2021 IHANY GPRO Education Series

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Medicare Shared Saving Program: GPRO Reporting

INNOVATIVE Health Alliance of New York

In order to be eligible to share in any savings generated, an ACO must meet the established quality performance standard that corresponds to its performance year.

Quality reporting for the Shared Savings program is done by a manual abstraction process called **Group Practice Reporting Option (GPRO).**

For 2020 IHANY was assigned over 2600 patient files consisting of over 6,000 quality measures to be **manually abstracted** and reported. The main abstraction team spent 850 hrs. to complete the abstraction, not including the hours of the practice teams.

Reporting for 2021 will occur during January-March 2022. During this time TINs will also need to report Promoting Interoperability (PI) directly to CMS. Education for Promoting Interoperability (PI) will be our next topic in our IHANY education.

2020 Preliminary Performance

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Measure	Pay for Reporting or Performance	2019 Final Performance	2020 Preliminary Performance	% Change
CARE 2: Falls: Screening for Future Fall Risk	Performance	90.37%	97.13%	+6.76%
DM2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Performance	17.62%	16.34%	+1.28%
HTN2: Controlling High Blood Pressure	Performance	78.96%	80.03%	+1.07%
MH1: Depression Remission at Twelve Months	*Reporting*	8.33%	7.61%	-0.72%
Prev 5: Breast Cancer Screening	Performance	65.63%	72.14%	+6.51%
Prev 6: Colorectal Cancer Screening	Performance	64.17%	81.19%	+17.02%
Prev 7: Preventive Care and Screening: Influenza Immunization	Performance	68.33%	74.71%	+6.38%
Prev 10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Performance	87.18%	94.52%	+7.34%
Prev 12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	*Reporting*	70.33%	77.26%	+6.93%
Prev 13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	*Reporting*	87.05%	85.45%	-1.6%

DM2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): *2020 GPRO takeaways, best practices*

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Hemoglobin A1c (HbA1c) must be taken at least once within the calendar year.

- PCP notes that A1c had been taken in previous year with no notes or orders for current year.
- A1c is noted in endocrine consult note in labs that were at the end of the consult but not noted in the patient's labs (common occurrence with AMC Endocrinology patients). Had several instances where PCP was looking for A1c and it was in the last page of the endo consult notes.

Diagnosis inconsistencies

- Several cases where the patient was diagnosed and/or had a denominator eligible diagnosis billed but not noted in problem list or in encounter. I.e. patient is noted as pre-diabetic with PCP but cardiology consult has patient as a type 2 diabetic supported with billing codes.

DM2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): *The Why*

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According to the CDC, as of 2020:

- **34.2 million Americans—just over 1 in 10—have diabetes**.
- 88 million American adults—approximately 1 in 3—have prediabetes.
- For adults diagnosed with diabetes:
  - New cases significantly decreased from 2008 through 2018.
  - The percentage of existing cases was highest among American Indians/Alaska Natives.
  - 15% were smokers, 89% were overweight, and 38% were physically inactive.
  - 37% had chronic kidney disease (stages 1 through 4); and fewer than 25% with moderate to severe chronic kidney disease (stage 3 or 4) were aware of their condition.
- The percentage of adults with prediabetes who were aware they had the condition doubled between 2005 and 2016, but most continue to be unaware.

The American Diabetes Association (ADA) released new research on March 22, 2018 estimating the total costs of diagnosed diabetes have risen to $327 billion in 2017 from $245 billion in 2012, when the cost was last examined. This figure represents a 26% increase over a five-year period.

DM2: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): *Measure Details*

DM2

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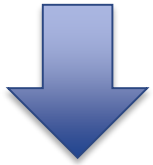
Description:

- Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. **(The more patients that have an A1c >9, the worse our scores are)**

Improvement Notation:

- Lower score indicates better quality



Less Patients with Poor Control

Increases Quality Score

Initial Population:

- Patients 18 - 75 years of age with diabetes with a visit during the measurement period

2021 Complete Measure Specifications:
https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2021_Measure_DM-2_CMSWebInterface_v5.0.pdf
2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

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The Last BP taken in the Calendar year will be what needs to be reported.

- Patient's BP at the beginning and the end of the appointment.

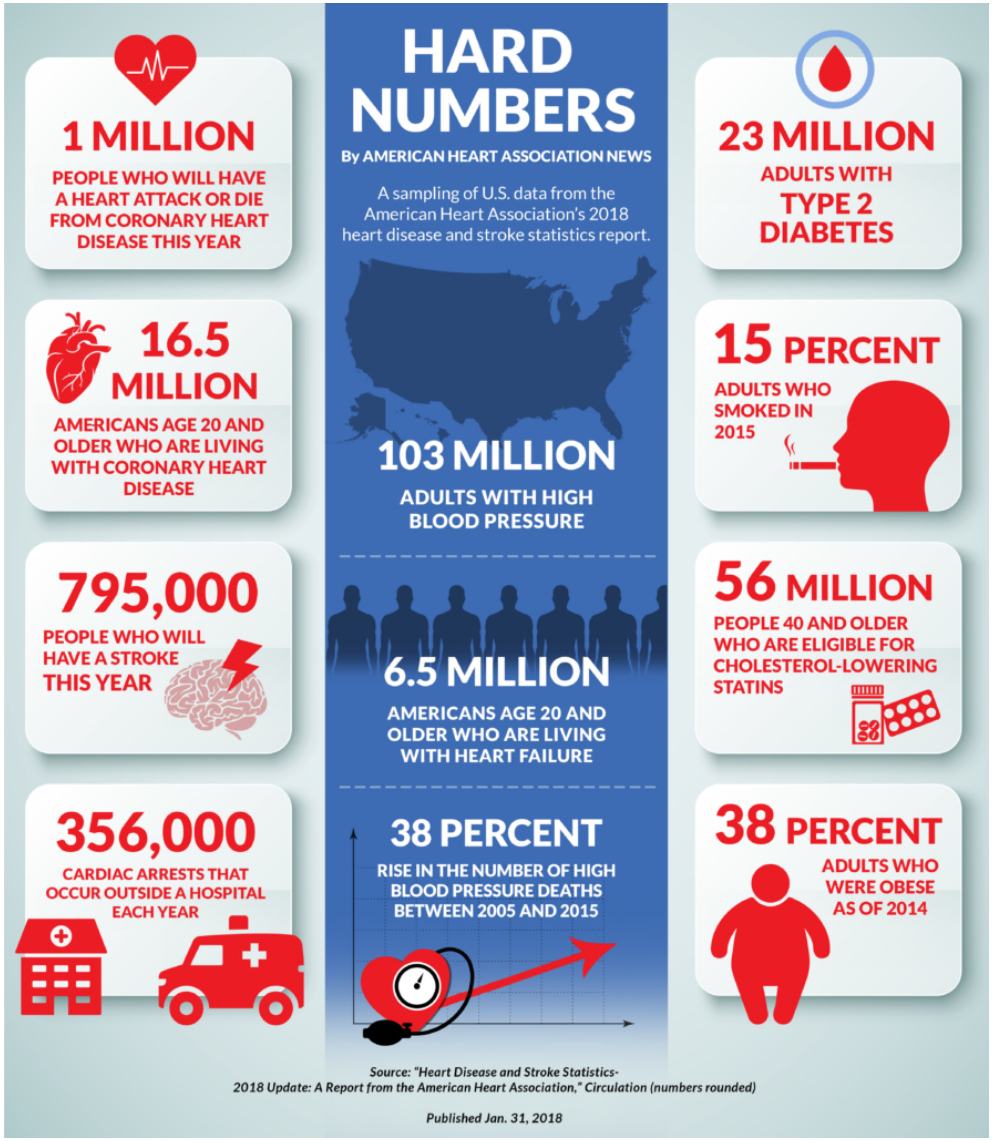
Self Reported BP via Telehealth

- 2020 Guidance: A blood pressure reading may be taken by either a clinician or a remote monitoring device and conveyed by the patient to their clinician via a telehealth encounter.

HTN2: Controlling High Blood Pressure:

The Why

INNOVATIVE Health Alliance of New York



HTN2: Controlling High Blood Pressure:
Measure Details

HTN2

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Description:

- Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period

Improvement notation:

- Higher score indicates better quality

Initial Population:

- Patients 18 - 85 years of age who had a visit and a diagnosis of essential hypertension overlapping the measurement period.

2021 Complete Measure Specifications:
https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2021_Measure_HTN2_CMSWebInterface_v5.0.pdf

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

PHQ2

- Most common assessment used. This measure is for patients **without** an active depression/bipolar diagnosis. MH1 is for those with an active diagnosis of depression. We will address MH1 in a later volume of the series but for that measure it is for patients WITH an active depression diagnosis and a PHQ9 should be used.

Incomplete Assessments

- We ran into several instances where there was an AWV billed but no screenings done or the screening was done but not filled out completely. If the patient refuses the screening it needs to be noted.

PREV 12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan:

The Why

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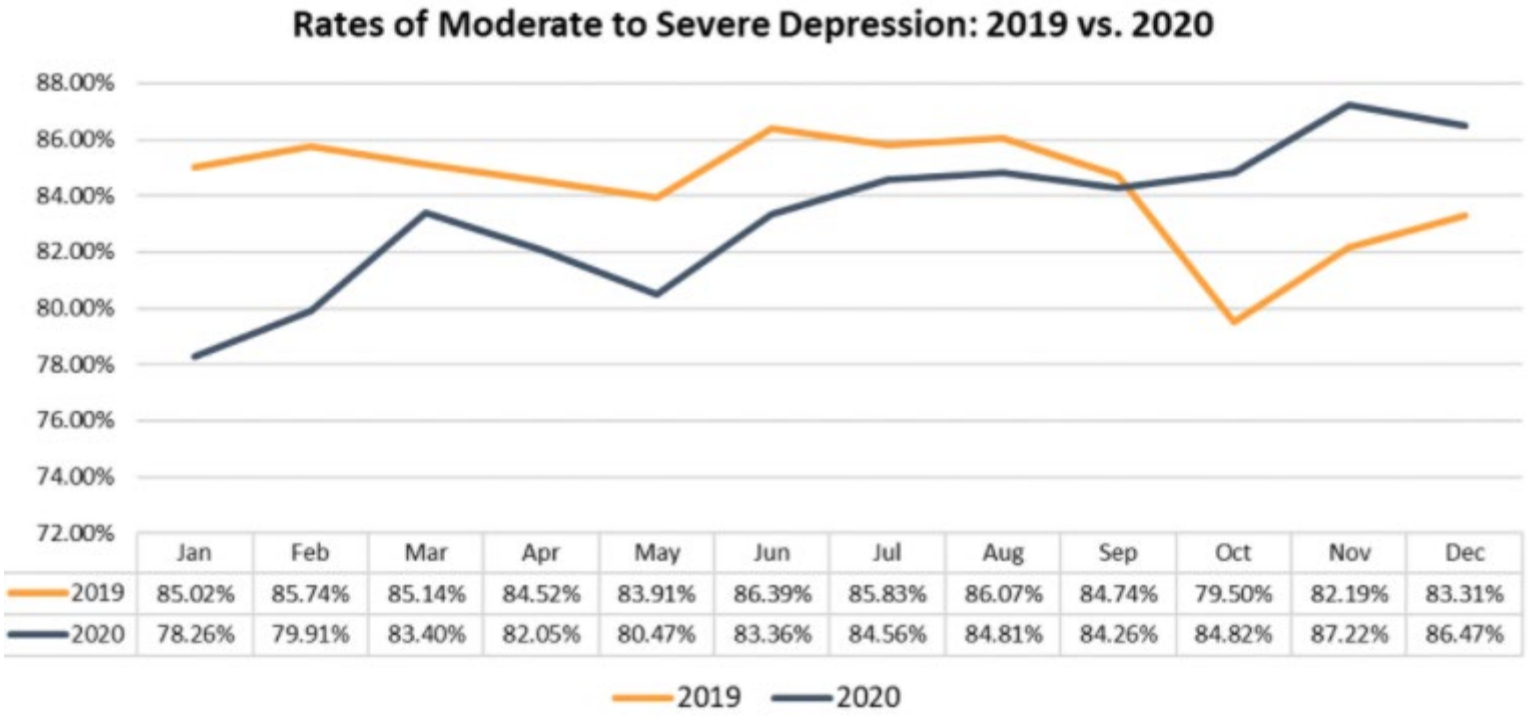

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	85.02%	85.74%	85.14%	84.52%	83.91%	86.39%	85.83%	86.07%	84.74%	79.50%	82.19%	83.31%
2020	78.26%	79.91%	83.40%	82.05%	80.47%	83.36%	84.56%	84.81%	84.26%	84.82%	87.22%	86.47%

Source: https://mhanational.org/mental-health-and-covid-19-what-mha-screening-data-tells-us-about-impact-pandemic#AnxietyandDepressionontheRise

PREV 12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan: *Measure Details*

Depression Screening

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Initial Population:

- All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period. (The more patients that are screened, the better our score are, the more likely we are to receive shared savings)

Denominator:

- Equals Initial Population

Exclusions:

- Patients with an active diagnosis for **depression or a diagnosis of bipolar disorder**

2021 Complete Measure Specifications:
https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2021_Measure_PREV12_CMSWebInterface_v5.0.pdf
2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

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If there is an active diagnosis of depression, utilize PHQ-9 not PHQ-2.

- The measure requires a PHQ-9 to be performed if there is an active diagnosis of major depression or dysthymia. We had several instances where several PHQ-2 were done within the timeframe but no PHQ-9.

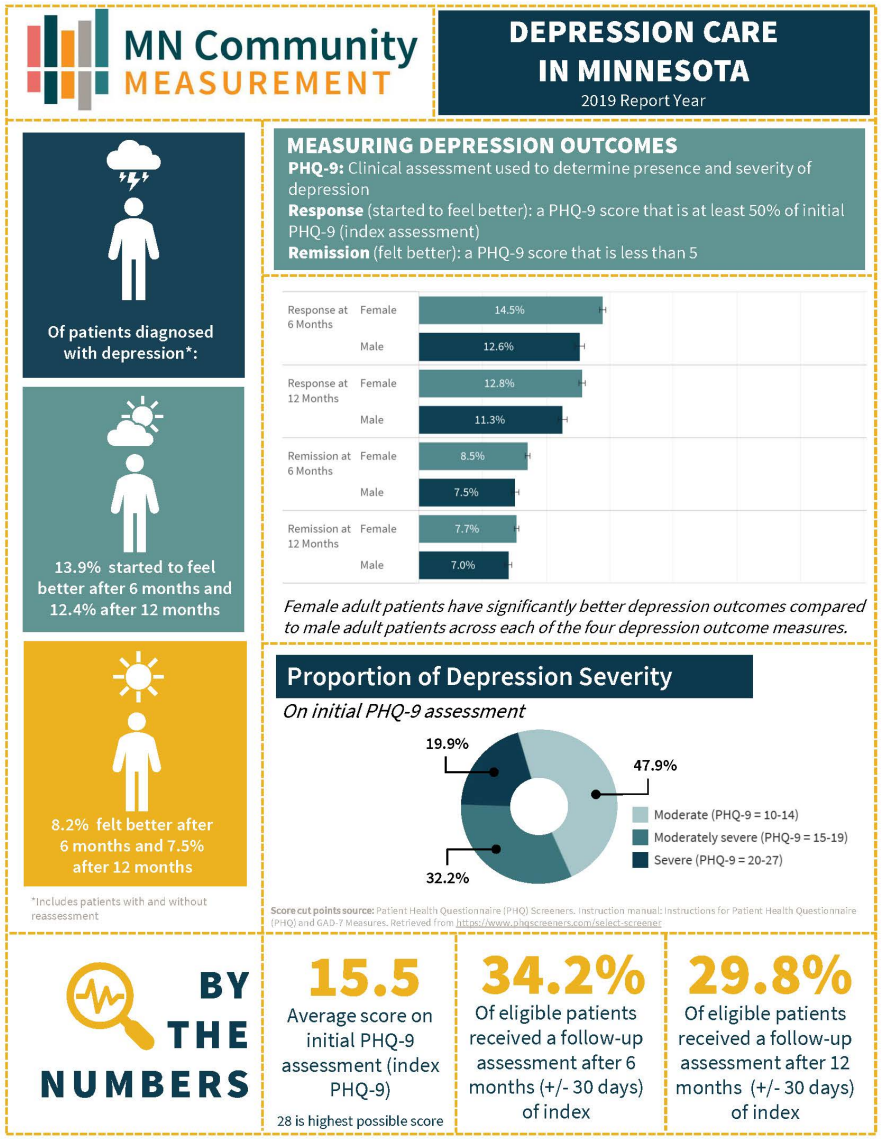
Timeframes

- If a patient had a PHQ-9 greater than 9, schedule a follow up appointment within 10-15 months post the greater than 9 screening. Many PHQ-9's were done just out of the timeframe and therefore not qualifying for the measure for the 2020 performance year.

MH-1: Depression Remission at 12 months

The Why

INNOVATIVE Health Alliance of New York



MH-1: Depression Remission at 12 months

Measure Details

Depression Remission

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DESCRIPTION:

- The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

INITIAL POPULATION/DENOMINATOR:

- Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and an initial Patient Health Questionnaire-9 item version (PHQ-9) or Patient Health Questionnaire-9 Modified for Teens and Adolescents (PHQ-9M) score greater than nine during the index event.

DENOMINATOR EXCLUSIONS:

- Patients with a diagnosis of bipolar disorder
- Patients with a diagnosis of select personality disorders
- Patients with a diagnosis of schizophrenia or psychotic disorder Patients with a diagnosis of pervasive developmental disorder Patients who were permanent nursing home residents

NUMERATOR:

- Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five.

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

Prev 7: Influenza Vaccination

2020 GPRO takeaways, best practices.

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Documentation

- We had several instances where the patient stated they had the vaccine already but no documentation of where and when.

Patient refusal

- If a patient refuses vaccination it needs to be documented annually. We cannot take a note for another performance year to exclude the patient from the metric for the current year.

Prev 7 Influenza Vaccination:
The Why

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CDC: Why Get a Flu Vaccine handout:
https://www.cdc.gov/flu/pdf/freeresources/general/strong-defense-against-flu.pdf

- Flu vaccine prevents millions of illnesses and flu-related doctor's visits each year. For example, during 2019-2020, flu vaccination prevented an estimated 7.5 million influenza illnesses, 3.7 million influenza-associated medical visits, 105,000 influenza-associated hospitalizations, and 6,300 influenza-associated deaths.
- Flu vaccine prevents tens of thousands of hospitalizations each year. For example, during 2019-2020 flu vaccination prevented an estimated 105,000 flu-related hospitalizations.
- Flu vaccination has been associated with lower rates of some cardiac events among people with heart disease, especially among those who had had a cardiac event in the past year.

Prev 7: Influenza Vaccination:
Measure Details

Influenza Vaccination

INNOVATIVE Health Alliance of New York

DESCRIPTION:

- Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

INITIAL POPULATION:

- All patients aged 6 months and older seen for a visit during the measurement period

DENOMINATOR:

- Equals Initial Population and seen for a visit between October 1 and March 31

DENOMINATOR EXCEPTIONS:

- Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reasons)
- Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reasons)
- Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reasons)

NUMERATOR:

- Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

PREV 13: Statin Therapy:
2020 GPRO takeaways, best practices.

INNOVATIVE Health Alliance of New York

The medical record documentation of pure or familial hypercholesteremia must match the coding and is not the same as hyperlipidemia

- Hyperlipidemia was noted as a diagnosis in a lot of cases, and we were unable to pass the measure because even though pure hypercholesteremia was the diagnosis billed it was not noted in the medical record as a diagnosis.

The measure assesses patients with a high risk for a cardiovascular event who are on a statin based on the following…

- Diagnosis of ASCVD (see coding document in measure details slide)
- Elevated LDL >190 *or* diagnosis of pure or familial hypercholesteremia
- Diagnosis of Diabetes with LDL between 70-189. *We had a similar problem with this measure as we did with DM-2 in that a patient was billed for a type 2 diagnosis, but the diagnosis was not noted in the medical record.*

PREV 13: Statin Therapy:
The Why

INNOVATIVE Health Alliance of New York

CLINICAL QUESTION: Do statins reduce rates of cardiovascular events when used for primary prevention?

BOTTOM LINE: When used for primary prevention, statins are associated with lower rates of all-cause mortality, major vascular events, and revascularizations compared with placebo. Statin therapy is not associated with increased rates of life-threatening adverse effects such as cancer.

JAMA Clinical Evidence Synopsis:
https://www.portailvasculaire.fr/sites/default/files/docs/jes130012-2.pdf

PREV 13 Statin Therapy: *Measure Details*

Statin Therapy

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DESCRIPTION:

- Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:
- 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

INITIAL POPULATION:

- All patients aged 21 years and older at the beginning of the measurement period with a patient encounter during the measurement period.

DENOMINATOR:

- All patients who meet one or more of the following criteria (considered at "high risk" for cardiovascular events, under ACC/AHA guidelines):
  - Patients aged ≥ 21 years at the beginning of the measurement period with clinical ASCVD diagnosis
  - Patients aged ≥ 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia
  - Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

PREV 13 Statin Therapy: *Measure Details continued*

INNOVATIVE Health Alliance of New York

DENOMINATOR EXCLUSIONS:

- Patients who have a diagnosis of pregnancy Patients who are breastfeeding
- Patients who have a diagnosis of rhabdomyolysis

DENOMINATOR EXCEPTIONS:

- Patients with adverse effect, allergy, or intolerance to statin medication
- Patients with active liver disease or hepatic disease or insufficiency Patients with end-stage renal disease (ESRD)
- Patients with diabetes who have the most recent fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy (only applies to denominator 3)

NUMERATOR:

Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period

NUMERATOR NOTE: *In order to meet the measure, current statin therapy use must be documented in the patient's current medication list or ordered during the measurement period. ONLY statin therapy meets the measure Numerator criteria (NOT other cholesterol lowering medications). Prescription or order does NOT need to be linked to an encounter or visit; it may be called to the pharmacy. Statin medication "samples" provided to patients can be documented as "current statin therapy" if documented in the medication list in health/medical record. Patients who meet the denominator criteria for inclusion, but are not prescribed or using statin therapy, will NOT meet performance for this measure. Adherence to statin therapy is not calculated in this measure. Denominator Exceptions should be active during the measurement period.*

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

Prev 5: Breast Cancer Screening

2020 GPRO takeaways, best practices

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Documentation

- We found several instances where there was notation that a screening was ordered and after further investigation, we found it was completed but the documentation had not made its way back to the patient's chart.

Timeframes

- The CMS measure looks for a screenings done in the 27 months prior to the end of the performance period.

Prev 5: Breast Cancer Screening

The Why

INNOVATIVE Health Alliance of New York

American Cancer Society Recommendations for the Early Detection of Breast Cancer

Finding breast cancer early and getting state-of-the-art cancer treatment are the most important strategies to prevent deaths from breast cancer. Breast cancer that's found early, when it's small and has not spread, is easier to treat successfully. Getting regular screening tests is the most reliable way to find breast cancer early. The American Cancer Society has screening guidelines for women at average risk of breast cancer, and for those at high risk for breast cancer.

https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html

Prev 5: Breast Cancer Screening

Measure Details

Breast Cancer Screening

INNOVATIVE Health Alliance of New York

DESCRIPTION:

- Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

INITIAL POPULATION/DENOMINATOR:

- Women 51 - 74 years of age with a visit during the measurement period

DENOMINATOR NOTE:

- *The intent of the measure is that starting at age 50 women should have one or more mammograms every 24 months with a 3 month grace period.*

DENOMINATOR EXCLUSIONS:

- Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy
- Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 days during the measurement period
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period or the year prior to the measurement period

NUMERATOR:

- Women with one or more mammograms during the 27 months prior to the end of the measurement period.

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

Prev 6: Colorectal Cancer Screening

2020 GPRO takeaways, best practices.

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Documentation

- This measure has a 9 year lookback period. Identifying patients who are denominator eligible for this measure and updating their documents in their current EMR is important.

Alternatives to Colonoscopy

- We found several instances where a colonoscopy was refused but a FIT test was completed or Cologuard.

Prev 6 Colorectal Cancer Screening:

The Why

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Of cancers that affect both men and women, colorectal cancer is the second leading cancer killer in the United States, but it doesn't have to be. Colorectal cancer screening saves lives. Screening can find precancerous polyps—abnormal growths in the colon or rectum—that can be removed before they turn into cancer. Screening also helps find colorectal cancer at an early stage, when treatment works best. **About nine out of every 10 people whose colorectal cancers are found early and treated appropriately are still alive five years later.**

CDC Resources: https://www.cdc.gov/cancer/colorectal/basic_info/

Prev 6: Colorectal Cancer Screening:
Measure Details

Colorectal Cancer Screening

INNOVATIVE Health Alliance of New York

DESCRIPTION:
- Percentage of adults 50 - 75 years of age who had appropriate screening for colorectal cancer

INITIAL POPULATION/DENOMINATOR:
- Patients 50 - 75 years of age with a visit during the measurement period

DENOMINATOR EXCLUSIONS:
- Patients with a diagnosis or past history of total colectomy or colorectal cancer
- Patients age 66 and older in Institutional Special Needs Plans (SNP) or residing in long-term care with a POS code 32, 33, 34, 54 or 56 for more than 90 days during the measurement period
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND a dispensed medication for dementia during the measurement period or the year prior to the measurement period
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either one acute inpatient encounter with a diagnosis of advanced illness or two outpatient, observation, ED or nonacute inpatient encounters on different dates of service with an advanced illness diagnosis during the measurement period

NUMERATOR:
- Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:
- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- Fecal immunochemical DNA test (FIT-DNA) during the measurement period or the two years prior to the measurement period
- Computed tomography (CT) Colonography during the measurement period or the four years prior to the measurement period

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

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Screening was done, patient identified as a smoker, but no cessation counseling noted for the *current* performance period.

- For the measures that we failed this was the most common issue. Most of the time the patient was identified as a smoker in the past and cessation counseling was offered at that time, but it is outside of the current performance.

PREV 10: Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention

The Why

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Cost of Smoking-Related Illness

- Smoking-related illness in the United States costs more than $300 billion each year, including:[11,12]
  - More than $225 billion for direct medical care for adults
  - More than $156 billion in lost productivity, including $5.6 billion in lost productivity due to secondhand smoke exposure

CDC Resources: https://www.cdc.gov/tobacco/quit_smoking/index.htm

PREV 10: Preventive Care and Screening Tobacco Use: Screening and Cessation Intervention

Measure Details

Tobacco Cessation

INNOVATIVE Health Alliance of New York

DESCRIPTION:

- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user
- Three rates are reported:
    - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months
    - Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention
    - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

INITIAL POPULATION:

- All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR:

- Population 1: Equals Initial Population
- Population 2: Equals Initial Population who were screened for tobacco use and identified as a tobacco user Population 3: Equals Initial Population

DENOMINATOR EXCEPTIONS:

- Population 1: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
- Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)
- Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)

NUMERATOR:

- Population 1: Patients who were screened for tobacco use at least once within 24 months Population 2: Patients who received tobacco cessation intervention
- Population 3: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

Care 2: Falls: Screening for Future Fall Risk

2020 GPRO takeaways, best practices.

INNOVATIVE Health Alliance of New York

We did well on this metric since there are several different ways to document a falls risk screening…

- Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

Needs to be documented annually.

- The few that we did fail we found that there was inconsistent documentation. Patient was seen several times in the year, but no assessment was done.

Care 2: Falls: Screening for Future Fall Risk

The Why

INNOVATIVE Health Alliance of New York

Falls: Definition and Magnitude of the Problem

Falls occur more often with advancing age. Each year, approximately 30% to 40% of people aged 65 years and older who live in the community fall.[1] Roughly half of all falls result in an injury,[2] of which 10% are serious,[3] and injury rates increase with age.[4] The direct medical costs for falls total nearly **$30 billion annually**.[5]

Falls in the outpatient setting are usually defined as "coming to rest unintentionally on the ground or lower level, not due to an acute overwhelming event"[6] (eg, stroke, seizure, loss of consciousness) or external event to which any person would be susceptible.

Falls are a major threat to older adults' quality of life, often causing a decline in self-care ability and participation in physical and social activities. Fear of falling, which develops in 20% to 39% of people who fall, can lead to further limiting activity, independent of injury.[7]

Full NIH study: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707663/

Care 2: Falls: Screening for Future Fall Ris

Care 2

Measure Details

INNOVATIVE Health Alliance of New York

DESCRIPTION:

- Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

INITIAL POPULATION/DENOMINATOR:

- Patients aged 65 years and older with a visit during the measurement period

DENOMINATOR EXCLUSIONS:

- Exclude patients who were assessed to be non-ambulatory during the measurement period

NUMERATOR:

- Patients who were screened for future fall risk at least once within the measurement period

DEFINITION:

- **Screening for Future Fall Risk:** Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

2021 Coding Document: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1257/2021+CMS+Web+Interface+Measure+Specifications+and+Supporting+Documents.zip

2022 Shared Saving Program: Preparing for EHR Reporting.

INNOVATIVE Health Alliance of New York

What Are the Reporting Requirements Under the APP?

Quality
50% of MIPS Final Score

Promoting Interoperability
30% of MIPS Final Score
Same reporting as traditional MIPS

Improvement Activities
20% of MIPS Final Score
Automatic full credit in 2021

Cost
0% of MIPS Final Score
No requirements

APP participants will be scored on the following quality measure set:

- CAHPS for MIPS (Quality ID: 321)
- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479)
- Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs (Quality ID: 480)
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control (Quality ID: 001)*
- Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134)*
- Controlling High Blood Pressure (Quality ID: 236)*

* Note: For the 2021 performance year only, Medicare Shared Savings Program ACOs have the option to report the 10 CMS Web Interface measures in place of these 3 measures (001, 134, 236) in the APP.

2022 Shared Saving Program: Preparing for EHR Reporting.

INNOVATIVE Health Alliance of New York

IHANY Participants need to prepare now for 2022 reporting.

- Starting January 1, 2022 you will need to be collecting data on the 3 measures we reviewed today via your EHR.
  - EHR reporting is based on all payer performance not just Medicare Part B patients like CMS Web Interface/GPRO reporting.
  - Need to confirm with EHR that:
    1. You can run a QRDA 3 report
    2. You have a MIPS/Performance dashboard set up to review at least the 3 measures we reviewed today.
    3. Your practice is following the proper workflow for these measures. The most common issue with EHR Quality Measure reporting is an issue with workflow.

Next Steps

INNOVATIVE Health Alliance of New York

- Contact your EMR/EHR vendor about dashboard/workflow set up for these 3 quality measures. If you would like me to join you for that phone call, please let me know and I'll be happy to join.
- Review over how you currently work on the measures we learned about today. Is there something you can change in your workflow to increase our performance? Specifically, what the abstraction team found during the 2020 GPRO review.
- Identify members of your practice who can participate in the learning process for quality and possibly help contribute to the 2021 GPRO effort. These sessions will be recorded for reference.

Contact Information

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