YOUR GUIDE TO PROGRAMS AND REWARDS

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A Clinical Focus

Navigating Patient Barriers in Behavioral Health

Behavioral health conditions are common in the United States. Approximately 1 in 5 individuals are living with a mental illness and only half are receiving treatment. These conditions are also the leading cause of disability in the U.S. population. Despite their frequency, there are significant barriers to receiving care for these conditions. Barriers to care include stigma, as well as social determinants of health (SDoH), and our providers are critical in helping members get the care they need.

Stigma

Often patients delay or avoid seeking treatment for behavioral health conditions due to a fear of what others may think, the impact it could have on their self-worth, and the fear of being treated differently in their community. Stigma often comes from a lack of understanding and is fueled by the misrepresentation of what it means to live with a behavioral health condition. Stereotypes and prejudices associated with stigma can lead to discrimination, whether it be overt or subtle.

How You Can Help

Having an awareness of stigma associated with behavioral health conditions can help. Try these tips:

- Talk openly about behavioral health and normalize treatment
- Learn about and use recovery-oriented language
- Show compassion for those with behavioral health conditions
- Offer screenings for behavioral health conditions
- Learn about behavioral health care stigmas to respond to misperceptions or negative comments
- Recognize stigma may look different for patients from different cultural backgrounds and seek to increase cultural competency in your practice
- To learn more about ways to promote cultural competency in health care, take a look at our **online resource**.

Social Determinants of Health

Social determinants of health (SDoH) are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.

SDoH can be overlooked in the development of treatment and after-care planning and can have a significant impact on follow-through with step-down levels of care, medication compliance and overutilization of the ER. For example, individuals living in poverty may face challenges in accessing health care, including behavioral health care, due to a shortage of behavioral health professionals in their area; lack of transportation or childcare; housing instability; lack of insurance coverage (if they don't qualify for Medicaid or ACA coverage); and high out-of-pocket costs associated with high deductibles and copays.

You can help by:

- Including questions about SDoH-related barriers during office visits
- Considering potential out-of-pocket costs for medications and other treatment recommendations during treatment planning
- Providing education about known resources like prescription assistance programs, housing assistance, and transportation
- Encouraging patients to connect with our Care Management Team

What We're Doing to Address Barriers

Our care teams are available to collaborate with providers, pharmacies and community agencies to ensure your patients have the resources they need. Each care team includes Licensed Social Workers who can specifically address SDoH barriers for our members.

To address barriers, we use:

- Unite Us, a closed loop referral platform to connect members to care
- United Way's 211 hotline
- Internal referrals to Teladoc®, Nurseline, social workers, registered dietitians and behavioral health providers as benefits allow
- Connections to transportation resources, support agencies and home health

It's important for us to work together to increase access to behavioral health care in underserved communities, provide culturally competent care, and increase awareness of behavioral health issues. By working together, we can help ensure everyone has access to the care they need and deserve.

Sources

- National Institute of Mental Health: **https://www.nimh.nih.gov/**
- University of Buffalo: **https://www.buffalo.edu/ubnow/stories/2024/01/mu-health-disparities.html**
- Centers for Disease Control and Prevention: **https://www.cdc.gov/**
- National Alliance on Mental Illness: **https://www.nami.org/Home**
- Substance Abuse and Mental Health Services Administration (SAMHSA): **https://www.samhsa.gov/**
- American Journal of Accountable Care: **https://www.ajmc.com/about/ajac/journal**

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Behavioral Health

Newport Pediatrics: Focus on Care for the Whole Family

Children and adolescent vaccination rates have continued to decline since 2020, but in rural Tennessee, Newport Pediatrics is thinking outside the box to continuously meet the goals of their immunization and well-care measures.

Shannon Barnes, Practice Administrator, attributes much of their success to their employees. "Everyone in the office from clinical to non-clinical staff is on board. They understand what our goal is for well-care visits and why they're important to meeting the immunization measures," said Barnes.

The practice employs four care coordinators, with one who focuses on quality goals and measures by monitoring patient records and making sure they're up to date on vaccines and well-care visits. Barnes said that in addition to every staff member receiving vaccination schedule training, they also encourage staff to turn a sick visit into a well-care visit when appropriate.

Getting Creative with Well-Care and Immunizations

Making well-care fun and accessible has also been a win for Newport Pediatrics and their patients. Throughout the year, they host themed health care screenings and immunizations clinics for children and adolescents. Clinic staff change into fun costumes and transform the office with decorations to bring the experience to life. Some of their most popular themes include superheroes, sports and Harry Potter™.

During the events, patients visit different care stations, starting with triage then moving to hearing and vision screenings. They also see a physician for a quick well-care visit and any needed immunizations.

Newport Pediatrics markets their events through social media and offers door prizes to patients and staff members to get everyone engaged.

"Parents really enjoy the quick-moving format. It's fun not only for our patients, but our staff loves it, too," Barnes said. "Our team members set goals and win prizes for encouraging patients to sign up."

Newport Pediatrics also works to address vaccine hesitancy and refusal. The team accepts patients whose parents/guardians refuse to vaccinate, but also revisits the topic of immunization at each appointment. "We let them know in advance that we'll continue to encourage vaccines at each visit, and they're required to agree before we take them as a patient," Barnes explained. "Each time we see them, we emphasize the importance of vaccines and offer ongoing education and modified immunization schedules."

Making Primary Care the Primary Focus

Patient experience surveys continue to tell us that patients want to feel supported by their providers and that means focusing not only on their physical health, but their overall well-being. In a rural town like Newport, children can face many disparities that affect their ability to access care – something that Newport Pediatrics faces head on.

"We not only give everyone a needs assessment, but we act on as much as we can," Barnes said. "For example, we work with a local food bank to keep boxes of non-perishable items on hand if we encounter a parent concerned about feeding their family. If they come back and still have food insecurities, we sit down and help them contact resources for more assistance. Our goal is to help them find a solution."

Newport Pediatrics has built relationships with other groups and businesses in the community to help provide resources and assistance when a need arises.

"We don't want them to think they can only utilize us when they're sick. Our purpose is to provide primary care and that means addressing their needs as a whole person," Barnes said. "It's about building trust with our patients and being a resource for them and their families."

Starting Off on the Right Foot

Welcoming a baby and establishing their care can be a stressful time for new parents. That's why Newport Pediatrics created their Prenatal Program.

Care coordinators meet with expecting parents and establish a relationship before delivery to discuss what to expect during well-care visits, including immunization schedules. They also provide parents with a book that offers guidance on basic newborn care, car seat and sleep safety, and when to call the doctor versus visit the emergency room.

Newport Pediatric providers are also equipped to check-in on the health of new mothers. All of Newport Pediatrics' care coordinators are certified lactation consultants and can assist moms with breastfeeding challenges. Providers also check on the mother's physical and mental postpartum health and work directly with their OB-GYN to make sure their health needs are met, too.

A Clinical Focus

Insight into the Patient Experience

Patient Experience: What It Is and Why It Matters

Gaining insight into how your patients feel about their health care experience can benefit you and your patients. Most patients will be more engaged, have higher adherence rates 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 Consumer Assessment of Healthcare Providers & Systems (CAHPS®) annual survey, conducted by an outside entity, is so important to providers as well as health plans. This anonymous 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 your patients.

Patient experience surveys can often be mistaken for customer satisfaction surveys. They focus on how a patient experiences or perceives key aspects of their care, not how satisfied they are with their care. These surveys focus on asking patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding their medication instructions and the coordination of their health care needs.

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

Improving Patient Experience Scores

Your interactions with patients have a direct impact on their response to the CAHPS survey. In the sections below, you'll see some of the CAHPS survey questions with suggestions for ways to improve the patient's overall care experience.

In the last 12 months, when you phoned your provider office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?

Allow patients to schedule appointments online and remind patients of upcoming appointments by text or phone calls. Complete our provider surveys, such as Provider Satisfaction and Wait Time Surveys, to communicate your preferences and common wait times for routine/urgent care appointments so we can continue to work with you to improve our processes.

In the last six months, how often did you and your provider talk about the prescription medications you're taking?

Ask patients to bring a list of their current prescription medications. During the visit, discuss correct dosing and instructions for each medication and review the purpose and possible side effects.

In the last six months, when you visited your provider for a scheduled appointment, how often were they familiar with your medical records or other information about your care?

Before each patient visit, review the reason for the visit and determine if you need to follow up on any health issues or concerns from previous visits, including lab results and referrals to specialists. If you know patients received specialty care, discuss their visit and the treatment plan they received.

In the last six months, when your provider ordered a blood test, X-ray or other test for you, how often did someone from your primary care provider's office follow up to give you those results?

Establish a system to follow up on each diagnostic or lab result and set appropriate timeframes for communicating results.

Educate patients about your established timeframes and how results will be communicated, such as through phone calls, mail, patient portal and follow-up visits. Ask patients how they prefer to receive test results and provide them as requested.

In the last six months, did you get the help you needed from your provider's office to coordinate your care with other providers or services?

Ask patients about other providers they're seeing. There may be specialists you're unaware of. When referring to a specialist, explain the reason for the referral and what the specialist's role will be. Help coordinate appointment scheduling and the transfer of records rather than assigning these tasks to the patient. Educate patients on timeframes for obtaining specialist appointments depending on their symptoms and discuss and plan for possible appointment delays. To help avoid delays, consider suggesting multiple specialists in the patient's network.

Establish follow-up processes with specialists to be sure you receive results within a specific timeframe after the patient's appointment. Follow up with patients by phone after visits to answer questions and address any challenges with filling prescriptions, completing lab work or attending specialist visits.

Building Trusted Relationships

Trust is a key component in building relationships with your patients and seeing treatment success. Consider these tips to help you build trust and assure patients you're actively engaged in their care:

- Make eye contact and spend time listening.
- Avoid medical jargon and explain things in ways that are easy to understand.
- Respect each patient's thoughts and beliefs while encouraging conversations.
- Use the teach-back method, which involves asking patients to explain what they need to do in their own words.
- Talk with patients about services they get from other providers.

Treating Your Patients with Asthma

According to the Centers for Disease Control and Prevention (CDC), more than 27 million people in the United States (8% of adults and 7% of children) have asthma, and it's the leading chronic disease in children. Help your patients manage asthma by educating them about symptom triggers, taking medications and preparing to treat asthma episodes if they occur.

Medication adherence is the key to symptom control. The HEDIS® Asthma Medication Ratio (AMR) measure focuses on the percentage of patients, 5-64 years old, who were identified as having persistent asthma and had a ratio of controller medications of 0.50 or greater (measured as medication units).

Appropriate medication management can also reduce the need for rescue medication — as well as the costs associated with ER visits, inpatient admissions, deaths and missed days of work or school.

Disparities in Asthma

In the U.S., big differences exist based on race and ethnicity. Black, Hispanic and American Indian/ Alaska Native people have the highest rates of asthma, hospital visits and asthma-related deaths. Health care quality has improved for many people in recent years, but racial inequities in asthma still exist. Social and structural disadvantages are the biggest reasons for differences in asthma rates and outcomes for certain racial and ethnic populations. Puerto Ricans have the highest rate of asthma prevalence, and Black Americans are disproportionately diagnosed with asthma compared to White Americans.

Help Improve Patient Compliance and Close Gaps in Care

Talk with your patients about the types of asthma medications available. Patients don't always understand the difference between long-acting controller and rescue medications. The AMR measure ratio is calculated by the units of controller medications divided by the units of total asthma medication used. When calculating the ratio, count each individual medication (defined as an amount lasting 30 days or less) as one medication unit.

Note: One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication.

Several resources are available to help improve compliance, and you can access them **here**.

Strategies to Improve Asthma Medication Adherence and Patient Outcomes

You can help your patients improve medication adherence and outcomes by:

- Preparing an Asthma Action Plan to educate them on the importance of medication adherence and avoiding asthma triggers.
- Providing education and resources on the differences between quick relief and controller medications and the importance of using controller medications to avoid inflammation.
- Reviewing proper inhaler techniques and providing education about the importance of using the correct technique when using an inhaler.
- Prescribing 90-day medication fills.
- Referring those with moderate to severe asthma to an allergist or pulmonologist.
- Encouraging active smokers to stop smoking and educating them on the resources available to do so.

Sources

- CDC: **Asthma | CDC**
- AAFA.org: **Asthma Information and Facts | AAFA.org**

Caring for Patients with Chronic Obstructive Pulmonary Disease (COPD)

According to the American Lung Association, COPD is the sixth leading cause of death in the United States. More than 565,000 Tennesseans are currently living with COPD, placing us near the top of the list for states with a high prevalence rate of COPD.

Unfortunately, early signs of COPD are rarely reported and often overlooked as normal signs of aging. Patients with COPD often have significant comorbid conditions such as cardiovascular disease, diabetes, osteoporosis, lung cancer and depression.

Health Disparities in COPD Patients

According to the CDC, health disparities are most notable in patients diagnosed with COPD who live in rural areas. These patients are more likely to be smokers, less likely to have access to smoking cessation programs and experience an increased exposure to secondhand smoke. Patients in rural areas with lower income and educational levels have worse outcomes, higher prevalence and more barriers to treatment. These barriers include a higher risk of poverty, decreased access to specialists and comprehensive chronic disease management programs, and a lack of public transportation resources.

Improving Patient Outcomes While Closing Gaps in Care

You can help your patients improve outcomes and quality of life by:

- Helping them prepare a COPD Action Plan to reduce triggers and inflammation.
- Reviewing what an episode looks like and how to spot early warning signs.
- Talking with them about the importance of staying active and how to pace themselves.
- Discussing both maintenance and rescue bronchodilator adherence.
- Emphasizing the importance of following up with their primary care physician after any visit to the hospital, regardless of admission.
- Educating them on the importance of taking their medications as prescribed after hospital discharge.
- Evaluating triggers including air quality, pollen counts and smoke exposure.
- Explaining the need for spirometry and pulmonary function testing.
- Encouraging them to stay up to date on vaccinations for pneumonia, flu and COVID-19.
- Assessing them for signs of anxiety and depression.
- Discussing a plan of care including end-of-life care planning when appropriate.

Sources

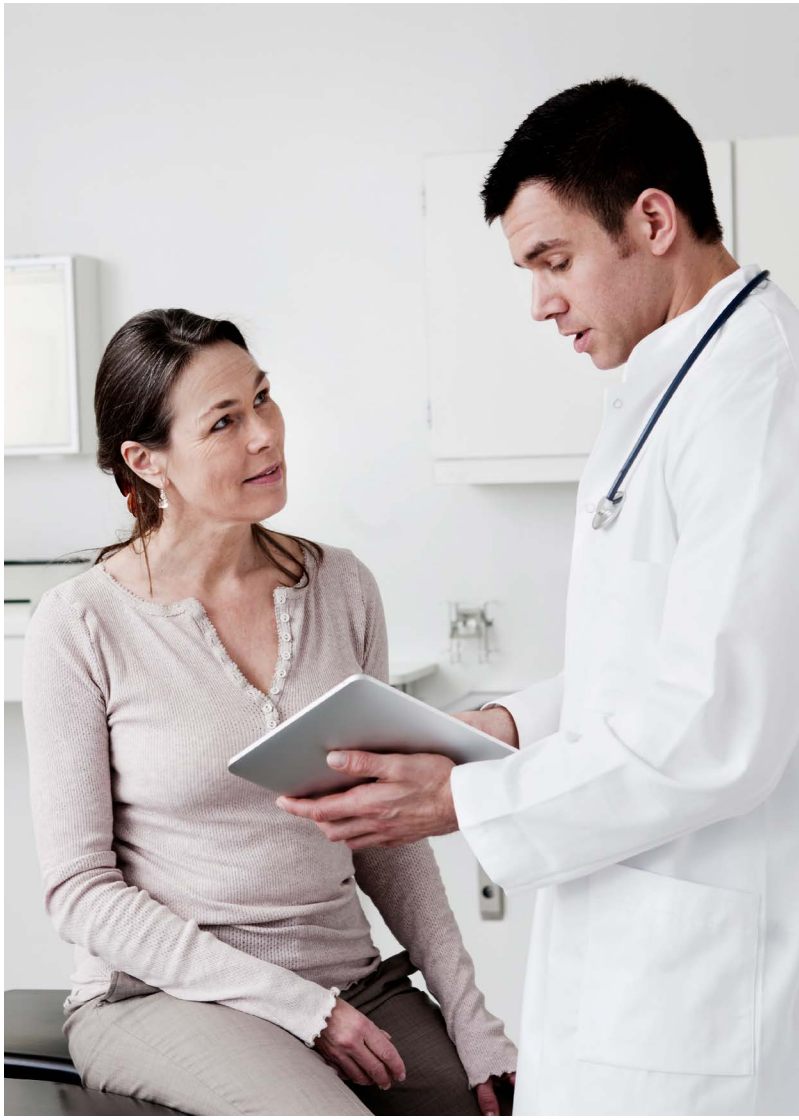
- Resources for COPD Health Professionals | American Lung Association: **https://www.lung.org/lung-health-diseases/lung-disease-lookup/copd/for-health-professionals**

  https://www.lung.org/getmedia/00578045-51a4-4a46-9d7b-19938f27c9ab/2023-COPD-State-Briefs-Tennessee.pdf
- 2024 GOLD Report - Global Initiative for Chronic Obstructive Lung Disease - GOLD: **goldcopd.org**

Pharmacotherapy Management of COPD Exacerbations (PCE) Measure

Patients ages 40 and up who are discharged from an acute inpatient hospital stay or ER visit for COPD should receive and fill prescriptions for both systemic corticosteroids within 14 days of discharge and bronchodilators within 30 days of discharge. Patients in hospice or using hospice services are excluded from the measure.

Follow-Up Care for Substance Use Disorder: An Essential Support to Providing Quality Care



Substance use disorders (SUDs) continue to be a prominent health issue in our country. According to the 2020 National Survey on Drug Use and Health (NSDUH), 40.3 million people in the United States, ages 12 and older, had an SUD in the past year. Only 2.7 million of those individuals received treatment.

SUDs are treatable, chronic diseases characterized by a problematic pattern of substance use, leading to impairments in health, social function and the ability to control substance use. These diseases cause a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues using the substance despite harmful consequences. Patterns of symptoms resulting from substance use (drugs or alcohol) can help providers diagnose a person with an SUD or SUDs.

Substance Use Disparities

Patients who suffer from SUDs experience an array of health disparities, including, but not limited to:

- **A rise in drug overdoses.** The rate of drug overdose among Black Tennesseans rose by more than 270% compared to 58% for White Tennesseans since 2014.
- **A gap in receiving treatment.** According to SAMHSA, of individuals who need treatment for illicit substance use disorders, White patients receive treatment 23.5% of the time, while Black and Hispanic individuals receive treatment 18.6% and 17.6% of the time, respectively.
- **Inconsistencies in treatment completion.** Older Black Americans who start treatment are much more likely to have their treatment terminated or not finish the treatment compared to White adults.
- **Sexual identity and orientation.** According to the 2020 NSDUH, approximately 6.7% of people who identify as lesbian, gay or bisexual misused opioids (prescription opioids or heroin use), compared to 3.6% of the overall adult population.

SUD diagnoses can be applied to alcohol use, as well as the following classes of drugs:

- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives
- Hypnotics or anxiolytics
- Stimulants
- Tobacco (nicotine)
- Other (or unknown) substances

Follow-Up Care for Substance Use Disorders

Appropriate follow-up care is crucial to successfully treating SUDs. HEDIS measures require patients with new SUD episodes that result in treatment and engagement to adhere to these guidelines:

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Patients 13 years and older with new SUD episodes that result in treatment and engagement should have two levels of care:

- Initiation of SUD treatment within 14 days; and
- Engagement of SUD treatment within 34 days of initiation. Engagement is defined as having two or more additional services for SUD or Medication Assisted Therapy (MAT) after care initiation.

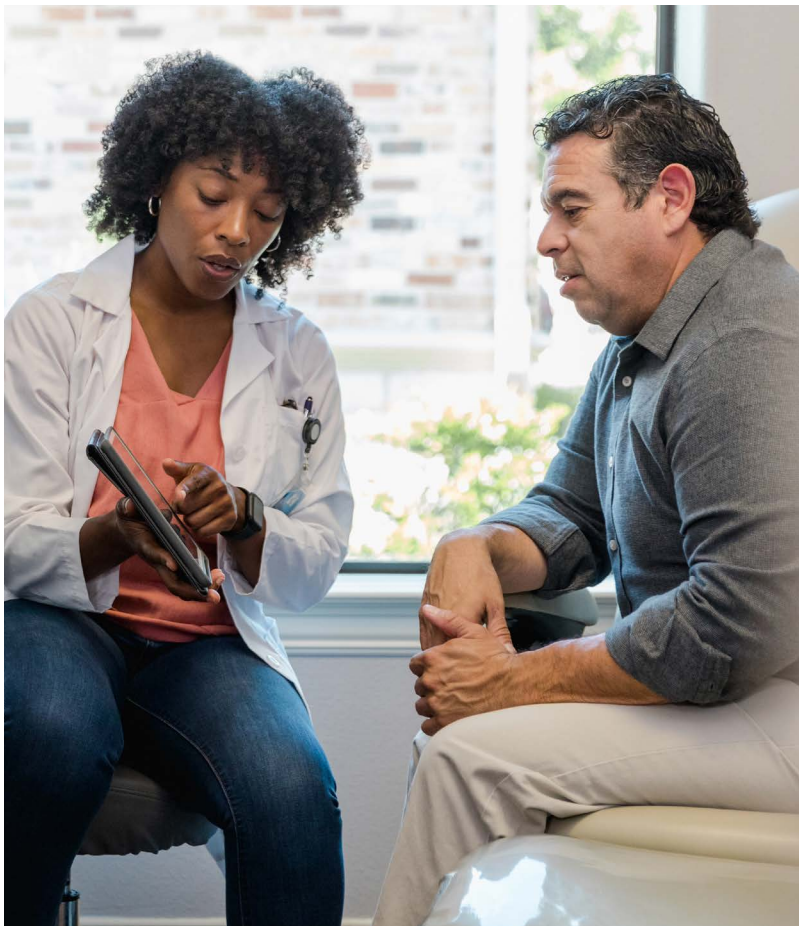
Follow-Up After Emergency Department Visit for Substance Use Disorder (FUA)

Patients 13 years and older who were seen in the ER with the principal diagnosis of SUD or any diagnosis of drug overdose should have follow-up visits for SUD within seven and 30 days of the ER visit. Telehealth visits may be used, and the visits can be with any practitioner, if the claim includes an SUD diagnosis.

Exclusions to the HEDIS measures include:

- Patients in hospice care or using hospice services
- Patients who died any time during the measurement year

For additional questions about HEDIS SUD measures, please see our 2024 Quality Care Measures and Comprehensive Program Information Guide or contact our Commercial Quality Improvement Team.



Sources

- Centers for Disease Control (CDC)
- NCQA HEDIS MEASURE: Technical Specifications for Health Plans (HEDIS)
- **https://healthpolicy.usc.edu/evidence-base/racial-disparities-in-accessing-treatment-for-substance-use-highlights-work-to-be-done/**
- Position Statement on Addressing Racial and Ethnic Health Disparities in Substance Use Disorder Treatment in the Justice System: **https://www.psychiatry.org/getattachment/b5119be4-6159-4187-831d-f02bd602e0fe/Position-Addressing-Racial-and-Ethnic-Health-Disparities-in-Substance-Use.pdf**
- **https://nida.nih.gov/research-topics/substance-use-suds-in-lgbtq-populations#references**

Improving Quality: Colorectal Screening

Colorectal cancer is the second leading cause of cancer deaths in the United States and accounts for 10% of all new cancer cases. The COL-E* measure includes the percentage of members 45-75 years of age who had an appropriate screening for colorectal cancer.

Disparities exist in colorectal cancer incidence and mortality among racial and ethnic minorities. Black Americans have the highest incidence and mortality rates of all racial groups in the United States, have a 20% higher likelihood of getting colorectal cancer and a 40% higher death rate. Among Native Americans, it's the second most common cancer and the second leading cause of cancer death. Inequalities in screening, follow up and treatment may contribute to these disparities.

The U.S. Preventive Services Task Force (USPSTF) now recommends colorectal cancer screening start at age 45 instead of age 50, due to evidence indicating an increasing risk of colorectal cancer in younger adults. NCQA updated the HEDIS Colorectal Cancer Screening measure to align with the updates to the USPSTF guidelines.

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 including the following information and tips to 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 a provider 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 correct diagnosis code is used. A screening colonoscopy is covered at 100% in most benefit plans.

While a colonoscopy is the gold standard, the colorectal cancer screening measure will close with any of the following screening types:

- Colonoscopy during the measurement year or the nine years prior (every 10 years).
- Flexible sigmoidoscopy during the measurement year or the four years prior (every five years).
- CT colonography during the measurement year or the four years prior (every five years).
- Stool DNA (sDNA) with a fecal immunochemical testing (FIT) DNA test during the measurement year or the two years prior (every three years).
- Fecal occult blood testing (FOBT), including FIT, requires only one stool sample (yearly). If using guaiac testing, three samples are required.

Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result isn't required if the documentation is clearly part of the patient's medical history section of the record. If this isn't clear, the result or findings must also be present. This ensures that the screening was performed and not just ordered. The length of time that this gap is closed is based on the type of screening performed.

Measure Exclusions

- Patients in hospice
- Patients in palliative care, Z51.5
- Patients with colon cancer or a history of colon cancer
- Patients with a total colectomy
- Patients 66 years and older with both advanced illness and frailty diagnoses (at least two indications of frailty diagnoses with different dates of service during the measurement year)
- Patients who died any time during the measurement year

Sources

- **NCQA.org**

The Cause and Effect of Medication Adherence in Patients with Medicare Advantage

Low medication adherence can have serious consequences and costs, causing more than 125,000 deaths per year and more than $100 billion in preventable medical costs.

For 2024 Medicare Advantage and BlueCare Plus (HMO SNP)[SM] Quality+ Partnerships programs, the three medication adherence measures are triple weighted again, making these measures critically important to each provider's Stars score.

These measures are focused on patients filling their medication at least 80% of the time they're supposed to be taking it. Creating an action plan early in the year can help increase adherence.

Adherence to a treatment regimen is a key factor in successful management of chronic diseases like hypertension and diabetes. Along with lifestyle modification coaching, medication selection is crucial in the success of slowing progression and driving outcomes. Understanding the obstacles your patients may face from their prescribed medication can help you manage and plan for them together.

Financial Side Effects

Often, the cost of medications can become an overlooked barrier to medication adherence. This financial toxicity includes both direct cost to the health care system, such as increased ER visits or hospitalization, and indirect costs, like decreased productivity or an increased need for home health care. When the cost of a medication is too high, patients find themselves choosing between their medication and other commodities like utility bills and food. They may ration the medication, skip days, delay refilling or stop taking the medication altogether resulting in an unstable, worsening condition.

Most Medicare Advantage drug plans have a coverage gap (also called the "donut hole"). This means there's a temporary limit on what the drug plan will cover for drugs. Not everyone will enter the coverage gap. The coverage gap begins after a patient and their drug plan have spent a certain amount for covered drugs.

How Prescribing Affects the Coverage Gap

Prescribing brand name medications will put a patient in the coverage gap much sooner. According to AARP®, the average cost of a brand name prescription medication in 2020 was $6,604, compared to the average generic drug product's price of $679. Prescribing generic drugs can lower the cost during all stages of Medicare drug coverage and delays or avoids progression into the coverage gap, as well as unintended financial side effects.

You can use Surescripts® through CVS Caremark® to get real-time benefits and see the patient's out-of-pocket cost, alternative medication options and costs, and member-specific utilization management restrictions for each drug. This will allow you to communicate costs to patients at the point of care and allow for open dialogue about financial resources and concerns. Therapies can be adjusted or changed during the office visit, making treatment easier for the patient.

We also have five cost-sharing tiers for Medicare Advantage plans:

- Tier 1 – Preferred Generic Drugs
- Tier 2 – Generic Drugs
- Tier 3 – Select Insulins and Preferred Brand Name Drugs
- Tier 4 – Non-Preferred Drugs
- Tier 5 – Specialty Drugs

Patients will have the most cost savings with Tier 1 Preferred Generic Drugs, which are also covered during the coverage gap.

Overlooked Barriers of Medication Adherence

Cost isn't the only factor driving medication adherence. Negative side effects, drug interactions, forgetfulness and health literacy issues may all contribute to non-adherence.

"If we want to increase medication adherence, we have to consider the patient's social determinants of health and the downstream impacts prescribing that medication could have on the individual," said Sarah Smith, PharmD, BCPS, Quality Pharmacy Director.

Other SDoH, such as housing, literacy, transportation and family/community support account for up to 90% of health outcomes. These factors can impact a patient's ability to pick up prescriptions, understand instructions or influence their medication beliefs.

"Forbes recently named Tennessee as the third unhealthiest state and our latest health equity report dives into how poverty, unequal access to care, and race and ethnicity contribute to poorer outcomes," Smith said. "These social risk factors need to be recognized as potential reasons for unexpected disease progression, missed appointments, or perceived lack of interest in motivation to drive one's own care."

When assessing your patients and determining a treatment plan, consider that patients experiencing multiple social risk factors may need a higher level of care to achieve expected and desired outcomes.

We have a team of quality pharmacists dedicated to improving the health and outcomes of the populations we serve. Pharmacists prioritize customized patient care, a critical component to addressing social determinants. Providers can contact their network principal or provider consultant for more help.

Partner with Your Patients to Encourage Medication Adherence

We've included some tips to help you encourage patients to follow your prescribed medication instructions.

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

- Focus primarily on patients who will experience a barrier to refilling their medication after one fill and provide intervention, when possible, to help maintain adherence and improve clinical outcomes.

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.
- Patients trust their prescriber to give them the best medication possible, so even though there are usually many options with varying price points, many assume that taking a generic versus a brand name medication will result in worse outcomes.
- 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).

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

- Write a 30-day supply. This allows for titration, potential dose changes due to side-effects and avoiding patient stockpiling if a dose is changed.
- Provide an adequate number of refills until the patient's next appointment or until their new prescription is available.
- Encourage patients to use digital resources like alarms or phone apps to create reminders.

For established maintenance medications:

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

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 and ensure safe transitions of care in the event of a hospitalization or care status change.
- Provide clear instructions to the pharmacy to cancel/discontinue the old prescription either through a phone call or note on the updated prescription.

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; take one tablet twice daily for blood sugar).

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

- As an example: For metformin, reassure the patient that gastrointestinal problems (diarrhea, nausea, etc.) are usually short-lived especially when "starting low and going slow."
- Discuss any possible drug-to-drug interactions and how patients can avoid them.
- Consider medication adherence packaging for patients on multiple medications with multiple comorbidities.

Sources

- Medicare: **https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap**
- Journal of Managed Care & Specialty Pharmacy: **https://www.jmcp.org/doi/10.18553/jmcp.2022.28.3.379**

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

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 performance. Here's what you need to know.

EPSDT Visits

Children and adolescents enrolled in BlueCare℠ or TennCare*Select* are eligible for TennCare Kids exams until they turn 21. 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 get 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 the **BlueCare Tennessee Quality Program Measures Guide**. 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.
- **Administer vaccines during well-child visits.** You can use a scheduled well-child visit to make sure patients are up to date and catch them up on any past due vaccinations.
- **Combine visits for well-child and acute care as appropriate.** TennCare Kids guidelines allow 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, for example, may make it easier for busy families to visit your office.
- **Perform "inter-periodic" screenings when needed.** TennCare Kids guidelines also allow for exams that fall outside of the state's periodicity schedule when medically appropriate and to help ensure children and teens get preventive care.
- **Make 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 TennCare*Select*. 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.
- **Schedule sibling visits on the same day.** When possible, consider extending appointment times to allow you to see siblings at one visit or scheduling siblings in back-to-back appointment slots.
- **Coordinate care with other providers.** Coordinated care is essential to healthy outcomes, but it can be difficult when PCPs don't know when patients see other providers. Help bridge this gap and ensure you have a complete health history for each patient in your files by:
  - Asking patients (or their parents/guardians) if they've recently visited the ER or a specialist.
  - Discussing services and medications they've received elsewhere.
  - Contacting their other providers to request information about test results and treatment plans.

For more care coordination tips, see page 5 and 6 of this newsletter.

Coming Soon: 2024 EPSDT Virtual Training

We'll host our first EPSDT virtual training of 2024 in June. Watch the BlueAlert℠ for more information.

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