A Primer for PrimaCARE: NextGen ACO/MIPS and ACI

I have been working with MJ and Rosemary over the past month to better understand the NextGen ACO measures and Meaningful Use measures – in hopes of making this clearer to us all. First, a few definitions:

1. Advancing Care Information (ACI) replaces Meaningful Use – but includes pretty much the same measures/benchmarks we have been using for years. The benchmarks/measures are tweaked a bit each year, but they should sound quite familiar to you in general. These measures apply to ALL PrimaCARE patients (including Medicare, MassHealth, UH, BCBSMA, Tufts, etc.). All these measures must be reported to CMS (under both ACI and MIPS)

2. NextGen ACO has replaced the Pioneer ACO for Steward.

3. MIPS (Merit-based Incentive Payment System) measures are pretty much the same measures we are using in the NextGen ACO – Steward tried to make these overlap one another. You may recall the discussion of MACRA and MIPS at a few POD meetings – it is a bit confusing – we don't know if we will have to report MIPS benchmarks, but we HAVE to assume that we WILL. MIPS reporting includes ALL PrimaCARE patients – although we are familiar with a lot of these measures from the Pioneer and NextGen ACO – this year they are required for MIPS for ALL PrimaCARE patients – Medicare ACO or not. The ONLY measure in this document that applies just to NextGen is the fall risk measure (the MIPS version is a lot more complicated, so it was decided to stick with the simple NextGen fall risk measure and forget about all the elements in the MIPS version).

ACI/Meaningful Use/MIPS (ALL PrimaCARE patients, no age restrictions)

1. **Electronic prescribing**: This has been described as "low hanging fruit". It is simple – we all do it. We need to hit 90% or better. My current score is 93%. I rarely write out prescriptions now – but some medicines requires printed prescriptions (opiates, benzodiazepines, methylpenidate, Lyrica, and testosterone) – these are not counted as "electronic prescribing".

2. **Portal use**: There are 2 portal measures.
   • Patients must provide their email address at check-in and register for the portal DURING the visit or at check-out. ECW provides a pop-up screen if the patient is not signed up for the portal.

   Patients who are web-enabled will have an appointment screen that looks like the one for Six Pcaretest shown to the right.

If the patient is not web enabled, you will see a screen like the one seen to the left. Simply add the email address and click the box next the "W" to web-enable the patient. Very simple.

If the patient does not have an email address or chooses not to give it – DO NOT put this in the Info/Additional Info screen as shown to the right. This spot should NOT be used for this purpose. It messes up web-enabling.

Info screen --> Additional Info
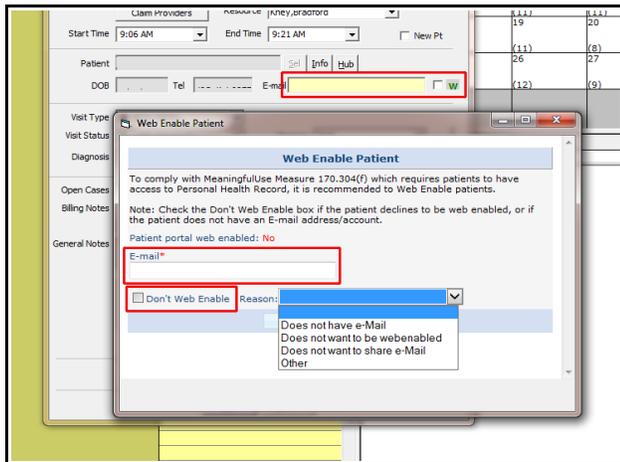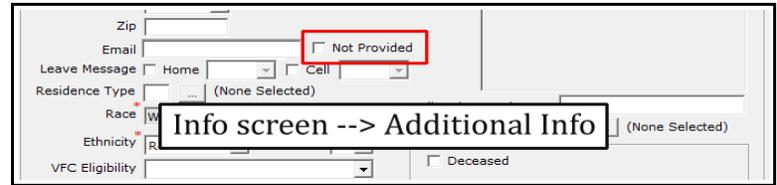
In order to "count", we need to enter this in the pop-up that should appear as you are signing in a patient who is NOT web-enabled. In the pop-up, either enter the email address to web-enable the patient, OR click the box "Don't Web Enable" and enter a reason from the drop-down list as shown to the left. Unfortunately, this function has been a bit glitchy. IF you have clicked the box "Not Provided" in the Info/Additional Info screen, the pop-up will not engage. We are working with ECW to make sure the web-enabling pop-up works correctly.

- VDT (View, Download, Transmit) – Requires that the patient view, download something, or transmit something via the portal. We try to have the patient sign in to the portal during a visit using the office tablets – this way we are sure they are really going to the portal.

3. **Health information exchange**: This has to do with sending referrals via P2P. The video I made earlier this year outlines the process. It is a bit complicated. A new twist is that if certain errors exist (especially Snomed errors – see a prior document on errors to explain this) in the record, you will get a pop-up reporting an error when you try to send the referral. These errors MUST be corrected in order for this referral to "count" - after correcting the error, try sending the referral again. Most specialty offices now accept referrals via ECW assigned to the office manager in the respective office (without a phone call if the referral is not urgent). Please see the a prior video on P2P referrals for details.
- Primary Care Offices: Send referrals to PrimaCARE specialists using P2P – correct any errors that pop-up when you try to send the referral (remember to attach the patient chart to the message – if you don't know how to do this, please review the video).
  Specialty office referral coordinators (use the ellipsis search function under "Assigned To" in the Outgoing Referral screen):

Office	Referral Coordinator	Office	Referral Coordinator
Orthopedics	Rose Paquette	Pulmonary	Cheryl Quinlan
Podiatry	Judith Costa	Gastroenterology	Pamela Bower
ENT	Heather Taborda	Optometry	Samantha Raposo
Vascular	Laura Carpentier	Gynecology	Brenda Pereira
Endocrinology	Michelle Valkanos	Neurology/Morcos	Ana M. Pereira
Chiropractors	Diane Benjamin	Neurology/Douglas	Betty Sorel

• Specialty Offices: Send a note back to the primary care provider using the P2P function under the "Share" button on the hub.

4. **Patient education**: As I mentioned in a recent email, the ONLY patient education that currently counts is when you click on Education → Rx Education. Try to print up Rx Education at every visit possible (a medication must be "continued" or prescribed for it to show up in the Rx Education list). My ecofriendly conscience is really opposed to this waste of trees, but CMS doesn't seem to care much about effective patient education or our forests.
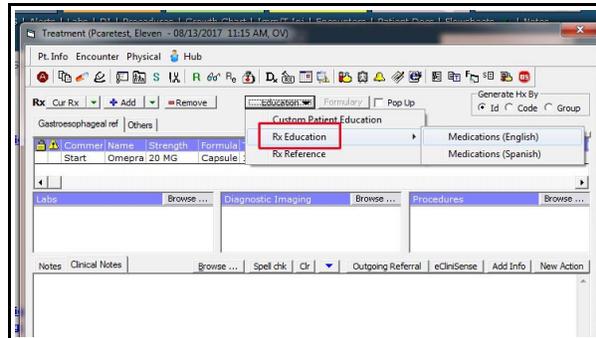
4. **Secure messaging**: This pertains to web messages you get from patients. One detail I was not aware of – in order for this to count, you must send a message back to the patient. In the past, when my office got a refill request from the patient via the portal, we just refilled the medication – and let the pharmacy notify them that it was received. This DOESN'T count as "secure messaging". We MUST send a response back to the patient.

Another way to fulfill this measure is to send out a message to a patient (or all patients) via email. If you have a general message for all patients – like notifying them that your office has the flu vaccine – send the email to Ernst, and he will send out a broadcast email to all of your patients (and only to YOUR patients). And this will count for you towards the secure messaging benchmark.

5. **Medication Reconciliation**: This is pretty straight-forward. I think we all do this at every visit. The only thing here that I was not aware of: the "Transition of care" box (seen below both in the Chief Complaint area as well as the appointment pop-up screen). If the patient was seen anywhere else


by a medical provider since his/her last visit with you, you should check the box "Transition of care". This measure counts only if you reconcile the

medications after the patient was seen somewhere else. If you check the "Verified" box in the med list without checking the transition of care box, this doesn't count for this measure. One single oversight of a click, and your work doesn't count against this benchmark!
So click the box WHEN APPROPRIATE. Don't click the box for every encounter – only those where it is true.
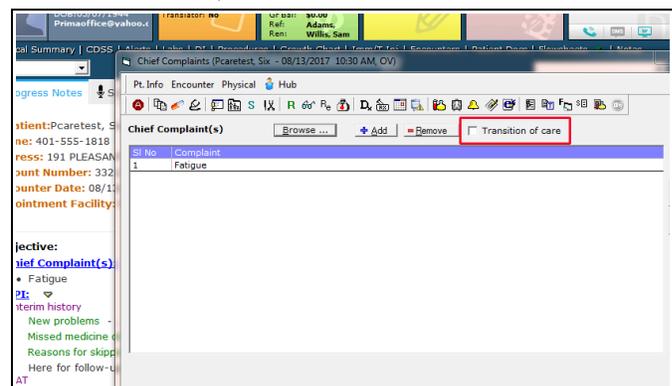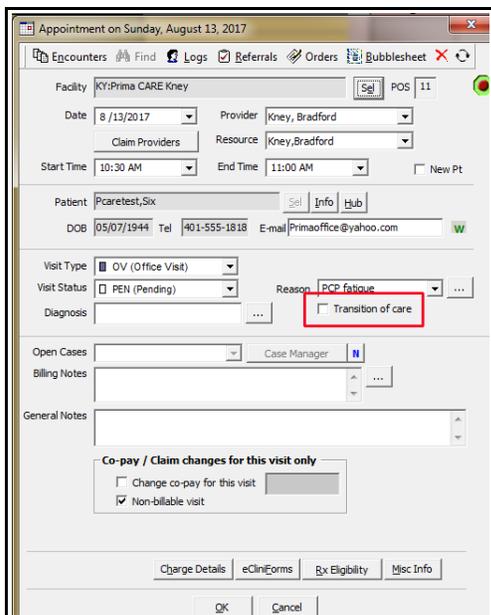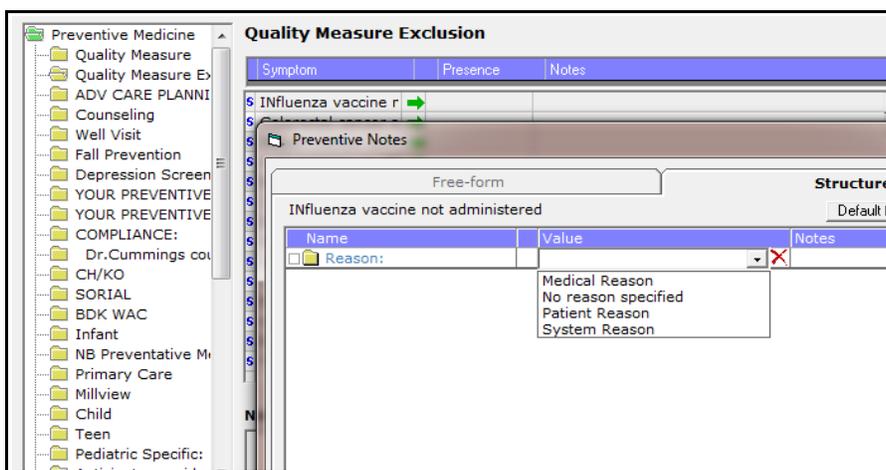
On to NextGen/MIPS

The following measures are an overlap of NextGen and MIPS. Other than the fall measure (which is ONLY a NextGen measure for us), all these measures apply to ALL PrimaCARE patients.

1. **Fall risk (age 65+)**: This is old hat – we have done this for a few years. This year, the measure is stupidly simple – all you need to do is go to Preventive Medicine → Quality Measure → Fall Risk Assessment
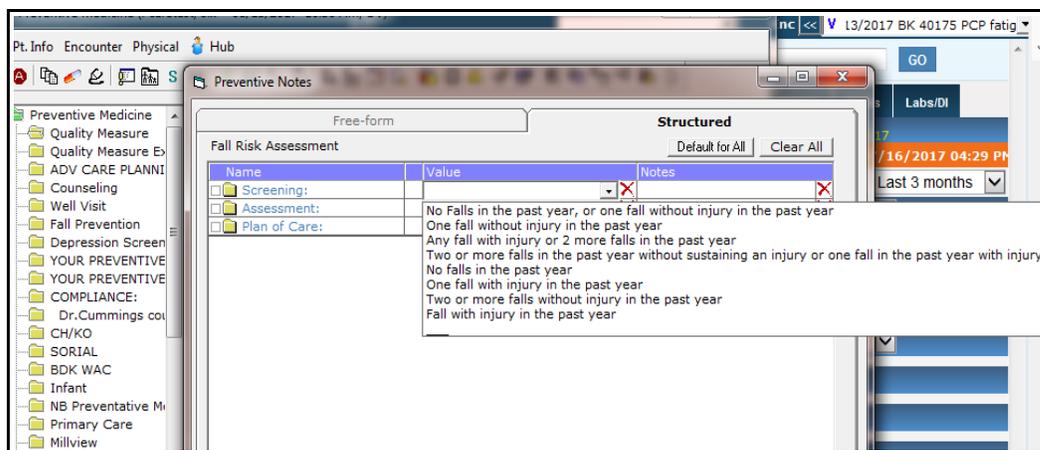

and choose a response. You DO NOT NEED TO DO ANYTHING MORE. For MIPS, we would need to do more – but this measure is ONLY a NextGen measure (the ONLY one of these measures that applies only to the NextGen ACO population). Document this ONCE during 2017 and you are DONE with this measure. Easy!

2. **Influenza immunization (age 6 months and older)**: If the flu vaccine is done in your office or at the flu clinic, you are done with this measure in 2017. If it is done outside of PrimaCARE, you need to enter it under Immunizations as "Vaccination Given in the Past" (since you usually find out about this after the fact). IMPORTANT: If the patient refuses or has some other valid reason for not getting a flu shot, this needs to be documented in Preventive Medicine → Quality Measure Exclusion → Influenza vaccine not administered. Choosing a response here opens another dropdown option as shown in the screenshot on the NEXT page. You can ALSO enter the flu shot as "Declined" under immunizations – this does "count" as well in the numerator of influenza vaccinations.
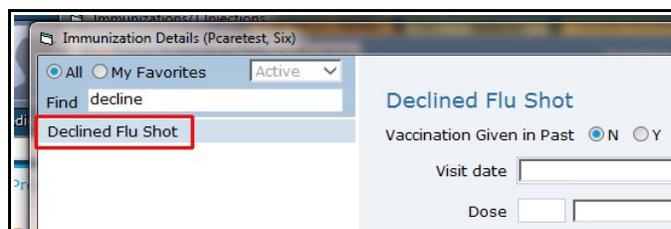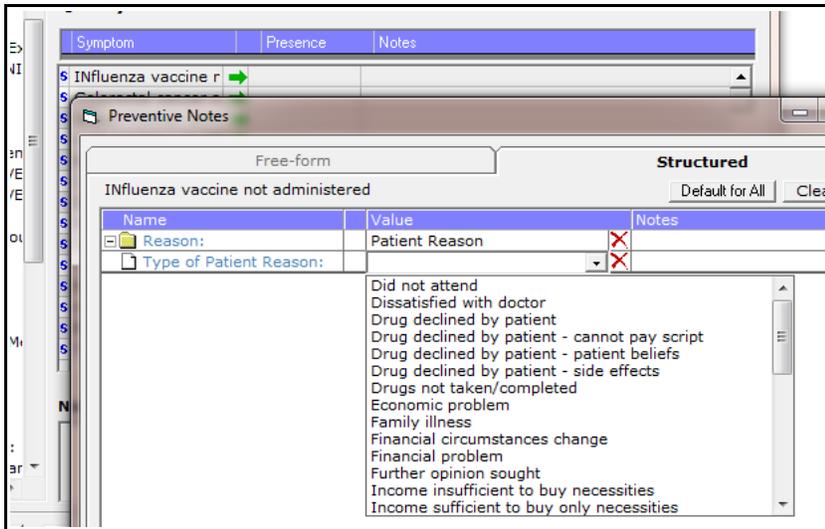
The most common reason in my office for not getting a flu shot is "Drug declined by patient". In order to get credit for offering the flu shot, you must document a reason why it was not given.
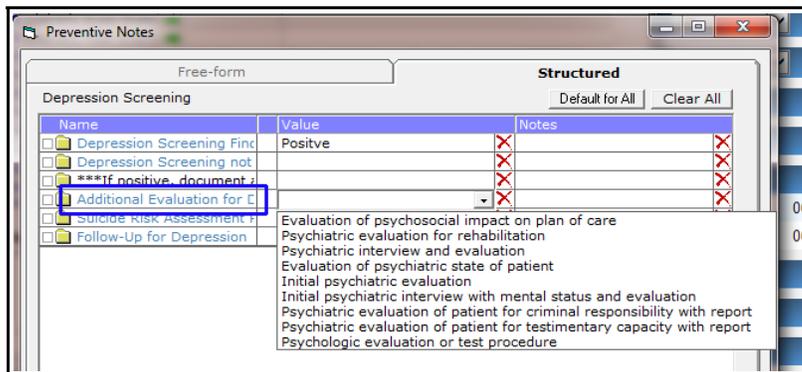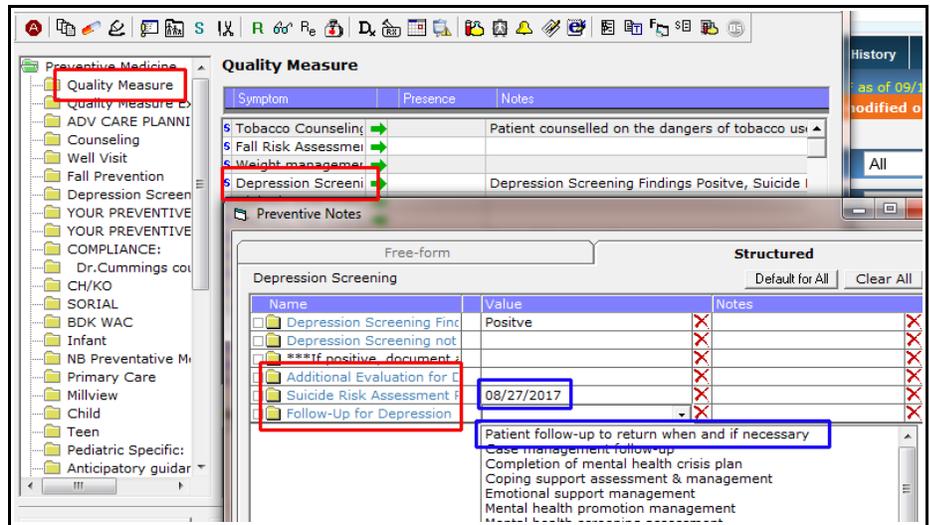
3. **Pneumonia Immunization (age 65+)**: This measure is identical to the flu vaccine measure. ANY pneumonia vaccination (PPSV23 or PCV13) EVER given meets the benchmark – it just needs to be recorded properly in ECW. Although there is a spot in the exclusion folder to report that the patient refused the vaccine, this does not actually count – refusal for the flu vaccine counts in our numerator, but refusal of a pneumonia vaccine unfortunately does not. The key here is just making sure the Pneumovax you gave 10 years ago is documented in the immunizations in ECW.

4. **Body Mass Index (age 18+)**: Nothing new here. Remember that BMI range is different for those under age 65 (>= 18.5 and < 25) and those 65 and older (>= 23 and < 30). If the patient falls out of this range, you need to document that counseling was provided. If you are not sure what this means, please review the video on this topic I made earlier this year. Just remember that if you documented this in January and the patient is seen again during the fall, it needs to be documented again (documentation must occur "during the encounter or during the previous 6 months of the current encounter").

5. **Tobacco Use (age 18+)**: We are all using the Smart Form for documentation of smoking. However, I have not been going to the Preventive Medicine section to document that I counseled the patient about the dangers of smoking and about methods to assist in smoking cessation – silly me, I just documented this in my note. In order to meet the benchmark, you must document this in Preventive Medicine once during the year. MJ may be able to "backfill" this if you billed for tobacco counseling.

But it would be best to spend a few clicks once during the year to document counseling under Preventive Medicine.
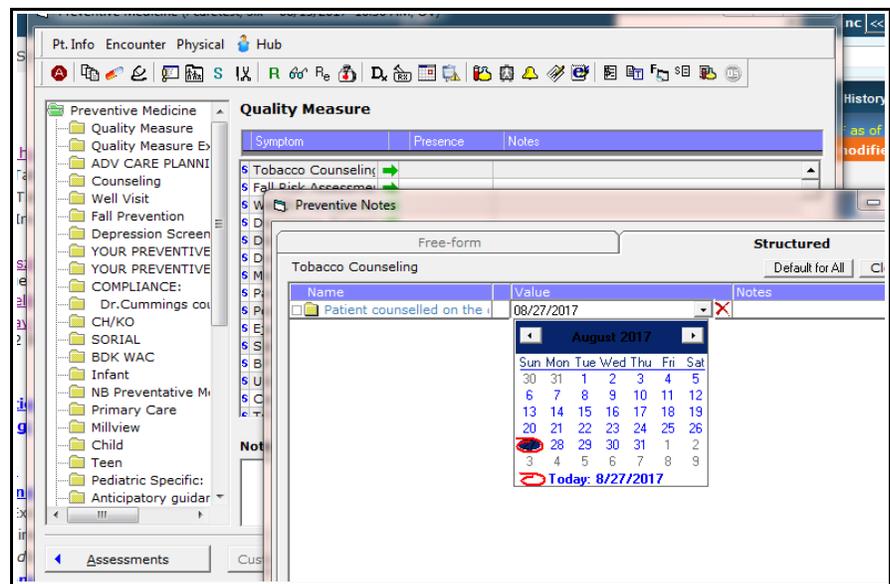
6. **Depression screening (age 12+)**: This is not new. Just remember that any patient with a positive PHQ-2 needs a PHQ-9 (both are Smart Forms). The only ridiculous element of this (in my view) is that ANY response greater than 0 on the PHQ-9 requires that I document in Preventive Medicine Quality Measures folder that I did something – even though a PHQ-9 score of 1 to 4 is usually not a sign of depression. In any event, any PHQ-9 score greater than zero requires that you go to Preventive Medicine/Quality Measures and complete the screen to the above. If the PHQ-9 was greater than 0 – report "Positive" in the first box. Then choose **ONE of the last 3 elements to complete**: "Additional Evaluation for Depression", "Suicide Risk Assessment Performed" (the current date is entered by default), or "Follow Up for Depression". Note that IF an antidepressant is prescribed at the visit, no further documentation is needed. I don't fully trust this promise of data-capture, so I tend to enter something in this area even for patients with depression on medication – ONCE during 2017.

7. **Breast Cancer Screening (women aged 50 to 74)**: So long as a mammogram was done in the past 2 years for a woman aged 50 to 74, AND this is documented by an order and a result in ECW, this measure is met. If the mammogram was done elsewhere, it needs to be scanned into ECW and LINKED TO AN ORDER. This should not be news to anyone – we have talked about linking scans to orders in ECW for the past 2 years – there are a few videos that outline this process. If the mammogram is done at PrimaCARE, you don't need to do anything special – the measure is met. There are some reasons for exclusion (under the Quality Measure Exclusion area in Preventive Medicine) – but patient refusal doesn't count.

8. **Colorectal Cancer Screening (ages 50 to 75):** This is similar to breast cancer screening, but a bit more problematic, as older colonoscopies need to be found, scanned, and linked in ECW. Again, to meet this measure, the colonoscopy report must be scanned into ECW and linked to an order. Any colonoscopy done by PrimaCARE in the past year or 2 SHOULD be in ECW properly – but there have been problems with the St. Anne's Hospital interface, but MJ and Ernst are working on these system problems. Our job is to make sure screening is DONE (colonoscopy every 10 years or FIT every calendar year). There are some reasons for exclusion (under the Quality Measure Exclusion area in Preventive Medicine) – there is a spot to report that the patient refused screening, but patient refusal does not get us off the hook.

9. **Depression Remission (age 18+)**: This measure is met if a patient had a PHQ-9 score of > 9 or a diagnosis of major depression – AND then had a PHQ-9 score of < 5 within 12 months of the PHQ-9 score of > 9. What this means is that, when the patient returns in follow-up feeling much better on sertraline, you MUST repeat the PHQ-9, and document the improved PHQ-9 score using the Smart Form. If you simply note in the chart that the patient is feeling better – your work doesn't count in the eyes of MIPS/CMS. Please remember to have the patient repeat the PHQ-9 score when his/her depression has improved. Note that a diagnosis of bipolar disorder or a personality disorder excludes the patient from this measure. Make sure that patients with personality disorders (like borderline personality disorder) are documented so the patient is excluded from this measure. DSM-5 does not recognize the "depressive personality disorder" (which was included in some earlier DSM iterations) – but there is a category of "personality disorder not otherwise specified". Note that Smart Search does include F34.1 for dysthymia or depressive personality disorder – we are working with Rosemary to make certain what personality disorders qualify as exclusions.

10. **Hemoglobin A1c (ages 18 to 75)**: Enough said! We have been hammered about this measure for YEARS. We want the A1c < 9% - and if the A1c is done OUTSIDE of PrimaCARE, it needs to be scanned in and linked to a lab order – just like the outside mammograms and colonoscopies. If the A1c is done at PrimaCARE and less than 9 – you are fine.

11. **Diabetic Eye Exam (ages 18 to 75)**: There is a video outlining this measure. It is not new to us. Enter the ophthalmology visit/results in Preventive Medicine/Quality Measures folder – this can be done either at the time of a visit, or in a "Virtual Visit" accessed in a

Telephone Encounter. For PCP's: When the ophthalmology note comes in – just open a Telephone Encounter and go to the "Virtual Visit" area and choose "Preventive Medicine" just like you would in a normal office note, and document the date and findings.

12. **Imaging for Low Back Pain (ages 18 to 50)**: Another old measure. Try not to order any imaging in the first 28 days of an episode of back pain. Obviously, if the patient has intractable pain with radiculopathy, I am not going to wait 28 days. But we all know that imaging doesn't change the management for most patients presenting with run-of-the-mill low back pain.

13. **Controlling High Blood Pressure (ages 18 to 85)**: Another old measure. Remember that the BP must be LESS than 140/90 – as Dr. Fogle has told us a hundred times – don't round the BP numbers – if it is 139/89, you met the measure. As far as I know, the last BP of the year is still what counts.

14. **Ischemic Vascular Disease (ages 18+)**: Patients with MI, CABG, or PCI in the previous 12 months OR a diagnosis of ischemic vascular disease in the assessment section of a progress note (CAD and cerebrovascular disease qualify, but not PAD) must have aspirin or some other antiplatelet agent on their medication list, OR a reason for exclusion from this measure needs to be entered in Preventive Medicine → Quality Measure Exclusion → Aspirin or Antiplatelet therapy not given.

12: **Statin Therapy for Prevention/Treatment of Cardiovascular Disease (ages 21+)**: Patients included in this measure must be in one of the following groups:

- have an active diagnosis of clinical atherosclerotic cardiovascular disease, OR
- have an LDL >= 190, OR
- be aged 40-75 AND have a diagnosis of diabetes mellitus AND an LDL of 70-189

If the patient fits into one of these categories, they must have a statin on their medication list OR have a reason for exclusion noted in the allergy section (for example, simvastatin → myalgia), or ICD-10 codes that exclude statin use (ESRD, pregnancy, active liver disease or palliative care).

13. **Medication Reconciliation Post-Discharge (ages 18+)**: Any patient discharged from a hospital or nursing home needs to have medications reconciled (obviously) – but we also need to go to the Preventive Medicine area under Quality Measures and record that date of discharge and document whether we changed medications or not – as shown in the screenshot to the right.
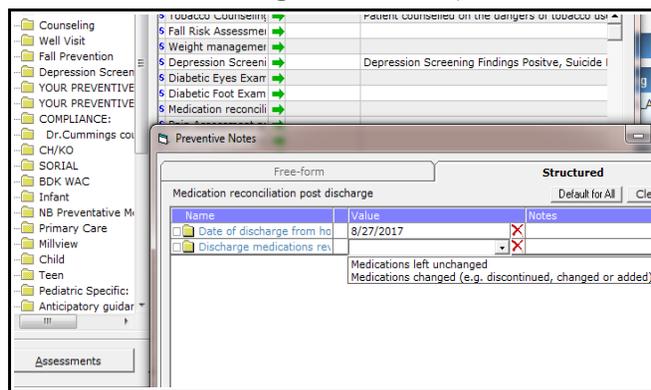
Thus concludes this not-so-brief summary of Meaningful Use/ACI/NextGen ACO/MIPS measures/benchmarks for PrimaCARE. Many of these are not new to us, but I was unaware of some of the subtleties of documentation in ECW – and have been missing out of having my work "count" just because I missed a click or two. This does seem a bit overwhelming, but if everyone in my office keeps an eye on these measures and does a little piece of this, I think we can manage. Printing out this document and assigning different components to different office staff may help – some measures could be done by the receptionist, some by the nurse, some by the medical assistant, some by the office manager, and some by the provider. Setting up a clear workflow so everyone consistently does his/her part should make complying with all these requirements easier.

Remember, because we might need to report these as MIPS measures, all but the fall measure apply to ALL PrimaCARE patients. It is easiest just to do this across the board without trying to figure out what insurance wants what measure. With MIPS – EVERYONE is included.

As new information becomes available, this page will be updated. To review videos about many of these measures, go to http://www.drkney.com/html_pages/ecw.htm.

Brad Kney, MD
September 16, 2017