Best Practices for EMR Configuration: Meeting New Quality Requirements

Fourth Edition (2022)

Introduction

In 2019, the California Department of Health Care Services (DHCS) initiated many changes to its quality measurement and quality oversight processes for MediCal Managed Care Plans. Many of these changes require changes in the way information is captured, processed and reported by our primary care provider network.

In 2020 and 2021, DHCS introduced required codes for use for coding for Social Determinants of Health and DHCS started placing more emphasis on pediatric measures outside the Managed Care Accountability Set (MCAS). NCQA has made few changes to the HEDIS measures in 2021.

By mid-2022, DHCS released an updated Comprehensive Quality Strategy, a Population Health Management Framework, and updated requirements related to Health Equity.

While many details of these new measures may be found in the Primary Care Provider Quality Incentive Program (PCP QIP) specifications, and in various state documents, they are not brought together in a way that targets those who configure PCP electronic health systems. This document is targeted to the needs of this group. This document was updated in August 2022 to reflect these changes.

This document was created with input and advice from an advisory group with experience in using the three electronic health record systems with the greatest footprint in the Partnership the committee members for their contributions.

Any questions or feedback on this document can be directed to Robert Moore, MD, rmoore@partnershiphp.org

Organization of Recommendations

The 45 individual recommendations are divided up as follows:

1. Changes for 2022. (10) This summarizes changes and priorities for 2021.
2. Top Ten Configuration Recommendations for All PCPs. (10) These are either part of the PCP QIP or have other financial implications for the PCP.
3. Additional Recommended Configuration Options (3)
4. Recommended Alerts and Workflows. (6) These are more general recommended best practices for improving quality of care. The target interventions each can potentially improve one or more quality measures which have financial implications.
5. Recommended Templates and Order Sets: (6) The first four relate to measures which have financial implications. The last two are best practices related to supporting patients with substance use disorder

6. Miscellaneous EMR and Billing Configuration Recommendations (10): Additional recommendations not covered above.
7. Appendix A: Template for screening for medical clearance for admission to Alcohol Use Disorder Detox or Treatment program.

The following color coded key is used to direct attention to additional categorizations of recommendations.

Key:

Type of Provider: L-large providers; P-PPS providers; All-All providers; NP-Non-pps providers

Type of Best Practice: T- Template, B- Billing, Ph- Pharmacy, A- Alert, R- Reporting, E- Education of providers, H- HIE, O- Other

Changes for 2021

1. Addressing Health Inequities. **O** Over the next several years, DHCS has asked providers and health plans to measure health inequities and work to close inequities. Initial focus should be looking for health outcome/clinical measure disparities by race/ethnicity and gender. In future years, as better SOGI data is available, this may be added.

   We recommend you start exploring for inequities in your own organization by using either the reporting capability built into your EMR or your data reporting tool to look for disparities in the following measures of focus:

   NCQA Equity Measures:
   a. Colorectal cancer screening
   b. Controlling Blood Pressure
   c. HbA1c control for those with DM
   d. Prenatal and Postpartum care (two measures)
   e. Child and adolescent well child visits

   DCHS additions

   f. Childhood immunizations (CIS-10)
   g. Adolescent immunizations (IMA)
   h. FU after ED visit for MH or SUD (two measures)
   i. Depression screening and follow up for adolescents and adults (two measures- See ECDS measures below)

2. Population Health Management Analytics Needs. **O** Certain clinical measures can only be fully captured by extracting structured data from the electronic health record that is not captured by ICD10 or CPT/HCPCS codes. Attempts to automatically generate CPT/HCPCS codes based on services provided have a number of drawbacks.

Health plans are expected to collect this data from extracted data from the PCP's EMR. In our pilot years, certain data fields for Electronic Clinical Data Systems (ECDS) measures are being requested as a report extracted from the EMR database and sent to PHC for ingestion. Looking into the future, DHCS has a goal for PCPs to have a Population Health Platform, with a variety of functionality, but in particular with the ability to generate rates at the PCP level for ECDS measures. Conveniently, once such population health platforms are available, they more easily produce the data needed by health plans, and thus interfaces will enable us to move past sharing abstracted date files through SFTP sites. We encourage PCPs to look into such population health management tools but ensure they capture depression screening, pregnancy gestation, and substance use screening and treatment options.

One implication: whether you are using Pop Health system or some kind of reporting tool, a best practice is to be able to ingest the value set changes each year instead of having to recode or manually compare the new value set with the old value set.

3. Asthma Controller Medications: All, Ph Several new medications were added to the Asthma Controller medication list, section 8, below.

4. Value Based Purchasing: Most were discontinued this year, so recommendations related to these were removed. The measures that remain are developmental screening, ACEs screening and contraception.

5. Remote Patient Monitoring. All, B, HIE Coverage of remote patient monitoring began in July, 2021. Here are the codes that may be used, and may be built into templates related to RPM.

CPT 99453	Initial set-up & patient education on equipment (one-time fee).
CPT 99454	Supply of devices, collection, transmission, and report/ summary of services to the clinician.
CPT 99457	Remote physiologic monitoring services by clinical staff/MD/ QHCP first 20 cumulative minutes of RPM services over a 30-day period.

CPT 99458	Remote physiologic monitoring services by clinical staff/MD/ QHCP for an additional cumulative 20 minutes of RPM services over a 30-day period.
CPT 99091	Collection and interpretation of data by physician or QHCP, 30 minutes.

A few providers in our network have tried to integrate remote monitoring of blood pressure or blood sugar into their office flow, with suboptimal results or with positive results that are not easily scalable. We encourage practices to evaluate options and test some now. This will likely become the standard in years to come.

Major options for workflow include:

a. Vendor monitors patients and intervenes directly, letting provider know what they are doing afterwards, with variable amounts of granular detail.
b. Vendor monitors patients and sends data to the provider who evaluates the results and makes adjustments if needed.
c. Patient monitors home results, and saves on smart phone or paper, making adjustments as needed based on instructions, and communicating with providers by phone, video or in person when needed.

6. MediCalRx Covered BP monitors: In June 2022, MediCalRx began covering certain specified BP monitors through community pharmacies. Medi-Cal Rx covers 1 monitoring device every 5 years and 1 cuff every 365 days. Covered products are restricted to the Medi-Cal Rx *List of Covered Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs*. Click here for a summary of what is covered.
TARs will not be accepted for products not on the Medi-Cal Rx list. Covered items include standard blood pressure monitors, monitors with talking functions, and monitors with Bluetooth connectivity and remote patient monitoring capabilities. Please refer to the Medi-Cal Rx Covered Product Lists https://medi-calrx.dhcs.ca.gov/provider/forms/ for additional information.

   Additionally, we recommend you configure your electronic health record prescription list to include devices that will be covered and carried. For convenience, we recommend a generic phrase like: “BP Monitor-Large Cuff” and let the pharmacy see what they have in stock that MediCal will cover and dispensing that. An exception: if you want a specific connected device you will want to specify the device exactly. You may be limited by your e-prescription transmission requirements for an NDC code.

We recognize that some pharmacies do not carry BP monitors covered by MediCalRx. For that reason, we are keeping our Medical Equipment Distribution Program active (see next item).

7. Partnership Medical Equipment Program Updates. To respond to the Medi-Cal CarveOut, Medical Equipment currently available in pharmacies is not available directly from PHC. This includes BP monitors and cuffs, humidifier, vaporizer, nebulizer, pulse oximeters, scales, thermometer, and prescription lock boxes. To request equipment, providers are required to review the Medical Equipment Distribution guidelines, complete the request form, and submit the completed form to PHC.
    a. Best Practice: Integrate the fillable form into your EMR. One best practice in ECW: make the form into a letter, tagged with data fields. The provider then checks what they want and click send (which faxes). We hope to automate this process in 2023, but the current process will remain until then.
8. CAIR de-duplication All, HIE, E Currently, about 10% of the time, vaccine data entered into a vaccine profile is not accurately linked to a patient record in CAIR that is recognized as having Medi-Cal. To remedy this:
    a. If a patient CAIR profile is found that doesn't match, due to the name being different from that on the MediCal card, or a DOB not matching, etc., please have your Medical Assistant fix the demographics in CAIR to make it match the Medi-Cal enrollment information.
    b. If the patient has proof of prior vaccination and the data is not in the EMR or CAIR, enter the information on vaccination into the EMR and into CAIR.
9. NCQA HEDIS changes All, E, T
    a. Advance Care Planning (new MediCare HEDIS measure) requires administrative capture of Advance care planning conversations for those age 66 and older with advanced illness. Here are the codes they are looking for:

99483		CPT
99497		CPT
1123F	Advance Care Planning discussed and documented advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)	CPT-CAT-II
1124F	Advance Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)	CPT-CAT-II
1157F	Advance care plan or similar legal document present in the medical record (COA)	CPT-CAT-II
1158F	Advance care planning discussion documented in the medical record (COA)	CPT-CAT-II

S0257	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service) (S0257)	HCPCS
Z66	[Z66] Do not resuscitate	ICD10CM

There are a number of SNOWMED codes as well, but most EMRs are not set up for those yet. Check with us at PHC if you need those.

POLST going to become electronic with implementation of a POLST registry in California in the next few year. EMR vendors will need to incorporate new national standards (from the Federal Office of the National Coordinator of HIE) which are based on the National POLST form. The ability to add state POLST requirements that are in addition to the national POLST form will need to be programmed as well.

The final specifications and the implementation guide are now available: *HL7 CDA® R2 Implementation Guide: ePOLST: Portable Medical Orders About Resuscitation and Initial Treatment, Release 1 - US Realm* is published by HL7. You can find the implementation guide at http://www.hl7.org/implement/standards/product_brief.cfm?product_id=600

EMR vendors will want to begin their planning in early 2023.

10. New Dementia Screening Requirements **All**, **T, E**

Pursuant to SB 48, MediCal added a CPT2 code for Dementia Screening for adults over age 65 not covered by MediCare: 1494F. The reimbursement rate is pending at the time of this white paper being published.

Only clinicians who have completed the training on www.dementiacareaware.org are eligible to be reimbursed. The mechanism for sending names of those who have completed the training to health plans has not been operationalized at the time of this white paper being published.

DHCS lists several options for screening tests eligible for reimbursement. Many electronic health records systems already have a Mini Mental Status Exam (MMSE) built into their EMR. This test takes about 10-15 minutes to complete. One of the shortest screening tests is the Mini-Cog, which requires only about 3 minutes to complete. This is a good option to add as a screening tool in your EMR if it is not already present.

CMS requires MediCare patients to have a screening test for dementia as part of the annual MediCare physical. Thus, a screening test for dementia should be part of your health maintenance visits for patients aged 65 and older. The 1494F code may only be paid for Medi Cal members age 65 and older without MediCare coverage.

Top 10 Configuration Recommendations for All PCPs

1. ELECTRONIC CLINICAL DATA SYSTEM (ECDS) MEASURES. **HIE, T** NCQA has a long term plan to capture granular data from within electronic health records directly, instead of relying exclusively on claims data. This will improve the accuracy and usefulness of affected clinical quality measures. PHC has developed a package of specifications for generating and transmitting files for the following measures (part of the PCP and Perinatal QIPs)
    1. Depression Screening and Follow Up
    2. Breast Cancer Screening
    3. Follow up for Attention Deficit Disorder
    4. Screening for Alcohol Misuse

    Full specifications for generating reports on these ECDS measures are available on the eReports part of the PHC website. Here are some configuration considerations:

    Depression Screening: The PHQ-2 and PHQ-9 can be used for all depression screening measures (with a modified version for adolescents called the PHQ-A). Other screening tools may be used for one of the depression screening measures, but they will not scale to other measures. **Most important is to capture the actual score associated with a PHQ2 or PHQ9 as a discrete field that can be extracted from the electronic health record, along with the interpretation (positive or negative) of this numerical result.** If a warm handoff is used in your practice for those who screen positive, you will need to keep track of the codes used for this warm handoff to set up the future QIP measure.

    Alcohol Use Screening: The two most common screening tests are the **single question screen and the AUDIT-C. Ensuring that the numerical value of the AUDIT-C the interpretation of this result are in discrete fields will position the EMR well for the ECDS programming.**

2. WELL CHILD TEMPLATES: NOTE ELEMENTS
    a. All, T: Ensure all well-child templates follow the American Academy of Pediatrics standards as documented in the Bright Futures website. Specific elements of the DHCS Medical Record Review that are commonly missing are listed below. Templates should be double checked on these factors.
        i. All ages: Documentation of education on physical activity and healthy diet (restored HEDIS measure in 2020). This should be customized to be age appropriate for each template.
        ii. Newborns: documentation of review of newborn screening results
        iii. Two Blood lead test results between ages 1 and 3. Larger health centers may consider obtaining lead tests at the point of care to increase screening rates. If lead testing is done in the office, tests must be billed with the CPT code 83655. Lead screening is a PCP QIP unit of service measure for 2022.

In addition, children should receive an educational handout about lead exposure and risks from ages 6 months to 5 years of age, and clinicians should screen for risk of lead exposure at all well-child visits in this age range. For a detailed presentation on this topic, see the PHC webinar or review the presentation materials on our website. Finally, DHCS policy and State Law now require that parents who refuse lead screening have a written refusal documented in the medical record. PHC will be auditing for the presence of these forms at periodic medical record reviews. Options:

1. Saved as a scanned document.
2. Sign electronically
3. Consider decision support tag: if refuses lead screening: sign form
4. Put into well child template/order sets (see below)

iv. Fluoride varnish application to teeth at the time of the well child visit (age 9 months to 5 years). This must be linked to use of CPT code 99188.

v. Screening for tobacco use and vaping, for well-child visits aged 12 and above. This should be linked to the CPT II code: 4004F. In practice this should be a screening for both tobacco and non-tobacco nicotine delivery devices (vaping), with appropriate counseling and referral afterwards but CPT codes only exist for tobacco use screening/counseling referral. This measure was added to the 2022 PCP QIP as a unit of service measure.

Of the many codes that could be used for tobacco screening, DHCS has selected four for tracking this: 99406, 99407, 4004F and 1036F. The .25 modifier is needed when 99406 or 99407 are provided in the same visit that an E&M code is used.

99406.25: Smoking and tobacco use cessation counseling visit: 3-10 min
99407.25: Smoking and tobacco use cessation counseling visit: >10 min
4004F: Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy or both) if identified as a tobacco user
1036F: Current tobacco non-user.
Of these 4 codes, the 4004F is the most appropriate for use in a typical well child visit, starting at age 12 and in adults well adult template or MA template.

vi. Lipid screening (at least once after age 8)
vii. Screening questions for risk of TB (all ages)
viii. Skin cancer behavioral counselling starting at age 6 months.
ix. Blood pressure screening starting at age 3.
x. Prescription of Fluoride vitamin supplement (if living in location with non-fluoridated water).
xi. Dental flouride varnish, done at the time of well child visits from tooth eruption (around 9 months well-child visit) to 5 years of age. This must be linked to use of CPT code 99188. If routinely done, consider in template; otherwise in

order set. This measure was added to 2022 PCP QIP as a unit of service measure.

xii. Documented referral or recommendation for routine dental hygiene care (every visit, starting at age 6 months).

3. ACUTE VISIT TO WELL VISIT CONVERSION TEMPLATE

   All, T: Template for converting office visit to health maintenance visit. Epic: option 1: change visit type (front office), option 2: "dot phrase" or merge template which brings in entire well child template. Option 3: "dot phrase" or merge template which brings in an abbreviated template of factors that are part of a well-child template, but typically missing in an acute visit template:

   i. Age appropriate Physical developmental history
   ii. Age appropriate Mental developmental history
   iii. Age appropriate Anticipatory Guidance; common options for routine anticipatory guidance to add:
      1. Most ideal: Conducting the age appropriate Staying Healthy Assessment and counseling on findings (and documenting in chart)
      2. Documenting assessment of diet, weight and physical activity and counselling about physical activity and diet at every visit.
      3. Conducting other screening such as PRAPARE or PEARLS, again with actions taken depending on finding.
   iv. Review of vaccination status with ordering of age appropriate immunizations
   v. Add ICD10 code for well child visit: Z00.121 for children over 28 days old. (Since child is coming in with other problem, Z00.122 would not be appropriate for an add-on code to an acute visit. Children with acute problems in first 28 days of life should have the visit completely converted to a well-child visit, which uses different codes.)
   vi. Use CPT code for well child templates for this converted visit. (see next item)

4. WELL CHILD TEMPLATES: BILLING CODES

   b. All, T: Ensure that all well child templates are linked to the age appropriate CPT code for preventive child visits (99381-99385 and 99391-99395).

   c. If these visits were conducted virtually, the .95 modifier must be added to the CPT code. This is no longer considered acceptable by PHC, DHCS or AAP, but virtual well child visits would count towards HEDIS/QIP numerator rates.

5. TOBACCO USE SCREENING

   NP, T: For Prop 56 VBP, one of the following CPT codes should be associated with tobacco use/nicotine use screening templates: 99406, 99407, G0436, G0437, 4004F, or 1036F. The **4004F code would be the best** to associate with well person visits or (if smoking is assessed at every visit) with other office visit templates.

6. HYSTERECTOMY DOCUMENTATION

   All, O: Change default choices for documenting a surgical history of hysterectomy to include the specific options needed to satisfy HEDIS denominator exclusion.

   i. Not acceptable: "Hysterectomy"

ii. Acceptable: Total hysterectomy, Total Abdominal Hysterectomy (TAH), Total Vaginal Hysterectomy (TVH), Total Abdominal Hysterectomy with salpingo-oophorectomy (TAH-BSO), Radical Hysterectomy
iii. Acceptable for medical record documentation, but will not allow patient to be excluded from cervical cancer screening denominator: Supracervical (sometimes called "sub-total") Hysterectomy, Supracervical Abdominal Hysterectomy (SAH)

7. GC/CHLAMYDIA SCREENING

All, T: all women up to age 24 receiving cervical cancer screening or birth control should be tested annually for Chlamydia and Gonorrhea (GC). (Although only Chlamydia is in the HEDIS measure, USPSTF and the CDC recommend concurrent testing for GC, as the incidence is increasing). This can be done at the same time as cervical cancer screening, or can be done via a urine DNA amplification test if a cervical exam is not indicated. Family planning templates and well women templates should include these tests as defaults (under age 25) or as options (age 25 and older).

8. ASTHMA MEDICATIONS **(2022 Changes in Bold)**

All, Ph: EMR medication defaults for AMR measure: controllers 3 months at a time with 3 refills; rescue one RX with one refill. Here is a current list of controller and rescue inhalers:

i. Inhaled Rescue Medications (Default in system: one device with one refill)
    1. Albuterol HFA (Ventolin, ProAir, Proventil) and Nebulizer
    2. Albuterol breath activated (ProAir RespiClick)
    3. Levalbuterol HFA and Nebulizer (Xopenex)

ii. Controller medications: (Default in system: 3 month supply with 3 refills)
    1. Oral Controllers
        a. Montelukast (Singulair)
        b. Zafirlukast (Accolate)*
        c. Ziluteon (Zyflo)*
        d. Theophylline (Theochron)
    2. Other Inhaled Controller Medications (Not counted as controller by NCQA)
        a. Cromolyn Nebulized Solution
        b. Budesonide Nebulizer
    3. Inhaled Corticosteroid Controller Medications
        a. Budesonide (Pulmicort Flexhaler)*
        b. Fluticasone Diskus and HFA (Flovent) or inhalation powder (Arnuity Ellipta)
        c. Beclomethasone Dipropionate (Qvar Redihaler)
        d. Flunisolide (Aerospan)
        e. Ciclisone (Alvesco)
        f. Mometonsone Furoate (Asmanex HFA and Twisthaler)
    4. Combination Medications (counts as controller)
        a. Fluticasone & Salmeterol (Advair Diskus, AirDuo RespiClick, Wixela Inhub)*
        b. Fluticasone & Vilanterol

c. Fluticasone, Umeclidinium, & Vilanterol (Trelegy Ellipta)
d. Mometsosone Furoate & Formoterol Fumarate Dihydrate (Dulera)
e. Budesonide & Fomoterol Fumarate dehydrate (Symbicort)*

5. Inhaled Anticholinergic Controller Medication
   a. Tiotropium (Spiriva Respimat)

iii. *Low-dose inhaled corticosteroid with formoterol combination products (Symbicort and Dulera) have an acceptable off-label use as a rescue medication *and* as a single maintenance and rescue therapy for ages 12 and older as supported by the 2021 Global Initiative for Asthma (GINA) report. Both products count as controller medications for the purposes of the AMR score calculation.

iv. *Medi-Cal Rx Restrictions:

- **Zileuton and Zafirlukast TAR required**
- **Pulmicort Flexhaler 90mcg strength is limited to 1 per 30 days**
- **Ciclesonide (Alvesco) TAR required**
- **Fluticasone propionate/Salmterol limited to brand name Advair Diskus/HFA only**
- **Budesonide/formoterol limited to brand name Symbicort only**

Note: the one exception of a medication FDA approved for asthma but left off the list is Serevent Diskus (salmeterol) as the single ingredient product is not recommended and it is preferred to be used in combination with ICS in a single inhaler.

v. Biologics for reference: (considered controllers for HEDIS AMR)

TAR required for Medi-Cal Rx and PHC medical benefit

- **Omalizumab (Xolair)**
- **Dupilumab (Dupixent)**
- **Benralizumab (Fasenra)**
- **Mepolizumab (Nucala)**
- **Reslizumab (Cinqair)**

9. DEVELOPMENTAL SCREENING
   d. All, T: Developmental screening: Ensure developmental screening (CPT code 96110) billing to templates for 9 month, 18 month, 2 year old well child visits. Several screening acceptable:
      i. Ages and Stages Questionnaire (ASQ or ASQ-3) is most widely used
      ii. Other options can be found in the CMS specifications for this measure. Effective January 1, 2020, CPT code 96110 may only be used to bill one of the nine measures in these specifications, for children under age 3.
      iii. The M-CHAT (which only screens for autism) and the ASQ-SE (socio-emotional) are NOT acceptable for the incentive payment. If your clinical team decides to continue to use the MCHAT for screening for autism, it may

be billed as 96110.KX, which will be paid as a fee for service, but not be eligible for the incentive payment. If your EMR templates use either of these measures, we recommend adding the ASQ or ASQ-3, as well for more comprehensive screening, where 96110 can be used.

iv. Rate: $59.50 allowed; paid via claim (may consider setting rate 20% higher so don't have to change with Medi-Cal rate changes)

10. SCREENING FOR ALCOHOL AND DRUGS. All, B DHCS has asked PHC to add two codes for coverage of drug and alcohol screening (of note SBIRT for adults for drug misuse was added as a USPSTF class B recommendation in 2020).
    a. New codes:
        i. H0049: To be used for Drug use screening with valid tool (for example DAST-20 or the NM-ASSIST or TAPS or NIDA or 4Ps)
        ii. H0050: To be used for either Drug and/or Alcohol misuse counseling, for each 15 minute period of time
    b. Continue to use this code:
        i. G0042: Alcohol misuse screening
    c. Do not use this code:
        i. G0043: Brief intervention for alcohol misuse (switch to H0050)

    Of note, other payers, like MediCare may have different rules on the use of these codes, so you may need to make payer-specific templates for these.
    You will want to be sure a validated tool for screening for drug and alcohol misuse is build into your EMR, capturing results as structured data.

Additional configuration options for capturing hybrid measure quality data (Required for MediCare MIPS, but can be captured for HEDIS as well).

I. BLOOD PRESSURE CONTROL
    a. NP, B&E: Prop 56 VBP for blood pressure control requires documentation of control using CPT-2 codes (also require for MediCare supplemental payments).
        i. Controlled Systolic:
            – CPT 3074F (systolic blood pressure less than 130)
            – CPT 3075F (systolic blood pressure less than 130-39)
        ii. Controlled Diastolic:
            – CPT 3078F (diastolic blood pressure less than 80)
            – CPT 3079F (diastolic blood pressure less than 80-89)

        Hypertension must be documented using the ICD-10 code: I10 (essential hypertension) to count

II. DIABETES CONTROL:

a. NP, B&E: For the Prop 56 Value Based Payment measure for diabetes control, the results of the most recent Glycohemoglobin (HBA1c) must be documented in the claim using the following CPT-2 codes:
    i. CPT 3044F most recent HbA1c < 7.0%
    ii. CPT 3045F most recent HbA1c 7.0-9.0%
    iii. CPT 3046F most recent HbA1c > 9.0%

III. DEPRESSION SCREENING
a. NP, T &E: For Prop 56 VBP, one of the following codes should be submitted in a claim to document screening:
    i. G8431 – Positive screen with plan
    ii. G8510 – Negative screen

Recommended Alerts and Workflows

I. PREVENTIVE REMINDERS
a. All, A: Develop system to push out preventive gaps whenever a chart is opened. As an example, this is called the Care Gap list in OCHIN EPIC.

II. BLOOD PRESSURE CONTROL
a. All, A: Elevated Blood pressures documented at visits by medical assistants are commonly ignored by the clinician: they are not repeated and not addressed in the assessment or plan. Consider if any configuration or audit mechanism is available for one or more of the following:
    i. Alerting the provider and MA at the time of the visit (highlighting the abnormal blood pressure)
    ii. Forcing selection of a diagnosis when the measure is elevated, either bringing over HTN from the problem list or selecting “elevated blood pressure” as an ICD10 diagnosis, requiring explanation.
    iii. Generating a weekly report of elevated blood pressures for staff to follow up on, with a nurse or pharmacy-only visit, for example.
    iv. Quality measure of repeat blood pressure done when initial BP out of range.

III. WELL CHILD VISITS
a. All, A: Alert systems for well child visits starting at age 2 or 3, for annual well child visits, starting alerts about 9 months after the last visit. Note that here is no minimum interval for well child visits from a billing or HEDIS perspective for PHC Members; State MediCal (which may still require the old PM160 form) still follows the old minimal intervals established by CHDP. Thus the time to the next visit may vary, depending if the child has PHC or state Medi-Cal; education of providers may be needed.

IV. CHILD IMMUNIZATION
a. All, E: Ensure a robust system for having vaccines for adults and children given outside the clinic setting are entered into the patient record as structured data (not merely scanned) and that they are also entered into CAIR.

b. **Note than annual influenza vaccination is often the driver of low vaccination rates. Ensure that you have mechanisms for tracking and encouraging that.**

V. ADULT IMMUNIZATION
   a. All, A: Since children older than age 6 months and adults require annual flu vaccination, set up an alert system to remind all staff (front office, medical assistants and providers that a patient has not yet had an annual flu vaccination, starting when influenza vaccines arrive in mid-September, through the end of March.

VI. CERVICAL CANCER SCREENING
   a. All, A: Set up reminders for front office staff, medical assistants and clinicians if cervical cancer screening is due, to offer patients option to do the screening while they are there (separate from a well woman exam), instead of risking a no show for a well woman exam in the future.

Additional Recommended Templates and Order Sets

I. SCREENING FOR PSYCHOLOGICAL TRAUMA
   a. All, T: Template for PEARLS and ACES.
      i. Two codes: Probably need to conduct screening before visit an select a template based on the results (a bit like PHQ2 screening).
         1. G9919 for positive screen and provision of recommendations (score 4 or greater)
         2. G9920 for screening performed and results negative (score 0-3)
         3. Set rate for these at least at $29 as this may turn out to be paid via claims, but this is not certain. It may be prudent to build in a rate about 20% higher to lessen changes of changes to Medi-Cal rates.
         4. Adults age 18 to 65: Build questionnaire with scoring capability into EMR. Use original ACEs tool: frequency of screening once in a lifetime with any given provider (configure alerts/reminders similar to other once in a lifetime tests: (Hep C, HIV)
         5. Children: Build questionnaire with scoring capability within EMR. Frequency rules: screen up to once every year with PEARLS tool, which includes a few questions on social determinants of health, so overlaps a little with the Staying Healthy Assessment and PRAPARE. We recommend it be added to the templates for well child visits for age 12 month, 24 months, and each annual visit from age 3-19.

II. POSTPARTUM VISITS
   a. All, T: Postpartum visits: Now that ACOG, DHCS and PHC recommend two post-partum visits (one between 7 and 21 days and one 21 days to 84 days after delivery). Consider having two slightly different post-partum templates (one early and one late). Both should use the ICD10 code for a postpartum visit: (Z39.2).
      i. We recommend review of the HEDIS specifications for what must be included in a postpartum visit for it to count; note that NCQA/HEDIS only require one postpartum visit, so the minimum specification for this visit must be in both postpartum template.

ii. In particular, HEDIS requires reference to abdominal exam, which is not required by ACOG. One minimum option for documenting abdominal exam: three choices: normal /abnormal/ not clinically indicated.
iii. All postpartum notes should address family planning, lactation status, and include depression screening.
iv. If the postpartum visit is conducted virtually, the .95 modifier should be used.

III. WELL-CHILD VISIT (ASTHMA)
a. All, T: Since visits for asthma alone are infrequent, ask at every well child visit if the child has asthma. If the answer is yes, merge an asthma template with the well child visit.

IV. ASTHMA ORDER SET
a. All, T: Adapt Asthma Order Set to align with Asthma Medication Ratio best practices. Set up alerts for patients with asthma. Embed provider best practice summary into chart (best practice alert), triggered by medication or diagnosis.

V. MEDICATION ASSISTED THERAPY
a. All, T & B: Create a template for a clinician Medication Assisted Therapy visit (for *opioid* MAT) attached to the Dx Code: F1**1**.2x, which allows the visit to be paid fee for service, even if the patient is not assigned as a primary care patient. If a similar arrangement is in place for conducting physical exams for clearance for *alcohol* detox or initiation of home detox, a template with the code F1**0**.2x would be used to pay fee for service even if the patient is not assigned as a primary care patient.

VI. ELEMENTS OF TEMPLATE FOR CLEARANCE FOR ALCOHOL WITHDRAWAL MANAGEMENT
a. All, T &E: See Appendix A for example.

Miscellaneous EMR and Billing Configuration Recommendations.

I. L, O: Those who customize EHR for HEDIS: Buy the NCQA Specifications and Value Set. Note that if you are part of a health center consortium, they may have a mechanism for sharing these with their members. We recommend checking with them before independently purchasing the specifications.

II. All, O: Ensure all electronic signatures give the title of the person, for example: MD, RN, DO, DC, RN, MA, MFT, LCSW, PsychD etc. One method of doing this for some EMRs is to include the title as part of the last name, for example: Last name: "Smith RN"

III. REFERRAL TRACKING
a. All, O: Set up referral tracking in the EMR to include the following:
i. Referral status (for each referral)
1. Specialty of specialist ordered by clinician
2. Referral ordered by clinician (include date)
3. Referral processed (information sent to specialists; on-line RAF completed if needed)-- Include date
4. Appointment made (include date)

5. Appointment confirmed to be completed (include date), no records received.
6. Appointment confirmed to be completed, records received from specialist (date of receipt of records/letter
7. Appointment canceled by patient, date and reason; list of reasons below
    a. Problem resolved
    b. Appointment rescheduled
    c. Loss of insurance coverage
    d. Lack of transportation
    e. Specialist canceled
8. Unable to schedule referral; date; list of reasons below:
    a. No specialist available
    b. Specialist refused referral

ii. EMR can generate summary report which consolidates the above information by insurance type of the patient.

IV. L, E: Special issue of elevated BP measured at a dental visit. HEDIS rules currently require the blood pressures measured in a dental office that shares an EMR with a medical practice be counted as a potential BP for purposes of control. In other words, blood pressures measured by a dental office are not excluded if they are integrated within an overall medical record shared with medical care. Since such patients are commonly anxious, the blood pressures may be higher than general for the patient. As this is discriminatory against integrated medical-dental practices, PHC is petitioning NCQA to change this. In the meantime, <u>if you have an integrated medical and dental record, consider an alternative way of documenting BP,</u> that will not integrate it with the blood pressures of the medical record.

V. All, O: Documenting BMI percentile in children: ensure your EMR <u>documents the BMI percentile as a number</u>, not just allowing access to a graph generated by the computer. Note: documenting a numerical value for BMI is a meaningful use measure.

VI. All, O: Ensure a system for capturing prior cervical cancer results allows capture of type of study done (with or without HPV), the month it was done and a summary of results. Results reported by patient and signed off on by a clinician are sufficient for HEDIS, although not for HRSA/UDS, which requires a copy of the actual report. Be sure your system can differentiate measurement for these two standards, or (as a best practice) set up the system to adhere to the more stringent specifications, to ensure both standards are met.

VII. All, E: Adjust refill protocol used by nurse/pharmacist, with no auto refills of rescue inhalers; additional action required.

VIII. **<u>Make Gender Identity/Sexual Orientation (SOGI) a core demographic field,</u>** All, O: which can be used for analysis of health care disparities. SOGI data collection is a UDS

requires reporting of health center populations by specified sexual orientation and gender identity categories. As a result, major EHRs include a location to capture this data. EPIC and ECW have SOGI button. This information may be collected by the front office as part of the registration process, or in the back office by clinicians. Best practice is to include the following:

i. Legal name (comes over from eligibility files)
ii. Preferred name
iii. Gender assigned at birth
iv. Legal gender (not ECW, not Next gen) (comes over from eligibility file)
v. Gender identity
vi. Pronoun preference (convention for ECW)
vii. Sexual orientation
viii. If transgender: surgical transition status (not ECW and Next gen)

IX. **Social Determinants of Health/ACES Codes.** All, T, B When the following are identified or updated in the social history, they should ideally automatically trigger population of the associated claim to add the associated ICD10 code (major EMR vendors working on this):

a. Ideally, the codes related to ACES be linked to ACES screening results but this is difficult because the details of the results of the individual screening questions are often not saved, just the final score of the screening tool.
b. DHCS list of codes:

Code	Description
Z55.0	Illiteracy and low-level literacy
Z59.0	Homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty (migration, social transplantation)
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.21	Child in welfare custody (non-parental family member, foster care)
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood

Z62.812	Personal history of neglect in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z62.820	Parent-biological child conflict
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

X. TELEPHONE AND VIDEO VISITS

e. All, B: Set up codes for billable telephone and video visits, which will count as visits for 2020 in the PCP QIP. These visits are between patients out of the office and clinicians typically in the office, and would be documented in your EMR.

f. Virtual visits: Since April 2020, through end of the public health emergency (final date likely at end of 2022), applies to phone and video visits, documented as progress notes. This seems likely to be extended after the PHE is over.
   i. Usual visit CPT codes used, with a .95 modifier to indicate that the visit was done virtually.
   ii. A new CPT code created in January 2022 for telephone only visits (.93 modifier) does not apply to most types of visits, in the official AMA specifications. Until further guidance, recommend sticking with the .95 modifier for now.

g. Minimal phone visits, not meeting standard for virtual visits: The codes depend on the provider type:
   i. For FQHCs and Rural Health Centers: G0071
   ii. For all other providers: G2012

Appendix A: Screening for medical clearance for admission to an alcohol use disorder detox or treatment program

Patient Name:_____ DOB:_____
MR#_____

Treatment program being considered

Facility Name: _____ASAM level: _____

KEY to ASAM Levels

1: Outpatient

2: Intensive outpatient

3: Residential

3.1 or 3.2: Residential with clinical supervision

3.7 or 4.0: Inpatient, medically supervised

History:

Alcohol/Drug/Psycho-active substance use in past week:

Drug name	Specific Name/Form	Recent use/day	Last Used
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Benzodiazepine(s)	_____	_____	_____
Marijuana	_____	_____	_____
Opioids	_____	_____	_____
Methamphetamine	_____	_____	_____
Cocaine	_____	_____	_____
Other	_____	_____	_____

Medical Risk factors that would affect the management of the withdrawal:

___pregnancy

___Chronic kidney failure

___Cirrhosis/liver insufficiency

___Angina requiring nitrates

___Class III or IV CHF

___Severe HTN (chronic, poorly controlled at baseline)

___Acute medical condition requiring inpatient treatment (e.g. sepsis, surgical problem)

Current Medications:

Medication Allergies:_____

Psychiatric History:

____Schizophrenia: Psychosis present?_____

____Bipolar disorder: Psychosis present?_____

Prior SUD treatment History:

History of _____ alcohol withdrawal delirium (give details)

History of _____ alcohol withdrawal seizure (give details)

Treatment Dates	Drug	Treatment Modality
_____	_____	_____

Social History:

____Unstable Housing status

Physical exam,

Vital signs: Weight, Height, Pulse, Respiration, Blood Pressure, O2 Saturation

Mental status exam: (See attachment)

Neuro exam:

____Gait

____Coordination

____Focal findings: _____

Depression screen: PHQ9 score: ____ Suicidal? _____

Examination directed on history:

Lab work:

CBC with differential,

CMP

Magnesium, Phosphorus

Blood alcohol level

Screen for other drugs in system

Qualitative HCG (urine or serum pregnancy test) if woman of reproductive age

If liver disease: PT/INR, Lipid profile or Cholesterol

If residential program: Quantiferon TB test or other TB screening test.

If not recorded previously, screening for HIV and Hep C is indicated for all adults

Imaging:

If cough: CXR to R/O TB/pneumonia: _____

If suspected head trauma or unexplained altered LOC: Head CT: _____

Modified CIWA scale[1] score _____

Assessment:

_____Acute Alcohol Intoxication

_____Chronic Alcohol use (Blood alcohol level: _____)

_____Alcohol Use Disorder

_____Other substance use: _____

_____ Alcohol Withdrawal: Low Risk (CIWA score less than 8)

_____ Alcohol Withdrawal: Medium Risk (CIWA-Ar score of 8 or lower, with the co-morbidities noted below, or a CIWA-Ar score of 9-15 without co-morbidities.)

_____ Alcohol Withdrawal: High Risk

[1] While the CIWA scale is intended for inpatient use, this is the tool specified by DHCS for assessing for potential hospitalization and for justification of inpatient hospitalization. Other options intended for outpatient screening are the Brief Alcohol Withdrawal Scale (BAWS), the Newcastle Alcohol Withdrawal Scale (AWS) and the Short Alcohol Withdrawal Scale (SAWS).

Co-morbidities:

_____

Plan:

_____Observe in Emergency Department

_____Admit to hospital

_____Medically stable for outpatient sobering (non-medically supervised)

_____Medically stable for medically supervised sobering

_____Medically stable for outpatient withdrawal management

Medication Regimens Options:

Moderate withdrawal symptoms and risk for serious withdrawal symptoms (C1WA score between 10 and 18). Maximum prescribed medication: sufficient for 4 days according to one of the following regimens; may direct to use extra doses earlier for severe symptoms, but refills should only be done after clinical re-evaluation.

1. Long acting benzodiazepine protocol (chlordiazepoxide; brand name Librium; best for normal liver function)
    a. Loading dose: 100 mg (give in ED), plus 15 tablets of 25 mg prescribed with these instructions:
    b. Day one: 50 mg every 6 to 12 hours
    c. Day two: 25 mg every 6 hours
    d. Day three: 25 mg twice a day
    e. Day four: 25 mg at night
2. Shorter acting benzodiazepine protocol (oxazepam; brand name Serax; best if impaired liver function as demonstrated by elevated PT)
    a. Loading dose: 30 mg (given in ED), plus 10 tablets of 30mg prescribed with these instructions:
    b. Day one: 30 mg every 6 hours
    c. Day two: 30 mg every 8 hours
    d. Day three: 30 mg every 12 hours
    e. Day four: 30 mg at night

Mild withdrawal symptoms-symptom triggered (for supervised settings).

1. If withdrawal symptoms are not present or are mild (C1WA score less than 10), then one of the following protocols applies:
    a. Non-benzodiazepine option: Gabapentin 300mg #28 tablets. 1 in the am, 1 mid-day, 2 at bedtime for 7 days.
    b. Long acting benzodiazepine protocol (chlordiazepoxide; brand name Librium; best for normal liver function) (15 tablets of 25 mg)

i. Day one: 50 mg every 6 to 12 hours as needed
ii. Days two to five: 25 mg every 6 hours as needed

c. Shorter acting benzodiazepine protocol (oxazepam; brand name Serax; best if impaired liver function as demonstrated by elevated PT) (15 tablets of 15mg)
i. Day one: 30 mg every 6 hours as needed
ii. Days two to five: 15 mg every 6 hours as needed

All patients who may experience withdrawal:

thiamine 100 mg for 3 days
multivitamins with minerals daily
ondansetron, 4mg PO or SL q4 hours prn nausea
loperamide 2mg: 1-2 prn loose stools
acetaminophen 500mg q 6 hr prn pain
hydroxyzine 25-50mg po q6 hrs. prn anxiety