QUALITY INSIDER NEWSLETTER

2024

Opening remarks

The Senior Whole Health, LLC (SWH) Quality Improvement Program focuses on continuous quality improvement for the benefit of our members. Partnering with our provider network is a key component of our success. The annual Quality Insider Newsletter contains helpful information, resources and quality improvement tips for providers.

Christopher A. Post, MD
Chief Medical Officer

HEDIS® and gap closure

Annual data is collected for the Healthcare Effectiveness Data and Information Set (HEDIS®) to help inform Star ratings and demonstrate quality of care to SWH members. HEDIS® results also help identify opportunities for improvement.

HEDIS® highlights – Measures in the spotlight

Controlled Blood Pressure (CBP)

According to the Centers for Disease Control and Prevention (CDC) and National Center for Health Statistics (NCHS), heart disease was the leading cause of death in the United States between 2020 – 2021 (CDC 2023)[1]. Heart disease is also the leading cause of hospital readmissions. Uncontrolled hypertension increases the risk of developing heart disease and other conditions, including kidney disease. SWH is committed to working with providers to improve rates of controlled blood pressure among our members. We would like to share some helpful tips to support our members with high blood pressure:

- Reserve time for routine blood pressure checks for patients with uncontrolled blood pressure
- Check in with high-risk patients for home readings on a planned schedule
- Provide education and resources for patients to follow low-sodium/heart-healthy diets
- Prescribe automated home blood pressure cuffs and provide education on use at home
- Utilize current clinical practice guideline recommendations for prescribing medications
- Promote smoking cessation programs
- Provide education on the benefits of physical activity
- Refer members to disease management programs offered by SWH

[1] National Center for Health Statistics. Health, United States 2020 – 2021, Heart Disease Prevalence. Hyattsville, Maryland. 2023.

Use the following when coding for patients with hypertension:

Description:	Code:
Essential hypertension	**ICD-10:** I10
Outpatient and telehealth without UBREV	**CPT:** 98966-98968, 98970-98972, 98980, 98981, 99202-99205, 99211-99215, 99241, 99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411,99412, 99421-99423, 99429, 99441-99443, 99455-99458, 99483 **HCPCS:** G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250-G2252, T1015
Systolic blood pressure	**CPT II:** 3074F (Less than 130 mm Hg) **CPT II:** 3075F (Between 130-139 mm Hg) **CPT II:** 3077F (Greater than/equal to 140 mm Hg) *Note:* Do not include codes with CPT CAT II Modifier: 1P-2P, 8P. Do not include BPs in an acute inpatient setting or during an ED visit with POS 23.
Diastolic blood pressure	**CPT II:** 3078F (Less than 80 mm Hg) **CPT II:** 3079F (Between 80-89 mm Hg) **CPT II:** 3080F (Greater than/equal to 90 mm Hg) *Note:* Do not include codes with CPT CAT II Modifier: 1P-2P, 8P. Do not include BPs in an acute inpatient setting or during an ED visit with POS 23.

Plan All-Cause Readmissions (PCR)

SWH would like to partner with providers to reduce hospital readmission rates. Data from the National Readmission Database (NRD) demonstrates that an average of 20% of patients discharged from the hospital end up readmitted within 30 days (Wang and Zhu 2022[2]). Rates are even higher for patients with disparities and inequities impacting social determinants of health (SDOH). Improving access to care and timely post-discharge follow-up supports a safe transition of care and can reduce readmission rates. Performing direct outreach to high-risk patients, and communications with our nurse care manager team helps keep our members safe at home. Some tips to help patients avoid unplanned readmission include:

- Communicate with the inpatient team during hospitalization if your patient has been admitted
- Ensure SWH members receive a follow-up appointment within seven days of discharge
- Implement systems for routine check-ins with SWH members upon notification of discharge
- Communicate with the SWH nurse care manager for any concerns or updates
- If indicated, refer patients to a home care agency for a home safety evaluation and medication review
- Communicate with the patient's pharmacy for safe post-discharge medication reconciliations

The CMS Office of Minority Health recently revised the Guide for Reducing Disparities in Readmissions: www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf. Please review the information, which highlights the importance of addressing health inequities and primary care provider involvement during hospitalizations and transitions of care.

[2] Wang S, Zhu X. Nationwide hospital admission data statistics and disease-specific 30-day readmission prediction. Health Inf Sci Syst. 2022 Sep 2;10(1):25. doi: 10.1007/s13755-022-00195-7. PMID: 36065327; PMCID: PMC9439279.

Medication reconciliation (TRC-MRP)

The Joint Commission lists medication safety as one of the 2024 Ambulatory Health Care National Patient Safety Goals. Improving rates of medication reconciliation post-discharge is a priority SWH Performance Improvement Project (PIP) topic required by Mass Health and a high-priority HEDIS® measure. Reconciling medications during transitions of care is a complex process involving numerous stakeholders. Providers are key to ensuring their patients are taking the right medication, in the right dose, at the right time once they have been discharged from an inpatient setting.

The Agency for Healthcare Research and Quality (AHRQ) created the Medications at Transitions and Clinical Handoffs (MATCH) Toolkit to assist providers and patients. Please review this valuable resource for promoting medication safety at: www.ahrq.gov/patient-safety/settings/hospital/match/index.html.

Use the following when coding for medication reconciliation during transitions of care:

Description:	Code:
Medication reconciliation encounter	**CPT:** 99483, 99495, 99496
Medication reconciliation intervention	**CPT-CAT- II:** 1111F (Do not include codes with CPT CAT II Modifier: 1P-3P, 8P)
Medication reconciliation (procedure)	**SNOMED CT US Edition:** 430193006
Medication reconciliation by pharmacist (procedure)	**SNOMED CT US Edition:** 428701000124107

Glycemic Status Assessment in Patients With Diabetes (GSD)

Controlling Hemoglobin A1c (HbA1c) in patients with diabetes is a high priority HEDIS® measure for SWH members. The HEDIS® measure name for 2024 has been updated to Glycemic Status Assessment in Patients With Diabetes (GSD). According to the 2023 SWH population assessment, diabetes is the 2nd highest chronic condition diagnosis among SWH members. We would like to partner with providers to focus on providing education and monitoring for controlling HbA1c among SWH members with diabetes.

Use the following when coding for GSD:

Description:	Code:
Diabetes	**CPT:** 99483, 99495, 99496
Medication reconciliation intervention	**CPT-CAT- II:** 1111F (Do not include codes with CPT CAT II Modifier: 1P-3P, 8P)
Medication reconciliation (procedure)	**SNOMED CT US Edition:** 430193006
Medication reconciliation by pharmacist (procedure)	**SNOMED CT US Edition:** 428701000124107

Osteoporosis Management in Women Who Had a Fracture (OMW)

Management of osteoporosis for women who suffer a fracture is a time-sensitive HEDIS® measure. Women must have a bone marrow density (BMD) test within 180 days of the date of their fracture, or they must have an eligible prescription filled within 180 days of the date of their fracture to comply with the measure. Medications that meet the criteria for osteoporosis treatment to satisfy HEDIS® requirements include:

Bisphosphonates: Alendronate; Alendronatecholecalciferol; Ibandronate; Risedronate; Zoledronic acid
Others: Abaloparatide; Denosumab; Raloxifene; Romosozumab; Teriparatide

Use the following when coding for OMW:

Description:	Code:
Bone mineral density test	**CPT:** 76977, 77078, 77080 77081, 77085, 77086 **ICT-10:** BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1
Osteoporosis medication therapy	**HCPCA:** J0897, J1740, J3110, J3111, J3489
Long-acting osteoporosis medications (for inpatient stays only)	**HCPCA:** J0897, J1740, J3489

The Availity Essentials provider portal contains valuable information on codes needed to close gaps and tips on best practices.

SWH offers HEDIS® tip sheets in the Availity portal as a resource for our provider network. Tip sheets contain codes needed to close gaps, valuable information on all HEDIS® measures, including eligibility and exclusion criteria, along with tips on best practices for providers. Please review and utilize the HEDIS® tip sheets, located in the Payer Spaces/Resources section of the portal at: apps.availity.com/public/apps/home/#!.

To register for Availity, go here: www.availity.com/Essentials-Portal-Registration.

Please encourage members to contact SWH Member Services to help schedule needed screening appointments at (888) 794-7268 (TTY: 711), 7 days a week, 8 a.m. to 8 p.m., local time.

Motivational interviewing and culturally and linguistically appropriate services

SWH offers resources to providers to support culturally and linguistically appropriate services (CLAS). Motivational Interviewing and CLAS trainings can be found in the Payer Spaces section in the Availity portal. For access and to register for Availity, please review the information located here:

MolinaHealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/ma/comm/Availity-Intro-Letter-SWH.pdf.

CLAS trainings and other resources and tools for providers can also be found on the public website at: MolinaHealthcare.com/providers/ma/swh/health/cme.aspx.

Clinical practice and preventive health guidelines

SWH reviews and updates clinical practice and preventive health guidelines quarterly. Links to current approved guidelines are available on our provider website to help guide the care of our members. New guidelines adopted in Q1 and Q2, and recent updates to existing guidelines include:

Topic	New clinical practice guidelines for SWH 2024:	Link:
Anxiety/panic disorder	Panic Disorder: A Review of Treatment Options from American Academy of Clinical Psychiatrists	www.aacp.com/wp-content/uploads/2021/02/0221-ACP-Ziffa.pdf
Bipolar disorder	Clinical Practice Guidelines for the Management of Bipolar Disorder from the Department of Veterans Affairs & Department of Defense	www.healthquality.va.gov/guidelines/MH/bd/VA-DoD-CPG-BD-Full-CPGFinal508.pdf
Depression	Guideline for the Management of Major Depressive Disorder	VA/DoD_Clinical_Practice_Guideline_for_the_Management_of_Major_Depressive_Disorder_(MDD)
Topic	**Updates to existing preventive health guidelines for SWH 2024:**	**Link:**
Adults preventive health	Recommended Adult Immunization Schedule for ages 19 Years or older from the Centers for Disease Control and Prevention (CDC)	www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
Adult preventive services	Adult Preventive Services Recommendations from U.S. Preventive Services Task Force	www.uspreventiveservicestaskforce.org/BrowseRec/Index

Practice guidelines and other valuable resources are in the Health Resources section of our website located at: MolinaHealthcare.com/providers/ma/swh/home.aspx.

Performance improvement projects (PIP)

SWH conducts ongoing performance improvement projects (PIPs) over three-year cycles as part of the MassHealth Comprehensive Quality Strategy. Projects are managed by the SWH quality team in collaboration with internal and external stakeholders and are focused on two topics mandated by MassHealth. The PIPs are overseen and validated as mandated under 42 CFR 438.330 by the Island Peer Review Organization (IPRO), the external quality review organization (EQRO) contracted with Mass Health.

SWH has received approval from IPRO and Mass Health to move forward with proposed interventions for projects addressing the following two topics:

- Controlling High Blood Pressure (CBP)
- Transition of Care – Medication Reconciliation Post-Discharge

Partnering with provider stakeholders is essential for implementing measurable and effective interventions. SWH has designed interventions aimed at providers, members and internal staff to achieve project goals. The planned provider interventions for both PIPs are aimed at patient education, provider education and systems improvement. The SWH quality team is working closely with our provider network team to plan for upcoming provider communications related to these interventions. Please be on the lookout for more information relevant to your practice as these projects launch. We appreciate your care of our members and your support of continuous quality improvement.

Help us spread the word to members about our new Member Advisory Committee (MAC)

SWH conducts a quarterly Member Advisory Committee for our MAPD, SCO & D-SNP members. We believe the health care system is stronger when we listen to the people we serve. We encourage our members to participate and provide feedback on how we are doing as a plan. Our goal is to educate members about our services, and obtain their feedback in order to make improvements.

Here is some basic information about the MAC that you can share with our members:

- The MAC is for SWH members and/or caregivers. SWH staff will be in attendance to answer any questions.
- Some topics discussed in meetings include but are not limited to health management programs, benefit education, and obtaining feedback on enhancing the member experience.
- The meetings are held quarterly. Currently, they are conducted by computer or telephone and may eventually move to an in-person environment.

If you know a member and/ or caregiver who is interested in joining our MAC, please let us know or have them contact SWH Member Services at (888) 794-7268 (TTY: 711) from 8 a.m. to 8 p.m., 7 days a week.

We look forward to creating better health care experiences- together!

SWH member support focus workgroups

SWH would like to partner with our providers to educate the community on the importance of maintaining healthy blood pressure levels. We aim to provide the community with the resources they need to help them live healthy lives. We will be traveling to several communities in the State. We will have dedicated SWH staff from our clinical, quality and sales departments available to supply valuable education on blood pressure management. SWH will provide interpretation services and staff will be available to answer any questions attendees may have. Information that we will be presenting at these member support focus workgroups sessions include:

- Healthy habits to keep in mind, such as taking your blood pressure daily, keeping a log of your blood pressure readings, the importance of sharing your readings/log with your MD, and how high blood pressure is treated.
- Understand what your blood pressure means and how to accurately take it, and know the healthy ranges for your blood pressure.
- Provide tools and tips on how to maintain healthy blood pressure, such as diet/food selection, reading nutritional labels and exercise.

Please feel free to contact the SWH quality department if you are interested in collaborating with our SWH plan. We look forward to partnering with you on this initiative!

Access to electronic medical records

SWH partners with network providers to establish electronic medical records (EMR) access. Following the recommendations from the Center for Medicare and Medicaid Services (CMS), the goal of sharing EMR access helps to reduce time constraints on providers by streamlining prior authorization (PA) processes and improving the exchange of health information. The benefits of increasing access include reducing the burden of providers filling out complicated forms, reducing wait times for authorizations and access to information, improving timely access to care for your patients, and cost savings by reducing time wasted on administrative tasks. Please work with our network team to establish these connections to better support the care of our members. You can find out more from CMS on this topic at: **www.hhs.gov/about/news/2024/01/17/cms-finalizes-rule-to-expand-access-to-health-information-and-improve-the-prior-authorization-process.html.**

To set up EMR access with SWH, please contact Alisha Ely, RN, at (614) 516-4621.

Supplemental data source (SDS) file exchange

SWH has been working with our network providers to establish a supplemental data source (SDS) file exchange. Establishing an SDS connection allows for sharing comprehensive data beyond administrative claims, improving efficiency and reducing administrative burden on providers. Other benefits of an SDS file exchange include:

- Reduces the need for office staff to participate in HEDIS® manual record retrieval
- Allows the health plan to download what is required for HEDIS® data securely
- Increases data transparency between providers and SWH
- Supports HEDIS® through increased access to data, improving rates of gap closure
- Allows for HIPAA compliance through secure exchange of Personal Health Information (PHI)
- Supplemental data can be extracted year-round

Please be on the lookout for communications from the SWH quality team related to this project.