YOUR GUIDE TO PROGRAMS AND REWARDS

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Inside this Issue

A Message from Dr. Judith Overton and Dr. Jill Amos

Engaging Patients to Achieve Positive Outcomes

Lifespan Health's Focus on Diabetes Care

Enhanced Access to Care and a Standardized Approach Improve Health Outcomes

A Clinical Focus

Medicare Advantage Medication Adherence Tips

Increasing Emphasis on Patient Experience

Help Your Patients Lower Their Risk for Heart Disease

Improving Adherence for Statin Therapy in Patients with Cardiovascular Disease or Diabetes

Helping to Prevent Cervical Cancer

Improving Quality: Colorectal Cancer Screening

Explore the Differences Between EPSDT- and HEDIS-Compliant Well-Child Exams

Engaging Patients to Achieve Positive Outcomes

Using Motivational Interviewing to Bring Change

Motivational Interviewing (MI) is an evidence-based technique used to help patients resolve ambivalence about behaviors that prevent change. It was originally used in counseling individuals with behavioral health and substance use disorder, but the principles that can help improve motivation can be used in a variety of settings when there's a need for change and traditional approaches aren't working.

MI is best suited for individuals who are considering, but unsure about, making a change. It focuses on using the patient's internal motivation, which can lead to longer lasting improvements.

Asking open-ended questions can help you better understand the patient's perspective of treatment and the pros and cons that are personal to them. By using the patient's goals as a basis for their personal plan, you may find there's less opportunity for disagreement. Once you summarize and present the plan, they may be more motivated to begin.

There's also an increase in research that shows using MI can lead to positive impacts with minority groups, because it's based on the patient's perspective. However, be aware that some patients may be from a culture where the individual lacks autonomy. In that case, a change plan may need to be discussed with the patient's family members or others.

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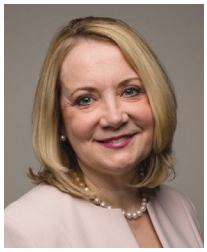

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The MI technique was developed by William R. Miller and Stephen Rollnick. More information is available on the following sites:

- **About Motivational Interviewing | Stephen Rollnick**
- **USING MOTIVATIONAL INTERVIEWING IN - Advisory 35 (samhsa.gov)**
- **Cultural adaptations of motivational interviewing: A systematic review - PubMed (nih.gov)**
- **Culture and motivational interviewing - PMC (nih.gov)**

Lifespan Health's Focus on Diabetes Care

Enhanced Access to Care and a Standardized Approach Improve Health Outcomes

Diabetes is a top health concern across the country, and Tennessee is no exception. According to the Centers for Disease Control and Prevention, roughly 11% of Tennesseans have diabetes, and our state spends $5.2 billion annually on direct medical costs attributed to the disease.[1]

As you know, people with diabetes have a higher risk of heart disease, stroke, kidney and eye disease, and other serious complications. Ensuring patients with diabetes receive necessary preventive care, including A1C and blood pressure management, kidney health evaluation, and retinal eye exams, is an important part of preventing related health complications. In recent years, Savannah-based Lifespan Health has adopted several best practices to positively impact diabetes care in West Tennessee. Thanks to these efforts, the practice consistently exceeds quality benchmarks for the BlueCare Tennessee Patient-Centered Medical Home program in areas including blood pressure management, HbA1c control and diabetic retinal eye exams.

Making Retinal Eye Exams More Accessible

Patients 18 to 75 years old with type 1 or type 2 diabetes should have a retinal or dilated eye exam during the measurement year to meet the Eye Exam for Patients with Diabetes (EED) measure. To make it easier for patients to access this care, Lifespan Health purchased retinal cameras in 2018 and began using them to perform in-office exams. Cameras are currently available in all family practice clinics.

"This purchase has significantly helped capture diabetic eye exams for patients who might not otherwise see an eye doctor," said Rebecca Wright, MBA, Special Projects at Lifespan Health. "Since adding the cameras, Lifespan Health has been a top performer among all MCOs [managed care organizations] in the state for the diabetic eye exam care measure."

Standardizing Care for Diabetes

Diabetes care can be very complex. Another best practice Lifespan Health uses is Diabetic Care Guidelines within the electronic health record. These evidence-based guidelines were launched during the first quarter of 2021 and are designed to visually display all the patient's diabetic-related medical needs in one place. According to Wright, having these guidelines has helped improve clinical values, while ultimately ensuring patients obtain the necessary diabetic care.

Partnering with Patients

Lifespan Health providers work closely with patients to make sure they're educated about the best way to manage their health. During the first office visit after a diabetes diagnosis, patients receive resources about proper nutrition, the causes of diabetes, and why it's important to take diabetes seriously and get needed services. Patients are also encouraged to chart daily eating habits and test their glucose levels to find the type of diet that will work best for them.

To ensure patients get needed screenings and engage with their providers, Lifespan Health's outreach staff regularly contacts patients to schedule upcoming or overdue services. The team also uses its EHR to put alerts in the charts of patients needing care to complete the Diabetic Care Guidelines. This has been successful, especially for those who don't seek regular care.

Looking ahead, Lifespan Health plans to continue building on these efforts to ensure patients receive the best possible care.

"These methods are all sustainable and can even be built upon as a model for additional target areas," Wright said. "We'll continue to use these methods to serve our patients into the future."

[1] CDC Tennessee Diabetes Profile, cdc.gov/diabetes/programs/stateandlocal/state-diabetes-profiles/tennessee.html

Clinical Focus

Medicare Advantage Medication Adherence Tips

Develop Strategies Early in the Year

For 2023 Medicare Advantage and BlueCare Plus Quality+ Partnerships programs, the three medication adherence measures are triple weighted again this year, making these measures critically important to the overall Star score. It's necessary to actively work on adherence all year to maintain or reach a high adherence rate for each one.

These measures (Medication Adherence for Cholesterol, Hypertension and Diabetes Medications) are focused on the patient filling their medication at least 80% of the time they're supposed to be taking it.

The measures start off strong with high adherence rates and decrease as the year progresses. BlueCross pharmacy reports offer timely data that's useful for actionable interventions, listing patients after their first fill of an adherence medication. While Centers for Medicare & Medicaid Services (CMS) requires two fills to be officially included in an adherence measure, it's important to monitor all patients who've filled a prescription for an adherence medication. Only monitoring patients with two fills will negatively impact adherence scores if the second fill occurs late in the calendar year. At this point, the member won't be able to reach the 80% proportion of the days covered threshold.

You Play an Important Role in Your Patients' Medication Adherence

Health care providers have a critical role in educating patients on the benefits and risks of prescribed medication regimens. We've included tips that can help your patients follow your prescribed medication instructions.

Use the reports located in the "Pharmacy Reports" tab in the Quality Care Rewards application located in Availity®.

- Focus primarily on patients late to refill after one fill and provide intervention, when possible, to help maintain adherence and improve clinical outcomes.

When prescribing new therapies (or therapies associated with frequent dose changes)

- Write a 30-day supply. This will allow for titration, potential dose changes due to side-effects, and avoid patient stockpiling if a dose is changed.
- Provide an adequate number of refills until the patient's next appointment or until anticipated new prescription is available.

For established maintenance medications:

- Write for 90-day or 100-day* fills when possible to ensure patients have an adequate supply.
- Provide an adequate number of refills.

Note: Prescriptions (non-controlled) expire one year after the written date and all remaining refills are canceled.

Make it easier for patients to adapt to dose changes

- Write a new prescription with the updated directions. The pharmacy claim for quantity and day-supply should reflect how the patient is taking the medication to increase adherence scores.
- Instruct the pharmacy to cancel/discontinue the old prescription either through a phone call or note on the updated prescription.
- These tips will prevent the patient from filling an old prescription and cutting pills in half, which would make them appear as noncompliant.

Review prescription directions

- Include the intended use of the medication in the directions. This will help the patient keep track of what the medication is used for (e.g., take one tablet daily for blood pressure; or take one tablet twice daily for blood sugar).

Discuss drug cost when initiating a new prescription

- Patients can be reluctant to come forward with financial concerns due to fear of social bias/stigma, or because they're afraid their quality of care will be jeopardized.
- If a patient can't afford a medication, they may ration the medication, skip days, delay refilling, or stop taking the medication altogether resulting in a worsening condition, increased comorbid diseases, and secondary hospital stays.
- Be conscious of the coverage gap. A medication cost can increase drastically if the patient enters the coverage gap (donut hole).

Set expectations for therapy, especially for medication classes with known side effects

- Example: For metformin, reassure that gastrointestinal (GI) problems (diarrhea, nausea, etc.) are usually short-lived especially when "starting low and going slow."

Consider medication adherence packaging for patients on multiple medications with multiple comorbidities.

Refer your MA PPO patients to our Care Management program at **1-800-611-3489** for assistance with other barriers to medication adherence. We have nurse case managers, social workers, a pharmacist and a dietitian available to help.

Refer your BlueCare Plus HMO D-SNP patients to our Care Management program at **1-877-715-9503** for assistance with other barriers to medication adherence. We have nurse case managers, social workers and pharmacy technicians available to help.

Increasing Emphasis on the Patient Experience

What You Need to Know About Member Experience Surveys

It's important to know what your patients are thinking. Most patients will be more engaged, respond better, and feel more confident in the care they receive when they're highly satisfied with their provider's customer service, communications, and coordination of care. That's why the CAHPS® annual survey, conducted by outside entity, is so important to providers as well as health plans. The survey is used by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) to evaluate care and services provided to all your patients.

All lines of business within BlueCross measure member experience using some version of the CAHPS survey. Each year, randomly selected BlueCross members are asked to complete a survey about their member experience between March and June. Please encourage your patients to participate in all surveys sent by BlueCross and outside organizations so we're better able to identify opportunities for improvement.

We've included some CAHPS survey questions below to assist you with improving the patient experience.

Answer options for these questions include Always, Usually, Sometimes and Never. Answers of Always and Usually have the most positive impact to your scores.

Getting Appointments and Care Quickly

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a checkup or routine care as soon as you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Care Coordination

- In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?
- In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 months, how often did you get the help you needed from your personal doctor's office to manage your care among these different provider and service?
- In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

Helpful Tips and Techniques

Your interaction with patients has a direct impact on their response to our member experience surveys. Below you'll find some simple techniques shared by high-performing provider groups. They've found that using these in their daily interactions with patients can provide a better experience, help them achieve better health outcomes, and lead to better patient retention.

Member Experience: Getting Appointments and Care Quickly Survey Tips

- Acknowledge wait times longer than 15 minutes by apologizing, providing an explanation and giving an approximate time that patients can expect to be seen.
- Manage patients' expectations when they're significantly early for their appointments, i.e., thank them and explain they may wait longer than 15 minutes.
- If you're running behind schedule, let patients know before they come to the office so they can adjust their arrival or reschedule their appointment.
- Ensure a few appointments each day are available to accommodate urgent or unplanned visits.
- Maintain an effective triage system to ensure that frail and/or very sick patients are seen right away.
- Offer appointments with a nurse practitioner or physician assistant to patients who want to be seen on short notice but can't be seen by their doctor.
- Encourage patients to make their routine appointments for checkups or follow-up visits as soon as they can (weeks or even months in advance).
- Proactively schedule patients' appointments weeks or months before their tests, screenings or physicals are due. Don't wait for patients to call.
- Consider limited-hour Saturday appointments weekly or bimonthly.

Member Experience: Care Coordination Survey Tips

- Establish a system to follow up on each diagnostic or lab result.
- Set appropriate timeframes for result communication, i.e., five days for normal results, 24 hours for stat results.
- Educate patients on established timeframes and communication avenues for results, such as phone calls, mail, patient portal and follow-up visits.
- Ask patients how they prefer to receive test results and provide as requested.
- Educate patients on why they're being referred to a specialist and help coordinate the scheduling of referrals and transfer of records rather than assigning this task to the patient.
- Educate patients on timeframes for obtaining specialist appointments according to their symptoms. Discuss and plan for possible appointment delays.
- Standardize your referral tracking process. Set up a system for tracking outstanding referrals once a week and follow up to ensure care's moving forward. Monitor the response times of referral partners and provide feedback when response times aren't satisfactory.
- Establish workflow processes to ensure that the primary care provider is informed of lab results and specialist reports.
- If you know a patient's received specialty care, discuss their visit and the treatment plan they received at their next office or telehealth visit.

Please encourage your patients to participate in member experience surveys so we're better able to identify opportunities for improvement.

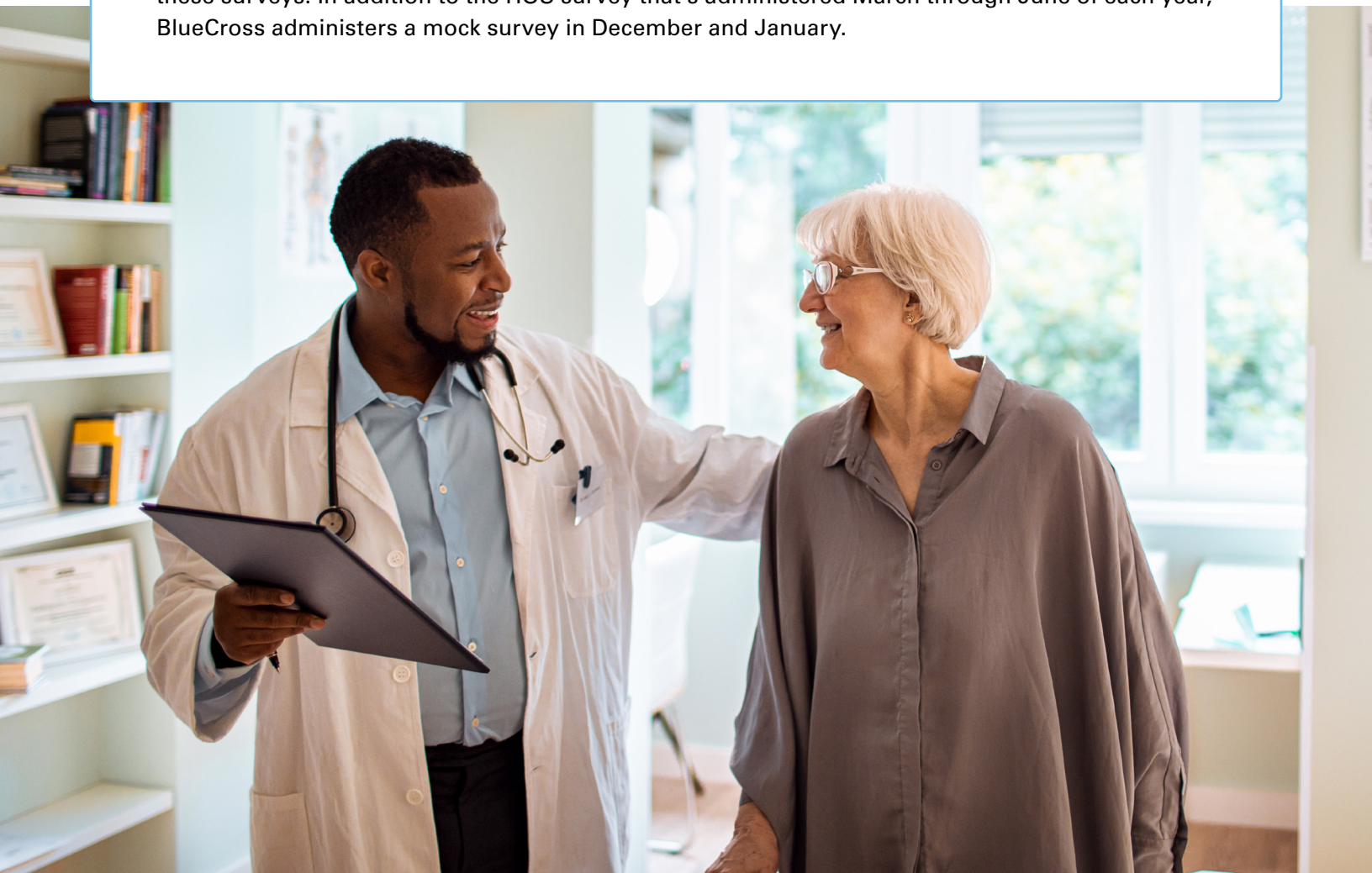
A Change for Medicare Advantage

The weight of the CAHPS survey has been gradually increasing – shifting the calculation of Medicare Star ratings from a focus on process, outcomes and improvement to a focus on member/patient experience. The CAHPS survey has now become the most heavily weighted data source for a health plan's rating.

Effective Jan. 1, 2023, the Member Experience CAHPS measure in the Medicare Advantage Quality+ Partnerships program has a weight of four. This measure is scored on the combination of two of the CAHPS survey component measure categories (for randomly selected members who are enrolled continuously with the health plan for at least six months):

- Getting Appointments and Care Quickly
- Care Coordination

CMS has become increasingly focused on the patient's quality of life, functional health status and experience with key aspects of their care over the past several years. That's why they use the Enrollee Experience Survey for Marketplace (similar to Commercial CAHPS), as well as the Health Outcomes Survey (HOS) which is only sent to Medicare Advantage patients, to measure their perception of the service, care and communication they receive from both their providers and their health plan. Each year, randomly selected BlueCross members are asked to complete these surveys. In addition to the HOS survey that's administered March through June of each year, BlueCross administers a mock survey in December and January.



Help Your Patients Lower Their Risk for Heart Disease

High blood pressure (hypertension) increases the risk of heart disease and stroke which are the leading causes of death in the U.S. About half of adults with uncontrolled hypertension have a blood pressure of 140/90 mmHg or higher. That's 37 million adults.*

The HEDIS measure, Controlling High Blood Pressure (CBP), assesses patients (18-85 years old) who had a diagnosis of hypertension reported on at least two outpatient, telephone or e-visit claims, and whose blood pressure is adequately controlled (<140/90 mmHg) on the latest reading as of Dec. 31 of the measurement year.

According to the HEDIS specifications, you can use blood pressure CPT® II codes to establish patient compliance with the CBP measure. That means we don't need to review medical records to confirm blood pressure values when you confirm the readings and add the CPT® II codes to your patient's claims.

Patient-reported readings taken with a digital device are acceptable and should be documented in the medical record along with the date. You don't need to see the reading. The patient can verbally report it.

The following patients are excluded from the CBP HEDIS measure:

- Patients in hospice during the measurement year
- Patients in palliative care during the measurement year
- Patients 66-80 years and older who meet both advanced illness and frailty criteria
- Patients 81 years and older with a frailty diagnosis/encounter (at least two indications of frailty diagnoses/encounters with different dates of service during the measurement year)

The following patients may be optionally excluded from the CBP HEDIS measure:

- Patients with end-stage renal disease or a kidney transplant
- Patients with a diagnosis of pregnancy during the measurement year
- Patients who died any time during the measurement year

Tips on Improving Measure Results

- Talk to your patients about taking medications as prescribed and making lifestyle changes that can enhance their quality of life and reduce their risk of heart disease.
- Educate them on the importance of monitoring their blood pressure regularly and how to monitor their blood pressure at home. Knowing their numbers can alert them to any changes early and detect problems to communicate to their providers.
- Educate your staff on recording readings. You can retake a blood pressure reading for a patient on the same visit if the first one is out of acceptable range. Let the patient have a few minutes to relax and take some deep breaths before you recheck. You can use the lowest systolic and the lowest diastolic readings for a patient if they're taken on the same date and same visit. The most recent value submitted as of Dec. 31 of the measurement year will stand for the patient's reading for the year.

*https://www.cdc.gov/bloodpressure/facts.htm

Improving Adherence for Statin Therapy in Patients with Cardiovascular Disease or Diabetes

The NCQA has established specifications that impact HEDIS measures for patients with cardiovascular disease or diabetes. These measures are focused on two major statin benefit populations described in the American College of Cardiology/American Heart Association guidelines and align with recommendations from the American Diabetes Association. Both statin-prescribing measures recommend statin therapy for people with either cardiovascular disease or diabetes, regardless of cholesterol levels.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Patients identified as having clinical atherosclerotic cardiovascular disease (ASCVD), and who meet the below criteria, should receive at least one moderate- or high-intensity statin medication during the measurement year. Once a patient has received this medication, they should stay on it for at least 80% of their treatment period.

Other criteria:

- Males 21-75 with ASCVD
- Females 40-75 with ASCVD

ASCVD is identified for this measure in two ways:

- By an event in the previous year
- By both previous and current diagnoses

Event criteria:

- Myocardial infarction (heart attack)
- Coronary artery bypass graft surgery
- Percutaneous coronary intervention
- Other revascularization procedures

Statin Therapy for Patients with Diabetes (SPD)

Patients diagnosed with diabetes, who meet the below criteria, should receive at least one statin medication of any intensity during the measurement year. Once a patient has received this medication, they should stay on it for at least 80% of their treatment period.

Other criteria:

- Any patient ages 40-75 with diabetes
- Patients who **don't** have ASCVD

Patients are identified for this measure through claims and encounter data or by pharmacy data during the measurement year or the year prior with a diagnosis of diabetes. Data can come from:

- An acute inpatient encounter or acute inpatient discharge with a diagnosis of diabetes
- Two or more outpatient, observation, ED, telephone or e-visits on different dates of service with a diagnosis of diabetes — or any combination of these visits
- Pharmacy data from patients who were dispensed insulin or hypoglycemics/antihyperglycemics

Comparison Chart for SPC and SPD

This comparison chart helps to highlight the differences between the statin measures.

Measures	Age Range	Brief Inclusion / Qualifying Criteria	Requirements to Meet the Measure	Level of Statin Required
SPC-Received Statin Therapy	**Males** 21–75 **Females** 40–75	Patients with clinical atherosclerotic cardiovascular disease (ASCVD)	Patients need to fill their statin medication prescription.	Moderate to High Intensity
SPC-Adherence Statin Therapy	**Males** 21–75 **Females** 40–75	Patients with clinical ASCVD	Patients should fill enough statin medication to cover at least 80% of their treatment period.	Moderate to High Intensity
SPD-Received Statin Therapy	**Patients** 40–75	Patients with diabetes, who don't have ASCVD	Patients need to fill their statin medication prescription.	Any Intensity
SPD-Adherence Statin Therapy	**Patients** 40–75	Patients with diabetes, who don't have ASCVD	Patients should fill enough statin medication to cover at least 80% of their treatment period.	Any Intensity

What This Means for You and Your Patients

Research has shown that limited patient education and engagement, alongside concerns about adverse side effects, are significant medication adherence barriers for patients with cardiovascular disease or diabetes.

Encourage your patients to adapt healthy lifestyle habits and take their medications as prescribed to help manage their diabetes and prevent heart disease.

If you have questions about measure requirements, refer to the chart above.

Helping to Prevent Cervical Cancer

According to the Centers for Disease Control and Prevention (CDC), cervical cancer is the easiest gynecologic cancer to prevent if caught early and treated appropriately. You can help your patients prevent cervical cancer by making sure they're up to date on their screenings.

One of the main causes of cervical cancer is long term human papillomavirus (HPV) infection. HPV is the most common sexually transmitted infection, and most adults who are sexually active have been exposed to HPV at some point. It's common for those who are infected with HPV to be unaware that they're infected. There's currently an HPV vaccine available which is recommended for ages 9 through 26, and there are even some cases when vaccination may be recommended through age 45. Making a strong recommendation, as the health care provider, can encourage your patients to get vaccinated. Approaching the HPV vaccine as a strategy for cancer prevention can be helpful when making your recommendation.

Starting at age 21, patients should be receiving cervical cancer screenings at least every three years. Once they turn 30, there are additional options for cervical cancer screening:

- Cervical cytology tests at least every three years,
- Co-testing of cervical cytology and high-risk human papillomavirus (hrHPV) testing every five years, or
- Just the high-risk hrHPV testing every five years.

An annual pap test is still a covered benefit for most patients if you feel it's necessary for any patient age 21 to 65. You, as their doctor, can make the best decision for your patient. The U.S. Preventive Services Task force (USPSTF) suggests additional guidelines for patients younger than 21 or older than 65.

- Screening those younger than 21 may not be appropriate. Assess for risk factors in this age group to make the appropriate recommendation.
- Screening those older than 65 may not be necessary if the patient has had cervical screenings and isn't at high risk for cervical cancer.
- Screening isn't recommended for those who've had a hysterectomy with their cervix removed and no history of high-grade precancerous lesion or cervical cancer.

Please note: The guidance above doesn't apply to certain patients, including those who've had cervical cancer or a high-grade precancerous lesion, those who were exposed to diethylstilbestrol in the womb, or those who are immunocompromised. The guidance does apply to any patient with a cervix, regardless of HPV vaccination status or sexual history.

Cervical cancer is one of the most treatable cancers when found early through screening. The five-year survival rate for cervical cancer is 92% if it's caught early.

Resources

- Basic Information About Cervical Cancer | CDC
- Cervical Cancer Overview | Guide To Cervical Cancer
- Cervical Cancer Prognosis and Survival Rates—NCI
- Cervical Cancer Statistics | Key Facts About Cervical Cancer
- Recommendation: Cervical Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)
- STD Facts—Human papillomavirus (HPV) (cdc.gov)
- What Are the Risk Factors for Cervical Cancer? | CDC
- What Can I Do to Reduce My Risk of Cervical Cancer? | CDC

Improving Quality: Colorectal Cancer Screenings

Investing in healthier communities is a priority for BlueCross. By working together, we can make an impact on the health of your patients by ensuring they have a colorectal cancer screening. While overall rates of colorectal cancer are decreasing, there are disparities in incidence and mortality among racial and ethnic minorities. Inequalities in screening, follow up and treatment may contribute to these disparities. The COVID-19 pandemic initially caused most elective procedures to be placed on hold, so many people didn't get screened for cancer.

Colorectal cancer is the second leading cause of cancer deaths in the United States and makes up 8% of all new cancer cases.

Changes in the HEDIS measure

The USPSTF now recommends colorectal cancer screening start at age 45 instead of 50, because incidence is rising in younger adults. NCQA updated the HEDIS Colorectal Cancer Screening (COL) measure to align with the updates to the USPSTF guidelines.

The current Colorectal Cancer Screening (COL, COL-E*) measure focuses on members ages 45-75 who had the appropriate COL screening.

Support and Tips for Success

We support your efforts by raising awareness with clinical reminders, patient education, and preventive screening opportunities that encourage colorectal cancer screenings. We know you're committed to providing quality care, so we're also including the following information and links to tips that can help you be as successful as possible.

A **Screening Colonoscopy** is a preventive procedure used to detect abnormalities that could lead to colorectal polyps and cancer when no gastrointestinal symptoms are present. In some cases, when the doctor is conducting this procedure, it may be necessary to remove a polyp discovered during the screening. Under most benefit plans, this would still be considered a preventive colonoscopy screening, if the physician uses the screening diagnosis code. A **Screening Colonoscopy is covered at 100% in most benefit plans**.

You can find descriptions for the measure, applicable codes, tips and exclusions in the **Medicare Advantage 2023 Quality Program Information Guide** and the **Commercial 2023 Quality Care Measures & Comprehensive Program Information Guide**.

Explore the Differences Between EPSDT- and HEDIS-Compliant Well-Child Exams

TennCare Kids Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams have reporting criteria and eligibility requirements that differ from the HEDIS measures for well-child-visit performance. Here's some information to help you brush up on the basics for each.

EPSDT Visits

Children and adolescents enrolled in BlueCare [SM] or TennCare*Select* are eligible for TennCare Kids exams from birth until their 21st birthday. The schedule for EPSDT exams follows the Bright Futures/American Academy of Pediatrics Periodicity Schedule.

The fiscal year for EPSDT visits begins Oct. 1 and ends Sept. 30 of the following year.

HEDIS Quality Measures

Two performance measures apply to well-child checkups: Well-Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV). These measures determine if children and adolescents receive the appropriate number of well-child visits during the measurement year for their age.

- W30 has two reported rates, which evaluate whether children get the correct number of well-child visits with a PCP on or before age 15 months and between ages 15-30 months.
- WCV evaluates the rate of children and adolescents between ages 3 and 21 who receive an annual wellness visit with a PCP or OB/GYN during the measurement year.

For more information about the HEDIS measures for well-child care, see our [BCT Measures Guide link]. To learn more about EPSDT exams and coding EPSDT visits, please refer to our **TennCare Kids Tool Kit**.

Best Practices for Well-Child Care

Consider these tips to help ensure children in our state get needed preventive care.

- **Review your patient roster in the Quality Care Rewards application to find out which patients are past due for services.** Then, contact them to schedule an appointment.
- **Combine well-child and "sick" visits as needed.** TennCare Kids guidelines allow you to receive reimbursement for a well-child exam performed at the same time as office visits for other services.
- **Consider alternate or extended office hours.** Offering evening or weekend hours may make it easier for busy families to visit your office.
- **Perform "inter-periodic" screenings when appropriate.** TennCare Kids guidelines also allow for exams that fall outside of the state's periodicity schedule when medically appropriate and to help ensure children get preventive care.
- **Schedule a full year of appointments for newborns during their first visit.** This not only helps new parents plan for upcoming visits, but also keeps a plan of care in place if a checkup is missed. For children 2 years and older, schedule the next well-child exam at the end of each appointment.
- **Convert sports physicals to well-child exams.** Sports physicals aren't covered services for those enrolled in BlueCare or TennCareSelect. However, if a child is due for a checkup, you can convert the sports physical to an EPSDT exam. Doing so meets the requirements of the sports physical and ensures the child also receives needed services.

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