Care + Community + Equity Best Practice Sharing Meeting

Type Name & Organization in the Chat

September 28, 2022

AGENDA – September 28, 2022

Welcome and Introductions	5 minutes	Der Kue, PMP (RICHA)
CHN Updates	5 minutes	Kelsea Tucker, MS (RIDOH)
RIght Moves Provider Toolkit	5 minutes	Jasmine Franco, MS (RIDOH)
AHA QI Congratulations	1 minute	Jayne Daylor (RIDOH)
QRS update and stratification ideas	10 minutes	Adrian Bishop (AHP)
Year 4 Quality Improvement Project PDSA Report Out **1. WellOne Primary Medical and Dental (1)** **2. Wood River Health Services (2)** **3. Thundermist Health Centers (3)** **4. Tri-County Community Action Program (3)** **5. Rhode Island Free Clinic (1)** **6. Comprehensive Community Action Program (3)** **7. Clinica Esperanza, Hope Clinic (1)**	60 minutes	All
National Assoc. of Chronic Disease Directors (NACDD) Award	5 minutes	Megan Fallon (RIDOH)
Closing Thoughts and Evaluation **<u>Next Meeting</u>: December, 2022** • **Please complete today's meeting evaluation and indicate best day for next meeting in December** • **Q2 data slides available for review**	5 minutes	Der Kue, PMP (RICHA)

CCE Community Health Network Referral Incentives

Kelsea Tucker &
Jasmine Franco

September 28th, 2022

Referral Incentives

CHN Incentive Option 1: Identify members of your care team who refer patients to evidence-based programs within the CHN and meet with the CHN Manager in July, August, or September to develop or adapt existing workflows that support CHN referrals. Submit the finalized workflow to your practice facilitator in October or November 2022.

Strategies to support workflows for CHN referrals may include the following:

- Identify and group patients based on defined criteria (i.e., clinical criteria for prediabetes) and submit a bulk referral to the CHN
- Create an "always" event, standing order, or an EHR flag to support automatic referrals to the CHN
- Implement the use of a fillable PDF CHN referral form that may be embedded into the EHR
- Incorporate CHN referrals into existing PDSA(s) or create and test a tailored 6-month PDSA for CHN referrals
- Implement the RIghtMoves Provider Toolkit for physical activity counseling and utilize its resources to generate CHN referrals

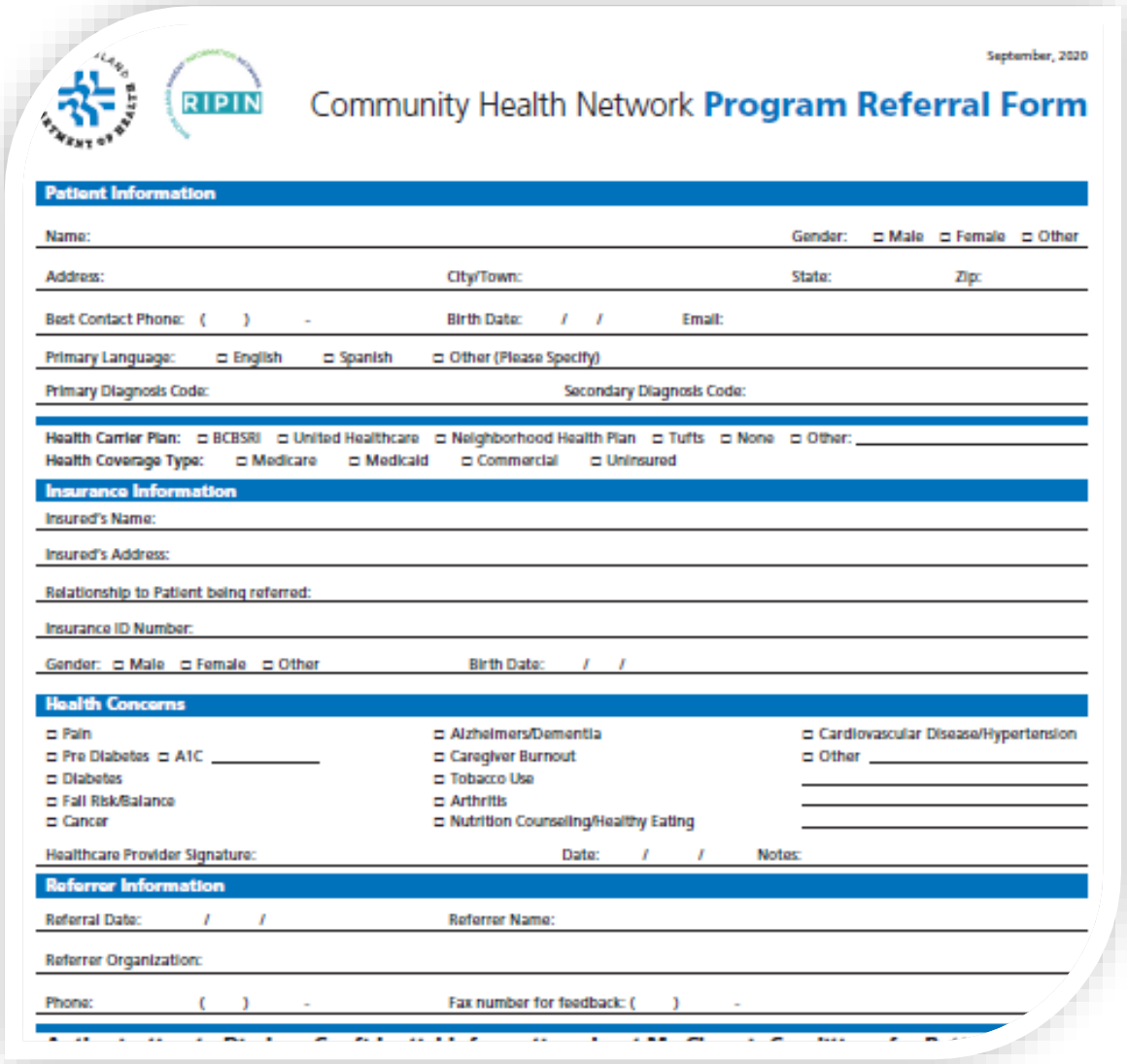
Referral Incentives

CHN Incentive Option 2: Refer patients to DPP or DSMES through the contract year. Practices can refer to DPP and DSMES through the CHN. Practices will receive the incentive if all three steps are achieved:

- Step 1: Refer at least 25 patients by October 15th, 2022, with at least 15 referrals to DSMES or DPP
- Step 2: Refer an additional 25 patients by February 15th, 2023, with at least 15 referrals to DSMES or DPP
- Step 3: Refer an additional 25 patients by June 29th, 2023 with at least 15 referrals to DSMES or DPP

Note: If practices have the capacity to offer DPP or DSMES on site, this may satisfy the intent of this incentive. Please discuss with your practice facilitator and the CHN Manager.

How to Refer



September, 2020

Community Health Network **Program Referral Form**

Patient Information

Name: Gender: ☐ Male ☐ Female ☐ Other

Address: City/Town: State: Zip:

Best Contact Phone: ( ) - Birth Date: / / Email:

Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify)

Primary Diagnosis Code: Secondary Diagnosis Code:

Health Carrier Plan: ☐ BCBSRI ☐ United Healthcare ☐ Neighborhood Health Plan ☐ Tufts ☐ None ☐ Other:

Health Coverage Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Uninsured

Insurance Information

Insured's Name:

Insured's Address:

Relationship to Patient being referred:

Insurance ID Number:

Gender: ☐ Male ☐ Female ☐ Other Birth Date: / /

Health Concerns

☐ Pain
☐ Pre Diabetes ☐ A1C _____
☐ Diabetes
☐ Fall Risk/Balance
☐ Cancer
☐ Alzheimers/Dementia
☐ Caregiver Burnout
☐ Tobacco Use
☐ Arthritis
☐ Nutrition Counseling/Healthy Eating
☐ Cardiovascular Disease/Hypertension
☐ Other _____

Healthcare Provider Signature: Date: / / Notes:

Referrer Information

Referral Date: / / Referrer Name:

Referrer Organization:

Phone: ( ) - Fax number for feedback: ( ) -

Ways to refer:

1. Complete a CHN Referral Form or have a patient fill out a self-referral form and fax or send via secure email.
2. Call or email CHN directly.
3. Use the CHN website to register for a program.
4. Unite Us – Send to RIPIN using the tag Chronic Disease Prevention and Management.

RIghtMoves Toolkit

- **What is it?** A guide for health care providers on discussing physical activity with patients
- **Goal:** to increase and support the conversations around physical activity between health care providers and patients
- **Toolkit Contents:**
  - RIghtMoves Health Care Provider Guide
  - Patient Resources
  - Promotional flyers
- **Health Care Provider Guide Contents:**
  - Ask Questions: to learn about patient's current physical activity behaviors
  - Assess Readiness to Change: to determine patient's readiness to engage in physical activity
  - Refer to the Community Health Network: to help patients learn more about physical activity and to become more physically active refer them to CHN programs such as Tools for Health Living and Walk with Ease

Kelsea Tucker, MS (she/her/hers)
Community Health Network Manager
Rhode Island Department of Health
Kelsea.Tucker@health.ri.gov
Home: 401-484-7419
Office: 401-222-7635

Jasmine Franco, MS (she/her/hers)
Chronic Disease Self-Management Education Program Manager
Rhode Island Department of Health
Jasmine.Franco@health.ri.gov
Office: 401-222-4520

CHN Phone: 401-432-7217
CHN Fax: 401-633-6229
CHN Email: CommunityHealthNetwork@ripin.org
Calendar: https://ripin.org/chn/

Target: BP

Clinic Name	State	Recognition level
CCAP Family Health	RI	Gold+
CCAP Primary Care Partners	RI	Gold+
CCAP Wilcox	RI	Gold+
WellOne Pascoag	RI	Gold+
WellOne Foster	RI	Gold+
CCAP Coventry	RI	Silver
Tri-County	RI	Silver
WellOne North Kingstown	RI	Silver
WellOne Scituate	RI	Silver
Wood River	RI	Silver

Target: Type 2 Diabetes

Clinic Name	State	Recognition level
CCAP Coventry	RI	Gold
CCAP Family Health	RI	Gold
CCAP Cranston	RI	Gold
CCAP Wilcox	RI	Gold
Tri-County	RI	Participant
Wood River	RI	Participant

Check, Change, Control Cholesterol

Clinic Name	State	Recognition level
CCAP Family Health	RI	Gold
CCAP Primary Care Partners	RI	Gold
CCAP Wilcox	RI	Gold
Tri-County	RI	Gold
WellOne Foster	RI	Gold
WellOne Pascoag	RI	Gold
WellOne N. Kingstown	RI	Participant
WellOne Scituate	RI	Participant

Summary of CCE eCQM Measure Changes 2022

Measure	Specification Changes	Guidance Changes
CMS122v10 (Diabetes)	• No core measure changes • Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period. • Definition of frailty clarified	
CMS165v10 (BP Control)	• Diagnosis was overlapping MP. For 2022, starting before and continuing into, or starting during the measurement period or the first six months of the measurement period • Definition of frailty clarified.	"It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record".

Summary of CCE eCQM Measure Changes 2022

Measure	Specification Changes	Guidance Changes
CMS347v5 (Statin)	1. All patients (was >=21) with ASCVD diagnosis or 2. Patients >=20 (was >=21) with high LDL or 3. All patients aged 40-75 with a diabetes diagnosis (used to also require LDL 70-189)	• Measure updated to meet the requirements of the latest (2020) AHA recommendations. • Multiple Guidance Changes

New tool on eCQI site:
https://ecqi.healthit.gov/

CMS122v10 (was v8) Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

Measure Description	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Initial Population	Patients 18–75 years of age with diabetes with a visit during the measurement period	Patients 18–75 years of age with diabetes with a visit during the measurement period
Denominator Statement	Equals Initial Population	Equals Initial Population
Denominator Exclusions	Exclude patients whose hospice care overlaps the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.	Exclude patients ~~whose~~who are in hospice care ~~overlaps~~for any part of the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria: - Advanced illness with two outpatient encounters during the measurement period or the year prior - OR advanced illness ~~and frailty because it is unlikely that~~with one inpatient encounter during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior Exclude patients ~~will benefit from~~receiving palliative care during the ~~services being measured~~measurement period.
Numerator Statement	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period.
Numerator Exclusions	Not Applicable	Not Applicable
Denominator Exceptions	None	None

CMS165v10 (was v8) Controlling High Blood Pressure

Measure Description	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension ~~overlapping~~starting before and continuing into, or starting during the ~~measurement period or the year prior to~~first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period
Initial Population	Patients 18-85 years of age who had a visit and diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period	Patients 18-85 years of age who had a visit and diagnosis of essential hypertension ~~overlapping~~starting before and continuing into, or starting during the first six months of the measurement period ~~or the year prior to the measurement period~~.
Numerator Statement	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

CMS165v10 (was v8) Controlling High Blood PressureCMS165v10 (Continued)

Denominator Exclusions	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients ~~whose~~who are in hospice care ~~overlaps~~for any part of the measurement period. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria: - Advanced illness with two outpatient encounters during the measurement period or the year prior - OR advanced illness with one inpatient encounter during the measurement period or the year prior - OR taking dementia medications during the measurement period or the year prior Exclude patients 81 and older with an indication of frailty ~~because it is unlikely that~~for any part of the measurement period. Exclude patients ~~will benefit from~~receiving palliative care during the ~~services being measured~~measurement period.

CMS347v5 (was v3) Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Measure 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	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~~*All patients who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR ~~*Adults~~*Patients aged >= ~~21~~20 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~~*Patients 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	Population 1: All patients who were previously diagnosed with or currently have an active diagnosis of clinical ASCVD, including an ASCVD procedure Population 2: Patients aged ~~21~~>= 20 years ~~and older~~at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia Population 3: Patients aged 40 to 75 years at the beginning of the measurement period with ~~a patient encounter during the measurement period~~Type 1 or Type 2 diabetes

CMS347v5 (was v3) Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Denominator Exclusions	Patients who have a diagnosis of pregnancy Patients who are breastfeeding Patients who have a diagnosis of rhabdomyolysis	Patients who have a diagnosis of pregnancy at any time during the measurement period Patients who are breastfeeding at any time during the measurement period Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period
Numerator Statement	Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period	Patients who are actively using or who receive an order (prescription) for statin therapy at any ~~point~~time during the measurement period
Numerator Exclusions	Not Applicable	Not Applicable
Denominator Exceptions	Patients with adverse effect, allergy, or intolerance to statin medication Patients who are receiving palliative or hospice care 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	Patients with ~~adverse effect, allergy,~~statin-associated muscle symptoms or ~~intolerance~~an allergy to statin medication Patients who are receiving palliative or hospice care 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~~

Year 4 Quality Improvement Project PDSA Report Out

1. WellOne Primary Medical and Dental (1)
2. Wood River Health Services (2)
3. Thundermist Health Centers (3)
4. Tri-County Community Action Program (3)
5. Rhode Island Free Clinic (1)
6. Comprehensive Community Action Program (3)
7. Clinica Esperanza, Hope Clinic (1)

Congratulations! We couldn't have done it without you.

RI awarded NACDD's 2022 Chronic Disease Innovator Award

The Chronic Disease Innovator Award is given to a state, tribal, or territorial Chronic Disease Unit that demonstrates an innovative approach to reducing the burden of chronic disease prevention and control. The Committee was impressed by your innovative approaches to health system transformation through health information technology, including the validation of chronic disease measures within the state's Quality Reporting System. Thank you to all who participate in this work!

Closing Thoughts & Evaluation

Next Meeting TBD:

December 2022

Next data submissions due:
October 15, 2022

Please leave us feedback on your overall participation in CCE and indicate your availability for the next ***meeting. Click HERE or*** *link* ***in the chat***