Oakland Physician Network Services

News & Highlights

Quarter 1
2021

Inside this issue

Board Members

Oakland Physician
Network Services

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What's up Doc?

From Dr. Imad Mansoor, OPNS CMO

Along with the effects of the COVID-19 Pandemic on practice patterns, delivery of services and interventional priorities, the state of Michigan has continually struggled with optimizing care and mitigation of adverse medical events related to chronic conditions. In response, Blue Cross Blue Shield of Michigan (BCBSM) has instituted a number of new quality-based programs available to Primary Care Physician Practices to optimize care delivery and patient outcomes. Oakland Physician Network Services is planning to participate in three new statewide quality improvement collaborative focusing on Low Back Pain, Obesity and Diabetes.

The **Michigan Back Collaborative (MIBAC)** initiative involves participants to contribute data to a clinical registry, review data to identify potential "best practices", identify factors associated with good outcomes and organize QI initiatives designed to achieve consistently better outcomes, along with more satisfied patients and clinicians. Participation is based on on-line training program that is offered at no charge to participants. After that, participants may elect to become involved in the collection of patient-reported outcomes data using a smartphone app, and then may elect to become involved in the full set of collaborative QI activities.

The training incentive offered by the BCBSM Value Partnership program is outlined below:

- Bonus option #1 –
  - must meet 75% of PO's affiliated physicians trained by 9/1/21
  - if met, the PO will get an additional $100 per PCP/chiro trained
  - Total PO incentive per (AFFILIATED) PCP/chiro ("DC" 0R "CHIROPRACTOR") would be $200 per
- Bonus option #2 -
  - Must have 75% or greater of PO's affiliated PCPs trained by 11/1/21
  - If met, the PO will get an additional $75 per PCP/chiro (DC) trained
  - Total PO incentive per PCP/chiro would be $175 per

The **Obesity Summit** will be held on **October 29, 2021** (in-person at the Radisson Hotel Lansing at the Capitol; adjusted if needed). During this meeting, experts will present on best practices for obesity management in behavior modification, diet, and pharmacology.

- Attendees will forge ideas and partnerships to address obesity and identify ways for PCPs and surgeons to collaborate; includes an understanding of the various state-of-art approaches to addressing obesity in the outpatient setting, opportunities for outcomes improvement in a more holistic, integrative approach, a better understanding of surgical management of the obese patient, including treatment options prior to referral for surgical treatment, appropriate indications for surgery, and how to best optimize care of the surgical patient and about virtual care of patients (non-surgical and surgical) with obesity

To support engagement, BCBSM is offering the following incentives upon participation:

- **PO Incentive**: To reward POs for recruiting practices in the Summit.
  - Level I: $2500 per PO (attendance of <5 Practices)
  - Level II: $5000 per PO (attendance of 5-10 Practices)
  - Level III: $7500 per PO (attendance of > 10 Practices)
  - PO medical director leaders (1-2 MD/DO's) are required participate in Summit
- **Physician Practice Unit Incentive**: To compensate PCPs to participate in the Summit
  - $1000 maximum per practice unit (2 or more PCP's in attendance);
    -OR-
  - $500 per practice unit (only 1 PCP in attendance)
- **Non-physician clinician staff** within the Physician Practice Units (i.e. nurses, dieticians, APPs)
  - $500 per practice unit (please limit to 3 total in attendance per practice)
  - Non-physicians should be encouraged to attend along with PCP

The **Michigan Collaborative for Type 2 Diabetes (MCT2D)** is another initiative designed to prevent and reverse Type 2 Diabetes through the systematic prescribing of GLP1 agonists and SGLT2 inhibitors, supporting low carb dietary interventions and expanding the use of glucose monitoring devices. The goals of these interventions are to improve glycemic control, support weight loss and mitigate/prevent adverse medical events related to Diabetes. This initiative will include claims/clinical/social and behavioral data through existing data hubs while reducing burden on practices for collection purposes.

OPNS would be providing administrative participation, including clinical, administrative and quality lead, provide primary contact for the initiative communication, provision of necessary data for the initiative and collaboration with practices to optimize success.

- Practices are required to identify 2 patient/caregiver advisors, representative of the population the initiative seeks to serve, serve as primary communication source on information related to the initiative and participate in a training program on continuous glucose monitoring devises and newer diabetes medications.

All three programs are open for participants right now. We should take the opportunity to educate ourselves on the most current best-practice research available, leverage existing tools and optimize our patient success rate and practice quality outcomes through engagement of these initiatives.

From the desk of Rodger Prong

The Reason I Came to Work Today

Most of us don't work just for the money, In the myriad of tasks at a medical practice it's easy to lose track of the value of the work itself. To help prevent this eventuality, one office team started to share "The Reason I Came to Work Today" stories. Sharing positive work experiences is one way to reconnect with the meaning and mission of the work. "The Reason I Came to Work Today" story originating doctor relates that It began when a patient one day said that she almost didn't keep her appointment but changed her mind when she remembered how kind Teresa had been to her two weeks earlier. Care is a team effort there and before he enters a room this physician huddles with the relevant staff person for any insight gained from the staff interaction like, "She seems depressed today." Teresa in this case noticing a reserved nervousness and going deeper into the history, eventually discovered that the patient was a victim of domestic abuse. Teresa then gathered referral information for the local domestic violence center.

With this preparation, the doctor was better positioned to immediately care for this patient than if he had walked into the room cold. The key to this "The Reason I Came to Work Today" concept seems to be encouraging initiative, catching staff doing a good job and then publicly complimenting them. So latter that day during a break when the staff was gathered, the doctor shared the story of this patient's gratitude for Teresa's kindness. Teresa said that when the patient told her how much she appreciated her attention, Teresa replied, "*You* were the reason I came to work that day. And *you* are the reason I came to work today." Teresa then expressed that every day she tries to find at least one encounter that defines "The Reason I Came to Work Today," one interaction that is particularly meaningful.

So now, when anyone in the practice feels especially good about how they've served a patient, how an interaction went well or an expression of kindness from a patient that was offered, they share it with the others as "The Reason I Came to Work Today." Doctor says "I've noticed a subtle increase in our performance since we started sharing the 'reason' stories." There's a little more compassion and willingness to go the extra mile. Intentionally sharing meaningful stories and experiences with co-workers makes for a richer work life and builds on itself and giving these stories the code name, "The Reason I Came to Work Today," helps overcome the natural reluctance to speak positively about one's own achievements and as a result all gain perspective on the value of their work.

Patient Satisfaction Surveys through Survey Monkey 2021

Its that time of year again! The PCMH Team will be glad to send a survey link upon email request. Your office will have 2 weeks to complete the surveys from the date of the email (50 survey Minimum). If you have internal medicine and peds in your practice you will need 25 surveys of each minimum. Upon completion, we will send you a power point of the results. You will need **2 consecutive years** of results to keep/put 4.4 11.4 and 14.9 PCMH capabilities in place. If you did the surveys last year and not this year, we would have to revert those capabilities.

Gaps in Care/Unmet measures and Performance Reports

PCMH Domain 2 talks about **gaps/unmet measures** so keep in mind that whatever capabilities your office has in place for this domain, you should be running these reports every month and working them to prove your process to BCBSM.

PCMH Domain 3 speaks to population Health in **Performance Reporting**. This is where all the work that is being done in unmet measures is now correlated to report on the practice as a whole. The performance report should be run every 3-6months by PO, Practice and Physician by All Payor. If you only have one physician, only one report is necessary. If you have more than one Physician, one report for the whole practice and one for each Physician should be suffice.

Please let our informatics team know if you do not have a PD Focus sign on or your access is locked out.

BCBSM Quality Announcement

The new 2021 Tip Sheets under the Clinical Quality Corner have just been released!

Make sure to check out the Clinical Quality Corner webpage to check out the new Tip Sheets, including the Telehealth Tip sheets for more information to help you practice complete gaps in care and optimize your performance.

Please note that a BCBSM login may be required to access the Clinical Quality Corner webpage.

Feel free to contact Lauren Maier at lmaier@opns.org for more information on these Tip Sheets.

OPNS is participating in Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT), a collaborative quality initiative (CQI) supported by Blue Cross Blue Shield of Michigan and Blue Care Network. I-MPACT is the first formal hybrid collaborative that requires hospitals and physician organizations partner together to improve care transitions for patients and family members/caregivers. OPNS and SJMO are collaborating on this initiative.

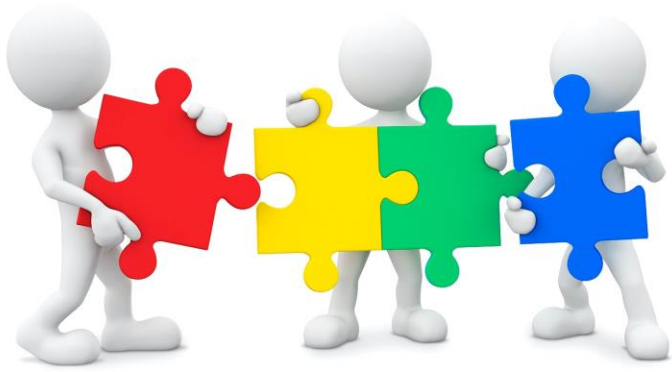
Goals of the I-MPACT are to contribute to and to learn from others across the state who are also working on improving care transitions and decreasing avoidable readmissions. The target population for this initiative is Congestive Heart Failure (CHF).

Interventions aimed at improving Transitions of Care (TOC) and reducing avoidable readmissions include:

1. Standardized discharge process
2. Timely communication of discharge summary
3. Follow-up call within 2 days of discharge
4. Follow-up appointment scheduled within 7 days of discharge

A 2020 Pay-for-Performance Scorecard indicates favorable performance in the following areas:

- 30-day Emergency Department utilization: **2020 rate: 6.0%; 2021 goal: 5.7%**
- 7-day follow up compliance: **2020 rate: 63.4%; 2021 goal: 68.7%**
- TOC interventions: **2020 rate: 100%; 2021 goal: ≥80%**



BCBSM PCMH-N Specialist Nominations

Specialist nominations are complete for 2020 engagement. If you are a specialist and are wanting to participate in PCMH-N to potentially earn a Value Based Reimbursement from BCBSM, as well as OPNS incentives, please contact one of the PCMH team members, Deborah Spencer at dspencer@opns.org, Kortnie Strain at kstrain@opns.org or Lauren Maier at lmaier@opns.org or you can also call the OPNS office at 248-682-6044.

PCMH/PCMHN Self-Management Training

Self-Management Training needs to be completed yearly to put or keep PCMH Capabilities 11.1 and 11.8 fully in place. If your training certificate has expired or is going to expire and your office does not have a self-management trained Care Manager than a staff member, that can train the rest of the staff, will need to attend a training session. Please contact the PCMH Team for future training dates.

Controlling high blood pressure (CBP) Measure Highlights

Patients ages 18–85 in the measurement year who had a diagnosis of hypertension, and whose blood pressure was adequately controlled (<140/90mm Hg) as of December 31 of the measurement year.

- Include **all** blood pressure readings and the dates they were obtained. The last blood pressure reading of the year will be used for HEDIS compliance determination.
- Document **exact** readings; do not round up blood pressure readings.
- Self-reported blood pressure readings taken by an electronic device are acceptable if via telehealth.

Submit blood pressure CPT® II codes for each office visit:

CPT® II code	Most recent systolic blood pressure
3074F	< 130 mm Hg
3075F	130–139 mm Hg
3077F	≥ 140 mm Hg
CPT® II code	**Most recent diastolic blood pressure**
3078F	< 80 mm Hg
3079F	80–89 mm Hg
3080F	≥ 90 mm Hg

- Tips for taking blood pressure readings in the office
  - Use the proper cuff size.
  - Advise the patient not to talking during the measurement.
  - Ensure that patients don't cross their legs and have their feet flat on the floor during the reading. Crossing legs can raise the systolic pressure by 2–8 mm Hg.
  - Make sure the elbow is at the same level as the heart. If the patient's arm is hanging below heart level and unsupported, this position can elevate the measured blood pressure by 10–12 mm Hg.
  - **Take it twice**. If the patient has a high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit. Consider switching arms for subsequent readings.
    - **Report the lowest systolic and diastolic pressure readings for that visit**
  - If patients have an abnormal reading, schedule follow-up appointments for blood pressure readings until their blood pressure is controlled.

Medication Reconciliation Measure Highlights

Reconciling medication within 30 days after discharge from a hospital.

Documentation must indicate that the provider is aware of the member's hospitalization or discharge and of the current medications with evidence of medication reconciliation:

- Notation that the provider reconciled the current and discharge medications.
- Notation that references the discharge medications (e.g., no change in medications since discharge, same medications at discharge, discontinue all discharge medications).
- Evidence that the patient was seen for post-discharge hospital follow up with medication reconciliation review.
- Notation that no medications were prescribed or ordered upon discharge.
- Date medication reconciliation was performed.

When the following CPT® codes are billed within 30 days of discharge, it will close the treatment opportunity, reducing medical record requests.

CPT® II code	Description
1111F	Discharge medications are reconciled with the current medication list in outpatient medical record. Can be billed alone since a face-to-face visit is not required.
99483	Assessment and care planning for a patient with cognitive impairment. Requires an array of assessments and evaluations, including medication reconciliation and review for high-risk medications, if applicable.
99495	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **moderate** complexity and a face-to-face visit within **14** days of discharge.
99496	Transitional care management that requires communication with the patient or caregiver within two business days of discharge (can be done by phone, email or in person) and decision-making of at least **high** complexity and a face-to-face visit within **seven** days of discharge.

- If 1111F is billed alone or with a telephone CPT code, the med rec documentation requirements in the patient's medical record must be met.

Well Care/Child Visits Measure Highlights

Documentation of the visit in the medical record must include the date when the well-care visit occurred and evidence of **all** the following:

- Health history
- Physical developmental history
- Mental developmental history
- Physical exam
- Health education/anticipatory guidance

Note: *This measure can only be met through appropriate coding and claims.*

Tips for coding

Codes to identify **Well-Care** Visits:

- ICD10CM: Z00.00, Z00.01, Z00.5, Z00.8, Z00.110, Z00.111, Z00.121, Z00.129, Z02.0-Z02.6, Z02.71, Z02.82,
- Z76.1, Z76.2
- CPT® codes**: 99381-99385, 99391-99395, 99461
- HCPCS: G0438, G0439

Codes to identify **Well-Child** Visits:

- ICD10CM: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3,
- Z02.4, Z02.5, Z02.6, Z02.71, Z02.82, Z76.1, Z76.2
  - CPT® codes** 99381, 99382, 99383, 99384, 99385, 99391, 99392-99395, 99461
  - HCPCS: G0438, G0439

Can also use synchronous telehealth to complete Well Care/Child visits, including proper telehealth code modifiers and documentation of all required elements.

It is important to education patients on completion of visits, can be difficult when parents are looking for physicals for their children; it nis important to differentiate the difference and the importance of getting a full wellness check:

Well Check

- All medical problems, including personal and family medical history
- Full physical exam
- Monitor year-to-year growth compared to peers
- Review all developmental issues appropriate for age
- Age-appropriate screening labs
- Vaccinations
- Referrals if needed for any of the above

Sports Physical

- Medical problems, which affect sports participation (e.g., old injuries, chronic conditions like asthma)
- Inherited problems, which affect sports (e.g., genetic heart conditions)
- Check for specific findings, which affect sports
- Check height, weight, and BMI
- Review common subjects related to sports (e.g., signs of concussion, proper nutrition, hydration)
- As needed labs

Don't Miss This Incentive Opportunity!

Deadline September 30, 2021

In 2021 OPNS is again offering an incentive metric for **Advance Care Planning (ACP)** as part of the annual physician shareholder payout program. Primary Care and Specialty physicians who demonstrate they have met the components of the metric that enhance tracking of ACP conversations and sharing of completed directives with other providers, will be eligible for this reward opportunity.

Advance Care Planning Metric: (Primary Care and Specialty Practices) 1/1/2021 – 9/30/2021

- **Part 1** - PCMH ACP capability 4.16 reported as "fully in place" to BCBSM by September 30, 2021 and **5 or more** 2021 ACP conversations documented in the Physician Direct Focus Registry. (Both components needed to qualify for part 1 of the Incentive.)
- **Part 2** – Storage of completed Advance Directives in the Physician Direct Focus Registry
  - Level 1 - **2-5** Advance Directives executed or updated in 2021 and scanned into the PD Focus registry
  - Level 2 – **6 or more** Advance Directives executed or updated in 2021 and scanned into the PD Focus registry.

OPNS PCMH leaders, Deborah Spencer at dspencer@opns.org and Lauren Maier at lmaier@opns.org or IT specialist, Verly Safry at vsafry@opns.org are ready to assist practices in meeting these requirements and will be monitoring the incentive metrics. OPNS has also developed an ***ACP Toolkit*** and a ***GUIDELINES for ACP in the Medical Office.*** To receive either of these helpful resources contact Beverly Walters RN, End of Life Planning lead, at bwalters@opns.org

Registration is Now Open

Advance Care Planning (ACP) Facilitator Training
Respecting Choices® Program

For the past 3 years OPNS has sponsored the highly respected ACP facilitator training course ***Respecting Choices*** ® taught by the Rev James Kraft PhD, Director of ACP and Collaborative Care at Henry Ford Macomb and WB Hospitals.

OPNS is offering another facilitator *First Steps* training class on **April 30, 2021** in a virtual format to assure the safety of all participants. Information on the course and OPNS's subsidy of this program can be obtained by contacting Beverly Walters RN at bwalters@opns.org

With the coronavirus epidemic the need for end of life conversations and planning has become more critical but for many having these conversations can be intimidating and challenging. Facilitator training can help physicians and their staff feel more confident with the basic skills of end of life planning communications. The course is appropriate for physicians, NPs, PAs, RN/LPNs, Care Managers, Social Workers and Medical Assistants who assist professional staff with these important discussions. 6.25 CEU are available for those who qualify and complete the full program.

Don't miss this opportunity. Contact Ana Alvaraz at 248-682-0088 ext 116 or aalvarez@opns.org to reserve your spot today.

Addressing implicit bias in health care can improve care delivery

You might have heard that implicit bias plays a role in how health care is delivered indoctor's offices, hospitals and other health care settings. But what exactly is meant by implicit bias?

Implicit bias refers to the attitudes, stereotypes and generalizations that affect our understanding, actions and decisions in an unconscious manner. It often results inprejudices in favor of — or against — a thing, person or group.

"All human beings are wired to have bias, and biases are often based on assumptions and stereotypes that are learned over time," explained Bridget Hurd, vice president of Inclusion and Diversity for Blue Cross Blue Shield of Michigan. "These unrealized or unconscious beliefs can affect our decision-making."

In a health care setting, implicit bias can have dangerous consequences.

"Every medical professional is mission-driven to heal their patient, but research indicates that bias shows in various ways in the delivery of health care — more often implicitly rather than explicitly," said President and CEO Daniel J. Loepp in a recent blog "It benefits all medical professionals to spend time working to recognize where implicit bias may be present in the delivery of care and developing approaches to address it to the benefit of patients everywhere."

Consider these examples:

- Non-white patients presenting to the emergency room with the same symptoms as white Americans are less likely to receive pain medication, according to an article in *Physician's Weekly*.
- An article published in the National Academy of Sciences reported that a survey of white medical students in 2016 showed that many had false beliefs about the biological differences between Blacks and whites, leading to different treatment recommendations.
- Early in the COVID-19 pandemic, reports indicated that African-Americans with concerning symptoms weren't tested as often as their white counterparts, according to a review of billing information conducted by a biotech data firm.

Creating widespread understanding of these disparities in how health care delivery differs based on implicit bias is the first step in successfully addressing this issue.

That's why Blue Cross is rolling out implicit bias education to health care providers over the next two years. It covers such topics as the science of bias, how it influences behaviors and patient outcomes, and how to make efforts to overcome implicit bias.

In September, leaders and staff at 40 physician organizations that participate in the Physician Group Incentive Program were introduced to implicit bias education. Next, it's being rolled out to patient-centered medical home physicians and office staff.

"Creating awareness among physicians and office staff is an important step in building cultural competency and addressing gaps in care that may occur due to biases related torace, ethnicity, gender, sexual orientation, obesity or socioeconomic status," said Hurd,who is leading the new Office of Health and Health Care Disparities.

Practices with PCMH designation will be required to take part in implicit bias educational opportunities this year to continue to receive value-based reimbursementtied to the PCMH designation.

Additionally, Gov. Gretchen Whitmer announced a directive last year that requires medical professionals to go through implicit bias training when obtaining or renewing their licenses.

Lunch and learn webinars for physicians and coders focus on risk adjustment, coding

Action item: Sign up now for our live, monthly, lunchtime webinars.

Starting this month, we're offering webinars that will provide updated information ondocumentation and coding of common challenging diagnoses. These live, lunchtimeeducational sessions will also include an opportunity to ask any questions you mayhave.

The April through September webinars are led by physicians. The last three sessions ofthe year focus on coding guideline updates and are led by coders.

Here's our current schedule and the tentative topics. All sessions start at 12:15 p.m. Eastern time and generally run for 15 to 30 minutes. Click on a *Register here* link belowto sign up for a session.

Session date	Topic	Sign-up link
Tuesday, April 20	Acute conditions reported in the outpatient setting	Register here
Wednesday, May 19	Morbid (severe) obesity	Register here
Thursday, June 17	Major depression	Register here
Tuesday, July 20	Diabetes with complications	Register here
Wednesday, Aug. 18	Renal disease	Register here
Thursday, Sept. 23	Malignant neoplasm	Register here
Tuesday, Oct. 12	Updates for ICD-10-CM	Register here
Wednesday, Nov. 17	Coding scenarios for primary care andspecialty	Register here
Thursday, Dec. 9	E/M coding tips	Register here

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions regarding registration, email PatriciaScarlett at pscarlett@bcbsm.com.

OPNS Physician Credentialing Rights

Applicants shall be permitted access to their credentialing file at any time with reasonable notice during normal business hours. This includes information obtained to evaluate their credentialing application as well as information obtained from outside sources. This does not include references or any other peer protected information. Applicant shall be notified of these rights in the application packet cover letter, on the OPNS website, and no less than annually in the OPNS newsletter. Applicant must submit a written request to view his/her file to the Provider Services Manager.

Last Name	First Name	Degree	Specialty
Ali	Tarik	DO	Family Medicine
Allar	Brian	NP	Nurse Practitioner
Chandross	Marilyn	NP	Nurse Practitioner
Clemens	Jerrica	PA	Physician Assistant
DeNardis	Elizabeth	PA	Physician Assistant
Eisenstein	David	MD	Obstetrics & Gynecology
Holt	Marcelle	NP	Nurse Practitioner
Mathia	Lynn	DO	Vascular Surgery
Richardson	Theresa	PA	Physician Assistant
Robinson	Jennifer	NP	Nurse Practitioner
Servito	Daniel	NP	Nurse Practitioner
Theoharis	Evan	MD	Obstetrics & Gynecology
Vrabel	Karen	NP	Nurse Practitioner