Why do I keep seeing some care gaps after I already addressed them and submitted a claim?

MSHP receives payers' new claim data on a monthly basis but claims data inherently lags at least two months. Therefore, it can take up to three months before the data is refreshed with new claim information.

When do I need to submit the Care Gap Worksheet to MSHP?

Most care gaps can be cleared off your list by submitting a claim for the service that is required to meet that care gap. In some cases, you may not submit a claim because, for example, the service has been delivered by another provider. In these cases, you should identify on the Excel worksheet that the services were rendered, the date the service was rendered, and add any applicable comments. The worksheet may be returned to MSHP via Box, Mount Sinai's enterprise cloud-based file-sharing portal. MSHP will submit this information back to the payer on your behalf so that you can get credit.

Note: If a patient self-reports that they received a service through another provider, please document it in the patient's chart and also in the MSHP Excel worksheet.

What burden of proof is required to demonstrate a patient with an open care gap has already met the measure?

Documenting the date that the measure was met and returning the Excel worksheet to MSHP is sufficient to demonstrate that a patient has met the measure. Please ensure that the date of care is also documented in the patient's chart.

Why am I only seeing this for some and not all of my patients?

MSHP only sends Care Gap Reports for patients whose lives are attributed to you, based on the health plan agreements with which you participate through MSHP.

Mount Sinai Health Partners

150 East 42nd Street
New York, NY 10017

Contact Us!

If you have questions, please contact your Provider Engagement Manager or reach us in the following ways:

Phone: **877-234-6667**
Fax: **212-523-5775**
Email: **MSHP@mountsinai.org**

Closing Gaps in Care

MSHP supports physicians in their ongoing effort to provide wellness- and disease-related outreach to patients with the goal of improving health outcomes

Mount Sinai Health Partners

Today's health care environment is driven by data to improve clinical and quality outcomes and achieve cost efficiencies. Addressing gaps in care is a critical issue for physicians, health systems and payers that grows in importance as value-based care efforts mature. To promote and achieve these goals, Mount Sinai Health Partners seeks to enter into value-based agreements with payers that may offer, among other things, care coordination fees and other payments for coordinating the care of attributed members so long as MSHP's network meets established benchmarks for quality of care.

Data aggregation and analysis can assist physicians in identifying care gaps within their practices. Since health plans obtain data from a variety of sources on patients they insure, claims data that payers aggregate and share with MSHP may reflect a broader spectrum of care than what is documented in your charting system.

At MSHP, we aggregate care gap data from numerous insurance plans. We share back with you a single worksheet of care gaps for all your patients under a value-based contract. Through your review and attention to these care gaps, we are able to further our goal to improve patient outcomes.

MSHP Process for Closing Gaps in Care

- Every quarter, MSHP practices will receive by secure email an Excel worksheet identifying care gaps for their attributed members for the health plans with which they participate through MSHP.
- Practices outreach to patients to deliver needed care.
- Should there be any patients on your list whom you have identified as having *already had the needed care*, please fill out the appropriate fields in the Excel worksheet, document it in the patient's chart and return the Excel worksheet to MSHP via Box, Mount Sinai's enterprise cloud-based file sharing portal.
- Returned file should be named "Physician Name_Care Gap Report_Date" Example: John Doe_Care Gap Report_09-09-16

Fields to Complete for Patients Who Already Received Care

- Services Rendered (Y/N/NA)
- Date of Service Rendered
- Notes

Care Gap Measure Descriptions

Below, you'll find a chart of the measures MSHP is tracking for gaps in care, including measure requirement and interval/intervention for each measure.

Measure Title	Measure Requirement	Interval/Intervention
Breast Cancer Screening	Female patients ages 50-74 should have a screening mammogram	Order screening mammogram once every two years
Colorectal Screening	Patients ages 50 to 75 should have an appropriate screening for colorectal cancer during the current year.	Colonoscopy every 10 years for average risk. Fecal occult blood testing or FIT testing is okay if performed annually
Cervical Cancer Screening	Female patients ages 21-64 should receive screening for cervical cancer	Once every 3 years (if concomitant HPV negative every 5 years)
Osteoporosis Management	The % of female patients 67 and older who suffered a fracture during the measurement year, and who subsequently had either a bone mineral density test or were prescribed a drug to treat or prevent osteoporosis	Obtain DEXA scan within 6 months after the fracture
DM- Eye Exam	Patients with Type 1 and 2 diabetes ages 18-75 should have an eye exam (retinal) performed	Refer to ophthalmology for annual retinal exam
DM- Kidney Dx Monitoring	The % of patients 18-75 years of age with diabetes (Type 1 and Type 2) who received a nephropathy screening or monitoring test or had evidence of nephropathy	Obtain urine microalbumin test annually
HbA1c>8.0%	The % of patients 18-75 years of age with diabetes (Type 1 and Type 2) whose most recent HbA1c level during the measurement year was greater than 8.0% or was missing a result, or if an HbA1c test was not done during the measurement year. If HbA1c >8.0, clinicians should consider additional therapy and/or referral to diabetes educator or endocrinologist.	Initiate therapy for improved glycemic control and follow-up HbA1c until under 8.0%. Referral to diabetes educator or endocrinologist as needed.
Rheumatoid Arthritis	All patients diagnosed with this disease should be prescribed a Disease Modifying Anti-Rheumatic Drug (other than NSAIDs or Prednisone)	If diagnosis of Rheumatoid Arthritis confirmed begin on disease modifying agent. If does not have RA but rather OA, remove RA from diagnosis code and notify MSHP
High Risk Medication	HRM list with 2 or more RX in measurement year. List maintained by Pharmacy Quality Alliance (PQA). Source is Prescription Drug Event (PDE). Attempt to discontinue high-risk medication	Attempt to avoid HRM and discontinue if one script filled
Med Adherence DM	Patients with diabetes who have at least two prescriptions of oral hypoglycemic medication during measurement year should have Proportion of Days Covered (PDC) of at least 80%	Stress compliance and give 90 day refills where possible
Med Adherence HTN	All patients with high blood pressure who have at least two prescriptions for ACEI/ARB during the measurement year should have Proportion of Days Covered (PDC) of at least 80%	Stress compliance and give 90 day refills where possible
Med Adherence Chol	All patients with Hyperlipidemia who have at least two prescriptions for statin during measurement year should have Proportion of Days Covered (PDC) of at least 80%	Stress compliance and give 90 day refills where possible
Tobacco Screening & Cessation Counseling	Every patient age 18 and over should be screened for tobacco use and engaged in cessation counseling if the patient is identified as a current tobacco user	Annually
Preventive Care and Screening for Clinical Depression	Patients 12 years and should be screened for clinical depression during the measurement period using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented with the date of the positive screen (National Quality Forum)	Annually
Pneumovax	Patients 65 and older should be given a Pneumovax vaccine	Administer Pneumovax
Well Child Visit: 15 months	Children should have 6 or more visits from birth to 15 months	6 or more visits from birth to 15 months should be scheduled
Well Child Visit: 3-6 years	All children ages 3-6 should have an annual check up	Schedule patient for an annual well visit