MaineHealth
Accountable Care Organization

HEAT MAP QUALITY METRICS GUIDE

Publication Date: December 10, 2021

Laura K. Larssen, MA, Program Manager

LLarssen@mainehealth.org

Introduction

The MaineHealth ACO (MHACO) currently has 16 value-based care contracts with almost 90 quality performance measures. The MHACO Quality Heat Map highlights the top 11 priority measures. These measures are reviewed and approved by the Quality Workgroup of the ACO and the Value Oversight Committee, comprising physicians and other leaders from each local health system. In fiscal year 2022, the MHACO Quality Heat Map measures are:

- Annual Wellness Visits
- Breast Cancer Screening
- Colorectal Cancer Screening
- Depression Screening (12+)
- Diabetes: Eye Exam
- Diabetes: HbA1c >9
- Diabetes: Kidney Health Evaluation
- Diabetes: Statin Therapy
- Hypertension Control
- Well-Child Visits: 0-15 Months
- Patient Experience: Would Recommend

Together, these measures are worth more than $5,500,000 in pay-for-performance incentives and impact MHACO's eligibility to earn shared savings in 11 value-based care contracts, which typically offer total opportunity of $3,000,000 to $10,000,000. Medicare Advantage contracts rely heavily on quality incentives in their contract structure, which is why many of the Heat Map measures align with Medicare Advantage Star measures.

Heat Map targets are set based on NCQA HEDIS and Centers for Medicare & Medicaid Services (CMS) national benchmarks and are weighted to represent the MaineHealth ACO patient population mix. A patient's medical history, a provider's clinical expertise, and shared decision-making always supersede the recommended guidelines, so targets typically do not exceed 90%.

Performance on the Heat Map quality metrics is based on full-panel data pulled from Epic by the MaineHealth Medical Group Analytics team and are the same metrics used to populate the BI Portal quality reports. As a result, care teams can utilize the BI Portal to run reports and generate gap lists at the provider and patient levels to support patient outreach and practice improvement efforts. Data for St. Mary's are self-reported from a separate Epic EMR instance.

More details on each measure definition are included on the measure's summary page below.

Annual Wellness Visits

Significance

- Annual Wellness Visits (AWVs) were shown to increase quality and decrease utilization in a randomized trial. This trial included a control for "the number of baseline primary care visits, to account for the level of engagement with a PCP and the ability to come in for a visit."[1]
- Annual Wellness Visits provide multiple opportunities to effectively manage patient care and support the ACO in achieving shared savings in our value-based care contracts:
    - AWVs provide an opportunity to discuss patients' chronic conditions. Documenting and coding applicable chronic conditions allow us to stratify our panels for population health management activities, and allow the health plans to see the risk level of the patient population that is being managed and ensure realistic cost targets.
    - AWVs are a great opportunity to develop care plans to assist patients with their health conditions. Care plans may include review of a patient's care team, screening services they need for the year, and medications review. Developing a care plan may reduce unnecessary utilization and help close gaps in care.
    - Many Medicare Advantage plans allow Annual Wellness Visits to be completed at the same time as a physical exam.
- Payers recognize the impact that Annual Wellness Visits and physical exams (PE) have and offer financial incentives based on performance. AWVs are tied to ~$1,384,000 in pay-for-performance incentives.

Measure Description

Numerator: Number of patients in the denominator with a Medicare Wellness Visit in the last 12 months.

Denominator: Number of Medicare or Medicare Advantage patients on the active panel, defined as an office visit to the PCP's office within the past 24 months.

HCPCS/CPT codes for AWV: G0402, G0438, G0439, G0468

Strategies and Resources for Improvement

- **ACO Insider Webinar: Annual Wellness Visits and Clinical Documentation**
- **MaineHealth Annual Wellness Visit Webpage**
- **Making Annual Wellness Visits Work PDF**
- **Reimbursable Preventative Services**

Breast Cancer Screening

Significance

- U.S. Preventative Services Task Force (USPSTF) Grade B recommendation: Biennial screening mammography for women aged 50 to 74 years.
- Excluding some types of skin cancer, breast cancer in the United States is the most common cancer in women and the second most common cause of death from cancer among white, black, Asian/Pacific Islander, and American Indian/Alaska Native women.[2]
- Payers recognize the impact that breast cancer screening has on patient outcomes and offer financial incentives based on performance. Breast cancer screening is tied to ~$800,000 in pay-for-performance incentives.

Measure Description

Numerator: Number of patients in the denominator with a breast cancer screening documented in the last 27 months.

Denominator: Number of female patients ages 50-74 at the end of the measurement period and age <74 at the beginning of the measurement period, with an office visit in the last 12 months.

Exclusions: A history of bilateral mastectomy or a right and a left unilateral mastectomy.

Strategies and Resources for Improvement

Quick Tip: Be sure to scan and document external exam results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more detail on documentation.

Colorectal Cancer Screening

Significance

- U.S. Preventative Services Task Force (USPSTF) Grade A Recommendation: Screening for colorectal cancer in all adults aged 50 years to 75 years.
- Of cancers that affect both men and women, colon cancer is the second leading cause of cancer mortality in the United States, causing approximately 50,000 deaths each year.[3]
- Payers recognize the impact that colorectal cancer screening has on patient outcomes and offer financial incentives based on performance. Colorectal cancer screening is tied to ~$815,000 in pay-for-performance incentives.

Measure Description

Numerator: Number of patients with one or more screenings documented for colorectal cancer: colonoscopy in the last 10 years; flexible sigmoidoscopy in the last 5 years; computed tomography colonography in the last 5 years; multi-target stool DNA test/cologuard in the last 3 years; and a fecal immunochemical DNA test (FIT-DNA) in the measurement period.

Denominator: Number of patients ages 50-75 at the beginning of the measurement period, with an office visit in the last 12 months.

Exclusions: A diagnosis or past history of total colectomy or colorectal cancer.

Strategies and Resources for Improvement

Quick Tip: Be sure to scan and document external lab results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more detail on documentation.

Depression Screening

Significance

- U.S. Preventative Services Task Force (USPSTF) Grade B recommendation: Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Screening for depression has been shown to lead to earlier detection and a greater decrease in depressive symptoms. Studies identified by the USPSTF in their rationale statement demonstrate that screening for depression with subsequent intervention leads to a 19% to 71% increase in remission of symptoms.[4]
- Payers recognize the impact that depression screening has on patient outcomes and offer financial incentives based on performance. Depression screening is tied to over $1,000,000 in pay-for-performance incentives.

Measure Description

Numerator: Number of patients in the denominator with a PHQ2 or PHQ9 documented in the last 12 months.

Denominator: Number of patients with age >=12 at the beginning of the measurement period, with an office visit in the last 12 months.

Exclusions: Bipolar disorder and depression

Exceptions: Patients who declined screening for personal, medical, or functional reasons and did not have a screening at any other point in the measurement year.

Strategies and Resources for Improvement

- **Quick tip:** Clinical staff can ask PHQ9 questions during rooming, and then flag the provider if a patient scores above 10.
- **MaineHealth Behavioral Health PHQ-9 and PHQ-2 Guidelines**
- **Using the PHQ-9 for Screening, Diagnosis and Management of Depression**
- **Maine Behavioral Health referral information**

Diabetes: Eye Exam

Significance

- Diabetes can lead to eye disease and blindness. Because diabetic retinopathy has an insidious onset and progression, and there are effective treatments for the disease, screening for diabetic retinopathy can significantly decrease future morbidity.
- It is estimated that 20% of patients with type 2 diabetes have retinopathy at the time of diagnosis of their diabetes.[5]
- Studies suggest that screening for retinopathy in patients with type 1 diabetes would save 70,000 years of sight. For patients with type 2 diabetes, screening would save an estimated 94,000 years of sight. [6] [7]
- Payers recognize the impact that screening for retinopathy has on patient outcomes and offer financial incentives based on performance. The Diabetes Management: Eye Exams measure is tied to over $1,100,000 in pay for performance incentives.

Measure Description

Numerator: Number of patients in the denominator with documentation of a retinal or dilated eye exam in the last 24 months or last 12 months for patients with retinopathy.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed, and having an office visit during the measurement period.

Strategies and Resources for Improvement

Quick Tip: Be sure to scan and document external lab results appropriately. For MaineHealth Epic practices, refer to the Clinical Quality Measures guide for more detail on documentation.

Diabetes: HbA1c >9

Significance

- Better glycemic control is associated with 50–76% reductions in rates of development and progression of microvascular (retinopathy, neuropathy, and diabetic kidney disease) complications.[8]
- Achieving A1c targets of <7% (53 mmol/mol) has been shown to reduce microvascular complications of type 1 and type 2 diabetes when instituted early in the course of disease. In type 2 diabetes, there is evidence that more intensive treatment of glycemia in newly diagnosed patients may reduce long-term cardiovascular disease rates. [9]
- Payers recognize the impact that HbA1c control has on patient outcomes and offer financial incentives based on performance. The Diabetes Management: HbA1c Control measure is tied to over $750,000 in pay-for-performance incentives.

Measure Description

Numerator: Number of patients in the denominator whose most recent HbA1c in the last 12 months is > 9 or no HbA1c test was completed.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed, and having an office visit during the measurement period.

Strategies and Resources for Improvement

- **Quick Tip:** Implement Point-of-Care testing or order an A1c test before patients come in for their visit.
- **MaineHealth Diabetes Podcast – Episode 4: Shared Decision Making in Diabetes Care -** This podcast discusses ways to have an open conversation, identifies important questions to ask your patients, and how to help your patients set A1C and self-care goals.
- **MaineHealth Project ECHO – Endocrinology**: Meets on the second Tuesday of each month, 7:30-8:30 a.m. Endo ECHO sessions provide primary care physicians and other clinicians with the opportunity to learn about and discuss a broad range of disorders in the fields of endocrinology and diabetes: https://mainehealth.org/healthcare-professionals/telehealth/project-echo#

Diabetes: Kidney Health Evaluation

Significance

- Diabetic kidney disease affects about 20% of patients with diabetes. Diabetic kidney disease is associated with increased risks of morbidity and mortality and is the leading cause of end-stage renal disease in the United States.[10]
- Many people with hypertension and diabetes are not receiving both a urine microalbumin/creatinine ratio (uACR) and serum creatinine test necessary to detect and assess chronic kidney disease as recommended by clinical practice guidelines, despite these being the top two markers of developing chronic kidney disease.[11]
- The 2020 HEDIS measure aims to improve kidney disease testing by assessing the percentage of adults with diabetes who have received both blood and urine kidney tests within the last 12 months.
- The combination of eGFR and uACR testing is a strong predictor of cardiovascular mortality and kidney failure risk.[12]
- Payers recognize the impact of kidney health evaluation on patient outcomes and offer financial incentives based on performance. Kidney Health Evaluation is tied to nearly $90,000 in pay-for-performance incentives.

Measure Description

Numerator: Number of patients who received an annual kidney health evaluation, including both eGFR and uACR.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 18-75 at the beginning of the measurement period diagnosed, and having an office visit during the measurement period.

Exclusions: End-Stage Renal Disease, frailty and advanced illness.

Note: There are no exclusions for patients on ACEs or ARBs.

Strategies and Resources for Improvement

- **Quick Tip:** The MaineHealth Epic team has added Health Maintenance support topics to help providers order both tests needed to detect and assess chronic kidney disease.
- **NCQA Kidney Health Provider Guide**

Diabetes: Statin Therapy

Significance

- Statin therapy has been shown to be effective as both a primary and secondary prevention of cardiovascular disease and mortality for individuals with diabetes.[13]
- Payers recognize the impact that statin use has for patients with diabetes and offer financial incentives based on performance. Statin Therapy in patients with diabetes is tied to ~$380,000 in pay-for-performance incentives.

Measure Description

Numerator: Patients in the denominator who were seen in the last year with an active statin medication of any intensity on their medication list.

Denominator: Number of patients with diabetes (type 1 or type 2), ages 40-75 at the beginning of the measurement period diagnosed, and having an office visit during the measurement period.

Exclusions: Clinical atherosclerotic cardiovascular disease (ASCVD)

Hypertension Control

Significance

- Elevated blood pressure has been shown to account for 58.3% of deaths from hemorrhagic stroke and 54.5% of deaths from ischemic heart disease.[14]
- Payers recognize the impact that hypertension control has on patient outcomes and offer financial incentives based on performance. Hypertension control is tied to ~$800,000 in pay for performance incentives.

Measure Description

Numerator: Number of patients in the denominator whose most recent and lowest BP reading of the day in the last 12 months is < 140/90.

Denominator: Number of patients with hypertension, ages 18-85 at the beginning of the measurement period diagnosed, with an office visit in the last 12 months.

Exclusions: End-Stage Renal Disease

Strategies and Resources for Hypertension Improvement

- **Quick Tip:** If a patient's first blood pressure reading is elevated, the clinical staff can alert the provider to take a second blood pressure reading before the patient leaves and document the second result in the EMR.
- **MaineHealth Hypertension Control Toolkit**
- Other strategies and recommendations are available in the American Heart Association's **Target: BP Guidelines and Practices**
- Additional highlights from the **2017 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.**
- Help your patients manage their weight with **Small Steps.**

Well-Child Visits 0-15 Months

Significance

- One of the most important reasons for early well-child visits is to ensure that newborns get their vaccines, which are scheduled at every visit from 0-15 months except the 9-month visit.
- Well-child visits of newborns and young children are also times when children receive the following care and services:
    - Growth monitoring: height/weight/head circumference monitoring[15]
    - Developmental screening, shown to increase appropriate referrals to further services[16] [17]
    - Adverse Child Events - trauma screening[18]
    - Food insecurity screening[19]
    - Maternal post-partum depression screening[20]

Payers recognize the impact that well-child visits have on patient outcomes and offer financial incentives based on performance. Well-child visits are tied to ~$5,000 in pay for performance incentives.

Measure Description

Numerator: Number of patients in the denominator who had at least 6 well-child visits by their 15-month birthday with a 1-month grace period.

Denominator: Number of patients who turned 15 months old in the measurement period with at least one visit to their PCP's department(s) both in the measurement period and the year prior.

Strategies and Resources for Improvement

- **Quick Tip:** Schedule all six visits at the initial or second visit. Set up a reminder and recall workflow to remind parents about their upcoming visits and call to reschedule if they miss it.
- **MaineHealth Childhood Immunizations Webpage**

Patient Experience: Would Recommend Office

Significance

- Better patient experience of care correlates with improvements in:
  - Chronic disease management[21]
  - Adherence to medical advice and treatment plans[22] [23]
  - Better health outcomes[24] [25] [26]
  - System issues, such as access, timeliness of test results, etc.
- Better patient experience is not associated with low-value care[27]
- Patient Experience measures are increasingly weighted in Medicare Advantage Stars.
- Payers recognize the impact that the patient experience has on patient outcomes and offer financial incentives based on performance. Patient Experience measures are tied to ~$180,000 in pay-for-performance incentives.

Measure Description

Numerator: Net promoter score for email/phone survey question, "How likely would you be to recommend this office to your family and friends?" for the National Patient Experience Survey question from NRC (rolling 3 months)

- Net promoter score: % patients with a 9-10 rating minus % of patients with 0-6 rating

Denominator: Number of patients surveyed by the National Patient Experience Survey question within the past rolling 3 months.

Data source: NRC Health Real-Time survey *(note: St. Mary's uses the Press Ganey survey question for "Likelihood of recommending")*

Strategies and Resources for Improvement

- **Quick Tip:** For access to MaineHealth Patient Experience coaching and resources, contact Helena Ackerson, VP of Patient Experience.
- The Beryl Institute is a leadership organization focused on providing resources and research for improving patient experience. This includes:
  - **The Patient Experience Journal (PXJ),** a peer-reviewed, open-access journal
  - **To Care Is Human: A Patient Experience Podcast**
  - A library of patient experience **case studies**

Sources

[1] Beckman, Adam L, et al. “Medicare Annual Wellness Visit Association with Healthcare Quality and Costs.” *The American Journal of Managed Care*, vol. 25, no. 3, 19 Mar. 2019.
[2] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on 2019 submission data (1999-2017): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, released in June 2020.
[3] “Colonoscopy (Position Paper).” AAFP Home, American Academy of Family Physicians, www.aafp.org/about/policies/all/colonoscopy-position-paper.html
[4] O'Connor E, Rossom RC, Henninger M, et al. Screening for Depression in Adults: An Updated Systematic Evidence Review for the U.S. Preventive Services Task Force [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Jan. (Evidence Syntheses, No. 128.) 3, Results. Available from: https://www.ncbi.nlm.nih.gov/books/NBK349031/
[5] Harris MI, Klein R, Welborn TA, Knuiman MW. Onset of NIDDM occurs at least 4-7 yr before clinical diagnosis. Diabetes Care. 1992 Jul;15(7):815-9. doi: 10.2337/diacare.15.7.815. PMID: 1516497.
[6] Jonathan C. Javitt, Joseph K. Canner, Richard G. Frank, Donald M. Steinwachs, Alfred Sommer, Detecting and Treating Retinopathy in Patients with Type I Diabetes Mellitus: A Health Policy Model, Ophthalmology, Volume 97, Issue 4,1990, Pages 483-495, ISSN 0161-6420, ttps://www.sciencedirect.com/science/article/pii/S0161642090325733
[7] Preventive Eye Care in People With Diabetes Is Cost-Saving to the Federal Government: Implications for health-care reform Jonathan C Javitt, Lloyd Paul Aiello, Yenpin Chiang, Frederick L Ferris, Joseph K Canner, Sheldon Greenfield Diabetes Care Aug 1994, 17 (8) 909 917; DOI: 10.2337/diacare.17.8.909
[8] Glycemic Targets: Standards of Medical Care in Diabetes—2019 American Diabetes Association Diabetes Care Jan 2019, 42 (Supplement 1) S61-S70; DOI: 10.2337/dc19-S006
[9] Glycemic Targets: Standards of Medical Care in Diabetes—2019 American Diabetes Association Diabetes Care Jan 2019, 42 (Supplement 1) S61-S70; DOI: 10.2337/dc19-S006
[10] American Diabetes Association. 10. Microvascular Complications and Foot Care: Standards of Medical Care in Diabetes—2018. Diabetes Care. 2018;41(Suppl 1): S28-S37.
[11] American Society for Clinical Pathology. https://www.ascp.org/content/docs/default-source/get-involved-pdfs/istp-ckd/ckd-infographics.pdf
[12] Inker, L.A., et al., KDOQI US commentary on the 2012 KDIGO clinical practice guideline for the evaluation and management of CKD. American Journal of Kidney Diseases. 2014; 63(5): 713-35
[13] American Diabetes Association Indications for Statins in Diabetes Roy Eldor, Itamar Raz Diabetes Care Nov 2009, 32 (suppl 2) S384-S391; DOI: 10.2337/dc09-S345
[14] Hypertension - 1. Lee JH, Kim SH, Kang SH, et al. Blood Pressure Control and Cardiovascular Outcomes: Real-world Implications of the 2017 ACC/AHA Hypertension Guideline. Sci Rep. 2018;8(1):13155. Published 2018 Sep 3. doi:10.1038/s41598-018-31549-5
[15] Well child 1 - Impact of Implementing Developmental Screening at 12 and 24 Months in a Pediatric Practice Hollie Hix-Small, Kevin Marks, Jane Squires, Robert Nickel Pediatrics Aug 2007, 120 (2) 381-389; DOI: 10.1542/peds.2006-3583
[16] Guevara JP, Gerdes M, Localio R, Huang YV, Pinto-Martin J, Minkovitz CS, Hsu D, Kyriakou L, Baglivo S, Kavanagh J, Pati S. Effectiveness of developmental screening in an urban setting. Pediatrics. 2013 Jan;131(1):30-7. doi: 10.1542/peds.2012-0765. Epub 2012 Dec 17. PMID: 23248223.

[17] Schonwald A, Huntington N, Chan E, Risko W, Bridgemohan C. Routine developmental screening implemented in urban primary care settings: more evidence of feasibility and effectiveness. Pediatrics. 2009 Feb;123(2):660-8. doi: 10.1542/peds.2007-2798. PMID: 19171635.
[18] Sege RD, Amaya-Jackson L, AAP AMERICAN ACADEMY OF PEDIATRICS Committee on Child Abuse and Neglect, Council on Foster Care, Adoption, and Kinship Care; AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY Committee on Child Maltreatment and Violence; NATIONAL CENTER FOR CHILD TRAUMATIC STRESS. Clinical Considerations Related to the Behavioral Manifestations of Child Maltreatment. Pediatrics. 2017;139(4):e20170100
[19] Schwarzenberg SJ, Georgieff MK, AAP COMMITTEE ON NUTRITION. Advocacy for Improving Nutrition in the First 1000 Days To Support Childhood Development and Adult Health. Pediatrics. 2018;141(2):e20173716
[20] Earls MF, Yogman MW, Mattson G, et al; AAP Committee on Psychosocial Aspects of Child and Family Health. Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. Pediatrics.2019;143(1):e20183259
[21] Sequist TD, Schneider EC, Anastario M, et al. Quality monitoring of physicians: Linking patients' experiences of care to clinical quality and outcomes. J Gen Intern Med 2008;23(11):1784–90.
[22] DiMatteo, MR. Enhancing patient adherence to medical recommendations. JAMA 1994;271(1):79-83.
[23] Zolnierek KB, Dimatteo MR. Physician communication and patient adherence to treatment: A meta-analysis. Med Care 2009;47(8):826-834.
[24] Safran DG, Taira DA, Rogers WH, et al. Linking primary care performance to outcomes of care. J Fam Pract 1998;47(3):213-20.
[25] Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: effects on patient outcomes. Ann Intern Med 1985;102(4):520-8.
[26] Stewart MA. Effective physician-patient communication and health outcomes: A review. CMAJ 1995;152(9):1423-33.
[27] Sanghavi Pr, et al. Association of Low-Value Care Exposure With Health Care Experience Ratings Among Patient Panels, JAMA Intern Med. 2021;181(7):941-948