Amerigroup

An Anthem Company

HEDIS metrics 2021 for care coordinators

Tennessee Health Link

Agenda

Topics covered:

- Health Link HEDIS® quality metrics
- Importance of these quality metrics
- The role of the care coordinator to help close gaps
- SMART goals
- Writing a care plan to address gaps in care

Health Link reports

- Reports show:
  - The percentage of Health Link members assigned to your group and those enrolled in Health Link.
  - Performance on specific quality metrics for members.

Health Link reports released quarterly with quality metric performance from each TennCare organization:

- **May** — Entire previous year's data (Interim Final)
- **August** — Quarters 1 and 2
- **November** — Quarters 1 through 3
- **February** — Entire previous calendar year

Quality measures on the Health Link report example

Quality Measure	Observations	Your Performance	Threshold
7- and 30- day psychiatric hospital/RTF readmission rate			
➢ 7 day rate	150	6.00%	≤ 5.00%
➢ 30 day rate	120	10.00%	≤13.00%
Adherence to antipsychotic medications for individuals with Schizophrenia	100	62.00%	≥59.00%
Antidepressant medication management (adults only)			
➢ Effective continuation phase treatment	50	30.00%	≥40.00%
Child and Adolescent Well-Care Visits			
➢ 7--11 years	10	50.00%	≥65.00%
➢ 12--17 years	15	54.00%	≥57.00%
➢ 18--21 years	20	40.00%	≥39.00%
Comprehensive diabetes care			
➢ Eye exam	90	50.00%	≥51.00%
Controlling high blood pressure	150	40.00%	≥49.00%
Diabetes screening for people with Schizophrenia or Bipolar Disorder who are using antipsychotic medications	120	85.00%	≥82.00%
Follow-up after hospitalization for mental illness			
➢ Within 7 days of discharge	75	40.00%	≥45.00%
Metabolic Monitoring for Children and Adolescents on Antipsychotic	20	40.00%	33.00%

Total number of Amerigroup Community Care members in this category.

Your percentage of members who met this goal at the time of the report.

TennCare's minimum target.

Must have 30 members in a category to be eligible for credit towards the final performance report.

SMART goals

Connecting the gaps in care to the care plan

Care planning for Health Link

- **Goals:**
  - What does the member want to accomplish? How can you guide the member to choose goals to promote recovery and resiliency?
- **Objectives:**
  - What is the member going to do to achieve the goal?
- **Interventions:**
  - What is the care coordinator going to do to support the member in achieving the goal?

Adherence to Antipsychotic Medications for Individuals With Schizophrenia

People 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period

- An example of how to understand and use the numbers on the Health Link report:

Adherence to Antipsychotic Medications for Individuals With Schizophrenia	100	62.00%	≥ 59.00%

- You have 100 members in this category.
- Needed 59 members to meet your goal (to reach 59%).
- Had 62 meet this goal as of the timing of this report (62%).

Adherence to antidepressant medication

People 18 years of age and older with a diagnosis of major depression who remained on an antidepressant medication for at least 180 days.

Amerigroup members can get $5 on a gift card each quarter for filling prescriptions for their depression medication

HEALTHY REWARDS

Medication adherence for schizophrenia and depression

Role of the care coordinator in the behavioral health practice

- Ask what challenges members may have with taking medications as prescribed.
- Become familiar with the medications that the member is taking specifically for mental health. You can check with the pharmacy to see if prescriptions are being filled or see medication refills in the Care Coordination Tool.
- Be sure members are keeping appointments for injections.
- Encourage individuals to talk to their prescribers if they are experiencing adverse medication side effects. This is a frequent cause of non-adherence.
- Develop person-centered plans for medication reminders (such as text messages, alarms, signs on the fridge, pill dispensers, etc.).
- Find out if the member is having any difficulty picking up medications. Be sure there is not a barrier with the five prescription limit, co-pays, or prior authorizations. Have the prescriber/nurse help resolve concerns.

Medication adherence care plan

Care plan: Too generalized

Goal:

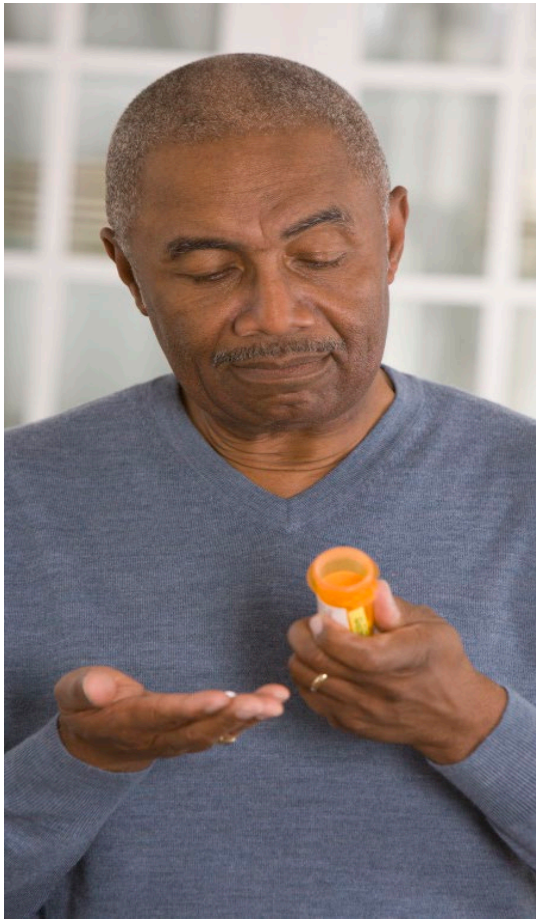
- Member will improve physical health.
- Member will close all HEDIS gaps.

Objectives:

- Member will attend all scheduled medical appointments.
- Member will meet with PCP at least once a year to close gaps.
- Member will take medications as prescribed daily for the next six months.

Interventions:

- Care coordinator will meet with member monthly.
- Care coordinator will meet with member every six months to updated goals.



Medication adherence SMART care plan

Goal:

- Member will maintain compliance with antidepressant medications.

Objectives:

- Member will obtain a pillbox within the next 30 days.
- Member will fill pillbox with all medications weekly and ask identified family member for assistance if needed.
- Member will place medications by the coffeepot each day in order to remember to take meds each morning with breakfast.
- Member will set daily alarm on her phone to remind her to take medications.

Interventions:

- Check CCT monthly to ensure member is picking medications up at the pharmacy.
- Call pharmacy and inquire about medication refills.
- Care coordinator will inquire about barriers to obtaining medications should the CCT show delinquency.

Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT)

Members ages 7 through 20 years of age who had at least one comprehensive well-care visit with a primary care physician (PCP) or OB-GYN within the calendar year.

Usually thought of as an annual physical exam or a check-up for members through their 20th year.

Amerigroup members can get $50 on a gift card for completing this visit each year.

Core EPSDT program activities

The elements of the program include:

Early	• Assess and identify problems early, starting at birth.
Periodic	• Check children's health at periodic, age-appropriate intervals in comprehensive well-child visits, including health education.
Screening	• Provide physical, dental, mental, developmental, hearing, vision, and other screening or laboratory tests to detect potential problems.
Diagnosis	• Perform diagnostic tests and assessments to follow-up when a risk is identified during screening and examinations.
Treatment	• Control, correct, or ameliorate any problems that are found.

https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs/early-periodic-screening-diagnosis-and-treatment

EPSDT

"States are required to assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly, … that informing methods are effective, … and that services covered under Medicaid are available."

— CMS, State Medicaid Manual

EPSDT (cont.)

Role of the care coordinator in the behavioral health practice

- Typically, encourage members to have this visit in their birth month if they are up to date on visits and vaccines.
- If there has not been a check up appointment within the last year, go ahead and schedule it immediately.
- If the member is taking antipsychotic medication, this would be a good time to complete the metabolic monitoring metric. PCPs may not be aware of this recommendation, so communicate this to the PCP office if there is an open gap.
- School schedules can be a barrier to completing this visit. Use school holidays or summer vacation to get a visit completed.
- All children newly enrolling in a Tennessee school or entering 7th grade will need an updated immunization certificate with up-to-date vaccines.
- Students enrolling in college will also typically need updated vaccines to apply.

Diabetic eye exam

Members 18 to 75 years of age with a diagnosis of type 1 or 2 diabetes who have a retinal eye exam performed and billed by an eye care professional or a PCP if a retinal screening device is available

- Annual exams for members with evidence of any type of retinopathy.
- Screen those who remain free of retinopathy every other year.

Amerigroup members can get $50 on a gift card for completing this visit.

Retinal screening is not vision screening

Retinal screening is covered by TennCare for members with diabetes.

Vision screening (for glasses) is *not* covered by TennCare for members over the age of 21.

Diabetic retinopathy (DR) is the leading cause of blindness in American adults. It is characterized by progressive damage to the blood vessels of the retina, the light-sensitive tissue at the back of the eye that is necessary for good vision.

Diabetic eye exam (cont.)

- The risks of DR are reduced through disease management that includes good control of blood sugar, BP, and lipid abnormalities.
- Early diagnosis of DR and timely treatment reduces the risk of vision loss; however, as many as 50% of patients are not getting their eye examined or are diagnosed too late for treatment to be effective.

https://cdc.gov/visionhealth/basics/ced/index.html#a5

Diabetic eye exam (cont.)

Role of the care coordinator in the behavioral health practice

- Be sure you assist in getting an appointment scheduled with the current eye care professional in each calendar year unless you have documentation of a normal exam in the previous year.
- If a member does not have an eye care provider, a referral can be done by the PCP or endocrinologist (diabetes specialists). Coordinate with the PCP to be sure it is scheduled and member keeps the appointment.
- Schedule these appointments earlier in the year if possible so that there is time to reschedule during the calendar year when necessary.
- Talk to members about maintaining a high quality of life by caring for their vision.

Diabetic eye screening SMART care plan

Goal:

- Member will complete diabetic eye exam.

Objectives:

- Member will meet with PCP and obtain referral for eye exam within 30 to 60 days.
- Member will identify eye doctor and schedule appointment within 60 days.
- Member will attend eye exam appt within 90 days.

Interventions:

- Care coordinator will provide educational materials to member within 30 to 60 days.
- Care coordinator will assist member with identifying eye care professionals within 60 days.
- Care coordinator will assist member in scheduling eye exam within 60 to 90 days.
- Care coordinator will follow up with eye care professional and inquire about members attendance within 90 days.

Diabetic eye screening SMART care plan modified

Objectives:

- Member will meet with PCP and obtain referral for eye exam within 30 to 60 days.
- Member will identify eye doctor and schedule appointment within 60 days.
- Member will attend eye exam appt within 90 days.

Member missed an appointment so care plan is modified to address the barrier.

Objectives:

- Member will reschedule eye appointment within 30 days.
- Member will add eye appointment to calendar and store on the fridge as a reminder and check daily.
- Member will schedule transportation X days before the appointment.

Controlling high blood pressure

Members 18 to 85 years of age with a diagnosis of hypertension and BP (BP) was controlled

- Complaint BP is defined as < 140/90 mm Hg for all members.
- The latest reading in the calendar year is used to meet the measurement.
- If no reading is recorded for the year, the assumption is that the member is not controlled.

Amerigroup members can get $5 on a gift card each quarter for filling prescriptions for BP medications.

Controlling high blood pressure (cont.)

- You can take multiple BP readings and report the lowest systolic and diastolic to make the compliant BP reading:
  - For example, if your first reading was 141/88 and the second was 138/91, you can combine the 138/88 to make the compliant BP reading to close the gap in care.

Controlling high blood pressure (cont.)

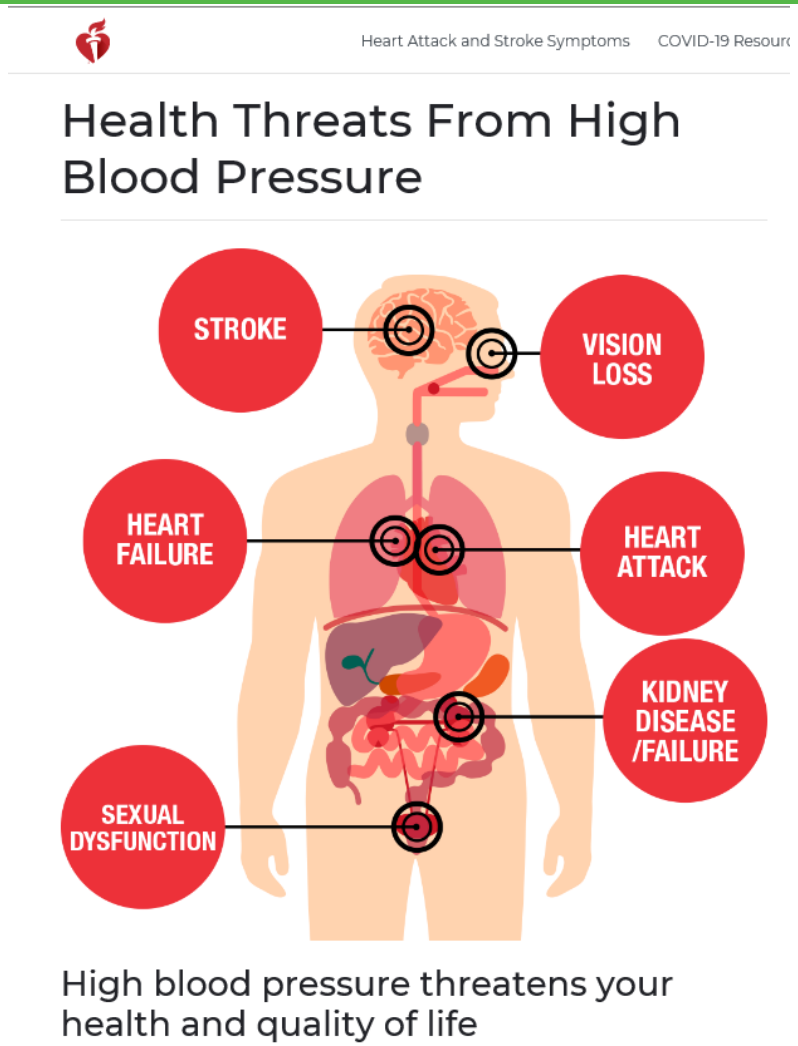
Systolic:
Top number
pressure in arteries
at the pulse

Maximum
139

Diastolic:
Bottom number
pressure in arteries
between pulses

Maximum
89

Controlling high blood pressure (cont.)



https://heart.org/en/health-topics/high-blood-pressure/health-threats-from-high-blood-pressure

Remember: High BP *rarely* has symptoms!

Controlling high blood pressure (cont.)

Role of the care coordinator in the behavioral health practice

- Be sure that member is aware of the goal for hypertension 139 or less/89 or less.
- Be sure the member knows which medication is for BP (for example, have member write it on the bottle). Stress that it is important to take the medication every day as prescribed.
- Ask if the member is having any barriers to taking the medication such as cost or concern about prescription limits.
- Share with PCP or specialists to retake the BP if it is high at the office visit (140/90 mm Hg or greater). The BP reading should be coded on a claim.
- Remind members that even if they feel fine, high BP puts a lot of stress on the body and medications can help prevent complications.
- Check with the pharmacy to be sure member is picking up meds. Use a pill dispenser or alarm for a reminder.

Controlling high blood pressure SMART care plan

Goal:

- Member will maintain BP no higher than 139/89.

Objectives:

- Member will attend PCP appointments as scheduled for the next six months.
- Member will take medications daily for the next six months.
- Member will place note on fridge as a reminder to take medications daily within 30 days.
- Member will report any side effects to care coordinator and PCP as they occur over the next 180 days.

Interventions:

- Check CCT monthly to ensure member is picking medications up at the pharmacy.
- Care coordinator will provide educational material to member for BP within 30 days.
- Care coordinator will work with member on locating resources for education around health eating and lifestyle changes to better manage BP within 60 days.

Controlling high blood pressure SMART care plan modified to address barriers

Objectives:

- Member will attend PCP appointments as scheduled for the next six months.
- Member will take medications daily for the next six months.
- Member will place note on fridge as a reminder to take medications daily within 30 days.
- Member will report any side effects to care coordinator and PCP as they occur over the next 180 days.

Objectives:

- Member will attend PCP appointments as scheduled for the next six months.
- **Member will pick up medications from pharmacy each month when they are available.**
- **Member will notify care coordinator when she experiences barriers to picking up medications.**
- Member will take medications daily for the next six months.
- Member will report any side effects to care coordinator and PCP as they occur over the next 180 days.

Screenings for those using antipsychotic medication

Annual diabetes screening for members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder if they receive an antipsychotic medication at any time during year and *do not* have a diagnosis of diabetes.

The percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (blood glucose and cholesterol testing).


Unhealthy lifestyles with poor diets and inadequate physical activity
Genes involved in both glucose metabolism and cognitive function may increase the risk of diabetes
Nutritional factors may have a common pathway for development of both diabetes and schizophrenia
Low level of vitamin D during childhood may be associated with schizophrenia and vitamin D may affect insulin response to glucose stimulation
The dysregulation of hormones seen in schizophrenia may also influence blood glucose, insulin resistance, and metabolic syndrome
Common inherited susceptibility to both diabetes and schizophrenia
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Diabetes Screening for People Using Antipsychotic Medications

From the World Health Organization:

- People with severe mental disorders on average tend to die earlier than the general population. This is referred to as premature mortality.
- There is a 10 to 25 year life expectancy reduction in patients with severe mental disorders.
- The vast majority of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes, and hypertension.
- People with bipolar mood disorders have high mortality rates ranging from 35% higher to twice as high as the general population.
- People with severe mental illness do not receive the same quality of physical health care as the general population.

https://who.int/mental_health/management/info_sheet.pdf

Diabetes Screening for People Using Antipsychotic Medications (cont.)

From the World Health Organization:

- The majority of deaths of patients with severe mental illness that are due to physical medical conditions are preventable with more attentive checks for physical illness, side effects of medicines, and suicidal tendencies.
- Interventions exist to promote the mental and physical health of individuals with severe mental disorders.
- There is a need for increasing access to quality care for patients with severe mental disorder, and to improve the diagnosis and treatment of coexisting physical conditions.
- The integration of mental and physical healthcare could facilitate this.

https://who.int/mental_health/management/info_sheet.pdf

Diabetes screening

- Screening may be done with a glucose or A1c test (finger stick or a venipuncture):
  - A glucose test gives measures the sugar level at that moment. Test should be fasting.
  - An A1c measures average blood sugar levels over the past three months. When sugar enters the bloodstream, it attaches to hemoglobin, a protein in the red blood cells. The A1C test measures the percentage of red blood cells that have sugar-coated hemoglobin. Members do *not* need to fast for this test.

Diabetes screening (cont.)

Glucose test	
Normal fasting	Below 100
Elevated	100 to 125
Diabetes	Above 126

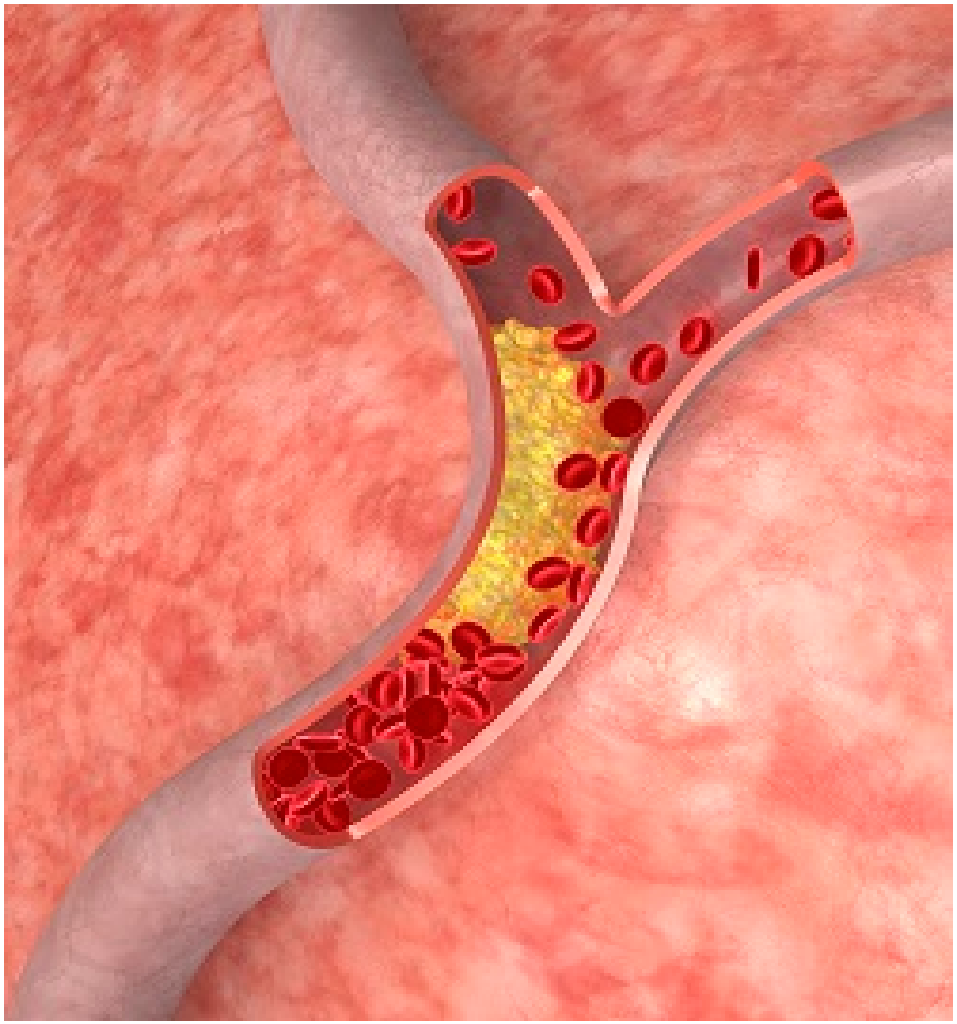
A1c test	
Normal	Below 5.7%
Prediabetes	5.7% to 6.4%
Diabetes	6.5% or above

Cholesterol Screening for Children and Adolescents on Antipsychotics

- Some antipsychotic medications are associated with elevated cholesterol (hypercholesterolemia, hypertriglyceridemia, and low high-density lipoprotein cholesterol).
- Members with mental illness may be at increased risk for these abnormalities because of lifestyle choices.
- Members with mental illness may have less frequent medical care, and many primary care providers are unaware of the increased risks.
- The metabolic effects of medications and mental illness are associated with up to a six-fold increase in the risk of type 2 diabetes and death from coronary heart disease.

https://psychiatrictimes.com/view/metabolic-monitoring-antipsychotic-medications-what-psychiatrists-need-know

Cholesterol Screening for Children and Adolescents on Antipsychotics (cont.)



As cholesterol (plaque) builds up in the arteries, the arteries begin to narrow, which lessens or blocks the flow of blood.

https://cdc.gov/cholesterol/about.htm

Diabetes screening and metabolic monitoring

Role of the care coordinator in the behavioral health practice

- Provide member education that persons who use antipsychotics are at increased risk of cardiovascular diseases and diabetes, so screening and monitoring of these conditions is important to maintain a high quality of life.
- Encourage shared decision-making by encouraging families to discuss medication risks and benefits.
- Review symptoms for at-risk members of new-onset diabetes including excessive hunger, excessive thirst, and/or excessive urination.
- Testing may be performed or ordered by your providers. Coordinate care and communicate test results to the member's PCP if abnormal.
- Communicate with PCPs by scheduling an appointment for testing or calling the PCP office to be sure this is checked at the next appointment. Orders for testing can be written on a prescription by the Health Link medication providers to facilitate completion of testing.
- Reach out to members who cancel PCP appointments and assist them with rescheduling as soon as possible.

Diabetes screening for schizophrenia or bipolar disorders SMART care plan

Goal:

- Member will complete screening for diabetes (or metabolic monitoring).

Objectives:

- Member will meet with PCP and obtain order for labs within the next 30 days.
- Member will ensure appt is scheduled to complete lab work within the next 60 days.
- Member will complete bloodwork within the next 90 days.

Interventions:

- Care coordinator will provide educational materials to member within 30 to 60 days.
- Care coordinator will assist member with obtaining order for labs within the next 30 days by communicating with PCP.
- Care coordinator will request records to ensure lab work was completed within 30 days of member's appt.
- Care coordinator will assist member in communicating with PCP regarding any concerns related to results within 90 days.

Hospital follow-up and readmissions

The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses (including self-harm) and who had a follow-up visit with a mental health practitioner within seven days after discharge.

Psychiatric hospital or residential treatment facility readmission within seven and 30 days after discharge

Hospital follow-up and readmissions (cont.)

- These measures will not usually be a part of the care plan unless you have a member who is an over-user. However, following up from ER visits are an important role for care coordinators.
- Add to the **SMART** care plan for members who need goals on the care plan to help overuse of ER visits/hospitalizations. Include:
  - Education and resources.
  - Alternatives to the ER.
  - Crisis lines/clinic nurse triage.
  - Amerigroup 24-Hour Nurse HelpLine.

Hospital follow-up within seven days

Role of the care coordinator in the behavioral health practice

- Ensure that the follow-up appointment is made with a mental health practitioner before the patient leaves the hospital and is scheduled within seven days of discharge.
- Work with local hospitals to be sure the member has all the information needed for the appointment and you have good contact information for the member.
- Have conversations with social services at nearby psych hospitals to understand how to best collaborate.
- Use the census reports to try to follow up with members promptly.
- A telehealth appointment within the appropriate timeframe meets the measure.

Seven and 30 day readmissions

Role of the care coordinator in the behavioral health practice

- Ensure that the member came for a seven day follow up appointment and, if indicated, has an appointment for follow-up before 30 days.
- Ensure that the member is able to pick up medications that were prescribed and that there were not problems with authorizations or prescription limits.
- Ask if the member is having any side effects from psychiatric medications that need to be addressed by the psychiatric provider to help prevent readmission and encourage medication compliance.
- Review with the member any walk-in or open-door policies of the behavioral health provider should an urgent situation arise so the situation can be addressed in the clinic.
- For repeat offenders, request an Amerigroup case management referral for additional support.

Questions?

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