



# **HEDIS Quality Training for Providers**

# Training Topics

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# HEDIS Overview

## What is HEDIS?

- The Healthcare Effectiveness Data and Information Set (HEDIS) is a comprehensive set of performance measures used by health plans to evaluate the quality of care provided to members
- It is managed by the National Committee for Quality Assurance (NCQA) and is widely recognized as a standard for measuring healthcare performance





# Why HEDIS Matters to Providers

- HEDIS results have a direct impact on health plan ratings, provider reimbursements, and patient outcomes. They ensure that evidence-based care and preventive services are consistently delivered, leading to improved health outcomes and higher patient satisfaction.
- Additionally, strong HEDIS performance can enhance eligibility for value-based care (VBC) incentives, such as Pay-for-Performance (P4P) programs and shared savings opportunities, further rewarding providers for delivering high-quality, efficient care.



# Key HEDIS Measures for Primary Care Providers (PCPs)

## Preventive Care Measures

- Childhood Immunizations (CIS)
- Well-Child Visits (W30, WCV)
- Adolescent Well-Care Visits (AWC)
- Adult BMI Assessment (ABA)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL)
- Adult Preventive/Ambulatory Health Services (AAP)
- Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)

# Key HEDIS Measures for Primary Care Providers (PCPs)

## Chronic Disease Management

- Comprehensive Diabetes Care (CDC)
- Controlling High Blood Pressure (CBP)
- Asthma Medication Ratio (AMR)
- Eye Exam for Patients with Diabetes (EED)
- Kidney Health Evaluation for Patients with Diabetes (KED)
- Adult Blood Pressure Control for Patients with Diabetes
- Glycemic Status Assessment (GSD)



# Key HEDIS Measures for Primary Care Providers (PCPs)

## Behavioral Health

- Antidepressant Medication Management (AMM)
- Follow-Up After Hospitalization for Mental Illness (FUH)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Screening for Depression and Follow-Up Plan (CDF)
- Initiation and Engagement of Substance Use Disorder Treatment (IET)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

# STRATEGIES FOR PROVIDERS TO CLOSE CARE GAPS





# Proactive Patient Outreach



## Automated Reminders

- Set up reminders through phone calls, text messages, or patient portals to notify patients of due or overdue preventive services like screenings, vaccinations, and annual wellness visits.



## Direct Outreach for High-Risk Patients

- Contact patients with chronic conditions or those at high risk directly to schedule follow-ups and necessary care. Tailor the outreach method to meet the patient's preferences for better engagement.



## Engaging New Patients

- When a new patient is accepted, reach out promptly to schedule their first appointment. Use this opportunity to engage the member in conducting preventive visits, establishing a foundation for ongoing care and promoting proactive health management.

# Utilizing Technology Effectively



## Electronic Health Records (EHR) Alerts

- Use EHR systems to flag patients due for screenings or preventive services. Ensure that providers and staff receive alerts during each patient encounter to address these gaps in real-time.



## Access Real-Time HEDIS Data

- Use real-time HEDIS and FRG reports to track performance measures and identify gaps in care. Review these reports regularly to focus on high-priority measures and guide quality improvement efforts.



## Maintain an Up-to-Date Patient Registry

- Use a patient registry to track individuals needing chronic care management or routine screenings. This enables targeted outreach and helps streamline follow-up care.

# Adopting a Team-Based Approach



## Engage the Entire Care Team

- Involve all members of the practice in quality improvement activities, including Medical Assistants (MAs), nurses, and billing staff. Train them to recognize care gaps and support efforts to close them.



## Leverage Front-Office Staff

- Empower front-office staff to review patient records during check-in. Encourage them to flag any missing preventive services and assist in scheduling necessary appointments while the patient is present.



## Care Coordination Efforts

- Assign care coordinators or case managers to monitor patients with complex care needs, ensuring timely follow-up and connecting them with appropriate resources.



# Importance of Accurate Coding & Documentation

## Why Accurate Coding is Critical

- **Captures All Services Provided:** Accurate coding helps ensure that every service and intervention is documented, directly impacting quality scores and reimbursement rates.
- **Reflects the Level of Care Provided:** Proper documentation demonstrates the comprehensive care delivered to patients, supporting clinical decisions and compliance with quality standards.

## Coding Tips to Improve HEDIS Scores

- **Document Key Details:** Always include the date of service, patient's condition, and any relevant observations in the medical record.
- **Use Specific Codes:** Select the most specific ICD-10, CPT, and HCPCS codes that accurately capture the services provided, such as screenings, vaccinations, and chronic disease management.
- **Ensure Consistency:** Verify that the documentation in the medical record supports the codes billed (e.g., include BMI measurements, lab results, or diagnostic findings).
- **Address Care Gaps During Visits:** Use each patient encounter as an opportunity to close care gaps by addressing necessary screenings, immunizations, and chronic conditions.

# Common Documentation & Coding

## Tips by Measure

### Breast Cancer Screening (BCS)

- **Documentation:** Record the date of the mammogram screening clearly in the patient's record.
- **Codes:** 77067, 77063, G0202 (mammogram screening).

### Comprehensive Diabetes Care (CDC)

- **Documentation:** Include HbA1c results, retinal eye exam dates, and nephropathy screening details.
- **Codes:** HbA1c tests: 83036, 83037; Retinal eye exam: 2022F, 3072F

### Controlling High Blood Pressure (CBP)

- **Documentation:** Ensure accurate recording of blood pressure readings during each visit.
- **Codes:** Systolic BP <140/90: 3074F; Diastolic BP codes: 3078F, 3079F.

# Common Documentation & Coding

## Tips by Measure

### Colorectal Cancer Screening (COL)

- **Documentation:** Capture all types of screenings (colonoscopy, FIT-DNA, FOBT) with dates and results.
- **Codes:** FIT-DNA: 81528; FOBT: G0328, 82270; Colonoscopy: 45378.

### Cervical Cancer Screening (CCS)

- **Documentation:** Record the dates of Pap smears and HPV tests.
- **Codes:** Pap smear: 88142; HPV test: 87624, 87625.

### Eye Exam for Patients with Diabetes (EED)

- **Documentation:** Include details of retinal or dilated eye exams, indicating presence or absence of retinopathy.
- **Codes:** With retinopathy: 2022F, 2024F; Without retinopathy: 2023F, 3072F.



# Common Documentation & Coding Tips by Measure

## Weight Assessment and Counseling (WCC)

- **Documentation:** Record BMI percentile, nutrition, and physical activity counseling during visits for patients aged 3-17.
- **Codes:** BMI Percentile: Z68.51-Z68.54; Physical activity counseling: Z02.5, Z71.82.

## Follow-Up After Hospitalization for Mental Illness (FUH)

- **Documentation:** Ensure a follow-up visit with a mental health provider within 7 days of discharge.
- **Codes:** Outpatient visit: 99201-99205, 99211-99215.

## Screening for Depression and Follow-Up Plan (CDF)

- **Documentation:** Record the results of depression screenings and any follow-up plans for positive results.
- **Codes:** Positive screening with follow-up: G8431; Negative screening: G8510.



# Thank You!