

This guide is a tool to help close HEDIS gaps in care; it is a quick reference for common preventive health screenings for anyone with the ability to impact measures (i.e. clinicians, administrators and staff). It is not designed to replace clinical judgment but as a support to reinforce the importance of preventive care and share how clinical decisions impact HEDIS performance.

Helpful Hints

Exclusions:

Appropriately coding for exclusionary criteria removes patients from the respective HEDIS population. Palliative/hospice coding during the measurement year excludes patients from most measures. Additional measure-specific exclusions are listed under each measure.

Electronic Clinical Data Systems (ECDS):

NCQA is transitioning from medical record review to claims or encounter data only. Measures marked with an "E" are now electronic-only and require accurate coding, as medical record review is no longer accepted for compliance.

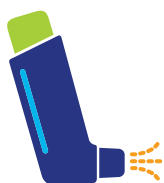
Telehealth:

Telehealth is often an acceptable and underutilized method to close many gaps in care. Telehealth encounters can also place patients into the population.

Health Education and Wellness/ Disease Management:

Refer to Disease Management for patients with **asthma, diabetes, obesity, cardiac conditions, or kidney disease** for support with managing these chronic health conditions. Additionally, Health Education and Wellness support services are available for patients. Referrals can be made through the online provider portal at

provider.healthplanofnevada.com or call **702-242-7346**.



Adults' Access to Preventive/ Ambulatory Health Services (AAP)

Patient Population:

- Ages 20 and older who had an ambulatory or preventive care visit
- Medicaid members annually
- Commercial members once every three years
- Qualifying visits include:
 - Annual wellness visits
 - Office visits (new or established)
 - Telehealth visits
 - Urgent care visits
 - Most outpatient E/M services

Action:

Reach out to members who have not been seen to schedule an appointment.

Goal: Build or maintain member/provider relationship, and address any preventive screenings and health concerns.

Adult Immunization Status (AIS-E)

Patient Population:

- Ages 19 and older for flu and Td/Tdap
- Ages 19 and older for hepatitis B
- Ages 50 and older for herpes zoster
- 19 and older for pneumococcal
- Ages 65 and older for COVID-19

Action:

Provide vaccinations and/or code any anaphylactic reactions for the following immunizations and document in WebIZ:

1	influenza vaccine
1	Td/Tdap vaccine (within MY26 and 9 years prior)
1	hepatitis B
1	(live) or 2 recombinant herpes zoster
1	adult pneumococcal vaccine
1	COVID-19 vaccine

Goal: Disease protection.

Antibiotic Stewardship

Avoidance of Antibiotic Treatment for Acute Bronchitis (AAB) and/or Appropriate Treatment for Upper Respiratory Infection (URI)

Patient Population:

- Ages 3 months and older
- Diagnosed with acute bronchitis and/or upper respiratory infection

Action:

Avoid prescribing antibiotics for members on or 3 days after the diagnosis. Must code for comorbidities if antibiotic Rx is appropriate even without positive cultures (i.e. immunocompromised patients) to remove patient from measure.

Goal: Reduce overuse of antibiotics.

Note: Remember to update diagnosis codes when clinical circumstances change or if suspicions/results change from bronchitis to pneumonia or otherwise.

Appropriate Testing for Pharyngitis (CWP)

Patient Population:

- Ages 3 and older
- Pharyngitis diagnosis

Action:

Complete a group A streptococcus (strep) test or rapid strep test prior to prescribing antibiotics for suspected infection when patient presents with sore throat.

Goal: Reduce overuse of antibiotics.

Note: Avoid prescribing antibiotics for patients on or 3 days after the diagnosis.



Plan All-Cause Readmissions (PCR)

Patient Population:

- Ages 18 and older
- Discharged from an acute inpatient or observation stay

Action:

- Schedule and complete a post-discharge follow-up visit within 7 days
- Perform and document medication reconciliation and confirm the patient has obtained and understands all medications
- Review the discharge summary (diagnoses, pending tests, red flags) and ensure needed labs, referrals, DME, and home services are in place
- Address barriers that commonly drive readmissions (transportation, caregiver support, follow-up access) and reinforce return precautions

Goal: Reduce avoidable 30-day readmissions.

Colorectal Cancer Screening (COL-E)

Patient Population:

- Ages 45–75
- Has not completed a listed screening for colorectal cancer

Action:

Ask and document last colorectal cancer screening date and test type. If overdue: place order or provide at-home testing kit.

- FOBT – annually
- FIT-DNA (i.e. Cologuard®): current year - 2 years prior
- Flexible sigmoidoscopy: current year - 4 years prior
- CT Colonography: current year - 4 years prior
- Colonoscopy: current year - 9 years prior

Additional Exclusions: History of colorectal cancer or a total colectomy

Goal: Cancer detection.

Controlling High Blood Pressure (CBP)

Patient Population:

- Ages 18–85
- Hypertension diagnosis

Action:

- Take and record BP
- Repeat BP if value is >139/89

Goal: Ensure blood pressure (BP) is adequately controlled (<=139/89 mmHg) during measurement year.

Additional Exclusion: Pregnancy

Note: Telehealth counts; patient-reported BPs from a digital home cuff are acceptable when documented in the record.

Tobacco Use Screening & Cessation (TSC-E)

Patient Population:

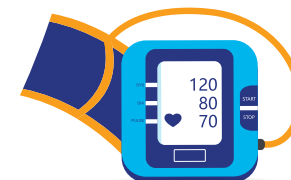
- Ages 12 and older

Action:

- Screen once/year for commercial tobacco use; document with an acceptable screening format, such as a structured questionnaire, standard tobacco use questions, or EMR tobacco use field
 - If positive, provide cessation intervention (counseling and/or FDA for ≥18).
 - Code screening + intervention to be compliant

Goal: Tobacco cessation support.

Note: Refer to Health Education and Wellness for tobacco cessation through the online provider portal or call **702-242-7346**.



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Comprehensive Diabetic Care (CDC)

Patient Population:

- Ages 18-75
- Type 1 or Type 2 diabetes diagnosis

Action:

- Measure and report all of the following labs:
 - HbA1c or glucose management indicator (GMI)
 - eGFR ages 18-85
 - Urine Albumin-Creatinine Ratio (uACR) ages 18-85
 - Albumin/microalbumin and a urine creatinine test (<4 days of each other)
- Consider prescribing a statin (ages 40-75)
- Take and record BP
 - Repeat the BP if either value >139/89
- Refer to eye care provider for retinopathy screening
- Refer to Disease Management for help managing HbA1c through the online provider portal or call **702-242-7346**

Goal: Monitor and manage complications of diabetes through key annual assessments that reduce morbidity, mortality, and cost.

Note: If any required component/coding is missing, the patient is non-compliant for that element.

This guide is not comprehensive; for additional resources use your phone to scan the QR code below.



Healthplanofnevada.com/Provider/HEDIS-Measures

Statin Therapy for Patients with Cardiovascular Disease (SPC-E) & Statin Therapy for Patients with Diabetes (SPD-E)

Patient Population:

- SPC-E: Ages 21-75 with clinical atherosclerotic cardiovascular disease (ASCVD), geared toward treatment
- SPD-E: Ages 40-75 with diabetes without clinical atherosclerotic cardiovascular disease (ASCVD), geared toward prevention

Action:

- Prescribe statin
- Support and improve adherence by prescribing 90-day fills

Additional Exclusions: (must be coded):

- Pregnancy or pregnancy related conditions (IVF, clomiphene use)
- End stage renal disease (ESRD), dialysis or cirrhosis diagnosis
- Myalgia, myopathy, myositis, or rhabdomyolysis; and history of statin induced myalgia/rhabdomyolysis

Goal: Cardiovascular event prevention.

Note: Evidence is a dispensed prescription from pharmacy claims, does not include samples, cash paid or GoodRx that do not generate a pharmacy claim.



Reproductive Health

Cervical Cancer Screening (CCS-E)

Patient Population:

- Patients ages 21-64 with female sex assigned at birth who have not been screened for cervical cancer

Action:

- Schedule, perform, and document the applicable screening type, date and result:
 - Pap smear in the measurement year or 2 years prior (ages 21-64)
 - High-risk human papillomavirus (hrHPV) testing in the measurement year or 4 years prior (ages 30-64)

Additional Exclusions: Hysterectomy with no residual cervix, male sex assigned at birth, cervical agenesis or acquired absence of cervix (document total hysterectomy without residual cervix)

Goal: Cancer detection, early treatment.

Additional Exclusion: Preterm delivery (<37 weeks gestation)

Breast Cancer Screening (BCS-E)

Patient Population:

- Patients ages 40-74 with female sex assigned at birth who have not had a mammogram in 2 years

Action:

- Schedule or place referral for a mammogram

Additional Exclusions: Bilateral mastectomy / acquired absence of both breasts, persons who had gender-affirming chest surgery with a diagnosis of gender dysphoria

Note: Unilateral mastectomy ≠ exclusion.

Goal: Cancer detection, early treatment.

Prenatal Care (PPC)/Prenatal Immunization Status (PRS)/Prenatal Depression Screening and Follow-Up (PND-E)

Patient Population:

- Diagnosed pregnancy

Action:

- Perform and document date of prenatal visit within the first trimester
- Indicators of pregnancy: prenatal flow sheet, LMP, EDD, positive pregnancy test result, gravidity and parity, complete obstetrical history, fetal heart tones, measurement of fundus height, prenatal risk assessment and counseling/education
- Complete depression screening (document test type and score); follow up on positive screenings within 30 days
- Schedule/administer influenza & Tdap vaccinations per guidelines

Goal: Ensuring early initiation of prenatal care/improving maternal health outcomes.

Contraceptive Care - Postpartum Women (CCP-AD)

Patient Population:

- Patients aged ages 15-44 who have had a history of live birth

Action:

- Provide a mostly or moderately effective method of contraception within 3 - 90 days of delivery
- Provide a long-acting reversible method of contraception (LARC= IUD/implants) within 3 - 90 days of delivery

Goal: Prevent unintended postpartum pregnancy, supporting healthy birth spacing and maternal recovery to reduce the instance of subsequent maternal complications, low birthweight infants and preterm deliveries.

Postpartum Care (PPC)/Postpartum Depression Screening and Follow-Up (PDS-E)

Patient Population:

- Delivery of live birth(s)

Action:

Perform and *document* a postpartum visit on or between 7-84 days (1-12 weeks) after delivery and one of the following:

- Postpartum care (PP care, PP check, etc.), pelvic exam, evaluation of weight, BP, breasts and abdomen, perineal or cesarean incision/wound check, screening for depression, anxiety, tobacco use, substance use disorder or pre-existing mental health disorders, glucose screening for women with gestational diabetes, infant care/breast feeding, resumption of intercourse, family planning, sleep/fatigue, resumption of physical activity or attainment of healthy weight
- Complete a standardized, validated depression screening (document test type and score); follow up on positive screenings within 30 days
 - Acceptable screening tool examples: PHQ-9, PHQ-2, EPDS, PHQ-9M, BDI-II, PROMIS depression
 - Acceptable follow-up examples: behavioral health visit/referral, counseling encounter, antidepressant medication prescribed, depression case management encounter

Goal: Setting the stage for long-term health and well-being of new mothers and their infants.

Additional Exclusion: Preterm delivery (<37 weeks gestation)