REFERENCE GUIDE PURPOSE:

The purpose of this Reference Guide is to outline the process for documenting Quality HEDIS measures within the sub-domain of Prevention and Screening. This includes education documentation for the following measures, Breast Cancer Screening, Cervical Cancer Screening, Colorectal Cancer Screening, and Care for Older Adults.

DEFINITIONS & ACRONYMNS:

- HEDIS: Health Effectiveness Data and Information Set
- MY: Measurement Year
- Measurement Year: The audit year in which quality measure data is collected from.
- DOS: Date of Service
- Date of Service: The date a rendered service was provided.
- Ongoing Care Providers: Clinicians who manage the member's ongoing care, such as: NP, PA, MD, DO
- Clinical Staff: LPN, RN
- Non-clinical staff: Non licensure holding staff including, but not limited to health information management specialist,health outreach workers, etc.
- Qualifying Event: Specified event, such as diagnosis code, event code, etc. as detailed per measure, that will counttowards a member's compliance.
- Measure Cohort: All the details which create a measure, be it a specific set of diagnosis, an age range, or otherparameters which are defined to calculate a measure population.
- Denominator: All members with qualifying events defined by a measure cohort to make them a part of the eligiblepopulation.
- Numerator: All the members within a specified measure denominator that have had a qualifying event such as diagnosis code, event code, or whatever is detailed in the measure that shows the member has had a qualifying eventto be counted as having the service of interest.
- Numerator Compliant member: A member with a qualifying event for a measure.
- Administrative Data: Transaction data, or other administrative data used to identify the eligible population andnumerator. This information includes both claims and other transaction data, as well as supplemental data.
- Supplemental Data: Data used to capture missing service data not received through administrative sources (claims orencounters) or by standard electronically generated files from the service providers.
- Hybrid Data: Medical record data used to identify eligible numerator events.
- Transaction Data: Data that is created and updated within operational systems, which collects information related tointake, service, diagnostic testing, procedures, purchasing, billing, accounts receivable and accounts payable. Can be from claims, EMR data exports, etc.

Contents

Breast Cancer Screening (BCS)

Measure Member Cohort: Women, 50-74 years of age
Measure Lookback: October 1 two years prior to the MY through December 31 of MY
Description: The percentage of women who had a **mammogram** to screen for breast cancer.
Intent: Second to skin cancer, breast cancer is the most prevalent form of cancer affecting women. Early detection, and increased screening can improve outcomes.

Virtual or telephone visits are not acceptable to complete a Mammogram, however virtual or telephone visits are acceptable to collect member reported information about previously completed mammograms.

What does HEDIS Require and By Whom?

Credentials	Documentation Requirement
Ongoing Care Provider	Member reported Mammograms with DOS and Test Type documented in the legal health record
Non-clinical staff, clinical staff, ongoing care provider	Mammography Report uploaded into the legal health record.

Examples of How to Document and Where.

Member Reported Information	Electronic Health Record - Defined Structed Data Location o Test Type (Bilateral Mammography) o Date of Service
Report Information	Electronic Health Record - Defined Folder o Diagnostic Tests ▪ Defined Document Naming Convention • MM DD YYYY Mammogram

Cervical Cancer Screening (CCS)

Measure Member Cohort: Females, 21-64 years of age
PAP: Females, 21-64 years of age
HrHPV: Females, 30-64 years of age **at the time of screening**
Measure Lookback: *PAP*: January 1 two years prior to the MY through December 31 of MY
HrHPV: January 1 four years prior to the MY through December 31 of MY
Description: The percentage of women 21-64 y/o who were screened for cervical cancer.
Intent: Cervical Cancer mortality has been reduced by 50% over the past 30 years. Early detection, and increased screening can improve outcomes.

Virtual or telephone visits are not acceptable to complete a PAP and/or HPV screening, however virtual ortelephone visits are acceptable to collect member reported information about previously completed PAP and/or HPV screenings.

What does HEDIS Require and By Whom?

Credentials	Documentation Requirement
Ongoing Care Provider	Member reported Cervical Cancer Screening with DOS and Test Type documented in the legal health record
Non-clinical staff, clinical staff, ongoing care provider	Pap and/or HPV Report the uploaded into the legal health record

Examples of How to Document and Where.

Member Reported Information	Electronic Health Record - Defined Structed Data Location o Test Type (PAP/HPV) o Date of Service
Report Information	Electronic Health Record - Defined Folder o Diagnostic Tests ▪ Defined Document Naming Convention • MM DD YYYY PAP/HPV

Colorectal Cancer Screening (COL)

Measure Member Cohort: 45-75 years old

Measure Lookback:

10 Years	5 Years	5 Years	3 Years	1 Year
Colonoscopy	Flexible Sigmoidoscopy	CT Colonography	FIT-DNA	FOBT

Description: Members who had a colorectal cancer screening.

Intent: Colorectal Cancer treatment in its earliest stage can lead to a 90% survival rate after five years. More than 1/3 of adults 50-75 do not get recommended screenings. Early detection, and increased screening can improve outcomes.

Virtual or telephone visits are not acceptable to complete a colorectal cancer screening, however virtual ortelephone visits are acceptable to collect member reported information about previously completed colorectal cancer screenings.

What does HEDIS Require and By Whom?

Credentials	Documentation Requirement
Ongoing Care Provider, clinical staff	Member reported colorectal cancer screening test with DOS and Test Type documented in the member's "medical history" in the legal health record
Non-clinical staff, clinical staff, ongoing care provider	Colonoscopy, Flexible Sigmoidoscopy, CT Colonography, FIT-DNA, FOBT report uploaded into the legal health record.

Examples of How to Document and Where.

Member Reported Information	Electronic Health Record - Defined Structed Data Location o Test Type (Colonoscopy, etc.) ▪ Date of Service • MM DD YYYY
Report Information	Electronic Health Record - Defined Folder o Diagnostic Tests ▪ Defined Document Naming Convention • MM DD YYYY Colonoscopy

Care of Older Adults (COA)

Sub-measure(s):(3): Annual Medication Review

Measure Member Cohort Age Range: 66+ years old
Measure Lookback: 1 year
Description: The percentage of members 66+ y/o who had a medication review performed during the MY
Intent: Older adults may have more complex medication regimens.

Virtual or telephone visits are accepted for this measure.

WHAT DOES HEDIS REQUIRE AND BY WHOM?

Credentials	Documentation Requirement
Prescribing Practitioner	Annual medication review of all the member's medications, including over-the-counter, and herbal or supplemental therapies, as well as a medication list in the member's legal health record.
Clinical Pharmacist	Annual medication review of all the member's medications, including over-the-counter, and herbal or supplemental therapies, as well as a medication list in the member's legal health record.

EXAMPLES OF HOW TO DOCUMENT AND WHERE.

Visit Information	Electronic Health Record - Visit completed by appropriate provider o Medication List ▪ Medications Reviewed Checkbox ▪ Medications Reconciled *(*Note must be signed by appropriate provider)*

Care of Older Adults (COA)

Sub-measure(s):(3): Functional Status Assessment

Measure Member Cohort Age Range: 66+ years old
Measure Lookback: 1 year
Description: The percentage of members 66+ y/o who had a functional status assessment during the MY
Intent: As the population ages, physical and cognitive function can decline. Screening of elderly patients is effective in identifying functional decline.

Virtual or telephone visits are accepted for this measure.

WHAT DOES HEDIS REQUIRE AND BY WHOM?

Credentials	Documentation Requirement
Clinical staff, ongoing care provider	Result of completed standardized functional status assessment tool.
Clinical staff, ongoing care provider	Notation that Activities of Daily Living (ADL) were assessed or that at least **5** of the following addressed: Bathing, dressing, eating, transferring, using toilet, walking
Clinical staff, ongoing care provider	Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least **4** of the following were assessed: Shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handing finances.

EXAMPLES OF HOW TO DOCUMENT AND WHERE.

Visit Information	Electronic Health Record - Defined Structed Data Location ▪ Functional Status Assessment examples: • Katz Index • ALSAR • B-ADL Scale
Visit Information	Electronic Health Record - Defined Structed Data Location o Review of System ▪ List of assessed ADL/IADL

Care of Older Adults (COA)

Sub-measure(s):(3): Pain Assessment

Measure Member Cohort Age Range: 66+ years old
Measure Lookback: 1 year
Description: The percentage of members 66+ y/o who had a pain assessment during the MY
Intent: As the population ages, pain may become more prevalent. The COA measure ensures that older adults receive the care they need to optimize quality of life.

Virtual or telephone visits are accepted for this measure.

WHAT DOES HEDIS REQUIRE AND BY WHOM?

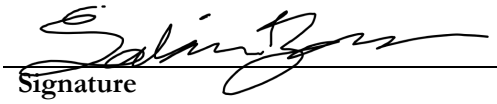
Credentials	Documentation Requirement
Clinical staff, ongoing care provider	Pain Assessment result using a standardized pain assessment tool, or documentation that the member was assessed for pain (not including acute pain management plan, chest pain, or other specific acute events)

EXAMPLES OF HOW TO DOCUMENT AND WHERE.

Visit Information	Electronic Health Record - Defined Structed Data Location o Review of Systems ▪ Pain Frequency
Visit Information	Electronic Health Record - Defined Structed Data Location o Review of Systems ▪ Pain Scale • 1-10

RELATED DOCUMENTS:

APPROVALS:

Sabrina N Zecher	Manager, HEDIS
CCA SUBJECT MATTER EXPERT[Print]	**Title [Print]**
	12/01/2021
Signature	**Date**