YOUR GUIDE TO PROGRAMS AND REWARDS

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Inside this Issue

Controversy in the Prevention of Preterm Labor

The preterm birth rate is increasing.

Preterm birth is the nation's leading cause of infant mortality and disability. According to the CDC, the preterm birth rate increased from 2007 to 2017, partly due to fewer teen and young women giving birth. However, the preterm birth rate rose for the fifth year in a row in 2019.

To further complicate the issue, in October 2020 an FDA advisory committee recommended that the FDA pursue withdrawal of approval for Makena® (17-hydroxyprogesterone caproate injection or 17OHP) for the prevention of preterm birth. Pending a final decision, Makena remains on the market.

The History and Studies on Makena

Many clinicians have prescribed 17OHP since the publication of a National Institutes of Health study in 2003. Makena was approved in 2011 for the prevention of preterm labor in women that have a history of preterm birth – administered in a weekly injection of 17OHP beginning in the second trimester and continuing until 37 weeks gestational age.

There are now two studies that need to be considered. The first, done in the U.S. prior to approval of Makena, showed that 17OHP was effective. The second study was conducted by the drug's manufacturer after the approval of Makena, at the request of the FDA. That study is a larger international study that concluded 17OHP wasn't more effective than the placebo in the prevention of preterm birth in women with a previous preterm birth.

Recommendations to Consider

The American College of Obstetricians and Gynecologists and The Society for Maternal-Fetal Medicine haven't changed their recommendations regarding the use of 17OHP for the prevention of preterm labor in women that had a previous preterm birth.

Prevention of preterm birth remains challenging. The causes are complex and not well understood. While there appears to be conflicting data regarding the efficacy of 17OHP in the prevention of preterm labor in individuals with previous preterm birth, there are some things that can be recommended to all pregnant women to decrease the risk of preterm labor. These include:

- Quitting smoking
- Avoiding alcohol and illicit drugs
- Seeking early prenatal care
- Waiting at least 18 months between pregnancies
- Being cautious when using in vitro fertilization (IVF) or other assisted reproductive technologies that may lead to multiple gestation
- Seeking medical attention for any warning signs or symptoms of preterm labor

J. Calvin Channell, MD

Medical Director

BlueCross Total Health Management

ETSU Health Shares Best Practices for Women's Quality Care

For many women, health care takes a back seat to caring for their families and other daily responsibilities. Making it easy to schedule and receive needed screenings helps ensure women get the care they need.

ETSU Health in Johnson City, Tenn., emphasizes outreach, education and teamwork – with great results. In 2020, the group scored at the 90th percentile in our Commercial Quality Care Partnership Initiative for key women's health measures, including Breast Cancer Screening, Cervical Cancer Screening and Chlamydia Screening.

A Team Effort

"I consider all team members a part of our health care team," said Ginger W. Carter, MD, OB/GYN Clinical Director at ETSU Health. "We try to train each level of 'patient contact' with what they need to do in order for us to provide the best care for our patients."

The commitment to quality starts with those who take patients' calls. By asking the right questions during each patient encounter, the phone team connects women with appointments for the appropriate health care services. Then, at check in, staff members look for obstacles that may arise during the visit by verifying insurance coverage and updating patient information as needed. If a staff member has concerns, they notify an administrator. Finally, patients work with a nurse at each visit who leads them through the screening process.

"All of this and much more occurs before the patient sees their medical provider," Dr. Carter said. "Team member education and evaluation of processes is ongoing to ensure that we are delivering the most efficient care possible at each patient visit."

Prioritizing Access and Education

The practice's goal is to provide quality care to all women in the region. To help achieve that goal, the team works hard to make care available and accessible.

Because it's not always convenient to call the office, patients can schedule appointments and request a medication refill or phone call from a nurse online using the **Follow My Health** application. In cases where women or their children have an upcoming appointment at another ETSU Health clinic, the team tries to schedule well-woman visits on the same day. Appointment reminders through a phone call or text – whichever patients prefer – make it easier to keep track of visits. During each patient encounter, the team also routinely checks to see what screenings are needed, which Dr. Carter credits with closing gaps in women's health care.

Additionally, Dr. Carter finds it useful to talk with women about the health risks associated with delaying screenings, like routine mammography.

"I think when you remind women that breast cancer affects one in eight women – that gets their attention," Dr. Carter said. "Reminding women that a monthly self-breast exam along with annual mammograms (at age 40 or younger, if clinically indicated) and a yearly clinical breast exam by a medical provider is the best defense that they have in detecting breast cancer at an early stage is essential. While doing a breast exam, I use that time to remind women of the importance of doing their own self-breast exams. If they have not been doing self-breast exams, then I encourage them to go home after the appointment and begin to do so on a monthly basis."

Innovative Solutions to Support New Moms

ETSU Health has developed several novel protocols to care for new moms during and after pregnancy. The team hired an area lactation consultant, and all women participate in a prenatal "feeding" consult. The appointment is called a feeding consult to prevent deterring women who aren't interested in breastfeeding and takes place at 28 weeks gestation while women are in the office for their one-hour glucola test.

"This way, we equip women with the proper expectations if they want to breastfeed and try to identify any obstacles that they may have prior to their delivery," Dr. Carter said. "This has allowed lactation to transition from being only a 'rescue' role to a 'preventive and educational' role. We are already seeing great results, and the feedback from patients has been outstanding."

After delivery, women's postpartum checkups are automatically scheduled for two weeks after birth, helping to ensure all women have their postpartum visit within seven to 84 days. During these appointments, the team looks for any possible mental health concerns, provides blood pressure checks and lactation support, and addresses other health needs.

Moving forward, the ETSU Health team plans to continue innovating and developing new ways to provide even more support for new and expecting moms.

"Prior to COVID-19, we were looking at doing some group prenatal care, especially for some specific groups of patients that could benefit from the support of being in a group," Dr. Carter said. "Unfortunately, many great ideas have been placed on hold, but I look forward to revisiting them soon!"

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– Ginger W. Carter, MD, OB/GYN Clinical Director at ETSU Health

A Clinical Focus

Helping Women Focus on Their Health

While women are often focused on taking care of others, it's important to encourage your patients to make their health a priority and take care of themselves. Women of all ages should have an annual wellness check with their primary care provider. This is a good time to:

- Monitor BMI
- Check blood pressure, with a goal of maintaining 139/89 or less
- Check for adult immunizations that might be needed, such as the flu shot
- Check cholesterol levels to see if statin medications are needed
- Screen for depression
- Ensure refills are given and prescriptions are being filled
- Order recommended screenings as appropriate for age and risk factors

If you would like copies of the BlueCross BlueShield of Tennessee Comprehensive Women's Preventive Health Screening Guides for your BlueCross patients, contact the Commercial Quality Improvement team at **gm_commercial_quality_improvement@bcbst.com.**

Women's Recommended Screenings

At minimum, women should have the following:

Sexually active women 16-24

- Chlamydia screening every year through a urine test or cervical cell sample

Women 21-64

- Cervical cancer screening
  - Age 21-29 – Pap screening every three years
  - Age 30-64 – Pap screening every three years; high-risk human papillomavirus (hrHPV) test every five years or co-testing with both the Pap test and the hrHPV test every five years

Women 50 and older

- Mammogram for breast cancer screening at least every two years
- Colorectal cancer screening of some type. Although a **colonoscopy every 10 years** is the gold standard, other options include:
  - Sigmoidoscopy – every five years
  - CT colonography – every five years
  - Fecal immunochemical DNA test (FIT – DNA) – every three years
  - Fecal (stool card) test of fecal immunochemical test (FIT) – every year

Women 18-75 with diabetes should also have:

- Hemoglobin A1C test with a goal of 7.9% or less
- Retinal eye exam each year
- Kidney screening tests (eGFR and UACR)
- Prescription for statin medication
  - Guidelines recommend statins starting at age 40. Statins for persons younger than 40 would be based on additional risk factors.

Women who are pregnant need the following in addition to all other visits/screenings:

- A documented visit during the first trimester
- A documented follow-up visit between seven and 84 days after delivery

Best Practices and Tips for Closing Gaps in Care

Coding and Attestations

Accurate coding is key to ensuring you get credit for the quality work you do. Make sure you confirm that all diagnosis codes, procedure codes and applicable modifiers have been listed on the claim form and submit it as soon as possible. You can find a list of the most common sample codes here in our 2021 Commercial HEDIS® Measures Guide.

Submitting attestations within our Quality Care Rewards (QCR) application is another great option to close gaps in care. But, make sure you follow these guidelines:

- Never attest to a screening, wellness visit, or gap closure that hasn't yet occurred.
- Include documented proof within the chart that what you're attesting to has already taken place.

General Documentation Errors

Some examples of documentation that won't close gaps in care include:

- Documentation of a patient's refusal of a test or screening
- Only including the date due, ordered, scheduled, etc. without documentation that the test or screening was completed
- Noting only that the screening is "up to date"
- Documentation of "patient reported"

Frequently Asked Questions

Q. Can I submit an attestation to close a gap in care if there's a doctor's order on file for the test?

A. No, you must have a documented date and result from when the test was completed in order to submit an attestation.

Q. Are charts sometimes audited by BlueCross to look for validation of attestations made?

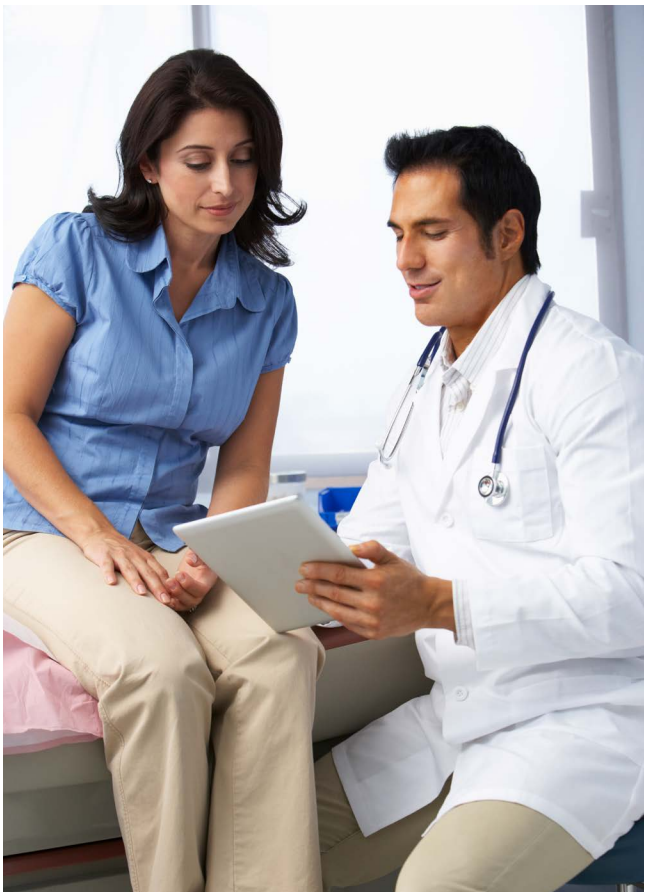
A. Yes, especially during our annual primary source verification audit.

Q. What should I do if I submit an attestation in error?

A. Notify us as soon as possible.

Q. Does a patient's refusal to get a screening or test exclude them from the HEDIS measure?

A. No, refusal doesn't exclude a patient so the gap will remain open.



Q. How do I find out what exclusions are acceptable for certain measures?

A. Exclusions are very specific, and are listed in the Commercial Measures Guide and in the QCR application for applicable measures. If you have questions, please contact one of our team members to discuss.

Tips for Measures Related to Women's Health

Breast Cancer Screenings

Patients must have a documented history of having a bilateral mastectomy to be excluded from this measure. The left and right sides can be completed on different dates, but both must be documented. Biopsies, ultrasounds, and MRIs will **not** close the gap in care because they're considered a diagnostic tool instead of a preventive screening tool.

Documentation

- Documentation in the chart should include **both the date and result** of the mammogram.
- The following documentation is not acceptable, and won't close the gap in care:
  - Using date ranges such as "mammogram 1-2 years ago".
  - Indicating only the year for 2019 mammograms (For 2021, it must show completion was in October 2019, or later).
  - Documentation of only "mastectomy" isn't acceptable. It won't meet the intent of the exclusion unless it's documented as bilateral.

Cervical Cancer Screenings

Patients must have a documented history of having their cervix removed to be excluded. For example, you can document as a “total” or “complete” hysterectomy, cervical agenesis or no residual cervix. Biopsies will **not** close the gap in care because they’re considered diagnostic and not valid for primary cervical cancer screening.

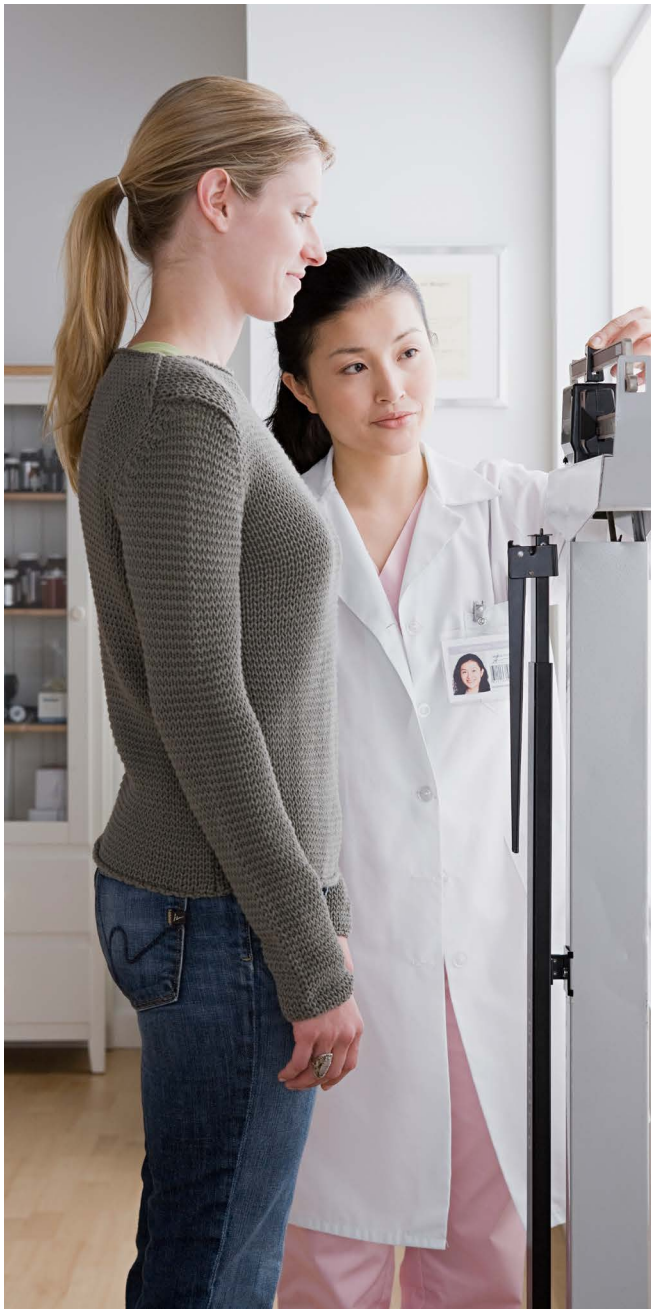
Documentation

- Documentation in the chart should include **both the date and result** of the test.
- The following documentation is not acceptable, and won’t close the gap in care:
  - Notation of only “hysterectomy” unless there’s chart documentation as listed above for “total” or “complete” hysterectomy.
  - Date ranges, such as “cervical cancer screening within the last two years”.

Chlamydia Screenings

Screenings must be specific to chlamydia testing. Cervical cancer screenings don’t close this measure. Patients are identified as needing this screening if they’re determined to be sexually active, which includes:

- Patients who receive a pregnancy test
- Patients who were dispensed a prescription for contraceptives during the measurement year, regardless of the diagnosis for which they were given



There is an exclusion for patients who had a pregnancy test and were prescribed and filled a retinoid medication, or had an X-ray, within six days following the pregnancy test.

The Importance of Coding to the Highest Specificity and its Impact on Patient Quality

A Conversation with Samuel Breeding, MD, Chief Medical Officer of Holston Medical Group

Holston Medical Group has successfully put measures in place to help ensure their physicians are diligent in capturing the highest specificity of ICD-10 codes for chronic conditions in their patient records. In a recent conversation with Dr. Breeding, he answered our questions about the importance of proper coding, and shared suggestions on measuring accuracy and training physicians.

How does coding to the highest specificity benefit patients?

Dr. Breeding: Stratifying patients according to chronic conditions helps us take better care of our patients. One way we do that is by encouraging our providers to be specific in the diagnosis codes they are selecting so we know the full extent of the condition of the patient. As physicians, we need to remember codes aren't just for *our* records, but for any other provider who is taking care of this patient. Some patients are seeing three to five doctors and clear communication between those providers is critical. When you code more specifically, another doctor would understand how to adequately treat the patient. If you have a generic code, and aren't listing any complications, it changes your mindset on how you treat the patient.

Here's an example we encountered. A patient's records included a code for diabetes without complications. There was also a diagnosis for malnutrition. The patient had been given a prescription for Metformin and Ensure®. Upon further investigation, we saw that the patient had chronic kidney disease, stage 4, which means that Metformin isn't the best medication choice, and they should be using Glucerna® and not Ensure as a supplement. This shows why you should link any complications to a diabetes diagnosis.

Before we began using E/M codes, our notes were only for us. But in 1995, notes became like an invoice requiring more complete documentation. This changed the way we do things. Then in 2004, we started thinking about risk adjustment.

Which conditions do providers have the most difficulty with?

Dr. Breeding: Definitely diabetes with complications, depression codes, and

obesity with BMI of 35-39.9. You must put a complication with it before it counts as morbid obesity.

Do you have any tips about including diagnoses that might seem too personal to a patient?

Dr. Breeding: When we first began adding these diagnoses to our own notes, there was the thought that patients may be concerned with seeing some of them – like morbid obesity. Patients would comment that they weren't morbidly obese or that they weren't depressed. Some physicians were reluctant to include this information. Our providers use this as an education opportunity and explain to the patient that the term "morbid obesity" is based on a BMI number and diagnosing this condition is important because obesity can create other health problems. Then, the education around improving that BMI occurs.

I ask our doctors if they're talking to patients about losing weight, for instance. This is a good opportunity to talk to patients about the other risk factors they have. Education is important and doesn't always have to be done by the provider. For instance, we have a PharmD that can educate on medications and provide a lot of diabetic education. If they have chronic kidney disease, we can send them to a nephrologist for specific education.

How do you measure progress of coding to the highest specificity?

Dr. Breeding: We have a very robust analytics team. They provide us with reports to see how our physicians are coding. We look at it annually to see if there are trends. For instance, are there more codes as diabetes without complications than with complications? We look for morbid obesity and depression. We're also running reports looking at any *unstaged* kidney disease. If the codes are wrong, we can submit a corrected claim. Knowing the conditions that our patients have helps us better plan and prepare for treatment opportunities and development of new service lines.

Do you have any suggestions for new physicians out of residency?

Dr. Breeding: We have sessions with new providers on Hierarchical Condition Categories (HCC) and E/M coding. Medical school doesn't really prepare physicians for this aspect of practice, so we focus on coding education. We help them understand the importance of clearly reflecting the conditions the patient has in the notes. We also provide and encourage coding education that's specific to their specialty.

For new doctors, I always recommend the first CME course they take be a coding course. It helps their practice, and it helps their patients. We encourage all physicians to code all HCC codes the first time they see the patient each year. Who knows when you might see them in the office again? This past year is a good example of what can happen.

We've also taken it a step further by encouraging several providers to either become certified in coding or take courses specific to their specialties. It's so important. The physician is the only person who really knows what's going on with the patient in the exam room and if they don't document and record those conditions, accurate coding can't occur.

Medical Home Partnership (MHP) Care Coordinators Move to Digital Platform

BlueCross uses Wellframe, a third-party vendor, to provide a digital resource that supports patient health. MHP care coordinators will soon be using this platform, giving them the ability to contact BlueCross members and answer their questions when it's convenient for them.

The new platform, CareTN, will first be used for commercial members with a diabetes diagnosis. As the team becomes more familiar with the tool, other conditions may be added. CareTN is available for Commercial members, except those in the Federal Employee Plan (FEP) or BlueCard members.

CareTN offers your patients:

- Chronic condition education
- An easy way to contact their care coordinator with questions about their health
- A daily list of simple reminders, short articles, and videos relevant to their health needs and diabetes
- A convenient place to find information on helpful topics that can be reviewed at their own pace

MHP care coordinators will call members to offer the CareTN application – starting with those in the Diabetes Care Program. Care coordinators will check the Wellframe dashboard at least daily and will address any alerts, insights or messages within two business days – during normal business hours, Monday through Friday.

Protecting Preteens from Serious Diseases

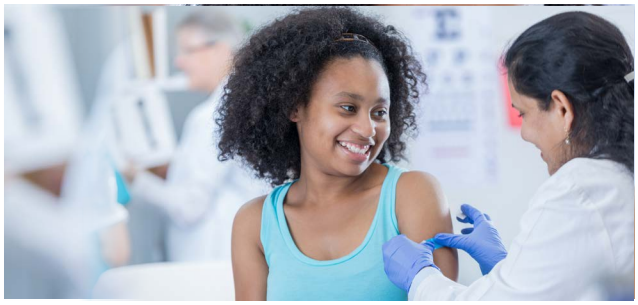
Vaccines to Get Them Ready for School

All preteen boys and girls need vaccines to protect them from serious diseases, including meningococcal disease, whooping cough, and cancers caused by the human papillomavirus (HPV). According to the Centers for Disease Control and Prevention (CDC), clinician recommendation is the number one reason parents decide to vaccinate. This is especially important for the HPV vaccination.

Most preteens will need to provide an updated vaccine record when it's time to go back to school. So, this is great time to remind parents.

The CDC, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the National Association for School Nurses (NASN) all agree that preteens need the following vaccines:

- **Meningococcal vaccine** – protects against bacteria that can cause infections of the lining of the brain and spinal cord, and the bloodstream. Preteens should get the first dose of the meningococcal conjugate vaccine at age **11 or 12** with a **booster dose at age 16**.
- **HPV vaccine** – protects both boys and girls from future infections that can lead to certain types of cancer. All **11- and 12-year-olds** should get **two doses of the HPV vaccine 6 to 12 months apart**. According to the CDC, this vaccine could prevent more than 90% of the cancers caused by HPV from ever developing. Getting vaccinated on time protects preteens long before ever being exposed to the virus.
- **Tdap vaccine** – protects against tetanus, diphtheria, and pertussis. Preteens should get **one dose of Tdap at age 11 or 12**.



Tips for Immunization Success

- **Make the recommendation** for vaccines and mention the HPV vaccine on the same day, and in the same way you recommend others. For example, "John is due for his vaccinations to help protect against meningitis, HPV cancers, and whooping cough today."
- **Establish office workflows and standing orders** that include regular checks on immunization records, placing calls or sending letters to remind families about getting vaccines, and incorporating vaccines into well-child visits.
- **Maintain open communication** with parents and their preteens so that they will feel comfortable discussing their vaccine questions.
- **Motivate positive vaccine decisions** by having posters and educational materials displayed and available in the office.
- **Educate, educate, educate** by using resources from the CDC, the local health department, and BlueCross to help inform parents on the importance of these preteen vaccines.

You can find more information on adolescent vaccines at cdc.gov/vaccines.

Well-Child Care Offers a Healthy Start for Tennessee's Kids

Routine checkups are important at every age, but these visits can be especially important for newborns and young children. At these appointments, you have an opportunity to administer needed immunizations, make sure children are hitting developmental milestones, and quickly address any questions or concerns.

All children covered by BlueCare Tennessee are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits on the same schedule recommended by the American Academy of Pediatrics. During their first year of life, babies should see their provider at:

- 3-5 days after birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months (1 year)

To help new parents stay on track with these visits, consider scheduling all first-year visits during the first newborn appointment three to five days after birth. This keeps a path of preventive care in place, even if one visit is missed.

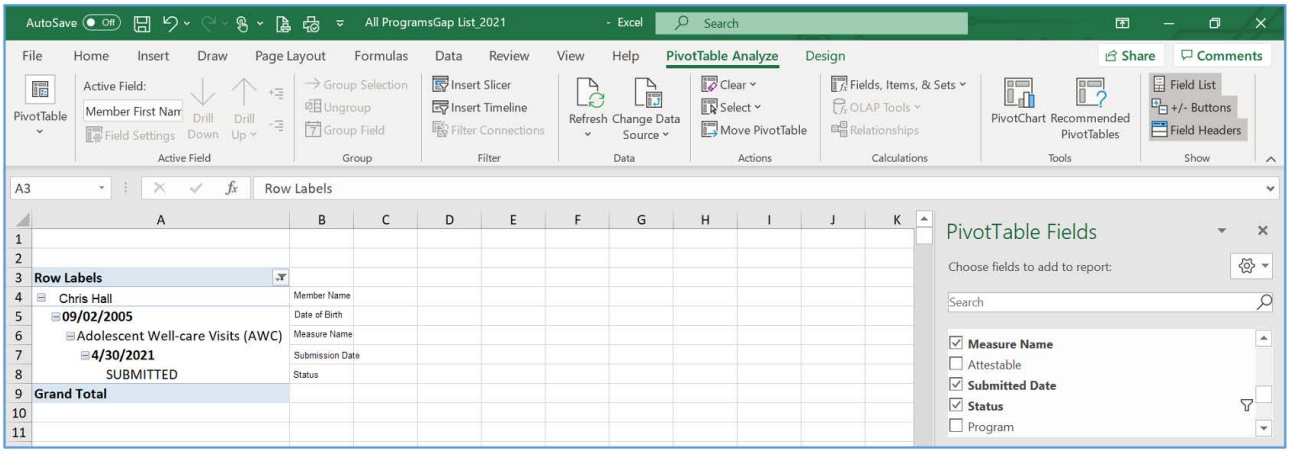
For more helpful tips about well-child care, including best practices and coding information, see our TennCare Kids Tool Kit.

QCR Tips

How to Monitor Attestation Submissions

You can view attestations that are closed each day by looking at the gap export report. To begin, follow these steps:

- Select the quality program in the QCR application.
- Then, click on the Gap List Export.
- Next, click on the non-compliant gap list worksheet.
- Insert a pivot table and check the box next to the desired pivot table fields. *Note: The pivot table will be created based upon the order in which you select the pivot table fields.* Selecting the Submitted Date and Status pivot table field will show when attestations were submitted.



Information is updated within the QCR by the following:

- Measure compliance, both open and closed, is updated weekly during a refresh of QCR data.
- As your attestations are submitted, the status shows as Submitted. *Note: follow steps above to track attestation progress within your practice*.
- Some attestations could be updated to Reconciled if a claim is received during the weekly refresh.

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