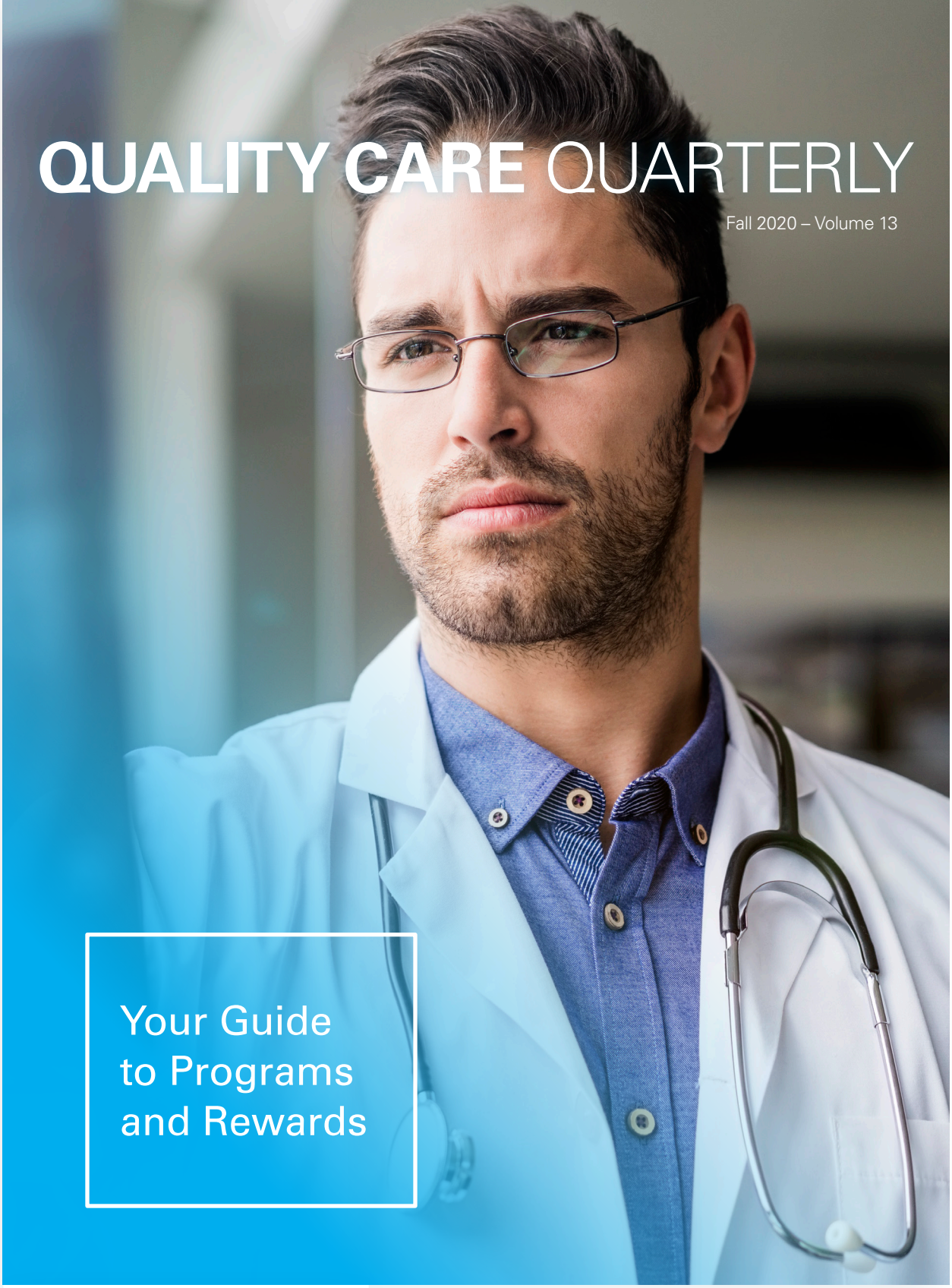

QUALITY CARE QUARTERLY

Fall 2020 – Volume 13

Your Guide to Programs and Rewards

Blue Cross Blue Shield of Tennessee

Featuring

- A Message From Dr. James
- Sewanee Pediatrics and Adolescent Medicine's Approach to Well-Child Care

Inside This Issue

Renewing Our Focus on Preventive Care

During the novel coronavirus (COVID-19) outbreak, fewer children received well-child care. According to the Tennessee Chapter of the American Academy of Pediatrics, April 2020 vaccination rates are 39% lower than April 2019.

Over the last several months, we've been focused on the pandemic, but preventive care is still important. Well-child visits allow you to perform developmental screenings, administer vaccines, and make sure your patients are adapting well to recent changes in their routines. If your patients have missed their checkup or vaccines, the Centers for Disease Control and Prevention recommends establishing a catch-up strategy that starts with children up to age 24 months and then extends to school-age children and adolescents.

Now is a great time to encourage your patients to schedule their well-child appointment and start thinking about flu season. The flu shot will be even more important this year, so consider starting discussions with families about the flu vaccine early.

A Dose of Reassurance

Some parents may be hesitant to bring their children to the office for well-child care, so this is a good time to reach out to parents and let them know about the safety precautions you're taking. Strategies other providers have reported include seeing patients for illness and performing checkups at different times of the day. Some practices with multiple locations have also designated one location for sick visits and one location for well care.

The Tennessee Chapter of the American Academy of Pediatrics and other organizations have prepared a variety of resources that outline best practices for communicating safety information to patients and delivering well-child care while minimizing patients' COVID-19 exposure. To view these resources, select the appropriate link below:

Tennessee Chapter of the American Academy of Pediatrics:

https://www.tnaap.org/resources/blog/april-2020/covid-19-information-and-resources

American Academy of Pediatrics:

https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/

Centers for Disease Control and Prevention:

https://www.cdc.gov/

To learn more about our COVID-19 response, visit BCBSTupdates.com.

Thank you for everything you do for our members, especially during this crisis. We're here to assist you however we can.

Jeanne James, M.D., FAAP

Vice President and Chief Medical Officer, BlueCare Tennessee

Sewanee Pediatrics and Adolescent Medicine's Approach to Well-Child Care

Immunization Focus Earns National Distinction

When Sewanee Pediatrics and Adolescent Medicine joined the TennCare Patient-Centered Medical Home (PCMH) program in 2017, they started putting additional emphasis on childhood and adolescent vaccines, an area where they noticed room for improvement. Over the past two years, they've adopted several new processes and best practices that have led to higher rates, especially for human papillomavirus (HPV) vaccination. Last year, the practice achieved an HPV vaccination rate of 70% – a 21% increase from 2017 – and was named the *2019 HPV Vaccine is Cancer Prevention Champion* for Tennessee. This designation, which is jointly sponsored by the Centers for Disease Control and Prevention, American Cancer Society, and Association of American Cancer Institutes, is given to providers, groups, practices and health systems in each state that are dedicated to achieving high HPV vaccination rates in their communities.

Changing the Culture Surrounding Well-Child Care

One of the first changes Sewanee Pediatrics and Adolescent Medicine made was checking to see if patients were up to date on vaccines before every visit – not just visits for well-child care. The electronic health records system the practice uses includes vaccine forecasting, so nonclinical staff can open the patients' charts and find out if they're due for a vaccine when someone calls to schedule an appointment.

The Sewanee Pediatrics and Adolescent Medicine team also began reviewing data from the Tennessee Immunization Information System (TennIIS) to identify and contact children who are due for vaccines. The statewide immunization information system for Tennessee, TennIIS provides monthly recall/reminder lists of patients who are currently due or past due for immunizations, as well as practice-specific coverage rates. Additionally, Sewanee Pediatrics and Adolescent Medicine participates in the Tennessee Chapter of the American Academy of Pediatrics' Pediatric Healthcare Improvement Initiative for Tennessee (PHiiT), which allows them to routinely monitor data about their well-visit rates.

"With the PCMH funding, we were able to hire a fourth nurse who rotates with the other nurses to work on the proactive work of recalling patients who are behind on well checks and/or vaccines," said Amy Evans, M.D., FAAP, Sewanee Pediatrics and Adolescent Medicine Medical Director.

While the practice has had success, Dr. Evans notes that it can be challenging to encourage families to visit the office for care when their child isn't sick. She focuses on education – the Sewanee Pediatrics and Adolescent Medicine website includes a variety of resources for parents, including vaccine and well-child checkup schedules – and spends time talking with parents about the importance of preventive care and any concerns they may have.

"Many families are stressed, and preventive care is not a priority for them," Dr. Evans said. "We are working to change the culture, and this is a gradual process. Preventive care is so important because children who are seen regularly for well-child checks are healthier children and grow up to become healthier adults."

A Presumptive Approach to Vaccine Delivery

The medical team has also changed their approach to talking with parents about vaccinations. Instead of making participatory recommendations that gauge parents' willingness to vaccinate, the team makes presumptive recommendations that simply educate parents about the vaccines their children will receive during appointments.

"I love the presumptive approach of, 'Your child is due for these vaccines,'" Dr. Evans said. "And if a parent hesitates or declines vaccination, I'll ask, 'Please tell me your concern.'"

Additionally, Dr. Evans recommends discussing vaccines at the beginning of each appointment, rather than waiting until after the exam is complete.

"When we offer a vaccination at the end of the appointment, families often decline because they're ready to go and say, 'We'll get that later,'" Dr. Evans said. "When we address needed vaccines early in the visit, families are more likely to accept them."

If parents are hesitant to vaccinate, Dr. Evans directs them to the Centers for Disease Control and Prevention or American Academy of Pediatrics. While Dr. Evans notes that some parents have already made up their minds not to vaccinate and aren't looking for information, she has encountered parents who decide to vaccinate after these conversations.

"It's important to open the door and keep the conversation going about the importance of vaccinations," Dr. Evans said. "One family who moved to the area decided to vaccinate their four children after visiting our office. I asked the mom what changed her mindand she said, 'Because you talked with us.'"

During discussions with parents, Dr. Evans also likens vaccines to wearing a seatbelt, and in the case of the HPV vaccine, stresses cancer prevention.

"One approach that sometimes seems to resonate with parents is this: 'Imagine having the difficult conversation with your adult child, who is now in the prime of their life raising their own children, that their cancer caused by HPV could have been prevented with a vaccine."

Delivering Well-Child Care During the COVID-19 Outbreak

Like every practice, Sewanee Pediatrics and Adolescent Medicine had to make some adjustments to their processes during the COVID-19 outbreak. The practice has limited the number of people who can attend visits, checks temperatures at the door, and built an outdoor exam room with fans for ample circulation for sick visits.

In preparation for a possible second wave during flu season, the practice has put special emphasis on seeing as many children for well care as possible during the summer. At the beginning of the COVID-19 outbreak, the team began publishing themed content on Facebook every day. On Mondays, the practice posts an educational message, Tuesday's message focuses on telehealth, Wednesday is for wellness, Thursday is for thankfulness, and Friday is just for fun. The practice also held a raffle, and three children were able to get their bikes repaired for free at the local bike shop.

"It's a really challenging time," Dr. Evans said. "We try to keep things as fun as possible."

Educating Teens

Amy Evans, M.D., FAAP, Medical Director at Sewanee Pediatrics and Adolescent Medicine, was initially surprised to see the rise in HPV vaccination rates because the team didn't specifically target HPV vaccination. In addition to patient recall efforts, she credits teens' budding independence and the conversations the medical team has with teens about the vaccine. While the practice doesn't administer vaccines to patients under age 18 without a parent's or guardian's consent, they've found that it's helpful to talk with teens during checkups, sports physicals and other appointments and ask them to call their parents for permission during the appointment.

In most cases, when teens ask if they can get the vaccine, their parents agree, according to Dr. Evans.

Quality Care Rewards Application

A Reminder on Roles and Responsibilities for Attestations

In Availity®, the administrator can assign different roles (medical vs. staff) and responsibilities to members of your staff for the QCR application. Make sure your staff is aware of the different roles and responsibilities to ensure you get credit for the quality care you're giving to patients.

When a provider (an MD, PA or NP) has the **medical role** and closes a gap, the attestation takes place automatically and will be sent to BlueCross on a specific scheduled date. Other staff members, assigned the **staff role**, can also close gaps, but someone in a provider role must attest that the gap was closed, in the QCR application, before it will be sent to BlueCross.

A Clinical Focus

A Shared Responsibility for Antibiotic Stewardship

Fall and winter are around the corner, and so is the cold and flu season. This can be a difficult time for providers and patients, especially this year with the added risk of COVID-19. Waiting rooms get overcrowded, and patients will often ask for an antibiotic to ease their condition.

As doctors, you know antibiotics are the first line of defense when treating bacterial infections. However, it's our shared responsibility to ensure antibiotics are being prescribed for the right conditions at the right time.

By working together on antibiotic stewardship, we can increase awareness about the dangers of taking antibiotics when they aren't needed, decrease antibiotic resistance, and ensure the highest level of quality care for patients and members.

HEDIS and NCQA recommend that patients 3 months of age and older not receive an antibiotic for simple acute bronchitis/bronchiolitis or simple upper respiratory infections if there are no accompanying bacterial infections or comorbidities that would increase a patient's risk. Here's the guidance provided in our current Commercial Quality Care Measures guide:

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions
Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) Ages 3 months and older	Patients with acute bronchitis/bronchiolitis shouldn't be prescribed/ dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.	Report and document if the patient has an exclusion or has a competing diagnosis of infection such as: Otitis Media, Sinusitis, Pneumonia, Pharyngitis. **Sample codes** for acute bronchitis that will trigger the gap to open unless there is an exclusion or competeting diagnosis documented include: J20.1, J20.2, J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9, J21.0, J21.1, J21.8, J21.9, J40	A documented diagnosis of comorbid condition: • HIV • Cancer • COPD • Emphysema • Disorders of the immune System • Hospice

Measure	Goal of the Measure	What To Report (Sample Of Codes and/or Diagnoses)	Exclusions
Appropriate Treatment for Upper Respiratory Infection (URI) 3 months and older	Patients with only an upper respiratory infection shouldn't be prescribed/dispensed an antibiotic unless a competing diagnosis or an exclusion applies or the patient continues to worsen.	**Sample diagnoses** (where antibiotics may be appropriate): • Sinusitis (Acute/Chronic) • Tonsillitis • Bacterial Infection (unspecified) • Pneumonia • Otitis Media • Whooping cough • Pneumonia **Sample codes** for upper respiratory infections that will trigger the gap to open unless there is an exclusion or compteting diagnosis documented include: J00, J06.0, J06.9	• Patients in hospice Comorbidities excluded: • HIV • Malignant neoplasms • Malignant neoplasms of skin • COPD • Emphysema • Outpatient visits that result in an inpatient stay

Tips for Improving the AAB and URI Quality Measures

- Offer alternative treatment options, such as over-the-counter drugs, bed rest, fluids, etc., when necessary.
- Discuss appropriate antibiotic use with your patients and offer supporting educational material.
- Code specifically, to indicate clearly when a bacterial infection requiring antibiotic therapy is present. For instance, 460 and 465 might not be the most appropriate diagnosis codes because they are considered a "presumed viral" diagnosis. Consider other codes that reflect a bacterial infection.
- Code all cases appropriately, especially those that involve antibiotic prescriptions, so that an accurate diagnosis is included.

For more information about the core elements of outpatient antibiotic stewardship, please visit cdc.gov/antibiotic-use/core-elements/outpatient.html.

Flu Vaccinations for Adults (FVA)

Just a reminder: All adults and children age 6 months and older should get an annual flu vaccine, unless there are contraindications, such as allergic reactions, etc.

Consider scheduling annual vaccinations and flu shots for your patients or giving them during yearly checkups. Send out appointment reminders to keep them up-to-date on all vaccinations.

Scheduling ADHD Medication Follow-Up Visits

Children and adolescents who take medication for attention-deficit/hyperactivity disorder (ADHD) often take a break from their medicine when school is out. This year, your patients may have taken an extended break due to schools closing earlier because of COVID-19.

If you're very familiar with a patient's history, you may not find follow-up visits necessary after these breaks under normal circumstances. But, there could be a clinical need for some patients to have a follow-up visit as school starts back this fall – particularly if there's been a change in medications or their life circumstances. If there are concerns about conducting an in-office visit due to COVID-19, consider using telehealth. There has been extended coverage for telehealth services, and they may be available for your patient.

Research-Based Best Practices

Children who are newly prescribed ADHD medication should have a follow-up visit with the prescribing practitioner within 30 days of the initial visit. This visit can now be completed through telehealth, including telephone, if this is a better option for your practice. Children continuing ADHD medication should have at least two visits with a provider within 270 days (nine months) following the 30-day visit. These visits may also be conducted via telehealth, and one of the two can be an e-visit or virtual check-in (online assessment).

These guidelines are measured by HEDIS.

Tips for Higher Compliance Rates

Consider these suggestions from our providers who have a high success rate for follow-up appointments:

- All staff, from the medical director to the front office, should be educated on the need for follow-up visits and committed to the scheduling protocol. Meeting the standard could be included as a priority on annual review.
- Require a follow-up appointment for additional prescriptions, and write the prescription for only the number of days until the next recommended appointment.
- Put systems in place to schedule a follow-up appointment before the appointment ends.
- Make scheduled appointments convenient for the patient. For example, schedule a medication follow-up with a therapy visit.
- If you're understaffed, consider making night and weekend clinic hours available.

Follow-Up after ER Visit/Inpatient Stay for Mental Health, Substance Use Disorder

Seven-day Timeframe Recommended

If you have patients recently discharged from an acute inpatient stay or ER visit related to mental health or substance use disorders, you can help ensure they receive much-needed support during a vulnerable time by scheduling a follow-up appointment within seven days. These follow-ups help prevent medication interruption and decrease the likelihood of readmission.

The NCQA recommends a follow-up within seven days of:

- An emergency room visit with a principal diagnosis of mental illness, alcohol or drug abuse, or dependence, or
- An acute inpatient, residential treatment, or detoxification discharge with a primary diagnosis of a substance use disorder.

After an acute inpatient psychiatric stay, the NCQA recommends an appointment with a mental health practitioner, such as a psychiatrist or mental health counselor.

Tips to Help Facilitate Scheduling

Getting patients to keep their follow-up appointments is a challenge for many providers. Here are some best practices that can help you create a cultural commitment to successful discharge appointments:

- Begin follow-up planning at the time of an inpatient admission or ER visit.
- Encourage your patients to sign a release of information for better communication between various providers.
- Implement regular discussions with patients so they understand the importance of outpatient provider visits and the follow-up plan.
- If your patient signs a release, talk with their family or support system, so they understand the discharge plan and the importance of keeping aftercare appointments.
- Provide a checklist to the patient and their family members with "next steps" after discharge.
- Let the hospital staff know about your patient's discharge needs and any barriers so they can help if needed.
- Tell office staff/schedulers that it's extremely important that the patient have an appointment within seven days of discharge.
- Make sure you have accurate post-discharge contact and follow-up information, and call your patient to remind them of the appointment.
- Follow up with your patient to make sure appointments were kept. If not, try to reschedule as soon as possible.

For mental health and substance use follow-ups, grow your community relationships, particularly between the facility and community resources to ensure access. You can also offer telehealth options for patients in rural areas or those with transportation issues.

For follow-up after an emergency department visit for alcohol and other drug (AOD) abuse or dependence, telehealth options include:

- A telephone visit with a principal diagnosis of AOD abuse or dependence, ***or***
- An e-visit or virtual check-in (online assessment) with a principal diagnosis of AOD abuse or dependence.

For follow-up after an emergency department visit for mental illness, telehealth options include:

- A telehealth visit, with a principal diagnosis of a mental health disorder
- A telephone visit with a principal diagnosis of a mental health disorder, ***or***
- An e-visit or virtual check-in (online assessment with a principal diagnosis of a mental health disorder)

Methadone Treatment Now Covered by TennCare

TennCare now includes methadone as a Medication Assisted Treatment (MAT) option that helps providers assist patients who struggle with opioid use and addiction. Since June 1, 2020, TennCare providers are reimbursed for methadone-related services.

Because the needs of members recovering from opioid addiction vary, we can better serve them by offering treatment options like office-based treatment and outpatient treatment programs (OTPs). MAT combines medications with counseling and behavioral therapies, providing a whole-patient approach to the treatment of opioid use disorder.

In addition to State and Federal regulations, the Tenncare Opioid Treatment Program Description outlines treatment and clinical care activities expected of OTP facilities who dispense MAT products and the professionals who provide therapy, care coordination or other ancillary services to TennCare members.

For more information on MAT service, finding providers or making a referral, visit tn.gov/opioids.

Improving the Low Back Pain HEDIS Measure

The Low Back Pain (LBP) HEDIS measure is based on the percentage of patients with a primary diagnosis of low back pain that didn't have an imaging study (regular X-ray, MRI or CT scan) within 28 days of the diagnosis. These patients should also have a negative diagnosis history of 180 days.

Many patients believe they should have an X-ray, MRI or CT scan when they aren't indicated. We provide educational information for our members related to Low Back Pain. Here are some tips we're providing them:

- Imaging has risks and can be expensive. These tests usually won't help you feel better.
- Ask your doctor if there are alternatives that can help you avoid an X-ray, CT scan or MRI and which non-prescription pain relievers might help.
- You can often improve your back pain by walking, using heat, sleeping on your side or your back, and using a pillow between or under your knees.
- Try hands-on care, such as physical therapy, massage, yoga or acupuncture.

To improve this Quality measure, remind your patients of the points listed above, and avoid ordering imaging studies in the first four to six weeks of the onset of non-radiating pain with no signs of structural damage or defects. If your patient should be excluded from this measure due to complications or health issues, be sure to include all value sets for diagnoses, such as:

- Cancer
- Neurologic impairment
- Recent trauma
- IV drug abuse
- Prolonged use of corticosteroids
- Major organ transplant
- Spinal infection
- HIV
- Hospice

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