Answers to questions from 2023 Clinical Symposium

I thought payers pulled our HCC RAF codes purely from the ICD10 codes we bill in encounters, not from refills/orders?

> *I think the concern is that if we leave those 'less accurate' codes in the chart, it increases the chance we'll drop those during the encounters. Trying to avoid use of them in between visits will help keep the problem lists more accurate.*

To go along with the above question; if the MAs are doing the refills, they are using whatever dx code is attached at the time. We might have updated the code during a visit, but does that then transfer over to refills?

> *I think the concern is that if we leave those 'less accurate' codes in the chart, it increases the chance we'll drop those during the encounters. Trying to avoid use of them in between visits will help keep the problem lists more accurate.*
>
> *To follow your thought process--if the accurate dx is linked during the encounter, the accurate dx ought to be there when a refill is done by the MA.*

I have had a couple of patient complaints that they could not schedule the medicare wellness with the medicare nurse through the patient portal or with the centralized scheduling but only with the medicare nurse. Is there any way to bridge this gap so more quality measures are met through this way instead of the patient's frustration with phone tag? Thank you for looking into this, this is also the case with my nurse visits as well, so I wasn't sure how to proceed with this as well for my patients scheduling vaccination catch ups for these nurse visits.

> *Thank you for the question. Historically, we have not had the ability to schedule for providers that do not have an NPI number. New functionality has been released and this is a great suggestion to look into. I will pass this to Stacey Wyatt for review and potential implementation.*

One source of stress continues to be responding caring for patients through the portal. It has been over 2 years since we have asked for portal billing. When can we expect to see this take place?

> *As we have not yet been able to secure portal message response billing, many practice sites have implemented workflows to transition these portal message requests into in office or vpo visits, using criteria like request for medication change, dosage adjustment, extended explanation of testing results, etc.*

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Will the non-compete agreement in the contracts of providers be waived if displaced providers find work outside of Ascension, but in the Indianapolis area?

> *These considerations will need to be looked at on an individual basis--the DRO/RMD dyads will be having those conversations with the impacted clinicians.*

Are there plans for improved communication with leadership and admin given recent events?

> *Our current leadership team works to offer two way communication for our clinicians and associates through multiple forums. Be attentive to the following opportunities: rounding in the practice sites by your local leadership dyad; local practice site meetings; quarterly regional meetings; email communication from your state and regional leadership; the All Hands Call monthly; and all AMG leaders are intentional to be available to their teams as issues and concerns arise, please reach out to them individually as well.*

How do you suggest we continue to move forward effectively in good mental health with recent layoffs & not knowing the future of your position?

> *There is not a simple answer to this--we need to move forward with several tools in mind--self care, improved communication with our teams, being mindful of what is in our control and what is not. There will be several resources shared today--please utilize those that look like they will be helpful.*

The MAs and other staff are a critical part of our team, enabling efficiency and quality improvement. Sadly, I often see a lack of positive morale among them. Does Ascension have some sort of plan to address this.

> *As a member of the leadership I know morale has been difficult to lift up in the wake of closings and short staffing. But we continue to express gratitude to the staff, recognize good work with awards and words, and promote from within. This is evident at the All Hands meetings, MPO bi-monthly meetings, and dept. meetings. Please join us by thanking your staff everyday, for their support of your team. If you have other ideas that can be shared across our statewide practices, please bring those forward and we'll implement them as we can to improve our teams' morale.*

I think it would be nice to speak to people (anonymously) who have been through burnout to give a testimony on how they overcame this and what helped them. I feel there is a lot of info stated that mention heavily on what the provider can do but little on what the organization can do to help.

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> *There has been a lot of work done by the organization (both at the state level and the national level) to help improve practice efficiency and get resources out in front of our clinicians so it is easier to access them--working on lots of issues organizationally too, recognizing that the clinician experience is not the sole responsibility of the clinician. We have had experiences shared with us from clinicians who have recovered from burnout, and those things that were helpful to them are things that we are working to improve/share with our clinicians.*
>
> Thank you for saying this. I'm glad you are getting feedback from clinicians and working towards this.

For influenza vaccine recommendations- will AMG please update the "consent for flu" form to remove the egg allergy? Thank you!

> *This has been taken to Jerry Bishop for appropriate changes to be made–thanks!*

Can these slides and/or a copy of the 2023 immunization schedule be shared?

https://www.google.com/url?q=https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html&sa=D&source=docs&ust=1676389522202145&usg=AOvVaw1aAgV5G_sO-7tqgxydzT_m

Do they still recommend antibody infusions for people that cannot take paxlovid?

Do you have to give the shingles vaccine to those who have had the varicella vaccine

Won't pcv 15 be replaced pcv 20 very soon (for peds)?

Are you aware of any plans to change the live chickenpox to the dead shingrix type of vaccine for kids?

Medicare does not pay for Tdap; will it pay for hep B in non NASH/cirrhosis pt?

For Dr Ward et al re: osteopathic techniques: Can NP learn these techniques as well?

Where can we access documentation guidelines for students recording in the chart for billing purposes?

> *E/M Service Documentation Provided By Students Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.*

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> *Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.*
>
> *Latest CMS Manual Update E&M doc. By medical students.*

Within the huddle note, is there a way to have the free text huddle note be populated by what you say in the chart prep intake area? Or could Huddle note be embedded into the chart prep functioning? Transferring to a second place (i.e. prep intake into huddle note) seems inefficient.

> *We'll need to take this back to the Affirm team to find out what our options might be–thank you for this idea!*

What about diabetes with hyperglycemia? Sometimes the management improves and they are no longer having hyperglycemia. Shouldn't you then move back from DM with hyperglycemia to DM without complications (assuming they don't have other DM issues like nephropathy).

> *If the patient now has well controlled diabetes without complications, it would be appropriate to use that dm without complications code again. If however insulin therapy is part of their control, I would use the insulin code.*

For coding, do you code as BMI or code as Obesity. Then BMI code comes up with ranges of BMI; is that more appropriate or the Obesity coding?

> *It is appropriate to add both the specific bmi diagnosis and code and the morbid obesity diagnosis and code to the encounter. (Morbid) obesity is a disease/condition and the BMI is reporting a statistic. It's appropriate to code and bill both. Order sets will be available in the very near future to make this an easier diagnosis to capture.*

I have seen many acute dx reactivated from up to 8 years ago. This has made the ability to keep accurate records.

> *Agree–having old diagnoses populate the problem list that are no longer applicable does make it difficult to keep accurate records. Continue to change those resolved/historical diagnoses accordingly and delete diagnoses that no longer need to be included at all. Removing them from the list makes it less likely that they will be utilized in medication refills, etc again in the future.*

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Does MEAT need to be under each diagnosis or can it be free texted in the Assessment/Plan blank box?

> *MEAT can be documented in the HPI, in the ROS, or under the A/P section of the chart. It is sufficient to include it in the blank box, if it is clear to anyone else reading the note that the specific diagnosis was evaluated and addressed.*