Guidance on Collecting Clinical Quality Measures in a Virtual Visit

Capturing ACO Clinical Quality Measures during the COVID-19 public health emergency may seem daunting; healthcare organizations are limiting in-person visits and canceling most non-urgent care. This could mean that your usual approach to capturing this information, the in-person Annual Wellness Visit (AWV), is no longer an option. The good news is that the majority of the measures can be captured for compliance purposes over the phone or through a telehealth visit.

Of course, tracking compliance with clinical quality measures is about more than ACO quality measure performance- it's about creating workflows that hardwire the ability to get the right care to patients to keep them well, or prevent further declines. Because of this, Caravan recommends that you take a proactive approach to reaching out to your patients, particularly your Medicare patients who are especially vulnerable during the COVID-19 pandemic. This outreach is useful for:

- Instructing patients on your organizational guidance if they are experiencing symptoms concerning for COVID-19.
- Informing and educating patients about virtual care options, like telehealth visits.
- Maintaining a connection with the patient when they cannot be seen in-person.
- Screening for barriers to self-management and health maintenance due to shelter-in-place or stay home orders.

For guidance about billable telephone services, see **Telephone Visits** or **Virtual Visits**. You can also learn more about **Chronic Care Management**, **Transitional Care Management**, and **Principal Care Management**.

This outreach can also be used to capture information about quality measures, which will put you ahead of the curve no matter what CMS announces regarding the reporting obligations for Performance Year 2020. You can continue to identify and close care gaps and capture appropriate documentation.

Your entire team can contribute to this proactive patient outreach. Additionally, this outreach may be performed at the same time as a billable service, or lead to scheduling a billable service, such as a telephone E/M, telephone assessment, or virtual check-in. This outreach may also help you identify patients who would benefit from care management services, like Chronic Care Management or Transitional Care Management.

Many Clinical Quality Measures can also be captured during telehealth visits. Telehealth visits require real-time audio and visual, and during the COVID-19 Public Health Emergency, several actions have been taken by CMS to make these visits more accessible. The initial and subsequent AWV is an allowable service to furnish via telehealth, and the AWV can be provided on the telehealth platform with minor adaptions to the AWV workflow. Since so many of the quality measures are embedded in the AWV, a telehealth AWV remains the optimal choice for capturing the measures as well as ensuring care gaps and patient needs are identified and met. Other types of telehealth visits can also be used to capture quality measures.

Caravan Health has provided guidance about adapting the **AWV to telehealth**. You can also learn more about **telehealth services** and **telehealth physical exams**.

This document advises on the 2020 Medicare Shared Savings Program ACO Clinical Quality measures that are deemed acceptable by measure developers to capture numerator compliance and associated documentation over the phone or during a telehealth visit. **It's important to note that data capture for quality measure compliance is not always consistent with billing requirements. This document outlines compliance with quality measures only and should not be used for guidance on billing any service.**

Any quality measure screening that is positive should be escalated to the provider per your clinic protocol. For measures that require subsequent follow-up, establish a plan to ensure this care is provided. Much of this care is not critical and can be furnished after the COVID-19 Public Health Emergency has resolved. However, for follow-ups that are time-sensitive, essential, or critical, establish methods of delivering this care in ways that protect patients from the spread of the virus, such as "clean" clinics or labs.

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= Measure may be captured in a telephone-only visit

= Measure may be captured in a telehealth visit with real-time audio and video

CARE-2: Falls

Screening for Future Fall Risk - Screening for history of falls during the measurement period is acceptable to meet the intent of the measure, if adequately documented.

- Complete future fall risk assessment questions. Can utilize STEADI or any other question for future fall risk; the Caravan HRA template includes future fall risk screening questions.
- If using a telehealth application with real-time audio and video, use clinical judgement regarding gait and balance observation; do not require patient to stand or walk if it may result in a fall.
- Positive answers to the fall risk assessment questions or concerns when observing gait or balance should be followed-up.

DM-2: Diabetes

Hemoglobin A1c Poor Control – Patient reported A1c is acceptable to meet the measure.

- Document the date and distinct value of the most recent A1c result. Indicate that this is patient-reported data if appropriate.
- Assess if patient has had an A1c lab performed at another facility. If so, obtain results from the facility.
- Home glucose monitoring data is not currently acceptable to meet the measure, but can be useful to guide the need for additional lab tests.
- If warranted, consider a follow-up Hemoglobin A1c at a "clean" location. Follow CDC recommendations for reducing patient's risk of exposure during health care visits.

For patients who are monitoring blood glucose at home, review blood glucose logs with them. Many home glucose monitors can display an average blood sugar reading, which correlates to the A1c test. An average glucose level over 212 mg/dL correlates to an A1c >9%.

HTN-2: Controlling High Blood Pressure

Blood pressure readings captured by a remote monitoring device are acceptable for numerator compliance.

- CMS defines a remote monitoring device as "any approved device with a cuff that is able to transmit BP readings electronically."
- Blood pressure readings taken by and/or reported by the patient over the phone, or as part of a telehealth visit, are not officially acceptable to meet the measure; the reading must be transmitted electronically by the remote monitoring device.
- However, it is valuable to record patient-reported readings, or an average of multiple readings, and note any medication or treatment changes that are made as a result. Be sure to note that patient-reported readings were used as a substitute for in-office blood pressure measurements due to the COVID-19 Public Health Emergency. Schedule the patient to come in for confirmatory reads when it is safe to do so.

During the Public Health Emergency, it's especially important to make sure patients are appropriately self-managing their blood pressure. Take this opportunity to review blood pressure logs with patients who are monitoring at home. Review medications and other treatments with hypertensive patients.

PREV-12: Screening for Depression and Follow-Up Plan

Screening for depression with provider review of the screening tool and, when necessary, provision of a follow-up plan meets the measure.

- Any standardized tool may be used, but Caravan Health recommends use of the PHQ-9.
- The PQH-9 can easily be administered over the telephone or during the telehealth visit.
- Alternatively, the screening tool can be provided to the patient up to 14 days ahead of the encounter (including the day of the encounter), for instance, if the HRA is mailed to the patient in advance of a telehealth AWV.
- Screening results must be reviewed and documented on the date of the encounter, including the name of screening tool utilized and the results of the screening (positive or negative).
- If the screening is considered positive as determined by the provider who reviews the standardized tool, provider documentation of recommended follow-up plan must be completed; this may also be furnished over the phone or during the telehealth encounter.
- Protocols for positive screenings should be revisited, and if necessary, amended, to include immediate Telehealth and or Telephone E&M with provider to determine the appropriate follow-up plan.

MH-1: Depression Remission at Twelve Months

Follow up PHQ-9/9M administration at 12 months (+/- 60 days) to assess for remission in patients previously diagnosed with major depression or dysthymia; this does not require a face-to-face visit and multiple modes of administration are acceptable including telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk.

- Patients may be screened up to seven days prior to the encounter (including the day of the encounter).
- While screen can be completed in advance, it must be reviewed by the provider, and results documented, on the date of the encounter. Provider review and follow-up may be furnished in a telephone encounter or by telehealth.
- Protocols and workflows should be revisited to assure continuity of depression care; if remission screening is determined to be positive for continued depression, a follow-up plan must be addressed. .

Patients who have been diagnosed with depression may be at higher risk for exacerbation during times of social isolation. Consider proactively reaching out to these patients. Chronic Care Management or Behavioral Health Integration may provide them with much-needed social support during the Public Health Emergency.

PREV-5: Breast Cancer Screening

Patient self-report is acceptable to meet the measure.

- Ask female patients 50-74 years of age if they have had a mammogram screening for breast cancer anytime between October 1, 2018 to current date.
- If the patient has completed a mammogram screening, document the date, type of test and results/findings. Normal or abnormal is acceptable. Indicate that results are patient-reported.
- If a mammogram has not been completed, flag for provider review and order the screening after the Public Health Emergency has resolved.

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PREV-6: Colorectal Cancer Screening

Patient self-report is acceptable to meet the measure.

- Ask patients 50-75 if they have been screened for colorectal cancer during the following time frames:
  - Fecal Occult Blood Test: during the measurement period (2020)
  - Flexible Sigmoidoscopy: 2016-2020
  - Colonoscopy: 2011-2020
  - CT Colonography: 2016-2020
  - FIT-DNA: 2018-2020 (Per CMS, Cologuard is a FIT-DNA test and meets the measure)
- If patients have been screened, document the date (year), type of test, and results or findings; normal or abnormal is sufficient. Indicate that results are patient-reported.
- If a colorectal cancer screening has not been completed, flag for provider review. Consider providing a FIT-DNA or Cologuard test by mail to patients who meet appropriate criteria. Alternatively, order appropriate screening after the Public Health Emergency has resolved.

PREV-7: Influenza Immunization

Documentation of patient reported receipt of the influenza immunization is acceptable to meet the measure.

- Review immunizations and ask patient if they received a flu shot between August 1, 2019 and March 31, 2020.
- Flu season resumes August 1, 2020. Take this opportunity to discuss options for how the patient can get their influenza vaccination if social distancing and healthcare facility closures continue into the 2020-2021 flu season.

How will you provide influenza vaccinations if the Public Health Emergency continues into the next flu season? Consider drive-thru vaccination clinics or other options that reduce patient exposure.

PREV-10: Tobacco Use

Screening and Cessation Intervention – Screening for tobacco use and tobacco cessation intervention meets the measure.

- There is not a standardized questionnaire to screen for tobacco use, but you may utilize the Fagerstrom test for Nicotine Dependence. Alternatively, you can simply ask "Do you use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars or pipes)?"
- If the patient identifies as a tobacco user, provide cessation counseling, unless they have previously received a cessation intervention within the past 24 months. Cessation counseling can be brief (less than 3 minutes), and may be as simple as "tobacco use is bad for your health. We are here to assist you whenever you are ready to quit."
- Document the results of the tobacco use screening and the provision of the cessation counseling, if provided, or date of last cessation counseling if it was within the last 24 months.

Smoking related lung disease is a risk factor for poor outcomes from COVID-19, adding to the importance of the tobacco use screening and cessation intervention. Be ready to provide patients with options should they indicate readiness to quit. Consider enrolling in virtual classes from local hospitals, if they are available. Ensure protocols also address referral to providers for pharmacotherapy for tobacco cessation.

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PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

The measure is intended to assess provider behavior, not patient compliance. Only a prescription for statin therapy or documentation of statin therapy use in the patient's current medication list will meet the measure. This measure cannot be met with patient report of statin therapy use over the telephone or as part of a telehealth visit.

- Only a prescription for statin therapy or documentation of statin use in the patient's current medication list will meet the measure.
- However, the prescription or order for statin therapy does not need to be linked to an encounter or visit; it may be called into the pharmacy. Statin medication "samples" provided to patients can be documented as "current statin therapy" if it is documented in the current medication list in medical record.
- While it won't meet the measure, if the patient reports they are taking statin therapy, record the medication information in the EHR and note that it is patient-reported information collected during the Public Health Emergency. Try to obtain documentation from the prescribing provider, and if obtained, review and upload to the patient's chart.
- If the patient is not on statin therapy, but meets the denominator criteria for this measure, escalate for provider review and prescribe as appropriate.

Resources:

2020 CMS Web Interface Quality Measure Specifications can be accessed at: **www.qpp.cms.gov/about/resource-library**

Cardiovascular disease is the greatest risk factor for COVID-19 mortality. Consider proactive outreach to these patients. When reviewing statin therapy use, take the opportunity to discuss the patient's history of cardiovascular disease and their associated elevated risk from COVID-19. Be sure the patient knows how to manage their disease and how to reduce risk of transmission of the virus. These high-risk patients may benefit from Chronic Care Management.

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