

Trinity Health Mid-Atlantic

Network NEWS

Summer 2022

Trinity Health Mid-Atlantic Clinically Integrated Network (CIN) Update



Dan Bair, FACHE
Regional Executive Director
Clinically Integrated Network
Trinity Health Mid-Atlantic

I'd like to start by extending my sincere thank you to all our Trinity Health Mid-Atlantic (THMA) Clinically Integrated Network (CIN) participating physician practices, and other key health care providers across the continuum, for your continued commitment to improving the health of our communities. Because of your hard work and collaboration, we have been able to successfully improve our quality scores, as well as reduce utilization of unnecessary health care services across our value-based arrangements throughout 2021, despite the continued presence of the COVID-19 pandemic.

In this edition, I wanted to highlight some information about an extremely important

initiative we have been working on in collaboration with our Trinity Health System Office Team, it's called the CIN Operating Model 2.0.

This is an enhancement to the fundamental work we have done over the last 5 years in establishing the basic, foundational elements of a successful CIN. This work includes: a comprehensive care coordination infrastructure, robust data and analytics capabilities, and an extensive quality care gap closure and practice transformation system. All of which we have had in place across the region for quite some time.

The new next generation CIN Operating Model 2.0 will focus on several tactics to optimize performance, and make value-based care and population health, a cornerstone of the Trinity TogetherHealth 2023 strategy.

(continued on page 2)

Table of Contents

- 1 Introduction to the Trinity Health CIN Operating Model 2.0
- 2 Trinity Health Mid-Atlantic Transition to Epic TogetherCare
- 3 CIN Manager—Chronic condition documentation
- 7 Primary Care vs. Urgent Care vs. ED
- 8 Meet our Data and Analytics Team!
- 9 Care Coordination Program
- 10 Plastics Update and Physician Spotlights:
Dr. Nathaniel Holzman
Dr. John Fernandez
Dr. Karen Kaplan
- 11 Annual Wellness Visit: 2021 Results
Optimizing Medication Adherence

Trinity Health Mid-Atlantic Clinically Integrated Network (CIN) Update

OUR CIN OPERATING MODEL 2.0 TACTICS INCLUDE:



Creating a high-performance, high-value network of providers in all Trinity Health markets.



Taking on more risk from payers to get closer to the premium dollar and reduce the amount of savings we need to share with insurance companies and CMS.



Taking on more insurance company-like functions to support our value-based programs. For example: delegated credentialing, delegated care management, utilization management, etc.

There will be more to come about the roll-out of this model that will begin over the next couple months, but I wanted to make sure to socialize this with all our key stakeholders.

I want to sincerely thank you once again for your continued support and for your participation in our THMA CIN.

Sincerely,

Daniel Bair
Regional Executive Director
Clinically Integrated Network
dbair@mercyhealth.org

Trinity Health Mid-Atlantic Transition to Epic TogetherCare

On October 29, 2022, Trinity Health Mid-Atlantic will be transitioning to TogetherCare, our version of the electronic health record, Epic. As a part of this transition, we are offering EpicCare Link to Trinity Health Mid-Atlantic's Clinically Integrated Network (Quality Health Alliance, Mercy Accountable Care, Delaware Care Collaboration). EpicCare Link is a secure web-based portal connecting you to information stored in Trinity Health Mid-Atlantic's electronic health record system related to referred or admitted patients. We're proud to offer you EpicCare Link access to facilitate more efficient, patient-centered care.

TogetherCare

Powered by **Epic** to deliver
People-Centered Care

Alicia Irving, Clinically Integrated Network Manager, is your contact for EpicCare Link questions and requests: airving@mercyhealth.org. Please utilize the website and link for view only access requests: trinityhealthma.org/accountable-care/providers/epic.

TOGETHERCARE HAS TWO ACCESS TYPES:



EPICCARE LINK

You care for your patients who are seen by a Trinity Health Mid-Atlantic provider and/or utilize a Trinity Health site and you need to view information about your patient, but do not need to document in the medical record. **No documentation capability/view only with additional benefits.**



TOGETHERCARE HYPERSPACE

You need this access if you are an employed or contracted clinician at Trinity Health Mid-Atlantic or see patients in a Trinity Health owned site. **Documentation capabilities in the medical record.**

Hierarchical Condition Category (HCC) Coding 101: What you need to know

HCC coding was initiated by CMS in 2004 as part of a risk-adjustment model used for calculating risk scores, predicting future healthcare costs, and adequately reflecting the complexity of the patient's health status. It allows Medicare to project expected risk and future annual cost of care. Basically, HCC coding is a risk-adjustment prediction model designed to estimate a patient's healthcare costs during his/her lifetime. It uses health status in a "base year" to predict costs in the following year.

THE RAF SCORE CONSISTS OF TWO ELEMENTS:

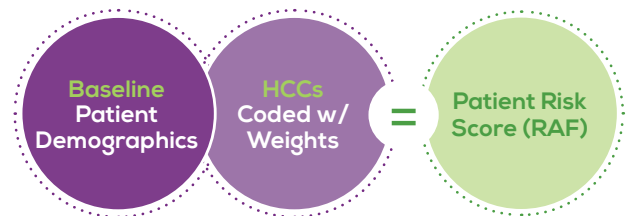
1. Clinical: The clinical portion of the Risk Adjustment Factor (RAF) score is a numerical value/weight assigned to ICD-10 diagnosis codes. Not all ICD-10 codes have an RAF score. The average RAF score for a CMS beneficiary is 1.0.

- Lower RAF score may indicate a healthy population.

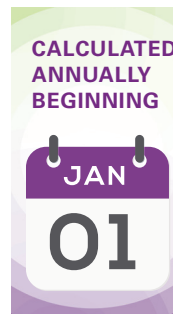
➤ IT MAY ALSO INDICATE INADEQUATE CODES BEING SUBMITTED THROUGH BILLING.

- High RAF score may indicate a sicker population—These patients are expected to require intensive medical treatment and practices managing these high-risk patients are reimbursed at higher rates than those with enrollees who have low HCCs. Practices not properly documenting HCC codes to the highest specificity will not receive additional reimbursement for applicable patients. In a nutshell, with risk adjustment payments, Medicare pays less for healthy patients and more for unhealthy patients.

2. Demographics: The demographic portion includes factors such as gender, age, living circumstances, etc. each of which is given a numerical value/weight.



Insurance companies use this coding scale to assign risk adjustment factor (RAF) scores to patients.¹



A major component of HCC Coding models is that they are valid for only one year. On January 1, regardless of the HCC's fundamental chronicity, the slate is blank on a patient's HCC listing. This includes every chronic disease, i.e., stomas, artificial openings, and amputation status to name a few.

Be specific when describing a condition—Code to the highest specificity. In most cases, the provider should refrain from using codes containing the word "unspecified" as they are often not the best option.



Hierarchical Condition Category (HCC) Coding 101: What you need to know (continued)

Accurate and thorough documentation to supply all diagnoses and codes is essential to providing the appropriate level of care. Consider the acronym MEAT:

M-MONITOR: How is the individual doing? Signs or symptoms?

E-EVALUATE: State of condition? Provider’s opinion of the condition(s)?

A-ASSESS: How will the condition be evaluated? Documentation of prior records, counseling, or studies?

T-TREAT: What care is being offered to help the patient w/the condition(s), i.e., medication, dx study, etc.?

Assure all captured conditions are supported by MEAT and documented in the patient’s medical record. This enables the coder to pick up the codes for chronic conditions. Remember, if the medical condition is mentioned in the assessment, it must be reflected in the coding and vice versa. Always review the claim before submission to ensure all codes have been captured.

ENSURE THE PROBLEM LIST IS UPDATED REGULARLY AND DATED.

PRE-VISIT PLANNING—Be as thorough and detailed as possible when reviewing records, i.e., medical history, medication list, consult notes, radiology reports, hospital records, lab work, etc.

CHRONIC CONDITIONS CONSIDERED TO NOT RESOLVE:

- Atrial Fibrillation
- Multiple Sclerosis
- Chronic Kidney Disease
- COPD
- Parkinson’s Disease

- Diabetes
- Rheumatoid Arthritis
- HIV/AIDS
- Hemiplegia
- Chronic DM

- Heart Failure (if not stated as acute)
- Manifestations
- Osteoporosis

Using combination codes, linking codes, as opposed to using two separate codes when available, delivers a higher RAF score:

TYPE 2 DIABETES MELLITUS W/CKD.

USE: E11.22 (Type 2 diabetes mellitus w/ diabetic CKD) and N18.30 (CKD, stage 3 unspecified).

AVOID: E11.9 (Type 2 diabetes mellitus without complications) and N18.30 (CKD).

DISEASE	ICD-10 CODE	LINKED?
DM w/o complications	E11.9	Not linked
Hyperlipidemia	E78.2	
VS		
DM w/ other complications	E11.69	Linked
Hyperlipidemia due to DM	E78.2	

When coding overweight, obese, or morbid obesity, BMI must also be coded. For example:

- E66.01 (Morbid obesity due to excess calories) and Z68.41 (BMI is 41)*

CODE IN THIS ORDER.

*Morbid obesity is an HCC code. A BMI of ≥40 is an HCC code.

Hierarchical Condition Category (HCC) Coding 101: What you need to know (continued)

Refrain from using language such as “past medical history” or “history of” as it indicates the condition is resolved and the patient no longer has the condition. This is case, a coder is unable to submit the code.

Use language such as: “Currently being treated for” or “Mr. Jones is an 80-year-old male w/the following conditions ... who presents to the office for. In that way, you can list the chronic conditions in one sentence in the HPI.

INCORRECT DOCUMENTATION	CORRECT DOCUMENTATION
H/O CHF, Meds: Lasix	Compensated CHF, stable on Lasix
H/O Angina, Meds: Nitroquick	Angina, stable on Nitro
H/O COPD, Meds: Advair	COPD Controlled w/ Advair

KEYS TO SUCCESS:

- **Address chronic conditions at least once per year**—even if you have addressed and treated the condition(s) in the previous year, you need to continually address them the following calendar year and onward.
- **Better to see patients sooner in the year**—the sooner you see the patient, the further along you are in the patient’s journey of managing his condition(s).
- **Give a full picture of the patient**—Be specific in your diagnosis of a condition. Do not settle for just diagnosing the underlying conditions; Make sure you are diagnosing the complications associated with it.

It is important to remember HCC coding assists in communicating the complexity of the patient to insurers. It paints a picture of the whole patient.



REFERENCES:

- ¹www.hccoders.com/what-is-hcc-coding-and-why-is-it-important
- ²www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
- ³bok.ahima.org/doc?oid=302516#.YWc6iJtycx
- ⁴www.imohealth.com/ideas/article/hcc-101-what-you-need-to-know-about-hierarchical-condition-categories

HCC Coding—Addressing Chronic Conditions Managed by Specialists

There have been many questions regarding accurate HCC capture and PCP documentation with conditions managed by the specialist. We took these questions to Trinity Health’s Risk Auditor. Below is the response:



PCP’s that are reviewing and documenting chronic conditions managed by a specialist should document next to the conditions under the assessment and plan that the patient is seeing or following up with the specialist(s). The documentation below depicts excellent examples of this documentation. It will pass a CMS audit because it touches on the elements of MEAT (Monitor, Evaluate, Assessment, Treatment).

DOCUMENTATION EXAMPLES:

- OPD stable, currently on Advair HFA and scheduled to follow up with pulmonologist within a month.
- Patient being treated by pulmonologist for pulmonary fibrosis. Currently prescribed OFEV. No issues at this time and will follow up with pulmonologist in a week.
- CHF stable, currently on Entresto. Patient will follow up with the cardiologist next week.
- PAD (peripheral arterial disease) stable, currently taking pentoxifylline as prescribed by the vascular specialist or cardiologist, will follow up with vascular specialist in April.

The auditor also suggests the PCP request the specialist’s medical records—findings such as nephrologist treating CKD to include in the patient’s charts; these records may be used as supporting documentation.

Depression Remission—CMS Requirements

Were you aware that the depression screening and depression remission quality measures are different? Depression remission looks at adolescent patients 12 – 17 years of age and adult patients 18 years or older with a diagnosis of major depression or dysthymia. The goal is to achieve depression remission within 12 months of initial diagnosis. A PHQ-9 of ≥ 5 is defined as depression by CMS. Depression remission is defined as a PHQ-9 score of < 5 .

When a patient has been identified with a diagnosis of depression, an initial treatment plan must be documented in the EMR by the provider. In addition, a documented follow-up visit with the PCP is essential, occurring every 4 – 6 weeks until a PHQ-9 score of ≤ 4 is reached.

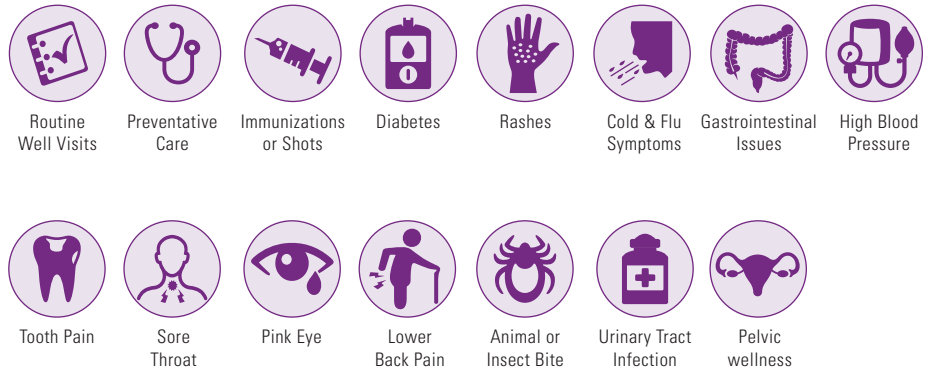
Once remission has been achieved, it is important to ensure a PHQ-9 is completed on every encounter that follows. Encounters are scheduled at the provider’s discretion.



WHEN TO VISIT YOUR DOCTOR'S OFFICE

For care and treatment of non-urgent issues

For most medical concerns, contact your primary care doctor first. Your doctor is your partner in good health and is most familiar with your medical history. Your doctor gives routine care and treatment when it is not an emergency.



WHEN TO VISIT URGENT CARE

For immediate needs, but not life-threatening

Urgent care can treat any health problem where you need to be seen quickly, but it is not an emergency. Urgent Care has evening and weekend hours when your primary care doctor may not be available.



ALWAYS BRING YOUR LIST OF CURRENT MEDICATIONS!

WHEN TO VISIT AN EMERGENCY ROOM

For any life or death emergency or urgent after-hours need (open 24/7)

When having a life-threatening emergency, call 911.

You should follow up with your primary care doctor after a visit to an emergency room.



Meet our Data and Analytics Team!

The THMA CIN data and analytics team provides a wide range of support across all our payer programs, and Mid-Atlantic markets. Everything from various patient lists, to directed action planning analyses, to high level strategic development and growth. As a cohesive and comprehensive working unit, we offer innovative alternatives and views of the patient populations we serve. We are moving from reactive analytics, to serve as an example of proactivity by leveraging natural language processing, advanced claims-based analyses and interpretation, predictive modeling, and geospatial technology. The analytics department also serves as a resource to identify financial opportunities, which fosters the CIN's sustainability and data transparency for our participating providers. An ongoing objective is to ensure our end users, and other departments alike, spend less time manually manipulating data and more time directly facing patients. An aspect of our departments vision is to be viewed as a reliable, consultative, and trusted partner because of our attentiveness to detail and data cleanliness. While remaining current with technological advancements and industry trends, we will continue to be the tip of the tip of the spear for our organization.



Mark Lewis, MPH
Regional Director
Data & Analytics

Mark has his Master's in Public Health and has worked most of his career in clinical research before coming to Trinity Health. He is passionate about finding creative solutions and asking critical questions related to the information at hand. In his free time, Mark enjoys photography and various forms of community service.



Avery Day, MPH
Senior Data Analyst
Data & Analytics

Avery earned her MPH at West Chester University and began her career at Mercy Accountable Care shortly after graduation. When she isn't working, she enjoys her part time job as a fitness instructor, reading, spending time with her friends and family, and taking her beloved dog on walks at the beach.



Donald Sabara
Senior Data Analyst
Data & Analytics

Working as a data analyst, Don Sabara is able to fulfill a few passions by using technology and helping people. Starting back many years ago, from using technology to record music, to using cutting edge data tools to help bring the latest information to our care management teams.

He looks forward to helping as many people as possible, with the right information at the right time.



Nathania Hau, MS
Senior Data Analyst
Data & Analytics

Nathania grew up in Vancouver, BC, where she discovered her passion for finding patterns in data and sharing these stories with others. Her graduate work in statistical mechanics focused on finding multiscale patterns in particle systems. Before joining the THMA data team, she worked at the Blue

Cross Blue Shield Association to find connections between claims data and the social determinants of health. When she's away from her computer, you can find her powerlifting, getting students excited about math, and restoring old typewriters.

Plastics Update & Physician Highlights

Trinity Health Mid-Atlantic Plastic and Reconstructive Surgery is a comprehensive practice dedicated to providing advanced reconstructive care in a compassionate, individualized manner to all our patients. Having trained at some of the finest medical centers in the country and with decades of experience, our surgeons offer innovative surgical and non-surgical care for a broad range of conditions. Whether for melanoma and non-melanoma skin cancers, breast cancer, head and neck cancer, orthopedic malignancy, craniofacial or lower extremity trauma, or abdominal wall reconstruction, our team offers the most technologically advanced care.

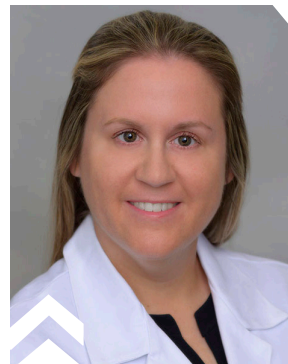
Recently, the practice has expanded to offer a full scope of microvascular reconstruction services. In addition to providing advanced wound care, **the group has established the only comprehensive medical and surgical lymphedema program in the region.**

IN ADDITION to our commitment to our patients and their families, Trinity Health Mid-Atlantic Plastic and Reconstructive surgery is devoted to providing cutting-edge treatment and the highest quality of cancer and reconstruction care, right here in our community.



John Fernandez, MD

John Fernandez, MD, is board certified by the American Board of Plastic Surgery and earned his medical degree from the Lewis Katz School of Medicine at Temple University. He completed his general surgery residency at St. Luke's-Roosevelt Hospital Center, and his plastic surgical residency at the University of Tennessee College of Medicine. Dr. Fernandez completed a fellowship in Cancer Research and a fellowship in microvascular reconstruction at Memorial Sloan Kettering Cancer Center.



Karen Kaplan, MD

Karen Kaplan, MD, earned her medical degree from the Lewis Katz School of Medicine at Temple University. She completed her residency at Hofstra Northwell School of Medicine and her fellowship at Jackson Memorial Hospital.



Nathaniel L. Holzman, MD

Nathaniel L. Holzman, MD, is board certified by the American Board of Plastic Surgery and earned his medical degree from the University of Maryland. He completed his general surgery training at Tufts University Hospital in Boston and completed his plastic and reconstructive surgery training at Lahey Clinic Medical Center and Brigham and Women's Hospital in Boston. Since 2012, Dr. Holzman has served as the Chief of the Division of Plastic and Reconstructive Surgery at St. Mary Medical Center.



HOW CAN I REFER MY PATIENTS?

To refer patients to our FREE program, please call or email your care manager or program director.

Rhonda Meredith, BSN, RN, CCM
Director of ACO Care Coordination, Delaware Care Collaboration
rmeredith@che-east.org
302.575.8313

Tanya Vogel, MSN, RN
Director of Acute and Ambulatory Care Integration, Mercy Fitzgerald Hospital
Mercy Accountable Care
tanya.vogel001@mercyhealth.org
610.237.4541

Allison Patzek, MSN, RN, CCRN-K
Director of Ambulatory Care Coordination, North Region and Quality Health Alliance
allison.patzek@stmaryhealthcare.org
215.710.4747

Care Coordination Program

HOW DOES PATIENT ATTRIBUTION GROWTH BENEFIT THE PROVIDER?

When a patient is attributed to the CIN, a team of Care Coordinators is made available to the patient and the provider. This team consists of RN care managers, social workers, behavioral health workers, community health workers, post-acute care liaisons and clinical ambulatory pharmacists. This team works together to support the provider's care plan, improve transitions through the care continuum and remove community barriers to achieving the patient's wellness goals. Additionally, shared savings financial incentives are linked to attribution volume along with utilization and key quality indicators. To learn more about our CIN's Care Coordination model please reach out to your market's care coordination lead.

HOW CAN I GROW MY ATTRIBUTED PATIENT PANEL IN THE CLINICALLY INTEGRATED NETWORK (CIN)?

The Annual Wellness Visit (AWV) has many benefits including the comprehensive view of a patient's medical care plan but also the supportive resources made available through CIN attribution. Additionally, AWVs provide one opportunity to grow your attributed patient panel. Through the completion of a comprehensive AWV, the provider can holistically assess a patient's care plan and achieve success in this quality metric. By submitting this AWV claim, the patient is more likely to be designated as attributed to your practice and included in your panel for our CIN value-based arrangements the following year. For more details on attribution growth opportunities, please reach out to Dan Bair at dbair@mercyhealth.org.

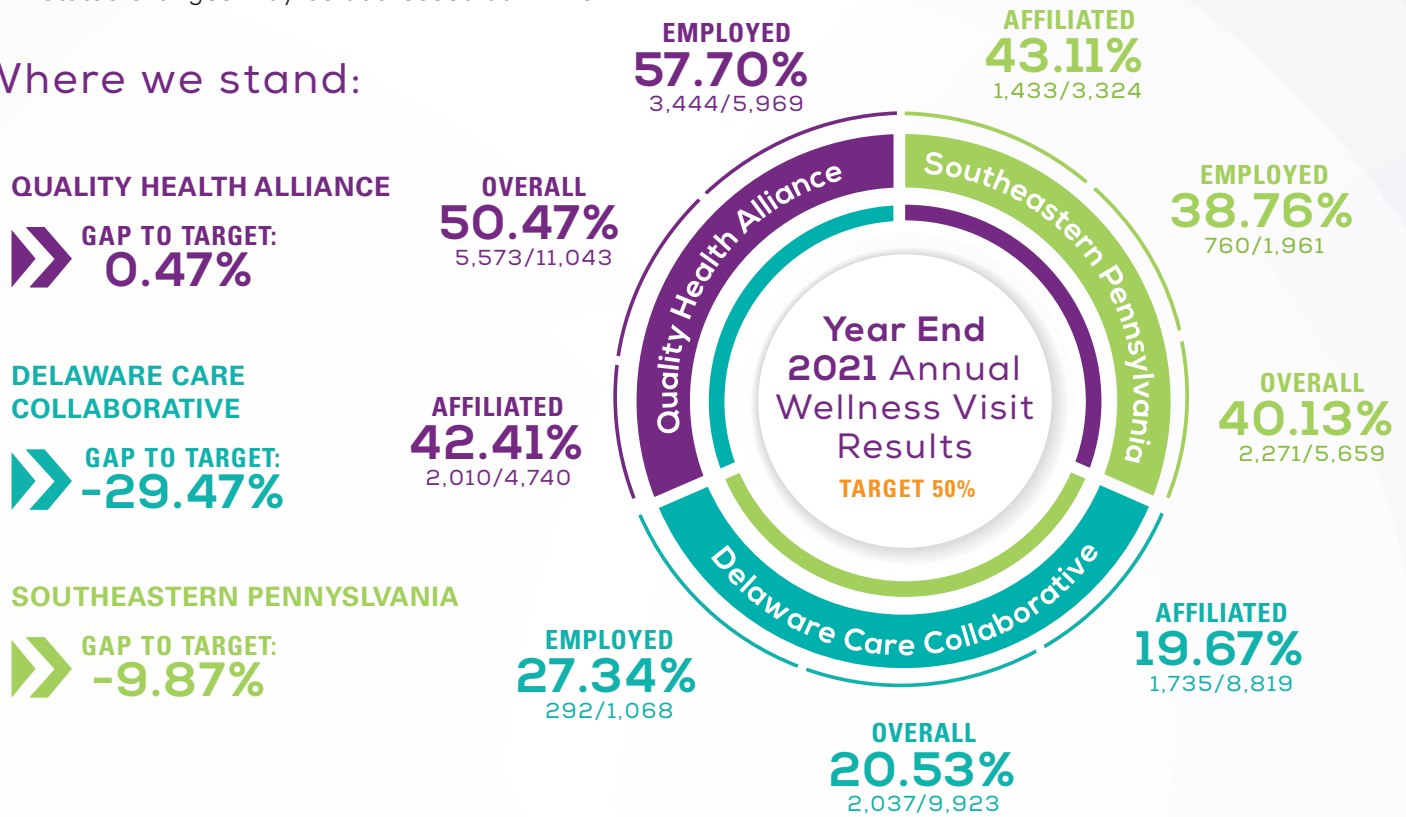
Trinity Health Mid-Atlantic Network NEWS

Annual Wellness Visits (AWV): What you need to know

Will completing AWW's assist with my documentation and coding? **YES.**

- The AWW is a great opportunity to update Clinical Condition Documentation (CCD).
- Annual revalidation of chronic, new, and status changes may be addressed at AWWs.
- Supports both excellence in quality of care and integrity of documentation and coding.

Where we stand:



QUALITY HEALTH ALLIANCE

GAP TO TARGET: **0.47%**

OVERALL **50.47%**
5,573/11,043

DELAWARE CARE COLLABORATIVE

GAP TO TARGET: **-29.47%**

AFFILIATED **42.41%**
2,010/4,740

SOUTHEASTERN PENNSYLVANIA

GAP TO TARGET: **-9.87%**

EMPLOYED **27.34%**
292/1,068

Optimizing Medication Adherence

CHANGING THE CONVERSATION WITHIN THE OFFICE VISIT

- ▶ Ask patients whether they have trouble filling, taking, or affording their medications.
- ▶ Discuss potential side effects in advance of starting new regimen.
- ▶ Patients who aware of side effects ahead of regimen initiation are less likely to become non-adherent.



QUESTIONS TO ASK:

- Of the medications prescribed to you, which ones are you taking?
- Do you have any questions or concerns about the side effects?
- Do you understand the side effects discussed for _____?
- Why are you having trouble filling _____?