensure that PCMH operations are financially sustainable
- Use VBP and other revenue sources to drive practice improvements
- Leverage electronic health record (EHR) technology to streamline PCMH operations
- Effectively integrate behavioral health into primary care

Providers from all practice sizes shared tips for sustaining PCMH operations. See [page 6](#) for a summary.

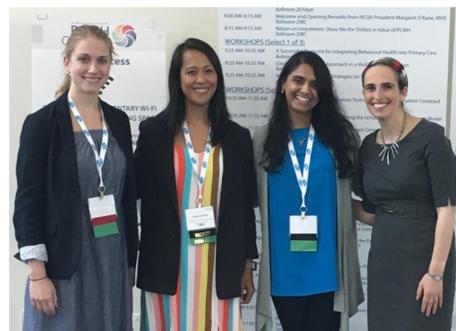
NYC REACH PRESENTATIONS

NYC REACH experts delivered two presentations: one on the importance of integrating VBP with PCMH operations and one on their efforts to help school-based health centers (SBHCs) achieve school-based medical home (SBMH) recognition.

► Value-Based Payment

NYC REACH presenters discussed the link between VBP and PCMH. A VBP arrangement ties practice revenue to quality outcomes and patient cost of care. Performing well under VBP arrangements requires that practices build or enhance their population health management skills in order to adopt a systematic approach to improving quality of care and reducing patient costs. PCMH provides a framework for a primary care practice of any size to effectively manage population health.

In other presentations, providers demonstrated how PCMH prepares providers for VBP arrangements. PCMH also supports participation in the Merit-Based Incentive Payment System (MIPS). PCMH puts providers on track to meet MIPS requirements throughout the year so that practices meet requirements well in advance of the reporting deadline. See [page 8](#) to learn more about VBP.



NYC REACH practice transformation experts

► School-Based Medical Home

Presenters shared how NYC REACH is working to implement the SBMH model at SBHCs throughout the city. These centers provide a range of free healthcare services; serving either as a complement to primary care providers (PCPs) or the main source of primary care for low-income students. SBMH incorporates the PCMH framework to apply a team-based approach to student care and ensure efficient, coordinated care with PCPs in students' home communities.



School-Based Medical Home presentation
National Committee for Quality Assurance

NYC REACH encourages PCPs and community-based organizations to initiate collaboration by finding out and keeping track of all the locations where their student patients receive care, including local SBHCs.

SUPPORT

To learn more about VBP, SBMH, or PCMH, contact pcmh@health.nyc.gov. NYC REACH provides free support with practice transformation through technical assistance, trainings, on-site visits, and more.

Continued from page 3: Using ICD-10 Asthma Severity Codes

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Tips from Providers

How to Operate as a Patient-Centered Medical Home

At the 2018 PCMH Congress, healthcare providers from all practice sizes shared their strategies for successfully operating as a patient-centered medical home (PCMH). Providers shared a number of simple steps that practices can take to adopt and sustain PCMH operations. (Any practice can implement these strategies to improve practice workflows, not only PCMH practices.)



HOW TO: OPTIMIZE PRE-VISIT PLANNING

Operating as a PCMH requires coordinating care for an entire patient panel (all screenings, outstanding orders, and other patient-specific needs). Efficient pre-visit planning ensures providers maximize time spent with patients and minimize gaps in care.

- ▶ A large health system built a “patient snapshot” in their electronic health record (EHR). Running this simple report compiles patient information from different areas of the chart, which allows the care team to see at a glance various issues such as missing colonoscopies or screenings. Reviewing this “snapshot” during pre-visit planning saves time and improves patient satisfaction.
- ▶ A pediatric practice delegates pre-visit responsibilities to care team members. Front desk staff prepare charts; medical assistants review outstanding orders, enter immunization data, and review quality gaps and care plans. The team reviews pre-visit planning information together in their daily huddle.



HOW TO: ALIGN PROGRAMS

Practices can integrate PCMH activities with other program requirements to minimize the overall administrative workload that comes with participating in multiple programs.

- ▶ A community development financial institution shared how practices use PCMH workflows to meet requirements for the NY Medicaid EHR Incentive Program (Meaningful Use) and the Merit-Based Incentive Payment System’s Promoting Interoperability performance category, and align PCMH workflows to qualified entity (or regional health information organization) workflows.
- ▶ A large health system seeks opportunities to connect PCMH workflows to revenue. For example, its providers may bill Medicare for Transitional Care Management after completing a PCMH-required post-hospital follow-up visit, and ensure that this PCMH-required patient outreach targets the HEDIS measures tied to incentives.

New York State (NYS) PCMH supports providers with connecting to a qualified entity, which eases access to the specialist and hospital information required for meeting program objectives related to care transitions.



HOW TO: INTEGRATE BEHAVIORAL HEALTH

One health system found that adding a behavioral health clinician to the primary care team improves patient and provider satisfaction, reduces the stigma associated with behavioral health conditions, and improves behavioral health outcomes.



HOW TO: PERFORM RISK STRATIFICATION

Whole-practice risk stratification (assigning a risk level to each patient and choosing interventions for each risk level) is a new NYS PCMH requirement. It is also a key component of meeting value-based payment arrangement requirements.

- A small practice in Ohio that uses eClinicalWorks determines patient risk level with the input of the entire care team. The practice assigns risk levels for each day's patients in daily team huddles to manage urgent appointments and prioritize patients with higher risk scores.
- A healthcare consulting group uses patient data when possible. The group suggests determining risk level by prioritizing certain conditions, such as diabetes or hypertension, then analyzing EHR data, such as lab results, alongside hospitalization information.
- A regional health system integrates risk stratification with Medicare's Chronic Care Management (CCM) program, which reimburses providers for out-of-visit services such as following up with patients by phone and tracking down lab results. As part of its stratification process, the system began providing CCM services to its highest-risk patients, who benefit most from care coordination support.
- A pediatric organization considers social determinants of health, including living conditions and food access, when assigning risk levels.



HOW TO: SUSTAIN OPERATIONS

Daily PCMH activities, such as holding care team huddles, quickly become habit for a practice. Practices may find it more difficult to keep up with monthly or quarterly activities, such as holding quality meetings or re-assessing performance on utilization measures.

- A hospital association recommends creating and adhering to a schedule for all intermittent activities to remain on task.
- A pediatric center made PCMH a permanent standing item on departmental meetings to ensure that all department contacts continue to discuss and optimize PCMH operations, even after achieving PCMH Recognition.

These recommendations are only a sample of the many effective strategies for optimizing practice workflows. Contact NYC REACH at pcmh@health.nyc.gov to learn more.

Value-Based Payment: 101

The concept of value-based payment (VBP) has taken root across the healthcare industry. VBP is a “value over volume” approach. Unlike fee-for-service (FFS) models, which motivate providers to see as many patients as possible, VBP models incentivize providers to optimize patient care by improving care quality, reducing costs and inefficiencies, and ultimately advancing population health.



This approach benefits both providers and patients. Under FFS, payers typically reimburse practices only for face-to-face patient encounters, and providers often need to pack schedules tightly to generate adequate revenue. Under VBP, providers generate revenue by improving patient outcomes and minimizing unnecessary patient costs. This makes it financially sustainable for practices to dedicate more resources to activities that keep patients healthy and focus less on increasing visit volume.

VBP Priorities

VBP prioritizes value over volume in all aspects of care. VBP emphasizes **care coordination**: care team members work together to reduce gaps in preventive and chronic care, and ensure patients attend specialist appointments and receive diagnostic testing. VBP allows providers to take a **holistic approach**: payers incentivize providers to address behavioral and social determinants of health - in addition to physical health - to improve overall patient outcomes. VBP emphasizes **preventive care** and chronic disease management: patients play a larger role in their own care and spend less on costly procedures. VBP rewards improved **population health**: providers can take the time to explore opportunities for improving outcomes across their entire patient panel.



VBP in action: contacting unengaged patients

Dr. Wu is a pediatrician whose patient population experiences high rates of asthma. After agreeing to a VBP contract with his largest payer, he started reviewing quality reports regularly and discovered that 50 patients with severe asthma had not visited the practice in over a year. His staff scheduled appointments and found that 20 visited an emergency department (ED) for asthma-related issues without his knowledge. The practice now uses EHR alerts to ensure he sees these patients regularly (not only when their condition worsens), creates asthma action plans, and educates parents on appropriate ED usage. The practice’s medical assistant contacts parents to ensure they fill long-acting asthma control prescriptions.

These workflow changes improved patient and provider satisfaction and reduced ED utilization, which lowered costs. Because Dr. Wu improved quality and lowered costs, his payer disbursed a “quality bonus” and shared the resulting savings with the practice. Under FFS, a payer would only reward Dr. Wu for seeing patients, not for reviewing quality reports or proactively contacting and educating patients. Although Dr. Wu saw fewer patients overall while the practice focused on these workflow changes, he **increased** overall practice revenue for the year.

VBP Arrangement Principles

Providers who thrive under VBP deliver high quality, team-based, holistic patient care. The specifics of VBP arrangements vary across payers, but these core tenets remain the same:

- ▶ **Providers are responsible** for the quality outcomes of their assigned patient panel. Payers reward providers for higher quality outcomes (e.g. improved diabetes control or blood pressure control).
- ▶ **Providers are scored** on total patient care costs and paid accordingly. Payers may or may not hold practices financially responsible for high costs. Lower costs lead to larger payments.
- ▶ **Providers are incentivized** to improve care coordination, address behavioral health needs and social determinants of health, and deliver more preventive care services.

Payer Approaches

All payers, including the Centers for Medicare & Medicaid Services, are shifting toward VBP. New York State Medicaid plans to cover 80% of primary care services under VBP arrangements by 2020. Most commercial payers already offer VBP arrangements, and New York State is working with payers to align their incentives.

Each payer has a different approach, and many already reimburse providers based on quality outcomes. The Quality Payment Program and the Medicare Shared Savings Program are Medicare's VBP programs. The Delivery System Reform Incentive Payment Program (DSRIP) was New York State's first step on the path toward a fully VBP system. Incentives for meeting Healthcare Effectiveness Data and Information Set (HEDIS) measures for any payer are a form of VBP. Payers establish VBP contracts with individual providers or with clinically integrated networks, Independent Provider Associations (IPAs), and Accountable Care Organizations (ACOs).



VBP in action: meeting established goals

Dr. Suarez has 415 hypertensive patients. Under her FFS contracts, she is only reimbursed for office visits. Under her new VBP contract, she is eligible for a significant “quality bonus” for achieving blood pressure control for 85% of those patients. To ensure the practice can meet this target, she hired a care coordinator to make appointment reminder calls, follow up on referrals, and remind patients every month to use their blood pressure logs (which she integrates with EHR records). The coordinator also uses the EHR's automated text reminder feature to ensure patients fill medications in a timely manner. Dr. Suarez' experience in quality payment led to improved performance in the Merit-Based Incentive Payment System, and her practice now has enough resources to consider more advanced VBP contracts.



VBP in action: investing in care coordination

Dr. Jackson has 40 patients with major depressive disorder. These patients require significant care coordination with specialists. Under Dr. Jackson's old FFS contract, the payer did not reimburse her for time spent on care coordination. Through her new VBP contract, Dr. Jackson's IPA helped to identify that these patients have a high total cost of care, then negotiated shared savings payments from two of her plans. These shared savings allow Dr. Jackson to financially sustain her strong care coordination workflows.

How to Prepare

Shifting from volume-based to value-based payment goes beyond signing new contracts. Providers need to invest time and resources in practice transformation to implement VBP operations and sustain them in the long term. This requires integrating administrative and clinical teams to align the new approach to patient care with workflows designed to meet VBP requirements. Practices can start preparing now by taking the following steps.

✓ **Assess the Practice**

- Examine the entire assigned patient panel and consider how new workflows could address common needs across the population.
- Connect to a qualified entity, also known as a regional health information organization, to improve care coordination.
- Review quality incentives in existing payer contracts; payers may include these same quality measures in new VBP contracts.
- Ask your payers, ACO, or IPA how future agreements will incorporate VBP. Contact them as soon as possible. Many new or renewed agreements will include a VBP component.

✓ **Learn About New York State Patient-Centered Medical Home (NYS PCMH)**

NYS PCMH prepares primary care practices for VBP. The New York-specific PCMH model focuses more on VBP readiness than other PCMH models .

✓ **Contact NYC REACH**

NYC REACH provides free support with VBP operations and assesses practices individually to determine readiness and identify opportunities for improvement. To learn more, contact pcmh@health.nyc.gov.

Watch the recorded webinar on the NYC REACH resource library called "Understanding Value-Based Payment" (Practice Transformation folder). NYC REACH will continue to develop VBP-related resources and trainings.

ABOUT NYC REACH

New York City Regional Electronic Adoption Center for Health (NYC REACH) is New York City's Regional Extension Center, a designation of the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology.

NYC REACH supports and enhances the healthcare delivery system to improve population health by assisting New York City-based independently-owned private practices, community health centers, and hospital-based ambulatory sites with adopting and implementing health information systems, quality improvement, and practice transformation initiatives. To accomplish these goals, NYC REACH provides technical expertise and guides healthcare practices to utilize delivery models that emphasize care coordination, patient engagement, and community resource linkages.

NYC REACH is operated by the Primary Care Information Project (PCIP), a bureau in the Division of Prevention and Primary Care at the New York City Department of Health and Mental Hygiene.

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