Welcome to Issue 9 of Harry's HEDIS Hints!
The second round of HEDIS data is out and we have some good things to share. Most scores have gone up since the end of the first quarter. We would like to especially congratulate Crossroads Mission, Marana Health Care and El Rio Health Care Center for scoring 100% in the Adult Access measure, Helping Associates for scoring 100% in the 7&30 Day Follow Up After Hospitalization measure and the 7&23 Day Access to BHP measure. If you have any insights to share regarding how you absolutely smashed the MPS, please feel free to share.

Additionally, a number of agencies met or exceeded MPS on many measures. The following agencies met or exceeded MPS for the measure 7&30 Day Follow Up After Hospitalization: Community Bridges, COPE, Crossroads Mission, Corazon, Empact, Helping Associates, HOPE and Pasadera.


Helping Associates and Pasadera exceeded MPS for HbA1c screenings.

Almost everyone met or exceeded MPS for Adult Access to Preventive Care with the exception of Community Bridges, Horizon Health and Wellness and Pasadera.

A shout out to all of you! Looking forward to seeing your scores continue to improve!
Integrated Health Information Exchange (HIE)

Healthcare information sharing between healthcare professionals is vital to providing safe and effective care for patients. Poor communication and failure to exchange patient healthcare information leads to an increase in errors in care and treatment decisions. The use of electronic healthcare information sharing allows for healthcare providers to access a patient’s health records when and where it is needed, particularly during emergency care. Health Information Exchange (HIE) is the electronic mobilization of healthcare information that permits doctors, nurses, pharmacists, other health care providers to appropriately access and securely share a patient’s vital medical information.

The Network, Operated by Arizona Health-e Connection (AzHeC), is Arizona’s non-profit statewide integrated HIE platform. The Network includes both physical and behavioral health information by linking physical health providers and behavioral health organizations across the state through a single connection. A broad integrated HIE like The Network improves the speed, quality, safety and cost of patient care by providing physical and behavioral health professionals a more complete look at patients’ healthcare needs.

Key services of The Network include:

- **Bidirectional Exchange** – the access and exchange of patient health information
- **Alerts & Notifications** – a service that sends real-time alerts of patient ED registrations, inpatient admissions, discharges and transfers, or notifications of patient lab and radiology results
- **Provider Portal** – a web-based portal that allows access to patient records
- **Payer Portal** – a web-based portal that allows access to beneficiary health records
- **Public Health Reporting Gateway** – an electronic gateway to submit state and federally required public health information from certified EHR systems
- **Direct Secure Email** – a HIPAA-compliant, encrypted application that enables secure messaging between providers for sending and receiving referrals, simple clinical messages and test results
- **eHealth Exchange** – a secure electronic exchange of patient information via the national eHealth Exchange network, enabling the access and sharing of patient records with HIEs in other states and federal agencies such as the Department of Veterans Affairs
- **Data Types** – allows for the review and distribution of data types such as diagnostic results and reports, immunizations, medications, procedures, vital signs and many more

The Network platform is growing quickly and recently surpassed the enrollment of 100 participants. AzHeC is working closely with the Arizona Health Care Cost Containment System (AHCCCS) to increase statewide participation by community providers. As part of an overall effort to incentivize participation in The Network, they have **eliminated the provider participation fees for all community providers, including behavioral health providers.**
Below are some of the community agencies already participating in The Network:

- Assurance Health & Wellness
- Cenpatico Integrated Care
- CODAC Health Recovery Wellness, Inc.
- Community Bridges, Inc.
- ConnectionsAz
- Crisis Preparation & Recovery, Inc.
- Crisis Response Network
- Horizon Health and Wellness
- La Frontera - Empact
- Southeastern Arizona Behavioral Health Services, Inc.
- Southwest Behavioral Health Services
- Touchstone Behavioral Health
- Desert Senita Community Health Center
- El Rio Community Health Center
- Marana Health Center

A complete list of up to date participants can be found by clicking here. http://www.azhec.org/?page=Network_Participants.

AzHeC offers a lunch and learn webinar, “The Network Services, Fees & Live Demo”, which allows attendees to learn about the features of The Network and watch a live demo of its capabilities. Upcoming webinar dates include:

- Thursday, May 19, 2016          12:00PM - 1:00PM
- Wednesday, June 22, 2016     12:00PM - 1:00PM
- Thursday, July 21, 2016          12:00PM - 1:00PM

To learn more about The Network or if your agency is interested in becoming a participant, contact at thenetwork@azhec.org, call (602) 688-7200 or visit http://www.azhec.org/?page=Network_Srvs

### The Network by the Numbers

<table>
<thead>
<tr>
<th>ACTIVE PARTICIPANTS</th>
<th>105</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNIQUE PATIENTS (in millions)</td>
<td>5.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSACTIONS AT A GLANCE</th>
<th>PAST 12 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ALERTS &amp; NOTIFICATIONS</td>
<td>$303,907</td>
</tr>
<tr>
<td>2. LABORATORY RESULTS</td>
<td>$29,724,733</td>
</tr>
<tr>
<td>3. RADIOLOGY RESULTS</td>
<td>$2,479,205</td>
</tr>
<tr>
<td>4. CLINICAL REPORTS</td>
<td>$6,687,713</td>
</tr>
<tr>
<td>5. ADT TRANSACTIONS</td>
<td>$35,521,656</td>
</tr>
</tbody>
</table>

### Key Terms and Definitions

- **AzHeC**: Arizona Health-e Connection
- **Active Participant**: A health care organization or provider with an executed participation agreement enabling active contributions and/or consumption of Network data
- **ADT Transactions**: Admissions, discharges or transfers from a hospital
- **CMS**: The Centers for Medicare and Medicaid Services
- **EHR**: Electronic Health Record
- **HIE**: Health Information Exchange
- **ONC**: The Office of the National Coordinator for Health IT
- **The Network**: Arizona’s statewide HIE, operated by AzHeC
- **Unique Patient**: An individually identifiable patient or beneficiary with clinical data in The Network
Focus on Improvement

The latest HEDIS results are out and have been distributed! Overall scores have increased since Q1, which is excellent. Plans and processes that have been put in place are bearing fruit and the prospect of continuous improvement for the remainder of the contract year is exciting.

Keeping this in mind, there are ample opportunities to continue to improve and Cenpatico-IC would like to assist agencies as much as possible. A non-compliant list for each ICCA is distributed monthly, identifying members who are in need of specific services. This list can be used in a variety of ways. CODAC is loading this information into their EHR to ensure members’ health needs are easily identifiable and are addressed in a timely fashion. La Frontera is looking to connect assigned clinic location and RC/DRC to each member. By doing this, the agency can look at non-compliance as it relates to specific staff and locations. Discovering patterns in care gaps can reveal opportunities for improvement.

The geographic distribution of non-compliant members may reveal important information impacting how an agency can approach change. This approach can identify if a specific location has a lower engagement in preventive services. Looking into performance by prescriber, recovery coach or team can also be impactful in moving the needle. Creative interventions for healthcare delivery will pay off by decreasing ED visits, inpatient utilization, as well as aiding to extending the lifespan of our members.

If an agency has members with diabetes who have not had an HbA1c test done in the past year, look at root causes. Issues could be related to location, transportation or difficulty in motivating members to manage their diabetes. Managing long term health conditions like diabetes can be very difficult for our members. Sources cite that trouble accepting the diagnosis of diabetes, aversion to getting bad results and ‘diabetes burnout’ all impact members’ willingness to engage in services. Are members just disengaged from dealing with diabetes? Diabetic education classes/groups may help to re-engage them. Getting members in for classes can also be problematic. If there are medical service providers on-site, a ‘diabetes clinic’ day could provide the services members need with the smallest impact on their time. A number of health plans have had success combining services on-site for members at a health fair. The fairs can provide HbA1c testing, lab work, flu shots, nutritional counseling and diabetic education in one event.

Referrals for services not provided by the ICCA or PCP can be intimidating and frustrating. Ensuring staff understand the process and are able to communicate it clearly to members is integral to success. If a member is diagnosed with diabetes, they need to be referred for an eye exam to check for retinopathy annually. Staff at each agency must be able fully assist the member in following up with this requirement. This may include explaining the process, assisting the member in scheduling the appointment, arranging for transportation and discussing other concerns or needs the member identifies.
Focus on Improvement

For staff new to or not comfortable with integrated care services, CODAC has instituted a program which aims to increase staff comprehension of integrated care. Staff meet with a Population Health Administrator for 30-60 minutes to explore health topics and to increase confidence with integrated care topics. Staff support and education can have an immediate impact on services.

Flu shots can be one of the hardest measures to impact. Since all of our Integrated Care members qualify for the flu shot, the denominator is the total Integrated Care population. For measures like this, impacting rates is more difficult and it requires assessing barriers to flu vaccine acceptance. Flu education for both members and staff is key to understanding the importance of the flu shot. Staff behaviors and perceptions can have a great influence on members. Member acceptance of the flu vaccine may also be enhanced by offering alternatives to injection with the inhaler nasal vaccine.

Members diagnosed with diabetes, asthma, heart disease, and compromised immune systems are at a higher risk for complications from the flu. Obtaining a flu shot each year can prevent both the flu and higher risk complications from the flu such as pneumonia, congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD), helping our members to have healthier lives.

Our goal is to provide impactful information to help our system improve the lives of our members. We hope the ideas above get you thinking! In closing, it should be noted that the creativity demonstrated in the Biannual PHA Projects was amazing. Continuing to pursue that level of creativity will have the most impact on progressive system improvement.
Is your ICCA ready for Timely Prenatal/Postpartum Care (PPC) Hybrid Measures HEDIS 2016?

Hybrid measures allow for medical records review in an attempt to increase the ICCA compliance in the measure. This means that each ICCA can directly impact their own HEDIS scores for this measure. It is important that the ICCA Population Health Administrator (PHA)/Quality Director be familiar with the elements of this measure. For a quick reference Harry’s HEDIS Hints, Issue 2, contains guidance on this measure, the MPS and the Goals. Keep in mind that Cenpatico-IC will be utilizing the AHCCCS Contract Year of 10/01/2015 through 09/30/2016 for the PPC Measure 2016.

**Timeliness of Prenatal Care:**

**Documentation:** The medical record must have date of service (a prenatal care visit as a member of the organization in the first trimester of pregnancy or within 42 days of enrollment in the organization) and ONE of the following:

- A basic physical obstetrical exam that includes auscultation (listening) for fetal heart tone OR
- Pelvic exam with obstetric observations OR
- Measurement of fundus (top portion of the uterus) height (as it rises above the pubic bone)
- Evidence that a prenatal care procedure was performed such as:
  - Screening test in the form of an obstetric panel (which must include all of the following: hematocrit, differential WBC count, platelets, Hepatitis B Surface Antigen, Rubella Antibody, Syphilis, RBC Antibody screen, RH and ABO blood typing) OR
  - TORCH Antibody panel alone (the blood tests in the TORCH panel are Toxoplasmosis, Rubella, Cytomegalovirus (CMV) and Herpes simplex virus (HSV), OR
  - A Rubella Antibody test/titer with RH Incompatibility Blood Typing OR
  - Echography (ultrasound) of a pregnant uterus
- Documentation of last menstrual period (LMP) or estimated date of delivery (EDD) in conjunction with either of the following:
  - Prenatal Risk Assessment and Counseling/Education OR
  - Complete obstetrical history

**Exclusions:** No prenatal care visit as a member of the organization in the first trimester of pregnancy or within 42 days of enrollment in the organization
Is your ICCA ready for Timely Prenatal/Postpartum Care (PPC) Hybrid Measures HEDIS 2016?

**Postpartum Care:**

**Documentation:** Must include the date of service (must be on or between 21 and 56 days after delivery) and **ONE of the following**:

- A pelvic exam **OR**
- Evaluation of weight, BP, breasts and abdomen (notation of “breastfeeding” is acceptable for evaluation of breast component), **OR**
- Notation of "postpartum care, including but not limited to: “Notation of “postpartum care”, “PP care,” “PP Check,” “6 week check”

**Exclusions:** Delivery did not result in a live delivery or birth. Examples are still birth and miscarriage, or the delivery occurred outside the valid time frame

**The Process:**

The initial PPC Non-Compliant List will be generated and sent via [SECURE] email no later than May 16th, 2016, and quarterly thereafter to each ICCA PHA or Quality Director notifying them of their assigned members who made it into the denominator of the measure but not the numerator (non-complaint with the measure)

- If the member’s name appears on the non-compliant list - medical records will be required
- If requested medical records are not on file at the ICCA, the ICCA is responsible to obtain the requested medical records from the member’s PCP, OB/GYN, or provider office
- Send the records [SECURE] email or fax them **within 10 days** from the Cenpatico-IC original request for medical records, per AHCCCS AMPM Chapter 900, Policy 940-7.d.xv
- Fax medical records to Cenpatico-IC at fax #844-870-6493, attention Vanessa Zuniga, LPN, HEDIS Specialist for inclusion into the measure, or [SECURE] email to vzuniga@cenpatico.com with a CC: copy to jneedham@cenpatico.com
- If requested medical records have not been received within 10 days a follow-up call will be made to the PHA / Quality Director for a follow-up discussion and to set up an appointment for the HEDIS Auditor to visit the office for a chart audit
- Cenpatico-IC is the insurance health plan for these members. Per Federal Guidelines 45 CFR 164.501, the information requested is intended for Health Care Operations and no health insurance release is necessary

**Best Practices/Key Points:**

- **Prenatal:** The American Congress of Obstetricians and Gynecologists (ACOG) form is used by most practitioners to document the progression of the pregnancy, including prenatal visit date of service, fundal height and/or auscultation (listening) of fetal heart rate. The easiest way to meet the measure is to request the ACOG form. A PCP visit must have a diagnosis of pregnancy to count as a prenatal visit. Ultrasound and/or labs alone, or a PAP test done alone, should not be considered a prenatal visit. If more than one estimated date of delivery (EDD) is provided – obtain the EDD closest to the delivery.
- **Postpartum:** Postpartum visits are almost always identified at the top of the ACOG form. A single postpartum visit within 21-56 days meets the requirements of the measure.
Q. **How are member months calculated for HEDIS utilization measures?**

A. Cenpatico Integrated Care (Cenpatico-IC) HEDIS member month calculations are made by NCQA certified software that approximates the HEDIS methodology based on AHCCCS specifications, so they are not exact. Cenpatico-IC Quality Improvement suggests ICCAs focus target interventions and measurement of progress using their own utilization rates as a point of reference.

A few things to keep in mind: the HEDIS Emergency Department (ED) Utilization measure and the Inpatient (IP) Utilization measure will be reported as per 1,000 member months. The balance of the HEDIS Utilization measures will continue to be reported as per 100,000 member months.

The HEDIS software calculates member months for the entire year based on actual eligibility of members in the month reported, including members that may no longer be active but are still open. Also, eligible members are assumed to be continuously active for the remaining 12 months of the contract. The HEDIS calculation of member months is the count of members eligible in the month x 12. For example, the Q2FY2016 count of eligible members is 13781.75. Member months is calculated as 13781.75 x 12 = 165381.

An example of the calculation of ED utilization using the count of ED visits/ member months * 1000 is: In Q2FY2016 the ED visit count is 3,559.

**ED Rate:**

Numerator = ED visit count *1000  
Denominator = member months * 12

\[
\frac{3,559 \times 1000}{13781.75 \times 12} = \frac{3559000}{165381} = 21.52
\]
Harry’s Health Highlights

**National Women’s Health Week is May 8-14**

The 17th Annual National Women’s Health Week kicks off on Mother’s Day, May 8, and is celebrated until May 14, 2016. The week serves as a time to help women make their health a priority and understand what steps they can take to improve their health.

http://womenshealth.gov/nwhw/

May 9 is National Women’s Check-Up Day. Regular Check-Ups are important and can help find problems before they start. Regular check-ups include screenings and services listed below according to U.S. Department of Health and Human Services, Health Resources and Services Administration:

- The following services are recommended annually:
  - Well-woman visits
  - Counseling for sexually transmitted infections
  - Counseling and screening for human immune-deficiency virus
  - Routine screening and counseling for interpersonal and domestic violence
  - Human papillomavirus testing is recommended beginning at age 30 ongoing every 3 years
  - Contraceptive methods and counseling as prescribed
  - Breastfeeding support, supplies, and counseling is recommended in conjunction with each birth
  - Gestational diabetes screening is recommended at 24 and 28 weeks of gestation and at the first prenatal visit for women identified to be at risk for diabetes

http://www.hrsa.gov/womensguidelines/

Women can receive check-ups with their PCP or by using this health center locator:
http://findahealthcenter.hrsa.gov/