

Partnership to Identify Undiagnosed Diabetes and Chronic Kidney Disease Patients

November 14, 2023





Health Quality Innovation Network





Logistics – Zoom Webinar

- To ask a question, click on the **Q&A** icon.
- **Raise your hand** if you want to verbally ask a question.
- Resources from today's session will be posted in **Chat**.
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Quality Improvement



Speakers



Vicky Kolar, EMT-P, CPHQ Quality Specialist Constellation Quality Health



Linda Fraunhofer, MS Director, Population Health Initiatives Labcorp





Objectives

- Understand how to incorporate lab data within practice quality improvement programming as a tool.
- Discuss LabCorp data and reports that can drive quality improvement programs.
- Conducting root cause analysis (RCAs) and PDSA cycles to connected patients with missed opportunities for diagnosis to appropriate diagnosis.







Considerations that Inspired the Project

- How can we work together to impact chronic disease improvements more effectively?
- What alternate data is timelier to help conduct PDSA cycles?
- Are there different, innovate approaches to impacting chronic disease improvement and outcomes?







Building the Pilot with LabCorp

- Leverage the existing chronic disease lab data
- Pilot integration leveraging both organizations' strengths
 - Robust data reports available to practices
 - Identifying possible gaps in care via lab reports
 - Leveraging quality improvement to close gaps
 - Opportunities to offer education, build workflows, and help conduct root cause analysis (RCAs) and PDSA cycles.
- Value-add for the partnering to conduct the pilot
 - Increased utilization, improved lab requisition documentation, and reducing billing gaps
 - Integration of labs into healthcare quality improvement continuums





Project Plan



Identify Areas for Improvement Opportunities Utilizing Lab Values



We are offering Technical Assistance and workflow support to evaluate your data and processes



Review Existing Data with Labcorp



Develop a project plan starting small an expanding



Set Outcome Goals and Outcome Measures for Chronic Kidney Disease, Diabetes and Hyperlipidemia



We offer Tools, Resources and Technical Assistance Needed for Success of Your Pilot



Labcorp Partnerships for Community Health





LABCORP PARTNERSHIP

Data and analytics

Labcorp enables provider organizations with a unique set of data that includes more than 150 million patient encounters each year and clinical information on 50% of U.S. patients



Laborp data made available through direct system integrations or Insight Analytics self-service portal



UNLOCK THE VALUE OF LABORATORY DATA



Chronic Disease Surveillance

Develop partnerships and programs at national, regional, state and local levels



Care Access Expansion

Supporting telehealth, clinical research participation and reaching patients where they are



Population Benchmarking

Enable insight into the needs and challenges facing specific communities



Quality Optimization

Provide health systems with lab analytics resources to improve quality of care

Labcorp data includes: 150+ million patient encounters annually, 50% of U.S. covered patients and global safety and efficacy data from 100+ countries.



SUPPORTING CHRONIC DISEASE SURVEILLANCE EFFORTS

Diabetes in South Carolina Hemoglobin A1C ZIP Level Average (Mean)

Data Overview

Jan 1, 2021 – Dec 31, 2021 ~440K HbA1C Results State Average A1C: 6.48 Average Age of Individuals Tested: 56





SUPPORTING CHRONIC DISEASE SURVEILLANCE EFFORTS

Kidney Function in South Carolina eGFR ZIP Level Average (Mean)

Data Overview

Jan 1, 2021 – Dec 31, 2021 ~1.3M eGFR Results State Average eGFR: 79.44 Average Age of Individuals Tested: 56





SUPPORTING CHRONIC DISEASE SURVEILLANCE EFFORTS

Cluster/Outlier Analysis Comparison: Hemoglobin A1C & eGFR

Cluster & Outlier Analysis Anselin Local Moran's I Statistic





Labcorp can provide prebuilt, lab-based population health analytics as a tool to define targeted opportunities

Interactive population analytics dashboards

- Utilizes Labcorp patient and results data
- Includes built-in filters
- Reveal details when hovering over visuals
- Provide ability to drill down to the provider or patient level
- Available on demand via Labcorp Link portal
- Report options available:
 - Chronic Conditions
 - Lab Stewardship
 - Population Analysis
 - Community Health

Example of Labcorp Insight Analytics[™] – *Chronic Conditions*

Review patient population & target gaps-in-care

PROPRIETARY & CONFIDENTIAL TO LABCORP						
Diabetes Patient Population Report			REPORT DATE RANGE: 1	0/19/2020 to 10/6/20;	21 (1)	D
POPULATION			CONTROL			
Diabetic Patients with A1c Results			Mean A1c			
844			10.50			
				Performanc	e Indicators	_ 1
Co-Morbid Conditions				A1c <= 6.4	2,260	- 1
СКД	CVD	LDI>100		6.5 <= A1c < 7	1,505	- 1
182	34	325		7<=A1c<8	1,612	- 1
102	34	323		8<=A1c<9	642	- 1
	Filter by patients with gap in care for eGFR		y patients with care for eGFR INES-BASED TESTING		U	
No A1c Performed in Last 6 Months	Overdue for eGFR Test		No Urine in Last	e ACR Year	ASCVD with No LDL in Last Year	
Overdue 844	Overdue	157	Overdue	467		



Insight AnalyticsTM with ZIP Code Filter Companion Reporting to Support Cluster/Outlier Analysis

The ZIP code filter enables assessment of population health metrics and care-gaps in specific communities.



Everett ZIP Code 98204



Analytics to support accurate ICD-10 coding

Gaps-in-care can also be associated with inaccurate ICD-10 coding¹ Insight Analytics uses lab-data powered dashboards to highlight and monitor comparison between ICD-10 codes and test results.

LabCorp Insight Analytic	:S	() labcorp			
Practice Name Filters (All)	Provider Name Pay	ver Name Specia II) • (All)	Ity Code Report Date Range Image 10/01/2021 - 09/30/2022		
Total Patients Tested Patients with CKD 3-5*		Related Codes Submitted			
437,198		88,239	eGFR indicates CKD, and related ICD-10 codes received 13,638		
CKD Stage breakdown by lab test result			ICD-10 codes submitted		
Patients with	Patients with Patients with Patients with		ICD-10 codes for CKD recieved, but eGFR does not suggest CKD 1,500		
CKD Stage 3	CKD Stage 4	CKD Stage 5	Agreement between ICD-10 codes and test		
78,185	7,872	2,189	results		
Related Coding Result and Code Submitted Agreement 14.44% 11.81%	Related Coding Result and Code Submitted Agreement 40.69% 20.81%	Related Coding Result and Code Submitted Agreement 40.20% 13.98%	ICD-10 code and test results agree on 11,176 ICD-10 indicates CKD, but test results 1,500 ICD-10 code indicates higher CKD Stage 692 ICD-10 code indicates lower CKD Stage 1,774		

1. Horsky, J., Drucker, E. A., & Ramelson, H. Z. (2017). Accuracy and completeness of clinical coding using ICD-10 for ambulatory visits. In AMIA annual symposium proceedings (Vol. 2017, p. 912). American Medical Informatics Association



-South

Chronic Kidney Disease

Carolina

Analytics to support accurate ICD-10 coding (cont.)

Gaps-in-care can also be associated with inaccurate ICD-10 coding¹ Insight Analytics uses lab-data powered dashboards to highlight and monitor comparison between ICD-10 codes and test results.

LabCorp Test resu	Insight Analytic	cs parison Report	t				() la	bcorp
Filters	Practice Name (All)	Provider Nar (All)	me Paye	r Name	Specialty Code (All)	()	Report Date Range 10/01/2021 - 09/30/2022	2
Total Patients Tested Patients with Diabetes			Related Codes Submitted					
	639,055		130	,548	HgbA1c indicates DM, ICD-10 cod	and related les received		86,095
Diabetes breakdown by lab test results			HgbA1c indicates DM, but n	o related I	48,853			
	Diabetes without Complications		Diabetes with Chronic Complications		Agreement betw	veen ICD-10 co	odes and test resu	11ts 70,531
	110,042		20,934		No coding receive	ed a 12,340	48,853	
Related Subm	Coding Result nitted Agre	and Code ement 02%	Related Coding Submitted 69 70%	Result and Code Agreement 11 24%	Cannot determin Implied mismatch complicat	6,537 t 1,297		
						Select Interr	pretation Grouping above to	o see Detail

1. Horsky, J., Drucker, E. A., & Ramelson, H. Z. (2017). Accuracy and completeness of clinical coding using ICD-10 for ambulatory visits. In AMIA annual symposium proceedings (Vol. 2017, p. 912). American Medical Informatics Association



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Chronic Kidney Disease

Curoling



Project Workflow

Verify the patient attribution

Verify the attributed patient is on the patient panel Review and reconcile diagnosis in EHR

Is the lab report/result in the patient's chart? Is the diagnosis in the patient's chart?

-- If yes, opportunity for training on workflows and proper documentation

-- If no, move to the next step

Diagnosis and treat

Work with clinical team to diagnosis and develop treatment plan for patient

Conduct an RCA for missed opportunity

Conduct PDSA to prevent further gaps in the future





Technical Assistance Offerings



Educational Offerings

- Proper documentation
- Lab Requisition procedures
- Diagnosing best practices
- Lab resulting procedures

- EHR alerting systems
- EHR order sets
- Change package implementation





Questions?







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