TNAFP 2022 Annual Practice Enhancement Seminar

Understanding the Ambualtory Quality Measures and Mapping a Successful Outcomes Glide-path

Nick Ulmer, MD CPC FAAFP

VP, Clinical Integration and Medical Dir., Case Mgmt SRHS

Chief Medical Officer, Regional HealthPlus PHO

Disclaimer/Conflicts

- E. G. "Nick" Ulmer, Jr., MD CPC is the owner of the entire content of this presentation. Any questions related to interpretation of the coding guidelines discussed herein should be directed to Dr. Ulmer at:
  - NUlmer@ProtimeLLC.com or
  - 864-684-4248 (cell/text)
- The ultimate authority on the interpretation of CMS guidance rests with your Medicare Administrative Contractor (MAC).
  - Search www.cms.gov and "Who are the MACs" to locate yours.
- Spartanburg Regional Healthcare System is in no way related to the educational content of this presentation.

Objectives

- Be able to state the HEDIS and Stars measures and how they overlay onto the Medicare ACO metrics and why they are important
- Know the definitions behind these measures and which metrics are single or triple weighted
- State strategies on how to successfully achieve on the ambulatory quality measures

The Quality Driver of Healthcare

- Cost is one important metric to measure. Claims payments show where $$ spend is.
- Quality is also an area of needed focus and population health measures tied to financial incentives/disincentives is another strategy
  - Saving money with risk contracts means nothing if quality gateway missed
  - Poor quality is not a good marketing strategy … word of mouth
  - Publicly reported sites tout us as well

HEDIS: Medicare Advantage and Commercial

HEDIS: Medicare Advantage and Commercial

- Healthcare Effectiveness Data and Information Set (HEDIS)
  - Developed and maintained by National Committee for Quality Assurance (NCQA)
  - Started in 1991 with HMO basis to use in quality measurements
  - Allows consumers to compare health plans
  - CMS used HEDIS metrics as foundation to the Star rating system to grade health plans
  - Metrics may apply to commercial, Medicare, or Medicaid. Not across the board
- 70 measures across domains of care, updated yearly
  - Effectiveness of Care
  - Measures Collected with Electronic Data Systems
  - Access/Availability of Care
  - Utilization and Risk Adjusted Utilization

Financial Incentives Can Tie to Stars/HEDIS

- Commercial and Medicare Advantage often ties quality to financial incentives when attaining baseline thresholds – usually 4-Star or 5-Star to merit such
- Helping get the MA/health plan to a 4-Star level brings in added revenues which in a shared savings arrangement, means more monies coming in to manage the plan (or bonuses for provider)
- A higher quality score is good clinical business…

2022 Stars and MSSP ACO Measures[1]

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

2022 Stars and MSSP ACO Measures

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

2022 Stars and MSSP ACO Measures

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

This is not fair!! I don't agree with measure!!

- We all feel your pain
- This is a national measure, so all providers who care for Medicare patients are in the same boat.
- It is re-addressed each year and the scores are adjusted accordingly based on national norms
- No one is expected to be 100%, so when you don't like a measure, rest assured it's been accounted for in the percentile score

2022 New HEDIS Measure: Transitions of Care (TRC)

- Ineffective care transitions (hospital → home → office → home) can lead to a myriad of complications in streamlined care: medication confusion, clinical case work-up flaws, appropriate follow-up needs not met, etc.
- One study estimated that inadequate care coordination and poor care transitions resulted in $25–$45 billion in unnecessary spending in 2011 alone
- There is pressure for hospitals, health plans and providers to improve delivery and coordination of care and lower risks for these patients. This includes examining the admission and discharge processes to prevent rehospitalization, ED visits and other poor health outcomes.

https://www.ncqa.org/hedis/measures/transitions-of-care/

2022 New HEDIS Measure: Transitions of Care (TRC)

- Assesses key points of transition for Medicare beneficiaries 18 years of age and older after discharge from an inpatient facility.
  1. *Notification of Inpatient Admission.* Documentation in the medical record of receipt of notification of inpatient admission on the day of admission or within the following 2 calendar days. Chart audit – not claims.
  2. *Receipt of Discharge Information.* Documentation in the medical record of receipt of discharge information on the day of discharge or within the following 2 calendar days. Chart audit – not claims.
  3. *Patient Engagement After Inpatient Discharge.* Evidence of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. Claims audit.
  4. *Medication Reconciliation Post-Discharge* Medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Closed by TCM code or 1111F.
- Will be single-weighted measure in 2022

https://www.ncqa.org/hedis/measures/transitions-of-care/

Post ED Follow-up

- The percentage of members ages 18 and older with multiple high-risk chronic conditions who had a follow-up service within seven days of an emergency department (ED) visit
- Chronic conditions like COPD, Asthma, HF, AMI, Afib, CVA/TIA, CKD, ALZ, Depression
- Exclusions: Members receiving hospice care or those with ED visits that result in acute or non-acute inpatient care on the day of the visit or within seven days after the visit
- Will be single-weighted measure in 2022. Collected from claims.

https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/

Controlling Blood Pressure (CBP)

- Was a single-weighted display measure and in 2022 is now triple-weighted
- The percentage of patients (18–85 years of age) who had a diagnosis of hypertension reported on an outpatient claim and blood pressure adequately controlled (<140/<90 mm Hg) as of December 31 (last BP) of the measurement year. (need CPT II code or data feed to report)
- Capture in office visit, video visit, telephone (patient reported), or e-visit
- Patient reported need to be collected with a digital device and in record
- 4 Star ≥75% to <82%; 5 Star is ≥82% ideal control (<140/<90 is goal)

Strategies for Blood Pressure Control Goal Attainment

- Prepare the patient for accurate blood pressure collection in office. Educate staff over and over again ……

Proper Position: Proper BP

Common positioning problems can lead to inaccurate BP measurement can have a serious impact on the numbers you use to diagnose and determine treatment. These evidence-based tips can help ensure correct positioning in the clinical setting:

Patient Has...	Reading May Be Off By...*	Adjustment to Make
Crossed legs	2-8 mm Hg	Ask patient to uncross legs
Cuff over clothing	5-50 mm Hg	Place cuff over bare arm
Cuff too small	2-10 mm Hg	Ensure cuff fits properly. If an upper arm cuff does not fit the patient due to arm size, use a wrist cuff
Full bladder	10 mm Hg	Suggest patient use restroom
Talking or active listening	10 mm Hg	Ask for silence and stillness before beginning the measurement and to the last duration of measurement
Unsupported arm	10 mm Hg	Position patient with arm supported, cuff at heart level
Unsupported back/feet	6 mm Hg	Make sure patient is not on the exam table, but seated in a chair with back supported, feet flat on the ground or on a footstool

These values are not cumulative

https://www.heart.org/en/health-topics/high-blood-pressure/understanding-blood-pressure-readings/monitoring-your-blood-pressure-at-home

Strategies for Blood Pressure Control Goal Attainment

- Prepare the patient for accurate blood pressure collection in office. Educate staff over and over again ……
- After visit you (or staff) re-collect BP and update vitals in chart (office note is not capturable)
- Last BP of the year is what gets reported
  - End of year push for early December to give time for a "nurse visit" or telehealth ov
  - Patient reported BP is now OK, so even a phone call is good (validate device)

Controlling Blood Pressure CPT II Codes (<140/<90)

- 3074F SBP < 130
- 3075F SBP 130-139
- 3077F SBP ≥140

3078F DBP < 80

3079F DBP 80-89

3080F DBP ≥ 90

Strategies for Blood Pressure Control Goal Attainment

- Prepare the patient for accurate blood pressure collection in office. Educate staff over and over again ……
- After visit you (or staff) re-collect BP and update vitals in chart (office note is not capturable)
- Last BP of the year is what gets reported
  - End of year push for early December to give time for a "nurse visit" or telehealth ov
  - Patient reported BP is now OK, so even a phone call is good (validate device)
- *Lifestyle is still mainstay, so have you/staff continually address*

DASH Eating Plan

- Focus on eating fruits, vegetables, and whole grains
- Prefer intake of fat-free or low-fat dairy products, fish, poultry, beans, nuts, and vegetable oils
- Limits on foods that are high in saturated fatty acids (like fatty meats, full dairy products, and tropical oils like coconut, palm kernel and palm oils)
- Limits on sugar-sweetened beverages and snacks
- **BP Benefit** seen **within two weeks** in initial trial

Physical Activity Key Guidelines

Adults

- Move more and sit less throughout the day. Some physical activity is better than none.
- For substantial health benefits, do at least 2.5h - 5h/week of moderate-intensity, or 75 min – 2.5h/week of vigorous-intensity aerobic physical activity (or an equivalent combination of both)
- Do muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on 2 or more days a week

Older Adults

- The key guidelines for adults also apply to older adults.
- In addition, older adults should do multicomponent physical activity that includes balance training
- If unable to do the recommended moderate-intensity aerobic activity, then be as physically active as their abilities and conditions allow.

Older Adults with Chronic Conditions/Disabilities

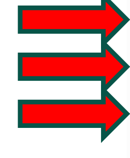
- If unable to meet the above key guidelines, they should engage in regular physical activity according to their abilities and should avoid inactivity.

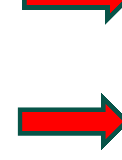
Where else to focus our efforts? 2022 Triple Weighted

2022 Stars and MSSP ACO Measures[4]

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

2022 Stars and MSSP ACO Measures





Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

Where else to focus our efforts? 2022 Triple Weighted

- Controlling BP (<140/<90) 3
- Diabetes Care – blood sugar control (A1c < 9)* 3
- Medication Adherence
  - For Diabetes (meds other than insulin) 3
  - For Hypertension (RAS) 3
  - For Lipids (Statins) 3

*varies with ACO or Stars

Diabetes Care – Blood Sugar Control

- The percentage of diabetic enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator).
  - "Reverse measure": To calculate this measure, subtract the submitted rate from 100. So, here higher is better.
  - Poor control of DM patients leads to higher complications (renal, ocular, etc.) – see prior slide….
- Strategy
  - Frequent office visits if not at goal (HbA1c of 7) – q 3 months (LAST # of year counts, if no ov fails)
  - Review blood sugar logs between times with phone calls (with PHE is CMS billable, but not free)
  - RD consults
  - Address pharmaceutical management in addition to dietary mgmt. and increased physical activity
- DM that is "out of control" can be re-assessed before 90d if so.
  - E11.65 (DM type II w hyperglycemia)
  - E10.65 (DM type I w hyperglycemia)
  - E08.65 (DM from underlying condition w hyperglycemia)

Diabetes Care – Blood Sugar Control

- The percentage of diabetic enrollees 18-75 (denominator) whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year (numerator).
  - "Reverse measure": To calculate this measure, subtract the submitted rate from 100. So, here higher is better.
  - Poor control of DM patients leads to higher complications (renal, ocular, etc.) – see prior slide….
- Strategy
  - Frequent office visits if not at goal (HbA1c of 7) – q 3 months (LAST # of year counts, if no ov fails)
  - Review blood sugar logs between times with phone calls (with PHE is CMS billable, but not free)
  - RD consults
  - Address pharmaceutical management in addition to dietary mgmt. and increased physical activity
- DM that is "out of control" can be re-assessed before 90d if so.
- 4 Star ≥72% to <81%; 5 Star is ≥81% ideal control (<9 on HbA1c is goal)
  - [28%/19% are 4/5 Star % > 9]

Where else to focus our efforts? 2022 Triple Weighted

- Controlling BP (<140/<90) 3
- Diabetes Care – blood sugar control (A1c < 9)* 3
- <u>Medication Adherence</u>
  - For Diabetes (meds other than insulin) 3
  - For Hypertension (RAS) 3
  - For Lipids (Statins) 3

*varies with ACO or Stars

Medication Adherence Defined

- A patient taking their medications (getting the med filled) over the course of the year 80% of the time (292 days if on med 01/01/2022)
  - If diagnosed with a condition that requires a medication, then it is 80% of the time left in the year
  - 90d Rx have higher fill rates, but one miss puts you at 75%......
    - …..and that patient then FALLS OUT (is non-adherent) of the measure score
- Exclusions: hospice, ESRD

Medication Adherence … Problem?

- Non-adherence to maintenance medications for chronic conditions has been reported to be as high as 50% in some populations
  - Nearly 80% of Americans > 50 years of age have one or more chronic conditions
- Evidence suggests adherence is associated with better patient health and lower cost of care (ED visits, hospitalizations)
  - $300B per year in avoidable healthcare costs linked to medication non-adherence
- All are guilty….
  - Non-adherence was common across all demographic, socioeconomic, regional and clinical subpopulations
- Top 3 diseases: Hypertension, Diabetes, and Hyperlipidemia (think "Stars")

The American Journal of Medicine. June 2020;pp690-704.

What counts in HTN Med Adherence? (3x Stars)

- Renin-angiotensin system (RAS) antagonists commonly used in the treatment of hypertension and proteinuria in patients with diabetes, in which these drugs have been shown to delay renal failure and heart disease[1,2]
- Patients 18 years of age and older
- Diagnosis of HTN and given a Rx for treatment for Renin-Angiotensin System (RAS) Antagonist drugs
  - Angiotensin Converting Enzyme Inhibitor (ACEI), Angiotensin Receptor Blocker (ARB), or Direct Renin Inhibitor (DRI)
- Exclusions include those patients in hospice, those with ESRD, and those who have one or more Rx fill for sacubitril/valsartan
- 4-Star success is at 87% compliance, 5-Star is 90+%

[1]Lau DT, Nau DP. Oral antihyperglycemic medication nonadherence and subsequent hospitalization among individuals with type 2 diabetes. Diabetes Care. 2004; 27(9):2149-53.
[2]Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Soc Hypertens. 2018; 12(8):579.e1-579.e73.
[3]Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005; 43(6):521-30.

What counts in DM Med Adherence?

- Certain medication classes (NOT insulin) are tracked
  - Patients 18 years of age and older with a Diabetes diagnosis
  - Biguanides, sulfonylureas, Di-Peptidyl Peptidase (DPP)-IV Inhibitors, GLP-1 receptor agonists, sodium glucose cotransporter 2 (SGLT2) inhibitors, thiazolidinesdiones, and meglitinides.
  - 4-Star is having >87% adherent (filling Rx for meds 80% of the time)
  - Exclusions: if on insulin, if in hospice or with ESRD

What counts in Cholesterol Med Adherence?

- HMG-CoA reductase inhibitors, also known as statins, are recommended for management of dyslipidemia and/or primary prevention of cardiovascular disease (CVD) in several treatment guidelines.[1,2,3]
- By lowering LDL cholesterol, statins decrease the risk of CVD morbidity and mortality.[4]
- There are several studies showing improved clinical outcomes for patients who are adherent to their medications.[5]

[1]Jellinger PS, Handelsman Y, Rosenblit PD, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease. Endocr Pract. 2017; 23(Suppl 2):1-87.

[2]Taylor F, Huffman MD, Macedo AF, et al. Statins for the primary prevention of cardiovascular disease. Cochrane Database Syst Rev. 2013; (1):CD004816.

[3]Stone NJ, Robinson JG, Lichtenstein AH, et al. American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2014; 129(25 Suppl 2):S1-45.

[4]Cholesterol Treatment Trialists' (CTT) Collaborators, Mihaylova B, Emberson J, Blackwell L, et al. The effects of lowering LDL cholesterol with statin therapy in people at low risk of vascular disease: meta-analysis of individual data from 27 randomised trials. Lancet. 2012; 380(9841):581-90.

[5]Sokol MC, McGuigan KA, Verbrugge RR, Epstein RS. Impact of medication adherence on hospitalization risk and healthcare cost. Med Care. 2005; 43(6):521-30.

What counts in Cholesterol Med Adherence?

- Patients 18 years and older prescribed a statin medication
- Adherence is filling the medication 80% or more of the time during the calendar year
- Exclusions include those patients in hospice or those with ESRD
- 4-Star success is at 87% or higher compliance (5-Star is 91%)

Statin Use (not adherence) – Tough Measure

- Statin Use in Persons with DM (SUPD)
- Statin Use in Persons with CV Disease

2022 Stars and MSSP ACO Measures

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

Statin Therapy for Prevention and Treatment of CV Disease

- Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy
  - Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
  - Adults aged ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR

Statin Therapy for Prevention and Treatment of CV Disease **or Diabetes**

- Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy
  - Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
  - Adults aged ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR
  - Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL (Moderate or High intensity statin for the Stars measure)
- Fill ONE and DONE for measure for the year

References

1Stone, Neil J., et al. "2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults." Journal of the American College of Cardiology (2013).

2PQA Statin Use in Persons with Diabetes. www.pqaalliance.org/measures/default.asp.

3Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2014. www.clinicalpharmacology.com. Updated January 2017

4Grundy, Scott M., et al. "2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/ APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines." Journal of the American College of Cardiology (2018): 25709.

What is “high” and “moderate”?

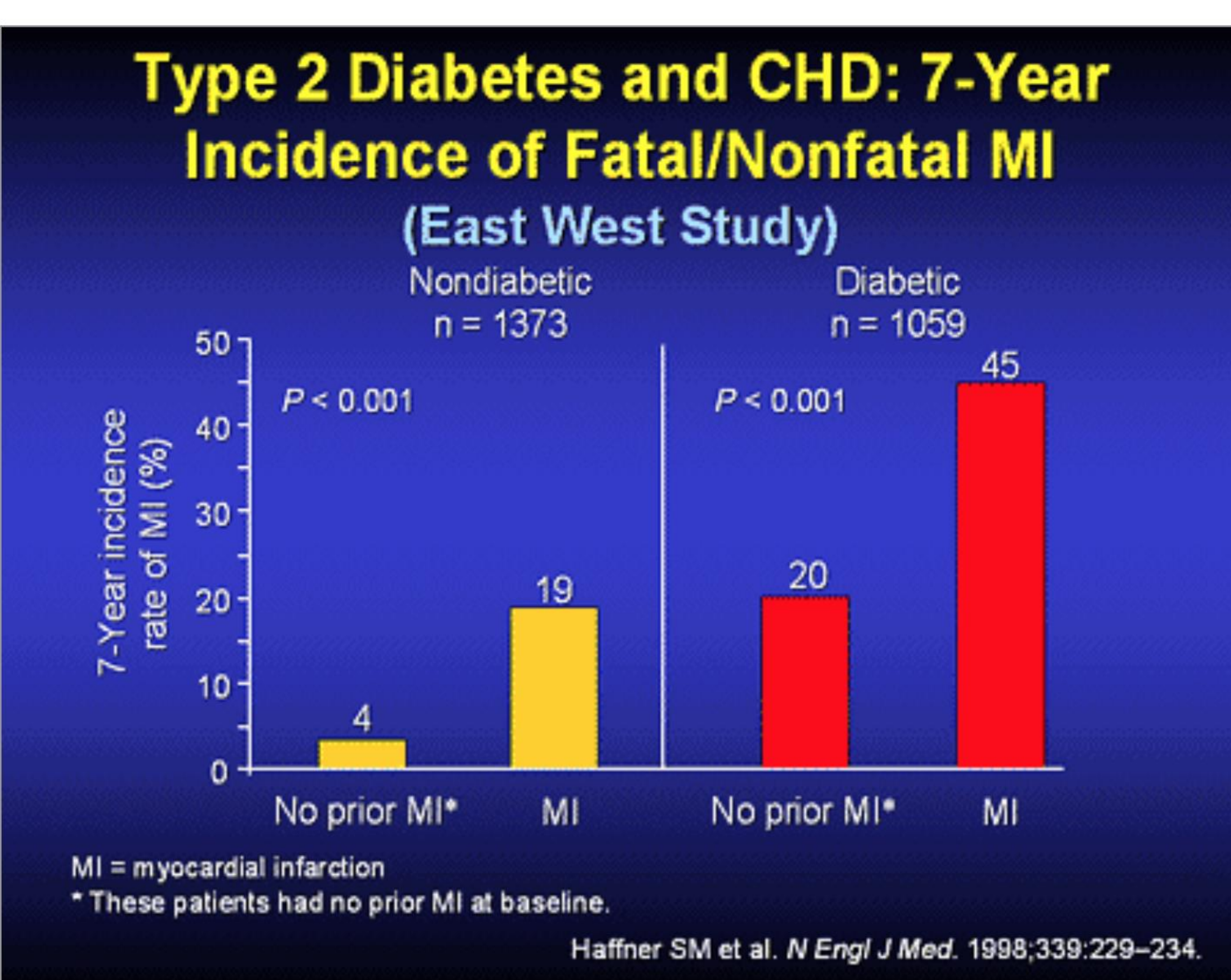
High Intensity	**Moderate Intensity**
Atorvastatin 40-80mg	Atorvastatin 10-20mg
Rosuvastatin 20-40mg	Rosuvastatin 5-10mg
	Simvastatin 20-40mg
	Pravastatin 40-80mg
	Lovastatin 40mg
	Fluvastatin XL 80mg

1. Grundy SM, Stone NJ, Bailey AL, Beam C, Birtcher KK, Blumenthal RS, Braun LT, de Ferranti S, Faiella-Tommasino J, Forman DE, Goldberg R, Heidenreich PA, Hlatky MA, Jones DW, Lloyd-Jones D, Lopez Pajares N, Ndumele CE, Orringer CE, Peralta CA, Saseen JJ, Smith SC Jr, Sperling L, Virani SS, Yeboah J. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol 2019;73:e285–350.
2. American Diabetes Association. 10. Cardiovascular disease and risk management: Standards of Medical Care in Diabetesd2021. Diabetes Care 2021;44(Suppl.1):S125–S150

“My diabetics don’t need a statin….”

“My DM don’t need a statin….”

- The SUPD discussion is sometimes best done with a picture…
  - 7-yr incidence of MI in non-diabetic who has HAD an MI (repeat event) is the SAME as a DIABETIC who had never had an MI
    - Therefore, it would be reasonable to treat all diabetics as though they have had a cardiac event (ie, Statin use)



https://www.nejm.org/doi/full/10.1056/nejm199807233390404

Statin Use Exclusions

- For Stars/HEDIS
  - ESRD
  - Hospice
  - Liver disease
  - Rhabdomyolysis
  - Myositis, myopathy, or myalgia
  - Pregnancy related conditions

- For CMS Quality Payment Program (ACO) measures, more lenient
  - All of the above, PLUS …
  - Allergy/intolerance to a statin also counts (which drug and what side effect)

Medication Non-Adherence Reasons

- Lack of understanding of benefit, of side effects.
  - ABC Project, 2012 (AlGhurar, et al., 2012) – this is #1 reason for non-adherence
  - Some diseases have "hidden" symptoms (HTN)
  - News media can inflame/pick and choose the information to share
- Cost of meds, weighing of social determinants (food, living expenses, etc.)
- Complexity of regimen (qd vs QID)
- Transportation to get meds (mail-in)

Medication Non-Adherence … is there a "fix"

- Not a one size fits all for sure
- Kaiser Permanente has a 5-Star program
  - Heavy infrastructure on technology and patient-level data: eRx reminders when fills not done (they own the health plan and practices)
  - Multiple touches – especially when compliance is questioned
- But…we are not KP, so
  - It takes a TEAM, too much for the front-line provider
    - Ancillary staff, extended care team, health plan, etc.

What can we as a TEAM do … the "fix"[3-6]

- Change over 30d Rx to 90d and (best practice) is MAIL ORDER to home
  - Addresses cost and time and travel
- Simplify the regimen: qd vs QID
- Use a pill dispensary (and get a family member to fill it-?)
- Educate and RE-educate about the long-term disease effects and the medication benefit to help avoid these negative outcomes
- Take a pill, not ½, since most of those meds fall into the "low cost" category anyway
  - Some pills have altered absorption when split
- Address the "offenders" from last year early and repeatedly in office visits (Provider/patient)

Overall Quality Measure Attainment Strategy

- Know the measures
  - Ideal patient care … use as a "roadmap for quality"
  - If contractually linked, have that front/center for providers, staff to focus
  - If in an MA/Mcare/Mcaid/insur. incentive program, have that front/center for providers, staff to focus
  - Use these partners or ACO to help with reporting, outreach, strategies, etc.
- Devise strategies for the most Stars score
  - Focus on triple weighted measures
    - 3 are tied to medication 80% adherence (DM, Statin, BP)
    - 2 are clinical outcomes
      - DM poor control (A1c of 9) - [MA plans use < 9 but ACO/MIPS is > 9]
      - BP control (<140/<90)
  - Focus on the other pharmaceutical linked measures (5 single-weighted ones)

Patient Experience Surveys: CAHPS and HOS

- **Consumer Assessment of Healthcare Providers and Systems** (CAHPS®) is an AHRQ program that began in 1995. Its purpose is to advance our scientific understanding of patient experience with healthcare.
- **Health Outcomes Survey** (HOS) is the first patient-reported outcomes measure used in Medicare managed care (MA plans).
  - Five HOS measures (two functional health measures and three HEDIS Effectiveness of Care measures) are included in the annual Medicare Part C Star Ratings:
    - Improving or Maintaining Physical Health.
    - Improving or Maintaining Mental Health.
    - Monitoring Physical Activity.
    - Improving Bladder Control.
    - Reducing the Risk of Falling.

https://www.ma-pdpcahps.org/en/Current-Data-Collection-Materials/

Patient Satisfaction matters on quality

- Patient surveys are done by CMS and these scores translate into the overall quality report a plan gets
  - Failing on patient satisfaction can undermine all of the quality measure success and is more heavily weighted as the clinical measures (53%)
- Focus questions … "has your provider talked to you about"
  - Talk about issues getting medications filled and need for compliance. Make note of all meds – yours and other consultants to have a source of updated medication list
  - Make note of other consultants and discuss the care from specialists – be an informed PCP
  - Address issues with falling or balance – investigate
  - Urinary incontinence is often a hidden issue with men and women, often hidden. Address.
  - Discuss your patient's level of exercise or physical activity and advise them on a plan

The New Kid Coming to Town: Social Determinants of Health

- Social determinants are the complex circumstances into which individuals are born and live that impact their health.
  - Include intangible factors such as political, socioeconomic, and cultural constructs, as well as place-based conditions including accessible healthcare and education systems, safe environmental conditions, well-designed neighborhoods, and availability of healthy food.
  - Indicators that patients may need added services to optimize healthcare and garner improved health outcomes – risk stratification
- Capturing these on claims during an encounter are starting to be incentivized by some
- Medicaid now, but these measures have impact on population health management ... expect they will grow in importance. (2023….?)

Some Social Determinants of Health (SDOH) Codes

- Education
  - Z550 (Illiteracy and low-level literacy)
- Employment
  - Z56.0 (Unemployment, unspecified), Z56.2 (Threat of job loss), Z56.3 (Stressful work schedule)
- Family and Social Support
  - Z630 (Prob in relationship with spouse/partner), Z633.1 (Family member absence due to military deployment), Z636 (Dependent relative needing care at home)
- Housing issues …
- Experiences with crime …
- Occupational exposures …
- Stress …
- Social environment difficulties …
- Upbringing …

The MA Needs (Stars, etc.) are important

- Medication Adherence is KEY
  - One of the toughest quality measures to achieve
  - Continual work all through the year: repeat with each encounter the importance and applaud when adherence is noted. (motivate the patient to be a part of the team)
- Clinical Quality is KEY
  - Manage depression, diabetes, blood pressure, cardiovascular disease and RA and osteoporosis
- Patient Experience is KEY
  - The weight of this measure is equal to quality
- Social Determinants are growing in importance, so KEY
  - Helps to direct added resources to those in need. A focus here helps us overlook less of those in need.

Closing

- Thanks for allowing me to present this session!

- Questions ….?
  - Nick Ulmer, MD CPC FAAFP
    - NUlmer@protimellc.com

Resources

1. **HEDIS and ACO Quality 2022 Measures. (https://www.ncqa.org/hedis/measures/ and https://www.naacos.com/assets/docs/pdf/2021/ACO-QualityChanges2021_2022.012521.pdf)**
2. https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf
3. Rinfret S, Rodes-Cabau J, Bagur R, et al. EASY-IMPACT Investigators. Telephone contact to improve adherence to dual antiplatelet therapy after drug-eluting stent implantation. Heart 2013;99(8):562-69.
4. Thom S, Poulter N, Field J, et al. UMPIRE Collaborative Group. Effects of a fixed-dose combination strategy on adherence and risk factors in patients with or at high risk of CVD: The UMPIRE randomized trial. JAMA 2013;310 (9):918-929.
5. Castellano JM, Sanz G, Penalvo JL, et al. A polypill strategy to improve adherence: results from the FOCUS project. J Am Coll Cardiol 2014;64 (20):2071-2082.
6. Nieuwkerk PT, Nierman MC, Vissers MN, et al. Intervention to improve adherence to lipid-lowering medication and lipid-levels in patients with an increased cardiovascular risk. Am J Cardiol. 2012;11(5):666-72.

TNAFP 2022 Annual Practice Enhancement Seminar

Understanding the Ambualtory Quality Measures and Mapping a Successful Outcomes Glide-path

Nick Ulmer, MD CPC FAAFP

VP, Clinical Integration and Medical Dir., Case Mgmt SRHS

Chief Medical Officer, Regional HealthPlus PHO

2022 Stars and MSSP ACO Measures

Measure	Program		Star Category & Weight		2021 MSSP	Thresholds 10/4/2021	
	Stars	ACO	Part C or D?	Weight	Threshold	4 Star	5 Star
Care for Older Adults - Functional Status Assessment	✓		C	0		85%	93%
Care for Older Adults - Medication Review	✓		C	1		84%	95%
Care for Older Adults - Pain Assessment	✓		C	1		87%	96%
Medication Adherence for Diabetes	✓		D	3		87%	91%
Medication Adherence for Hypertension (RAS)	✓		D	3		87%	90%
Medication Adherence for Cholesterol (Statins)	✓		D	3		87%	91%
Medication Reconciliation Post-Discharge	✓		C	1		69%	82%
Plan All-Cause Readmissions	✓		C	0		7%	3%
Osteoporosis Management in Women w/ Fracture	✓		C	1		50%	68%
Statin Use in Persons with Diabetes	✓		D	1		84%	88%
Diabetes Care - Kidney Disease Monitoring	✓		C	1		94%	97%
Diabetes Care - Eye Exam	✓		C	1		71%	79%
Diabetes Care - Blood Sugar Controlled	✓	✓	C	3	<23%	72%	81%
Breast Cancer Screening	✓	✓	C	1	70%	69%	76%
Colorectal Cancer Screening	✓	✓	C	1	65%	71%	80%
Controlling Blood Pressure	✓	✓	C	3	70%	75%	82%
Statin Therapy for Cardiovascular Disease	✓	✓	C	1	81%	84%	89%
Reducing the Risk of Falling		✓			70%		
Depression Screening		✓			70%		
Influenza Immunization		✓			75%		
Tobacco Screening and Cessation Intervention		✓			75%		

Controlling Blood Pressure CPT II Codes

- 3074F SBP < 130
- 3075F SBP 130-139
- 3077F SBP ≥140

3078F DBP < 80

3079F DBP 80-89

3080F DBP ≥ 90

CMS's *Care Compare*

- The Centers for Medicare & Medicaid Services' (CMS') Care Compare website (https://www.medicare.gov/care-compare/) provides consumers with information on how well hospitals, facilities, and providers deliver care to patients and encourages healthcare facilities to make continued improvements in care quality.
  - *Care Compare* reports information on more than 100 quality measures for over 4,000 hospitals nationwide and allows consumers to compare hospital performance across many conditions.
- *Care Compare* was created through the combined efforts of CMS in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other federal agencies.
- The data displayed on *Care Compare* are typically submitted by hospitals and other facilities in fulfillment of the reporting requirements of their respective quality reporting programs.

CMS's *Care Compare*

- Options to review on CMS's *Care Compare* …
  - Physicians
  - Hospitals
  - Nursing Facilities
  - Home Health
  - Hospice
  - Inpatient Rehab
  - Long Term Care Hospitals (LTAC)
  - Dialysis

CMS's *Care Compare:* Physician

- Physician Compare (prior version) had a two-fold purpose:
  - Created because of mandate from ACA in 2010 (12/2010) to help consumers make informed decisions about their health care and create clear incentives for physicians to perform well
- Information available
  - General info. Demographics, group affiliation, Board Certification, Medicare Assignment, etc.
  - "Innovative Model Participation" notes ACO/MSSP or other advanced payment models of care that you participate in
  - "Performance" information: Stars rating for eRx of medication; sending summary of care documents to referring or when transferring a patient; retrieving and reviewing patient medication lists, allergy info; and providing patients timely access to view/download/transmit PHI
- Concerns …. QPP@cms.hhs.gov