GlobalHealth

5 Star Guide

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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	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	Colonoscopy Sigmoidoscopy Stool DNA testing Fecal occult blood test	Every 10 years Every 5 years Every 3 years 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.	At least 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 T46.6X5_ Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs (for 7th digit - A = initial encounter, D = subsequent encounter, or S = sequela)	As needed

Care for Older Adults			
Measure	**Target Population**	**How the Measure Can Be Improved**	**Frequency**
Medication Review	66 years and older	Encourage patients to bring their medications or a list of their curret medications, along with the directions about quantity and consupmtion frequency, to each visit. Conduct medication review, document in medical record and submit both codes 1159F, G8427 (RX list) and 90863, 99605, 99606, and 1160F (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
Pain Assessment	66 years and older	Conduct at least one pain assessment or pain management plan and document with the date the assessment was performed in the medical record. Please consider using codes 1125F (pain present) or 1126F (no pain present).	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/Improving or Maintaining Physical Health	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
Improving or Maintaining Mental Health	65 years and older	Screen patients for depression, anxiety, and cognitive decline and treat, as necessary. Simple recommendations, such as increased social activity, exercise, and healthy eating, can have an impact on a patient's sense of emotional well-being. Consider using PHQ-2 and PHQ-9 where appropriate and document.	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 are recommendations that should be taken seriously.	At least annually

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. At a minimum, the discharge information must included the following: 1. Practitioner responsible for mbr care during inpt stay. 2. Procedures or treatment provided 3. Diagnosis at discharge 4. Current med list 5. Test results, or documentation of pending tests or no tests pending. 6. Instructions for pt care post-discharge	Every discharge within 3 total days
Patient Engagement After Inpatient Discharge	All discharges 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	All discharges 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).	Every discharge from the hospital or skilled nursing facility within 30 days

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 T46.6X5_ Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs (for 7th digit - A = initial encounter, D = subsequent encounter, or S = sequela)	As needed

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 (PCR)	All seniors discharged from acute or skilled nursing facility for non-elective admissions	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 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	Ask patients if they are taking their medications and assess barriers. Best practices to improve adherence include: • Prescribe 100 or 90 day supply; most patients have a $0 copay for a 3-month supply for Tier 1 & Tier 2 and pay only two copays on Tier 3 at preferred pharmacies. Most Tier 3 drugs are available in 100 or 90 supplies for the equivalent of two 30 day supply copays. • Prescribe generic and formulary medications (see Formulary Alternatives section). • Suggest auto-refill or refill reminder programs. • Educate patients on side effects and proper use. • Simplify regimen. • 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: • CVS • Walmart • Costco • Caremark Mail Order • Select Independent Pharmacies Online pharmacy search tool: https://www.globalhealth.com/oklahoma/pharmacy-directories/	Standard pharmacies include but are not limited to: • Walgreens • Reasor's • Homeland • Sam's Club • Select Independent Pharmacies Online pharmacy search tool: https://www.globalhealth.com/oklahoma/pharmacy-directories/

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

	Tier 1	Tier 2	Tier 3	Tier 4
Cholesterol†	Atorvastatin[1], Lovastatin[1], Pravastatin[1], Rosuvastatin[1], Simvastatin[1]			
Diabetes	Glimepiride[1], Glipizide[1], Glipizide XL[1], Glipizide/Metformin[1], Metformin[1], Metformin ER[1,2], Nateglinide[1], Pioglitazone[1], Repaglinide[1]		Bydureon®[1], Farxiga®[1], Glyxambi®[1] Janumet®[1], Janumet® XR[1], Januvia®[1], Jardiance®[1], Jentadueto®[1], Jentadueto XR®[1], Ozempic®[1], Rybelsus®[1], Synjardy®[1], Synjardy XR®[1], Tradjenta®[1], Trijardy XR®[1], Trulicity®[1], Victoza®[1], Xigduo® XR[1]	Byetta®[1]
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 Rewards and Classic Plus: All Tier 1 | Tier 3 ORAL Antidiabetics and insulin ONLY
Gap Coverage—Chronic Care, Chronic Care Savings: All Tier 1 | Tier 3 ORAL Antidiabetics and 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://www.globalhealth.com/oklahoma/pharmacy/drug-formularies/#medicare-2022

Important Message About What Members Pay for Vaccines, Insulins and Specific Part D Drugs

Our plan covers most Part D vaccines at no cost to the member. Members won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. For D-SNP, our plan covers insulin at no cost to the Member. Members will not pay more than the dollar amount of the CMS published adjusted coinsurance percetage that applies to the specific Part B rebatable drug (typically a single source drug, e.g. brand drug).

Medicare Part D (Generations Plans)
2023 Quick Reference Guide

Tiers	Plan Name	Standard Retail 30-Day Supply	Preferred Retail 30-Day Supply	Standard Retail 100-Day Supply	Preferred Retail 100-Day Supply	CVS Mail Order 100-Day Supply
Tier 1	Classic Rewards/ Classic Plus	$5	$0	$15	$0	$0
	OSR	$5	$0	$15 90-day supply	$0 90-day supply	$0 90-day supply
	Dual Support (D-SNP)/Dual Premier (D-SNP)	$0	$0	$0	$0	$0
	Chronic Care (C-SNP)/Chronic Care Savings (C-SNP)	$5	$0	$15	$0	$0
Tier 2	Classic Rewards/ Classic Plus	$15	$10	$45	$0	$0
	OSR	$20	$15	$60 90-day supply	$0 90-day supply	$0 90-day supply
	Dual Support (D-SNP)/Dual Premier (D-SNP)	$0	$0	$0	$0	$0
	Chronic Care (C-SNP)/Chronic Care Savings (C-SNP)	$10	$5	$30	$0	$0
Tier 3	Classic Rewards/ Classic Plus	$47	$42	$141	$84	$84
	OSR	$47	$42	$141 90-day supply	$84 90-day supply	$84 90-day supply
	Dual Support (D-SNP)/Dual Premier (D-SNP)	$0	$0	$0	$0	$0
	Chronic Care (C-SNP)/Chronic Care Savings (C-SNP)	$47	$42	$141	$84	$84
Tier 4	Classic Rewards/ Classic Plus	50%	40%	50%	40%	40%
	OSR	$100	$95	$300 90-day supply	$190 90-day supply	$190 90-day supply
	Dual Support (D-SNP)/Dual Premier (D-SNP)	$0	$0	$0	$0	$0
	Chronic Care (C-SNP)/Chronic Care Savings (C-SNP)	$100	$90	$300	$270	$270
Tier 5	Classic Rewards/ Classic Plus	33%	33%	N/A	N/A	N/A
	OSR	33%	33%			
	Dual Support (D-SNP)/Dual Premier (D-SNP)	0%	0%			
	Chronic Care (C-SNP)/Chronic Care Savings (C-SNP)	33%	33%			

Gap Coverage—Classic Rewards and Classic Plus: All Tier 1 | Tier 3 ORAL Antidiabetics and insulin ONLY
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Gap Coverage—OSR Plan: All Tier 1 and All Tier 2. In Tier 3, only Insulin and insulin syringes and only ORAL Antidiabetics