Physician Quality & Patient Safety Fact Sheet and Roadmap

HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE
A Division of the UCF College of Medicine

Goals

- Increase the use of clinical quality measures (CQMs) to drive improvements in physician quality and patient safety
- Maximize Electronic Health Record (EHR) technology through use of trackable and reportable quality measures
- Establish targets and benchmarks (e.g. Merit-based Incentive Payment System Quality Measure Benchmarks) to evaluate improvement efforts and outcomes routinely
- Increase value-based reimbursement through improved performance on quality measures
- Use evidence-based practices to address and reduce health disparities relating to patient safety and physician quality
- Ensure patient safety through quality metrics that reflect meaningful outcomes

CQMs

- *Quality ID #374: Closing the Referral Loop: Receipt of Specialist Report
  - Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred
- *Quality ID #130 (NQF 0419): Documentation of Current Medications in the Medical Record
  - Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter
  - This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration
- *Quality ID #154 (NQF 0101): Falls: Risk Assessment
  - Percentage of patients aged 65 years and older with a history of falls that had a risk assessment for falls completed within 12 months
- Quality ID #46 (NQF 0097): Medication Reconciliation Post-Discharge
  - The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years of age and older seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record
- ACO-38: All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions

**Are also Electronic Clinical Quality Measures (eCQMs)*

Documentation

- Review all medications at each visit
- Ask patients about ER visits and visits to specialists and have a process for requesting discharge summaries, care plans, etc. from the facility or provider and incorporate these into the patient record
- Ensure data required for quality measure reporting is being entered according to the EHR's workflow
- Review your payer-related quality programs for any additional required documentation

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Optimizing

- Review clinical practice workflows
- Utilize panel tools (i.e. CDS alerts, secure/direct messaging, medication reconciliation)
- Allow patients access to EHR data, clinician notes (i.e. patient portal)
- Ensure quality dashboards (MIPS/MU) are working properly
- Capability to access and interpret clinical quality measure reports
- Evaluate claims submission process for accuracy
- Optimize use of your EHR and health IT to meet quality measures thresholds

Population Health

- Share clinical information with registries (e.g. FL Shots, E-FORCSE, FL Cancer Registry) to enhance care coordination and improve patient safety
- Assess social context (i.e. food insecurities, housing stability, and financial barriers) and apply that information to treatment decisions
- Adopt a patient-centered communication style that includes patient preferences, assesses health literacy, and addresses cultural barriers affecting patient care and safety

Managing Disparities

- Identify or develop community resources to support healthy lifestyles
- Refer patients to local community resources when available
- Develop or offer educational programs and materials in multiple languages
- Utilize health IT (EHR) to outreach to vulnerable populations needing preventative care services

Provider Tips

- Identify your high-risk patients
- Use shared decision-making tools to create a patient-centered care management plan
- Optimize patient visits (preventive care visits)
- Provide education and counseling
- Encourage family and caregiver engagement
- Establish a case management program
- Avoid unspecified diagnosis codes
- Organize your practice for efficiency
- Educate your patients about available programs within health system or in the community
- Establish strong, team-based care to improve quality scores and patient safety

Coding Considerations

- Use Z codes to capture social determinants of health, including codes for underdosing medication due to financial hardship
- Review codes needed for the numerator and denominator of the selected quality measures

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Federal & State Initiatives

- CMS Quality Payment Program (MACRA)
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
- NCQA Quality Measurement - HEDIS
- NCQA Patient-Centered Medical Home (PCMH)
- Florida Medicaid Incentive Program - Promoting Interoperability (formally Meaningful Use)
- Accountable Care Organizations (ACOs)
  - Medicare Shared Savings Program

Resources

- CMS Quality Payment Program (QPP) – https://qpp.cms.gov/mips/overview
- Florida Medicaid Incentive Program – https://ahca.myflorida.com/Medicaid/EHR/contact.shtml
- NCQA Quality Measurement HEDIS – https://www.ncqa.org/hedis/
- Agency for Healthcare Research and Quality (AHRQ) Quality and Patient Safety Resources – https://www.ahrq.gov/patient-safety/resources/index.html