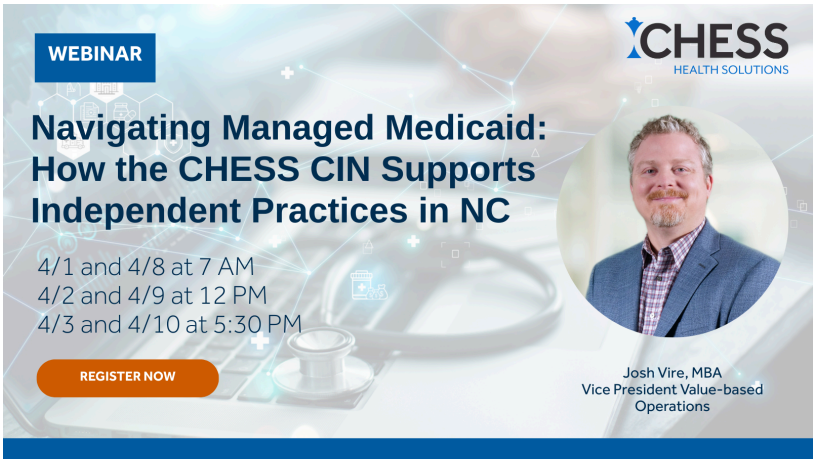
Value-based Care Chronicle: Guide to Improving Performance

March 2025



Join us for an exclusive webinar series introducing CHESS Health Solutions' new and innovative clinically integrated network (CIN) designed to maximize provider reimbursements, enhance patient outcomes, and simplify the transition to value-based care.

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Diabetes Quality Measures

Among chronic diseases, diabetes has been a focus of quality performance measurement for many years. Key quality measures for monitoring and managing diabetes include:

HEDIS Measure	Definition	Best Practices
Glycemic Status for Patients with Diabetes (GSD)	% of members 18-75 years of age with diabetes (types 1 & 2) whose most recent glycemic status (HbA1c or GMI) was at the following levels during the measurement period: *Glycemic Status <8% (Good Control)* *Glycemic Status >9% (Poor Control)*	- Quality reporting evaluates last A1c of year - Schedule quarterly visits for insulin-dependent or uncontrolled diabetes patients - Educate on importance of diet and exercise; refer to diabetes education program when available - Refer patients to CHESS Pharmacy Team for med review care coordination team for chronic condition support - Train staff on proper A1c documentation in EMR - GMI results with date range and terminal date can be used for reporting - Close gap by submitting CPT II codes
Kidney Health Evaluation for Patients with Diabetes (KED)	% members 18-85 years of age with diabetes (types 1 & 2) who receive a kidney health evaluation (eGFR and uACR) during measurement period.	- Measure requires **both** a blood (eGFR) and urine (uACR) test - Educate patients on diabetes' impact on kidneys and need for annual testing and med adherence - Order and complete labs before appointments - Set EHR alerts for due screenings - Engage Care Coordination & Pharmacy for medication management support
Eye Exam for Patients with Diabetes	% members 18-75 years of age with diabetes (types 1 & 2) who had a retinal eye exam.	- Educate patients on diabetes' impact on eyes and need for annual testing - Fundus photography meets the measure if optometrist or ophthalmologist reviewed results - Document retinal exam with date, test, result, and eye professional's name and credentials - Use appropriate coding and documentation to reflect care from year or in the year prior
Statin Use in Persons with Diabetes (SUPD)	% members 40-75 years of age with diabetes who receive at least 1 fill of a statin med in the measurement year.	- Rx must be filled via Part D to close gap - Submit ICD-10 code yearly for exclusions - Consider extended day fills or home delivery - Unstructured/supplemental data does not close SUPD gaps
Medication Adherence for Diabetes Meds (MAD)	% members 18 and older who adhere to diabetes med at least 80% of the time in the measurement period.	- Develop process for identifying and addressing patient barriers to med adherence - Tailor solutions to support adherence - Discuss continued therapy, timely refills, and extended supply prescriptions
Blood Pressure Control for Patients with Diabetes (BPD)	% members 18-75 with diabetes (types 1 & 2) who have BP reading of <140/90 mmHg in the measurement year.	- Most recent BP of the year is the one measured - List date of service and BP reading - For multiple readings on the same day, use the lowest systolic and diastolic reading

By prioritizing these measures, we can improve the health of patients while maximizing performance under contracts. Stay proactive, keep patients engaged, and drive better results for your patients and practice!

Visit the links below for more information on how to close the gap on these diabetes quality measures.

Diabetes Quality Measures

Diabetes Med Adherence

Kidney Eval Diabetes Quality Flyer

GSD Quality Flyer

HCC Recapture

The Risk Adjustment payment model identifies patients with serious and/or chronic illnesses, using ICD-10-CM codes that map to hierarchical condition categories (HCC), and assigns a risk adjustment factor (RAF) score to each patient. The average RAF score for a patient is 1.00. If a patient has a RAF score of 0.800, then it is presumed that the patient is 20% healthier than the average population and you would generally not expect high-cost utilization.

CMS resets the RAF score every January to only include demographics.

The HCC recapture rate measures the extent to which recurring conditions are re-documented, reflecting the ongoing health risks of patients with chronic conditions. High recapture rates help secure appropriate payments by reflecting the true complexity of patient populations, thereby reducing financial penalties for providers who care for high-risk patients. Failure to report each chronic condition, **every calendar year,** will skew the patient profile and negatively affect funding for the care and resources required.

HCC RECAPTURE GUIDE

MAXIMIZING HCC RECAPTURE

Guide for accurately documenting and coding conditions to ensure appropriate care and reimbursement.

Download Guide

Hierarchical Condition Category (HCC) coding ensures accurate risk adjustment and appropriate reimbursement.

Read More

Move to Value Podcast: Why Risk Adjustment Matters in Clinical Documentation & Coding

PATIENT EDUCATION POINTER OF THE MONTH

Zone Tools

Zone tools are one-page reference tools used to assist patients in managing common health conditions at home.

These guides use the colors of a spotlight to guide self-management and symptom awareness. For each zone (green zone -- all clear; yellow zone -- caution; and red zone -- medical alert), the tool provides signs, symptoms, and specific instructions for managing the condition, including guidance on when to seek medical assistance.

Encourage patients to hang these Zone Tools in a prominent place where they are frequently during the day to help them know what they're looking for and what to do once they find something out of the ordinary.

By teaching symptom awareness and self-management, we can empower patients and increase confidence in managing their health.

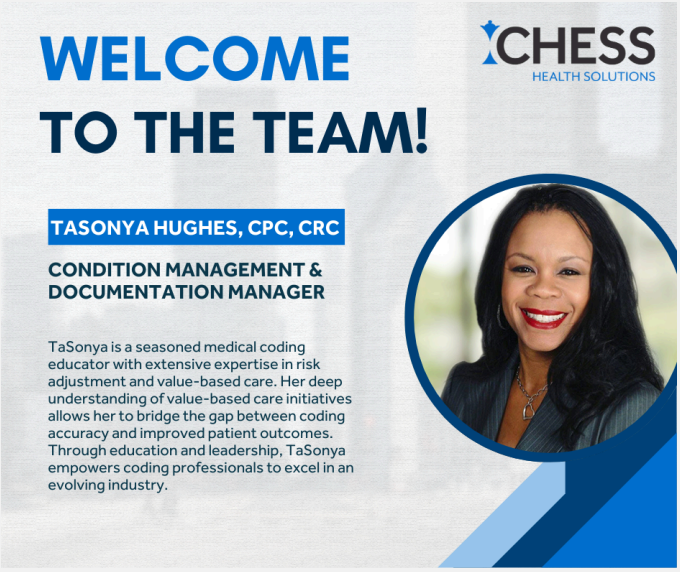
Download the Zone Tool template and learn more about implementing these tools in your practice: https://www.chesshealthsolutions.com/2022/09/28/patient-education-tools-zone-tools/ and https://www.chesshealthsolutions.com/2025/03/20/implementing-zone-tools-for-better-outcomes/.

Meet Our New Condition Management & Documentation Manager!

TaSonya Hughes is a seasoned medical coding educator with extensive experience in risk adjustment and value-based care. With a passion for accuracy

and mentorship, she has dedicated her career to helping providers and other medical coders navigate the complexities of medical coding.

Join us in welcoming her to the team! Be on the lookout for upcoming HCC education opportunities.



Additional Resources

- ACO REACH: Innovation in Payment Models Driving Better Care & Greater Rewards
- The Power of Collaboration in Value Based Care: Unlocking Better Patient Outcomes

Learn More!

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