



# 5 Star Guide

- Staying Healthy: Screenings, Test & Vaccines
- Chronic Conditions
- Medication Adherence
- Care for Older Adults
- Care Coordination
- Pharmacies
- Diabetes Care
- Preventing Hospitalizations
- Formulary Alternatives

Staying Healthy: Screenings, Tests and Vaccines			
Measure	Target Population	How the Measure Can Be Improved	Frequency
Annual Flu Vaccine	All patients	Encourage patients to get flu and pneumonia vaccines. Have standing orders for flu and pneumonia vaccines. Maintain vaccine in all offices. Provide take-home materials for members' records.	Each flu season
Breast Cancer Screening	50-74 years	Mammogram (be sure to document if patients have had mastectomy)	At least 2 years
Colorectal Cancer Screening	50-74 years	<ul style="list-style-type: none"> <li>• Colonoscopy</li> <li>• Sigmoidoscopy</li> <li>• Stool DNA testing</li> <li>• Fecal occult blood test</li> </ul>	Every 10 years Every 5 Years Every 3 Years Annually

Care for Older Adults			
Measure	Target Population	How the Measure Can Be Improved	Frequency
Medication Review	65 years	Encourage patients to bring their medications or a list of their current medications, along with the directions about quantity and consumption frequency, to each visit. Conduct medication review, document in medical record and submit <b>both codes 1159F, G8427</b> (RX list) and <b>90863, 99605, 99606 and 1160F</b> (RX Review) Consider including medications in the plan of care given to patients as they leave the office. Suggest smart phone applications or alarms to help patients remember to take their medications.	At least annually

Osteoporosis Screening in Women with Fracture	67-85 years	For patients with fractures diagnoses involving long bones or spine (excluding pathological fractures), perform bone density test, treatments or a Rx with bisphosphonates. Best practice: Assess patients at high risk for osteoporosis, screen with DEXA.	Within 6 months of fracture
Monitoring Physical Activity	65 years and older	Assess patients' physical activity. Document appropriately and recommend customized physical activities. Write your recommended exercise program recommendations in the plan of care given to patients as they leave the office. Praise your patients' physical health when possible and encourage patients to use their GlobalHealth plan's gym/fitness benefits.	At least annually
Reducing Risk of Falling	65 years and older	Screen patients for any recent falls and discuss fall risk interventions (visual exam, hearing exam, medication reconciliation, exercise, DME, vitamin D, etc.). If positive, provide recommendations and education handout(s) such as a referral for a home safety evaluation and modification or exercise to increase leg strength and balance. Remind patients that installing handrails or using a can prevent falls.	At least annually
Healthcare Quality	All patients	Ask open-ended questions to provide your patients a chance to disclose health issues and concerns. An apology and quick explanation for lengthy wait times has shown to markedly improve patient experience.	At each visit
Improving Bladder Control	65 years and older	Screen patients for any bladder control concerns. Communicate that urinary leakage problems can be common as we grow older, but there are treatments that can help. Recommend treatment options no matter the frequency or severity of the bladder control problem with educational handout(s). When recommending Kegel exercises or other conventional remedies, emphasize these treatment options for recommendations that should be taken seriously.	At least annually

Diabetes Care			
Measure	Target Population	How the Measure Can Be Improved	Frequency
Blood Sugar Controlled (HBD)	18 - 75 years	Test HbA1c, control to keep A1c <9%.	At least annually, or quarterly if uncontrolled
Eye Exam (EED)	18-74 years	Retinal or dilated eye exam by eye care professional to check for damage from diabetes.	Annually
Statin Use in Persons with Diabetes (SUPD)	40-75 years	Prescribe statin therapy in patients with diabetes according to ACC/AHA guidelines (see Formulary Alternatives section). For statin intolerance consider coding T46.6X5A Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs if a patient meets the criteria of intolerance to a statin.	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.	At each visit
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. For statin intolerance consider coding T46.6X5A Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs if a patient meets the criteria of intolerance to a statin.	As needed

Care Coordination			
Measure	Target Population	How the Measure Can Be Improved	Frequency
Coordination of Care	All patients	Prior to appointments, speak with specialist or review notes on the care they have provided. Share with the patient that you have reviewed communication from specialists. Educate staff to communicate expectations to patients about lab and/or test results. Encourage patients to use patient portal, if available.	At each visit
Getting Appointments and Care Quickly	All patients	Assist patients in making timely urgent and non-urgent appointments. Educate staff to communicate ways to schedule appointments, such as patient portal, office phone number, after hours phone number. Educate staff to triage patient calls to identify those who require office visits and those who can be treated through a virtual visit (patients' needs addressed electronically or over the phone). Provide support to the patient during referral and authorization process. Address "15 minute" timeframe by ensuring patients are receiving staff attention if provider is delayed - measure vital signs, engage in discussions related to Health Outcomes Survey Questions (urinary incontinence, fall risk, physical activity, etc.)	As needed
Getting Needed Care and Seeing Specialists	All patients	Encourage patients to schedule future visits before leaving the office. Utilize a system for appointment reminders and appointment confirmations. Ensure timely referrals to specialists and appointments for tests and treatments. Educate staff to set expectations and communicate referral process with patients. Onboard new patients regarding the referral process. Offer to contact the specialist's office and assist patients with scheduling the appointment. Set expectations regarding how long it may take to get a specialist appointment. Provide the patient with written contact information for the specialist.	As Needed
Notification of Inpatient Admission	All discharges from hospital, skilled nursing facility, or acute or non-acute inpatient facility to home	Document the receipt of notification of inpatient admission on the day of admission through two days after the admission (three days total). Show evidence of receipt of information through dated emails, faxes, phone encounters, ADT alerts, etc. Include the date of admission, facility name, reason for admission, and Provider(s) of hospital care.	Every inpatient admission within 3 total days
Receipt of Discharge Information	All discharges from hospital, skilled nursing facility, or acute or non-acute inpatient facility to home	Documentation that shows receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with date and timestamp.	Every discharge within 3 total days
Patient Engagement After Inpatient Discharge	All discharged from hospital, skilled nursing facility, or acute or non-acute inpatient facility to home	Documentation needs to show that within 30 days of discharge, member engagement has occurred—this can be either in the form of an office visit, home visit, synchronous telemedicine visit, or phone encounter. Be sure to document in medical record using codes 98969, 98970, 98972, 99421, 99422, 99423, 99444, or 99457.	Every discharge from the hospital or skilled nursing facility within 30 days
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 - does not have to be face to face. Be sure to document in medical records using codes 99495 (TCM - moderate complexity within 14 days post-discharge); 99496 (TCM - high complexity within 7 days post-discharge) or 1111F (MRP – on the discharge date through 30 days after discharge).	For every discharge from the hospital or skilled nursing facility within 30 days

Preventing Hospitalizations			
Measure	Target Population	How the Measure Can Be Improved	Frequency
Hospitalizations for Potentially Preventable Complications	67 and older	Schedule regular visit for patients with chronic conditions, such as diabetes, COPD and heart failure. Educate patient on accessing after hours 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
Plan All Cause Readmission	All seniors discharged from acute or skilled nursing facility for non-elective admissions	Schedule follow up visit 7 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
Follow-up after Emergency Department (ED) for High-Risk or Multiple Chronic Conditions (FMC)	18 years and older with multiple high-risk chronic conditions who had an ED Visit.	Schedule follow up service within 7 days of discharge. Ensure all discharge instructions, follow-up needs/services, and medications 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 emergency department visit that does not result in an acute or non-acute inpatient stay

Medication Adherence			
Measure	Target Population	How the Measure Can Be Improved	Frequency
Diabetes, Cholesterol, Hypertension	18 years and older	<p>Ask patients if they are taking their medications and assess barriers. Best practices to improve adherence include:</p> <ul style="list-style-type: none"> <li>• Prescribe 100 or 90 day supply with refills; most patients have a \$0 copay for a 3-month supply for Tier 1 &amp; Tier 2 and pay only two copays on Tier 3 at preferred pharmacies.</li> <li>• Prescribe generic and formulary medications (see Formulary Alternatives section). <ul style="list-style-type: none"> <li>• Suggest auto-refill or refill reminder programs.</li> </ul> </li> <li>• Educate patients on side effects and proper use. <ul style="list-style-type: none"> <li>• Simplify regimen.</li> </ul> </li> <li>• Encourage mail-order prescriptions.</li> </ul>	At each visit

## Pharmacies

Preferred Pharmacies	Standard Pharmacies
<p>Patients may have lower copays at Preferred pharmacies. Preferred pharmacies include but are not limited to:</p> <ul style="list-style-type: none"> <li>• CVS</li> <li>• Walmart</li> <li>• Costco</li> <li>• Caremark Mail Order</li> <li>• Select Independent Pharmacies</li> </ul> <p>Online pharmacy search tool: <a href="https://globalhealth.com/oklahoma/pharmacy-directories/">https://globalhealth.com/oklahoma/pharmacy-directories/</a></p>	<p>Standard pharmacies include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Walgreens</li> <li>• Reasor's</li> <li>• Homeland</li> <li>• Sam's Club</li> <li>• Select Independent Pharmacies</li> </ul> <p>Online pharmacy search tool: <a href="https://globalhealth.com/oklahoma/pharmacy-directories/">https://globalhealth.com/oklahoma/pharmacy-directories/</a></p>

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

	Tier 1	Tier 2	Tier 3
Cholesterol†	Atorvastatin <sup>1</sup> , Lovastatin <sup>1</sup> , Pravastatin <sup>1</sup> , Rosuvastatin <sup>1</sup> , Simvastatin <sup>1</sup>		
Diabetes	Glimepiride <sup>1</sup> , Glipizide <sup>1</sup> , Glipizide XL <sup>1</sup> , Glipizide/Metformin <sup>1</sup> , Metformin <sup>1</sup> , Metformin ER <sup>1,2</sup> , Nateglinide <sup>1</sup> , Pioglitazone <sup>1</sup> , Repaglinide <sup>1</sup>		Bydureon <sup>®1</sup> , Farxiga <sup>®1</sup> , Glyxambi <sup>®1</sup> , Janumet <sup>®1</sup> , Janumet XR <sup>®1</sup> , Januvia <sup>®1</sup> , Jardiance <sup>®1</sup> , Jentadu-eto <sup>®1</sup> , Jentaduetto XR <sup>®1</sup> , Ozempic <sup>®1</sup> , Rybelsus <sup>®1</sup> , Synjardy <sup>®1</sup> , Synjardy XR <sup>®1</sup> , Tradjenta <sup>®1</sup> , Trijardy XR <sup>®1</sup> , Trulicity <sup>®1</sup> , Victoza <sup>®1</sup> , Xigduo XR <sup>®1</sup>
Hypertension	Amlodipine/Benazepril, Benazepril*, Captopril*, Enalapril*, Fosinopril*, Irbesartan*, Lisinopril*, Losartan*, Moexipril, Olmesartan*, Olmesartan/Amlodipine*, Perindopril, Quinapril*, Ramipril, Telmisartan, Trandolapril, Valsartan*, Valsartan/Amlodipine*		

**Gap Coverage**—Classic, Classic Choice, Classic Plus, and Select: **All** Tier 1 | Tier 3 ORAL Antidiabetics ONLY

**Gap Coverage**—Special Care, Special Care Savings: **All** Tier 1 | Tier 3 ORAL Antidiabetics and senior savings insulins ONLY

**Gap Coverage**—OSR Plan: **All** Tier 1 and All Tier 2. In Tier 3, only Insulin and insulin syringes and only ORAL Antidiabetics

1= Quantity Limit

2= Generic of Glucophage XR

\* 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://globalhealth.com/oklahoma/pharmacy/drug-formularies/>

**GLOBALHEALTH MEDICARE PART D (GENERATIONS PLANS)**

**2022 Quick Reference Guide**

<b>Tiers</b>	<b>Plan Name</b>	<b>Standard Retail 30-Day Supply</b>	<b>Preferred Retail 30-Day Supply</b>	<b>Standard Retail 100-Day Supply</b>	<b>Preferred Retail 100-Day Supply</b>	<b>CVS Mail Order 100-Day Supply</b>
Tier 1	Classic/Classic Choice/Classic Plus	\$10	\$5	\$30	\$0	\$0
	Select	\$8	\$3	\$24	\$0	\$0
	OSR	\$5	\$0	\$15	\$0	\$0
	Special Care/ Special Care Savings	\$5	\$0	\$15	\$0	\$0
Tier 2	Classic/Classic Choice/Classic Plus/OSR	\$20	\$15	\$60	\$0	\$0
	Select	\$18	\$13	\$54	\$0	\$0
	Special Care/ Special Care Savings	\$10	\$5	\$30	\$0	\$0
Tier 3	Classic/Classic Choice/Classic Plus/OSR	\$47	\$42	\$141	\$84	\$84
	Select	\$45	\$40	\$135	\$80	\$80
	Special Care/ Special Care Savings Plans	\$47	\$42	\$141	\$84	\$84
	Senior Savings (Insulins ONLY)	\$35	\$35	\$105	\$84	\$84
Tier 4	Classic/Classic Choice/Classic Plus	50%	40%	50%	40%	40%
	Select	50%	40%	50%	40%	40%
	OSR	\$100	\$95	\$300	\$190	\$190
	Special Care/ Special Care Savings	\$100	\$90	\$300	\$270	\$270
Tier 5	Classic/Classic Choice/Classic Plus/OSR	33%	33%	N/A	N/A	N/A
	Select	33%	33%			
	Special Care/ Special Care Savings	33%	33%			