

HEDIS® 101 for Providers

Working together to improve the quality of care.



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“HEDIS” stands for Healthcare Effectiveness Data and Information Set, a standardized set of performance measures developed by the National Committee for Quality Assurance (NCQA, www.ncqa.org) in 1991.

- **Used by more than 90% of America's health plans to measure performance on important dimensions of care and service.**
- **HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.**

HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).



HEDIS® measures address a broad range of important health issues, such as:

- Newborn, Child, and Adolescent: Well Visits, Screenings & Immunizations
- Physical & Mental Health Chronic Conditions
- Appropriate Use of Antibiotics
- Women's Preventive Health & Pregnancy Care
- Member Experience



HEDIS® also includes the CAHPS® Health Plan Survey. **The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** Health Plan Survey measures members' experiences with their health care. Patient experience includes several aspects of health care delivery that patients value highly when they seek and receive care, such as:

- Rating of health care providers
- Rating of health plan
- Health plan customer service
- Appointment Timeliness
- HEDIS® Measures:
 - Aspirin Use & Discussion
 - Flu Vaccinations in Adults
 - Medical Assistance with Smoking & Tobacco Use



CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality



CAHPS® results offer an indication of how well health care organizations and meet member and patient expectations.

The plan conducts the following member experience surveys on an annual basis:

- **CAHPS® Adult**
- **CAHPS® Child**
- **CAHPS® Children with Chronic Conditions**
- **Member Experience with Behavioral Health Services**

Surveys are distributed to members from February – April. A high level of the results are reported annually in the member and provider newsletters.



- Measure health plan and provider performance.
- Identify quality improvement initiatives.
- Provide educational programs for members and providers.
- Monitor adherence to the clinical practice guidelines.
- Build a culture of continuous improvement.
- Support our Mission: **We help people get care, stay well and build healthy communities.**
- Support the *Triple Aim* framework.



The **Triple Aim** is a framework that describes an approach to improving and optimizing health system performance. HEDIS® and CAHPS® data collection and reporting are some of the tools used in pursuit of the Triple Aim.

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care



*The Triple Aim framework was developed by the Institute of Healthcare Improvement (IHI). For more information go to:
<http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>*



HEDIS® data is used to improve and develop priorities in health care quality improvement.

The U.S. Department of Health and Human Services (USDHHS) affirms that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule permits a provider to disclose protected health information to a patient's health plan for HEDIS.

For more information, please visit the following site:

www.hhs.gov/hipaa/for-professionals.



- Select Health of South Carolina complies with all applicable federal and state laws and regulations regarding health plan member privacy and data security, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Standards for Privacy of Individually Identifiable Health Information, and the HIPAA Security Rule as outlined in 45 CFR Parts 160 and 164.
- Under the HIPAA Privacy Rule, **data collection for HEDIS® is permitted and the release of this information requires no special patient consent or authorization.**
- Our health plan members' personal health information is maintained in accordance with all applicable federal and state laws and regulations. Data is reported collectively without individual identifiers.



Data is reported to NCQA every June of the reporting year (June 2019)

Data reflects services/events that occurred during the measurement year (calendar year)

HEDIS® 2019 data is reported in June 2018; however, it reflects data from January 1 thru December 31st, 2018.

HEDIS® 2019 results generally reflect services delivered during calendar year 2018.



Administrative data:

- Claims Data
- SC Immunization Registry
- Lab Data Files
- Health Information Exchange
- Encounter & data from FFS Medicaid
- Pharmacy Data

Hybrid data is a combination of the following:

- Administrative Data
- Medical Record Review (MRR)
- ***Allowed only for certain HEDIS® measures.***

Survey data:

- CAHPS® Health Plan Surveys



Denominator = eligible patients of the population assigned to your practice.

Numerator = assigned patients that met the criteria of a measure or number of compliant members.

Example: Adolescent Well-Care Visit

- **500** assigned patients who are between 12 and 21 years old during the year (**denominator**).
- **250** assigned patients who met criteria by completing an adolescent well visit during the year (**numerator**).
- **Practice Score = 250/500 or 50%.**

HEDIS® Annual Medical Record Review: Hybrid Methodology Explained



Hybrid Methodology Defined



The Hybrid method of data collection consists of the selection of a random sample of the population and allows for supplementation of Administrative data with data collected during the medical record reviews.

Hybrid rates consist of the following:

- Members whose care meets the measure standard based on administrative data (claims, labs, immunization registry, etc.)
- Members who do not have administrative data to satisfy the measure.
 - The plan conducts a review of the medical record. This is the annual HEDIS® Medical Record Review Project.

Measures Reported Using Hybrid Methodology



ABA	Adult BMI Assessment
AWC	Adolescent Well-Care Visits
CBP	Controlling High Blood Pressure
CCS	Cervical Cancer Screening
CDC	Comprehensive Diabetes Care
CIS	Childhood Immunization Status – Combo 10
FPC	Frequency of Prenatal Care \geq 81%
IMA	Immunizations for Adolescents (MCV, Tdap, HPV)
LSC	Lead Screening in Children
PPC	Prenatal and Postpartum Care
WCC	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents
W15	Well-Child Visits in the 1 st 15 Months of Live \geq 6 visits
W34	Well-Child Visits Ages 3-6 Years

All other HEDIS® measures are collected using administrative data OR survey data only.

Medical Record Requests (Hybrid)



- **Medical record requests are sent by our HEDIS® nurses starting in January each year.** Your practice can expect to receive requests on an annual basis.
- **Requests include:**
 - A list of your patients who are our members;
 - The assigned HEDIS measures;
 - The documentation needed.
- **Requested records can be sent using the following methods as indicated in the request:**
 - Secured fax as indicated on the request
 - Mailed directly to Quality Department
 - Onsite collection (nurse will work with practice to schedule an onsite time)

Timely Response to Medical Records Requests



HEDIS® data collection is a time sensitive project.



- Medical records should be made available on the date of the onsite review, or by the date requested, in the case of fax/mail.
- Its is imperative that you respond to a request for medical records within five days to ensure we are able to report complete and accurate rates to South Carolina Department of Health and Human Services (DHHS) and NCQA.
- **HEDIS® data collection typically ends in April. All data requested must be received by April or as indicated on the request.**
- If you utilize a Release of Information (ROI) vendor, it is your responsibility to make sure the vendor is also meeting this timeframe expectation. **Their response time can directly impact your scores.**

Medical Record Project Questions



Who do I contact if I have questions about HEDIS® medical record requests?

- During HEDIS® medical record review season, each medical record request includes the contact information for the requestor and how to send medical records.
- You may also contact Heather Simmons, HEDIS® Project Manager at value@selecthealthofsc.com.
- **Subject: HEDIS Medical Records Review**
- Your Account Executive is also available to answer basic questions or coordinate with the HEDIS® team on your behalf.

Your Network Management Account Executives



Upstate (all regions)	Joyce Mahon	843-787-0056
Upstate Western Region	Sarah Hipps	843-259-0482
Upstate Greenville Region	Vonda Butler	803-609-8041
Lowcountry Region	Ashkia Harman	843-709-8922
Midlands Region	Kaye Steele	843-354-1231
Upper Pee Dee Region	Paige Watford	843-933-0276
Lower Pee Dee Region	Sarah Wilkinson	843-754-8847
Lowcountry Border Region	Mary Wasden	843-666-2521
Ancillary Services statewide	Ruth Sisson	843-746-7497

HEDIS® Tips, Tools and Resources





Complete and accurate coding

Accurate and complete coding of claims is also very important. If a service or diagnosis is not coded correctly, the data may not be captured for HEDIS® or the patient's care gaps and may not be reflected accurately in your quality scores.

- **Use correct ICD-10, HCPCS and procedure codes.**
- **Submit claims and encounters timely.**
- **Improve standardization across providers/locations.**
- **Conduct internal audits of submitted encounters.**
- **If your patient has a primary insurance, it is important that you file a claim to Select Health as the secondary so it can be included in your HEDIS® quality scores.**





Scheduling & maximizing patient visits

Capturing all services due while patients are onsite is one strategy to keep patients as up to date as possible.

- Use opportunities, such as sick visits, to complete needed components of well visits, immunizations and other needed services where appropriate.
- Use your EMR system to develop standard care templates and standing orders where possible. **“Make doing the right thing, the easy thing.”**
- Use a reminder system.





Use your member roster.

The member roster is an important tool for improving HEDIS® scores. Your scores are based on all members **assigned** to the practice.

- Review and work reports of patients with gaps in care.
- Appoint a HEDIS® champion.
- Include the entire practice in HEDIS® results and improvement priorities.
- Review roster lists and outreach to patients who are new to the practice to get them in for a new patient appointment.



Common Problems Impacting Scores



- Lack of documentation in the medical record.
- Lack of referral or recommendation for services.
- Lack of complete and accurate coding.
- HEDIS® services received outside of the recommended timeframe.
- Member/Patient non-compliance (i.e. no shows, vaccine refusals.)
- Lack of outreach to newly assigned members.
- EMR Systems that allow providers to bypass key components of care or that are overlooked by providers.
- Lack of accurate, timely, and actionable data.



- Select Health uses **Treo** Solutions software. This software includes roster lists, care gap data, and ER data.
- Member clinical summary reports through **NaviNet**.

For information on accessing Treo or Navinet, contact your Select Health Account Executive.

- For general HEDIS improvement questions, contact department of quality management: value@selecthealthofsouthcarolina.com
- Provider HEDIS® Resources on Select Health's website: www.selecthealthofsc.com/provider/resources
- Provider newsletter, **Select News**: www.selecthealthofsc.com/provider/newsletters



The plan provides HEDIS® results to providers in the following ways:

- **HEDIS® Report Cards** are mailed to providers cards show the following by measure:
 - Practice current HEDIS® rate (year-to-date)
 - Practice final prior year HEDIS® rate
 - Health plan final prior year HEDIS® rate
- **Treo Solutions** - this software shows current rate based on a rolling 12 months of data.
- **Account Executives** visit provider offices at least once quarterly and more often if needed.
- **CAHPS® results** - published annually on the Select Health website and a results summary is published in *Select News*.



HEDIS[®] Measures & Tips:
Prevention & Screening: Newborn, Child, and Adolescent



Well-Child Visits in the First 15 Months of Life (W15)

*Babies turning 15 months old during the measurement year who completed six or more well-child visits with a primary care physician **on or before** reaching 15 months of age.*

Data Collection: HYBRID



Documentation must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- Health history
- A physical development history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance.

Improvement Tips:

- Provide documentation of history, education and anticipatory guidance at every visit.
- Schedule and complete the 6th visit **before** the 15 month birthday.
- Use appropriate coding.
- Use Bright Futures to guide scheduling: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Childhood Immunization Status (CIS): Combo 10

*Percentage of children who received **all** of the required immunizations on or before reaching 2 years of age.*

Data Collection: HYBRID



Documentation must include all of the below immunizations completed on or before the child's 2nd birthday:

BETWEEN 1st and 2nd birthday

1 MMR – measles, mumps, rubella

1 VZV – varicella zoster, chickenpox

1 HepA – hepatitis A

BY 2nd birthday

4 DTaP – diphtheria, tetanus, acellular pertussis

3 HepB – hepatitis B

4 PCV – pneumococcal conjugate

2 OR 3 RV - rotavirus

3 IPV - polio

2 Influenza

3 Hib – haemophilus influenza type B



- Continue to educate parents on the importance of vaccines and **make a strong recommendation for needed immunizations** at each visit.
- Document all vaccine allergies/contraindications and illness history of chicken pox, measles, mumps, and rubella.
- Document the 1st HepB vaccine given at the hospital when applicable or if unavailable, name of hospital where child was born.
- **Include vaccines in the SC immunization registry in your documentation.**
- Document and code RV immunizations correctly for the 2 and 3 dose. (2 dose - Rotarix/3 dose RotaTeq).
- Remind parents about influenza vaccination to make sure newborns receive 2 flu shots before their 2nd birthday.
- Follow the CDC Vaccine Schedules:
www.cdc.gov/vaccines/schedules/hcp/child-adolescent

Lead Screening in Children (LSC)

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning on or before their second (2) birthday.

Data Collection: HYBRID



Documentation must include:

- A note indicating the date the test was performed and the result or finding.

Improvement Tips:

- **Completion of a lead risk assessment does not constitute a lead screening.**
- The Medicaid EPSDT Program requires that all enrolled children have a **blood lead toxicity screening at 12 and 24 months of age. Providers have the option of obtaining the first lead test at 9 or 12 months of age.**
- Schedule lead screening so it is complete prior to the child's 2nd birthday.
- See SC DHEC information here: www.scdhec.gov/environment/your-home/lead

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

*Patients ages 3–17 years who had an outpatient visit and **completed the following during the measurement year: BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity.***

Data Collection: HYBRID



Documentation must include:

BMI (body mass index) percentile

- BMI percentile documented as a value (e.g. 90th percentile) OR BMI percentile plotted on a BMI for-age-growth chart.
- Weight, date and value.
- Height, date and value.
- Use Z codes on claim.

The height, weight, and BMI must be from the same data source.

Counseling for nutrition — Documented discussion about diet and nutrition, anticipatory guidance or counseling on nutrition.

Counseling for physical activity — Documented discussion of current physical activities, counseling for increased activity, or anticipatory guidance on activity.



- **Always code and document BMI Percentile, height and weight and date of service for each.**
 - This measure evaluates whether BMI *percentile is assessed*, rather than an absolute BMI value.
- Document any educational/anticipatory guidance handouts given to the patient.
- Use a pediatric template, such as Bright Futures, to assure age-appropriate anticipatory guidance is always provided. [Brightfutures.aap.org/Anticipatory Guidance.pdf](https://brightfutures.aap.org/AnticipatoryGuidance.pdf)
- Work with your EMR to have BMI percentiles automatically calculate at each visit (including sick visits).
- Use appropriate ICD-10 coding.

Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)

*Children ages 3 – 6 years
who had at least ONE
well-care visit with a PCP
during the measurement
year.*

Data Collection: HYBRID



Documentation must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

1. Health history
2. A physical development history
3. A mental developmental history
4. A physical exam
5. Health education/anticipatory guidance

Improvement Tips:

- Provide documentation of history, education and anticipatory guidance at every visit.
- Use appropriate coding.
- Don't miss an opportunity to provide a missed service. Many patients may not return to your office for preventive care.
- Use Bright Futures to guide scheduling:
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
- **Well Child Exams do not need to be 365 days apart. This provides greater flexibility in scheduling services.**

Adolescent Well-Care Visits (AWC)

*Patients ages 12 – 21
years who had at least
ONE comprehensive well-
care visit with a PCP or
OB/GYN during the
measurement year.*

Data Collection: HYBRID



Documentation must include a note indicating a visit with a PCP or OB/GYN, the date when the well child visit occurred and evidence of *ALL* of the following:

1. Health history
2. A physical developmental history
3. A mental developmental history
4. A physical exam
5. Health education/anticipatory guidance

Improvement Tips:

- Provide documentation of history, education and anticipatory guidance at every visit.
- Use appropriate coding.
- Don't miss an opportunity to provide a missed service.
 - Many patients may not return to your office for preventive care. Instead of completing a sports physical only, complete the well visit exam which will cover the components for the sports physical.

AWC Improvement Tips (cont.)



- Use a reminder system that includes a texting option for adolescent patients.
- Use Bright Futures to guide scheduling: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.
- **Well Care Exams do not need to be 365 days apart. This provides greater flexibility in scheduling services.**
- Resources: <https://www.selecthealthofsc.com/preventive-care/provider/awc/resources.aspx>.

Immunizations for Adolescents (IMA)

*Adolescent patients (males and females) turning 13 years of age during the measurement year who **completed listed immunizations on or before by their 13th birthday.***

Data Collection: HYBRID



Documentation must include:

- A note indicating the name of the specific antigen and the date of the immunization.
- An immunization record, including the specific dates and types of immunizations administered.

1 MCV	On or between 11 th & 13 th Birthdays
1 Tdap	On or between 10 th & 13 th Birthdays
2 HPV	On or between 9 th & 13 th Birthdays

Improvement Tips:

- Patients must complete all immunizations above ON OR BEFORE their 13th birthday. Schedule visits to assure the series is completed by this date.
- Use teen friendly reminders, such as texting or email appointment reminders.
- **Use the SC immunization registry to capture all vaccinations.**
- Continue to educate parents on the importance of vaccines **and make a strong recommendation for needed immunizations at each visit.**
- Follow the CDC Vaccine Schedules:
<https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>

HEDIS[®] Measures & Tips: Prevention & Screening: Adults



Adults' Access to Preventive/Ambulatory Health Services (AAP)

The percentage of patients 20 years and older who had an ambulatory or preventive care visit during the measurement year.

Data Collection: Administrative ONLY



Improvement Tips:

- Schedule adult patients for at least one visit annually.
- Use roster list to identify new patients assigned to your practice.
- Use appropriate coding on all visits.
- Use reminder systems to remind patients of upcoming visits.
- Address all care gaps during visit where appropriate.

Adult BMI Assessment (ABA)

Two-year look back period

*Patients ages 18 – 74
years who had an
outpatient visit with a BMI
documented during the
previous measurement
year and the current
measurement year.*

Data Collection: HYBRID



Documentation must include:

Patients 20 years and older on the date of service:

- Body Mass Index (BMI) value.
- Weight
- Weight and BMI must be from the same data source.

Patients younger than 20 years old on the date of service:

- BMI percentile documented as value (e.g., 85th percentile) OR BMI percentile plotted on a BMI-for-age growth chart.
- Height
- Weight
- Height, weight, and BMI must be from the same data source.
- Use Z codes on claims.

Improvement Tips:

- Use EMR to appropriately, automatically calculate BMI percentile and/or value for all patients. Add a hard stop or mandatory field to be completed.
- Use appropriate coding based on member's age as outlined above and in the coding documentation guides.
- Complete BMI at every patient encounter.

HEDIS[®] Measures & Tips:
Prevention & Screening: Women's Health



Breast Cancer Screening (BCS)

Women 50–74 years of age who had a mammogram to screen for breast cancer.

One or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

*Data Collection:
Administrative ONLY*



Improvement Tips:

- Add mammogram care gap data as an element of the EMR.
- Provide a strong recommendation for needed screening.
- Order and complete referral for mammogram services during the patient's visit.
- Call and schedule the patient's appointment before they leave the office.
- Use care gap list in Treo software to reach your patients who are due for mammograms.
- Use a reminder system.

Cervical Cancer Screening (CCS)

Female patients ages 21 – 64 during the measurement time frame (measurement year and two years prior) who had cervical cancer screening.
OR

Female patients ages 30 – 64 who had cervical cancer screening and HPV test (during the measurement year and four years prior) .

Data Collection: HYBRID



Documentation must include one of the following:

- Date and result of cervical cancer screening test.
- Date and result of cervical cancer screening test and HPV test.
- Evidence of hysterectomy with no residual cervix.

Improvement Tips:

- Ensure documentation related to women's health is in PCP charts.
- Ensure documentation related to hysterectomy indicates "total" hysterectomy when appropriate.
- Ensure results are documented and repeat sample completed if needed for insufficient sample collection.
- Don't forget to order HPV test.
- Use ACOG guidelines to ensure services are provided in a timely manner:

www.acog.org/Patients/FAQs/Cervical-Cancer-Screening

Chlamydia Screening in Women (CHL)

Women ages 16 – 24 who were identified as sexually active should receive at least one test for chlamydia during the measurement year.

*Data Collection:
Administrative*



Improvement Tips:

- Use appropriate specimen collection methodology; a chlamydia culture can be taken during:
 - A pap smear, if patient is due for other services where a pap smear is already indicated.
 - Urine Sample, if patient does not need a pap smear. A simple urine test can be used to test for chlamydia.
- Make screening routine for all female patients 16 years of age and older.
- Utilize chlamydia screening improvement tools located on the Select Health website:

<https://www.selecthealthofsc.com/provider/member-care/chlamydia.aspx>.



- Urine screening for chlamydia is acceptable for all female patients age 16 and older during adolescent well-care or other visits.
- Take a sexual history when you see adolescents.
- If your office does not perform chlamydia screenings, refer members to a participating OBGYN or other appropriate provider and have the results sent to you.

Positive test results:

- Manage positive chlamydia tests and provide treatment the same way as any other test result.
- Ensure continuity of care after a positive screening test.
- Set aside time to discuss the test result, treatment plan and the implications of a positive test result with your patients.
- Educate patients with positive tests on the need to inform their partner(s). Reinfection is common and may cause infertility.

HEDIS[®] Measures & Tips:
Pregnancy: Prenatal, Postpartum & Frequency Measures



Prenatal and Postpartum Care (PPC)

Timeliness of Prenatal Care

Data Collection: HYBRID



Timeliness of Prenatal Care:

The percentage of pregnant patients who received at least one prenatal care visit as a during the first trimester OR within 42 days of enrolling in a Medicaid plan.

Improvement Tips:

- Make sure patients have at least 14 visits for a 40 week pregnancy.
- Bill each prenatal visit/encounter (bundled billing is not allowed.)
- For PCP visits, the pregnancy diagnosis must be present on the claim.
- Refer high risk patients to our **Bright Start** maternity care management program.
- Always complete the pregnancy risk assessment form upon determination of pregnancy DX and fax to the plan OR complete the form online through NaviNet.
- Use appropriate coding.

Prenatal and Postpartum Care (PPC) (cont.)

Postpartum care

The percentage of members who had a postpartum visit on or between 21 and 56 days after delivery.

Data Collection: HYBRID



Document the date of the postpartum visit – documentation must indicate visit date and evidence of at least one of the following:

- Pelvic exam.
- Evaluation of weight, blood pressure, breasts and abdomen (notation of breastfeeding is acceptable for the evaluation of breasts component.)
- Notation of postpartum care (e.g., postpartum care, PP care, PP check, six-week check or a preprinted postpartum care form in which information was documented during the visit.)

Improvement Tips:

- **Only a visit between 21 and 56 days meets compliance for this measure.** Schedule the visit before the patient leaves the hospital.
- Incision check for post-cesarean does not constitute a postpartum visit.
- Postpartum visits are not bundled into the delivery and should be billed as a separate patient encounter.

HEDIS[®] Measures & Tips: Comprehensive Diabetes Care



Comprehensive Diabetes Care (CDC)

*Patients ages 18 – 75
with diabetes (Type 1 and
Type 2) who received
proper testing and care for
diabetes during the
measurement year.*

Data Collection: HYBRID



Patients with diabetes (Type 1 and Type 2) who had each of the following services:

- Hemoglobin A1c (HbA1c) control (<8.0%):
- Eye exam (retinal) performed.
- Medical attention for nephropathy.
- BP control (<140/90 mm Hg).

NOTE: Only the most recent screening dates with screening results during the measurement year count towards compliance.



Hemoglobin A1c Control < 8 %

- At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was *performed and the result or finding*. A1c is also known as the following:

A1c	Glycohemoglobin A1c
HbA1c	Glycohemoglobin
HgbA1c	Glycated hemoglobin
Hemoglobin A1c	Glycosylated hemoglobin

HbA1c control results measure = < 8 % and < 7% (for a selected population.)



Blood Pressure Control <140/90

- **Documentation of the most recent BP reading (s) during the measurement year.**
 - BP control < 140/90 mm Hg.
 - BP readings from remote monitoring devices that are digitally stored and transferred to the provider may be included.
 - **Readings reported or taken by member do not count.**



Eye Exam

- **Screening or monitoring for diabetic retinal disease as identified by administrative data or medical record review. This includes diabetics who had one of the following:**
 - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
 - A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
 - Bilateral eye enucleation anytime during the member's history through December 31 of the measurement year.



Medical Attention for Nephropathy

A nephropathy screening or monitoring test or evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

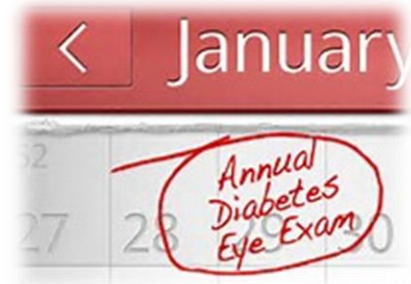
- A nephropathy screening or monitoring test (Urine Protein Tests Value Set.)
- Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set.)
- Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set.)
- Evidence of ESRD (ESRD Value Set) **without** (Telehealth Modifier Value Set; Telehealth POS Value Set.)
- Evidence of kidney transplant (Kidney Transplant Value Set.)
- A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted.)
- At least one ACE inhibitor or ARB dispensing event (ACE Inhibitor/ARB Medications List.)



- Record your efforts.
 - Vitals, labs, evaluation notes, medication reconciliation, and eye exam results should be captured at each visit as applicable.
- Code your services correctly.
- Refer high-risk patients to our diabetes *InControl* program.
- For the recommended frequency of testing and screening, refer to the Clinical Practice guidelines for diabetes mellitus.
- If your practice uses electronic medical records (EMRs), have flags or reminders set in the system to alert your staff when screenings are due.
- If you use hard-copy charts, have a template to identify the last date of screening and the due date of the next screening.
- Send appointment reminders and call patients to remind them of upcoming appointments and screenings.



- Follow up on lab test results, eye exam results or any specialist referral and document in the patient's chart.
- When possible, draw labs in your office rather than referring members to a local lab for screenings.
- Refer members to the network of eye providers for their annual diabetic eye exam and follow up. Ask the eye provider to fax you a copy of the results for the patient's medical record.
- Educate patients, caregivers, and guardians on the importance of:
 - Taking all prescribed medications as directed.
 - Adding regular exercise to daily activities.
 - Having the tests and screening at least once a year.
 - Having a diabetic eye exam each year.
 - Regularly monitoring blood sugar and blood pressure at home.
 - Keeping all medical appointments, getting help (if needed) with scheduling appointments and transportation.



Statin Therapy for Patients with Diabetes (SPD)

The percentage of patients 40-75 years old during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met criteria.

*Data Collection:
Administrative*



Compliance Criteria:

- **Received Statin Therapy:** Patients who were **dispensed at least one statin medication of any intensity** during the measurement year.
- **Statin adherence 80%:** Patients who **remained on a statin medication** of any intensity for at least 80% (10 months) of the treatment period during measurement year.

More information:

- Use the member clinical summary report in Navinet to identify medication adherence issues.
- Patients experiencing difficulty getting medications should be referred to First Choice member services department for assistance.



High, Moderate, and Low-Intensity Statin Medications

Description	Prescription	
High-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Ezetimibe-atorvastatin 40–80 mg 	<ul style="list-style-type: none"> • Rosuvastatin 20–40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Ezetimibe-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg • Niacin-simvastatin 20–40 mg 	<ul style="list-style-type: none"> • Sitagliptin-simvastatin 20–40 mg • Pravastatin 40–80 mg • Lovastatin 40 mg • Niacin-lovastatin 40 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg bid • Pitavastatin 2–4 mg
Low-intensity statin therapy	<ul style="list-style-type: none"> • Simvastatin 10 mg • Ezetimibe-simvastatin 10 mg • Sitagliptin-simvastatin 10 mg • Pravastatin 10–20 mg 	<ul style="list-style-type: none"> • Lovastatin 20 mg • Niacin-lovastatin 20 mg • Fluvastatin 20–40 mg • Pitavastatin 1 mg

HEDIS[®] Measures & Tips: Cardiovascular Conditions



Controlling High Blood Pressure (CBP)

Patients ages 18 – 85 years who had a dx of hypertension (HTN) and whose BP was adequately controlled during the measurement year.

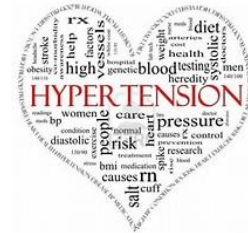
Data Collection: HYBRID



Both systolic and diastolic values for **all members must be below** stated value of <140/90 mm Hg.

Documentation must include:

- **Most recent BP reading(s) recorded measurement year:**
 - The most recent BP reading(s) recorded **on or after the date the second diagnosis of hypertension** occurred.
 - BP readings from remote monitoring devices that are digitally stored and transferred to the provider may be included.
 - Readings reported or taken by member **do not count.**
- Telehealth encounters can be used to satisfy certain components of this measure.



Only the most recent blood pressure measurements taken during the measurement year count toward compliance.



- Improve the accuracy of BP measurements performed by your clinical staff by:
 - Providing training materials from the American Heart Association.
 - Conducting BP competency tests to validate the education for each clinical staff member.
 - Making a variety of cuff sizes available.
- Instruct your office staff to **recheck BPs for all patients with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits. Have your staff record the recheck date and BP readings in patients' medical record.**
- Reach out to your account executive if you need assistance or data to help identify your hypertensive patients.
- Refer high-risk patients to our ***Heart First*** cardiovascular disease management program.
- Educate patients and their spouses, caregivers or guardians about the elements of healthy lifestyle such as:
 - Heart-healthy eating and a low-salt diet.
 - Smoking cessation and avoiding secondhand smoke.
 - Adding regular exercise to daily activities.
 - Ideal BMI.
 - The importance of taking all prescribed medications as directed.



Statin Therapy for Patients With Cardiovascular Disease (SPC)

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met criteria.

*Data Collection:
Administrative Only*



Compliance Criteria

- **Received Statin Therapy:** Patients who were dispensed at least **one high or moderate-intensity statin medication** during the measurement year.
- **Statin Adherence 80%.** Patients who remained on a **high or moderate-intensity statin medication** for at least 80% (10 months) of the treatment period.

More information:

- Use the member clinical summary reports in Navinet to identify medication adherence issues.
- Patients experiencing difficulty getting medications should be referred to First Choice member services department for assistance.



High and Moderate-Intensity Statin Medications

Description	Prescription
High-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 40–80 mg • Amlodipine-atorvastatin 40–80 mg • Ezetimibe-atorvastatin 40–80 mg • Rosuvastatin 20–40 mg • Simvastatin 80 mg • Ezetimibe-simvastatin 80 mg
Moderate-intensity statin therapy	<ul style="list-style-type: none"> • Atorvastatin 10–20 mg • Amlodipine-atorvastatin 10–20 mg • Ezetimibe-atorvastatin 10–20 mg • Rosuvastatin 5–10 mg • Simvastatin 20–40 mg • Ezetimibe-simvastatin 20–40 mg • Niacin-simvastatin 20–40 mg • Sitagliptin-simvastatin 20–40 mg • Pravastatin 40–80 mg • Lovastatin 40 mg • Niacin-lovastatin 40 mg • Fluvastatin XL 80 mg • Fluvastatin 40 mg bid • Pitavastatin 2–4 mg

HEDIS[®] Measures & Tips: Respiratory Conditions



Appropriate testing for children with pharyngitis (CWP)

Patients ages 2 to 18 years who received group A streptococcus (strep) tests with a diagnosis of pharyngitis, tonsillitis or streptococcal sore throats and were dispensed antibiotics appropriately within three days of the diagnosis.

*Data Collection:
Administrative ONLY*



- **Pharyngitis is the only condition among upper respiratory infections (URIs) whose diagnosis can be validated through lab results.**
 - **A strep test (rapid assay or throat culture) is the test of group A strep pharyngitis.**
 - **Serves as an indicator of appropriate antibiotic use among all respiratory tract infections.**

Improvement Tips:

- If a patient tests negative for group A strep but insists on an antibiotic:
 - Refer to the illness as a sore throat due to a cold; patients tend to associate the label with a less-frequent need for antibiotics.
 - Write a prescription for symptom relief like over-the-counter medicines.
- Educate patients on the difference between bacterial and viral infections (this is a key point in the success of this measure).

CWP Improvement Tips (cont.)



- Document the performance of a rapid strep test and code for the testing, when appropriate.
- Code all applicable procedure and ICD-10 codes.
- Discuss with patients ways to treat symptoms:
 - Get extra rest.
 - Drink plenty of fluids.
 - Use over-the-counter medications.
- Educate patients and their parents or caregivers that they can prevent infection by:
 - Washing hands frequently.
 - Keeping an infected person's eating utensils and drinking glasses separate from other family members.
- In accordance to the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/acip>), administer influenza vaccine annually to all children beginning at age 6 months.
- Use CDC Get Smart about antibiotics patient education materials.

Medication Management for People With Asthma (MMA)

The percentage of patients 6-24 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.

*Data Collection:
Administrative Only*



Reported Rates:

- The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.
 - At least **6 filled asthma controller medications during the year.**
- The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.
 - At least **9 filled controller medications during the year.**

Improvement Tips:

- Use NaviNet member clinical summary reports to validate that patients are filling prescriptions.
- Prescribe controller medications.

Samples given to patients in the office impacts data; patient will list as noncompliant.

- Educate members in identifying asthma triggers and taking controller medications.
- Create an asthma action plan (document in medical record).
- Remind patients to get their controller medication filled regularly.
- Remind members not to stop taking the controller medications even if they are feeling better and are symptom-free.
- Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.
- Use the clinical practice guidelines for best practices in asthma management.
- Refer high risk members to our ***Breathe Easy*** asthma case management program.



MMA Asthma Controller Medications



Description	Prescriptions		
Antiasthmatic combinations	• Dyphylline-guaifenesin	• Guaifenesin-theophylline	
Antibody inhibitor	• Omalizumab		
Inhaled steroid combinations	• Budesonide-formoterol	• Fluticasone-salmeterol	• Mometasone-formoterol
Inhaled corticosteroids	• Beclomethasone • Budesonide	• Ciclesonide • Flunisolide	• Fluticasone CFC free • Mometasone
Leukotriene modifiers	• Montelukast	• Zafirlukast	• Zileuton
Mast cell stabilizers	• Cromolyn		
Methylxanthines	• Aminophylline	• Dyphylline	• Theophylline

Pharmacotherapy Management of COPD Exacerbation (PCE)

*Data Collection:
Administratively Only*



Measure Details:

This HEDIS measure looks at assigned patients age 40 and older who had an acute inpatient discharge or emergency department (ED) visit with a diagnosis of chronic obstructive pulmonary disease (COPD) and who were dispensed appropriate medications.

- Dispensing of a systemic corticosteroid (or there was evidence of an active prescription) **within 14 days of the acute inpatient discharge or ED visit.**
- Dispensing of a bronchodilator (or there was evidence of an active prescription) **within 30 days of the acute inpatient discharge or ED visit.**

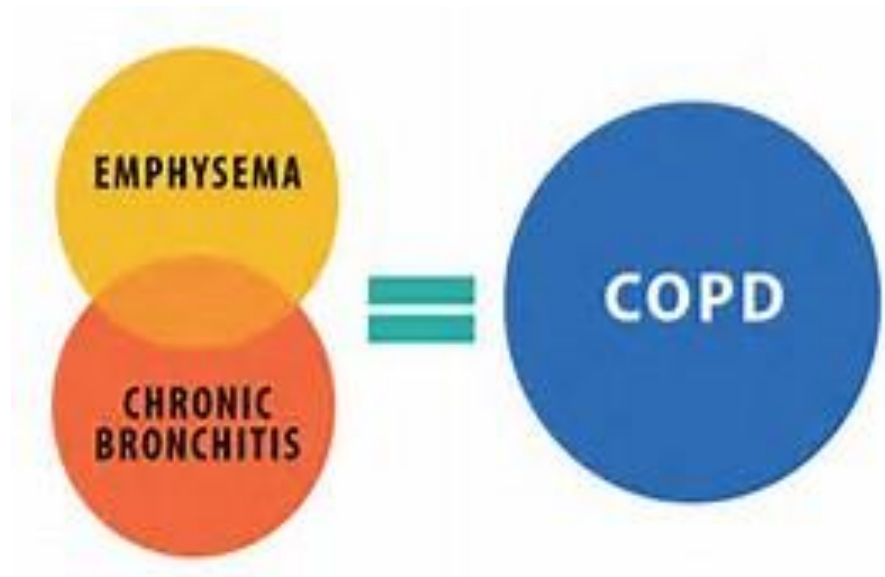
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

*Data Collection:
Administratively Only*



Measure Details:

The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.





- Make sure you schedule an appointment with your patient upon notification of an acute inpatient discharge or ED visit.
- Discuss the importance of smoking cessation; offer solutions to assist to quit. <http://www.selecthealthofsc.com/member/english/staying-healthy/quitting-smoking.aspx>.
- Offer annual flu shots in your office or inform your patients of the importance of getting the vaccine and where they can get it.
- Offer pneumonia vaccine as appropriate.
- Assure that medical records reflect all of the following:
 - Your review of the discharge summary, along with the discharge medications for both a systemic corticosteroid and a bronchodilator.
 - Schedule of regular follow-up visits to review the medication management/compliance.
 - Confirmation calls by office staff to the member prior to the visit.
 - Record of any new prescription written at the follow-up visit.



COPD Improvement Tips (cont.)



- Educate patients about the use of and compliance with, prescribed treatments and medications including controller medications, relief medications, smoking cessation, pharmacotherapy options and avoiding triggers.
- Encourage your staff to use tools within the office to promote smoking cessation. Place posters and educational messages in treatment rooms and waiting areas to help motivate patients to initiate discussions with you about smoking cessation.
- Provide staff training on proper use of inhalers and breathing techniques used for patients with COPD. Offer a continuing medical education (CME) course to enhance training for treatment and prevention of COPD exacerbations.
- Talk to your local Account Executive to assist you with implementing and evaluating events for a particular screening, such as spirometry testing.
- Perform a spirometry test for individuals who present with dyspnea, chronic cough, increased sputum production or wheezing.
- Document in the medical record spirometry testing performed prior to the initiation of pharmacotherapy treatment to support a COPD diagnosis.

HEDIS[®] Measures & Tips: Behavioral Health



Antidepressant Medication Management (AMM)

Patients ages 18 years or older with a diagnosis of major depression who were newly treated with an antidepressant medication and remained on antidepressant medication treatment.

*Data Collection:
Administratively Only*

Measurement details:

- **Effective acute phase treatment:**
Patients newly diagnosed and treated who remained on an antidepressant medication for at least 84 days (12 weeks.)
- **Effective continuation phase treatment:**
Patients newly diagnosed and treated who remained on an antidepressant medication for at least 180 days (6 months.)



Educate your patients and their spouses, caregivers and/or guardians about the importance of:

- Compliance with long-term medications.
- Not abruptly stopping medications without talking to their physician.
- Understanding the medication side effects and contacting your office immediately if they experience any unwanted/adverse reactions so that their treatment can be re-evaluated.
- Scheduling and attending follow-up appointments to review the effectiveness of their medications.
- Calling your office or the health plan if they cannot get their medications refilled.

Ask your patients who have a behavioral health diagnosis to provide you access to their behavioral health records if you are their primary care provider.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Patients ages 6 – 12 years newly prescribed ADHD medication who had at least three follow-up care visits within a 10-month period. The first visit needs to be within 30 days of when the first ADHD medication was dispensed.

*Data Collection:
Administrative Only*



Two rates are reported:

- **Initiation phase:** follow-up visit with prescriber within 30 days of prescription.
- **Continuation and maintenance phase:** remained on ADHD medication and had two more visits within nine months.



When prescribing a new ADHD medication:

- **Be sure to schedule a follow-up visit right away.** Schedule follow up for 15-21 days **following the new ADHD prescription.** That will allow time to meet the 30 day criteria should the appointment need to be rescheduled.
- **If a patient restarts ADHD medication after a 120-day break,** that is considered a new start. They should receive a follow up visit within 30 days.
- Schedule follow-up visits while patients are still in the office and send patient reminders.
- Educate your patients and their parents, guardians or caregivers about the use of, side effects and compliance with long-term ADHD medications.
- After the initial follow-up visits, schedule at least two more office visits in the next nine months to monitor patient's progress.

Follow-Up After Hospitalization for Mental Illness (FUH)

Patients ages 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.

*Data Collection:
Administrative Only*



Two timelines are required:

- An outpatient visit, intensive outpatient encounter or partial hospitalization **within 7 calendar days of discharge.**
- An outpatient visit, intensive outpatient encounter or partial hospitalization **within 30 calendar days of discharge.**



- Educate your patients and their spouses, caregivers or guardians about the importance of compliance with the long-term medications prescribed.
- Encourage high risk patients to participate in our behavioral health case management program for help getting follow-up discharge appointments and other support.
- Teach patients' families to review all discharge instructions for patients and ask for details of all follow-up discharge instructions, such as the dates and times of appointments.
- Ask patients with a mental health diagnosis to allow you access to their mental health records if you are their primary care provider.

Metabolic Monitoring for Children and adolescents on Antipsychotics (APM)

*Patients ages 1-17 years of age
who had two or more
antipsychotic prescriptions and
has metabolic testing (both
glucose and HbA1c or LDL or
Cholesterol).*

*Data Collection:
Administrative Only*



ONCE PER YEAR!



Metabolic testing needs to be completed at least once per year while children are on antipsychotic medications.

Children need to be lab tested for the following:

- **At least one test for blood glucose or HbA1c.**
- **At least one test for LDL-C or cholesterol.**

****BH and LIPs providers refer patient to prescribing physician for lab testing orders and results.***

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Children and Adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first line treatment.

*Data Collection:
Administrative Only*



Talk First!

Psychosocial care is recommended as a first-line treatment option for children and adolescents prior to initiation of medication therapy.





Best Practice Considerations:

- Consider safer alternatives before prescribing an antipsychotic for clearly identified mental health condition(s) or target symptom(s).
- Documentation of psychosocial treatment is documented first which includes a comprehensive assessment and a coordinated treatment plan.
- Before considering an antipsychotic for target symptoms, treat the primary condition first (e.g., ADHD, anxiety), as it may resolve the targeted symptoms (e.g., aggression.)
- Consult a psychiatric specialist prior to initiating long-term use of antipsychotics as long-term effectiveness and safety are not established in children and adolescents.
- Providers should encourage parents with high risk children to participate in the Behavioral Health Case Management program.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Adolescents (between the ages of 13-17 years old) and adult members (18 + years) with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following treatment recommendations:

Initiation of AOD Treatment and Engagement of AOD Treatment

*Data Collection:
Administrative Only*



Two rates are reported: 14 & 34 days

- **Initiation of AOD Treatment:** visit must occur within **14 days** of the new alcohol or other drug abuse or dependence diagnosis.
- **Engagement of AOD Treatment:** members who initiated treatment and who had **at least two or more additional AOD services or medication assisted treatment (MAT) within 34 days** of the initiation visit.

Follow up visits need to be with qualified drug and alcohol specialists.



- **Early Identification:** Screen for and document substance use or other drug dependence annually in your treatment plans.
- **Coding:** Remember to code for *all* AOD diagnoses on every claim when applicable. (Refer to the HEDIS coding guidelines.)
- **Initial Appointment :** schedule an initial **14 day** follow-up visit (ideally within **10 days**) of a **new dx** of AOD.
- **Follow Up Appointments:** After the 14 day visit, schedule **2 or more** additional visits/services within **30 days** of the initiation visit.
- **Community Resource Assistance:** When appropriate connect the member with community resources to help them manage their condition.

Important Phone Numbers



For prior authorizations, clinical questions, membership verification, behavioral health, care management and health management programs:

Bright Start (maternity program)	843-569-4657
Foster Care Liaison	843-414-2681
Behavioral Health Utilization Management	1-866-341-8765
Medical Management: toll free	1-888-559-1010
Medical Management: Charleston area	843-764-1988
Medical Management Fax: toll free	1-888-824-7788
Medical Management Fax: Charleston area	843-863-1297
Medical Management Right Fax (scans faxed documents directly into system)	1-866-368-4562

Important Phone Numbers



Member Services: for membership verification, care management referrals and transportation issues:

Member Services: toll free	1-888-276-2020
Member Services: Charleston area	843-764-1877
Member Services Fax: Charleston area	843-569-4875
Member Services Fax: toll free	1-800-575-0419

Pharmacy Services/Perform RX: for pharmacy issues and medication prior authorizations:

Pharmacy Services/Perform RX: toll free	1-866-610-2773
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Select Health website: www.selecthealthofsc.com

NaviNet website: <https://navinet.navimedix.com>



THANK YOU for the valuable services you provide to our members!

