2018 5-STAR GUIDE

This guide details a sub-set of the 50 plus measures in the CMS 5-Star program and provides actionable, evidence-based information to impact the quality of your patients' care. SCAN Health Plan® hopes you find this guide useful.

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Staying Healthy: Screenings, Tests and Vaccines

Measure	Target Population	How the Measure Can Be Improved	Frequency
Annual Flu Vaccine	All patients	■ Remind patients to get flu shot, have standing orders for receiving flu shot during flu season. ■ Maintain vaccine in all offices. ■ Provide take-home materials for patients' records.	Each flu season
Breast Cancer Screening	50-74 years	Mammogram (be sure to document if patients have had mastectomy).	Every two years
Colorectal Cancer Screening	50-75 years	■ Colonoscopy ■ Sigmoidoscopy ■ FIT-DNA test ■ Fecal occult blood test (FOBT)/fecal immunochemical test (FIT)	■ Every 10 years ■ Every five years ■ Every three years ■ Annually
Improving or Maintaining Physical Health	65 years and older	■ Assess patients' physical health/functional status and activity. ■ Document appropriately and recommend customized physical activities. ■ Encourage patients to check if their SCAN plan offers gym benefits. ■ Assess pain and intervene. Submit CPT II codes 1125F or 1126F.	At least annually
Improving or Maintaining Mental Health	65 years and older	■ Screen patients for depression and anxiety and treat as necessary. ■ Consider using PHQ-2, GAD-7 and PHQ-9 where appropriate and document using CPT II and HCPCS codes G0451, G8431, G8510, G9212, G9393, G9395, G9396, 3351F, 3352F, 3353F or 3354F.	At least annually
Monitoring Physical Activity	65 years and older	■ Discuss the importance of physical activity – any activity is better than none. ■ Recommend patients start physical activity or increase or maintain their level of activity. ■ "Prescribe" exercise using an exercise prescription form.	At least annually

Care for Older Adults

Measure	Target Population	How the Measure Can Be Improved	Frequency
Osteoporosis Screening in Women with Fracture	67-85 years	For patients with fracture diagnosis involving long bones or spine (excluding pathological fractures), perform bone density test or prescribe bisphosphonates, calcitonin or other medications. Best practice: Assess patients at high risk for osteoporosis, screen with DEXA.	Within six months of fracture
Reducing Risk of Falling	65 years and older	Screen patients for any recent falls and discuss fall risk interventions (visual exam, medication reconciliation, exercise, DME, vitamin D, etc.). If positive, provide recommendations and education handout. For more information, visit **cdc.gov/steadi/patient.html**.	At least annually (the Annual Wellness Visit is a good time to include a falls risk assessment)
Improving Bladder Control	65 years and older	■ Screen all patients for urinary incontinence and, if positive, discuss treatment options. ■ Educate patients about noninvasive behavioral interventions for incontinence; when necessary, refer for appropriate treatment.	At least annually

Diabetes Care

Measure	Target Population	How the Measure Can Be Improved	Frequency
Blood Sugar Controlled	18-75 years	Test HbA1c, control to keep A1c <9%.	At least annually or quarterly, if uncontrolled
Eye Exam	18-75 years	Retinal or dilated eye exam by eye care professional to check for damage from diabetes.	Annually
Kidney Disease Monitoring	18-75 years	Urine microalbumin, random urine for protein/creatinine or 24-hour urine for total protein test.	At least annually
Statin Use in Persons with Diabetes (SUPD)	40-75 years	Prescribe a statin in patients with diabetes according to the American College of Cardiology/American Heart Association guideline (see **Formulary Alternatives** section).	As needed

Chronic Conditions

Measure	Target Population	How the Measure Can Be Improved	Frequency
Controlling Blood Pressure	18-85 years	Diagnosis of hypertension and target blood pressure: ■ 18-59 years old: <140/90 ■ 60-85 years old: <150/90 ■ 60-85 years old with diabetes: <140/90	At each visit
Rheumatoid Arthritis (RA) Management	18 years and older	Refer to rheumatology, confirm diagnosis and prescribe DMARD when appropriate. Consider ICD-10 M25.50 for generalized joint pain until RA diagnosis is confirmed.	Ongoing, once diagnosed
Statin Therapy for Patients with Cardiovascular Disease (SPC)	■ ASCVD patients ■ Males, 21-75 years ■ Females, 40-75 years	Prescribe moderate- to high-intensity statin. Refer to **Formulary Alternatives** section and review moderate- or high-intensity statin daily dose requirement notations.	As needed

Patient Experience

Measure	Target Population	How the Measure Can Be Improved	Frequency
Care Coordination	All patients	■ Discuss lab results, prescription medications and recommendations from specialists in a timely manner. ■ Encourage patients to use patient portal, if available. ■ Train staff to communicate expectations to patients about lab results.	At each visit
Getting Appointments and Care Quickly	All patients	Train staff to: ■ Assist patients in scheduling appointments and offer alternate ways to schedule, such as patient portal and after-hour phone numbers. ■ Triage calls from patients to identify those who require office visits and those whose needs can be addressed virtually. ■ Support patients during the referral and authorization process. ■ Ensure patients receive staff attention if provider is delayed beyond "15-minute" timeframe – measure vitals, address falls, urinary incontinence, mental health, physical activity, etc.	As needed
Getting Needed Care	All patients	■ Ensure timely referrals to specialists and appointments for tests and treatments. ■ Train staff to set expectations and communicate referral process with new and existing patients.	As needed

Preventing Hospitalizations

Measure	Target Population	How the Measure Can Be Improved	Frequency
Hospitalizations for Potentially Preventable Complications	67 and older	■ Schedule regular visits for patients with chronic conditions, such as diabetes, COPD and heart failure. ■ Educate patients on accessing after-hour care via resources (nurse lines, urgent care centers), especially for acute conditions, such as UTI, pneumonia, cellulitis, etc. ■ Confirm all chronic condition diagnoses have been well documented for diagnostic accuracy.	Routinely, as needed
Medication Reconciliation Post-Discharge	Discharge from hospital, skilled nursing facility or acute or non-acute inpatient facility to home	■ Under the direction of MD/pharmacist/RN/NP/PA, reconcile post-discharge medications with outpatient medications in ambulatory setting within 30 days of discharge – **does not have to be face to face**. ■ Be sure to document in medical records using CPT II codes 1111F, 99495 and 99496. ■ Schedule post-hospital discharge appointment within seven days of discharge for medication reconciliation.	For every discharge from the hospital or skilled nursing facility within 30 days
Plan All Cause Readmissions	All seniors discharged from acute or skilled nursing facility for non-elective admissions	■ Schedule follow-up visit within seven days of discharge. ■ Ensure all discharge instructions are reviewed with patients/caregivers at follow-up visit. ■ Refer patients to care transition program. ■ Confirm all chronic condition diagnoses have been well documented for diagnostic accuracy.	Every discharge

Medication Adherence

Measure	Target Population	How the Measure Can Be Improved	Frequency
Diabetes, Cholesterol, Hypertension	18 years and older	Ask patients if they are taking their medications and assess barriers. Best practices to improve adherence include: ■ Prescribe 90-day supplies; most patients pay only two copays for a three-month supply for Tiers 1 and 2 and get a $10 discount for Tiers 3 and 4. ■ Prescribe generic and Formulary medications (see **Formulary Alternatives** section). ■ Suggest auto-refill, refill reminder and medication synchronization programs at the pharmacy, if available. ■ Educate patients on side effects and proper use. ■ Reduce polypharmacy. ■ Simplify regimen by prescribing extended-release formulations for once daily dosing and combination drugs. ■ Encourage mail-order prescriptions.	At each visit

Pharmacies

Preferred Pharmacies	Standard Pharmacies
Patients may have lower copays at Preferred pharmacies. Preferred pharmacies include but are not limited to: ■ Walgreens ■ Rite Aid ■ Walmart ■ Costco ■ Ralphs ■ Safeway/Albertson's ■ Express Scripts Home Delivery ■ Select independent pharmacies	Standard pharmacies have the same copays as 2017. Standard pharmacies include but are not limited to: ■ CVS (including those in Target stores) ■ Medicine Shoppe ■ Kroger ■ Select independent pharmacies Search for Preferred and Standard pharmacies: **www.scanhealthplan.com/helpful-tools/pharmacy-search**

Formulary Alternatives: Medications for the Adherence, SUPD and SPC Measures

	Tier 1 (Preferred Generics)	Tier 2 (Generics)	Tier 3 (Preferred Brands)
Cholesterol†	Atorvastatin, lovastatin, pravastatin, simvastatin	Amlodipine and atorvastatin, rosuvastatin[2]	
Diabetes	Glimepiride, glipizide, glipizide ER, metformin, metformin ER, pioglitazone	Glimepiride and pioglitazone[3], glipizide and metformin, nateglinide, pioglitazone and metformin, repaglinide	Bydureon®[1], Byetta®[1], Farxiga®[2], Invokamet®[2], Invokamet® XR[2], Invokana®[2], Janumet®, Janumet® XR, Januvia®, Kombiglyze® XR, Onglyza®, Victoza®[1], Xigduo® XR[2]
Hypertension	Amlodipine and benazepril, benazepril*, captopril*, enalapril*, fosinopril*, irbesartan*, lisinopril*, losartan*, moexipril*, quinapril*, perindopril, ramipril, trandolapril, valsartan*	Olmesartan & amlodipine[2], valsartan and amlodipine, valsartan and amlodipine and HCTZ[2]	Olmesartan[2], Olmesartan-HCTZ[2], Tekturna®[2], Tekturna-HCTZ®[2]

1 = prior authorization 2 = step therapy 3 = quantity limit
* Drugs that are also available in combination with HCTZ.
† Moderate-intensity statin (daily dose): atorvastatin 10-20mg, lovastatin 40mg, pravastatin 40-80mg, simvastatin 20-40 mg. High-intensity statin (daily dose): atorvastatin 40-80mg, rosuvastatin 20-40mg

Please refer to online Formulary for the most up-to-date information: **https://www.scanhealthplan.com/helpful-tools/formulary-search.**

Visit **www.scanhealthplan.com/5Star** for additional resources.

For other questions related to the CMS 5-Star program measures, contact network management at **NetworkQuality@scanhealthplan.com**.