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As physicians, we know there are several major risk factors for cardiovascular disease (CVD). These include hypertension (the No. 1 risk factor for CVD, death and disability), hyperlipidemia and diabetes, which can increase a patient's risk for CVD by two- to three-fold.

While some risk factors, such as age and heredity, are outside your patients' control, there are a number of lifestyle modifications that can help reduce their risk of heart disease and stroke, and ultimately lower their cost of health care.

Practice the high-value, high-return approach to CVD by helping your patients make these everyday changes:

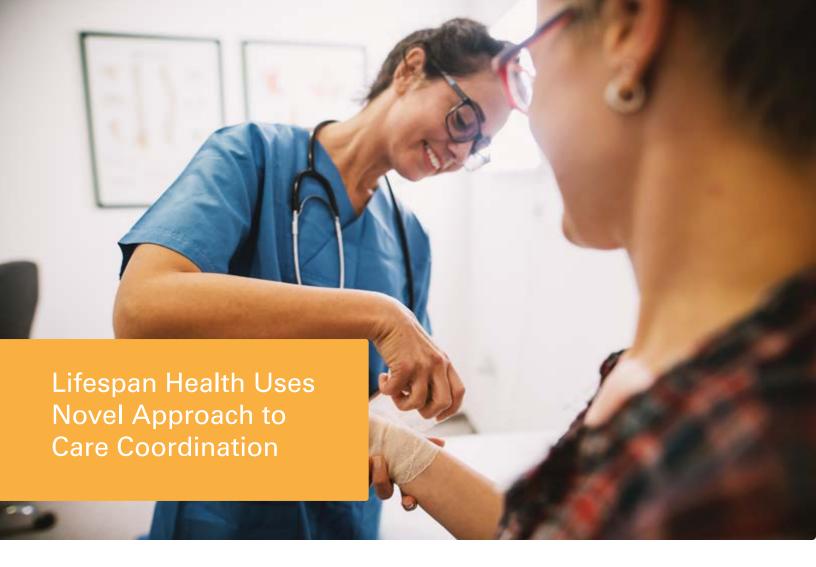
- Engage in regular physical activity.
- Implement a heart-healthy diet.
- Maintain a healthy weight.
- Quit smoking.

According to the Centers for Disease Control and Prevention, this approach has the potential to prevent at least 200,000 heart disease and stroke-related deaths annually in the U.S.

For more information on how you can help your patients reduce their cardiovascular risks and improve their health, check out our clinical article on heart health in this edition of Quality Care Quarterly.



Ian Hamilton, Jr. M.D., MBA, FACS, FSVS, FACPE Medical Director, Account Management-Team Lead BlueCross BlueShield of Tennessee



As a busy professional, it can be difficult to know when patients visit other providers, and building relationships with community hospitals, urgent care facilities and specialists who can provide that information can be challenging. Sometimes, patients forget to tell their primary care provider (PCP) if they've visited other facilities, or their other providers have a difficult time locating and contacting the right PCP. Savannah-based Lifespan Health has developed a unique answer to these common problems.

A Visual Cue

Patient education is at the heart of Lifespan Health's care coordination strategy. PCPs ask their patients if they've recently seen other providers during each office visit. In each exam room, the practice displays posters reminding patients to mention any visits with other providers. This education has helped patients learn to recognize Lifespan Health's role as their primary provider and given them a sense of a medical home, according to Christa Franks, Lifespan Health's quality improvement manager.

Three years ago, the practice decided to take this education one step further by giving patients a visual that not only serves as an important reminder between appointments, but also makes it easier for other providers and facilities to contact each patient's PCP and coordinate care.

During each office visit, patients receive a card the size and shape of a business card. Patients are instructed to give these cards to any specialists they see or present them when they visit an ER or urgent care facility. The cards contain contact information for the practice, including:

- The name and phone number of the patient's provider or nurse
- The Lifespan Health website address
- The office fax number and phone number for central scheduling

Team members at other facilities can use the information on each card to contact each patient's PCP — a task that can be difficult when they only receive a first or last name. Lifespan Health has three Dr. Halkes on their team and a team of nurse practitioners, physician assistants and other providers who go by their first names.

"Without that [full] name, the practice may be looking for a Dr. Darin, when in reality they [should be] looking for Darin McLain," said Lifespan Health CEO Janie McGinley. "That makes it difficult. We're trying to make it as easy as possible for outside groups to cooperate with us."

Since providers began handing out these cards, the Lifespan Health team spends much less time trying to secure medical records and other information. The team has also found that patients engage more with their PCPs and are more likely to attend follow-up appointments after an ER visit or hospitalization.

Preventing Avoidable ER Visits

After hours, patients may turn to the ER for minor illnesses or injuries, such as a sore throat or splinter. To help make sure patients use the appropriate level of care, Lifespan Health has an after-hours phone line that's staffed by nurse practitioners and physician assistants. Patients can call this phone line 24 hours a day to ask questions. They can also receive care from a provider who has access to their electronic medical record and the ability to give medical advice or prescribe medication.

"The person on the phone is a licensed, independent practitioner," McGinley said. "If they can't take care of the patient, then they should go to the ER."

Additionally, Lifespan Health recently hired several new providers to increase the number of patients they can see on a daily basis.

"[We] always have appointment slots available," McGinley said. "It may not be with their PCP, but there aren't many days that a patient would call and we don't have the ability to get them in."

Focusing on Follow Up and Transitional Care Management

When patients do need to go to the ER or hospital, Lifespan Health has several processes in place to facilitate follow-up visits. The practice employs a dedicated outreach coordinator who's responsible for maintaining a log of patient hospital and ER visits and contacting patients to schedule follow-up visits. During outreach calls, the outreach coordinator also provides education about appropriate ER use and reminds patients to bring a list of their medications with them to their appointment. This helps with medication reconciliation and makes sure patients' charts are up to date.

Many times, the outreach coordinator is made aware of ER visits or inpatient hospital stays because a facility or patient notifies the practice. Other times, she uses the Division of TennCareSM Care Coordination Tool to review admissiondischarge-transfer (ADT) data from local hospitals. This tool is available to practices that participate in the TennCare Patient-Centered Medical Home (PCMH) or Tennessee Health Link programs, and Lifespan Health reviews it daily to identify patients who've been in the hospital. The goal following a hospitalization is to determine if patients qualify for a transitional care management visit and schedule those accordingly.

"We do, I think, see very good results with our follow ups," Franks said. "Even if the patients say, 'I don't need to follow up or I don't want to follow up,' Melanie consistently gets positive feedback and [comments like] 'Thank you so much for calling.' ... we've seen a great response from a customer service aspect. They appreciate that outreach."

Lifespan Health's dedication to care coordination and after-hours care is paying off. When the Sept. 30 PCMH performance reports were released, the practice noticed a reduction in ER visits for all managed care organizations.

"We're down from a baseline of 51% to 48%," Franks said. "We're pleased with the progress so far. It's a work in progress, but we're pleased with the progress we're seeing."



A Fully Integrated Dual Eligible (FIDE) Special Needs Plan (SNP) Option

BlueCare Plus Choice, our new FIDE SNP plan, became effective Jan. 1, 2020. It promotes the full integration and coordination of Medicare and Medicaid benefits, and Long-Term Services and Supports (LTSS) for dual-eligible beneficiaries by a single managed care organization.

This means FIDE members will have a single entity coordinating both care and services, and you'll file one claim for us to process both Medicare and Medicaid benefits. You'll receive only one remittance advice showing how the claim processed, which means less paperwork for you.

The current DSNP plan, BlueCare PlusSM, is available for individuals that have Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and Medicaid. The FIDE SNP is available for individuals that have Medicare Part A, Part B, standard Medicaid, and Medicaid LTSS. Benefits for both the DSNP and FIDE SNP include physical and behavioral health services and prescription drug coverage, as well as coordination of all health care services.

Both plans will continue to provide member incentives to help encourage engagement in primary care, preventive and wellness screenings.

Sample Member ID Cards

BlueCare Plus Member ID Card (DSNP)





BlueCare Plus Choice Member ID Card (FIDE SNP)





A Clinical Focus

Setting Up an Interdisciplinary Care Team

A CMS Requirement for Patients with a Dual Special Needs Plan

CMS requires all DSNPs to provide an interdisciplinary care team (ICT) to coordinate services for each patient. The ICT ensures collaboration between the patient, PCP and others in the medical community who work together for a common goal for the patient. The ICT is comprised of:

- The patient and/or patient's family or representative
- The patient's PCP and specialist
- The Care Coordination Team (BlueCare PlusSM)
- Others requested by the patient

The ICT can collaborate through a telephone conference or in writing. You can bill for the ICT after you:

- Complete a patient assessment and care planning form (PACF) or provide an equivalent medical record after the annual wellness exam or upon request
- Return post-discharge records for medication reconciliation

You'll receive the \$54 reimbursement by filing a claim with the appropriate code.*

After completing the PACF or sending equivalent medical records or post-discharge medication reconciliation, you can submit the claim with the code through Availity or fax to **(423) 591-9504**. The PACF should also be included in your patient's chart as part of their permanent record. For additional information about the PACF or ICT, please call BlueCare Plus at **1-877-715-9503**.

To learn more about the ICT, complete the annual Model of Care provider training by March 31, 2020, at BlueCarePlus,bcbst.com.

^{*}Rate is based on the amount listed in your current provider agreement.

Focusing on Your Patients' Heart Health

Age and Disease-Specific Quality Measures

For patients who have diabetes but don't have heart disease, the American Diabetes Association recommends prescribing a statin of any intensity as a primary way of helping prevent heart disease from developing. Patients should remain on this medication unless contraindicated.

The American College of Cardiology and American Heart Association (ACC/AHA) guidelines recommend prescribing a moderate- or high-intensity statin to adults (women age 40 to 75 and men age 21 to 75) with established clinical atherosclerotic cardiovascular disease (ASCVD).

The National Committee for Quality Assurance (NCQA) established the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures for statin medications for both diabetic patients and adult patients with cardiovascular disease:

Statin Therapy for Patients with Cardiovascular Disease (SPC) (men 21–75 years; women 40–75 years)

Received a high- or moderate-intensity statin medication

Adherence of Statin Therapy for Patients with Cardiovascular Disease (SPC) (men 21–75 years; women 40–75 years)

 Remained on a high- or moderate-intensity statin medication for at least 80% of their treatment period

Received Statin Therapy for Patients with Diabetes (SPD) (40–75 years)

 Members with diabetes who don't have cardiovascular disease who received at least one statin medication of any intensity

80% Adherence of Statin Therapy for Patients with Diabetes (SPD) (40–75 years)

 Members with diabetes who don't have cardiovascular disease who remained on any intensity of statin medication for at least 80% of their treatment period

Maintaining a healthy weight and controlling high blood pressure are essential to good heart health.

The NCQA also set these additional heart-related HEDIS measures:

Adult BMI Assessment (ABA) (18–74 years)

BMI documented in the past year

Controlling High Blood Pressure (CBP)

(18-85 years)

Hypertension with BP controlled <140/90

Educate your patients on the importance of managing high blood pressure. By keeping their numbers in check, they can decrease their risk of heart disease, stroke and kidney damage. Here are some helpful tips you can share:

- If your patient gets "white coat syndrome" when visiting your office, have them relax in the exam room for a few minutes before their blood pressure is checked.
- If your patient's first reading is high, recommend a recheck before their visit is over, and document the second reading. You can use the lowest systolic and the lowest diastolic reading to document a patient's blood pressure if they're taken on the same date or during the same visit.
- Have your patients keep a home journal and check their blood pressure routinely.
- Encourage your patients with high blood pressure to embrace a diet low in salt and fat.
- Talk to your patients about the dangers of smoking and offer resources to help them quit, if needed.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). See www.ncqa.org.

New Screening Option for Cervical Cancer Quality Care Measure in 2020

Cervical cancer is the easiest gynecologic cancer to prevent, according to the Centers for Disease Control and Prevention. Regular screening tests and follow-ups can help prevent it or find it early.

Starting at age 21, your female patients should begin receiving cervical cancer screenings at least every three years. Once women turn 30, there are several options for this screening. In 2020, a new screening option was added to meet requirements for this measure. The options include:

- Cervical cytology tests at least every three years
- Co-testing of cervical cytology and HPV testing every five years
- New for 2020 high-risk human papillomavirus (hrHPV) testing every five years.

If you feel it's necessary for any of your patients, 21 to 65, to get a pap test every year, it will still be a covered benefit. We trust that you, as their physician, will make the best care decisions for your patients.

Tips for Closing the Cervical Cancer (CA) Gap

- Documentation of a hysterectomy alone won't close the gap in care. The documentation must also indicate that the cervix was removed by stating: complete hysterectomy, total hysterectomy, or that the cervix is surgically absent.
- Biopsies don't count because they're diagnostic and not valid for primary cervical cancer screening.
- Documentation must include both the date and result.

Simple Steps to Improve Care Coordination and Patient Communication

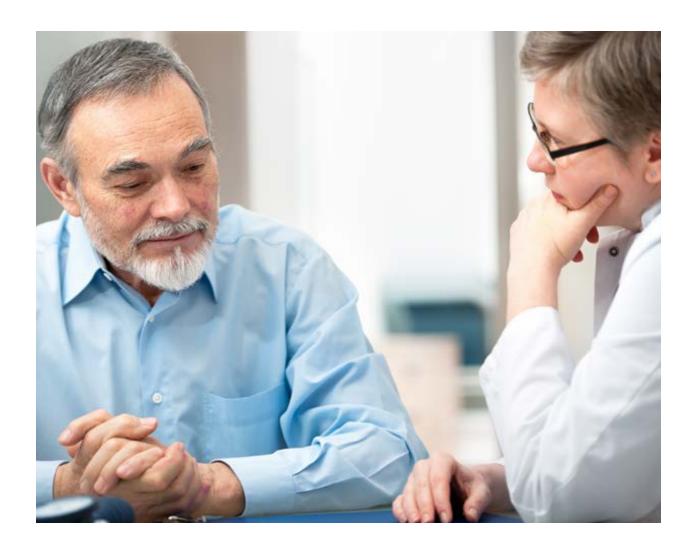
Each year, randomly selected BlueCross members are asked to complete the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This survey, conducted by an outside entity, measures the patient's perception of the consumer care, coordination of care, and communication they receive from their providers and BlueCross. Your interaction with patients can have an impact on their responses to the survey.

Patients can sometimes feel overwhelmed by the information they receive about their health, and this can affect whether their treatment is successful. These easy tips can help you make sure your patients get the information they need.

- Explain things in ways that are easy to understand. When talking with patients about a medical condition or treatment plan, try to avoid medical jargon and technical language. Consider using shared decision-making tools to help patients learn more about their conditions and options for treatment.
- Make eye contact with your patients, and spend time listening carefully to them. Ask
 them or their caregivers if they have concerns, as well as questions. The National
 Institutes of Health (NIH) recommends asking open-ended questions that require
 patients to reveal more than a simple yes or no.
- Be as respectful as possible about patients' thoughts and beliefs, and try to continue conversations at the next visit if they refuse care. For example, if parents don't want their child to receive a needed vaccination, work with them to find one action that you can agree upon, like scheduling a follow-up appointment.
- Use the teach-back method, which involves asking patients to explain what they
 need to do in their own words. According to the NIH, this technique lets you see
 if patients need additional information or if they understand the information you
 presented.

Your patients may see more than one provider to manage their health — especially if they have a complex or chronic condition. In these cases, it's important to work closely with their other providers to make sure you're up to date on their treatment plan. Here are some suggestions that may help improve care coordination with other practices:

- When completing a patient's health history, ask if they've visited other providers or facilities since their last visit. Examples may include appointments with specialists, home health services, an inpatient hospital stay, or visits to an emergency department or urgent care facility. If your patient has recently seen another provider, talk with them about the care they received to make sure they understand all of the information they've been given about their treatment plan.
- If a patient needs to see a specialist, help with the transition of care and facilitate the referral.
- Share patients' results, records and data with their other providers. If you're a specialist, make sure to share each patient's detailed health history with their primary care provider.
- Connect your patients to community resources as needed.



Helping Patients with Substance Use Diagnosis

New service available

You can make a difference in your patients' success when you schedule follow-up treatment for every patient newly diagnosed with alcohol and substance use disorders. BlueCross has made this step easier for you by contracting with Health Connect America to assess members in any of our health plans within two hours after a visit to the emergency room, urgent care or a primary care provider setting.

This assessment will help you determine the most effective and appropriate level of care, and will ensure that patients receive behavioral health services that support their overall care goals. You can reach Health Connect America at **1-800-374-5618** 24 hours a day, seven days a week.

The Elevated Health Risks of Patients with Serious Mental Illness

What you can do to help prevent them

Both adult and pediatric patients with bipolar disorder or schizophrenia diagnoses have a high risk for cardiovascular disease and diabetes. That's why it's important to closely monitor the health of patients who take antipsychotic medications and be responsive to changes.

Patients with serious mental illness often have the following risk factors:

- Reduced activity levels spending about 40% more time sitting each day.
- Likelihood of smoking or using alcohol – on average, 75% of adults with schizophrenia smoke daily.
 Tobacco users with major psychotic or affective disorders are also more likely to use alcohol.
- Poor diet more likely to use caffeine daily, and less likely to avoid salt and saturated fats.

Antipsychotic medications also have been found to cause weight gain and other metabolic abnormalities for children and adults. In fact, the prevalence of diabetes mellitus is four to five times higher in the schizophrenic population versus the general population.

Steps You Can Take to Help Prevent Health Risks or Mental Health Crises

- Help your patients find a personal reason to improve their health or to lose weight, and encourage physical activity. Suggest diet changes if needed.
- Offer tobacco cessation help.
- Encourage your patients to discuss any medical side-effects with you.
- Stress the importance of not skipping doses, waiting to refill, or discontinuing their medication.

Important Medical Monitoring

Keep in mind, the prescribing clinician is responsible for making sure monitoring is complete and for reviewing the results. Health conditions should be monitored and documented by:

- Establishing the baseline BMI and waist circumference when a patient begins taking a medication (particularly an antipsychotic), or if the patient is new to you.
- Scheduling lab work to be completed prior to the next appointment.
- Ordering a fasting glucose or HbA1c and lipid profile annually.
- Starting a process for metabolic monitoring. For example, you might designate a month, twice a year, for monitoring all at-risk patients.
- Monitoring blood pressure, BMI, cholesterol and glucose levels for patients diagnosed with schizophrenia or bipolar disorder who also have cardiovascular disease.

Collaboration with Other Providers

It's very important to include a patient's primary care or behavioral health provider's name in their chart, and request the necessary releases. Consider setting up a system to share lab results and concerns about changes.

Documentation Reminders: Top Tips for Recording Well-Child Care

Early and Periodic Screening, Diagnostic and Treatment TennCare Kids exams require the completion and documentation of seven key components:

- Comprehensive health and developmental history
 - Initial and interval history
 - Developmental/behavioral assessment
- Comprehensive unclothed physical exam
- Vision screening
- Hearing screening
- Laboratory tests
- Immunizations
- Health education and guidance

When your BlueCare Tennessee patients visit your office for their well-child checkup, please document all seven parts of the exam, as well as assessments of their nutrition and physical activity.

Preparing Medical Records and Claims

Your patients' medical records and the initial EPSDT records that you send to us should include all care administered during the exam, including seasonal flu shots. If you're unable to complete all or part of an exam because a patient refused or deferred the exam, please be sure to note this.

Claims submitted for EPSDT visits must match your patients' medical records and contain codes for all parts, including the physical exam, vaccines, lab tests, and hearing, vision, milestone and depression screenings.

Appropriate Coding for Childhood and Adolescent Vaccines

As you know, immunizations are an essential part of well-child care, and children need specific vaccines at each age. When submitting claims for immunizations given during a well check, please use the following CPT® administration codes:

CPT® Code	Description
90460*	Immunization administration through age 18, via any route, with counseling, first or only component of each vaccine
+90461*	Each additional vaccine or component, with counseling
90471**	Immunization administration ID, IM subQ, one vaccine (single or combined vaccine)
+90472**	Each additional vaccine ID, IM, subQ, one vaccine (single or combined vaccine)
90473**	Immunization administration, oral, one vaccine (single or combined vaccine)
+90474**	Each additional vaccine, oral (single or combined vaccine)

^{*}Report 90460 and 90461 if your patient is age 18 or younger, and you've performed face-to-face vaccine counseling.

Please refer to the American Academy of Pediatrics' list of Commonly Administered Pediatric Vaccines to find CPT® codes for each vaccine.

For more information about well-child care documentation and coding requirements, please see our TennCare Kids Tool Kit or visit tnaap.org to review the Tennessee Chapter of the American Academy of Pediatrics' EPSDT and coding resources.

^{**}Report 90471-90474 if your patient is over the age of 18 or counseling isn't performed.

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