HEALTHY PLANET LINK
CARE GAP CLOSURE
QUICK START GUIDE

CONTENTS

PURPOSE OF CLOSING CARE GAPS

The reports for quality measures are generated based on the documentation in Epic made available to our community partners through Healthy Planet Link access. To generate accurate quality reports, the documentation for each data element of the measure needs to be documented appropriately in Epic.

Healthy Planet Link allows users to enter clinical data from the provider's record to close these care gaps within the Epic system. Those entering data will need to first review the provider's record for documentation to support the care gap closure, and then enter that data into Healthy Planet Link.

Some care gaps may require you to upload supporting documentation. For example, if a patient was screened for High Blood Pressure by a provider, please review the documentation of the Blood Pressure screening in the provider record and enter the appropriate data elements specified for the measure. This document will guide you through entering the care gap data from the provider record.

Providers have added features available to enter medications and problem lists for measures that allow for exclusions.

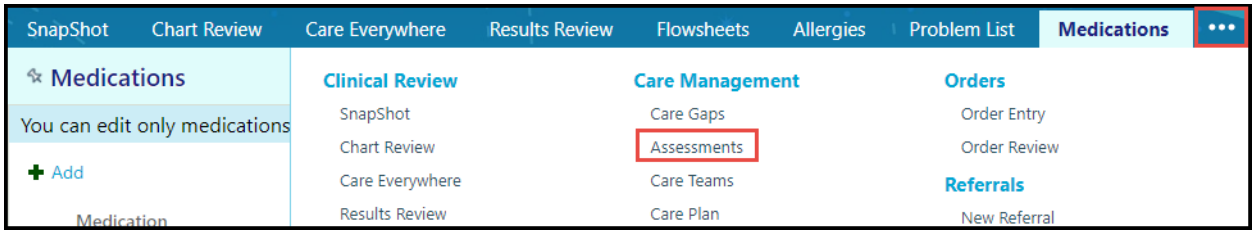
CONTROLLING HIGH BLOOD PRESSURE

Description:
ACO: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.

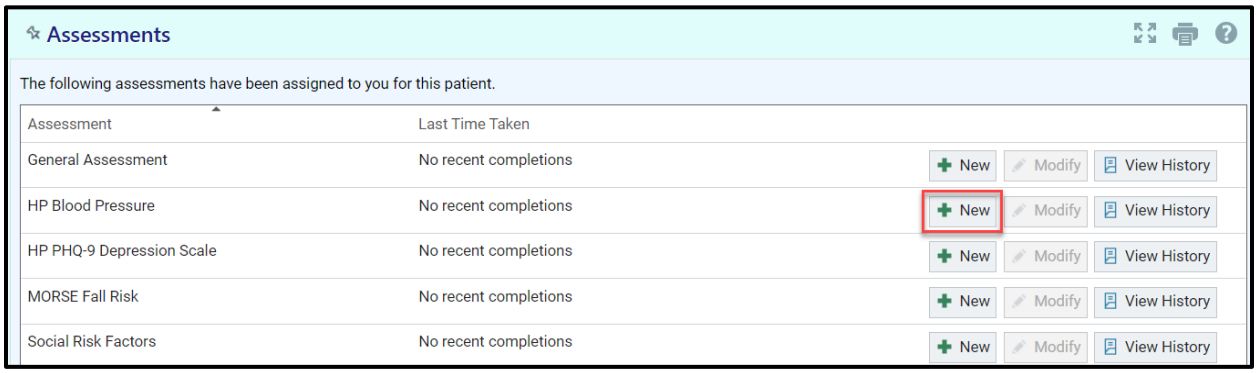
HEDIS: The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Document Blood Pressure

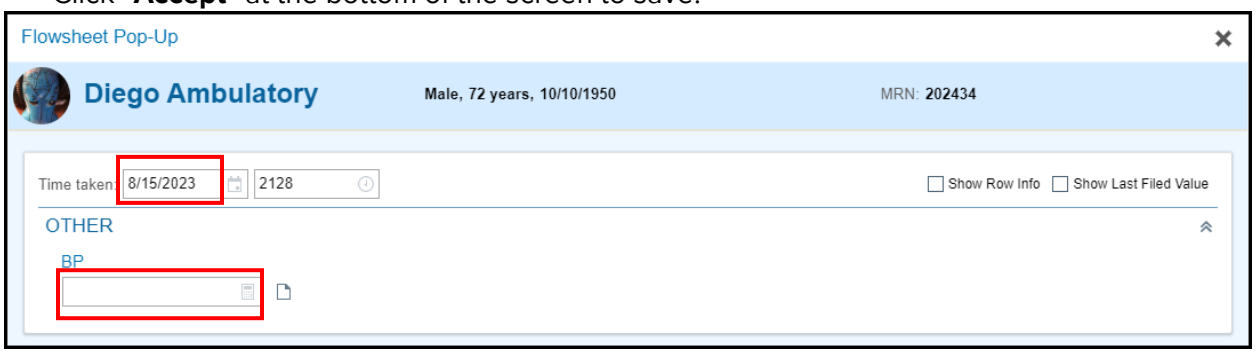
- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Assessments**.



- Find the HP Blood Pressure and click the "**New**" button.



- Document **Date** and **Blood Pressure** values.
- Click "**Accept**" at the bottom of the screen to save.



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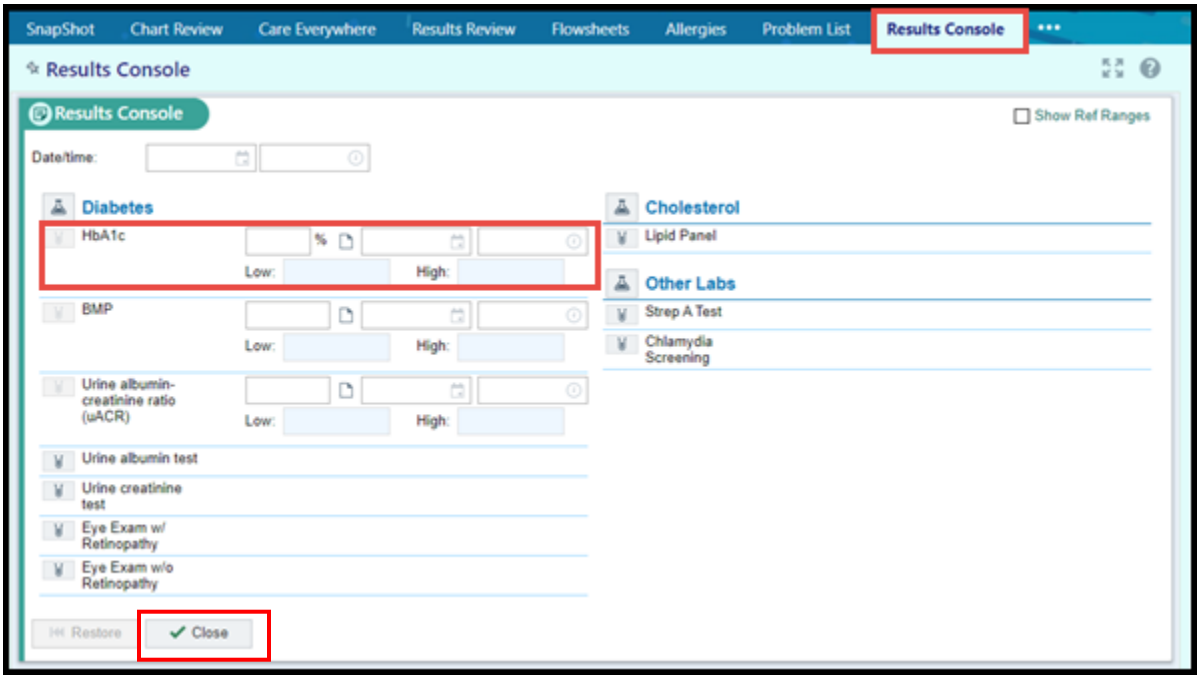
DIABETES HEMOGLOBIN A1C POOR CONTROL >9% & A1C CONTROL < 8%

Poor Control > 9% Description: Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

Control < 8% Description: Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c < 8.0% during the measurement period.

Document HbA1c Result

- Open the patient chart.
- Click the **Results Console** tab in the toolbar.
- Enter the result and date of test.
- Click **Close** to save.



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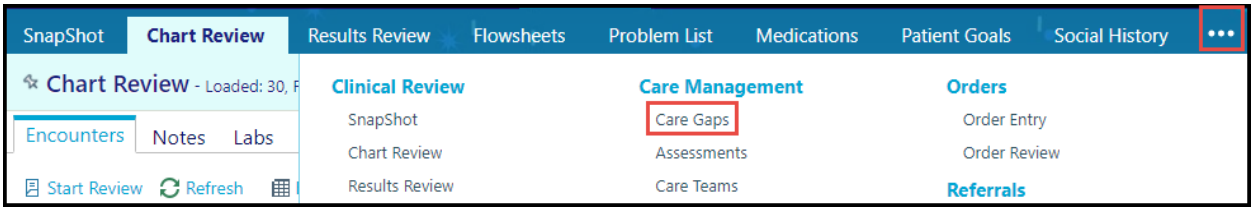
COLORECTAL CANCER SCREENING

Description: Percentage of adults 45 - 75 years of age who had appropriate screening for colorectal cancer:

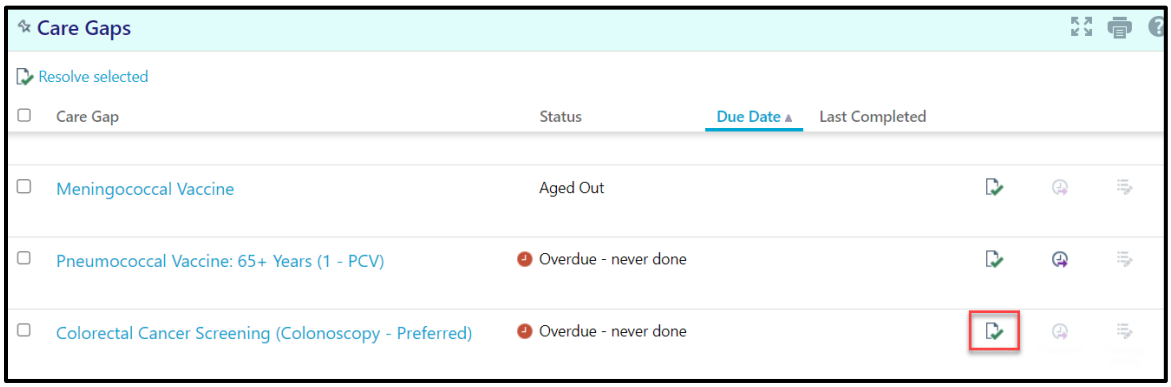
- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- Fecal immunochemical DNA test (FIT-DNA) during the measurement period or the two years prior to the measurement period
- Computed tomography (CT) Colonography during the measurement period or the four years prior to the measurement period

Add an Outside Colorectal Cancer Screening Procedure

- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Care Gaps.**



- Find the Colorectal Cancer Screening Care Gap and click **Resolve.**



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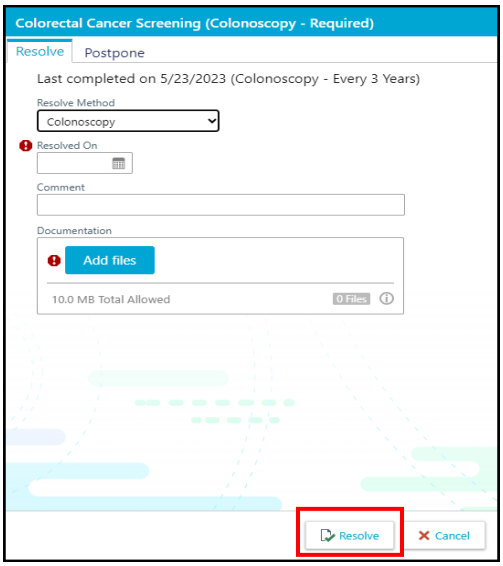
- To satisfy a Colorectal Cancer Screening Care Gap, document the following:
  - **Resolved Method**: Select procedure that was completed
  - **Resolved On**: Document the date when screening was completed
  - **Comments**: Enter comments if needed
  - **Documentation to Add files**: Add relevant files using the document type for the procedure performed (Colonoscopy, Cologuard, FIT-DNA, CT Colonography, Fecal Occult Blood Test, Sigmoidoscopy)
  - **Click Resolve**: To save the care gap information

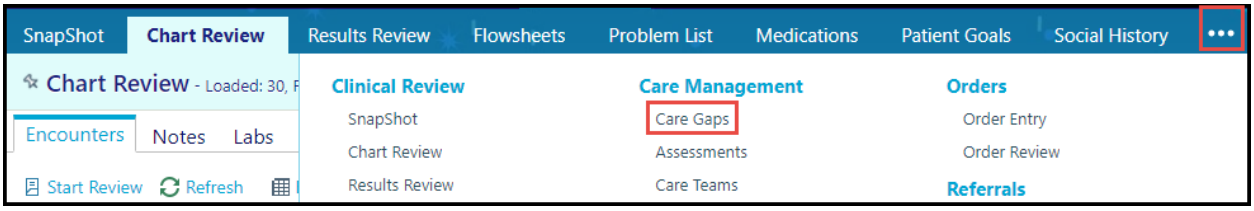


BREAST CANCER SCREENING

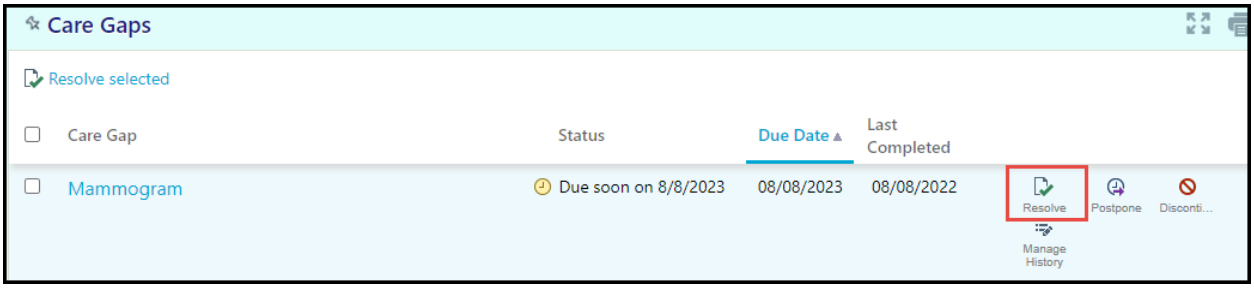
Description: Percentage of women 50 - 74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

Add an Outside Mammogram Procedure

- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Care Gaps.**



- Find the Mammogram Care Gap and click **Resolve.**



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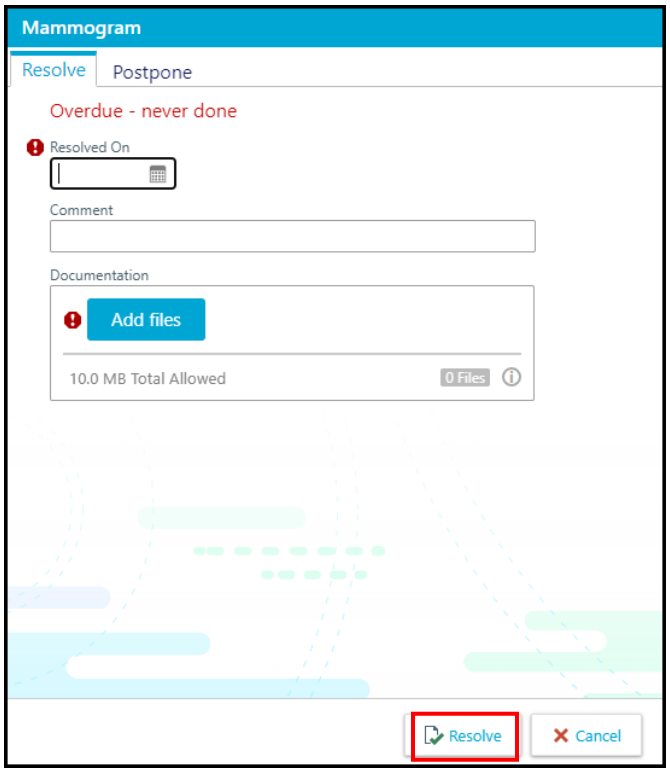
- To satisfy a Mammogram Care Gap, document the following:
  - **Resolved On**: Document the date when screening was completed
  - **Comments**: Enter comments if needed
  - **Documentation to Add files**: Add relevant files using the mammogram document type
  - **Click Resolve**: To save the care gap information

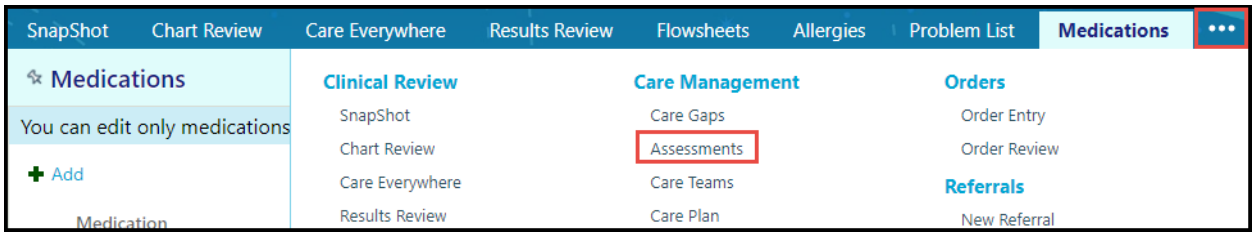


SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN

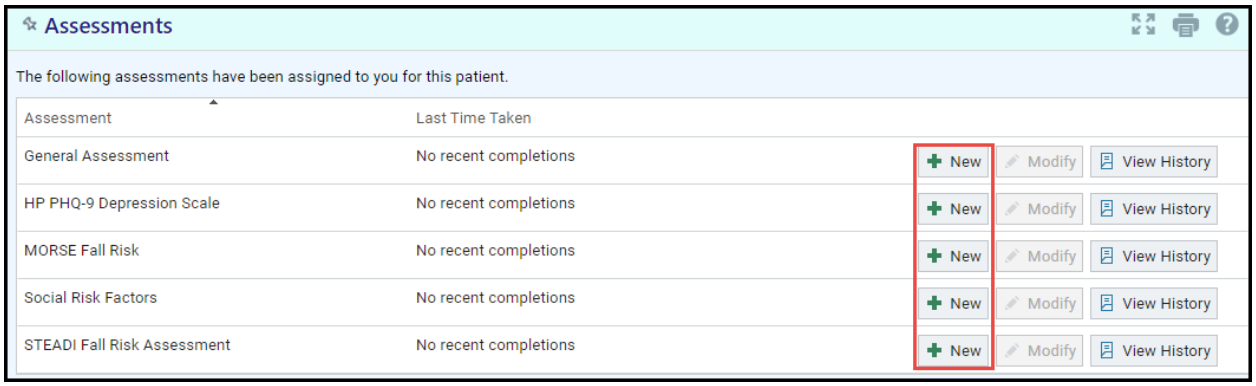
Description: Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter

Document Depression Screening Assessment

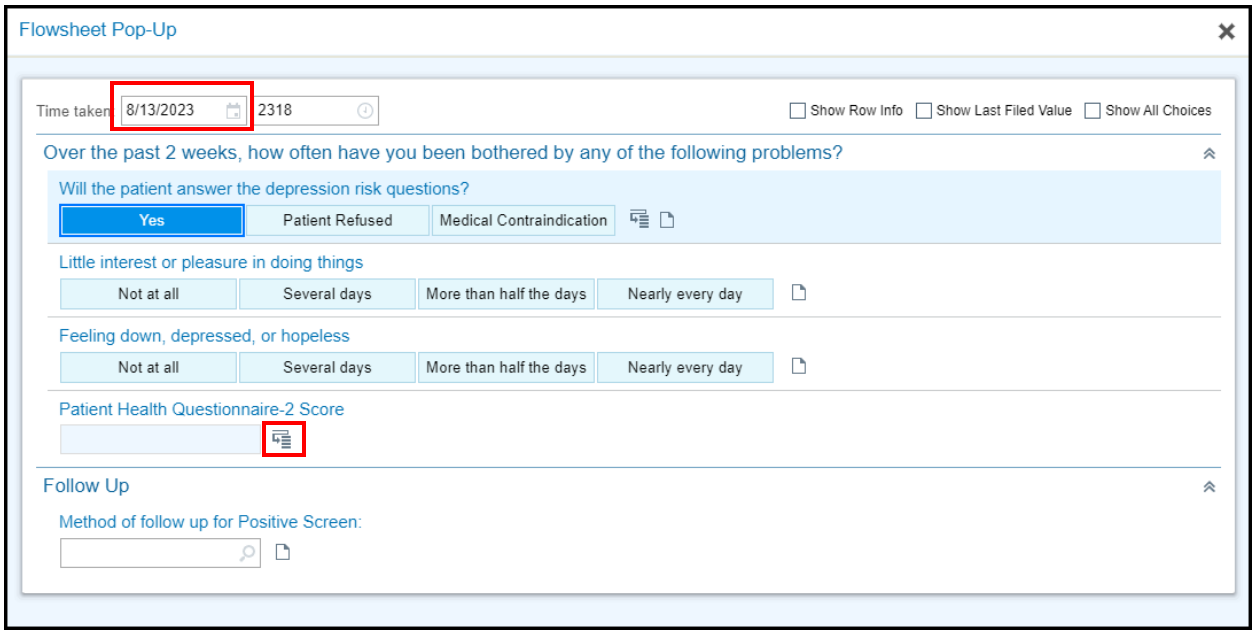
- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Assessments**.



- Find the HP PHQ-9 Depression Scale and click the "**New**" button to document.



- Enter the **date** of the screening.
- Document the PHQ-2 by completing the first three questions.
- Document the patient responses in the PHQ-9 Depression Scale by clicking to **expand** the screen to the right of the Patient Health Questionnaire-2 Score field.



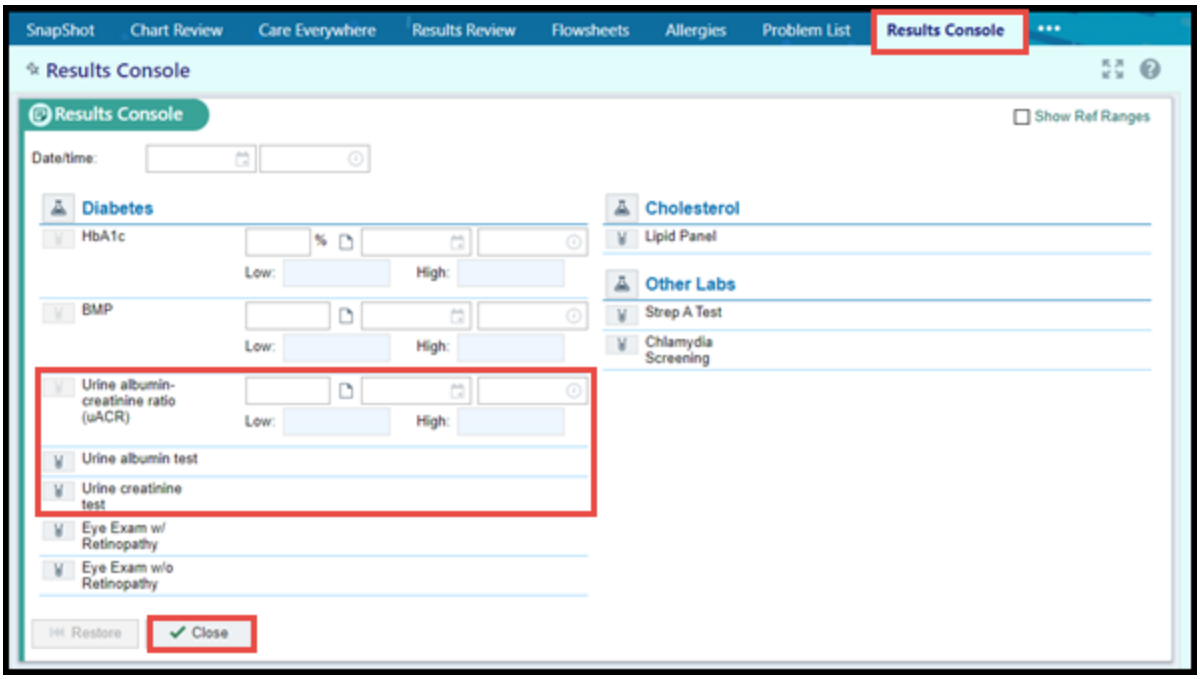
- A positive finding is a PHQ-2 of ≥ 3 or PHQ-9 of ≥ 10.
- Document the **Follow-up** method for a positive screening.
- Click **Accept** at the bottom of the screen to save.

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES

Description: The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

Document Estimated Glomerular Filtration Rate (eGFR) and Urine Albumin-creatinine Ratio (uACR)

- Open the patient chart.
- Click the **Results Console** tab in the toolbar.
- Enter the result and date of test.
- Click **Close** to save.

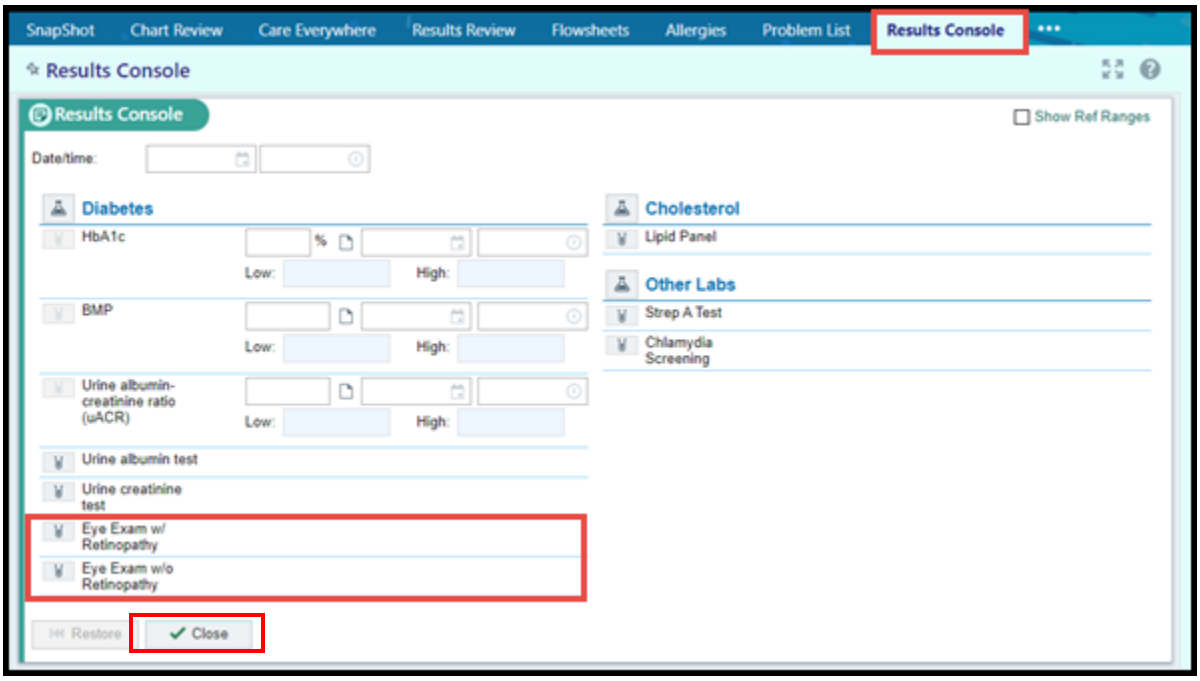


EYE EXAM FOR PATIENTS WITH DIABETES

Description: Patients age 18-75 with diabetes who received a retinal eye exam during the measurement period.

Document Eye Exam Result

- Open the patient chart.
- Click the **Results Console** tab in the toolbar.
- Enter the result.
- Click Close to complete the entry.



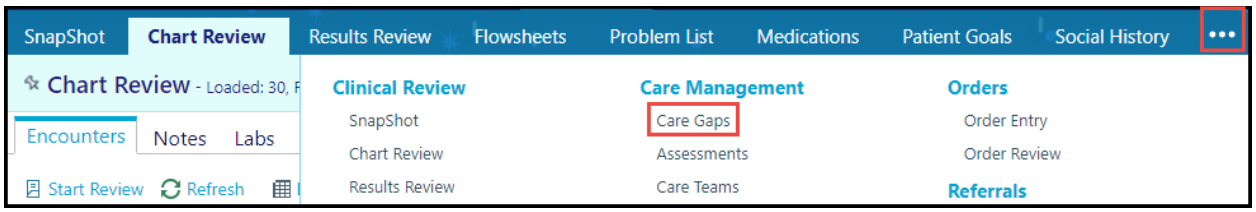
IMMUNIZATIONS: INFLUENZA & CHILDHOOD

Description:
Influenza (ACO): Percentage of patients aged 6 months and older seen for a visit during the measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Childhood (HEDIS): Percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB), one chickenpox (VZV); four pneumococcal conjugates (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

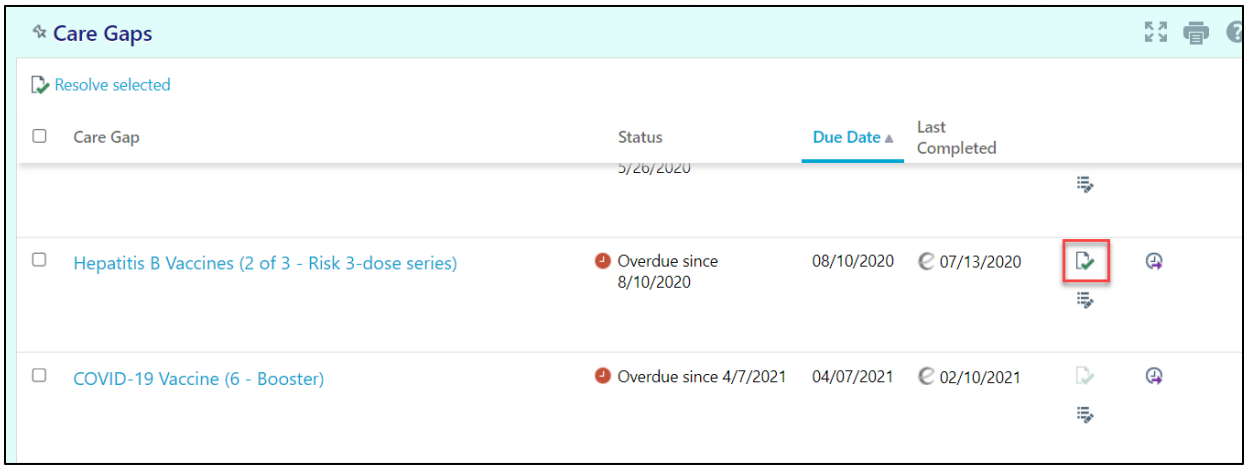
Add an Outside Immunization

If the patient has an immunization that's not in Epic, you can add historical administrations through the Care Gaps activity.

- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Care Gaps.**



- Find the Care Gap for the missing immunization and click **Resolve.**



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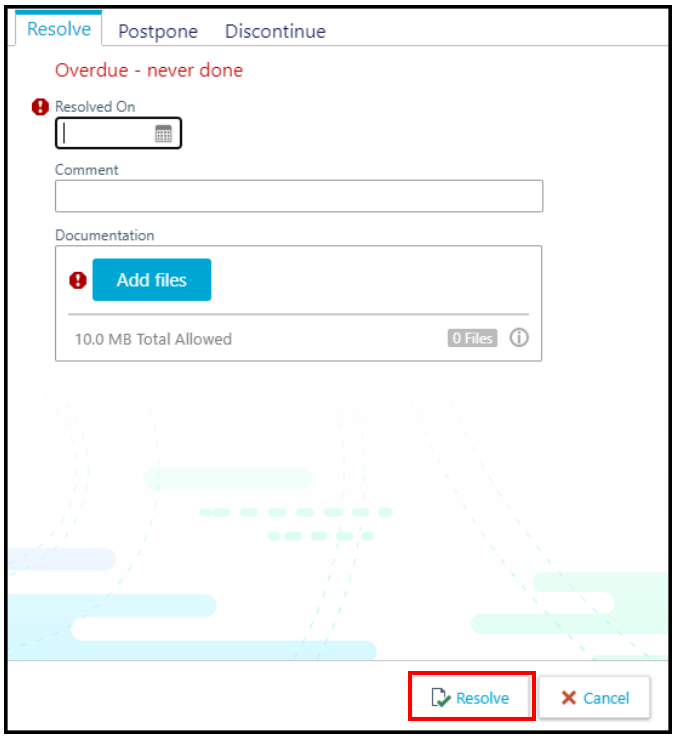
- To satisfy an Immunization Care Gap, document the following:
  - **Resolved On**: Document the date when screening was completed
  - **Comments**: Enter comments if needed
  - **Documentation to Add files**: Add relevant files using the “Immunization Record” document type
  - **Click Resolve**: To save the care gap information

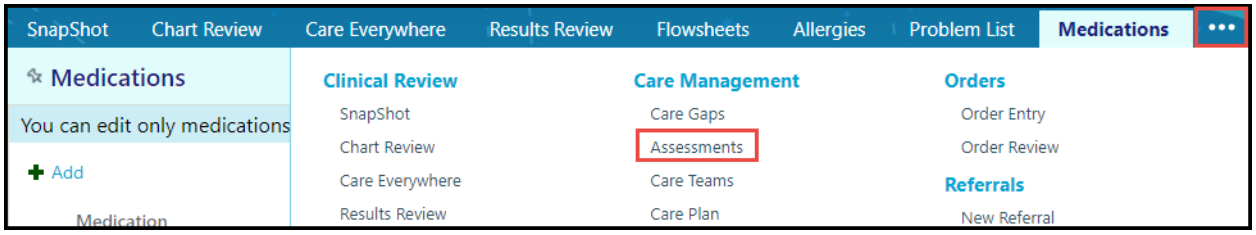


FALLS: SCREENING FOR FUTURE FALLS RISK

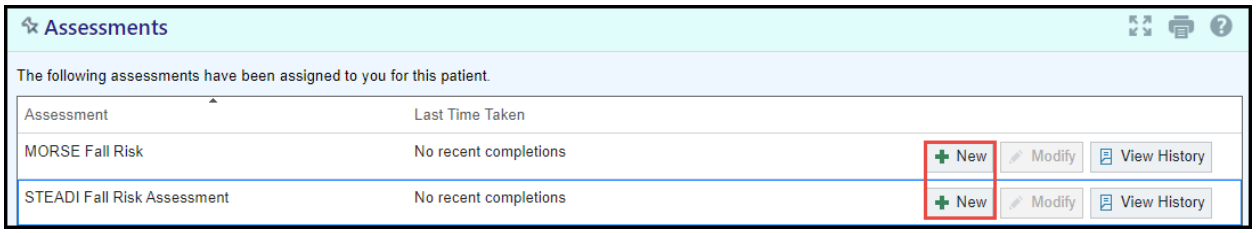
Description: Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

Document Fall Risk Assessment

- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Assessments**.

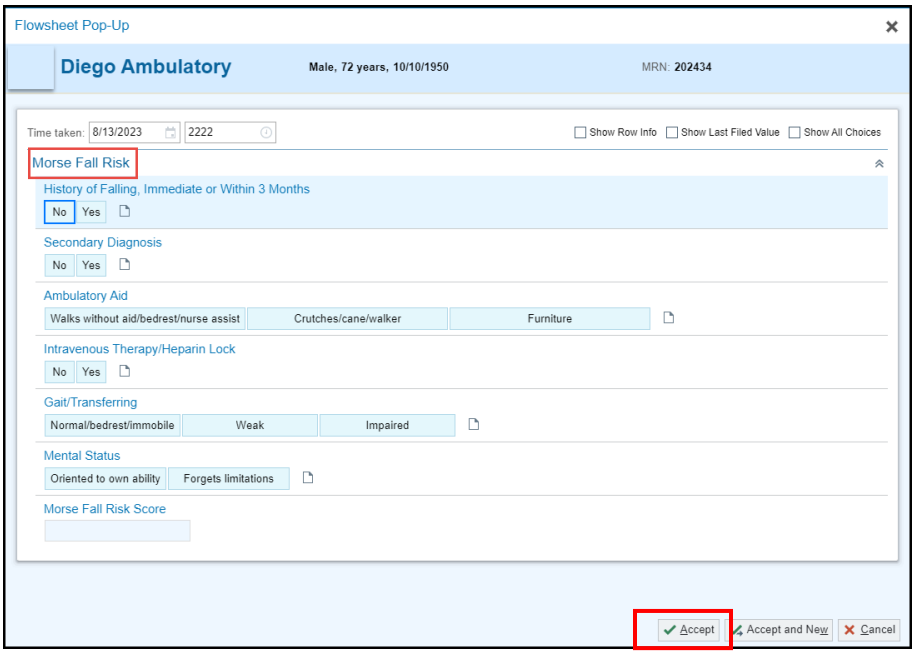


- Find the appropriate screening assessment (choose the **MORSE Fall Risk** or **STEADI Fall Risk** Assessment tool that aligns with the fall risk assessment used in your own EMR) and click the "**New**" button to document an assessment.

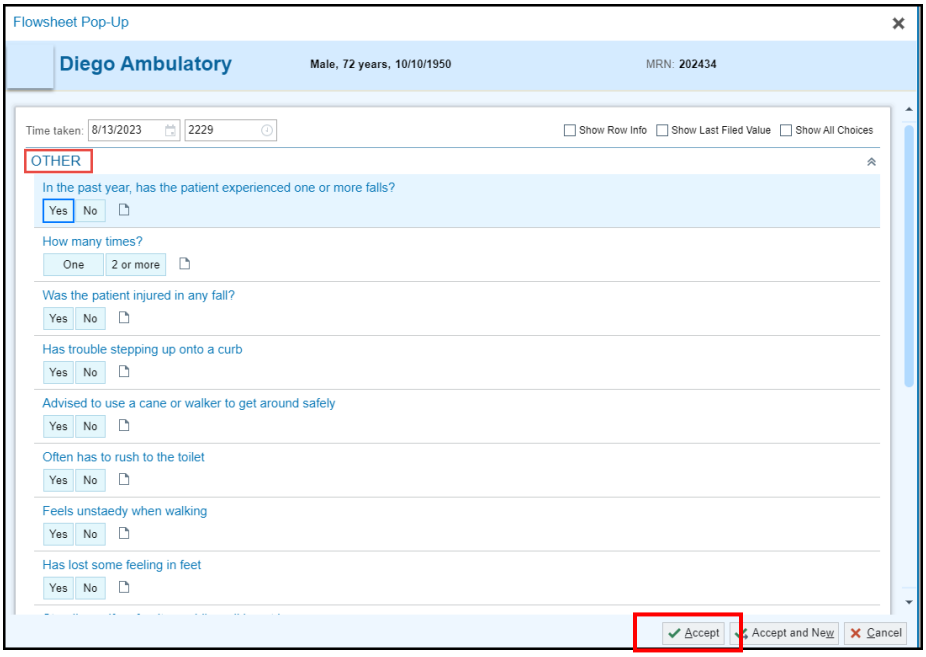


- Document the Assessment **date** and **values.**
- Click **Accept** to complete.

Morse Fall Risk Assessment



STEADI Fall Risk Assessment



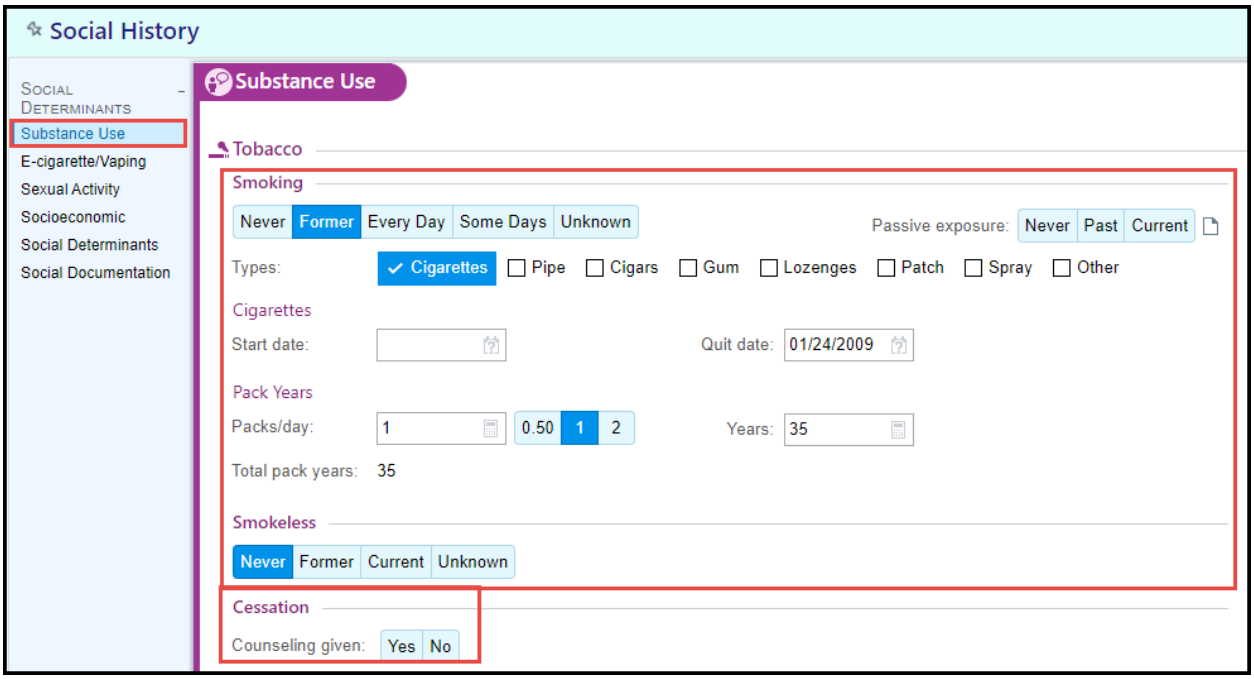
TOBACCO USE SCREENING AND CESSATION INTERVENTION POPULATION

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user

Document Tobacco Use and Cessation in Social History

- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Social History**.

- Click on the **Substance Use** section.
- For tobacco use, document the usage and type of Tobacco used in the **Smoking** section.
- For tobacco cessation counseling received, choose "**Yes**" for **Counseling Given** under cessation section.
- Click **Close** at the bottom of the screen to complete documentation.

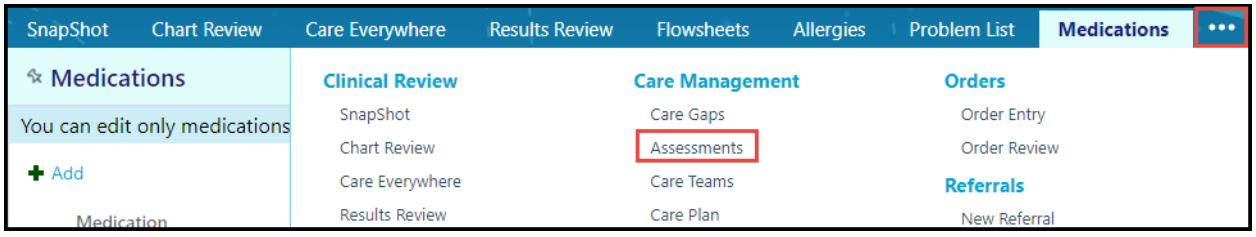


DEPRESSION REMISSION AT 12 MONTHS

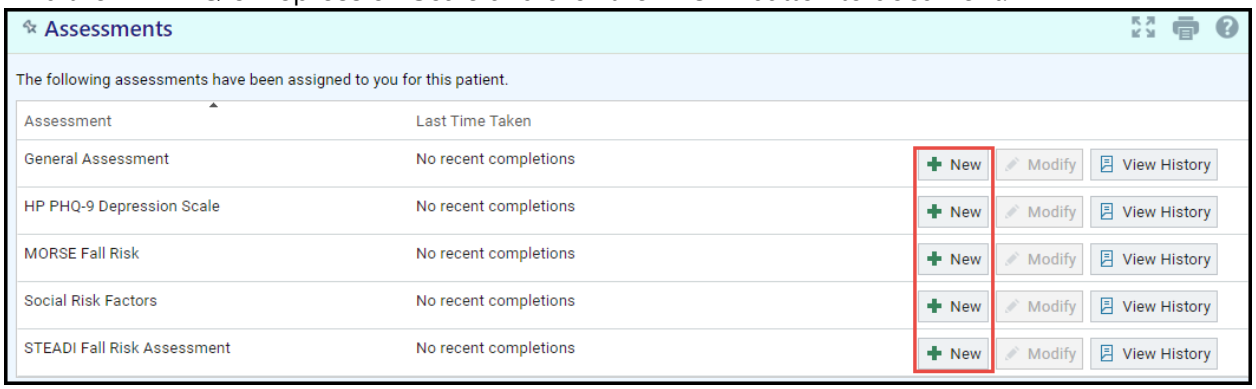
Depression Remission: The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

Document Depression Screening Assessment

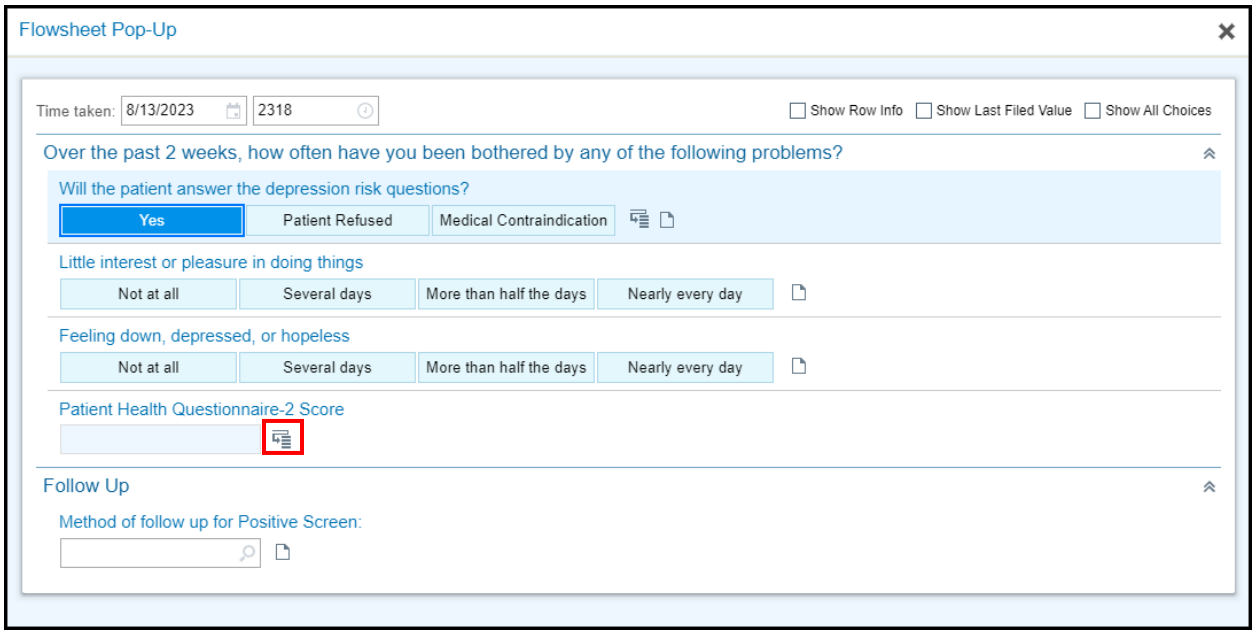
- Open the patient chart.
- Hover over the **More Menu** at the top right of the screen and click **Assessments**.



- Find the HP PHQ-9 Depression Scale and click the "**New**" button to document.



- Complete the PHQ-9 by clicking the **expand** button to the right of the Patient Health Questionnaire-2 Score field.
- Click **Accept** at the bottom of the screen to save.



  - A patient will meet the measure if a **PHQ-9 score <5** is documented after 12 months from the previous score **>9** with a grace period of sixty days prior and sixty days after.

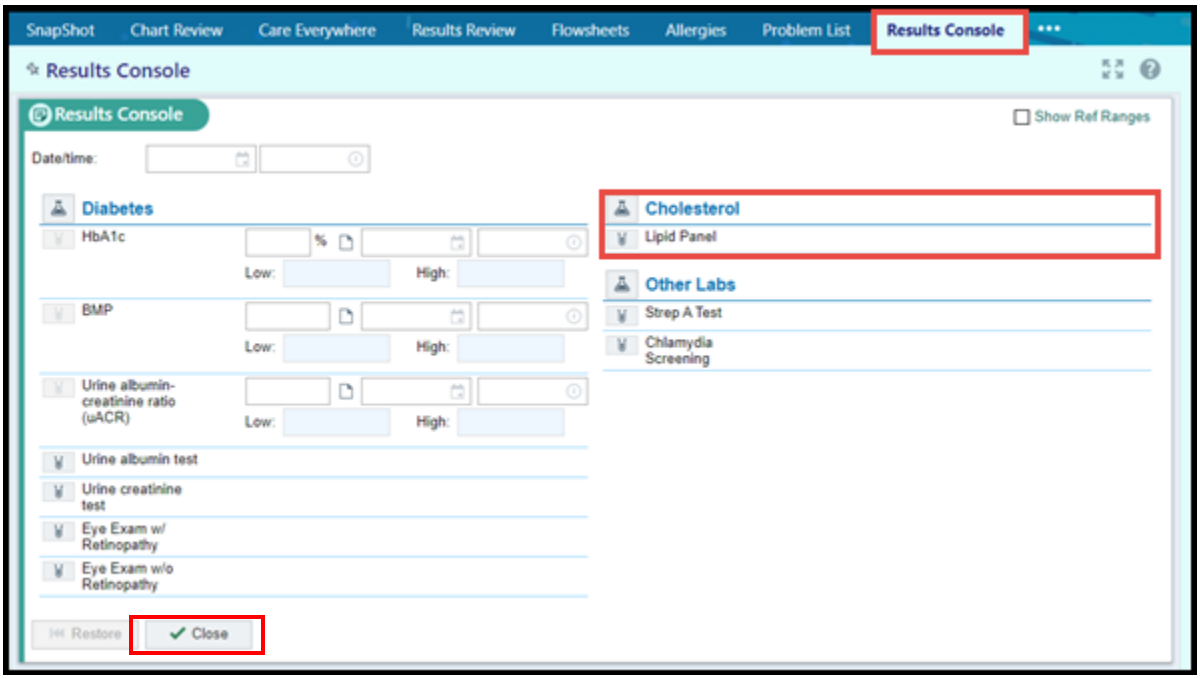
STATIN THERAPY FOR THE PREVENTION AND TREATMENT OF CARDIOVASCULAR DISEASE – ASCVD

Description: Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure, OR
- Patients aged >= 20 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia, OR
- Patients aged 40-75 years with a diagnosis of diabetes

Document LDL Result

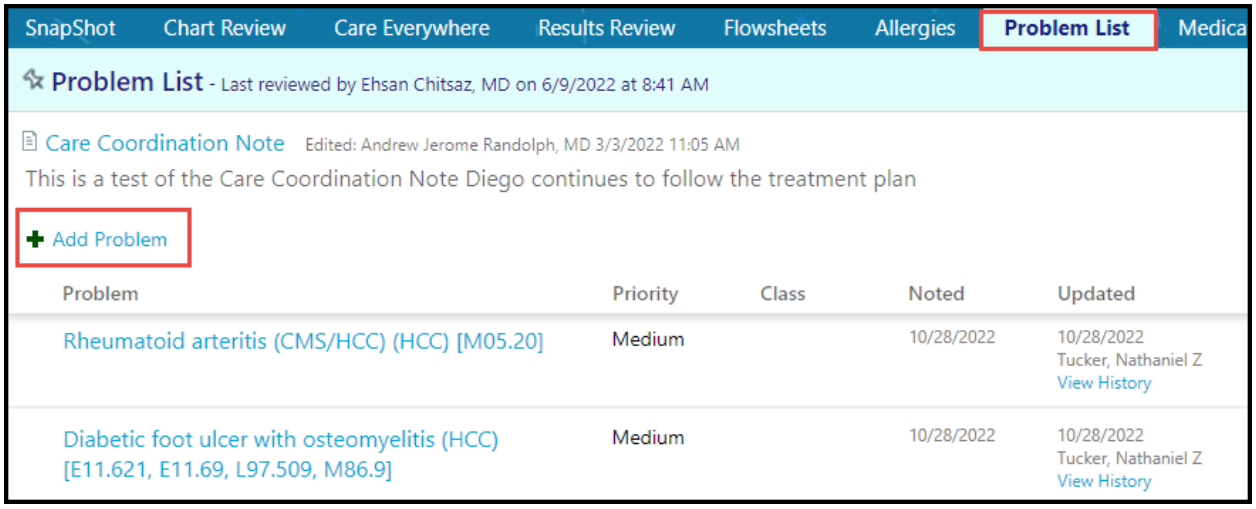
- Open the patient chart.
- Click the **Results Console** tab in the toolbar.
- Enter the result.
- Click Close to complete the entry.



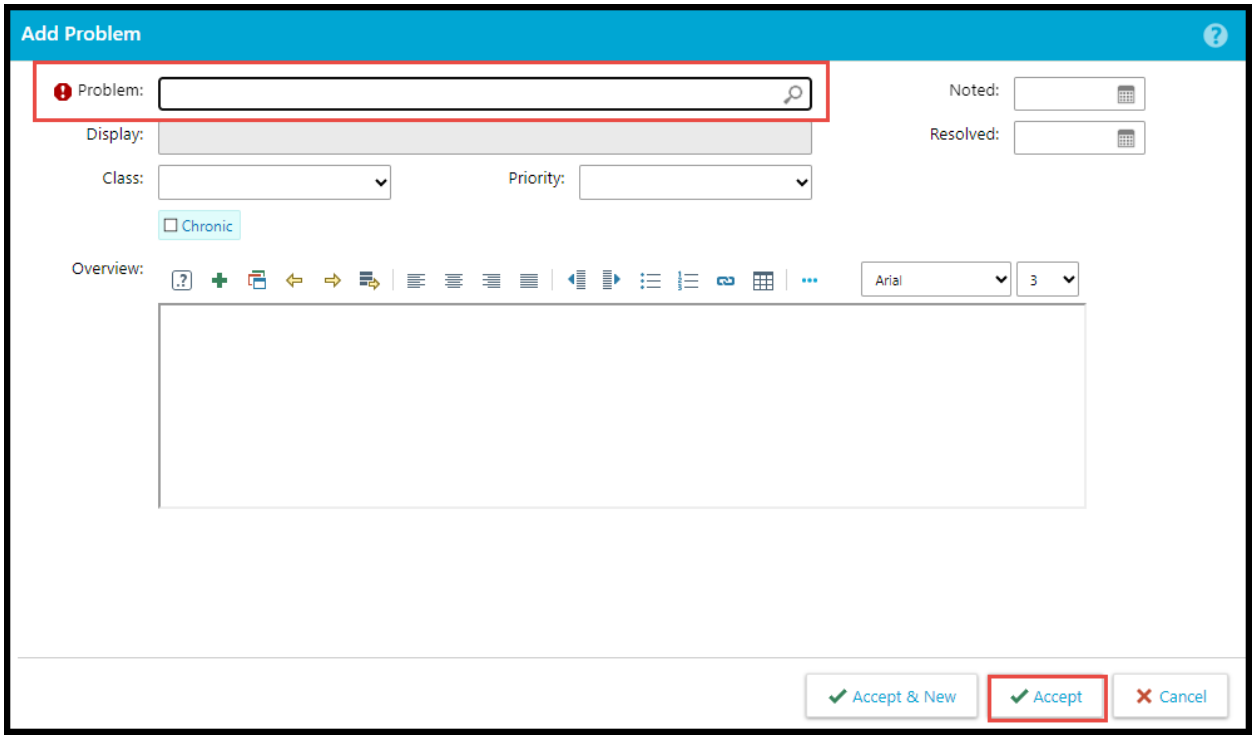
PROVIDER FEATURES

Add Diagnosis to Problem List

- Measure Exclusions impacted by this documentation:
  - ACO Only: Screening for Clinical Depression and Follow-up
  - ACO Only: Colorectal Cancer Screening
  - ACO Only: Breast Cancer Screening
  - ACO Only: Controlling High Blood Pressure
  - ACO Only: Depression Remission at 12 Months
  - ACO Only: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease - ASCVD
- Measure Exceptions impacted by this documentation:
  - ACO Tobacco Screening and Cessation Intervention
- Open the patient chart.
- Click on the **Problem List** from the menu.
- Click **Add Problem.**

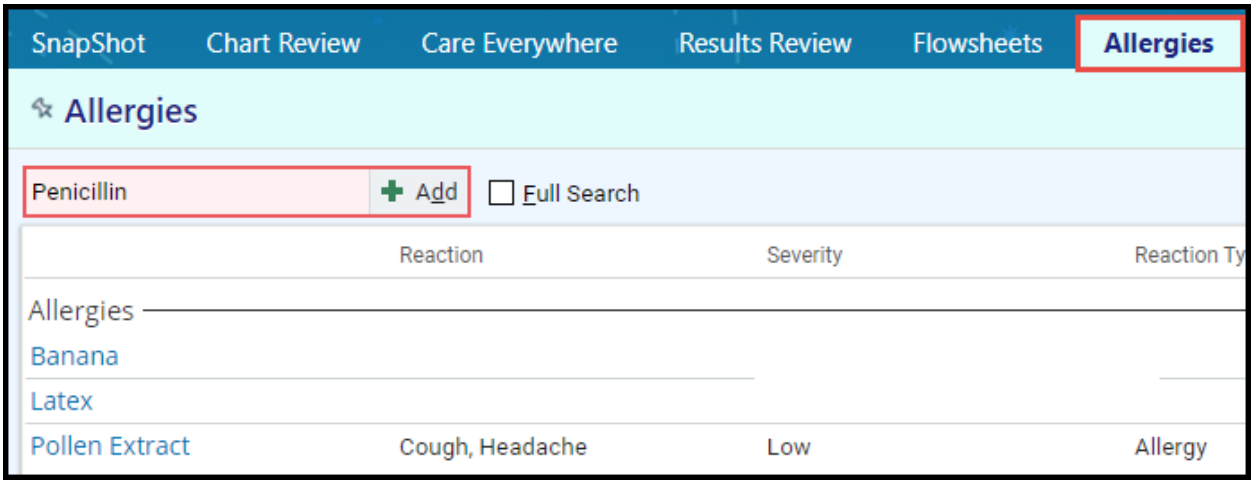


- Enter the **Problem** to be added and click "**Accept**."



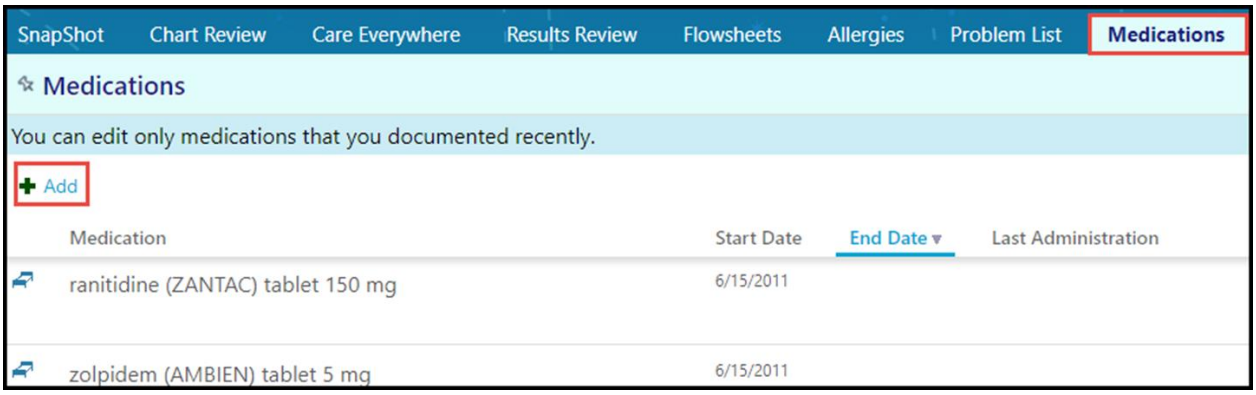
Add Allergies

- Open the patient chart.
- Click on **Allergies** from the menu.
- Enter the allergy to be added and click "**Add**" click enter.
- Enter any additional details such as **reaction**, **severity**, etc.
- Click "**Accept**".



Add Medications

- Measures impacted by documentation:
    - Medication Ordered for Follow-up Plan: Screening for Clinical Depression and Follow-up Plan
    - ACO Only: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease – ASCVD
- Measure Exclusion by documentation:
    - ACO Only: Colorectal Cancer Screening
    - ACO Only: Breast Cancer Screening
    - ACO Only: Diabetes Hemoglobin A1c Poor Control > 9%
    - ACO Only: Controlling High Blood Pressure
- Open the patient chart.
- Click on **Medications** from the menu.
- Click **Add**.
- Search for and **select** the medication.
- Click **Accept**.



Date Modified	What Changes	Modified by:	Revised By:
02.13.23	Formatted to AH Template and updated screenshots	Created by: Ashwin Reddy/Jillian Bacchus, HP Analysts	Giselle Dundas, HP PT
04.24.23	Added screenshots and steps to each measure	Emily Everett	
05.12.23	Edited		Giselle Dundas, HP PT
09.12.23	Edited and addition of screenshots	Melissa Barclay, PHSO Clinical Integrity Data Analyst Amanda Carter, PHSO Solutions Analyst Darlene Kolendo, PHSO Educator	Giselle Dundas, HP PT

This page is to be used as a reference page or an "answer page"