BEST PRACTICES FOR IMPROVING YOUR STAR RATING

network health

- Encourage members to come in for their annual wellness exams.
- Proactively schedule preventive screenings, follow up on all orders to ensure testing was completed and assist members with other options.
- Assess members for barriers to care and treatment and refer them to community support services or Network Health supplemental benefits that help them overcome these barriers.
- Provide education to members on the importance of preventive care, how to best manage their health, medication adherence and tests or treatments for chronic conditions.
- Submit codes on claims or through supplemental data file feeds for each element on measures that can only be closed with administrative data.
- Documentation accuracy and timely submission is important.
    - For test type, phrases such as “Up to date”, “Recent” or “Prior visit” do not contain enough detail and the date of service must be specific enough to determine when the test was performed.
        - Appropriate entry example: “Last screening colonoscopy with Dr. Jane Smith was on January 1, 2024, at General hospital.”
- Each record must include the following information.
    - Member name
    - Member date of birth (DOB)
    - Date of service (DOS) the test or procedure was performed
- **INCOMPLETE INFORMATION DOES NOT CLOSE GAPS.**

Some HEDIS and PQA measures can be closed with documentation of appropriate exclusions. Look for specific exclusions found within each measure description in the Quality Measure Description Table which is found within the Clinical Integration Program Manual.

Contact the Network Health clinical integration team for any questions or concerns by emailing QI@networkhealth.com.

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Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

HEDIS MEASURES

PHARMACY QUALITY ALLIANCE (PQA) MEASURES

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

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Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

HEALTH OUTCOMES SURVEY (HOS)

PART D MEASURE NOT CURRENTLY IN THE CONTRACT

SUBSTANCE ABUSE MEASURES NOT CURRENTLY IN CONTRACT

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Eye Exam: Diabetes (EED)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

EYE EXAM FOR PATIENTS WITH DIABETES (EED)

• Members without diabetic retinopathy need a retinal eye exam every one to two years. Members diagnosed with diabetic retinopathy need a retinal eye exam yearly.

• Ask member who and where they have their eye exams. Include this information within the EMR for ease of locating the report when needed.
  o Example: “John Smith states he is scheduled for an eye exam with Dr. Forest at Shopko Optical in Appleton on June 1.”

• Obtain eye exam report or letter signed by an ophthalmologist or optometrist. Documentation must include:
  o Date of service
  o If the test was a dilated or retinal exam and the result of the exam
    - If the word dilated is missing, look for "dilated eye drops used" and findings for macula and vessels
  o Care providers credentials (ophthalmologist or optometrist)
  o Example of documentation: "Annie Jones had a diabetic retinal exam on May 8, 2024 with Dr. Miller. No diabetic retinopathy."
  o Documentation does not have to specifically state "no retinopathy" but must be clear a dilated or retinal exam was completed by an ophthalmologist or optometrist and retinopathy is not present
  o Documentation "diabetes without complications" does not meet criteria

• If a chart or photograph of the fundus was completed, the document must indicate the results were by:
  o An ophthalmologist or optometrist.
  o A reading center under the direction for a medical director who is retinal specialist.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Eye Exam: Diabetes (EED)

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- A positive hypertensive retinopathy diagnosis is counted as positive for diabetic retinopathy. If the diagnosis is negative for hypertensive retinopathy, then it is counted as negative for diabetic retinopathy.
- Slit lamp examinations can only be accepted if there is documentation of dilation or evidence the retina was examined.
- If a member declines because they cannot return to the clinic, offer the alternative to have Network Health send PRN Home Health Care to the member's home to complete an in-home retinal screening free of charge.
  - Contact Network Health at QI@networkhealth.com
- Refusal of an eye exam does not close the care gap.
- Provide member education on risks of diabetic eye disease and encourage annual examinations.
- Members who are diet-controlled diabetics need annual eye exams as well.
- Educate members on the difference between an eye exam for glasses and a diabetic eye exam.
- Remind members that safe and effective management of their diabetes includes keeping the following within normal limits: blood glucose, urine albumin and creatine, blood pressure and blood lipids.
- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Glycemic Status: Diabetes (GSD)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES (GSD)

- The last value of the year is counted to close the gap. Consider having member repeat the lab value prior to the end of the year if the most recent result is elevated.
- Consider having labs completed or scheduling for future lab appointment while member is in the office.
- Members can report the most recent continuous glucose monitor (GMI) value. Remember to include the date range used to derive the value, using the terminal date (end date) in the range as the assigned date. This must be documented in the medical record.
- Encourage members to contact their provider if they are having high blood sugar readings or symptoms of highs and lows at home so early intervention plans can be discussed.
- Educate members on the importance of managing their blood sugars and the risks associated with elevated A1c.
- Discuss referring the member to diabetic educators or dietitians for education on optimal blood sugar control.
- Document, code and bill exclusions if applicable.
- Member refusing the test does not qualify as an exclusion.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Blood Pressure: Diabetes (BPD)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

BLOOD PRESSURE CONTROL FOR PATIENTS WITH DIABETES (BPD)

- If the blood pressure (BP) reading is greater than or equal to 140/90, consider repeating the BP before the member completes their office visit. A little rest can make a big difference.
  - o Ensure member is sitting with feet flat on the floor, back supported and arm at heart level.

- The last value of the year is counted to close the gap. Consider having the member repeat their blood pressure prior to the end of the year if the most recent result is elevated.

- Record member reported blood pressures in the medical record from phone, text, portal or telehealth communication.
  - o All recorded blood pressures must have date of reading and result recorded.
  - o Do not round the result. For example: reading is 138/89 - do not round to 140/90.
  - o Member must not use a non-digital device such as a manual cuff and stethoscope.
  - o BP documented as an average is eligible to be used, "average BP 122/68".

- Encourage members to contact their provider if they are having high blood pressure readings or symptoms of highs and lows at home so early intervention plans can be discussed.

- Consider following up by portal, phone or text if member does not call the office with home readings, as directed by provider.

- Educate members on the importance of managing their blood pressure, a healthy BP goal, and the risks associated with elevated readings.

- If member is fasting for labs prior to office visit, remind them to take their blood pressure medication with water.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Kidney Evaluation: Diabetes (KED)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

KIDNEY HEALTH EVALUATION FOR PATIENTS WITH DIABETES (KED)

- Members are compliant if they have both an eGFR (glomerular filtration rate – a blood test) and uACR (urine albumin-to-creatinine ratio) during the calendar year. Dates of service are completion on same day or different days, as follows:
  - o At least on eGFR
  - o At least one uACR, identified by either uACR or both a quantitative urine albumin test and a urine creatinine test with service dates four days or less apart.

- Complete a chart review prior to provider appointment and order both urine and blood lab components the member is due for.

- Consider having member complete kidney function labs prior to provider appointment.

- If member was unable to have labs prior to appointment, have labs completed while at the office or schedule the lab appointment to be completed soon after the appointment.

- Complete reminder notification to members who are overdue for labs via portal, phone, mail or text.

- Set care gap alerts in your medical record alert system.

- Educate members on complications from kidney disease that do not show symptoms, emphasizing the importance of having kidney function tests completed annually.

- Provide education on the importance of controlling blood pressure, blood sugars, blood lipids, being compliant with medications which protect kidneys, as well as avoiding medications which harm kidneys.

- Refer to endocrinologist and/or nephrologist, when needed.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Osteoporosis Management: Women (OMW)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

OSTEOPOROSIS MANAGEMENT IN WOMEN (OMW)

- The opportunity to close this measure is six months. Best practice is to schedule a visit soon after the event occurs and complete the BMD test before the member leaves the clinic.
    - o Provide education on need for osteoporosis screening with a BMD test for women who have increased risk for falls, a family history of osteoporosis, long-term use of steroids, tobacco or alcohol, or a history of medical conditions such as rheumatoid arthritis, diabetes, thyroid imbalance or early menopause (natural or surgical).

- A referral for a BMD does not close the measure. Ensure all ordered BMD testing was completed or assist with other options.

- Consider a partnership with orthopedic and podiatry clinics/providers to educate and place BMD order at the time fracture is diagnosed, with assurance the PCP will review results and act on potential treatments if needed. This helps to get a timely BMD order placed, removing specialist responsibility burden.

- Consider designating one individual or team to review most recent monthly OMW reports from Network Health and send PCP clinics a staff message for member follow-up on those who have not completed a BMD within six months of fracture date.

- If member declines for inability to return to the clinic, offer alternative to have Network Health facilitate a no-cost, in-home BMD screening.

- Ensure fracture codes are correct and have not been submitted prior to diagnostic testing verification. If an error is found, submit a corrected claim to remove member from the measure.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Osteoporosis Management: Women (OMW)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Member's osteoporosis medication prescription must be filled using their Part D prescription drug benefit so the prescription claims count as a "hit" for this measure.
- Documentation that osteoporosis medication is not tolerated does not close the measure.
- Assess member for barriers to receiving care and offer solutions to the barriers. Consider a referral to Network Health quality health integration team if unable to come to a satisfactory option for the member.
- Document, code and bill exclusion for frailty and advanced illness if applicable.
- Refer to endocrinologist and/or nephrologist, when needed.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Colorectal Cancer Screening (COL-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

COLORECTAL CANCER SCREENING (COL-E)

- Best practice is to submit the actual test and result.

- If the test result cannot be located but the completed screening is clearly mentioned in the medical record, this is acceptable documentation to use as evidence for measure compliance.
  - o Always include the date of service, type of screening and result.
  - o Member refusing the test does not qualify as an exclusion.

- Recommend colorectal (colon) cancer screening to all members aged 45 to 75 even if there is no history of colon cancer.
  - o Offer alternative colon cancer screening tests if the member does not want or cannot have a colonoscopy.
  - o Annually update and document the member's colon cancer screening history.
  - o Offer low-cost prep options for members who have financial barriers or low volume preps for members who have difficulty tolerating high volume solutions.
  - o Follow-up on all ordered colorectal screenings to ensure testing was completed or to assist member with other options.
  - o Document, code and bill exclusions for frailty and advanced illness, if applicable.
  - o Digital rectal exams and FOBT test completed in the office does not close the measure.
  - o Assess member for any barriers to receiving care and offer solutions to barriers. Consider referral to Network Health quality health integration team if unable to come to a satisfactory option for the member.

- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Breast Cancer Screening (BCS-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

BREAST CANCER SCREENING (BCS-E)

- Document in electronic medical record most recent mammogram and/or mastectomy dates.
- If member has had a unilateral mastectomy, it is recommended member have a mammogram on remaining breast to be compliant with this measure. Members with a bilateral mastectomy with a bilateral modifier will be excluded.
- Do not count breast biopsies, breast ultrasounds or MRIs. These do not close the gap.
- Follow up on all ordered mammograms to ensure testing was completed or to assist member with other options.
- Consider mobile mammography during health fairs or events.
- Encourage member to wait 4-6 weeks after receiving COVID-19 vaccination before completing their mammogram due the potential for lymphadenopathy.
- Educate members on importance of breast cancer screening at least every other year.
  - o Discuss any fears or concerns members may have about the screening.
  - o Provide options for testing methods which are less uncomfortable or provide lower radiation exposure.
  - o Assist member with scheduling a mammogram.
  - o Provide member with locations mammograms can be performed.
- Consider a standing order for annual screening mammogram for eligible population.
- Submit all codes related to a member's history of mastectomy, either unilateral or bilateral.
- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Cervical Cancer Screening (CCS-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

CERVICAL CANCER SCREENING (CCS-E)

- Best practice is to submit the actual test, test date and result.

- Documentation of a "hysterectomy" by itself will not meet exclusion criteria.
  - o Documentation must include words such as "total", "complete" or "radical" when describing the type of hysterectomy either vaginal or abdominal.

- Documentation of lab results stating the sample was inadequate or "no cervical cells were present" does not meet for the measure.

- Biopsies do not count as a cervical screening as they can be diagnostic and/or therapeutic.

- Educate members on importance for early detection and procedure of cervical cancer screening.
  - o Explore with member any fears or reasons of reluctance to complete testing.
  - o Provide options to help member address their concerns about testing.

- Review member's health history during any type of office visit and assist member with scheduling an appointment for screening while in office.
  - o Set care gap alert in electronic medical record.
  - o Outreach to members when overdue for screening. Use a variety of communication methods such a mail, phone call, text or portal messaging.

- Follow up on missed appointment and assist member with rescheduling and/or barriers to care.
  - o Offer community resources as needed.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Statin: Cardiovascular Disease (SPC)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

STATIN THERAPY FOR THOSE WITH CARIOVASCULAR DISEASE (SPC)

- Measure has two parts:
  - o Received Statin Therapy - members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
  - o Statin Adherence - members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

MODERATE INTENSITY
- Atorvastatin 10-20 mg
- Amlodipine-atorvastatin 10-20 mg
- Ezetimibe-simvastatin 20-40 mg
- Rosuvastatin 5-10 mg
- Simvastatin 20-40 mg
- Lovastatin 40 mg
- Pravastatin 40-80 mg

HIGH INTENSITY
- Atorvastatin 40-80 mg
- Amlodipine-atorvastatin 40-80 mg
- Ezetimibe-simvastatin 80 mg
- Rosuvastatin 20-40 mg
- Simvastatin 80 mg

- Remind member to use their Network Health member ID card when filling prescriptions. The adherence gap closes when the health plan card is used.
  - o Assess member for barriers to obtain medications and offer assistance for possible solutions.

- Consider 100-day medication fills to assist with adherence, especially if getting to the pharmacy is an issue.
  - o Members can get their prescriptions delivered to their home if having transportation issues.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Statin: Cardiovascular Disease (SPC)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Consider generic medications to reduce financial burden.
  - Offer resources for prescription assistance or assist member with completing the forms.

- If member had an intolerance or side effects such as myalgias consider the following if clinically appropriate:
  - Trial of an alternative statin. Due to the differences in distribution throughout the body, a member may tolerate a different statin then was initially tried.
  - Smaller dose or a dose reduction. Small doses can still provide protective benefits. Splitting tablets or adjusting the frequency to 1–3 times per week.
  - Coenzyme Q10 supplementation. A 30-day trial of Coenzyme Q10 100 mg daily may be an option to improve statin tolerance.

- If the member is unable to tolerate a statin, please document, code and bill the condition that supports exclusion from the measure annually. Qualifying conditions for exclusions include:
  - Myalgia, myositis, myopathy or rhabdomyolysis
  - Cirrhosis
  - ESRD or dialysis
  - Pregnancy or in vitro fertilization
  - Dispensed at least one prescription for clomiphene
  - Hospice or receiving palliative care
  - Document, code and bill for frailty and advanced illness, if applicable

- Consider referring member to a statin specialist for members who have difficulty tolerating a statin.

- Resources for provider review and/or use with your patient population to support education around statin myths can be found here:
  - Statin Myths Member Handout – English
  - Statin Myths – Providers

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Controlling High Blood Pressure (CBP)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

CONTROLLING HIGH BLOOD PRESSURE (CBP)

- If the BP reading is greater than or equal to 140/90, consider repeating the BP before the member completes their office visit. A little rest can make a big difference.
  - o Ensure member is sitting with feet flat on the floor, back supported and arm at heart level

- Record member-reported BPs in the EMR from phone, text, portal or telehealth communication.
  - o All recorded blood pressures must have date of reading and result recorded
  - o Do not round the result. For example: reading is 138/89 - do not round to 140/90
  - o If multiple blood pressures on same day document all BP readings, since the lowest systolic value and the lowest diastolic value should be used for measure compliance if multiple readings taken on the same date
  - o Blood pressure documented as an average is eligible to be used, "average BP 122/68."
  - o Member must not use a non-digital device such as a manual cuff and stethoscope
  - o Do not include blood pressures during emergency room or acute in-patient stay

- Encourage members to contact their provider if they are having high blood pressure readings or symptoms of highs and lows at home so early intervention plans can be discussed.

- Consider following up by phone or text if member does not call the office with home readings as directed by provider.

- The last value set of the year is counted, consider having the member repeat their blood pressure prior to the end of the year if the most recent result is elevated.

- Member education on the importance of managing their blood pressure, a healthy blood pressure goal, and the risks associated with elevated readings.

- If member is fasting for labs prior to office visit, remind them to take their blood pressure medication with water.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Transition of Care 30-Day (TRC)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

TRANSITION OF CARE 30-DAY FOLLOW-UP (TRC)

- Document must show the date when the engagement occurred.

- Index date is the date a member discharges from inpatient stay or a skilled nursing facility (SNF).
  - o If member discharges from inpatient to SNF, then the index date becomes the date the member discharges from the SNF

- Medication Reconciliation post discharge must occur between January 1-December 1 of current year and within 30 days of discharge. This includes day of discharge (total of 31 days).
  - o Must be completed by prescribing practitioner, clinical pharmacist, physician assistant or registered nurse
  - o Member does not need to be present since interaction between member caregiver and provider closes the gap if member is unable to communicate
  - o Medication list must be included with outpatient visit notes in the medical record
  - o Can use discharge summary if most current medication list and is part of the medical record
  - o Notation of current medications and discharge medications were reconciled/reviewed
  - o Notation that no medications were prescribed at time of discharge is acceptable
  - o Documentation of medication reconciliation or review occurred during outpatient visit and the provider is aware this is a post hospitalization visit
    - Look for words such as "admission", "hospitalization", "inpatient stay", or "SNF or rehabilitation stay"
    - If multiple admissions/discharges use the most recent documentation and the Quality Opportunity Member Detail report index dates

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Transition of Care 30-Day (TRC)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Engagement post discharge must occur between January 1-December 1 of current year and within 30 days of discharge. Engagement on day of discharge does not close the gap.
  - o Completed as an outpatient visit (in-home for office visit), telephone visit, transitional care management service, telehealth visit or a virtual check-in or E-visit
  - o SNF visits do not meet criteria for engagement
  - o If member is unable to communicate, interaction with the caregiver meets the gap
  - o Complete engagement with members after discharging from a SNF and document in the medical record
  - o If multiple admissions/discharges use the most recent documentation and the Quality Opportunity Member Detail report index dates

- Document, code and bill exclusions if applicable.

- Use the Ping_ADT spreadsheet, sent daily in the Quality Opportunity folder. It allows you to filter any attributed members seen in an ER or inpatient hospitalization at an outside system.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

After ED: Multiple Chronic Conditions (FMC)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

FOLLOW UP AFTER ED FOR MULTIPLE CHRONIC CONDITIONS (FMC)

- Only one ED visit per 8-day period is allowed. If more than one ED visit within eight days, only the first ED visit date will count towards the gap. Eight days includes day of ED visit and the seven days following. The following types of visits will close the gap:
  - o An outpatient visit, telehealth, or telephone visit
  - o E-visit or virtual check-in
  - o Traditional care management visit/service or complex care management services
  - o Behavioral outpatient, telehealth or community mental health center visit
  - o Substance abuse disorder service, counseling or surveillance
  - o Intensive outpatient encounter or partial hospitalization

- Reach out to members to encourage a follow up visit within seven days of ED visit.

- Develop a daily process to schedule members who have been recently discharged from ED or inpatient.

- Offer alternative follow up care if transportation is an issue, such as a virtual or E-visit.

- If member prefers not to have a provider visit, offer to have a case manager reach out to member to discuss follow-up care.

- Encourage member to call provider office with any change in condition or concerns to decrease need to return to ED.

- Alert member's provider of ED visit as they may not be aware member has been utilizing ED services instead of contacting the provider for an appointment.

- Use the Ping_ADT spreadsheet, sent daily in the Quality Opportunity folder. It allows you to filter any attributed members seen in an ER or inpatient hospitalization at an outside system.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Influenza Vaccine Rate (sub-measure of AIS-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

INFLUENZA VACCINATION RATE (SUB-MEASURE OF AIS-E)

- Ensure notation in the medical record indicating the specific antigen and date of the immunization.
  - o Words such as "member is up to date" but does not list the specific antigen and date given does not close the gap

- Discuss importance of flu vaccination at every visit simply and clearly to meet all learning levels.
  - o Address vaccine hesitancy, misconceptions and provide educational materials
  - o Be sensitive to diversity in learning ability, culture, language and social determinants of health (SDoH) barriers.

- Provide vaccine information sheet (VIS) for member to read while waiting.
  - o Have all staff trained to answer questions on VIS
  - o Provide VIS in member's preferred language
    - Immunize.org offers VIS translations in multiple languages

- Consider standing orders to allow vaccines to be given during a nurse visit.

- Have alerts in electronic medical record (EMR) for members who are due for flu vaccine.

- Timely data submission to Wisconsin Immunization Registry (WIR).

- Member refusal is not considered an exclusion and will not close the gap.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Social Need Screening/ Intervention (SNS-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

SOCIAL NEED SCREENING AND INTERVENTION (SNS-E)

- Screen members annually for food, housing and transportation.
  - o Consider using open ended questions to invite member to share their experiences
  - o Use motivational interviewing to establish a trust and empower the member
  - o Keep your approach positive and treat the member like they are part of the care team

- Explain the purpose of the screening.
  - o Be sensitive to diversity in health literacy, culture, religion, language and problem-solving skills
  - o Allow adequate time and privacy for the member to discuss their social needs
  - o Create a blame-free space to allow open discussion about their needs and challenges

- If member has a positive screening, charting should include offered resources and what action the member completed. Documentation encouraged to be submitted within 30 days.
  - o Have resources readily available in print or electronic form
  - o Know what community resources you have available for housing, transportation and food needs and how to refer a member
  - o Consider a follow up for all positive screenings in which you supplied resources; a member who needed an intervention six months ago may need assistance again in the future
  - o Consider a referral to Network Health case management to assist and follow up with member

- Document, code and bill exclusion if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Asthma Medication Ratio (AMR)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ASTHMA MEDICATION RATIO (AMR)

- Regularly evaluate with member understanding and correct use of inhalers.
  - o Clarify the member knows which inhaler is for prevention and which is for rescue
  - o Consider limiting auto refills for rescue inhalers to monitor member's progress
  - o 90-day supply of controller medications may help the member remain compliant
  - o Check with member to see if they are experiencing barriers to filling their asthma medication
  - o Discuss recent urgent care or ED visits related to asthma symptoms

- Ensure member is using more preventative medications then rescue medications. Consider follow up visits until member is stable.

- Education on member's asthma triggers and how to avoid them. Develop an asthma action plan.
  - o Provide education simply and clear to meet all learning levels
  - o Encourage member to incorporate inhaler use into their daily routine
  - o Avoid smoking or exposure to smoke

- Remind member to get annual flu shot.

- Report correct diagnosis coding for member's condition and include appropriate codes which may exclude member from the measure.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Antidepressant Medication Mgmt (AMM)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)

- Provide member education about the importance of antidepressant medication.
  - o Being consistent with medication is beneficial to symptom management
  - o Review it can take up to 12 weeks for full effectiveness of medication
  - o Review possible side effects and importance to contact provider to review how to manage symptoms
  - o Emphasize the importance to stay on medication for six months even after feeling better to achieve remission
  - o Remind member not to abruptly stop the medication

- Assist member with scheduling follow up appointments in person or virtual to evaluate member's progress with depression management.
  - o Consider a care management referral for phone check-ins to assist member in between appointments
  - o Remind members of upcoming appointments via phone, email, text or portal
  - o Reach out and assist members to reschedule missed or canceled appointments
  - o Affirm that their depression diagnosis is a medical condition and not a weakness or flaw
  - o Be sensitive to the members SDoH and demographic data and consider how this will affect member's perception of diagnosis/treatment

- Check with member to see if they are experiencing barriers to filling their depression medication and offer options.

- Normalize talking about depression and taking antidepressant medication.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Antidepressant Medication Mgmt (AMM)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Encourage member to share concerns and ask questions.
  - o Provide National Suicide Prevention Lifeline number **1-800-273-TALK**
  - o Provide **988** Suicide and Crisis Lifeline number (call or text)

- Consider a referral to a therapist if member declines to start or continue medication for depression.
  - o Offer Employer Assistance Program (EAP) as a therapy option if available
  - o Provide community links, peer groups or members support system to assist with recovery

- Discuss recent urgent care or ED visits related to depression symptoms.

- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Avoidance Antibiotic Treatment Bronchitis (AAB)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS (AAB)

- Avoid prescribing antibiotics unless there is bacterial etiology and is clinically indicated.

- If member needs to be treated with an antibiotic and has been diagnosed with one of the following diagnoses, submit the co-morbid and bacterial infection codes on the same claim to have the member removed from the measure.
  - COPD, HIV, emphysema, disorders of the immune system, malignant neoplasms or other malignant neoplasm of the skin

- Provide education about good antibiotic stewardship. The CDC offers free material at cdc.gov/antibiotic-use/communication-resources/
  - Explain difference between bacterial and viral infections
  - Emphasize the importance of the right antibiotic for the right condition
  - Introduce the idea of antibiotic resistance
  - Use the words “chest cold” or viral upper respiratory infection to describe their illness

- Educate on symptoms indicating the infection is getting worse and where/how to seek medical care.

- Offer alternative options for symptom treatment.
  - Over the counter medications (OTC)
  - Cough suppressants
  - Humidification
  - Formulating a plan to have member contact the provider office if new symptoms develop

- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Appropriate Testing for Pharyngitis (CWP)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

APPROPRIATE TESTING FOR PHARYNGITIS (CWP)

- Always complete a Group A Strep test or throat culture, when appropriate, to confirm a diagnosis of pharyngitis prior to prescribing an antibiotic.
  - o Document results of strep test and/or throat culture
  - o Clinical findings alone do not adequately distinguish between strep vs no strep pharyngitis; Member may have resistant strep, so a culture is needed each time

- Submit co-morbid diagnosis codes that apply.

- Provide education about good antibiotic stewardship. The CDC offers free material at cdc.gov/antibiotic-use/communication-resources/
  - o Explain difference between bacterial and viral infections
  - o Emphasize the importance of the right antibiotic for the right condition
  - o Introduce the idea of antibiotic resistance
  - o Use the words “chest cold” or viral upper respiratory infection to describe their illness

- Educate on symptoms indicating the infection is getting worse and where/how to seek medical care.

- Offer alternative options for symptom treatment.
  - o Over the counter medications (OTC)
  - o Cough suppressants
  - o Humidification
  - o Formulating a plan to have member contact the provider office if new symptoms develop

- Document, code, and bill exclusions if applicable.

- Consider focus audits throughout the year to pick up unbilled POC strep tests. Include dates three days before and three days after the diagnosis of pharyngitis, in case of positive culture test.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Adolescent Immunization Combo 2 (IMA-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ADOLESCENT IMMUNIZATION COMBO 2 (IMA-E)

- This is an electronic clinical data system (ECDS) measure.

- Vaccine must be given on different dates of service between the ages of 9-13.
  - o Immunizations must occur on or prior to member's 13th birthday
  - o HPV series must be completed on or prior to member's 13th birthday
  - o Notation in EMR indicating the specific antigen and date of the immunization
  - o Words such as "member is up to date" but does not list the specific antigen and date given does not close the gap

- Schedule members for well child visits and vaccines between the ages of 9-12.
  - o Schedule subsequent vaccine appointments when giving the first vaccine
  - o Send appointment reminders via text, phone, portal or mail to keep parents engaged
  - o Use alerts in your EMR system for vaccine due dates

- Giving your strong recommendation on the importance of vaccinating the member at their appointment may be an effective way to have the parents accept vaccines. Use phrases such as:
  - o "I strongly recommend your child receives these vaccines today" instead of "do you want to give your child their vaccines today?"
  - o "Your child needs two shots today" instead of "have you thought about what shots your child needs today?"

- Consider starting the series at age nine with the focus as cancer preventative.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adolescent Immunization Combo 2 (IMA-E)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Focus on HPV as a cancer prevention opportunity instead of dealing with sexual activity. Provide consistent messaging and education on importance of vaccines simply and clear to meet all learning levels.
  - o Address vaccine hesitancy of parents, misconceptions and provide educational materials
    - Information is available at cdc.gov or the American Academy of Pediatrics at aap.org
  - o Be sensitive to diversity in learning ability, culture, language and SDoH barriers
  - o Provide vaccine information sheet (VIS) in member's preferred language
    - Immunize.org offers VIS translations in multiple languages.

- Consider standing orders to allow vaccines to be given during a nurse visit.

- Take advantage of sick visits to administer delinquent or due vaccines.

- Timely data submission to Wisconsin Immunization Registry (WIR).

- Parental refusal is not considered an exclusion and will not close the gap.

- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Childhood Immunization Status Combo 3 (CIS-E)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

CHILDHOOD IMMUNIZATION STATUS COMBO 3 (CIS-E)

- For Network Health aligned incentive agreements, the performance metrics focus on CIS Combo 3 which includes DTaP, IPV, MMR, HiB, HepB, PCV and VZV.
  - o Is an electronic clinical data system (ECDS) measure

- Documentation should include:
  - o Notation in EMR indicating the specific antigen and date of the immunization
  - o Words such as “member is up to date” but does not list the specific antigen and date given does not close the gap
  - o Indicate if vaccine is a 2-dose or 3-dose schedule. If not indicated it is assumed it was a 3-dose schedule with only two dates entered thus not closing the gap
  - o Record vaccines given in the hospital

- Schedule members for well child visits and vaccines.
  - o Schedule subsequent vaccine appointments when giving the first vaccine
  - o Send appointment reminders via text, phone, portal or mail to keep parents engaged
  - o Use alerts in your EMR system for vaccine due dates

- Giving your strong recommendation on the importance of vaccinating the member at their appointment may be an effective way to have the parents accept vaccines. Use phrases such as:
  - o “I strongly recommend your child receives these vaccines today” instead of “do you want to give your child their vaccines today?”
  - o “Your child needs two shots today” instead of “have you thought about what shots your child needs today?”

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Childhood Immunization Status Combo 3 (CIS-E)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Provide consistent messaging and education on importance of vaccines simply and clear.
  - o Address vaccine hesitancy of parents, misconceptions and provide educational materials
    - Information is available at cdc.gov or the American Academy of Pediatrics at aap.org
  - o Be sensitive to diversity in learning ability, culture, language and SDoH barriers.
  - o Provide vaccine information sheet (VIS) in member's preferred language.
    - Immunize.org offers VIS translations in multiple languages.

- Consider standing orders to allow vaccines to be given during a nurse visit.

- Take advantage of sick visits to administer delinquent or due vaccines.

- Timely data submission to Wisconsin Immunization Registry (WIR).

- Parental refusal is not considered an exclusion and will not close the gap.

- Document, code and bill exclusions if applicable.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Statin Use: Diabetes (SUPD)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

STATIN USE IN PERSONS WITH DIABETES (SUPD)

- Members who qualify for the SUPD must have annual documentation and coding reflecting which statin the member is currently taking through a prescription fill or an exclusion that is documented, coded and billed.
  - o Statin medications within the Network Health formulary are:
    - Atorvastatin
    - Fluvastatin
    - Lovastatin
    - Rosuvastatin
    - Pravastatin
    - Simvastatin

- Remind member to use their Network Health member ID card when filling prescriptions. The gap closes when the health plan benefit is used to pay for the prescription.
  - o Assess member for barriers to obtain medications and offer assistance for possible solutions

- Consider 100-day medication fills through mail order pharmacy or local retail pharmacy, especially if transportation to the pharmacy is an issue.
  - o Contact Network Health's pharmacy team for member assistance if needed.

- Consider generic medications to reduce financial burden.
  - o Offer resources for prescription assistance or assist member with completing the forms
  - o Utilize manufacturer prescription assistance or the Veterans Administration benefits (if qualified) for all prescription fills if member doesn't plan to use Network Health's prescription drug benefits for medications that track "adherence."

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Statin Use: Diabetes (SUPD)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- If member had an intolerance or side effects such as myalgias consider the following if clinically appropriate.
  - o Trial of an alternative statin
    - Due to the differences in distribution throughout the body, a member may tolerate a different statin then was initially tried
  - o Smaller dose or a dose reduction.
    - Small doses can still provide protective benefits. Splitting tablets or adjusting the frequency to 1-3 times per week
  - o Coenzyme Q10 supplementation
    - A 30-day trial of Coenzyme Q10 100 mg daily may be an option to improve statin tolerance

- If the member is unable to tolerate a statin, please document, code and bill the condition that supports exclusion from the measure annually. Qualifying conditions for exclusion include:
  - o Pre-diabetes
  - o ESRD or dialysis
  - o Rhabdomyolysis, myositis, myopathy
  - o Pregnancy, lactation, or fertility
  - o Cirrhosis
  - o Polycystic ovarian syndrome
  - o Hospice
  - o Document, code and bill for frailty and advanced illness, if applicable

- Consider referring member to a statin specialist for members who have difficulty tolerating a statin.

- Resources for provider review and/or use with your patient population to support education around statin myths can be found here:
  - o Statin Myths – Member Handout - English
    - This booklet also comes in Spanish, Arabic and Hmong. Please contact Network Health clinical integration department to receive free copies.
  - o Statin Myths – Providers

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adherence: Diabetes Medications (ADH-Diabetes)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ADHERENCE TO DIABETES MEDICATIONS (ADH-DIABETES)

- Consider 100-day medication fills to assist with adherence, especially if getting to the pharmacy is an issue.
  - o Members can get their prescriptions delivered to their home if having transportation issues

- Consider generic medications to reduce financial burden.
  - o Offer resources for prescription assistance or assist member with completing the forms

- Assess member for barriers to obtain medications and offer assistance for possible solutions.

- Remind member to use their Network Health member ID card when filling prescriptions. The gap closes when the health plan benefit is used to pay for the script.

- If member plans to have all prescriptions filled through Veteran's Administration (VA) benefits (if qualified), encourage member to fill the very first prescription with the VA to prevent member from qualifying for this measure. If member fills the initial prescription with Network Health benefits, and has subsequent refills through the VA, the member will appear as non-adherent with medication use.

- Verify with member how they are taking their medication. If the directions are no longer valid, update the prescription.

- Schedule members before they leave the office for their next provider follow up, wellness visit or upcoming labs to prevent delays in refill requests.
  - o Review possible side effects to their medications and how to manage them
  - o Send appointment reminders

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adherence: Diabetes Medications (ADH-Diabetes)

network health

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Have pharmacists send messages in the electronic medical record (EMR) to providers about a member's medication needs.
  - o Send reminders to member through the portal when it is time to refill medication
  - o Notes sent to provider by staff when a member is out of medication

- Schedule monthly outreach to high-risk members to check on adherence.

- Educate members on why they take diabetic medication. Stress the importance of taking the medications as prescribed and to get timely refills, using tools or cues as needed.
  - o Encourage use of pill box
  - o Sign up for refill reminders at their pharmacy
  - o Use an alarm on their phone

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adherence: RASA (ADH-RAS)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ADHERENCE TO HYPERTENSION RENIN ANGIOTENSIN ANTAGONIST MEDICATIONS (ADH-RAS)

- RASA = Renin Angiotensin System Antagonists
- Consider 100-day medication fills to assist with adherence, especially if getting to the pharmacy is an issue.
  - o Members can get their prescriptions delivered to their home if having transportation issues
- Consider generic medications to reduce financial burden.
  - o Offer resources for prescription assistance or assist member with completing the forms
- Assess member for barriers to obtain medications and offer assistance for possible solutions.
- Remind member to use their Network Health insurance card when filling prescriptions. The gap closes when the health plan benefit is used to pay for the script.
- If member plans to have all prescriptions filled through Veteran's Administration (VA) benefits (if qualified), encourage member to fill the very first prescription with the VA to prevent member from qualifying for this measure. If member fills the initial prescription with Network Health benefits, and has subsequent refills through the VA, the member will appear as non-adherent with medication use.
- Verify with member how they are taking their medication. If the directions are no longer valid, update the prescription.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adherence: RASA (ADH-RAS)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Schedule members before they leave the office for their next provider follow up, wellness visit or upcoming labs to prevent delays in refill requests.
  - o Review possible side effects to their medications and how to manage them
  - o Send appointment reminders

- Have pharmacists send messages in the electronic medical record (EMR) to providers about a member's medication needs.
  - o Send reminders to member through the portal when it is time to refill medication
  - o Notes sent to provider by staff when a member is out of medication

- Schedule monthly outreach to high-risk members to check on adherence.

- Educate members on why they take hypertension medication. Stress the importance of taking the medications as prescribed and to get timely refills, using tools or cues as needed.
  - o Encourage use of pill box
  - o Sign up for refill reminders at their pharmacy
  - o Use an alarm on their phone

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adherence: Cholesterol Statins (ADH-Statins)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ADHERENCE TO CHOLESTEROL STATINS (ADH-STATINS)

- Consider 100-day medication fills to assist with adherence, especially if getting to the pharmacy is an issue.

- Consider generic medications to reduce financial burden.
  - o Offer resources for prescription assistance or assist member with completing the forms

- Assess member for barriers to obtain medications and offer assistance for possible solutions.

- Remind member to use their Network Health member ID card when filling prescriptions. The gap closes when the health plan benefit is used to pay for the script.

- If member plans to have all prescriptions filled through Veteran's Administration (VA) benefits (if qualified), encourage member to fill the very first prescription with the VA to prevent member from qualifying for this measure. If member fills the initial prescription with Network Health benefits, and has subsequent refills through the VA, the member will appear as non-adherent with medication use.

- Verify with member how they are taking their medication. If the directions are no longer valid, update the prescription.

- Schedule members before they leave the office for their next provider follow up, wellness visit or upcoming labs to prevent delays in refill requests.
  - o Review possible side effects to their medications and how to manage them
  - o Send appointment reminders

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Adherence: Cholesterol Statins (ADH-Statins)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Have pharmacists send messages in the electronic medical record (EMR) to providers about a member's medication needs.
  - o Send reminders to member through the portal it is time to refill their medication
  - o Notes sent to provider by staff when a member is out of medication

- Schedule monthly outreach to high-risk members to check on adherence.

- Educate members on why they take cholesterol medication. Stress the importance of taking the medications as prescribed and to get timely refills, using tools or cues as needed.
  - o Encourage use of pill box
  - o Sign up for refill reminders at their pharmacy
  - o Use an alarm on their phone

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

HOS: Reducing the Risk of Falling

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

Every year a random sample of Medicare Advantage (MA) beneficiaries are selected from each plan to take the HOS survey. This same sample of MA members will receive the survey again two years later. The HOS survey asks members questions about how they view their current health status and if their provider has discussed the members concerns with them. The results from the survey are then used for improvement of quality programs, public reporting and improving the health of MA members.

Best practice is to assist improving members' quality of life and meet the intent of the measure.

REDUCING THE RISK OF FALLING members are those who have had a fall or had problems with balance or walking in the past year, who discussed it with their provider and received treatment during the year.

- Complete a fall risk assessment at annual wellness exams.
  - o Send survey through member portal prior to appointment
  - o Provide a questionnaire while waiting for their visit
  - o Play an educational video in the waiting room

- Encourage vision and hearing test.

- Complete medication review and make member aware of meds which could contribute to falls.

- Check orthostatic blood pressure.

- Assess alcohol use.

- Discuss home safety tips and provide educational materials for member to review.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

HOS: Reducing the Risk of Falling

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Consider DME need or referral to therapy.
- Talk about ways to improve strength and balance.
- Complete bone density screening for high risk members.
- Asses health of feet and observe member's gait, consider referral to podiatry if needed.
- Review member's footwear or provide information on best types of shoes to prevent falls.
- Discuss urinary incontinence or frequency to address any needs in order to prevent rushing to the bathroom.
- Provide written or electronic member education on fall prevention.
- Resources:
  - Falls Free Wisconsin Home - fallsfreewi.org
  - Wisconsin Institute for Healthy Aging - wihealthyaging.org

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

HOS: Improving Bladder Control

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

IMPROVING BLADDER CONTROL looks at the percentage of members 65 years or older who reported having urinary leakage in the last six months and have discussed treatment options with their provider.

- Complete a urinary incontinence assessment at annual wellness exams.
  - o Send survey through member portal prior to appointment
  - o Provide a questionnaire while waiting for their visit

- Play informational video about urinary incontinence in the waiting room.

- Explain the purpose of the screening.
  - o Be sensitive to diversity in health literacy, culture, religion, language and problem-solving skills
  - o Allow adequate time and privacy for the member to discuss their needs
  - o Create a blame-free space to allow open discussion about their struggles

- Offer treatment options, referrals, ways to manage daily symptoms, exercises and educational material in print and/or digital form.

- Train staff to recognize patients smelling of urine or leaving damp marks on chairs to report to provider so the discussion can be started with the member.

- Schedule follow up appointment with member before leaving the office.
  - o If member cancels or no-shows for the follow up appointment, have staff contact member to see if interventions are working

- Consider having member keep a bladder diary to look for patterns causing incontinence.
  - o Visit urologyhealth.org/resources/bladder-diary for a free diary from Urology Care Foundation

- Educational Resources:
  - o Urology Care Foundation - urologyhealth.org/
  - o National Association for Continence - nafc.org/

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

HOS: Improve/Maintain Mental Health

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

IMPROVING OR MAINTAINING MENTAL HEALTH members report whether their mental health is the same or better than expected in the past two years.

- Complete a mental health assessment at annual wellness exams.
  - o Send survey through member portal prior to appointment
  - o Provide a questionnaire while waiting for their appointment
  - o Play an educational video in the waiting room

- Ask questions such as “Do you have a lot of energy?” or "How much time does your emotional health interfere with social activities?”
  - o Consider using a depression screening for signs of depression

- Explain the purpose of the screening.
  - o Be sensitive to diversity in health literacy, culture, religion, language and problem-solving skills
  - o Allow adequate time and privacy for the member to discuss their needs
  - o Create a blame-free space to allow open discussion about their struggles

- Talk with member about treatment options
  - o Referral to behavioral health (BH) services when appropriate
  - o Case management for regular check-ins
  - o Web based BH programs

- Schedule follow up appointment with member before leaving the office.
  - o If member cancels or no-shows for the follow up appointment, have staff contact member to see if interventions are working

- Consider testing member’s hearing as loss of hearing can feel isolating.

- Additional Resources:
  - o Emotional Wellness Toolkit - nih.gov/health-information/emotional-wellness-toolkit
  - o How to Improve Mental Health - medlineplus.gov/howtoimprovementalhealth.html

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

HOS: Improve/Maintain Physical Health

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

IMPROVING OR MAINTAINING PHYSICAL HEALTH members report that they discussed exercise with their provider and if they were advised to change their physical activity level during the year.

- Complete a physical health assessment at annual wellness exams.
  - o Send survey through member portal prior to appointment
  - o Provide a questionnaire while waiting for their appointment
  - o Play an educational video in the waiting room

- Explain the purpose of the screening.
  - o Be sensitive to diversity in health literacy, culture, religion, language and problem solving
  - o Allow adequate time and privacy for the member to discuss their needs
  - o Create a blame-free space to allow open discussion about their struggles

- Ask questions about current activity level and if member wishes to change this level
  - o What is stopping member from increasing activity?
  - o Assess pain level and if this affecting their ability to be more active
  - o Complete a functional level assessment

- Discuss treatment options such as
  - o Specialty referral such as pain management, rheumatology, pulmonology, etc
  - o Physical therapy or occupational therapy referral
  - o Use fitness benefits from Network Health
  - o Case management or wellness referral

- Provide self-management resources in print or digital format.

- Discuss check-in plan on how interventions are working.

- Additional Resources:
  - o Physical Wellness Toolkit - nih.gov/health-information/physical-wellness-toolkit
  - o Benefits of Physical Activity - cdc.gov/physical-activity-basics/benefits/index.html

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Opioids and Benzodiazepines (COB)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES (COB)

- Members 18 years or older, with concurrent use of prescription opioids and benzodiazepines.

- Members aged 65 and older are especially vulnerable to adverse effects of this class of medications due to decrease in metabolic rates. Benzodiazepines can exacerbate opioid-related respiratory depression.

- Involves the following medications in these classes:

OPIOID MEDICATIONS

- benzhydrocodone	- hydocodone	- opium
- buprenorphine	- hydromorphone	- oxycodone
- butorphanol	- levorphanol	- oxymorphone
- codeine	- meperidine	- pentazocine
- dihydrocodone	- methadone	- tapentadol
- fentanyl	- morphine	- tramadol

BENZODIAZEPHONE MEDICATIONS

- alprazolam	- diazepam	- oxazepam
- chlordiazepoxide	- estazolam	- quazepam
- clobazam	- flurazepam	- temazepam
- clonazepam	- lorazepam	- triazolam
- clorazepate	- midazolam	

- Review with member the benefits, risks, and alternative non-opioid therapies such as physical therapy, chiropractic and acupuncture.
  - o Provide education on side effects of medication, what do if member experiences side effects and possibility of addiction
  - o Provide clear directions on the treatment plan and medication schedule

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Opioids and Benzodiazepines (COB)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Coordinate care with all treating providers to avoid co-prescribing.

- If co-prescribing is unavoidable, use the guidelines from the Centers for Medicare & Medicaid Services (CMS) on the five central principles for co-prescribing.
  - o Initially avoid the combination by offering alternative non-opioid treatment options
  - o If new prescription is given, limit the dose and duration
  - o Taper long standing medications gradually and if possible, discontinue
  - o If long term co-prescribing is necessary, monitor the member closely
  - o Provide rescue medications such as naloxone and instructions on opioid overdose to member and their caregivers

- Schedule member for follow up appointments.
  - o Send appointment reminders through the portal or by phone
  - o Follow up with members who cancel or are a no-show for appointments

- Use alerts in electronic medical record (EMR) for criteria which indicate polypharmacy.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Anticholinergic (POLY-ACH)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

POLYPHARMACY USE OF MULTIPLE ANTICHOLINERGIC MEDICATIONS IN OLDER ADULTS (POLY-ACH)

The use of multiple anticholinergic medications leads to cumulative effected, referred to as the anticholinergic burden (ACB). The ACB is associated with adverse outcomes, including mortality, cardiovascular events, falls and cognitive impairment in older adults per the National Institutes of Health (NIH). Involves the following medications in these classes:

ANTIHISTAMINE MEDICATION

- bompheniramine
- carbinoxamine
- chlorpheniramine
- clemastine
- cyproheptadine
- dexbrompheniramine
- dexchlorpheniramine
- dimenhydrinate
- diphenhydramine (oral)
- doxylamine
- hydroxyzine
- meclizine
- pyrilamine
- triprolidine

ANTIPARKINSONIAN AGENT MEDICATIONS

- benztropine
- trihexyphenidyl

ANTIEMETIC MEDICATIONS

- prochlorperazine
- promethazine

ANTIPSYCHOTIC MEDICATIONS

- chlorpromazine
- clozapine
- lozapine
- olanzapine
- perphenazine
- thioridazine
- trifluoperazine

ANTIDEPRESSANT MEDICATIONS

- amitriptyline
- amoxapine
- clomipramine
- desipramine
- doxepin (>6mg/day)
- imipramine
- nortriptyline
- paroxetine
- protriptyline
- trimipramine

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Anticholinergic (POLY-ACH)

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

ANTIARRHYTHMIC MEDICATIONS
- disopyramide

ANTIMUSCARINIC (URINARY INCONTINENCE) MEDICATIONS
- darifenacin
- fesoterodine
- flavoxate
- oxybutynin
- solifenacin
- tolterodine
- trospium

ANTISPASMOTIC MEDICATIONS
- atropine (excludes opthalmic)
- belladonna alkaloids
- propantheline
- scopolamine (excludes opthalmic)
- dicyclomine
- homatropine (excludes opthalmic)
- clinidium-chlordiazepoxide
- methscopolamine
- hyoscyamine

- Schedule member for follow up appointments.
  - o Send appointment reminders through the portal or by phone
  - o Follow up with members who cancel or are a no-show for appointments

- Use alerts in electronic medical record (EMR) for criteria which indicate polypharmacy.

- Review medication list with member at every visit for indication and duration. Discontinue medications in which potential harm outweighs benefits or consider treating with a medication class that does not have anticholinergic properties.
  - o Consider current guidelines and evidence when reviewing members medications, co-morbid conditions and health goals

- Use alerts in electronic medical record (EMR) for criteria which indicate polypharmacy.

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Initiation Engagement Treatment (IET)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

INITIATION AND ENGAGEMENT OF SUBSTANCE USE DISORDER TREATMENT (IET)

Assesses new episodes of substance use disorder (SUD) episode 13 years and older that results in treatment initiation and engagement.

- Initiation of SUD Treatment.
  - o New episodes, after which the individual initiated treatment through an inpatient SUD admission, outpatient visit, telehealth or intensive outpatient encounter or partial hospitalization, or received medication within 14 days of diagnosis

- Engagement of SUD Treatment.
  - o New episodes, after which the individual initiated treatment and had two or more additional SUD services or medications within 34 days of the initiation visit

- Use the same SUD diagnosis for substance use at each follow up.

- Screen members annually for SUDs.

- Schedule member for first appointment within 14 days of episode and an engagement visit within 34 days for first appointment with PCP or BH provider.
  - o Address any barriers to keeping appointment
  - o If Member cannot be seen in the office, offer telehealth visit if appropriate
  - o Send appointment reminders via phone, text, portal or mail and follow up with members who cancel or no-show

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

5045-02-1024

Initiation Engagement Treatment (IET)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

- Coordinate care/transitions between PCP and behavioral health (BH) providers.

- Provide written and/or digital information on crisis intervention options.

- Reinforce treatment plan, promote member engagement in care plan, evaluate medication schedule, screen for side effects and instruct management of side effects.
  - Involve members caregivers or family with appropriate consent of member

- Document, code and bill exclusions if applicable.

- Resources Available:
  - 211 Wisconsin - 211wisconsin.communityos.org/
  - Substance Use Disorders - dhs.wisconsin.gov/aoda/index.htm

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Follow Up ED Visit: Substance Use (FUA)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

FOLLOW UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE (FUA)

- The percentage of ED visits for members ages 13 and older with a principal diagnosis of substance use disorder (SUD) or any drug overdose diagnosis and who had a follow up visit.

- See members within seven days of ED visit for substance use diagnosis and again in 30 days of ED visit.
  - o Address any barriers to keeping appointment
  - o If Member cannot be seen in the office, offer telehealth visit if appropriate
  - o Send appointment reminders via phone, text, portal or mail and follow up with members who cancel or no-show

- Coordinate care/transitions between provider and behavioral health (BH) providers.

- Provide written and/or digital information on crisis intervention options.

- Reinforce treatment plan, promote member engagement in care plan, evaluate medication schedule, screen for side effects and instruct management of side effects.
  - o Involve members caregivers or family with appropriate consent of member

- Consider referring member to a substance abuse specialist or case management for follow up on interventions.

- Document, code and bill exclusions if applicable.

- Resources Available:
  - o 211 Wisconsin - 211wisconsin.communityos.org/
  - o Substance Use Disorders - dhs.wisconsin.gov/aoda/index.htm

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.

Follow Up Hospital: Mental Illness (FUH)

network health

Yes
Supplemental Data Accepted

Best Practices to Help Close This Care Opportunity

Always check your most recently sent Quality Opportunities Gap Report for the latest information on members with an open care gap.

FOLLOW UP AFTER HOSPITALIZATION OF MENTAL ILLNESS (FUH)

- The percentage of discharges for members ages six years and older who were hospitalized for treatment of selected mental illness or intentional self-harm, who then had a follow up visit with a mental health provider.

- See members within seven days of discharge and again within 30 days of discharge
  - o Address any barriers to keeping appointment
  - o If Member cannot be seen in the office, offer telehealth visit if appropriate
  - o Send appointment reminders via phone, text, portal or mail and follow up with members who cancel or no-show

- Coordinate care/transitions between provider and behavioral health (BH) providers.

- Provide written and/or digital information on crisis intervention options.

- Reinforce treatment plan, promote member engagement in care plan, evaluate medication schedule, screen for side effects, and instruct management of side effects.
  - o Involve members caregivers or family with appropriate consent of member

- Consider referring member to a substance abuse specialist or case management for follow up on interventions.

- Resources Available:
  - o 211 Wisconsin - 211wisconsin.communityos.org/
  - o Substance Use Disorders - dhs.wisconsin.gov/aoda/index.htm

View our **HEDIS 101 Reference Guide** to find the associated codes for each measure.