Provider Medical Record HEDIS® Hybrid Training

2023

Why we're in business	OUR PURPOSE

Transforming the health of the community, one person at a time

What we do	OUR MISSION

Better health outcomes at lower costs

What we represent	OUR PILLARS

Focus on the Individual + Whole Health + Active Local Involvement

What drives our activity	OUR BELIEFS

We believe healthier individuals create more vibrant families and communities.
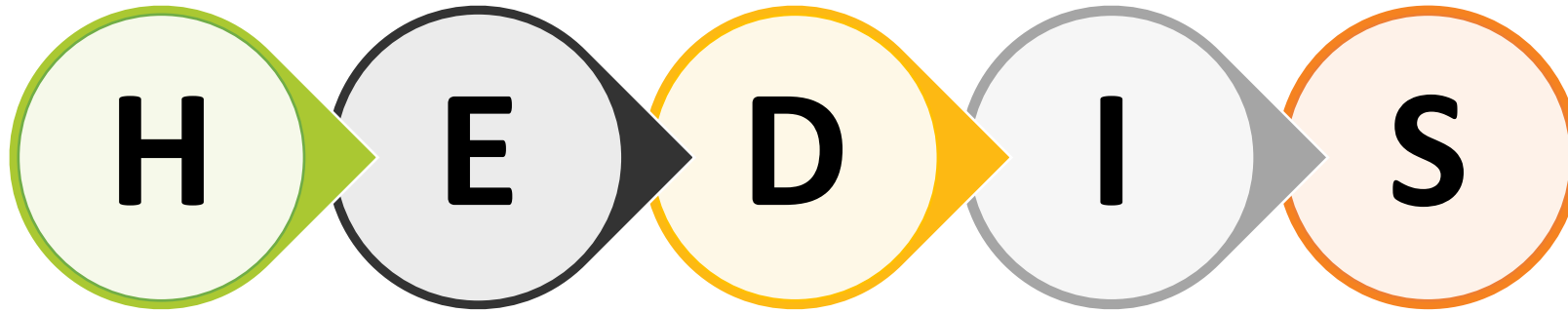
We believe treating people with kindness, respect and dignity empowers healthy decisions.

We believe we have a responsibility to remove barriers and make it simple to get well, stay well, and be well

We believe in treating the whole person, not just the physical body.

We believe local partnerships enable meaningful, accessible healthcare.

Introduction to HEDIS®

HEDIS® stands for:

Healthcare **E**ffectiveness **D**ata and **I**nformation **S**et

HEDIS® is a comprehensive set of standardized *performance measures* developed by the National Committee for Quality Assurance® (NCQA) to objectively measure, report, and compare quality across health plans.

HEDIS® rates are used to evaluate quality of care and services of health insurance companies to improve preventive health outreach for members and to evaluate practitioner's preventive care efforts.

Value of HEDIS®

HEDIS® provides value in **three** specific areas:

The ability to understand how well organizations achieve results

Offers a way to make an "apples-to-apples" comparison of organizations.

Is part of a larger system that requires accountability and quality improvement in healthcare.

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HEDIS® Data Sources

Administrative

Administrative Data is calculated from a claim or encounter(s). This includes:

- CPT codes
- ICD-10 codes
- Approved supplemental data
- Enrollment systems
- Insurance claims (both paid and denied)

Measure denominators and reported rates are based on the entire eligible population.

Hybrid

Hybrid Data is obtained from both administrative sources and abstracted from the patient's medical record (both paper and EMR).
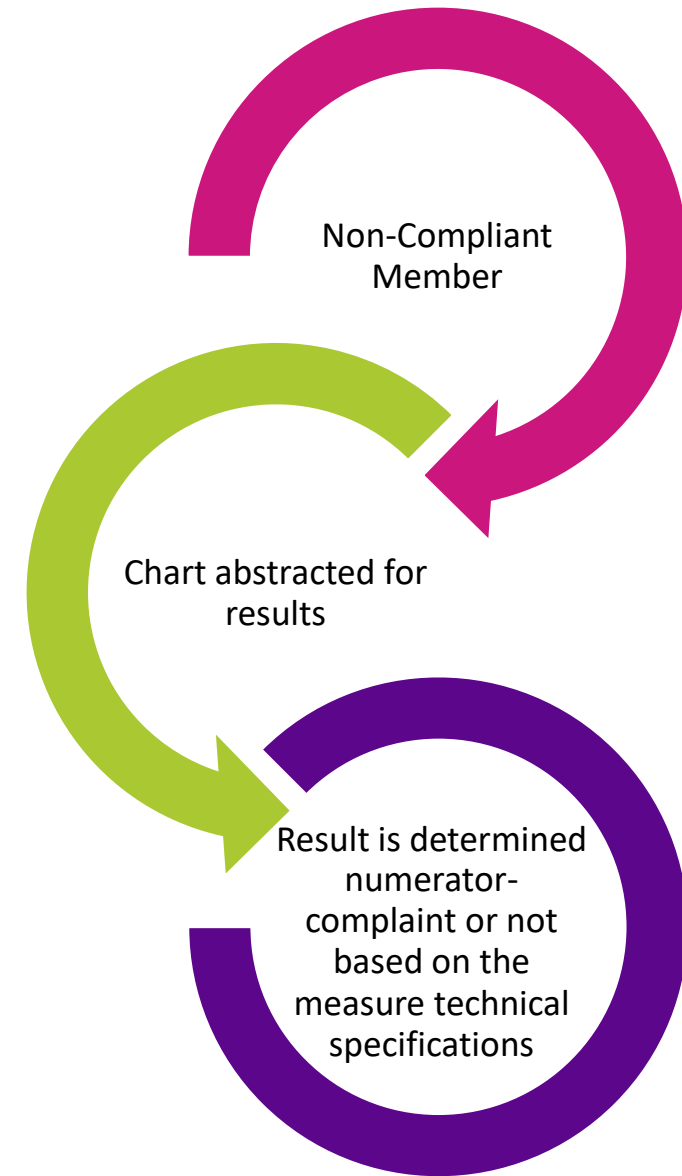
- Reviews a collection of medical records for members who are part of a randomly selected sample population to improve the administrative rate
- The hybrid method focuses on collecting medical records on a sample population of members to improve the administrative rate
- NCQA determines the hybrid measures allowed to be used for HEDIS data collection
- Hybrid medical record collection methods include fax (preferred), EMR access, onsite retrieval, email, mail

Hybrid Season

HEDIS® Hybrid Chart Chase

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HEDIS® Hybrid

- The **Hybrid Method** requires a sample to be drawn from the eligible population based on measure specifications.
- **HEDIS® Chart Chase** means that Sunflower Health Plan will collect records for members that fall into the hybrid measure samples. All sampled members are included in the denominator.
- The chart chase process supplements compliant administrative data and typically begins late January and wraps-up at the end of April.
- Health plans work to retrieve records as soon as possible during the season. The goal is to find the member's compliant event to ensure the highest compliant rate possible.

Non-Compliant Member

Chart abstracted for results

Result is determined numerator-complaint or not based on the measure technical specifications

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HEDIS® Technical Specifications

- Technical Specifications are commonly referred to as 'Tech Specs'

- Tech Specs serve as a required resource for anyone collecting, calculating, or submitting data to Medicaid, Medicare and Commercial insurance

- Tech Specs are the requirements or 'rules' of each of the specific HEDIS® performance measures

- NCQA releases technical specifications annually

- Reporting must follow the specifications and is heavily audited

HEDIS® Medical Record Process

- Sunflower Health Plan begins requesting medical record information for HEDIS® Hybrid Season **early February 2024**.
  - Medical record fax requests will include a member list identifying the measure(s) and the minimum necessary information needed.
    - Always include the patient/member demographic information on the initial page.
      - Information should include First Name, Last Name, Date of Birth (DOB), Insurance ID Number, etc.
  - **Requests may come from outside vendors who support the Health Plan with retrieval (ie: Change Healthcare, Ciox, MRO, etc)**

  - Submitting the requested medical records promptly is very important and is part of your provider agreement/ contract with Sunflower Health Plan
    - Submit requested information within seven calendar days of receipt of the request.
    - Medical records submitted via CD, USB drive, etc. are no longer accepted.
    - Do not staple copies of medical records/charts.
    - Records provided during this process help Sunflower Health Plan validate and demonstrate the quality of care you provide to our patients/members.

HEDIS® Medical Record Process

HIPAA:

- Under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule, data collection for HEDIS® is permitted, and the release of this information does not require special patient consent or authorization.

- Sunflower Health Plan's patient/member personal health information is maintained in accordance with all federal and state laws.

- Only the minimum medical record information is necessary to satisfy the requested information.

  - Submission of a patient's/member's entire medical record is often unnecessary and is not recommended.

HEDIS® Practitioner Copying Instructions for Medical Records

Please submit the requested supporting documentation to Sunflower Health Plan or the requesting vendor (Change Healthcare, Ciox) **within seven calendar days** of receipt of the request.

- Include a copy of the patient's/member's demographic page/face sheet (Name, Date of Birth, Insurance ID Number)

3 Ways to Return Records

Return to Vendor
per directions provided

Fax:
855-475-4399

Email: SM_HEDIS_Ops@sunflowerhealthplan.com
Attention: HEDIS® Operations

Medical Record Documentation

HEDIS® Measure for BPD

(BPD) Blood Pressure Control for Patients with Diabetes

Medical Record Documentation for BPD

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2023
  - Office Notes/Service Visit Notes/Encounters/History documentation
  - All consult reports/documentation
  - Problem Lists/Medical history
  - Blood Pressures readings during the year

HEDIS® Measure for CBP

(CBP) Controlling High Blood Pressure

Medical Record Documentation for CBP

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2023
  - Office Notes/Service Visit Notes/Encounters/History documentation
  - All consult reports/documentation
  - Member-reported blood pressures
  - Blood pressure readings during the year

Chart Example for BPD and CBP

Compliant

Number One Nursing Home
Weekly Vital Checks
Resident: John Doe

Feels well today. John is stopping by for his weekly vital sign check before lunch.

Vital Sign Check: 9/9/MY
BP: 138/58
Pulse: 88
Respirations: 28
Temperature: 98.6

Patient Active Problem List
Diagnosis
Essential hypertension, benign
Diabetic peripheral neuropathy associated with type 2 diabetes mellitus
DM, type 2 with renal complications

Signed by Dr. Snowman, MD, 9/10/2023

Non-Compliant

Welcome Hospital ER Department
Electronically signed by Dr. Snowman, 10/1/MY
Resident: Jane Doe

Chief Complaint: Lightheadedness and overall, not feeling well.
Vital Sign Check: 9/9/MY
BP: 158/62
Pulse: 80
Respirations: 20
Temperature: 98.6

Patient Active Problem List
Diagnosis

Seen in the ER over the weekend for reported hyperglycemic episode. Checked HgbA1c today.

HEDIS® Measure for CCS

(CCS) Cervical Cancer Screening

Medical Record Documentation for CCS

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- All consult reports/documentation
- Notation of gender, if not female
- Dates of Service:
  - 2021-2023: Patients with cytology report (pap test) and results, OR
  - 2019-2023: Patients with HPV test result alone OR a Pap test and HPV test and results

Acceptable Documentation for CCS

- Documentation in the progress note of a pap test and/or HPV with results or findings **AND** the date of service

- Documentation of complete, total, simple, full hysterectomy in the medical record

HEDIS® Measure for CIS

(CIS) Childhood Immunization Status

Medical Record Documentation for CIS

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Date of Service: Birth through 2nd Birthday
  - Office Notes/Service Visit Notes/Encounters/History documentation
  - All immunization records/certificates/logs, state immunization forms or registry printouts
  - Well-child checklists/Allergy list
  - Birth record/discharge summary
  - Lab tests/results

CIS Combo 10									
DTaP (4)	HiB (3)	Hep B (3)	IPV (3)	MMR (1)	PCV (4)	VZV (1)	Hep A (1)	Flu (2)	RV (2 or 3)
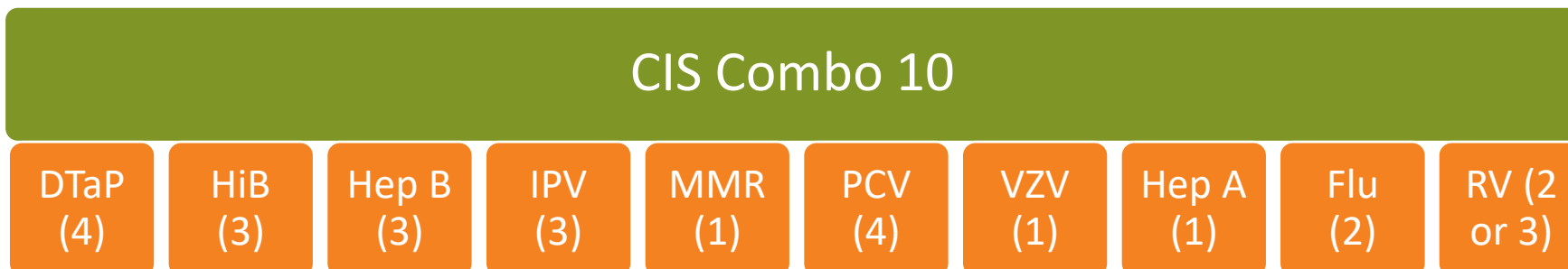
HEDIS® Measure for COA

(COA) Care for Older Adults

Medical Record Documentation for COA

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2023
  - Office Notes/Service Visit Notes/Progress Notes
  - Medication List

HEDIS® Measure for COL

(COL) Colorectal Cancer Screening

Medical Record Documentation for COL

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Office Notes/Service Visit Notes/Encounters which include history documentation of appropriate procedures and/or labs
- Surgical history documentation
- Lab/procedure documentation

Fecal Occult Blood Testing (FOBT):
2023 (1 year)

Stool DNA (sDNA) with FIT Test:
2021-2023 (3 years)

CT Colonography (Virtual Colonoscopy):
2019-2023 (5 years)

Flexible Sigmoidoscopy:
2019-2023 (5 years)

Colonoscopy:
2014-2023 (10 years)

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HEDIS® Measure for EED

(EED) Eye Exam for Patients with Diabetes

Medical Record Documentation for EED

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2022-2023
  - Retinal or dilated eye exam results (conducted by an optometrist, ophthalmologist, or other eye care professional)
  - Chart/photograph of retina performed by an eye care professional and results
  - Specialist notes/letters (nephrologist/endocrinologist/eye care provider)

Acceptable Documentation

RetinaVue® Care Delivery Model
Professional Medical Service

Retinal Diagnostic Report

Patient Information
Name:
Medical Record Number:
Date of Birth: 3/23/1954
Referring Physician:
Referring Clinic

Exam Date: 05/03/MY
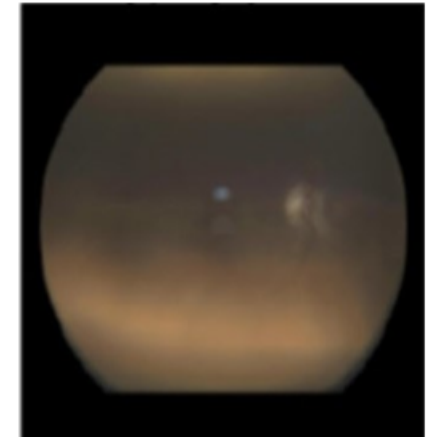Submission Date: 05/03/MY
Report Date: 05/04/MY
Exam ID: 123456

Retinal Image Assessment and Management Plan

Fundus Photograph of Left Eye (OS):

Fundus Photograph of Right Eye (OD):
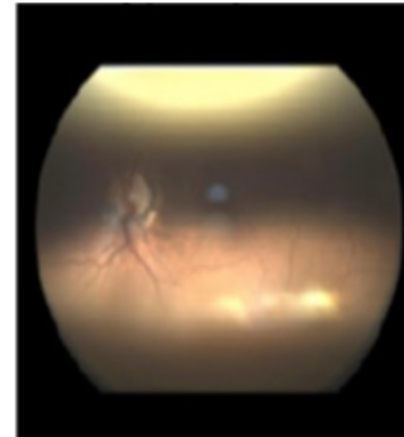
Left Eye (OS) Diagnosis:
No diabetic retinopathy

Right Eye (OD) Diagnosis:
No diabetic retinopathy

ICD-10 Diagnosis Codes:
E11.9 Type 2 diabetes mellitus without complications,   E11.9 Type 2 diabetes mellitus without complications

Recommendation and Management Plan:
Follow up photographs in 12 months.

Reviewing Physician: Donald   OD , MD

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HEDIS® Measure for HBD

(HBD) Hemoglobin A1c Control for Patients with Diabetes

Medical Record Documentation for HBD

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2023
  - Most recent (latest) HbA1c documented in medical record (dated and results)
  - Dated flow sheets: diabetic lab results

Acceptable Documentation

Component	Reference Range	11/5/MY	6/19/MY	2/11/MY	11/3/PY	8/27/PY
Hgb A1c	<5.7 (% of total Hgb)	6.8	5.9	7.4	6.8	6.6

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HEDIS® Measure for IMA

(IMA) Immunizations for Adolescents

Medical Record Documentation for IMA

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number

- Dates of Service: 2021-2023

  – Office Notes/Service Visit Notes/Encounters with documentation of immunizations for Meningococcal, Tdap and HPV

  – Immunization records/certificates/logs, state immunization forms or registry printouts for Meningococcal, Tdap and HPV

HEDIS® Measure for LSC

(LSC) Lead Screening in Children

Medical Record Documentation for LSC

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2022-2023
  - Office Notes/Service Visit Notes/Progress Notes
  - Well-child exams
  - Lab results
  - Lab flowsheets/immunization records

HEDIS® Measure for PPC

(PPC) Timeliness of Prenatal and Postpartum Care

Medical Record Documentation for PPC

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2022-2023
  - Prenatal flow sheets (ACOG, EMR, or other) and/or prenatal history, prenatal risk assessment and counseling/education
  - All progress/office visit notes for duration of pregnancy
  - All lab reports/results related to and during pregnancy
  - Ultrasound reports
  - Hospital/delivery records
  - All consult reports for duration of pregnancy
  - Postpartum visits following delivery

HEDIS® Measure for TRC

(TRC) Transitions of Care

Medical Record Documentation for TRC

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2023
  - Office Notes/Service Visit Notes/Progress Notes
  - Medication List
  - Hospital Notes (H&P)/Records/ER Notes

(TRC) Transitions of Care: Sub-Measures

Patient Engagement After Inpatient Discharge: Patient engagement (e.g., office visits, visits to the home, telehealth, phone, etc) provided within 30 days after discharge.

Medication Reconciliation Post-Discharge: Medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

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HEDIS® Measure for TRC

(TRC) Transitions of Care: Sub-Measures Continued

Notification of Inpatient Admission: Receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).

- Outpatient documentation must include proof that the notification was received within 3 days.
- For shared EMRs, documentation must show the admission notification occurred within 3 days AND evidence that the PCP had access.
- Examples of acceptable documentation include:
  - Dated communication note or copy of the original fax with received date.
  - Communication between PCP and emergency department or inpatient staff via phone, email, or fax.

Receipt of Discharge Information: Receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).

- Include a copy of the discharge summary (with proof that the record was received ≤3 days) within the outpatient record.
- At minimum, the discharge information must include ALL of the following:
  - Practitioner responsible for the members care during the inpatient stay.
  - Procedures or treatment provided.
  - Diagnosis at discharge.
  - Current medication list.
  - Testing results, documentation of pending tests, or no tests pending.
  - Instructions for patient care post-discharge.
- For shared EMRs, documentation must show the admission notification occurred within 3 days AND evidence that the PCP had access.

HEDIS® Measure for WCC

(WCC) Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents

Medical Record Documentation for WCC

- Demographic page/face sheet confirming patient's First Name, Last Name, Date of Birth (DOB) and Insurance ID Number
- Dates of Service: 2023
  - Progress notes/office visit notes/telephonic or telehealth notes
  - Well-child check forms
  - Daycare exam, state, sport or camp physicals
  - Consult notes
  - Height/weight/BMI growth charts and/or graphs
  - Height/weight/BMI percentile flow sheets
  - All referrals (dieticians, obesity/eating disorders, WIC)

Questions?

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