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Serving Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect

Quality performance — moving your practice toward excellence!

Agenda

Part one: Background

Part two: Performance drivers

- Understanding 2018-2019 quality programs
  - Program details
  - HEDIS® measures

Part three: Best practices

Part four: Questions

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

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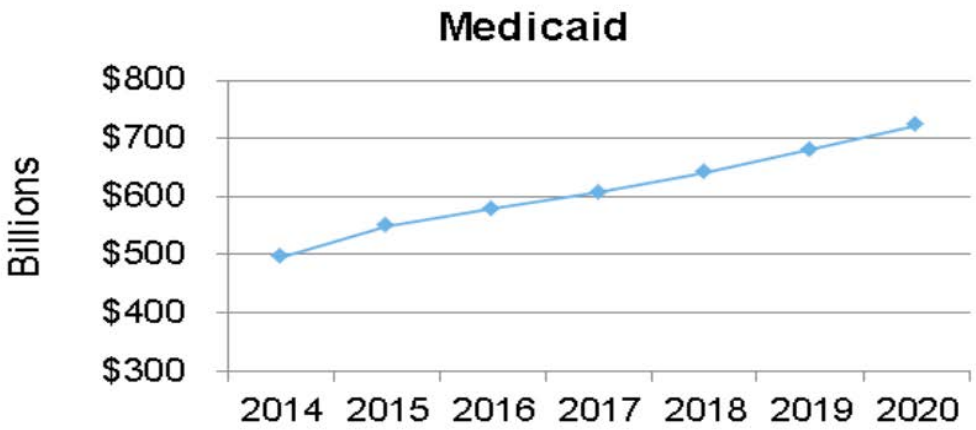
Background

Part one

Background

Challenges in national health care spending



Over the next five years, Medicaid health costs are expected to rise to nearly $722 billion by 2020; the need for reducing medical cost while increasing quality care is a major priority.

Source: Centers for Medicare & Medicaid Services. *National Healthcare Expenditures Projections, 2015-2025*. www.cms.gov.

Anthem Blue Cross and Blue Shield (Anthem) partnership model

What is provider collaboration?

Stronger connections, smarter health care

The benefits of provider collaboration

We are developing long-term relationships that unify the silos of health care; strengthen the bonds between patients, doctors and hospitals; and enable seamless delivery of the right care at the right time.

How we deliver provider collaboration

- Practice and care management support to deliver more effective health care solutions
- Proven expertise and presence across local markets to best serve each patient population
- Integrated data, analytics, tools and technology that improve population data

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Performance drivers

Part two

Performance drivers

Through our channels of engagement, there are many roads to achieve quality and cost results.

On-site support

- Monthly meetings to review scorecards and answer program questions
- Field team engages practice in understanding data, identifying opportunities, developing action plans and next steps

Collaborative learning

- Virtual learning collaborative
- Quality improvement (QI) principles and strategies centered around reducing avoidable ER use and closing gaps in care

Transformational tools

- Web-based tools
- HEDIS coding guides
- Quick reference guides
- Data-driven action plans

Performance drivers (cont.)

We will provide actionable data on:

- Avoidable ER use.
- Care opportunities.

We will provide interpretive guidance on:

- The data and the tools you need to intervene.
- Improving the health status of patients.
- Reducing costs associated with avoidable ER visits, readmissions and other cost drivers.

Quality programs

- Provider Quality Incentive Program (PQIP)
- Provider Access and Quality Care Program* (PAQCP)
- Obstetric Quality Incentive Program (OBQIP)
- Behavioral Health Quality Incentive Program (BHQIP)
- Behavioral Health Facility Incentive Program (BHFIP)

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* Name changed from PQIP Essentials for 2019.

Quality programs: PQIP and PAQCP

PQIP/PAQCP measures:

- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC) (ages 12 to 21)
- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- Appropriate Testing for Children With Pharyngitis (CWP)

Quality programs: PQIP and PAQCP (cont.)

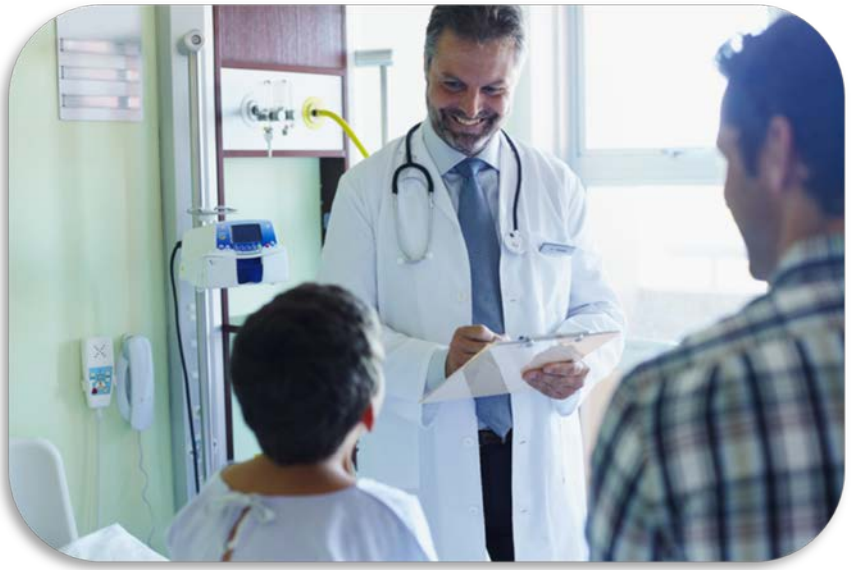
PQIP/PAQCP measures:

- Comprehensive Diabetes Care (CDC)
  - HbA1C testing
  - Nephropathy screening
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Medication Management for People With Asthma (MMA)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Annual Dental Visit (ADV) — *PAQCP program only*

Quality programs: PAQCP

PAQCP access utilization management measures:

- Nonemergent ER visits
- Use of inpatient care
- 14-day follow-up visit after discharge from inpatient care



Quality programs: OBQIP

OBQIP measures:

- First prenatal care visit
- Overall rate of Cesarean section
- Rate of preterm birth
- Rate of low birth weight
- Rate of postpartum visits
- Tobacco use assessment and intervention

Quality program: BHQIP

BHQIP performance indicators:

- Acute behavioral health inpatient 30-day readmission
- ER utilization
- PMP visits
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up Care For Children Prescribed ADHD Medication — Initiation Phase (ADD-i)
- Antidepressant Medication Management (AMM) — Initiation (AMM-i) and Continuation (AMM-c)
- Diabetic Glycated Hemoglobin (HbA1c) Screening

Quality program: BHFIP

BHFIP performance indicators:

- 30-Day readmission rate
- 60-Day readmission rate
- 90-Day readmission rate
- Seven-day Follow-Up After Hospitalization for Mental Illness (FUH7)
- 30-day Follow-Up After Hospitalization for Mental Illness (FUH30)

Quality programs: BHQIP, BHFIP

Best practices:

- Enable hard stops and check boxes in electronic medical records (EMR).
- Inpatient facilities should require an HbA1c for all patients with diabetes.
- Refer nonengaged, high-utilizing patients to our Locate and Engage team.
- Send care letter and warm outreach for FUH appointments.
- Designate FUH contacts at each center.
- Schedule appointments a few days before HEDIS deadline (for example, 28 days instead of 30 days).

HEDIS

HEDIS is the Healthcare Effectiveness Data and Information Set.
It is coordinated and administered by the National Committee for Quality Assurance (NCQA) and used by health plans to evaluate performance in terms of clinical quality and customer service.

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

Measure

Includes the percentage of children who had at least six well-child visits with a PMP that were at least two weeks apart, from birth to 15 months of life.

Typical place of service

PMP office

Best practices

Sick visits may be opportunities to complete an annual health check.

Consider extending your office hours to accommodate working parents.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

Measure

Includes the percentage of children who had one or more comprehensive well-child visits with a PMP during the measurement year. The visit must include physical evaluation and anticipatory guidance.

Typical place of service

PMP office

Best practices

Sick visits may be opportunities to complete an annual health check.

Consider extending your office hours to accommodate working parents.

Adolescent Well-Care Visits (AWC)

Measure

Includes the percentage of adult members ages 12 to 21 years who had at least one comprehensive well-care visit with a PMP during the measurement year. The visit must include physical and mental evaluation, and anticipatory guidance.

Typical place of service

PMP or OB/GYN office

Best practices

Sick visits and sports physicals may be opportunities to complete an annual health check. Consider hosting a *teen night* at your practice to meet the AWC measure. Consider extending your office hours to accommodate working parents.

Appropriate Testing for Children with Pharyngitis (CWP)

Measure

Includes the percentage of children ages 3 months to 18 years who received a *Group A Streptococcus* (*Strep A*) test, were diagnosed with pharyngitis and prescribed an antibiotic within the measurement year. A higher rate indicates appropriate testing is used.

Typical place of service

PMP office, urgent care center, ER

Best practices

If the test is negative for *Strep A* but the patient insists on an antibiotic, refer to the illness as a sore throat due to a cold; members tend to associate this term with a reduced need for antibiotics. Educate patients and their parents about the differences between viral and bacterial infections.

Appropriate Treatment for Children With Upper Respiratory Infection (URI)

Measure

The percentage of children ages 3 months to 18 years who were diagnosed with an of upper respiratory infection within the measurement year and were not prescribed an antibiotic. *This is reported as an inverted rate.*

Typical place of service

PMP office, urgent care center, ER

Best practices

Educate patients and their parents about the real cause of the illness; explain that using antibiotics when they are not needed can be harmful and cause antibiotic resistance.

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

Measure

The percentage of children ages 6 to 12 years who were newly prescribed ADHD medication and have at least one follow-up with a provider who has prescribing privileges within 30 days of medication being dispensed.

Typical place of service

PMP office, mental health specialist

Best practices

Schedule a follow-up visit within 30 days of ADHD medication initially prescribed or restarted after a 120-day break and at least two more office visits in the next nine months to monitor progress. Remind parents about appointments. Include the diagnosis of ADHD on all follow-up visits.

Medication Management for People with Asthma (MMA)

Measure

The percentage of members ages 5 to 64 years with persistent asthma who were dispensed an asthma controller medication every 30 days and remained on the medication for at least 50% of the treatment period during the measurement year.

Typical place of service

PMP office, pulmonologist

Best practices

Be sure to code your service correctly. Educate patients about asthma control, offer educational materials to hand out to members (available from Anthem). Emphasize the importance of compliance and controller medications.

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

Measure

The percentage of adult members (20 years and older) who had an ambulatory or preventive care visit at least once yearly

Typical place of service

PMP or OB/GYN office, eye care professional, home visits, or nursing facility

Best practices

Work panels or use the Provider Care Management Solutions (PCMS) *Care Opportunity Report* to identify members needing wellness exams. Make appointment reminder calls and consider your own texting campaign.

Breast Cancer Screening (BCS)

Measure

Includes the percentage of women 50 to 74 years of age who had at least one mammogram to screen for breast cancer every two years and three months. Excludes patients with bilateral mastectomy or two unilateral mastectomies with service dates 14 or more days apart.

Typical place of service

Diagnostic imaging center

Best practices

Use your EMR to create flags for reminders.

Reach out to members with the message *screening saves lives*.

Collaborate with mobile breast screening units to provide screening at your office.

Cervical Cancer Screening (CCS)

Measure

The percentage of women ages 21 to 64 with a preventive cervical cancer screening during either the previous two or current measurement year

Typical place of service

PMP or OB/GYN

Best practices

Promote the importance of well-woman exams, mammograms, Pap and human papillomavirus (HPV) testing with all female members ages 21 to 64. Refer members to another appropriate provider if your office does not perform Pap and HPV testing. Request copies of the results.

Comprehensive Diabetes Care (CDC) — HbA1c testing

Measure

The percentage of eligible members ages 18 to 75 with a diagnosis of diabetes (type 1 or 2) in either the previous or current measurement year who had at least one HgbA1c test during the current measurement year.

Typical place of service

Medical diagnostic laboratory

Best practices

Consider adding a diabetic educator to your staff.
Draw labs in your office rather than sending patients to a lab.
Educate on the importance of taking all prescribed medications and regular exercise.

Comprehensive Diabetes Care (CDC) — diabetic eye exam

Measure

Includes the percentage of eligible members ages 18 to 75 years with a diagnosis of diabetes (type 1 or 2) in either the previous or current measurement year who had a retinal eye screening during the current measurement year (or previous year for normal results) by a certified eye care professional.

Typical place of service

Ophthalmology clinic (optometrist or ophthalmologist)

Best practices

Educate patients about the importance of a dilated yearly eye exam and help members make an eye exam appointment.

Comprehensive Diabetes Care (CDC) — nephropathy

Measure

Includes the percentage of eligible members ages 18 to 75 years with a diagnosis of diabetes (type I or II) in either the previous or current measurement year who had nephropathy screening during the current measurement year.

Typical place of service

Medical diagnostic laboratory

Best practices

Offer assistance in a culturally competent manner to meet the diverse needs of your patients. Assist members in scheduling their screening appointment.

Annual dental visit

Measure

This includes members ages 2 to 20 in the measurement year who had at least one dental visit during the measurement year; visits for many 1-year-olds will be counted because the specification includes children whose second birthday occurs during the measurement year.

Best practices

- Dental visits can start before age 2, especially for children at risk for dental problems.
- Make a list of local dental providers who will accept Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members.
- Educate parents and children on the importance of oral hygiene.

Lead screening

Measure

Includes members who turned 2 years old during the year and had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Completing a lead risk assessment does not count as a lead screening.

Best practices

- Draw blood while they are in your office instead of sending them to the lab.
- Consider performing finger stick screenings in your practice.
- Assign one staff member to follow up on results when patients are sent to a lab for screening.
- Develop a process to check medical records for lab results to ensure previously ordered lead screening have been completed and documented.
- Use sick and well-child visits as opportunities to encourage parents to have their child tested.
- Include a lead test reminder with lab name and address on your appointment confirmation/reminder cards.

Access and utilization

Measures

- Nonemergent ER utilization — rate per 1,000 members per year of nonemergent ER visits within the measurement year
- Inpatient utilization — rate per 1,000 members per year of all general hospital or acute care inpatient admission, excluding maternity admission
- 14-day follow-up visit after inpatient discharge — percentage of attributed members with a visit to the PMP 1 to 14 days after discharge from an acute inpatient admission (excluding OB and surgical inpatient admissions) during the measurement period

Best practices

- Schedule a follow-up visit prior to hospital discharge.
- Make sure you have current contact information prior to hospital discharge.
- Reach out to members with reminder calls for appointments and to follow up after hospital visits.

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Best practices

Part three

Access and availability standards

Guidelines are as follows:

Nature of visit	Appointment standards
General appointment scheduling	
Emergency examinations	Immediate access during office hours
Urgent examinations	Within 24 hours of request
Nonurgent sick visits	Within 72 hours of request
Nonurgent routine exams*	Within 21 days of request
Specialty care examinations	Within 21 days of request
Outpatient behavioral health examinations	Within 14 days of request
Routine behavioral health visits	Within 10 days of request
Outpatient treatment	Within 7 days of discharge
Postpsychiatric inpatient care	Within 7 days of discharge
Call-back triage	
Wait time to speak to a medical professional if patient needs to be triaged	30 minutes or less
Prenatal visits	
First trimester	Within 14 calendar days of request
Second trimester	Within 7 calendar days of request
Third trimester	Within 3 business days of request or immediately if an emergency
High-risk pregnancy	Within 3 business days of identification or immediately if an emergency exists
Postpartum exam	3 to 8 weeks after delivery

* Exceptions are permitted for routine cases other than clinical preventive services when primary medical provider capacity is temporarily limited.

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Best practices: monthly panel work

Patient panel

Why is it important?

Know your patients	All assigned patients on provider's panel are included in the bonus program.
Quality	Focus on opportunities for care.
Clinical reporting	Attributed patients' data is available via PCMS, our web-based reporting tool.

General best practice tips

Use your member roster to contact members who are due for an exam or are new to your practice.

Use the *HEDIS Benchmarks and Coding Guidelines for Quality Care* booklet provided by Anthem.

Schedule the next well visits and preventive care at the end of the current appointments.

Most EMRs can create alerts and flags for required HEDIS services. Be sure to have all these prompts turned on, or check with your software vendor to have these alerts added.

If you do not use an EMR, create a manual tracking method.

Ask Anthem to perform a medical record review.

Consider extending your office hours to accommodate working parents or hosting a *teen night* at your practice to help your adolescent patients get the care they need.

If a member is seen for a sick visit and well-care visit during the same date of service, the sick visit can be billed separately using modifier 25.

Thank you

Questions?

www.anthem.com/inmedicaiddoc

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