Health Plan of Nevada
A UnitedHealthcare Company

Provider Resource Guide 2024
HEDIS® Adult Measures

Sierra Health and Life
A UnitedHealthcare Company

This guide is a tool to help close HEDIS gaps in care; it is a quick reference for common preventive health screenings for anyone with the ability to impact measures (i.e. clinicians, administrators and staff). The below information describes the measure population, action(s) to close the gap and goal. It is not designed to replace clinical judgment but as a support to reinforce the importance of preventive care and share how clinical decisions impact HEDIS.

Helpful Hints

Exclusions:

Appropriately coding for exclusionary criteria removes member(s) from the respective HEDIS population. Palliative/hospice coding during the measurement year excludes patients from most measures. Additional measure-specific exclusions are listed under each measure.

Electronic Clinical Data Systems (ECDS):

NCQA is transitioning the collection of data from a medical record review process to claims or encounters only. To ensure your measure compliance rates are accurate, be sure to document and submit the appropriate code. The measures with the "E" listed, indicate this measure has transitioned electronically only accepting coding (and not medical record review) for compliance.

Telehealth:

Telehealth is often an acceptable and underutilized method to close many gaps in care.

Health Education and Wellness/ Disease Management:

Refer to Disease Management for members with asthma, diabetes, or kidney disease for support with managing chronic health conditions. Additionally, Health Education and Wellness support services are available for members. Referrals can be made through the online provider portal or call **702-242-7546**.

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

Patient Population

- Ages 20 and older who had an ambulatory or preventive care visit
- Medicaid members annually
- Commercial members once every three years

Action:
Reach out to members who have not been seen to schedule an appointment

Goal: Build or maintain member/provider relationship, and address any preventive screenings and health concerns.

Adult Immunization Status (AIS-E)

Patient Population:

- Ages 19 and older for flu and Td/Tdap
- Ages 50 and older for herpes zoster
- 66 and older for pneumococcal vaccine

Action:
Provide vaccinations and/or code any anaphylactic reactions for the following immunizations and document in WebIZ:

1	influenza vaccine
1	Td/Tdap vaccine
1	(live) or 2 recombinant herpes zoster
1	adult pneumococcal vaccine

Goal: Disease protection

Antibiotic Stewardship

Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB) and/or Appropriate Treatment for Upper Respiratory Infection (URI)

Patient Population

- Ages 3 months and older
- Diagnosed with acute bronchitis and/or upper respiratory infection

Action:
Avoid prescribing antibiotics for members on or 3 days after the diagnosis.

Goal: Reduce overuse of antibiotics

Appropriate Testing for Pharyngitis (CWP)

Patient Population

- Ages 3 and older
- Pharyngitis diagnosis

Action:
Complete a group A streptococcus (strep) test or rapid strep test prior to prescribing antibiotics.

Goal: Reduce overuse of antibiotics

Colorectal Cancer Screening (COL-E)

Patient Population

- Ages 45–75
- Has not completed a listed screening for colorectal cancer

Action:
Ask and document last colorectal cancer screening date and test type. If overdue: place order or provide at-home testing kit.

- FOBT – annually
- FIT-DNA (i.e. Cologuard®): current year - 2 years prior
- Flexible sigmoidoscopy: current year - 4 years prior
- CT Colonography: current year - 4 years prior
- Colonoscopy: current year - 9 years prior

Exclusions: History of colorectal cancer or a total colectomy

Goal: Cancer detection

Controlling High Blood Pressure (CBP)

Patient Population

- Ages 18–85
- Hypertension diagnosis

Action:

- Take and record BP
- Repeat BP if value is 140/90 or higher (139/89 or less is compliant)

Goal: Ensure blood pressure (BP) is adequately controlled (<=139/89 mmHg) during measurement year.

Diabetes

Patient Population

- Ages 18-75
- Diabetes diagnosis
- Dispensed insulin or hypoglycemics/ antihyperglycemics

Action:

- Measure and report all of the following labs:
  - HbA1c or glucose management indicator (GMI)
  - eGFR ages 18-85
  - Urine Albumin-Creatinine Ratio (uACR) ages 18-85
  - Albumin/microalbumin **and** a urine creatinine test (<4 days of each other)
- Consider prescribing a statin (ages 40-75)
- Take and record BP
  - Repeat the BP if either value is 140/90 or higher (139/90 or 140/89 are not compliant)
- Refer to eye care provider for retinopathy screening
- Refer to Disease Management for help managing HbA1c through the online provider portal or call **702-242-7546**

Goal: To measure control of diabetes.

This guide is not comprehensive; for additional resources use your phone to scan the QR code below.

Healthplanofnevada.com/Provider/HEDIS-Measures

Social Determinants of Health (SDoH) such as food insecurity, homelessness or housing instability, psychosocial circumstances, economic challenges, etc. have been identified as key factors in impacting a patient's health and health outcomes. Coding for these can bring attention to their prevalence and help identify needed resources.

Health Plan of Nevada
A UnitedHealthcare Company

Provider Resource Guide 2024
HEDIS® Behavioral Health & Women's Measures

Sierra Health and Life
A UnitedHealthcare Company

This guide is a tool to help close HEDIS gaps in care; it is a quick reference for common preventive health screenings for anyone with the ability to impact measures (i.e. clinicians, administrators and staff). The below information describes the measure population, action(s) to close the gap and goal. It is not designed to replace clinical judgment but as a support to reinforce the importance of preventive care and share how clinical decisions impact HEDIS.

Behavioral Health (BH)

Patients with Substance use Disorders (SUD)

To determine an SUD and the appropriate level of treatment, the recommendation is to utilize Screening, Brief Intervention and Referral to Treatment (SBIRT). When diagnosing an SUD consider higher severity (i.e. active SUD) vs lower severity (hazardous substance use) and whether substance use is in early or sustained remission. Schedule a follow-up appointment or refer to a mental health provider to engage patient and discuss motivation to change.

For more information on behavioral health services please reach out to **702-364-1484**.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Patient Population:
- Ages 6 years and older
- Principal diagnosis of mental illness or intentional self-harm

Action:
- 7-day follow-up for mental illness within 7 days after the ED visit (8 days total)
- 30-day follow-up for mental illness within 30 days after the ED visit (31 days total)

Goal: Ensure proper follow-up care after a mental health ED visit

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Patient Population
- Ages 18-64
- Cardiovascular disease
- Schizophrenia or schizoaffective disorder

Action:
Place order or complete the following lab during the year:
- LDL-C

Goal: Metabolic monitoring

Diabetes Screening for People w/ Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Patient Population
- Ages 18-64
- Schizophrenia, schizoaffective or bipolar disorder diagnosis
- Dispensed antipsychotic medication

Action:
Place order or complete the following lab during the year:
- Blood glucose or HbA1c

Goal: Metabolic monitoring

Women's Measures

Cervical Cancer Screening (CCS)

Patient Population
- Women ages 21-64 who have not been screened for cervical cancer

Action:
Schedule, perform, and document the applicable screening and result:
- Pap smear in the measurement year or 2 years prior (ages 21-64).
- High-risk human papillomavirus (hrHPV) testing in the measurement year or 4 years prior (ages 30-64).
- Document type of service, date performed and result

Exclusions: Hysterectomy with no residual cervix, male to female transgender, cervical agenesis or acquired absence of cervix (document total hysterectomy)

Goal: Cancer detection

Breast Cancer Screening (BCS)

Patient Population
- Women ages 50-74 who have not had a mammogram in 2 years

Action:
Schedule or place referral for a mammogram

Exclusion: Bilateral mastectomy

Goal: Cancer detection

Chlamydia Screening in Women (CHL)

Patient Population
- Women ages 16-24 on birth control
- Sexually Active

Action:
Perform a chlamydia test if one hasn't been done within the year.

Goal: Chlamydia detection

Prenatal Care (PPC)/Prenatal Immunization Status (PRS)/Prenatal Depression Screening and Follow-Up (PND)

Patient Population
- Diagnosed pregnancy
- Prenatal care visit in the 1st trimester

Action:
- Perform and document date of prenatal visit
- Indicators of pregnancy: prenatal flow sheet, LMP, EDD, positive pregnancy test result, gravidity and parity, complete obstetrical history, fetal heart tones, measurement of fundus height, prenatal risk assessment and counseling/ education
- Complete depression screening (document test type and score); follow up on positive screenings within 30 days
- Schedule influenza & Tdap vaccinations

Goal: Ensuring early initiation of prenatal care

Postpartum Care (PPC)/Postpartum Depression Screening and Follow-Up (PDS)

Patient Population
- Delivery of live birth(s)

Action:
Perform and *document* a postpartum visit on or between 7–84 days (1-12 weeks) after delivery and *one* of the following:
- Postpartum care (PP care, PP check, etc.), pelvic exam, evaluation of weight, BP, breasts and abdomen, perineal or cesarean incision/wound check, screening for depression, anxiety, tobacco use, substance use disorder or pre-existing mental health disorders, glucose screening for women with gestational diabetes, infant care/breast feeding, resumption of intercourse, family planning, sleep/ fatigue, resumption of physical activity or attainment of healthy weight
- Complete depression screening (document test type and score); follow up on positive screenings within 30 days

Goal: Setting the stage for long-term health and well-being of new mothers and their infants

This guide is not comprehensive; for additional resources use your phone to scan the QR code below.

Healthplanofnevada.com/Provider/HEDIS-Measures

Social Determinants of Health (SDoH) such as food insecurity, homelessness or housing instability, psychosocial circumstances, economic challenges, etc. have been identified as key factors in impacting a patient's health and health outcomes. Coding for these can bring attention to their prevalence and help identify needed resources.