NEW YORK STATE | Department of Health | Medicaid Redesign Team

Medical Record Review Overview Training

September 2015

Introduction - PCG

Team Roles and Responsibilities

- Project Management: Independent Assessor (PCG)
- Oversight: Office of Quality and Patient Safety (OQPS)
- Validation: IPRO
- Medical Record Abstraction & Reporting: Verisk

Today's Topics

- Overview of MRR purpose
- Validation Process and Quality Improvement
- Abstraction Process
- Q&A

Overview of Purpose

Office of Quality and Patient Safety

DSRIP Data Sources

- ✓ Implementation Plan Data (Domain 1)
- ✓ Medicaid Claims and Encounters
- ✓ C & G CAHPS Survey (Medicaid insured)
- ✓ C & G CAHPS Survey (uninsured population)
- ✓ Patient Activation Measure survey
- ✓ **Medical Records**
- ✓ Uniform Assessment System (UAS)
- ✓ Minimum Data Set (MDS)
- ✓ Hospital Data
- ✓ NYS Prevention Agenda (Domain 4)

(Domain 2 & 3)

Medical Record Review

Measures Obtained from Medical Record Data

1. Screening for Clinical Depression and Follow-Up
2. Controlling High Blood Pressure
3. Comprehensive Diabetes Care
   - Screening for all 3 tests (HbA1c test, Eye exam and Medical attention for nephropathy)
   - Poor Control (>9.0%) of HbA1c
4. Viral Load Suppression

5. Prenatal and Post Partum Care*
   - Timeliness of Prenatal Care
   - Postpartum Visits
6. Frequency of Ongoing Prenatal Care (81% or more)*

7. Childhood Immunization Status**
8. Lead Screening in Children**

** **Measures share the same sample*

Measure Relationship to Projects

Projects	Project Descriptions	Measures with Medical Record Data
3.a.i – 3.a.iv	Integration of primary care and BH services, BH community crisis stabilization, BH medication adherence programs in community settings, withdrawal management and enhanced abstinence services within community based addiction treatment programs	• Screening for Clinical Depression and Follow-Up
3.b.i – 3.b.ii, 3.h.i	Evidence-based strategies for cardiovascular management in target populations, community focused primary and secondary prevention programs for cardiovascular disease, specialized medical home for chronic renal failure	• Controlling High Blood Pressure
3.c.i – 3.c.ii, 3.h.i	Evidence-based strategies for diabetes management in target populations, community focused primary and secondary prevention programs for diabetes, specialized medical home for chronic renal failure	• Comprehensive Diabetes Care
3.e.i	Comprehensive strategy to decrease HIV/AIDS transmission with Center of Excellence for management of HIV/AIDS	• Viral Load Suppression
3.f.i	Increase support programs for maternal and child health, including high risk pregnancies	• Prenatal and Post Partum Care • Frequency of Ongoing Prenatal Care (81% or more) • Childhood Immunization Status • Lead Screening in Children

Cholesterol Management Measures

- *Cholesterol Management for Patients with CV Conditions* (project 3.b.i – 3.b.ii)

- Cholesterol (LDL-c) testing and control of the *Comprehensive* Diabetes Care (project 3.c.i – 3.c.ii, 3.h.i)

Retired / removed from Measurement Year 1

Replacement measures may be added to the projects in future measurement years.

Determining the Population & Creating the Random Sample

Sample Creation Steps
1. Develop and validate the members eligible for each specific measure for the measurement year, including: • review by HEDIS certified auditor • comparison of eligible members from Medicaid health plan files (where available) • comparison of results using OQPS program in Data Mart with program developed by Medicaid Data Warehouse (MDW) vendor
2. Determine eligible population for the measure
3. Link eligible members to the attributed PPS; reconcile each January
4. Generate a random systematic sample from PPS attributed members (453 total = 411 with 10% oversample), following the same method used for health plan QARR/HEDIS reporting
5. Create member and provider files • *Member file*: include information about the member and any qualifying numerator events • *Provider file*: include providers associated with relevant visits in the measurement year and dates of visits

Reconciliation of Attribution and Incorporation Into Final Result

Reconciliation Requirements
1. Validated data will be used by abstraction partner for the member detail file production.
2. Exclusion and numerator data from the member detail file will be incorporated with administrative data for numerators.
3. Member attribution will be refreshed, linking the member to the PPS using the January 2016 file reflecting attribution results for July 2014 to June 2015 claims and encounters. This aligns the attribution claim period with the measurement year.
4. Members attributed to the PPS will be aggregated into the PPS-specific result for the measurement year.

Training & Improvement Opportunities for PPS'

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Training & Improvement Opportunities for PPS'

Planning and preparation for managing medical record review in future years:

- ✓ Set up systems to coordinate requests/retrieval
- ✓ Plan staffing for abstraction
- ✓ Plan over read and coordinate the review process
- ✓ Establish data repository
- ✓ Understand validation requirements
- ✓ Produce member detail file

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Training & Improvement Opportunities for PPS'

Measure knowledge

- ✓ Understand measure definition technicalities and codes which will facilitate work with providers and systems
- ✓ Gain an understanding of where data may be lost
- ✓ Able to abstract and work with providers throughout the year to monitor quality as improvement projects are implemented

Training & Improvement Opportunities for PPS'

Identification of improvement opportunities and best practices

- ✓ Tools/training needs of providers
- ✓ Member outreach needs

Validation Process and Quality Improvement

IPRO

Improving Healthcare for the Common Good®

IPRO provides a full spectrum of healthcare assessment and improvement services that foster the efficient use of resources and enhance healthcare quality to achieve better patient outcomes.

Key Contacts

Anna Koke, IPRO

Paul Henfield, CHCA

Jeanne Alicandro, MD, IPRO

Contact Us

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IPRO's Role

- ✓ Offer technical assistance to partners throughout the abstraction process to ensure consistency across New York
- ✓ Provide ongoing monitoring to help identify any issues early in the process
  - Inform PCG, OQPS, and the PPSs of problems as they arise and offer possible solutions
  - Educate PPSs regarding the measures, the record retrieval process and the accuracy of the attribution methodology used to match providers to patients
- ✓ Serve as the validator to ensure the integrity of the abstraction process
- ✓ As an NCQA Licensed Organization, act as a liaison with NCQA in instances where clarification is required

Importance of Medical Record Abstraction

Medical record abstraction can provide

- Supplemental information to augment claims information
- More specific evidence of clinical care provided than revealed by claims

For some measures claims information is incomplete

- Chart review information is used to supplement evidence of the service provided (numerators)
- Chart review information can also be used to verify population being measured (denominators/exclusions)

Screening for Clinical Depression and Follow Up Plan

Description: Percentage of Medicaid enrollees age 18 and older who were screened for clinical depression using a standardized depression screening tool, and if positive screen, received appropriate follow-up care

Purpose: Capture early identification and intervention within the context of routine preventive care visits

Eligible Population: 18 and older

- Report: ages18-64, 65 and older and total

Numerator: Members who were screened for clinical depression with a standardized tool in the measurement year and if positive, had appropriate follow up care within 30 days of the positive result.

- Requires evidence of 3 components to be compliant: screened using a tool, the result, and follow-up

Measure type: hybrid (uses either claims (G codes) or chart review information to identify the numerator)

DSRIP measurement year 1: July 1, 2014 to June 30, 2015

Relevance of the Measure

Screening for Clinical Depression and Follow Up Plan

Reflects importance of the integration of behavioral health and primary care

- Depression is commonly seen in primary care yet under-identified
- Evidence indicates that screening improves accurate identification of adults with depression in primary care settings (AHRQ)*

Consistent with DSRIP goal of achieving reduction in avoidable hospital use

- Individuals with chronic conditions, substance abuse disorders and other mental health conditions are at higher risk for developing depression
- Depression may reduce adherence to treatment plans and impair self management of other health conditions

*AHRQ evidence synthesis Screening for Depression in Adults July 2015

Viral Load Suppression

Description: The percentage of Medicaid enrollees living with HIV/AIDS during the year prior to the measurement year who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year

Eligible Population: Age 2 and older

Numerator: Number of Medicaid enrollees with a HIV viral load less than 200 copies/mL for the most recent HIV viral load test during the measurement year.

Measure type: hybrid

- Claims to identify the denominator (four methods: inpatient/ER/Outpatient visits/Pharmacy
- Medical records: to identify exclusions
  - HIV negative during the measurement year or year prior
- Medical records: to determine numerator compliance
  - Viral load test done and result less than 200 copies/ml

DSRIP measurement year: July 1, 2014 to June 30, 2015

Relevance of the Measure

Viral Load Suppression

New York State Prevention Agenda Focus Area 1: Prevent HIV and STDs

- **Viral load suppression is associated with:**
  - Prolonged survival,
  - Delayed disease progression
  - Quality of life
  - Reduced risk of HIV transmission to others

Viral load suppression is influenced by:

- Engagement and retention in care
- ART adherence, which is impacted by depression and other psychosocial barriers

New York State Prevention Agenda 2013-2017
New York State AIDS Institute HIV Clinical Resource
CDC Guidelines for the Use of Antiretroviral Agent
MMWR Diagnosis, Care, and Treatment Among Persons Living with HIV — United States, November 2014

Benefits of Validation

- ✓ **Identifies specification ambiguities concurrent to the abstraction process**
  - Enhances the clarity of specifications
- ✓ **Ongoing monitoring helps ensure abstractor consistency**
- ✓ **May uncover quality of care opportunities**
- ✓ **Provides PPSs with information for future internal quality improvement efforts**

Three Components of the Validation Process

1. **Validation of tools used by the vendors**
   - Update of existing tools for the HEDIS measures
   - Newly developed tools for the two non-HEDIS measures

2. **Chart abstraction validation– during collection ("convenience sampling")**
   - Ensure that the two non-HEDIS measures are being abstracted consistently by vendors
   - Uncover any specification ambiguities concurrent to the data collection process

3. **Chart abstraction validation – at the end of collection**
   - Assesses the integrity and accuracy of chart abstraction
   - Determine reportability of the hybrid measures

Validation Process – At the End of Collection

1. IPRO will request that the vendors provide a listing of the universe of numerator compliant cases for each measure by PPS
   - IPRO will randomly sample a total of 30 cases per measure for validation
2. IPRO will submit list of 30 sampled cases to the vendors
   - Vendors will submit record documentation for the cases requested
3. IPRO will request that the NYSDOH submit the volume of numerator compliant cases identified via claims
4. IPRO will verify that the medical record documentation contains evidence of the service
5. IPRO will score the accuracy by measure

Validation Process (Continued)

6. For measures that "fail" validation (i.e., the service could not be verified in the documentation submitted for a statistically significant number of cases in the sample)
   - IPRO will provide the reasons for failure and ask the vendors to submit additional documentation, if available
7. The vendors will be asked to undertake remedial action to correct the problems observed and IPRO will re-validate following the process outlined above
8. If the second sample fails, the measure will be deemed not reportable by the PPS
   - Should a measure fail, IPRO will provide recommendations for future improvement

Timeline

Event	Timeframe
Validation of abstraction tools	September 15, 2015
Validation of two-non HEDIS measures	Early in the abstraction process
End of Abstraction Validation	
Request list of numerator events	November 20, 2015
Samples for validation to abstraction partner	November 30, 2015
Documentation to IPRO	December 15, 2015
IPRO validates record documentation	December 15 – January 15, 2016
Results of the validation sent to abstraction partner	January 18, 2016
Re-validation, if necessary	January 18 - January 22, 2016
Final results of the validation	January 29, 2016

Abstraction Process

Verisk Health

Verisk Health Key Contacts

Andrew Hebert

- Client Executive
- Leading the account management portion of the project and will be primary contact for all questions pertaining the retrieval/abstraction.

Eli Wolter

- Assistant Vice President, Client Services
- Will be assisting Andrew with specific questions/escalations.

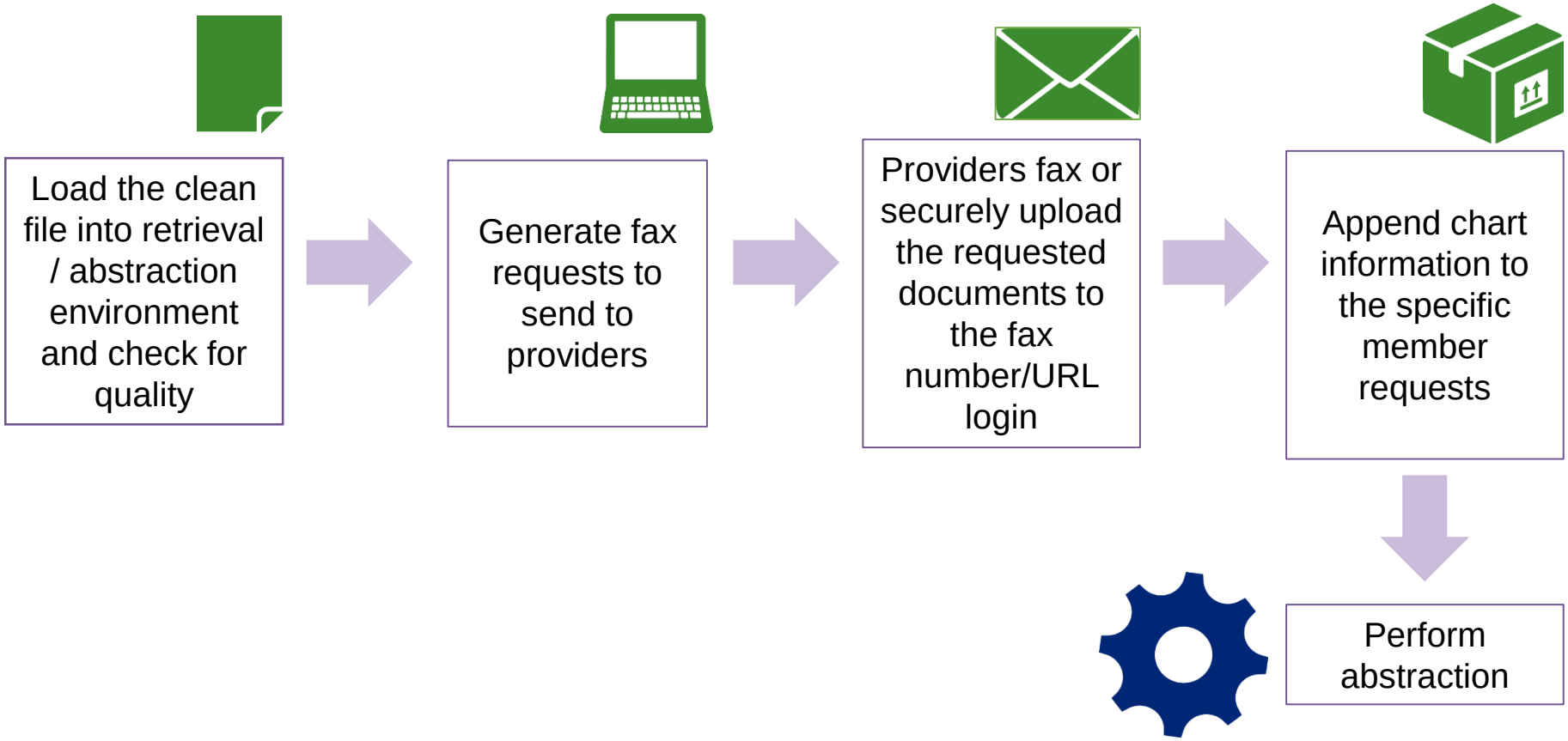
Carrie Taylor

- Manager HEDIS Abstraction
- Working with Holly Conk to manage the abstraction process and workflow. Will also be responsible for coordinating the overreads of the completed abstractions.

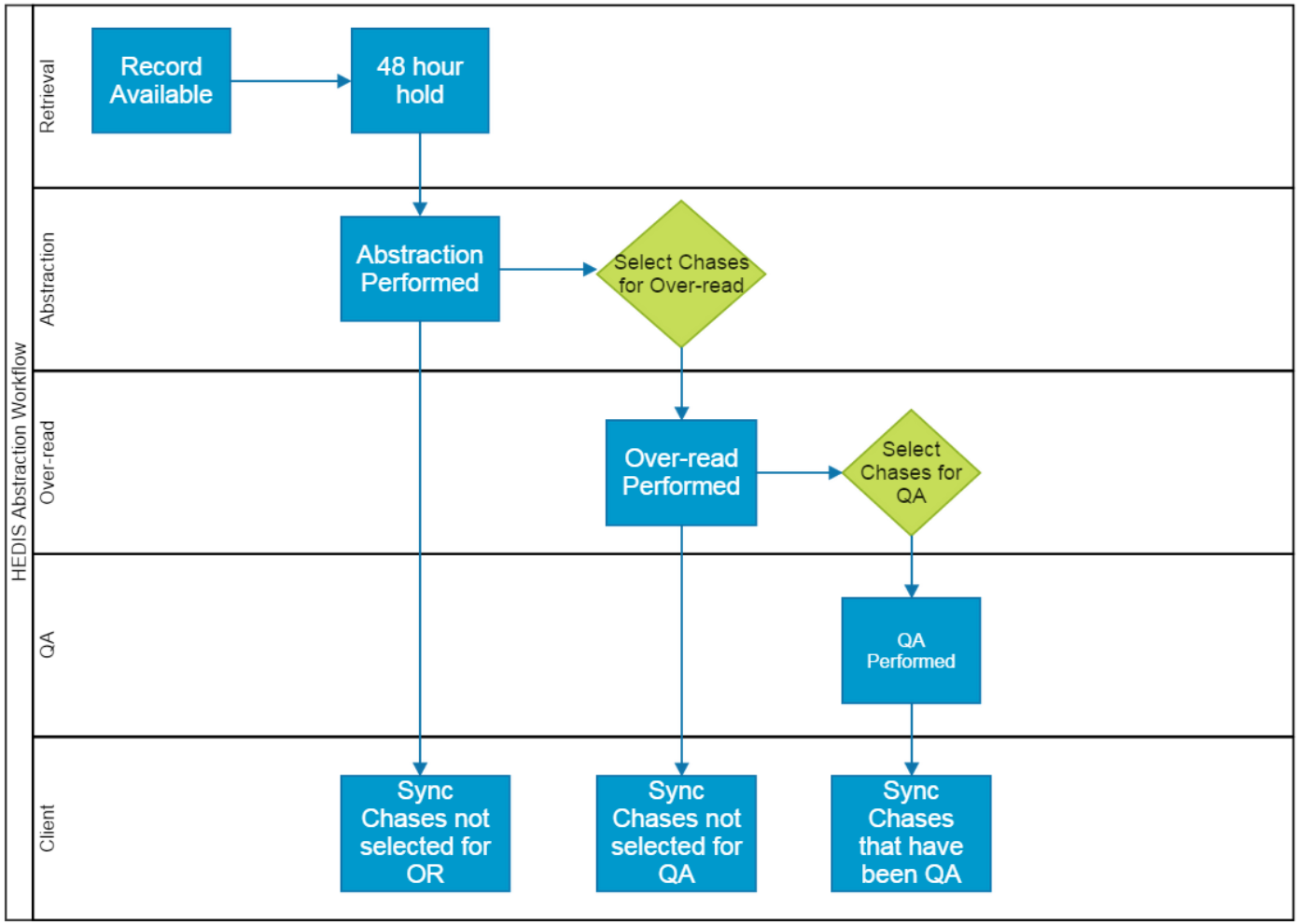
Holly Conk

- Assistant Manager HEDIS Abstraction
- Working with Carrie Taylor to manage the abstraction process and workflow. Will also be responsible for coordinating the overreads of the completed abstractions.

Verisk Health Retrieval Process



Abstraction Workflow



Verisk Health Tools Utilized

Rapid Retrieve

- Utilized during the retrieval process to pull specific records for audit purposes
- Successful record requests are stored in this system

Quality Reporter

- Utilized to abstract records and to calculate compliance
- Contains the HEDIS data collection templates and the custom template for the Clinical Depression Screening measure

Quality Reporter Collection Template Examples

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Controlling High Blood Pressure (CBP)

09/08/2015

Member Information:	<<MEMBERID>> - <<MEMBERNAME>>, (<<GENDER>>) <<DOB>>, Age: <<AEREPTYR>>		
Provider:	<<PROVIDER>>	Review Date:	<<REVIEWDATE>>
Location Description:	<<LOC_DESC>>	Reviewed By:	<<REVIEWEDBY>>
New Chart Location:	<<NEW_LOC>>	Chart not Found:	

For over-read personnel only

Over-read Status	<OVERREAD_STATUS>
Over-read Comments	<OVERREAD>

To confirm the diagnosis of hypertension, you must find notation of one of the following in the medical record on or before June 30th of the measurement year:

- HTN, high blood pressure (HBP), elevated blood pressure, borderline HTN, intermittent HTN, history of HTN, Hypertensive vascular disease (HVD), Hyperpiesia or Hyperpiesis.
- Identify the lowest systolic and lowest diastolic BP reading from the **most recent** BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.
- Do not include BP readings from outpatient visits which were for the sole purpose of having a diagnostic test or surgical procedure performed; during an acute inpatient stay or an ED visit; obtained the same day as a major diagnostic or surgical procedure; or reported by the member.

  For a member's BP to be adequately controlled, use the following criteria:

  - Members 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg
  - Members 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
  - Members 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg

Administrative Hypertension Diagnosis Date: **<<ADMIN_HYP_DATE>>**

Member Identified As Having Diabetes: **<<DIABETES>>**

Medical Record Confirmed Hypertension Diagnosis Date

OR

	Undated Hypertension Diagnosis Found in Problem List

Service Date	Systolic BP	Diastolic BP

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Childhood Immunization Status (CIS)

09/08/2015

Member Information:	<<MEMBERID>> - <<MEMBERNAME>>, (<<GENDER>>) <<DOB>>, Age: <<AEREPTYR>>		
Provider:	<<PROVIDER>>	Review Date:	<<REVIEWDATE>>
Location Description:	<<LOC_DESC>>	Reviewed By:	<<REVIEWEDBY>>
New Chart Location:	<<NEW_LOC>>	Chart not Found:	<<NOT_FOUND>>

For over-read personnel only

Over-read Status	<OVERREAD_STATUS>
Over-read Comments	<OVERREAD>

DTaP (Need 4) - Valid Range: <DTAP_RANGE>

Admin						
Hybrid						

IPV (Need 3) - Valid Range: <IPV_RANGE>

Admin						
Hybrid						

MMR (Need 1) - Valid Range: <MMR_RANGE>

Admin						
Hybrid					Undated:At Delivery or At Birth MMR	

HiB (Need 3) - Valid Range: <HIB_RANGE>

Admin						
Hybrid						

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Verisk Record Collection & Review Timeline

Event	Timeframe
Sample received	Early September
Initial medical request mailing/fax/schedule site visits	Mid-September
Medical record abstraction begins	September to November
Convenience sample to auditor	Mid-September
Follow-up mail / fax requests	Early October
Investigate returned mail and provider contact issues	On-going
Medical record review 50% complete	Mid-October
Medical record review 75% complete	Mid-November
Medical record review complete	December
Final medical record review validation	December

Questions