Best Practice Resource Guide:

A Primary Care Practice's Guide to Best Gap Closure Strategies

Population Health 2023

Independence

Table of Contents

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Independence Blue Cross (Independence) is deeply committed to helping practices improve the care that you, as a provider, deliver to our members. As part of this support, we developed this reference guide to supplement your current processes and help you achieve your goals on quality performance scores in the Medicare Advantage Five-Star Quality Rating Program (Stars Program) and the Quality Incentive Payment System (QIPS) program.

Section 1: Introduction

Independence Population Health Team Overview

The Population Health Team is a group of professionals with training in population health who act as your point of contact to assist with quality improvement. We collaborate closely with primary care practices across our network to improve the health and well-being of our members and community.

Section 2: Best Practices

General strategies

The following tips and strategies can help your practice close gaps in care and increase your quality performance management score:

- **Work as a team.** Teams with strong leadership by a practice physician who sets priorities for quality efforts tend to score the highest in Independence's incentive programs. Some efforts to close gaps in care can take a lot of time, so our advice is to build off small wins and track your increased performance over time.
- **Review performance, trends, and use Independence's resources.** Practices that create a member care routine in the office and educate staff on quality measures and care gaps tend to be more successful in closing these gaps. Here are a few suggestions on how to create a routine within your practice:
  - Identify physician and office managers to champion pay-for-performance programs and/or closure of gaps in care.
  - Educate office staff on how to use Independence's numerous resources and tools.
  - Prepare for a member's visit by identifying open care gaps.

Stay patient focused

High-performing offices understand the unique challenges of their member population. They recognize that a recommendation from a physician, certified registered nurse practitioner (CRNP), or physician assistant (PA) is a strong motivator to encourage members to seek appropriate screening and treatment. Clear information about the need for screenings, tests, and medications helps improve member engagement.

Below are several strategies that have been shown to improve access for members and to improve performance in preventive care measures across a practice population:

- Schedule the member's next visit before they leave the office.
- Create a tracking system to outreach members with follow-up lab work for those who have missed an appointment.
- Provide flexible hours and appointment times to members.
- Help schedule appointments for members with urgent needs or who may have difficulty scheduling appointments themselves.
- Refer members with complex needs to Independence Health Coaches.
- Be persistent and positive. It may take multiple outreaches and reminders for members to obtain care.
- Be proactive in identifying members who have not had a visit within a certain timeframe. Leverage the report titled, "Members with No Recent PCP Visit," in the Provider Engagement, Analytics & Reporting (PEAR) portal.
- Contact members to remind them of important services, such as cancer screenings.
- Create a telephonic campaign for scheduling appointments and discussing gaps in care.
- Send a follow-up letter on office letterhead to members you are unable to reach by phone.

Section 3: Reporting and Applications

Provider Engagement, Analytics & Reporting (PEAR) portal

The PEAR portal offers providers a single point of entry to access multiple digital tools. It was designed to connect providers quickly and securely to the plan information they need to deliver high-quality care. Through the various applications within the PEAR portal, providers can easily access the clinical and financial information specific to their provider organization and plan contracts.

Analytics & Reporting (PEAR AR) application

PEAR AR is essential to help manage your member population and improve your performance in the Stars and QIPS programs.

- **Financial Dashboard:** Under "Practice Financial Overview" on the PEAR AR home page, this real-time dashboard identifies your progress in reaching your QPM targets for QIPS measures, the potential earning opportunities available, and a detailed transaction check registry of all reimbursements made to your office.
- **Follow Up Items:** These can be found at the top of the PEAR AR home page. They can help identify members recently hospitalized, those currently hospitalized, those with recent Emergency Department (ED) visits, those behind in medication adherence, and those who are identified as high risk for hospitalization.

- **Gap Closure guides:** These documents provide measure-specific information on how to document the closure of gaps in care and are available on PEAR AR.

  To access the guides in PEAR AR, follow these steps:

  1. Go to the home page and click on the “i” (Information) icon at the top righthand corner.
  2. Select *Help & Feedback* from the drop-down menu and then the appropriate guide:
     a. The Adult Gap Closure Guide
     b. The Pediatric & Adolescent Gap Closure Guide
     c. The Advanced Illness and Frailty Exclusion Guide

Reports

The reports detailed below are accessible in PEAR AR throughout the year. You can print or download these reports as needed*. (Note: This is not an all-inclusive list of reports available on PEAR AR.)*

- **Gaps in Care Report** — identifies your open care gaps on a real-time, monthly basis.
- **RX Adherence and Usage Report** — provides detailed information on your members who are on maintenance therapy drugs for hypertension, cholesterol, or diabetes and their respective adherence to these medication regiments.
- **High-Cost Drug Report** — helps you identify the spend in utilization of all prescriptions given to your members and compares and evaluates if high-cost drugs are being prescribed.
- **Diabetes Report** — provides a list of members who have been diagnosed with diabetes, as well as specific information such as test results, medication treatment, and most recent specialist visits.
- **Members with No Recorded PCP Visit Report** — identifies Medicare Advantage and Commercial members with chronic conditions who have not visited your office in the past 12 months, based on claims or encounters, and provides information regarding visits to specialists, ED, or urgent care/retail health clinics.
- **Medical Cost, Utilization and Analytics Reports** — details the medical costs and utilization for your practice. You can access cost and total reimbursement for medical services incurred by your members.
- **Emergency Department (ED) and Urgent Care (UC) Visit Analytics Report** — identifies your members who had an ED or UC visit in a specified period. It provides insight into those visits that potentially could have been avoided.

Comprehensive Visit (PEAR CV) application

- Practices can earn incentives by utilizing PEAR CV. PEAR CV is a point-of-care application in which providers prepare for and accurately document member encounters, assessments, and treatment plans during a comprehensive encounter.

- **Best Practice:** Incorporate PEAR CV into clinical routines to enhance the value of every member encounter.
- **Enables quality member encounters:** Practices can use PEAR CV printouts with previously identified diagnoses and considerations for care to deliver high-quality encounters.
- **Promotes holistic member care:** PEAR CV's built-in logic produces past chronic diagnosis and screening considerations to enhance care coordination. It also displays member-specific quality measures to address preventive care and other clinical interventions. These elements of the CV form support a greater continuity of care when documenting the member's comprehensive encounter.

PEAR CV prompts providers to address non-medical concerns (social determinants) that could impact the member's health.

Practices earn incentives generated by attested assessments from the servicing provider. *(Note: a claim or an encounter submission is also required.)*

Using an EMR system

- Many electronic medical records (EMR) systems have existing or programmable features to support population health management. Practices should leverage the full suite of EMR system capabilities along with Independence's PEAR CV resources.
- Prior to a member's visit, the front office staff should check for gaps in care and place a "notification" on the member's chart to alert the physician/CRNP/PA.
- Practices should also use PEAR CV printouts with previously identified diagnoses and considerations for care to deliver high-quality encounters.
- Make the use of EMR preventive care pages mandatory. Use systematic leads to improve compliance.

Section 4: QIPS and measure specifics

Ideas to enhance your performance in the Stars and QIPS QPM Programs

The preventive services listed below are measures that are part of the Stars Program and/or the Quality Performance Measure (QPM) score program, which is a component of the QIPS program.

Two PEAR AR reports are excellent resources to review claims-based data on the current outcomes of your member population: the *Gaps in Care Report* and the *Rx Adherence and Usage Report.* These reports should be reviewed monthly, at a minimum. This will help your practice to track year-to-date performance and identify areas of opportunity.

Note: Some measures may have exclusion criteria that remove members from the population. Ensure proper coding by capturing these exclusions when applicable by using the Gap Closure Guides in PEAR AR.

Breast cancer screening

- Partner with local mammography screening sites to engage members and block appointment windows. Utilize local mammography van opportunities and book a date.
- Have standing orders for medical assistants to give members an order/script for

mammograms. No referrals are needed.

- Review the measure definition in the QIPS program guide and see if a member meets the exclusion criteria from the measure: bilateral mastectomies; two unilateral mastectomies.

Cervical cancer screening

Encourage all eligible members to see a gynecologist if exams are not routinely performed in your office. Partner with a gynecology office and obtain permission from the member for the gynecologist office to contact the member to set up the appointment. Request permission from the member to obtain the gynecological records. This will help to close gaps in care and ensure a more complete member medical record in your practice.

Colorectal cancer screening

For those members who are either reluctant or unable to schedule a timely colonoscopy:

- **Recommend an iFOBT or FIT test.** Some Independence members may be eligible for the iFOBT in-home testing program.
- **Work with your members to create reminders to complete the FIT or iFOBT tests.** Suggest placing the kit in the bathroom or nightstand for easier access and provide a deadline to perform the test.
- **Educate your members on the benefits of a colonoscopy.** Check the member's individual benefits to see if the member's plan requires any copayment and/or coinsurance.

Controlling blood pressure

Schedule regular visits with hypertensive members for continual assessment. For eligible Independence members, encourage them to visit a registered dietician.

Diabetic care tips

- Download the PEAR AR Diabetes Report to enhance care and identify care gaps.
- When submitting lab work requests, make sure to include both HbA1c and lab work specific to a complete Kidney Health Evaluation. For additional information, refer to the Adult Gap Closure Guide.
- Encourage eligible Independence members to participate in the diabetic in-home testing programs. Independence offers opportunities for providers to authorize in-home testing for our members through Labcorp.
- For members who had an eye exam in the prior measurement year, if the result is negative for retinopathy, use CPT® II code 3072F in the following measurement year.
- Explore purchasing a retinal eye camera and collaborating with an ophthalmologist for the professional interpretation.
- If a member has an eye examination in a setting that does not routinely send office notes (e.g., optometrist in the mall), recommend they obtain a copy of their visit notes when they have their next examination.
- Nephropathy is often missed because diabetics need a fasting specimen. Members wake, void, and then go to the lab where they are unable to produce a urine specimen. If

these members are identified as not having had a urine specimen, one can be obtained in the office.

- Make sure all members who have not had diabetic testing complete it as soon as possible. If there is no test result indicated, it is counted as a gap in control.
- For a member whose HbA1c is >8, the American Diabetes Association suggests the following actions:
  - Evaluate their medication adherence.
  - Suggest lifestyle and potential medication adjustments.
  - Consult with an endocrinologist.
  - Consult with a registered dietitian.
- Encourage members to remain adherent to their prescribed medications and/or statins by taking advantage of 90-day fills (if eligible for 90-day fills) and mail order.

Osteoporosis management in women who had a fracture

- Women ages 67 or older who have had a fracture should have either a DEXA scan and/or an appropriate prescription medication for the treatment of osteoporosis. Keep in mind, a recommendation for vitamin D or Calcium alone does not satisfy the quality measure for HEDIS® (Healthcare Effectiveness Data and Information Set).
- Do not recommend vitamin D and calcium treatments by themselves as this is not adequate to treat individuals who are high risk for another fracture (HEDIS).
- Please remember that it is important not to code history of a fracture with an ICD-10 diagnosis coding for a new fracture. This will place a member in the measure who should not be and may not need medication or imaging. If a historical fracture claim is submitted in error, follow the steps detailed in How to submit Claims Corrections to correct the claim.
- Consider using the Independence in-home program for bone density screening of Medicare Advantage members. Encourage members to register, or arrange, for in-home bone density screening if they do not wish to get the test done at a radiology site.
- Initiate drug treatment for osteoporosis as medically appropriate.

Statin therapy for members with cardiovascular disease or diabetes

- Use the *Gaps in Care Report* or the *RX Medication and Usage report* to determine which members with cardiovascular disease or diabetes have not filled a statin medication. *(Note: Members with cardiovascular disease need a moderate-intensity or high-intensity statin regiment in accordance with national guidelines.)*
- Encourage members to remain adherent to the prescribed statin by utilizing 90-day fills (if eligible for 90-day fills).
- Ensure members are not “potentially out of refills” by downloading the *RX Adherence and Usage report* from PEAR AR.
- Properly code members who are excluded from treatment. These exclusions can be found in the Adult Care Gap Closure Guide in PEAR AR.
- Use Independence’s preferred pharmacies because some pharmacies contract with our plan to offer lower cost-sharing to plan members. This is known as preferred pharmacy

cost-sharing. Members may fill prescriptions at either a preferred or standard pharmacy. Information regarding preferred pharmacies can be found in the Adult Gap Closure Guide. Mail order is also available.

Medication adherence (diabetes, hypertension, cholesterol)

- Use the *Rx Adherence and Usage Report* in PEAR AR to outreach to members who need to pick up their refills, need new scripts or are not adhering to their medication treatment. The Follow Up Items on the PEAR AR home page also lists these members.
- Identify pharmacy-based adherence solutions such as late refill calls, patient medication administration records, compliance packaging, prescription delivery, health/medication literature, and mobile apps/alarms.
- When possible, order a 90-day fill for members instead of 30-day fills.
- Leverage Optum mail-order options. Information regarding mail order is also available.

Transitions of Care

- Engage with members after inpatient discharge. This includes office visits, visits to the home, and telehealth within 30 days after discharge.
- Use the PEAR AR Follow Up functionality to identify these members. Additionally, leverage admission, discharge, and transfer alerts by partnering with HealthShare.
- Complete the medication reconciliation post-discharge. Review and compare the medication orders with the medication being taken on the date of discharge through 30 days after discharge (31 total days).
- Use CPT II Code 1111F to report medication reconciliation (also note the service in the member's chart).
- Follow up after an ED visit for members with multiple high-risk chronic conditions within seven days of the ED visit.

Childhood/Adolescent immunizations and well-care visits

Childhood immunizations:

- Make sure immunizations are completed in the recommended time frames. Review the measure definitions in the QIPS program guide.
- Download your *Gaps in Care Report* into Excel early in the year, then sort by age to identify those who will need vaccinations during the measurement year and outreach, when possible, to get members back on their 0–30-month well-visit schedule.
- Schedule the next routine immunization appointment when the member and family are on site (current visit). Consider prescheduling the entire well-visit set in advance if office staff can work with parents.

Adolescent immunizations:

- Having strong scheduling and return-to-office practices are important during the adolescent years to make sure members complete their vaccines on schedule. Consider treating the 9–13-year visits in a similar manner to 0–30-month visits by making efforts to reach members without a scheduled well-visit and prescheduling on check out.

- Download your *Gaps in Care Report* early in the year into Excel, then sort by age to identify those who will need vaccinations during the measurement year.
- It is strongly encouraged to consider beginning the HPV vaccine series at 9 years old. This process has resulted in improvements in overall completion of the series within the recommended time frame.

Well-care visits

- **Well-child visits in the first 15 months of life.** Most high-performing offices utilize EMR scheduling systems to pre-calculate the first patient's birthday + 90 days so that an appointment for the last of the six visits is not made one or two days after this date. This will help ensure the sixth visit occurs before the second birthday.

- **Well-child visits in the third, fourth, fifth, and sixth years of life.** Prepare a "master list" in the beginning of the year and track when these children come in for a visit. This will help you know (as needed) which members still have not had their yearly visit. It is also helpful to leverage the through December claims data *Gaps in Care Report* to identify who was not seen for well-care visits in the prior year.

  The *Attributed Member Snapshot* (AMS) report can also be leveraged at the beginning of the year to identify the member's last well-care visit. This supports any efforts of targeting those members who may wait a full year to see their PCP again.

- **Adolescent well-care visits.** Maintaining high rates of adolescent well-care visits is often challenging. Offices that perform well often have processes in place to track which members are behind on well-care and take advantage of opportunities like outreach lists, using telephonic interactions as opportunities to schedule well visits, and flipping sick to well visits when it can be done.

Well-care visits must be coded with either a well-care visit CPT or ICD code to meet the closure requirements. If a sick visit and a well-care visit are completed on the same day, the well-care visit should be coded first.

Scheduling a follow-up visit prior to the member leaving the office after a sick visit and turning any follow-up visits to a well-care visit may also support this gap closure.

Well-care visits must include documentation of "growth and development" and age appropriate "anticipatory guidance." Offices often have check lists by age group not only as a reminder of what should be included, but also to improve documentation.

Continue to leverage our calendar year coverage flexibility. Ninety percent of our plans cover well-care visits on a calendar year basis that allows members and families to come in for a well-care visit at any point in the new calendar year instead of waiting 365 days before seeing their pediatrician again. Take the appropriate steps by checking calendar vs. contract year coverage in the PEAR Practice Management application.

Section 5: Appendix

Resources

We also provide the following resources to help your practice close gaps in care and increase your quality performance management score.

- **The Gap Closure and Advanced Illness/Frailty Guide.** Leverage this document on the PEAR portal to assist with coding guidelines and exclusions.

- **QIPS Resources (ibx.com).** The QIPS Resources page, on the Provider News Center, provides you with all the QIPS news you need to know, including deadlines, new measures, available resources, alerts, guides, manuals, etc. We encourage you to bookmark this page and check it frequently.

- **The QIPS Quality Performance Measures (QPM) feedback process.** The QPM feedback process is your annual opportunity to provide information to close gaps in care that may not have been received through claims in the measurement year. The information you provide that closes a care gap will be added to each measure calculation, which will be reflected in your final QPM band percentages. *(Note: Not all measures are part of the feedback process.)*

- **Health Coaches.** Independence Registered Nurse Health Coaches (Health Coaches) are vital resources who can assist your practice. They can help coordinate care for your members enrolled in an Independence benefit plan. They provide information for Independence members, their families, and physicians. They also share community resources.

  Independence members who are covered through fully insured employer groups are automatically considered eligible for health coaching. Members covered through certain self-insured employer groups may not be eligible for all components of health coaching including condition management. Members can call Customer Service at 1-800-ASK-BLUE (1-800-275-2583) to verify their eligibility. If you would like to refer an Independence member to a Health Coach, complete the online Case and Condition Management Physician Referral Form or call 1-800-313-8628 and select prompt 2.

Independence offers on-site and virtual visit support from Population Health Specialists and Network Medical Directors. These visits can be used to help transform your practice workflows and improve your quality scores.

There are also many online and telephonic resources available to you and your members.

To learn more, please visit our Provider News Center.

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