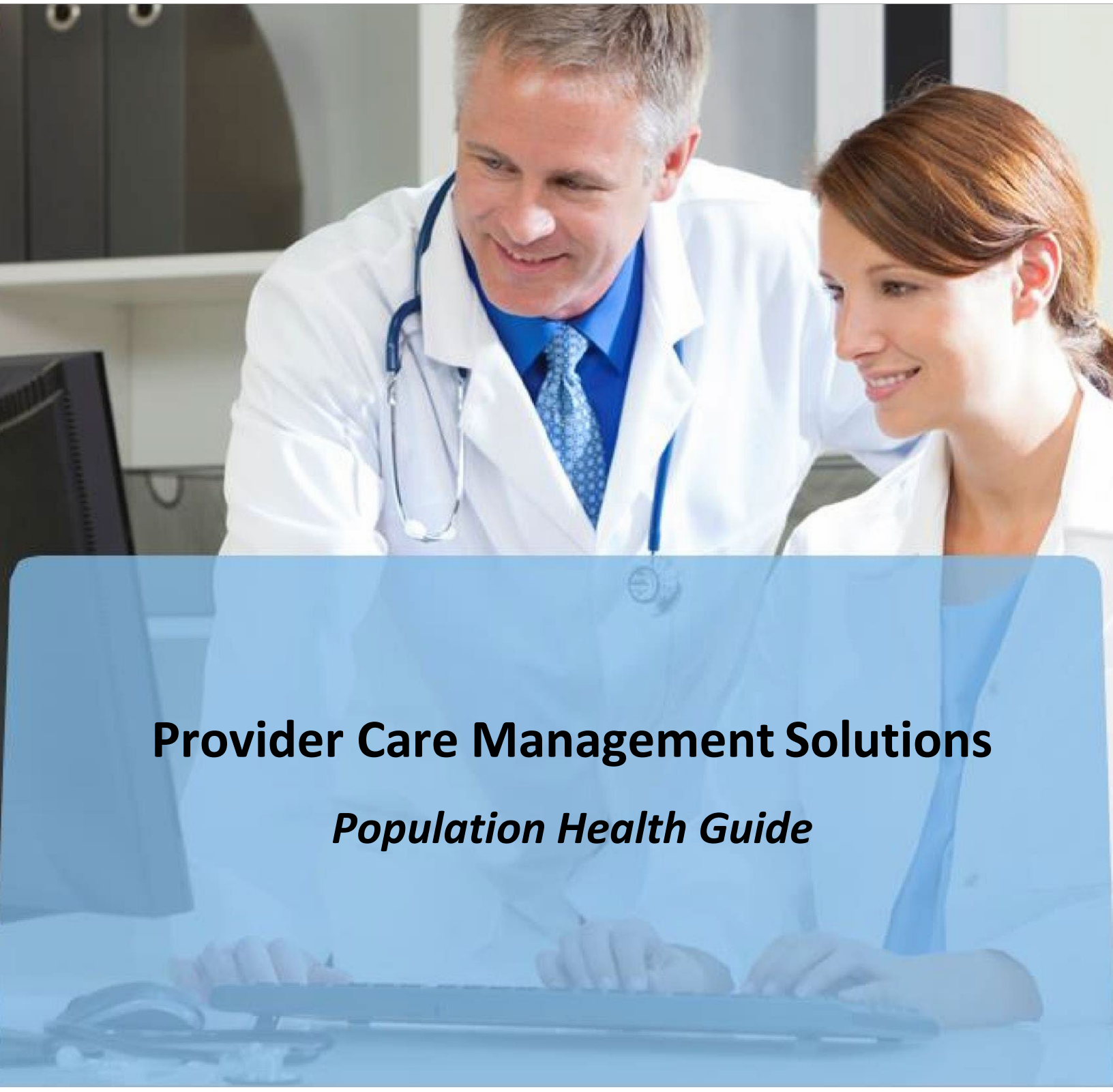
Simply Healthcare Plans, Inc.
Clear Health Alliance
Medicaid Managed Care



Provider Care Management Solutions

Population Health Guide

www.simplyhealthcareplans.com/provider | www.clearhealthalliance.com/provider

SFLPEC-1572-19 August 2019

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Welcome to Provider Care Management Solutions

Provider Care Management Solutions (PCMS) is a web-based population management application available to select providers. Through alerts, dashboards and reports, PCMS helps practices stratify their patient population based on risk and prevalence of conditions, and it offers actionable clinical insights, including alerts to potential gaps in care, ER utilization and patients who are high risk for avoidable admissions or readmissions.

How to use this guide

This guide will provide direction and tips for using the PCMS application, including information about:

- Icons
- Key PCMS terms
- Accessing PCMS
- Using different views in the application to stratify patient data and identify population health needs
- Exporting data to generate reports
- Supplemental appendices

What's New?

Select the links below to navigate to updated information and functions:

- Population Summary Chart
- Care Opportunities Chart
- Ambulatory Care Sensitive Admissions Condition Summary Chart
- Advanced Filters Pharmacy Report
- Program-specific Reconciliations

Icons

Icon	Description
	**Actions:** Three lines in a box; offers a menu to initiate specific actions available within the PCMS tool, including sending automated referrals to the health plan
	**Health Assessment:** Clipboard**; i**dentifies attributed patients who, based on their program and benefit coverage, are identified as requiring a Health Assessment to be completed in ePASS. The icon will display, only as applicable, for four months from initial identification date.
	**High Risk Comorbidities Risk Driver:** Orange indicator paired with Hot Spotter Chronic icon; indicates a Chronic Hot Spotter patient with amplified risk
	**High Risk Controlled Rx:** Pill icon; indicates a patient who is identified for early risk detection and/or controlled substance abuse monitoring (CSUM); the alert is updated weekly
	**Hot Spotter Chronic:** Flame with raised *C*; indicates a patient with at least one core chronic condition who also meets other risk criteria
	**Hot Spotter Readmission:** Flame with raised *R*; indicates a patient who has recently been admitted and is at risk for readmission, based on specific risk drivers, or who has a gap in care that the PCP can address
	**Information:** Gray circle with lower-case **i**; Indicates additional information is available; select the icon to view details

Icon	Description
	**Inpatient Authorization:** Red cross icon; indicates a patient who has been authorized for an inpatient admission in the past 30 days
	**New Patient:** Orange flag with *NEW* text; indicates a patient who is newly attributed to the provider within the past 30 days
	**New to view:** Green circle with white cross indicates the patient has been newly added to the view since the last time the data was refreshed
	**Patient 360 LPR icon:** Patient glyph; launches the Patient 360 Longitudinal Patient Record (LPR) for the associated patient, where available

Key PCMS terms

- **Attribution/Attributed Patients:** Patients who are assigned to the provider for this program

  Note: The attribution date will be the date the patient record was loaded into the PCMS system, which may not correspond with the date the patient's benefits became effective and began receiving care from the provider
- **Care Opportunities: Indicates a potential gap in care, based on HEDIS®* measures the patient** qualifies to receive; care opportunities are color-coded by their due date:
  - **Red:** past due
  - **Orange:** due in 30 days
  - **Yellow:** due in 60 days
  - **Blue:** due during the calendar year
  - **Green:** complete
- **Care Opportunity measures:** The HEDIS-based measures are grouped by categories/conditions, including:
  - **Well visits**
    - Adult access to preventive/ambulatory health services
    - Well-child visits ages 0-15 months
    - Well-child visits ages 3-6 years old
    - Adolescent well-care visits ages 12-21
  - **Upper respiratory infection (URI)/pharyngitis/ADHD**
    - Appropriate testing for children with pharyngitis
    - Appropriate treatment for children with URI
    - Follow-up care for children with newly prescribed ADHD medication
  - **Prevention**
    - Adult BMI
    - Lead Screen in Children
    - Adolescent Immunizations
      - Tdap
      - Meningococcal
      - Combo 1
  - **Pregnancy**

        - Prenatal Care
        - Postpartum Care
    - **Heart Health – Annual Monitoring of Persistent Medications**
        - ACE Inhibitors or ARB
        - Digoxin
        - Diuretics
        - Total
    - **Diabetes**
        - Diabetes: medical attention for nephropathy
        - Diabetes: eye exam
        - Diabetes: hemoglobin A1c testing
    - **Cancer**
        - Breast cancer screening
        - Cervical cancer screening
    - **Behavioral Health – Antidepressant Medication Management**
        - Acute Phase Treatment
        - Continuation Phase Treatment
    - **Asthma/chronic obstructive pulmonary disease (COPD)**
        - Medication management for people with asthma

Readmission Hot Spotter: A patient who has recently been admitted to an inpatient facility and who has a moderate to high risk of being readmitted or who has a gap in care that can be addressed by their PCP

Chronic Hot Spotter: Patients who have been identified as high risk and have at least one core chronic condition (asthma, COPD, congestive heart failure CHF, coronary heart disease CHD, diabetes, hypertension, migraine or morbid obesity).

Prospective Risk Score: A number predicting future health care costs and utilization based on demographic factors (age, gender) and current chronic conditions and comorbidities (diagnoses codes from administrative health care claim data); risk scores are updated monthly

Tickers: Quick reference view of key metrics for the provider and their patients, found on the PCMS home page; the tickers provide recent information about the metric, as well as an up or down arrow comparing the current status to the last time the data was updated, based on the update schedule (i.e., daily, weekly, monthly)

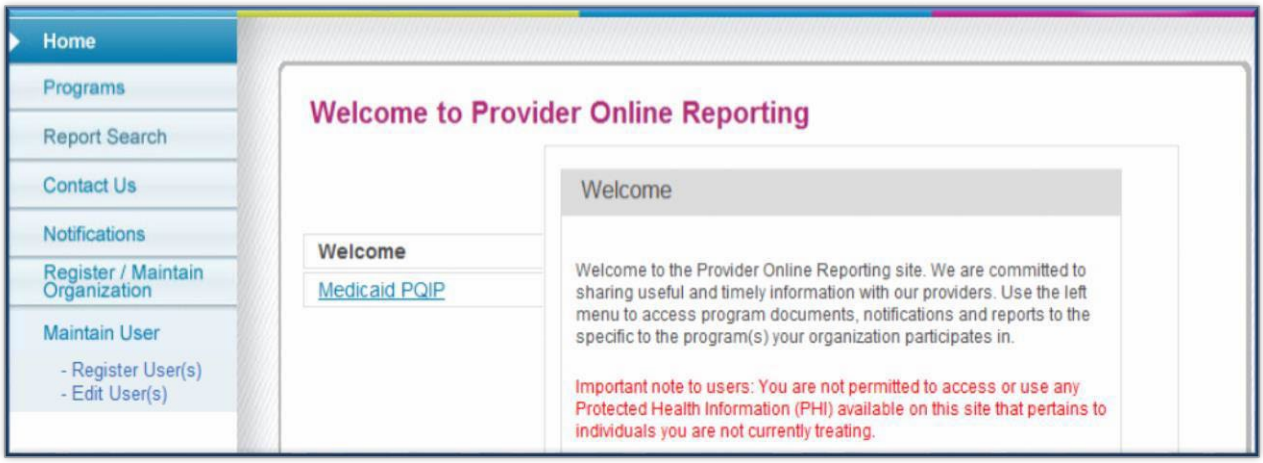
Global Filters: Specific criteria, accessible from the *Filters* link at the top right of the PCMS application, which can be selected and applied across the views in PCMS to narrow the patient information seen

**HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*

Access PCMS

1. Navigate to www.availity.com in your Web browser to access PCMS reports. The Administrator will need to assign authority and role assignment (clinical or financial, as appropriate) to access content in PCMS.
2. Log in.
3. Choose the **More** option.
4. Navigate to *Provider Online Reporting*. The *Provider Online Reporting Welcome Page* is the starting point for accessing reports. **Note:** More details about *Provider Online Reporting* follow.
5. Verify or select **Organization** and **Payer**, then choose **Submit**.
6. Select **Launch Provider Care Management Solutions** from the *Report Search* page.

Provider Online Reporting



From the Welcome Page, users can navigate to the following areas if applicable

- Select the applicable program you are participating in (e.g., PQIP, Risk, Shared Savings, etc.) you have an arrangement with "Medicaid PQIP or Risk/Shared Savings," then "Report Search" in the home panel on the left to "launch Provider Care Management Solutions"
- The "Programs" selection will display a brief description of the Program
- The "Report Search" selection will display a list of reports and the programs available, Launch
- Provider Care Management Solutions will appear at the bottom of the page
- The "Contact Us" selection allows providers to submit questions. Select the appropriate shared savings arrangement program under the comment section, the select "General Support Question" to submit your question.
- The "Notifications" selection will display program notifications
- The 'Register/ Maintain Organization' will display a page allowing users area to verify the organization registration
- Click "Online Resources" to view helpful external websites

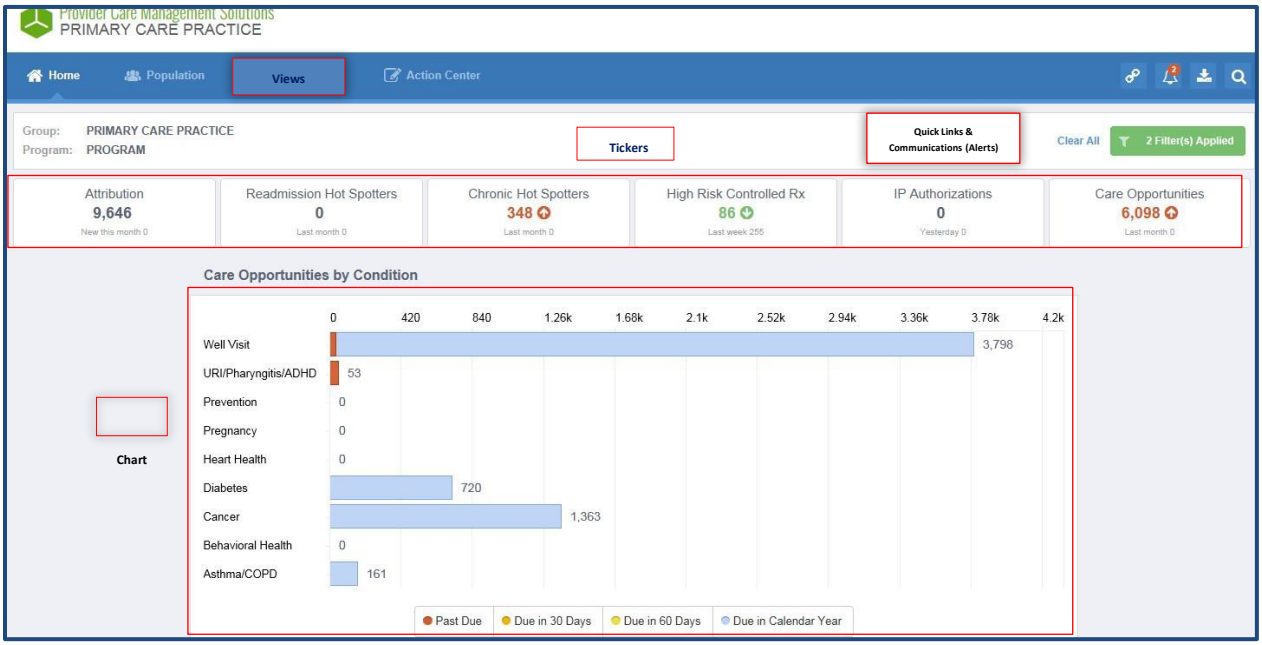
PCMS display

This section will orient you to PCMS' general layout and help you get started exploring all of the reporting capabilities available to users.

Before you get started, check your screen resolution. The recommended screen resolution for optimal viewing is 1400x900. This is typically adjustable by right-clicking on an empty spot on your desktop and selecting "screen resolution." Depending on the size of your computer screen, you may not be able to adjust to the optimal resolution, but the content displayed will be the same.

Home page

When you first log in to PCMS, you'll be on the *Home* page.



The PCMS system information shown throughout this guide is for demonstration purposes only. The information you see when you log in may look slightly different.

- Views (also referred to as tabs)
  - *Home*
  - *Population*
  - *Performance* (availability of data dependent on program; please contact your health plan representative with questions)
  - *Action Center*
- Quick Links
- Communications (i.e., alerts; shown as a bell at the top right)
- Group name
- Tickers
  - *Attribution*
  - *Readmission Hot Spotters*
  - *Chronic Hot Spotters*
  - *High Risk Controlled Rx*
  - *IP Authorizations*
  - *Care Opportunities*
  - *Health Assessments to Complete* (will only display when applicable)
- Chart
  - *Care Opportunities by Condition*
- Filters

Population tab

Select the **Population** tab to access clinical reports. The views under *Population Management* include:

- Attributed Patients
- Inactive Patients
- Care Opportunities
- ER Visits
- Inpatient Admissions
- Pharmacy

Quick Links

Select the **Quick Links**  icon to access the electronic version of this guide and other resources you may find useful.

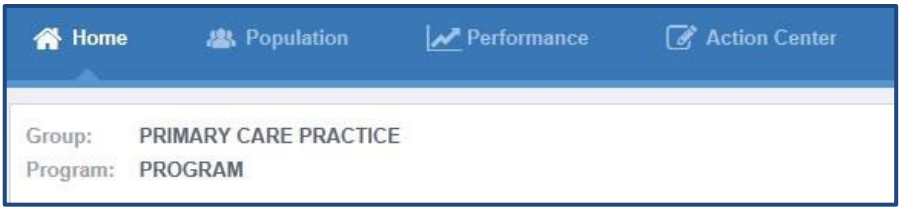
Note: We recommend always using the electronic version of the guide to ensure you have the most up-to-date information.

Communications (alerts)

The bell icon  on the *Home* tab offers the user PCMS alerts such as planned maintenance updates, upcoming enhancements and more.

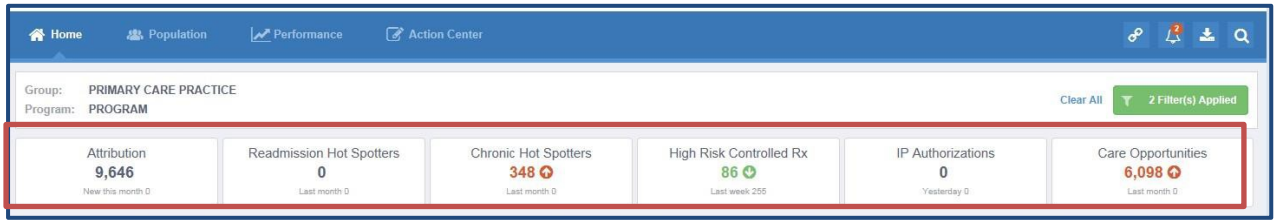
Provider Group Name

The name of the provider group that is tied to the data reflecting in PCMS will display at the top left of the page. Depending on the user's permissions and how the group is set up in PCMS, the user may be able to change the group using the *Filters* panel.



Tickers

Tickers allow the user to view key metrics on the *Home* page, including trends in the organization's patient population. Selecting the ticker displays patient information found in the *Population* view.



Attribution ticker

The *Attribution* ticker shows the number of attributed patients, including a count of newly-attributed patients for the current month. Select the **Attribution** ticker to display a list of all attributed patients (*Population* > *Attributed Patients* view). This ticker is updated monthly; inactive patients are removed daily.

Readmission Hot Spotters ticker

The *Readmission Hot Spotters* ticker shows the number of Hot Spotter patients with a significant risk of readmission, along with the count from the previous month and an arrow showing the trend. Select the ticker to display a list of patients that are readmission hot spotters. This ticker is updated daily.

Chronic Hot Spotters ticker

The *Chronic Hot Spotters* ticker shows the number of Hot Spotter patients with specific chronic conditions as compared to the population of Chronic Hot Spotters the previous month with an arrow showing the trend. Selecting the ticker navigates to a list of Chronic Hot Spotter patients. This ticker is

updated monthly.

High Risk Controlled Rx ticker

The High Risk Controlled Rx Pill ticker shows a patient who is identified for early risk detection and/or controlled substance abuse monitoring (CSUM). This ticker is updated weekly.

Inpatient (IP) Authorizations ticker

The Inpatient Authorizations (IP) ticker shows the number of current inpatient authorizations and the number authorized on the previous day with an arrow showing the trend. Selecting the **IP Authorizations** ticker navigates to a list of all patients with an inpatient authorization. This ticker is updated daily.

Care Opportunities ticker

The *Care Opportunities* ticker shows the current number of care opportunities and the number of care opportunities in the previous month with an arrow showing the trend. Selecting the **Care Opportunities** ticker navigates to a list of patients with active care opportunities. Information is updated monthly and refreshed daily. Once a past due care opportunity is resolved, it may take a few months to fall off the list, as the data is based on periodic claims data updates.

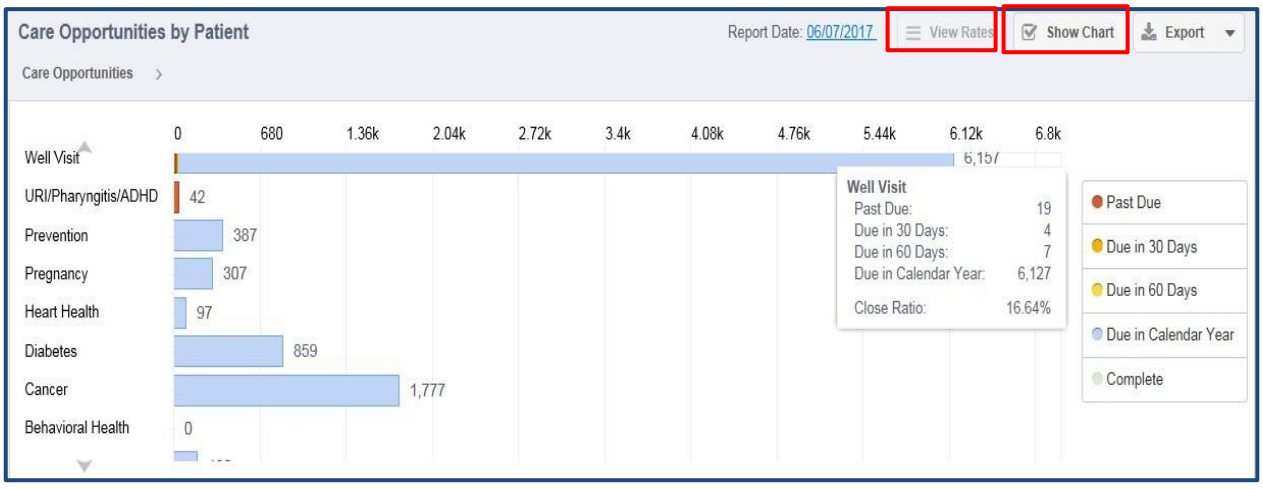
Health Assessments to complete ticker

The *Health Assessments to Complete* ticker indicates the number of patients who, based on program and benefit coverage, are identified as still requiring a Health Assessment to be completed in ePASS. This ticker may not show for all providers.

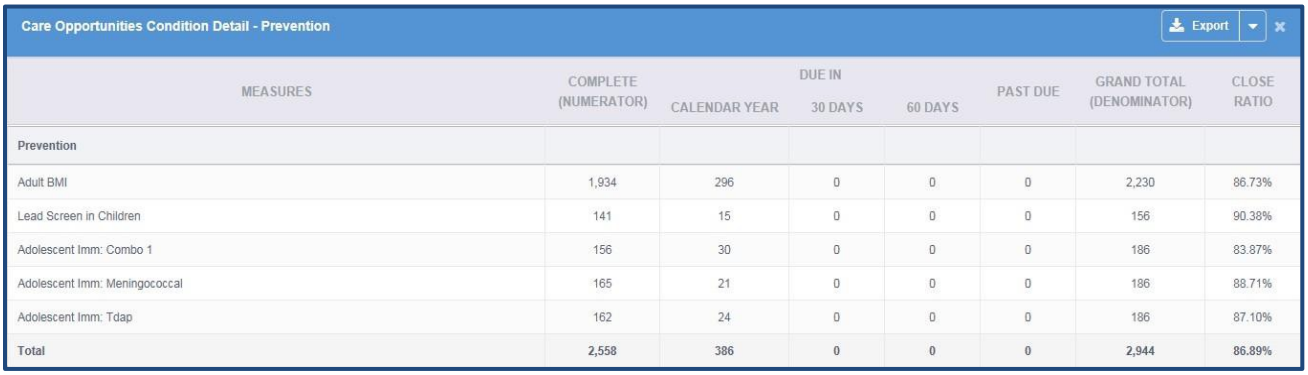
Chart

The *Care Opportunities by Condition* chart visually displays the various statuses of care opportunities among the attributed patient panel by condition/category. Selecting the **Show Chart** button will display the *Care Opportunities* chart:

Hovering over any of the opportunities will display additional information to indicate the number of patients who appear to be past due, those due in 30 and 60 days, those due this calendar year and the Close Ratio (the number of completed measures divided by the total number of measures for the opportunity for the rolling 12 months).



A summary table displays care opportunities by condition when clicking on **View Rates**, as shown below.



Care Opportunities Condition Detail - Prevention

Export

MEASURES	COMPLETE (NUMERATOR)	DUE IN			PAST DUE	GRAND TOTAL (DENOMINATOR)	CLOSE RATIO
		CALENDAR YEAR	30 DAYS	60 DAYS			
Prevention							
Adult BMI	1,934	296	0	0	0	2,230	86.73%
Lead Screen in Children	141	15	0	0	0	156	90.38%
Adolescent Imm: Combo 1	156	30	0	0	0	186	83.87%
Adolescent Imm: Meningococcal	165	21	0	0	0	186	88.71%
Adolescent Imm: Tdap	162	24	0	0	0	186	87.10%
Total	**2,558**	**386**	**0**	**0**	**0**	**2,944**	**86.89%**

Common Functions: Using filters to tailor your reports

Filters can help manage a specified set of patients within the provider's population and offer the ability to view attributed patients across all groups and programs associated with the user.

Note: Use filters to ensure appropriate criteria are applied and search results return the patient list intended.

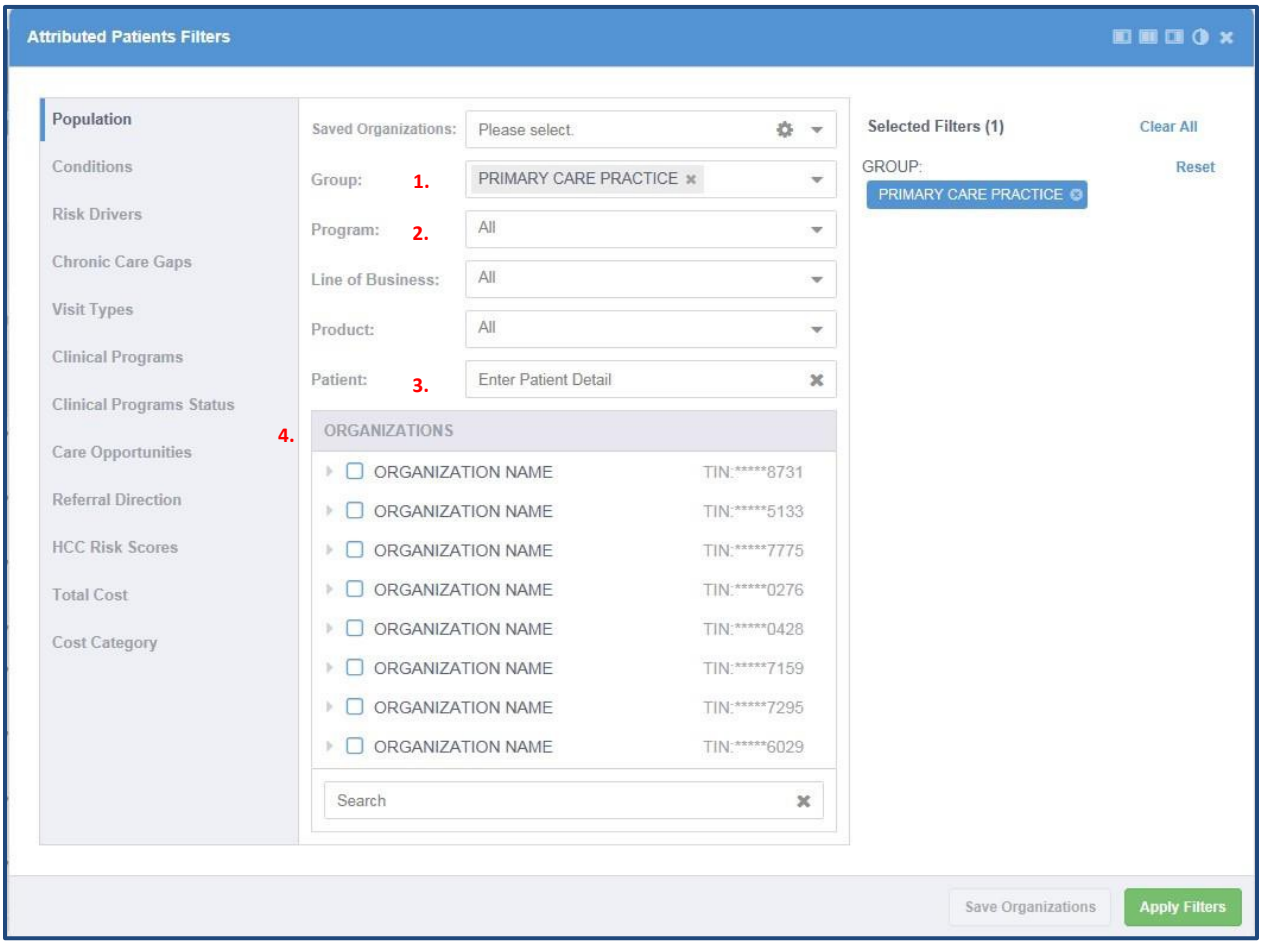
There are three categories of filters in PCMS:

- Global Filters
- Advanced Filters
- Simple Filters

Global Filters

A filter button 

displays at the top right of all views, showing the number of filters applied in the current view. Clicking the filter icon opens a new Global Filters panel. Any filter applied to Population Global Filters will update all Home and Population views if the applied filters are applicable to the respective view.



When filtering in the Population tab, filter in the order displayed – the Group selection (1. above) determines the selections for Program. The Program selection (2. above) determines the selections in LOB and Product.

To search for a particular patient (3. above), enter at least 2 characters of the patient's first or last name in the Patient Search box.

"Organizations" (4. above) contains a list of all TINs associated with the Group selected. Expanding the TIN allows for further drilldown to the individual NPIs of the Practitioners associated with the Organization (or TIN).

Any applied Global Filter automatically updates all Home and Population views. For example, choosing "LOB = Medicaid " for Attributed Patients will automatically update Home Tab, Inactive Patients, Care Opportunities and ER Visits views. This will be reflected in the applied filters box in each respective view. Similarly, removing a Global Filter will automatically update all applicable views.

> **Caution:** Use Global Filters carefully. Always check the white filter box to see what subset of data is currently being displayed. Access the Global Filters panel to make any necessary alterations to the data being viewed.

Customize the filter window by clicking on the function buttons on the top right: 

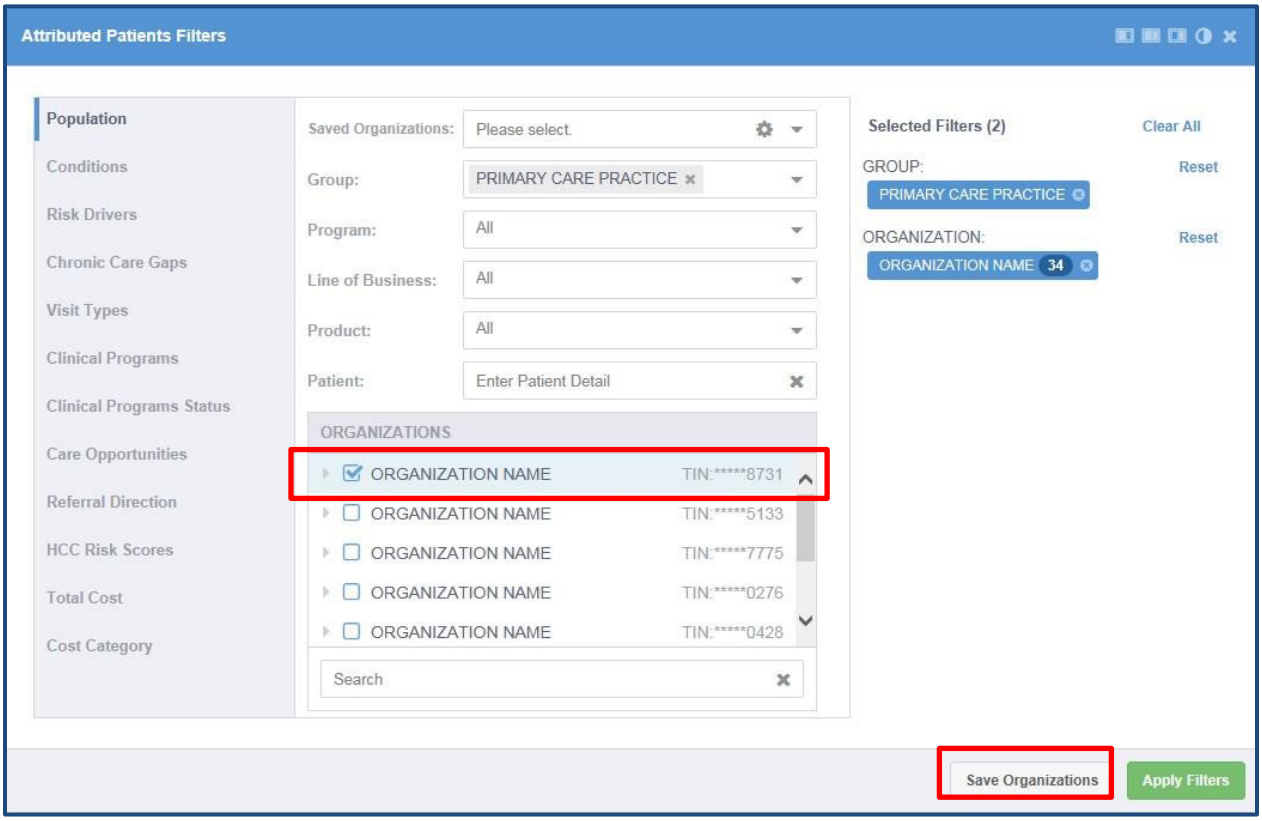
- only show filters
- Show filters and selected filters
- only show selected filters
- Adjust window opacity

Saving a Filter

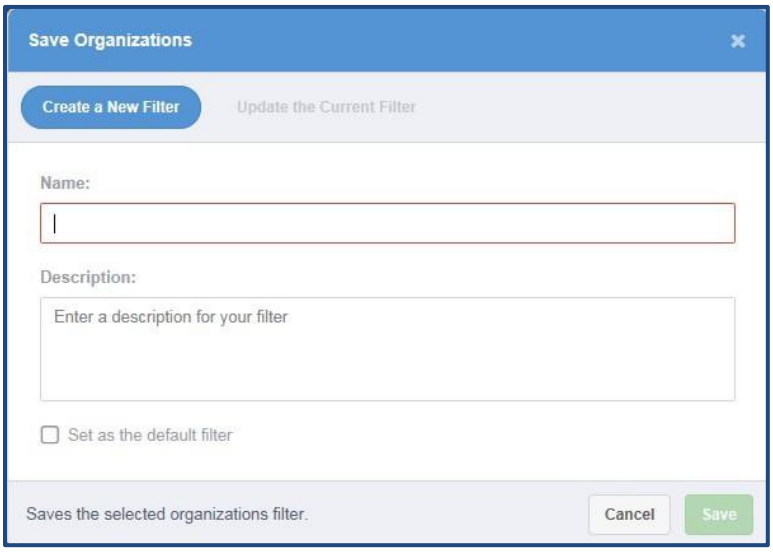
The Population tab allows users to save and manage filters by organization or provider. Organization Filters are saved for the user (by username) who created and saved the Organization Filter to use in their current and any future session of PCMS.

Saved Organization Filters can be combined with other Advanced Filters on the Global Filters Panel as necessary.

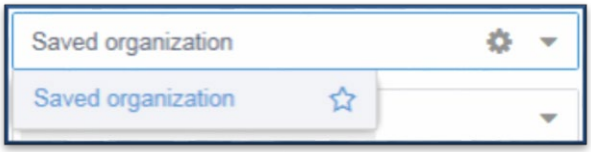
To save an organization, check the boxes to the left of the organization or provider you wish to save. Then click the Save Organizations button in the lower right corner.



Type a name and description for the filter and click “Save.” To save as the default filter, select “Set as the Default filter,” and click “Save.” This default filter will apply anytime the same username is logged in to PCMS.



To edit saved organization filters or select a new default, click on the wheel to the right of the Organization name.



To select a saved organization as a filter, click on the pull-down arrow to the right of “Saved Organizations” and click the star to select the organization.

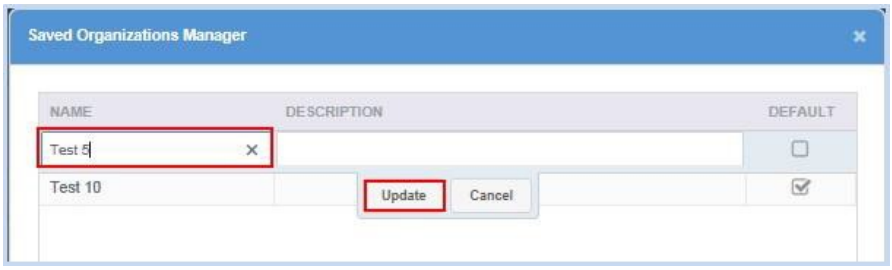
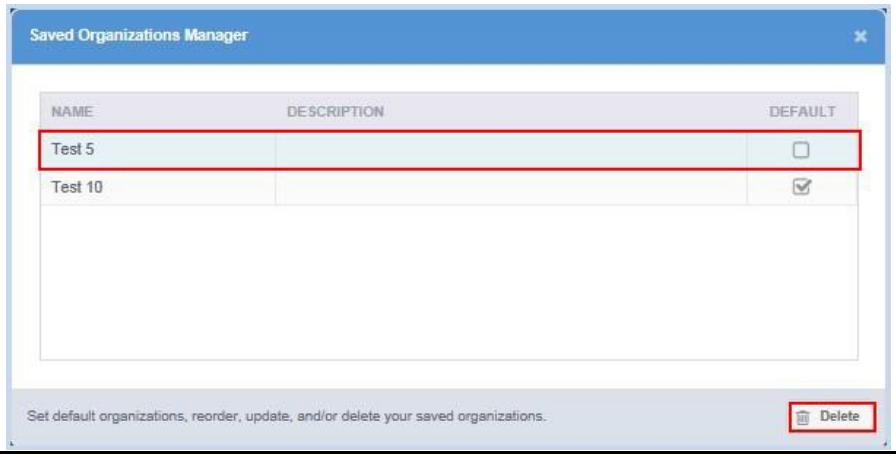
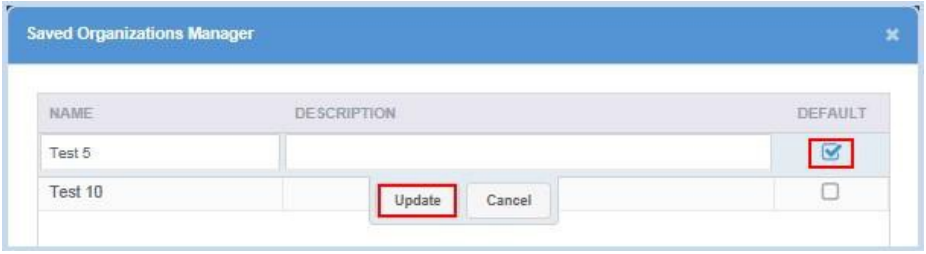
To return to the Global Filters Panel, click Close.

The saved filter is available for selection in the Saved Organizations field by opening the Global Filters panel. Default filters will apply anytime you log into PCMS. Default filters are identified with a solid star in the drop down menu of the Saved Organizations.

Managing Saved Filters

Click on the wheel icon and select your saved filter.

To change the name of a filter, reorder filters, delete or set default filters:
Follow one of the processes below to manage the filters.

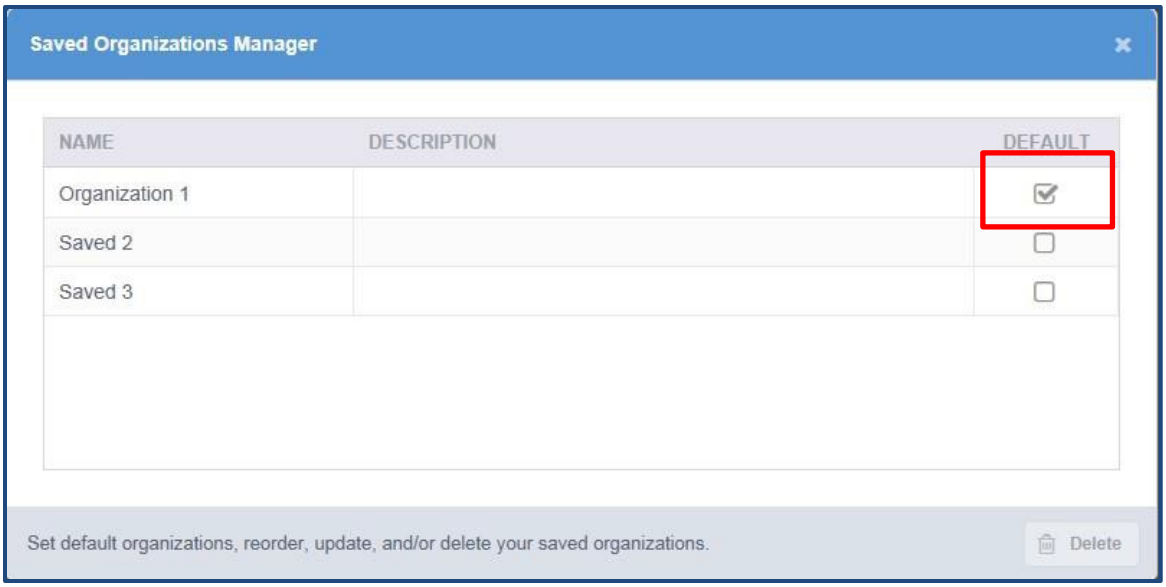
To...	Then...
Change name	Double-click on the name of the filter to select it. Type the new name and enter or change the description if you like. Click **Update**. 
Delete	Click on the name of the filter to select it. Click **Delete**. 
Set to default	Double-click on the name of the filter to select it. Select **Default** and click **Update**. 
Re-order	Click on the filter name and drag and drop the filter name into the desired order. Filter names will appear in the defined order in the **Saved Organizations** dropdown list box in the Global Filters panel

Double-click on the name of the Saved Filter and type over the name of your saved filter.

Click Update to save the updated name of your saved filter

Click on the filter name and drag and drop the filter name into the desired order. Filter names will appear in the defined order in the Saved Organizations dropdown list box in the Global Filters panel.
Click on the check box to the right of the filter name to delete that saved filter.

Click on the check box to set this filter as your default filter. This filter will apply anytime you log into PCMS.



Users may use the drop-downs for the Global Filters to filter by one or multiple Groups, Programs, Lines of Business (LOB) and Products; however, selections must be made in that order, as Group determines the options for Program; Program determines the options for LOB; Program and LOB determine the options for Product.

Patient search
The *Patient* search field is available in the *Global Filters* panel when the user is in the *Population* view.

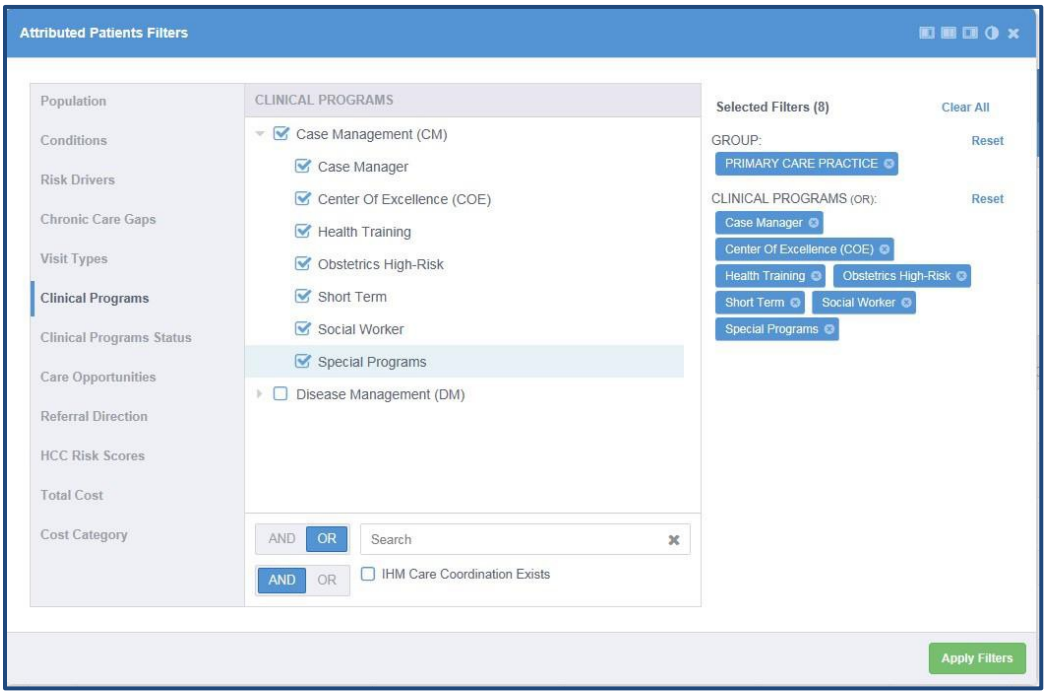
Type the patient's first, last name or any combination thereof and select **Update**.
The list of patients matching the search criteria will display.

Advanced Filters

The Population tab contains Advanced Filters that are applicable to the selected Population report views.

Advanced filters automatically populate the Global Filters panel by clicking on Attributed Patients, Care Opportunities, ER Visits and/or Inpatient Admissions report views. If an advanced filter is shared across multiple views, any applied filter automatically updates all applicable reports. This is reflected in the applied filters box in each respective report view.

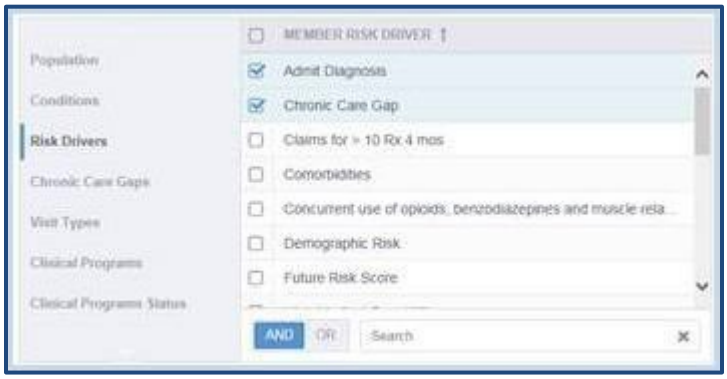
Example: 'Clinical Programs' is an advanced filter common to all Attributed Patients, Care Opportunities, ER Visits and Inpatient Admissions.
Applying a Clinical Program filter in Attributed Patients automatically updates Care Opportunities, ER Visits and Inpatient Admissions. Similarly, removing an advanced filter shared across multiple report views automatically updates all applicable report views.



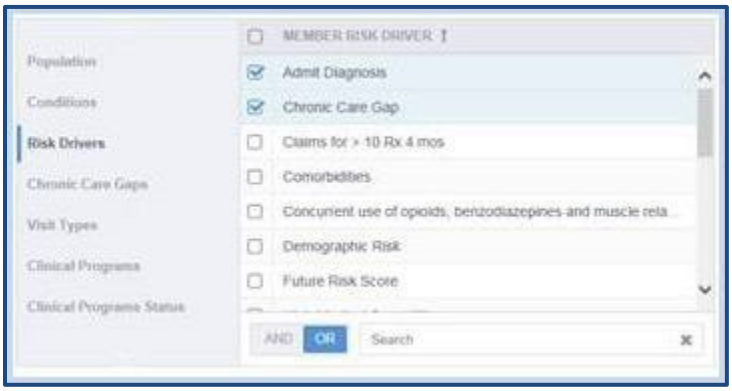
If multiple report view selections are made in the Global Filters panel, advanced filters applicable to any of the selections display.

An “And/Or” function is available for some filters, allowing for customized filtering criteria in order to target certain segments of the population.

The **AND** function filters members that have ALL of the selections made. For example if Admit Diagnosis AND Chronic Care Gap are selected for Risk Drivers, only members who have both Admit Diagnosis and Chronic Care Gap Risk Drivers will generate.



The **OR** function filters members who have any of the selections. For example; if Admit Diagnosis OR Chronic Care Gap are selected, members with Admit Diagnosis, Chronic Care Gap or both will generate.



Caution: Data is not filtered until the Apply filters button is clicked.

The table below indicates which filters are applicable to which view(s).

Views	Filters	
Attributed Patients	Patient Conditions	Clinical Programs
	Risk Drivers	Clinical Programs Status
	Chronic Care Gaps	Care Opportunities
	Visit Types	Referral Direction
Inactive Patients	Referral Direction	
Care Opportunities	Risk Drivers	Care Opportunities
	Chronic Care Gaps	Care Opportunities Status
	Clinical Programs	Referral Direction
	Clinical Programs Status	
ER Visits	Risk Drivers	Clinical Programs Status
	Chronic Care Gaps	Frequency ER Visit
	Types	Date Range
	Clinical Programs	Referral Direction
Inpatient Admissions	Inpatient Admit Types	Clinical Programs Status
	Risk Drivers	Frequency
	Chronic Care Gaps	Date Range
	Clinical Programs	Referral Direction
Pharmacy	Drug Class	

Population views

Listed below are tabs in the *Population* view:

- *Attributed Patients*
- *Inactive Patients*
- *Care Opportunities*
- *ER Visits*
- *Inpatient Admissions*
- *Pharmacy*

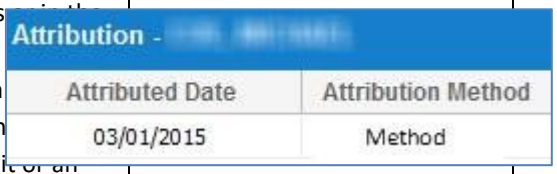
Icons

The icons shown below will display for a patient who meets the criteria associated with each icon. The icons are shown in each view in the *Population* tab, where applicable.

The table below describes each Simple Check Box Filter, and the corresponding icon:

Simple filter (checkbox)	Description	Icon
Hot Spotter Chronic 	This report identifies attributed patients who fall into the category: high risk (% per internal Anthem analytics) with at least one core one of the 8 chronic conditions (Asthma, COPD, CAD, CHF, Diabetes, Migraine, Hypertension and Morbid Obesity).	Icon in patient column is a flame with a small © and displays patient name, months as a Hot Spotter, list of risk drivers. Report frequency is monthly for chronic risk.
Hot Spotter Readmission 	This report identifies attributed patients using the following criteria: demographics, expected future cost, clinical features, such as presenting diagnosis at admission and co morbidity indices, prior utilization including ER use and previous inpatient admissions, length of stay > 10 days and/or high dollar claims > $75,000 over the prior 12 months.	Icon in patient column is a flame with a small “r” and displays patient name, months as a Hot Spotter, list of risk drivers. Report frequency is daily for readmission risk.
High Risk Controlled Rx 	Identifies a patient who is identified using predictive modeling rule for early risk detection and/or controlled substance abuse monitoring (CSUM).	Icon in patient column is a pill and displays patient name, date identified, list of risk drivers

Simple filter (checkbox)	Description	Icon
		Report frequency is weekly for dependency risk.
New Patient 	Identifies a patient newly attributed to a provider. • The attribution date will be the date the patient record was loaded into the PCMS system, which may not correspond with the date the patient's benefits became effective or the date the patient began receiving care from the provider. • PPH (primary care physician or provider) will be designated in the Attribution Method column. This means the patient could have self-selected the provider or was auto assigned.	Icon in patient column is a box with the word NEW. Displays patient name, attributed date and attribution method.
Inpatient Authorization 	Shows attributed patients who have been authorized for an inpatient admission. Attributed patients will appear on this report from the time admission is authorized through 30 days post-discharge.	Icon in patient column is a red cross. Displays patient name, Inpatient facility name, length of stay, admission date, discharge date, admitting diagnosis and readmission risk. Report frequency is daily.
New to View 	Will display if records are new to the selected report, based on the report refresh logic The green plus attached to another icon indicates the patient is newly identified as meeting other icon criteria. A patient is considered "new" if: • The patient was identified during the prior month as a chronic hot spotter (updated monthly) • The patient was identified as a readmission hot spotter during the	A small green plus sign is added to the icon in the patient column.

Simple filter (checkbox)	Description	Icon
	prior 14 days (updated daily) • The patient was identified as having an inpatient authorization during the prior 72 hours [illegible] future (updated daily) • We received a new claim [illegible] past 7 calendar days iden[illegible] the patient had an ER visit [illegible] inpatient admission	
Health Assessment 	If applicable - identifies attributed patients who need a Health Assessment completed in ePASS. The ePASS indicator will continue to display until the patient no longer has any open clinical documentation gaps.	Icon in patient column is a clip board. Displays link to ePASS tool and directions to complete a health assessment in ePASS.

New patients

The  icon indicates newly attributed patients. Selecting this icon will display the attribution date and method.

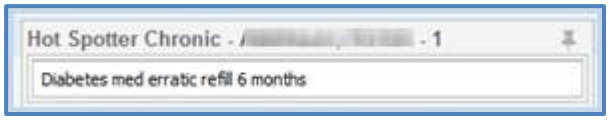
Notes:

- The attribution date will be the date the patient record was loaded into the PCMS system, which may not correspond with the date the patient's benefits became effective or the date the patient began receiving care from the provider.
- **PPH (primary care physician or provider)** will be designated in the Attribution Method column. This means the patient could have self-selected the provider or was auto-assigned.

Chronic Hot Spotter

The flame with a raised *C*  represents a Chronic Hot Spotter patient, who is high risk and has at least one core chronic condition (asthma, COPD, CHF, CHD, diabetes, hypertension, migraine, morbid obesity).

Selecting the Hot Spotter Chronic icon displays the risk drivers associated with the patient's conditions.

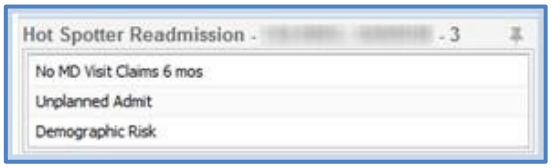


High Risk Comorbidities Risk Driver

The  icon, an orange indicator shown in conjunction with the Hot Spotter Chronic icon, identifies attributed a patient who is a Chronic Hot Spotter and also has at least one high-risk comorbidity. These comorbid conditions in combination with one of the core chronic conditions amplify the risk for the patient and tend to be linked with a higher tendency for self-care management issues. Selecting the information icon next to conditions will display the list of conditions associated with the patient. These risk drivers will be added to the Risk Factor filter options in the *Filters* panel.

Readmission Hot Spotter

The  icon, a flame with a raised *R*, identifies attributed patients with a recent inpatient admission that are at risk for readmission. Selecting this icon will display associated risk drivers.



Inpatient authorization

The red cross icon  identifies all attributed patients who have been authorized for an inpatient, acute care admission. Select the icon to get more information about the inpatient authorization including:

- The inpatient facility
- Length of stay
- Admission date
- Admitting diagnosis
- Discharge date: An asterisk indicates an estimated date of discharge based on authorized length of stay
- Readmission risk: Readmission risk is a patient's risk for an inpatient readmission within 90 days of a primary inpatient event; it is calculated with a proprietary predictive model using:
    - Current admission information
    - Overall utilization history and cost risk
    - Disease comorbidity
    - Demographic data


Inpatient - [redacted]

Inpatient Facility	Length of Stay	Admission Date ↓	Discharge Date	Admitting Diagnosis	Readmission Risk
[redacted] Hospital	18	03/21/2015	04/08/2015	HEMOPHAGOCYTIC SYNDROMES	54.62%

New to View

The green plus attached to another icon indicates the patient is newly identified as meeting other icon criteria. A patient is considered "new" if:

- The patient was identified during the prior month as a chronic hot spotter (updated monthly)
- The patient was identified as a readmission hot spotter during the prior 14 days (updated daily)
- The patient was identified as having an inpatient authorization during the prior 72 hours or in the future (updated daily)
- We received a new claim in the past 7 calendar days identifying the patient had an ER visit or an inpatient admission

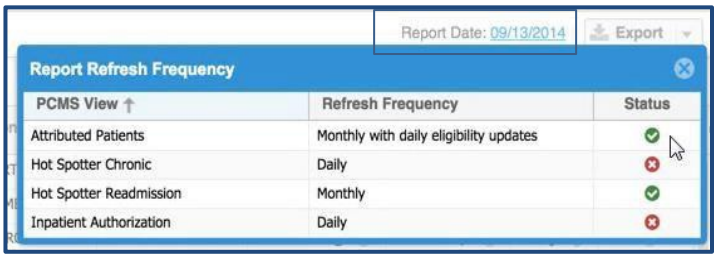
Health Assessment

The clipboard icon identifies attributed patients who, based on their program and benefit coverage, are identified as requiring a Health Assessment to be completed in ePASS. The icon will display, only as applicable, for four months from initial identification date.

Report Date

The Report Date displays in the upper right of each *Population* view. This window indicates each data point, the expectation for how frequently that data is refreshed in PCMS, and the status of the refresh—complete or incomplete.

Note: Data refreshes at different frequencies depending on the data type and data view. Select the *Report Date* link to view the *Report Refresh Frequency* table. A green check indicates that data has been updated as of the date of the report; a red X indicates the data has not been updated.



Export

The **Export** button is available at the top right of each view in the *Population* tab. This function allows the user to export PCMS data to an Excel xlsx. or PDF file format. Selecting the Export button without selecting the down arrow defaults to Excel. Refer to the *Export Glossary* for more information.

Attributed Patients view

The general purpose of attribution data is to identify the patients for whom a practice is responsible for providing primary care and coordinating care with other providers to ensure patient care needs are met.

This view, available in the *Population* tab, provides information on patients who are attributed to a provider and includes the data columns described in the table here. You can find additional details about some of these columns following this table.

Column/component	Description
Actions ≡	Select to access specific actions/functions in PCMS
Patient 360 LPR	Launches the Patient 360 LPR for the associated patient, where available

Patient	The full name (last name, first name), gender, age, date of birth of the patient
Attributed Provider	Either the full name (last name, first name) of the primary care physician or provider the patient is assigned to or the name of the primary organization the patient is assigned to
Organization	The provider organization (tied to tax identification number) assigned to patient
Prospective Risk Score	A score reflecting the patient's relative risk of future health care cost and use over the next 12 months
Care Opportunities	The total number of care opportunities identified for the patient for the incurred reporting period
Chronic Care Gap Score	Represents the weighted total of all identified risk drivers/gaps for the patient; the list of risk drivers/gaps have been prioritized and assigned a numerical value to create the score **Note:** If this column is not displayed in the tool: 1. Hover over the *Prospective Risk Score* column header 2. Select the drop-down arrow 3. Select **Columns** 4. Select the Hot Spotter Gap Score check box
Conditions	The number of chronic conditions identified for the patient for the incurred reporting period
Visits	The number of visits the patient has had (outpatient facility, inpatient, ER, urgent, attributed provider) in the past rolling 12 months
Clinical Programs	Indicates whether the patient is enrolled in a health plan Case Management or Disease Management program

Actions

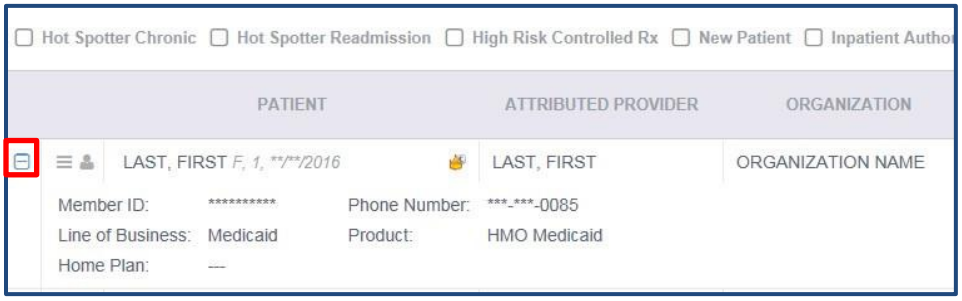
Select the *Actions* icon to display a list of actions/functions that can be initiated within PCMS, such as submitting patient referrals to the health plan for care management/disease management programs. Refer to the *Submitting Referrals* section later in this guide for more information.

Patient 360 Longitudinal Patient Record

Where available, the P360 LPR icon will launch the record for the associated patient. Refer to *Accessing the Patient 360 Longitudinal Patient Record* section later in this guide for more information.

Patient

Select the plus (+) sign to the left of the patient name to obtain more details about the patient, including sex, age, date of birth, member ID number (assigned to the patient by the health plan), line of business, product and patient phone number.



Attributed Provider

This is the provider that the patient is assigned to and who should be primarily responsible for managing the patients care needs.

Prospective Risk Score

The Prospective Risk Score is a number predicting the patient's risk of future health care costs and utilization based on demographic factors (age, gender) and current chronic conditions and comorbidities (diagnoses codes from administrative health care claim data). Scores are updated monthly using DxCG software developed by Verisk Health, an external health care data analytics company.

A score of 1 represents an "average" member. If someone has a score of 2, they are predicted to use twice the amount of medical services as the "average" member and cost twice as much as the average member. A score of 10 means the member is predicted to use 10 times the amount of services and cost as an "average" member.

The data elements used to calculate risk score are modeled to classify patients into coherent clinical groupings which result in aggregated, empirically valid scores at the member level. As prospective risk scores capture the chronic, or recurrent, disease burden of members, models and payments based on such scores can be thought of as a quantification of differences in illness burden or morbidity levels among groups of individuals and a true measure of associated resource utilization.

In the context of the visual indicators that may appear next to a patient's risk score:

A green arrow up indicates an increase of 10 percent.
A red arrow down indicates a decrease of 10 percent.

Care Opportunities

In the *Attributed Patients* view, the *Care Opportunities* column will display the number of open care opportunities and an information icon. Select the information icon to display details about the care opportunities the patient is eligible for based on evidence-based guidelines and clinical quality metrics, including:

- Name of care opportunities the patient is eligible for
- Last date of compliance for each care opportunity
- The number of remaining visits for each care opportunity
- Clinical due date for each care opportunity

In the example above, the patient is indicated as having four care opportunities in the *Care Opportunities* column and the number *4* is next to the patient's name in the *Care Opportunities* dialog box. While there are six total care opportunities the patient is eligible for, two have a complete status (indicated by the green color in the *Clinical Due Date* column) and the other four are still open for completion by the provider. Dashes in the *Last Date of Compliance* column indicate we have not received a claim for that care opportunity in the past 12 months.

Note: If a patient has no care opportunities, either open or closed, no information icon will display in the *Care Opportunities* column for that patient.

Care Opportunities are color-coded based on the clinical due date by which the service must be provided according to HEDIS guidelines. These status colors will display in the dashboard grid and in the *Clinical Due Date* column that displays when you select the information icon to view the details of the care opportunities that apply for the patient:

- Blue: due in calendar year
- Yellow: due in 60 days
- Orange: due in 30 days
- Red: past due
- Green: complete

Care Opportunities data is updated monthly and is based on claims information. Data may not display in the absence of a paid claim for the service or for a patient who is new to the practice or plan and no historical claims data is available. If more than one service is required for the measure, the date of the first paid claim is displayed as well as the clinical due date factors in all services.

Chronic Care Gap Score

The **Chronic Care Gap Score** represents a weighted total of the open chronic care gaps for Chronic and Nonchronic Hot Spotter patients. This score is based on how many open care gaps the patient has. Each care gap has a numerical score that is weighted by clinical priority based on our analytics risk model intended to identify gaps with the greatest impact to quality and cost.

A trending arrow up or down indicates movement for the measure. Arrows up or down indicate a change in gap score greater than or equal to three in the last month.

Selecting the information icon displays chronic care gaps, up to a maximum of 10 care gaps.

Deep Dive Reference Guide: Hot Spotter and Non-Hot Spotter Chronic Care Gaps

Purpose: The *Hot Spotter* filter helps providers target interventions by identifying patients at the highest risk for hospitalization, emergency care or complications based on demographics, ER utilization, care management engagement, cost of care, readmission and chronic conditions. The *Non-Hot Spotter Chronic Care Gaps* targets members that would benefit from interventions due to chronic conditions with identified gaps in care.

Hot Spotter

Description: Identifies attributed high-risk patients who may benefit from a care plan. The report targets attributed high-risk patients with a recent inpatient admission at risk for readmission and/or those with one or more core chronic conditions (asthma, COPD, CHD, CHF, diabetes, hypertension, migraine and morbid obesity).

Chronic Hot Spotter inclusion criteria

- Core chronic conditions include asthma, COPD, CHD, CHF, diabetes, hypertension, migraine and morbid obesity
- Specific Care Gaps for other high-risk members, otherwise not identified above by risk, will increase their inclusion as a Hot Spotter
- High-risk comorbidity conditions that amplify the risk score are identified
- Top 10 percent of Prospective Risk
- Chronic Care Gaps (identified chronic gaps in Chronic Care Gap Score column)

Readmission Hot Spotter criteria

- Continue to identify those members who have an inpatient admission and are at high risk for readmission, or
- Inpatient admission and one of three care gaps
    - No doctor visit in the last 6 months
    - Chronic medication noncompliance
    - More than 10 medications in the last 4 months
- High length of stay (10+ days) or high dollar costs ($75,000+ in the preceding 12 months)

Non-Hot Spotter Chronic Care Gaps

Description: Identifies attributed patients with one or more core chronic conditions identified for Hot Spotter Chronic methodology and who have care gaps—but who are not classified as Chronic Hot Spotters. The intent is to help providers in identifying patients that, through proactive interventions, can limit future risk of incurring health expense and improve quality of care.

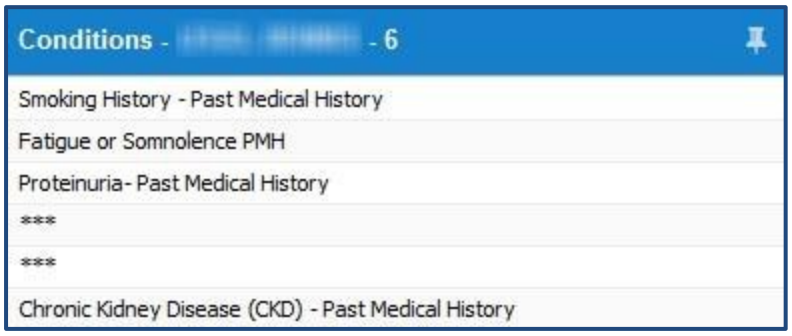
Criteria to be included for Non-Hotspotter Chronic Care Gap Score column:

- Identifies members who have one or more of the core chronic conditions who have not met the threshold to be considered a chronic Hot Spotter
- Identified with chronic care gaps

Conditions

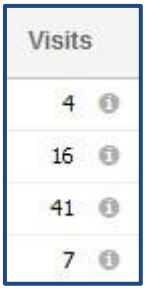
This field indicates the number of chronic conditions that are associated with the patient based on a specific condition list in PCMS.

Select the information icon next to a number in the *Conditions* column field to see that patient's conditions or past medical history of conditions, up to a maximum of 10 conditions. The conditions that display for the patient are sorted based on the greatest chance for impacting quality and cost (based on our Comprehensive Solutions analytics risk model), not in alphabetical order. Asterisks indicate the condition is on the sensitive condition list and is prohibited from being shared in accordance with HIPAA requirements and state and/or federal guidelines.



Visits

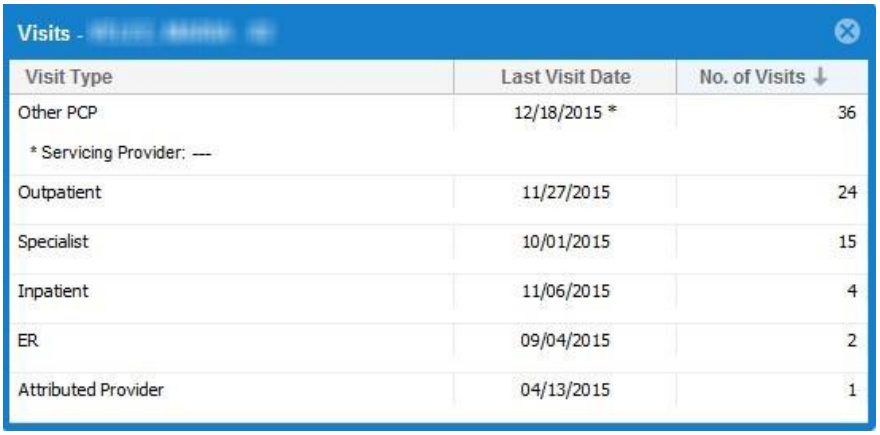
This column displays the total number of visits (outpatient facility, inpatient, ER, urgent care, attributed provider, specialist, other PCP) associated with the patient in the past rolling 12 months.



Select the information icon to display information including the visit type, the date of the last visit for each visit type and the total number of visits of each type.

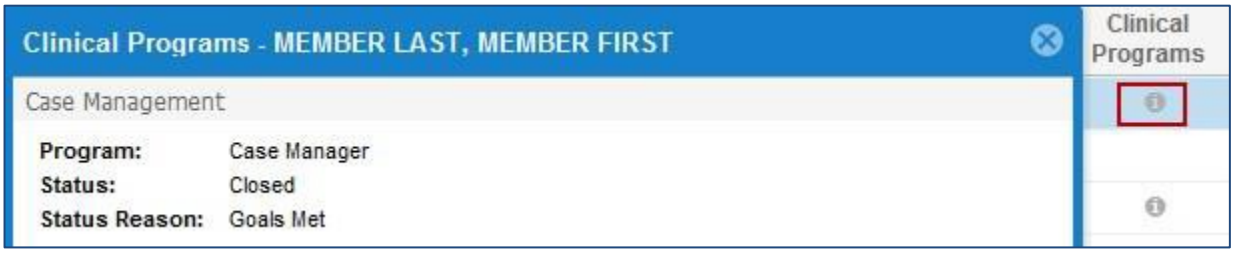
If the last PCP visit was not to the patient's attributed provider, the name of the PCP who provided the service will display in the *Other PCP* row when you select the *Visits* information icon.* Visits data is updated daily.

*Data field has known issues. We are actively working to resolve the issues and will communicate updates as they become available.

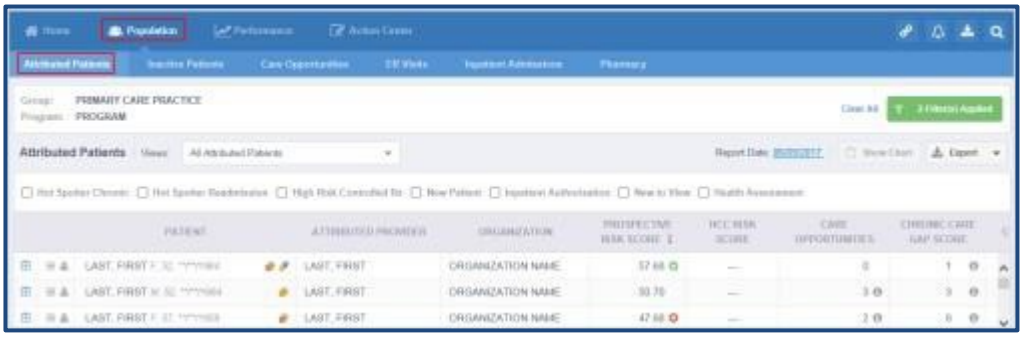


Clinical Programs (Case Management/Disease Management)

The *Clinical Programs* column indicates whether a patient is enrolled in one of our Case Management and/or Disease Management programs and the status of their participation in the program.



This report profiles the Provider's attributed members. Attribution data helps PCMS users identify the patients for whom a practice is responsible. It also provides basic patient information that may help the care team.

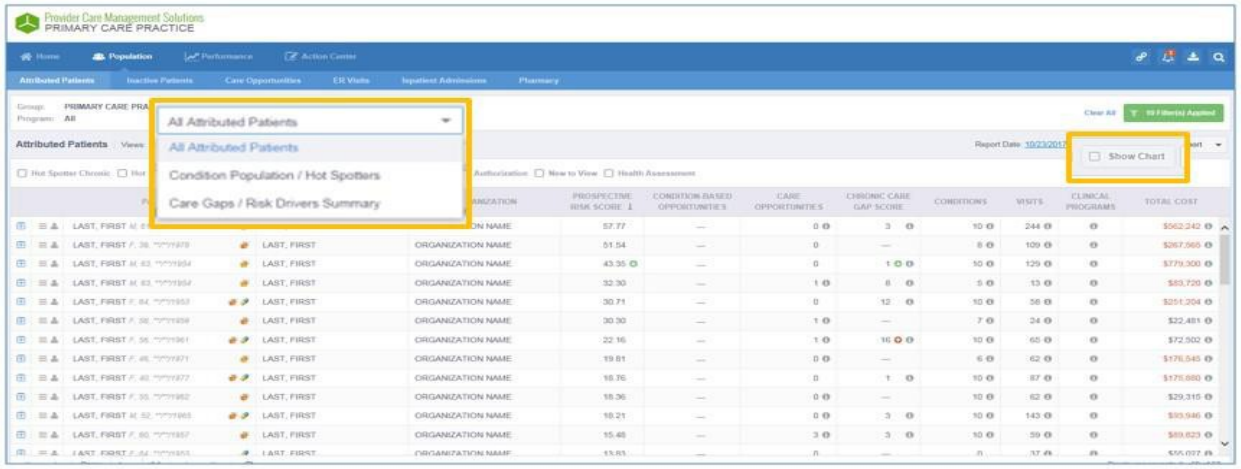


Population Summary Chart

The following Population Summary Charts are displayed at an aggregate view level in the Attributed Patients view when selected in the drop down menu:

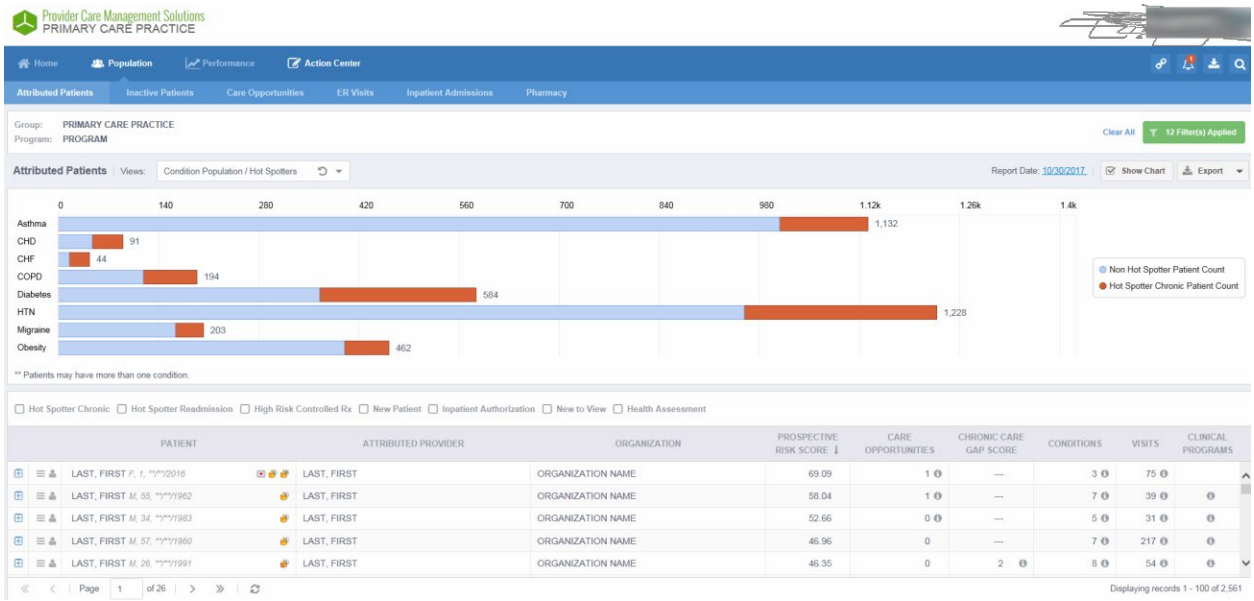
- Condition Population / Hot Spotters
- Care Gaps / Risk Drivers Summary

When one of these charts is selected, the **Show Chart** button is activated to enable the user to view the chart and the corresponding patient list or just the patient list.



Once a view is selected, a refresh symbol appears in the drop-down menu. Click the refresh icon to return to the default view.

Example: The following is an example of the Condition Population / Hot Spotters Chart displaying the chart, hover tool tip window and the patient list (with both non hot spotter patient count and hot spotter chronic patient count selected)



The total counts in the charts include both chronic Non Hot Spotter and chronic Hot Spotter. Click on a specific condition in the bar graphs, the graph highlights the selected condition while the other condition categories gray out. Both the graph and patient grid refresh accordingly, displaying all patients with the selected condition and all co-morbids identified (gray bars). Clicking on Hot Spotter / Non Hot Spotter legend to the right of the chart to display only those patients selected.

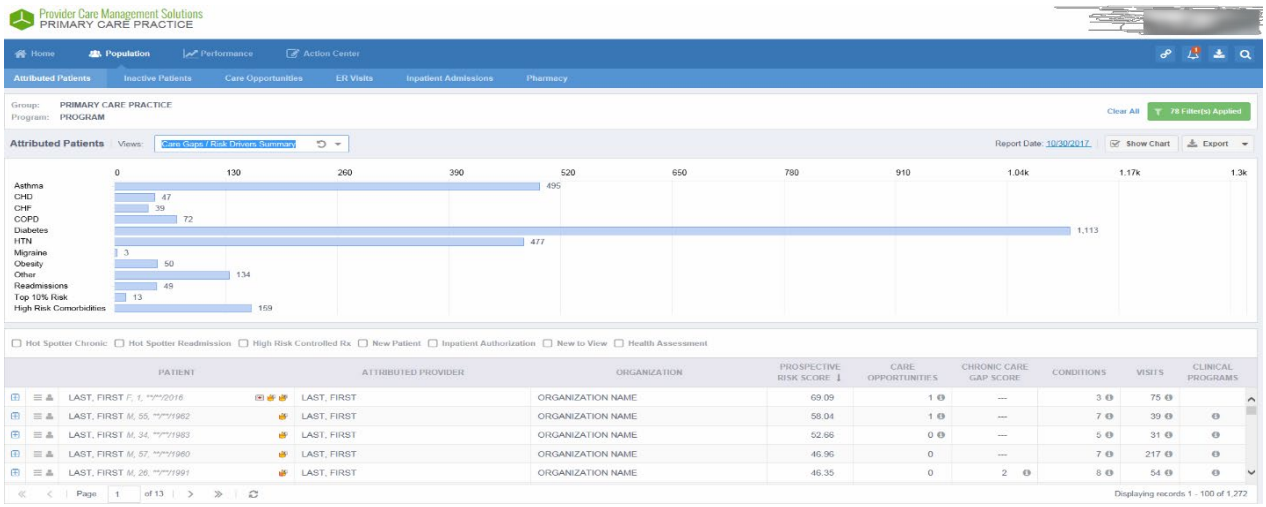
Hovering over a specific condition in the bar graph will display a tool tip window, the content includes:

- Total number of Non Hot Spotter Patients
- Total number of Hot Spotter Patients

- % of condition population on Hot Spotter
- Chronic Care Gap Count
- Average Gap Score

Average Gap Score

The following is an example of the Care Gaps / Risk Drivers Summary Chart displaying the chart and the patient list. Risk drivers display for non-Hot Spotter, Hot Spotter chronic and Hot Spotter readmission patients. **Other** represents care gaps not mapped to a specific chronic condition, such as preventive type screenings such as "Age 45 or older needs diabetes screening"



Clicking on a specific condition or risk driver category highlights the selected category while the other categories gray out. Both the graph and patient grid refresh accordingly, displaying all patients with the selected category and all care gaps/risk drivers identified (gray bars).

To export the patient list grid, select Excel or PDF. To export the graph, select PDF. Using the drop-down function select "Chart and Grid" or "Chart Only." When selecting Chart and Grid, two separate files download –- one PDF for the patient grid list and one PDF for the chart.

Using the Attributed Patients view

The *Attributed Patients* view offers multiple ways to stratify the provider's attributed patient panel according to specific risk factors, including:

1. Sort the patient list in order from highest Prospective Risk Score to lowest by selecting the column header (once or twice, depending on how the list currently displays) and establish a threshold for focus. Conduct outreach to those patients who have a Prospective Risk Score at or above the threshold. When setting the threshold, remember: the Prospective Risk Score is a number that predicts the patient's risk of future health care costs and utilization based on demographic factors (age, gender) and current chronic conditions and comorbidities (diagnoses codes from administrative health care claim data). The score for an average healthy patient is 1.0. So, for example, a score of 2.0 means the patient is twice as likely to require high cost services compared

to the average patient.

2. Use the simple filters to identify your hot spotter patients—chronic, readmission or chronic with high-risk comorbidities. Review the specific details for the patients in this list to identify strategies for managing the patients' conditions and risk drivers that can help keep these patients as healthy as possible in the context of their specific care needs.
3. Use the filters to identify your cohort of patients with a specific condition and identify opportunities to focus your efforts according to the needs of this patient population. For example, which of the patients with that condition have not yet seen their assigned PCP this year? Which of the patients among that condition set also have a high Prospective Risk Score? Which still have open care opportunities that can be closed?
4. Use the simple filters to identify those patients with a recent inpatient stay who have been identified as readmission hot spotters—those patients with an increased risk of experiencing an adverse event or readmission within 90 days of their stay. Outreach to these patients to ensure they have a post-discharge follow-up visit with their primary care team, which can help manage their care needs after their hospital stay.

Frequently Asked Questions: Attributed Patients view

Q1: A patient has selected one of our physicians as a primary care provider. Why does the patient not appear on the provider's Attribution report?

A1: A member may have changed their PCP after the attribution was applied. Physicians should treat the member and allow the data updates to process and self-correct in the next reporting period.

Q2: Is it possible for a patient to have a high Prospective Risk Score but not be a hot spotter?

A2: Yes, the patient can have high Prospective Risk Score without having the Hot Spotter criteria.

Members on the Hot Spotter Report are a subset of the full attributed population found on the Attributed Patients view report.

A Prospective Risk Score is provided for all members. It is a relative risk of the member's future health care costs and use so a member could have a low risk score (.5), average risk score (1), high risk score (10) – whatever that member's score is based on the most recent DxCG model update.

The Attributed Patient view does not limit the report to only those with a certain risk profile. The Hot Spotter criteria, on the other hand, contains only the subset of the provider's patients that are the highest risk based on a recent inpatient admission or a chronic condition that we believe may benefit from a provider care plan. Generally, it's about 4 percent of your overall population and tends to be your high cost utilizers. These patients are identified through a detailed claim history to have:

- At least one core condition (asthma, COPD, CHD, CHF, diabetes, hypertension, migraine, morbid obesity)
- A recent admission that places them at risk for readmission, length of stay more than 10 days and/or 12 months of claims costing more than $75,000

Q3: What does the Prospective Risk Score and the risk change mean?

A3: The Prospective Risk Score is used to predict future health care costs. The score is based on claims data related to diagnosis, gaps in care and utilization of services. The higher the risk score, the higher the potential for acute episodes due to uncontrolled management of their health and subsequent inpatient and ER utilization. Average risk score is 1 for a population, so if a patient has a risk score of 10, they are considered 10 times sicker than the average healthy patient.

Risk change can go up or go down from the previous month's report. This simply indicates either the patient has more claims driving the risk up or claims that have dropped off with no additional claim encounters in the reporting period, driving it downward. It is another opportunity to prioritize your outreach and management of these patients who particularly are having increased prospective risk change. A negative change indicates improvement in the risk score. An arrow is displayed if there is a change less than (<) or greater than (>) than 10 percent.

Q4: How are the risk drivers prioritized for hot spotter patients?

A4:

If a member is identified for care planning due to **readmission risk**, top model risk drivers will appear when hovering and selecting the Hot Spotter icon or by filtering on the risk drivers. A list of risk drivers are specified, nine of which come from the Readmission Risk Model and three from the Care Gap Model. Readmission trumps chronic in the list of risk drivers.

Q5: How are the conditions prioritized for hot spotter patients?

A5:

There is a list of conditions that may display in the Conditions column when hovering and selecting the information icon or by filtering on the conditions. Patients are identified as having a condition via multiple data sources such as claims and pharmacy. Identified conditions are displayed in order of clinical priority based on our comprehensive health solutions analytics risk model, designed to identify conditions that have the greatest impact on quality and cost. PCMS will display a maximum of 10 conditions per patient; some may have additional diagnoses beyond what is displayed. It's important to cross reference information in PCMS with the patient's medical record.

Q6: What are chronic care gaps?

A6:

Chronic care gaps identify treatment, monitory and/or screening interventions supported by evidence based guidelines, which are linked to chronic conditions. (See *Appendix 3.*)

Q7: What is a chronic care gap score?

A7: The chronic care gap score is a weighed total sum (0-100) of the open chronic care gaps for attributed patients identified with one or more core chronic conditions, including Hot Spotter and Non-Hot Spotter chronic patients. The score is based on how many open care gaps the member has. Each care gap has a numerical score that is weighted by clinical priority based on our analytics risk model. The number noted in the field represents the weighted score associated to the open care gap, not the number of care gaps.

Q8: How do I know how many identified chronic care gaps my patient has?

A8: By hovering over the information icon next to the chronic gap score, a pop-up displays up to the top 10 priority gaps identified for the patient for the current month. As the practice begins to address and close these gaps, the gap score will start to trend downward, thereby impacting a patient's potential risk. A green arrow down or red arrow up indicates movement in the score if the gap score has changed more than 3 points in the last month.

Q9: What is the difference between care opportunities and chronic care gaps?

A9: Care opportunities are active or potential care measures associated with clinical quality measures defined by the program.

Chronic care gaps are evidence-based indicators that may or may not overlap with care opportunity measures. Both are clinically proven standards of care.

Q10: Who shows with an Inpatient Authorization icon and how long are they on there?

A10: Patients remain on the report from authorized admission to 30 days post-discharge. Elective surgery and admissions will display if they happen within 30 days of the report. Emergency admissions may be delayed and show up on the report when authorization is received or completed. If the report comes up blank, there were no inpatient admissions at the time the report was run.

Q11: What report content is on the Inpatient Authorization icon that is not in the Hot Spotter icon?

A11: The Hot Spotter criteria targets patients with recent inpatient admission at risk for readmission and/or those with chronic conditions.

Content on the Inpatient Authorization not on the Hot Spotter include those that deliver inpatient admission information including:

- Facility name
- Admit date
- Admitting diagnosis

Q12: Do patients show up with Inpatient Authorization icon that do not meet the criteria for the Hot Spotter? Why?

A12: Not all patients listed with an Inpatient Authorization icon will display as a Hot Spotter patient.

- The Inpatient Authorization criteria displays all authorizations for the provider's attributed Population
- A patient with an inpatient authorization may have a high risk of readmission or not.
    - If they have a high risk of readmission, they will also show up as a Hot Spotter Readmission patient.
    - If they have a low or no risk of readmission, they will not be on the Hot Spotter Readmission patient.

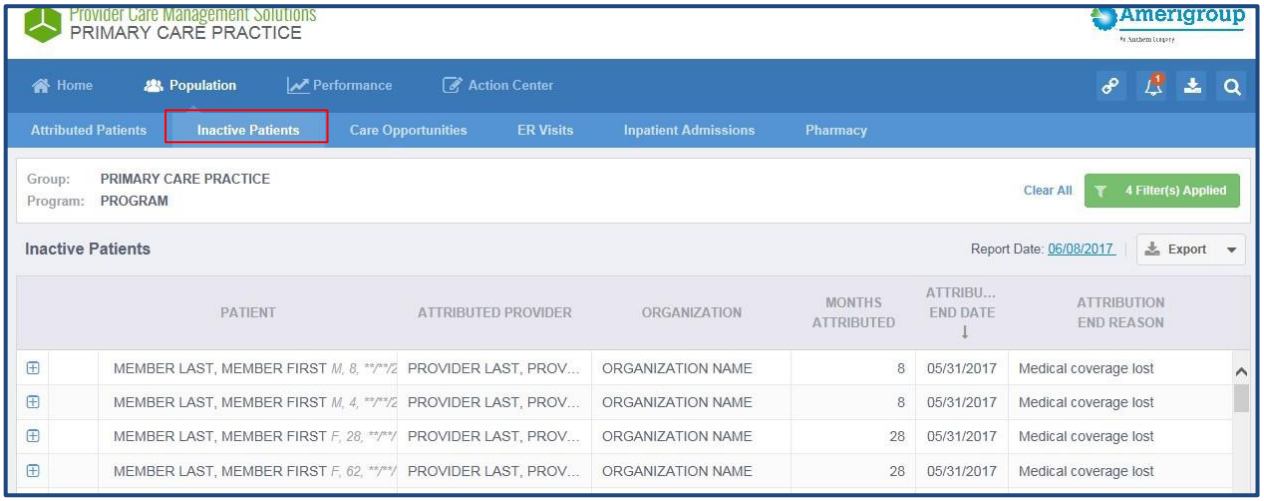
Q13: Where do I find the discharge date?

A13: The *Discharge Date* field is found by hovering on the Inpatient Authorization icon and can also be found in the exported spreadsheet by selecting the *Inpatient Authorization details* column.

- Consult P360 to see if it includes:
  - Approved length of stay
  - Discharge date, if available
  - Other information regarding that episode of care
  - The patient will fall off the report 30 days after discharge

Inactive Patients view

The *Inactive Patients* tab includes a list of patients who are no longer attributed to the selected provider group. Patients will appear on this report if their attribution ended within the past 12 months.



Report Date

The Report Date displays in the upper right of the *Population* view. Select the date next to **Report Date** to see the refresh frequency and refresh status

- Green check: refresh has completed per frequency schedule
- Red X: refresh has not completed per frequency schedule

Data Columns

The data columns that display in this view are described in the table below. You can find additional details about some of the view-specific columns in the information that follows the table.

Note: If you need more information about the columns that are not unique to this view (e.g., Patient, Attributed Provider), refer to the *Attributed Patients view* section of this guide.

Column	Description
Patient	The full name (last name, first name), gender, age, date of birth of the inactive patient
Attributed Provider	Either the full name (last name, first name) of the PCP or provider the patient is assigned to or the name of the primary organization the patient is assigned to
Organization	The provider organization (tied to tax identification number) assigned to patient
Months Attributed	The number of consecutive months a patient was attributed to the provider group
Attribution End Date	The date the patient became inactive to the provider group for this program
Attribution End Reason	The reason the patient became inactive

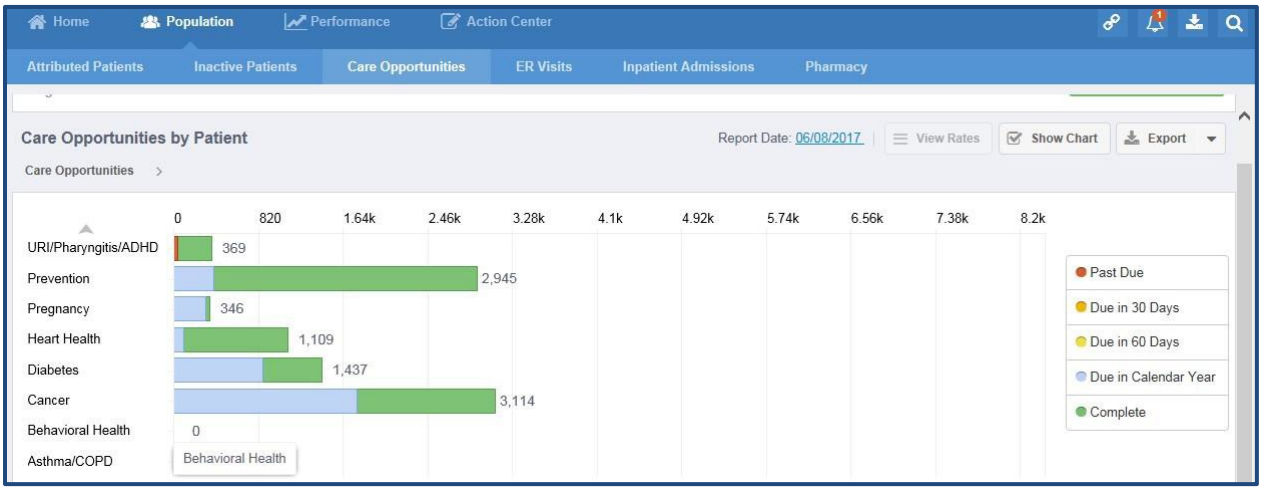
Attribution End Reason

The details that will display in this column include the reason the patient is no longer attributed to the provider group, including:

- *Affinity Change*: the patient is now assigned to a different provider
- *No Longer Eligible for Program*: the patient's eligibility status has changed Medical Coverage Lost

Care Opportunities view

PCMS provides information about a provider's attributed patients who are found to have care opportunities — active or potential gaps in care associated with recommended evidence-based care and clinical quality metrics. Providers can use this information to actively outreach to those patients to get them in for a visit to provide those needed services and close those care gaps.



Report Date

The Report Date displays in the upper right of the *Population* view.

Select the date next to *Report Date* to see the refresh frequency and refresh status.

- Green check: refresh has completed per frequency schedule
- Red X: refresh has not completed per frequency schedule

Data Columns

The data columns that display in this view are described in the table below. You can find additional details about some of the view-specific columns in the information that follows the table. **Note**: If you need more information about the columns that are not unique to this view (e.g., Patient, Attributed Provider), refer to the Attributed Patients view section of this guide.

Column	Description
Actions	Select to access specific actions/functions in PCMS
Patient 360 LPR	Launches the Patient 360 LPR for the associated patient, where available
Patient	The full name (last name, first name), gender, age, date of birth of the patient
Attributed Provider	Either the full name (last name, first name) of the primary care physician or provider the patient is assigned to or the name of the primary organization the patient is assigned to
Organization	The provider organization (tied to tax identification number) assigned to patient
Prospective Risk Score	A score reflecting the patient's relative risk of future health care cost and use over the next 12 months

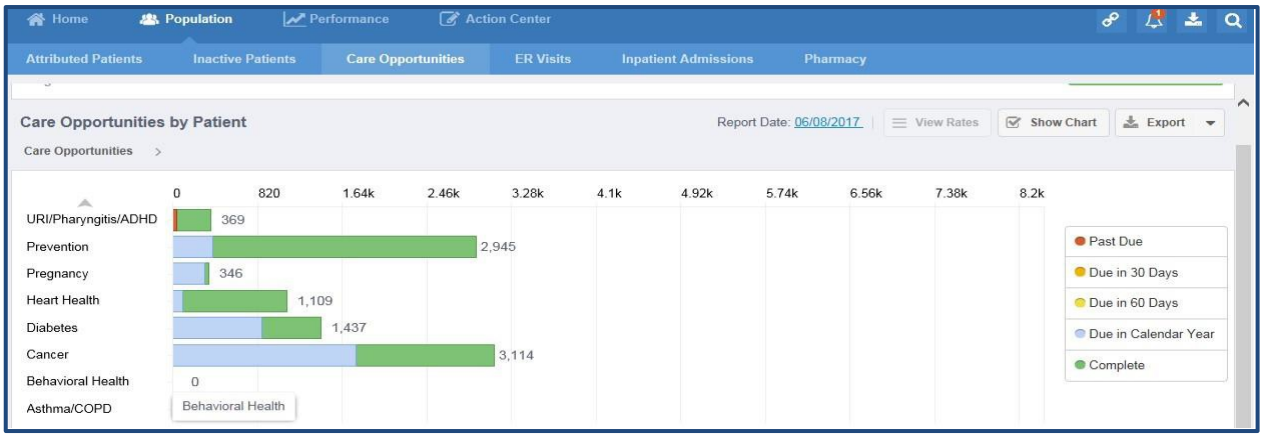
Column	Description
Care Opportunities	The total number of care opportunities identified for the patient for the incurred reporting period; select the information icon to view more details about the specific care opportunities
Next Clinical Due Date	The date for the care opportunity that is coming due soonest
Clinical Programs	Indicates whether the patient is enrolled in a health plan Case Management or Disease Management program
Chronic Care Gap Score	Represents a weighted total of the open chronic care gaps

Using the Care Opportunities information

Below, you will find details about various ways you can look at care opportunities for your patient panel, which can help you stratify your population and target outreach to close open care opportunities for specific cohorts among your patient panel.

Care Opportunities Chart

The Care Opportunities chart in the Care Opportunities view provides a graphical representation of the patients attributed to the provider group who have opportunities for the conditions included in the Care Opportunities view (e.g., Asthma/COPD, Cancer, Diabetes, URI/Pharyngitis/ADHD, Well Visit).



The Care Opportunities Report displays a chart of care opportunities when the user clicks the Show Chart button:

The chart shows conditions (and the measures associated within those conditions).

The total counts represent the number of care opportunities. Clicking on a specific condition category, the bar graph and patient grid refreshes to the measure level displaying all patients associated with a measure. Clicking on the color status legend to the right of the chart to display only those members associated with a measure status.

Measures are color coded according to status:

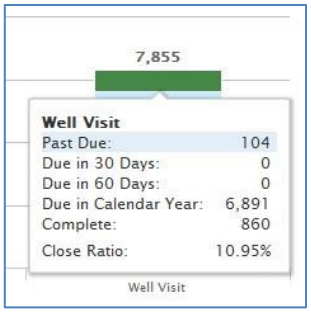
- Blue: due in calendar year
- Yellow: due in 60 days
- Orange: due in 30 days
- Red: past due

- Green: complete

Note: The chart will not include the completed measures by default. Select **Complete** on the legend to display care opportunities with a complete status. You can also use the filters to display only those statuses you wish to display.

Hover over a graph on the chart to view more detailed information, including:

- Total number of care opportunities for each status
- Close Ratio—what percentage of eligible care opportunities have been closed for that condition/category or for the specific measure

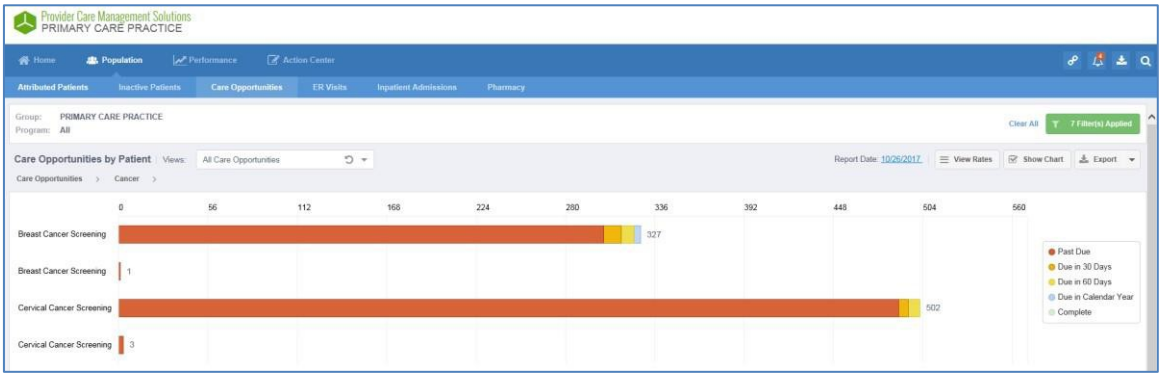


If the provider group does not have any care opportunities for a condition, the bar on the graph will not display.

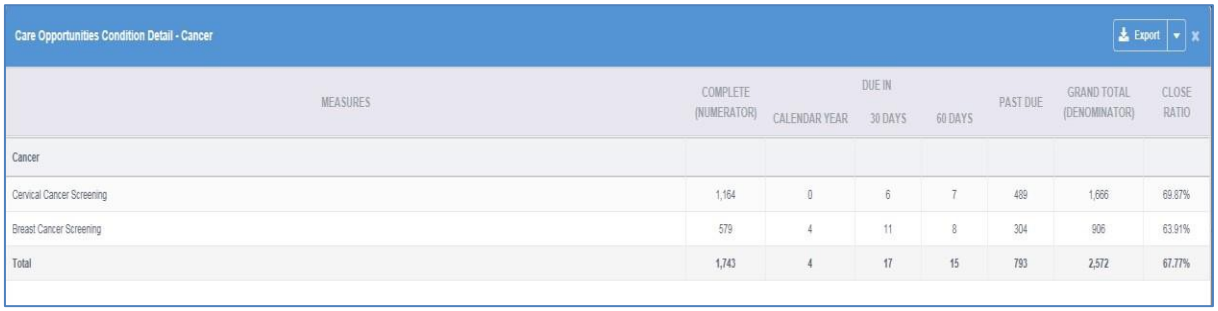
Select a graph on the chart to get more information about the services included in that condition.

When the chart updates, the patient list below the chart will also filter to include only those patients who are eligible for the services included in that condition group.

Filter on a condition for the chart to display (Diabetes condition is filtered below) to get more information on that specific measure. A button for **View Rates** is enabled when users drill down to the Condition level.



Click on a bar to see a summary chart for that specific condition. Click “View Rates” to see a pop-up table of condition-specific rates.



Note: The patient list table will indicate the reporting period for the care opportunities data—the claims-incurred period, as well as the claims-paid-through date.

View all Care Opportunities by Patient

To see all of the open care opportunities by patient, select the icon in the *Care Opportunities* column. This will display all of the open and completed care opportunities for a patient.

Even after selecting Care Opportunities for one condition (for example, diabetes) from the graph, selecting the icon will show all Care Opportunities (see below).

Last Date of Compliance: The date the patient was last treated for the given measure.
If the field displays dashes, it means we have not received a claim for that service in the past 12 months. If more than one service required for the measure, the date of the first paid claim is displayed and the clinical due date factors in all services.

Remaining Visits: This indicates the number of remaining visits needed to meet the measure compliance requirement. This is most useful in the Well-Child Visit Ages 0-15 Months measure.

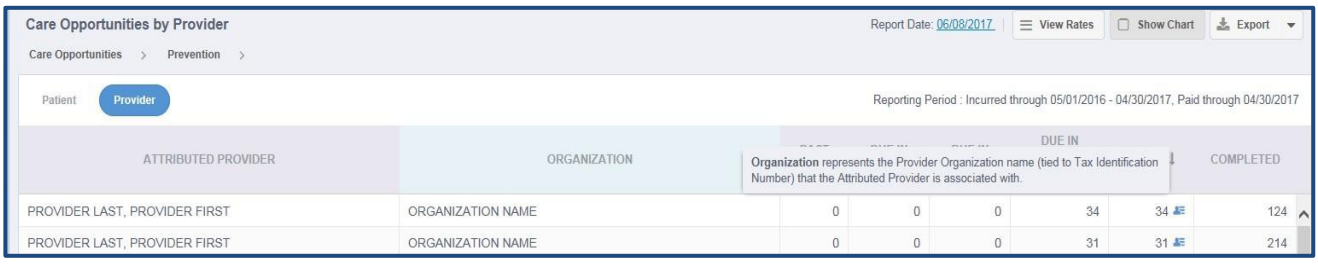
Clinical Due Date: The Clinical Due Date is calculated based on the last date the service is known to have been provided to the patient and on the next date the service is expected to be provided based on the frequency required for that service (e.g., a service due once a year will show as being due one year from the last time it is known to have been provided; so if the Last Date of Compliance for that measure is 06/07/2014, the Clinical Due Date will display as 06/07/2015).

Status: The status of the treatment and/or service for the given measure based on compliance specifications. Colors are associated with each status (i.e., past due red, due in 60 days yellow, due in 30 days orange, due in calendar year blue, complete green). Once complete, the patient status remains complete until it reaches due in the calendar year. It stays in due in calendar year until it reaches due in 60 days.

Note: The Clinical Due Date and the Status indicator (color) may not always align because the clinical due date is based on a frequency—of how often the service is expected to be provided to be compliant—and the status is based on the HEDIS-based compliance specifications (for example, due by the 15-month birthday for the Well-Child 0-15 months or due by the end of the calendar year for other well-visit measures). Please contact your health plan representative with questions.

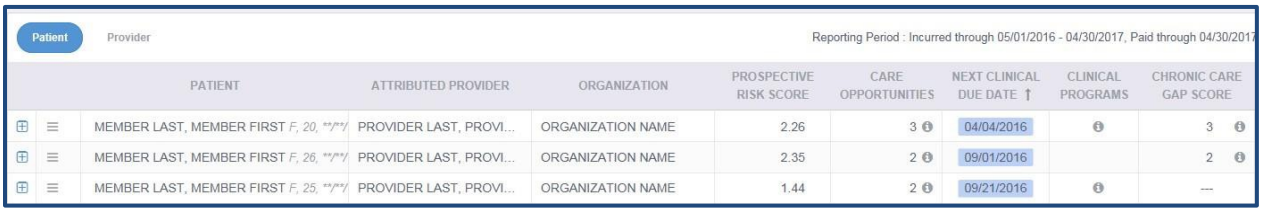
View Care Opportunities by Provider

Select the **Provider** radio button to filter the list by the attributed provider. This view will display the total number of care opportunities for each provider in the group, including the total number of care opportunities that are Past Due, Due in 30 Days, Due in 60 Days, Due in Calendar Year and Completed.



Note: Select the column headers to sort the list by that column in ascending or descending order.

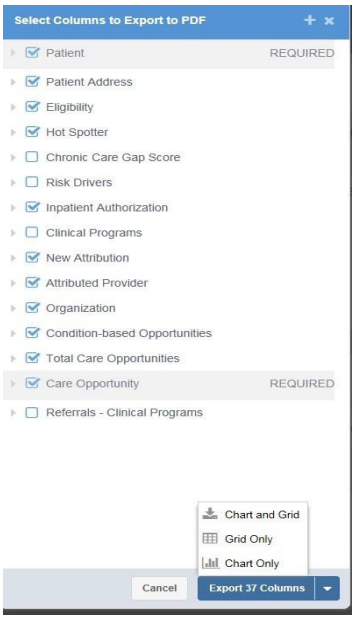
Select the icon next to the number in the *Total* column to display a list of only the patients attributed to that specific provider who have care opportunities.



Care Opportunities filters

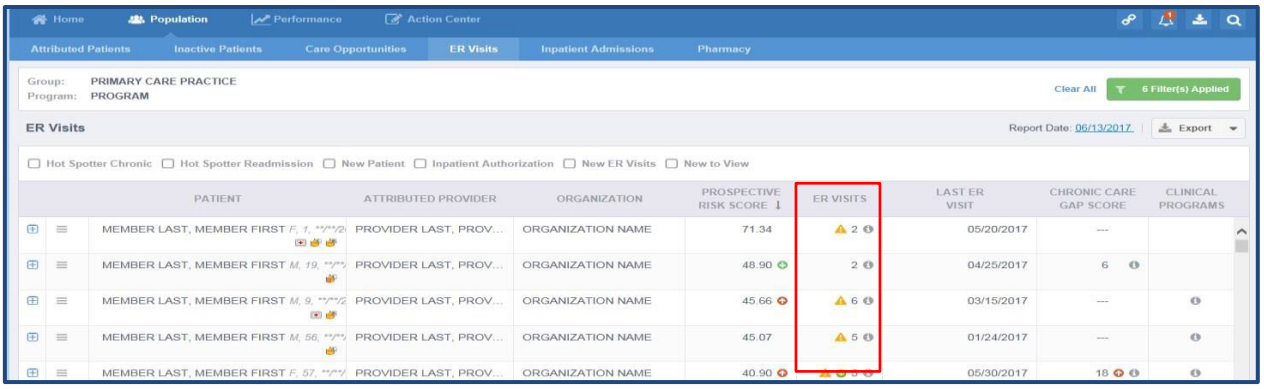
Select filters to open the panel and then use the filters to stratify the list of applicable patients based on specific criteria, including Care Opportunities status and Care Opportunities (by entire condition/category or by individual measures).

The Chart cannot be exported in Excel, only in PDF. The user has the option to export the patient list and/or chart. When selecting chart and grid, two separate files download – one PDF including the patient list and one PDF for the chart.



ER Visits view

Select the **Population** tab and then select **ER Visits**. The total count of ER visits per patient appears in the *ER Visits* column.



This view displays a list of patients who have had one or more ER visits in the past rolling 12 months of paid claims.

Report Date

The Report Date displays in the upper right of the *Population* view. Select the date next to Report Date to see the refresh frequency and refresh status.

- Green check: refresh has completed per frequency schedule
- Red x: refresh has not completed per frequency schedule

Data columns

The data columns that display in this view are described in the table here.

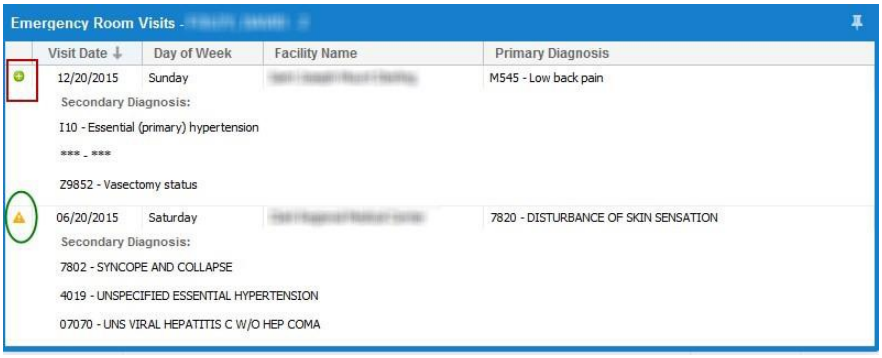
Note: If you need more information about the columns that are not unique to this view (e.g., Patient, Attributed Provider), refer to the *Attributed Patients view* section of this guide.

Column	Description
Actions ≡	Select to access specific actions/functions in PCMS
Patient 360 LPR	Launches the Patient 360 LPR for the associated patient, where available
Patient	The full name (last name, first name), gender, age and DOB of the patient
Attributed Provider	The full name (Last name, First name) of the primary care provider to whom the patient is attributed
Organization	The provider organization (tied to tax identification number) assigned to the patient
Prospective Risk Score	A score reflecting the patient's relative risk of future health care cost and use over the next 12 months
ER Visits	Represents the number of ER visits identified for a patient during the past rolling 12 months
Last ER Visit	The date of the most recent ER visit identified for a patient in the past 12 months
Chronic Care Gap Score	Represents a weighted total of the open chronic care gaps
Clinical Programs	Represents information regarding participation in, referrals to and/or association with Clinical Programs

ER Visit details

Select the information icon next to the number in the *Visits* column to display details about the ER visits associated with the patient in the past 12 months, including:

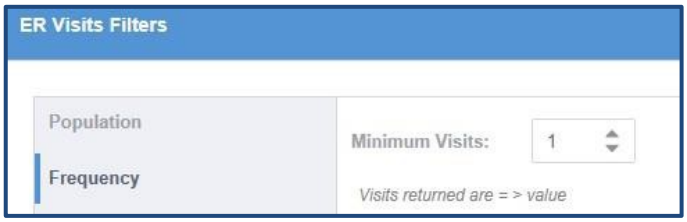
- ER visit date
- Day of the week of each visit
- Facility name
- Primary diagnosis (and secondary, if applicable and available) associated with the ER visit
- New-to-view icon: The green circle with a white cross indicates the ER visit was newly added to the *ER Visits* view in the past seven calendar days
  Note: New ER visit entries appear in PCMS based on when the claim is paid and processed, not necessarily as soon as the ER visit date occurs
- Potentially Avoidable ER visit icon: The yellow hazard icon indicates the ER visit was potentially avoidable, based on the primary diagnosis



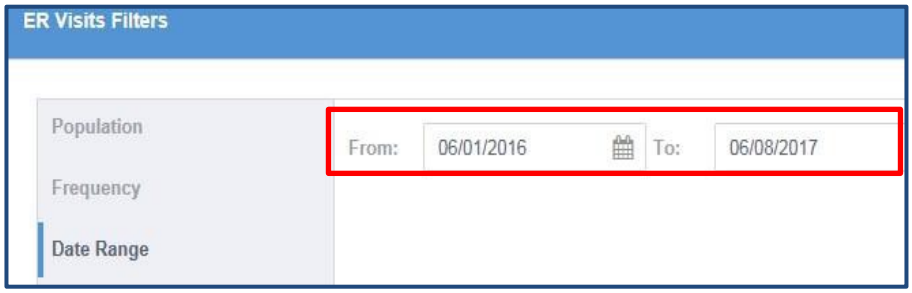
Using the ER Visits information

Use the *Filters* panel or simple filters to focus your patient population:

- ER visit types
    - **ER Visit (Potentially Avoidable):** Identify the list of patients who have had potentially avoidable ER visits—and who may benefit from education about seeking care for nonemergent services in a lower level care setting. A yellow hazard icon in the PCMS display indicates the ER visit was potentially avoidable, based on the primary diagnosis.



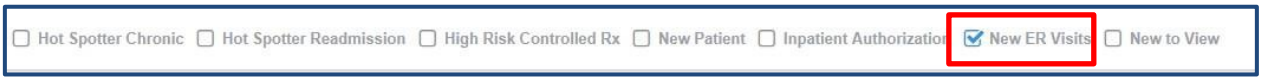
- **Frequency:** Filter the patient list by frequency of ER utilization. The list will display only those patients who have at least the number of ER visits specified, during the past 12 months. You can use this information to identify frequent utilizers of the ER to outreach and build the primary care relationship and to educate the patient about the services your team offers, which may reduce or prevent unnecessary ER usage.



- Date Range: Filter the patient list to identify your patients with a recent ER visit who may need a follow-up primary care appointment.

Select **Update** to update the filters or **Reset** to remove the filters in the panel.

- ER New to View: Use the *New ER Visits* simple filter to show the list of patients with new ER visit data—indicated by the green circle with a white cross . A new ER visit is defined as a claim that has been added to the PCMS application in the past 7 days.



Frequently Asked Question: ER Visit view

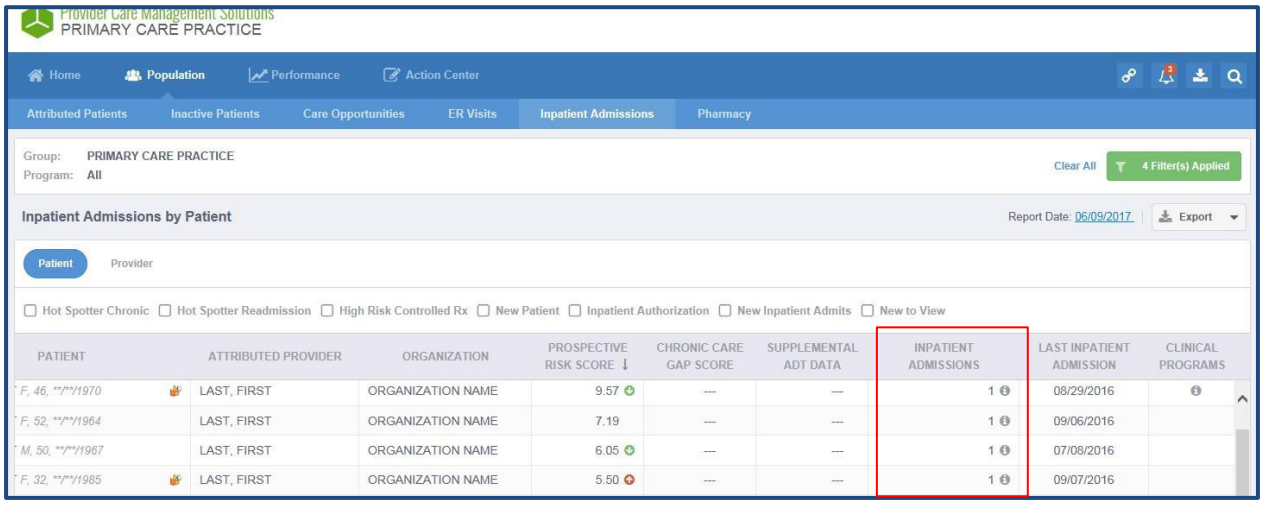
Q: If the patient is admitted from the ER, will this ER visit show up on the list?

A: No, if a patient gets admitted from an emergency room encounter, the visit is not included in the ER visits count and will not display in the ER Visit view.

Inpatient Admissions view

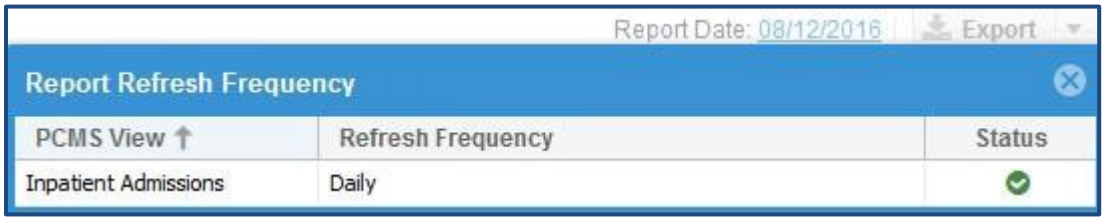
This report provides claims information on patients who have had one or more inpatient admissions for all levels of care, including sub-acute, skilled or rehab in the past rolling 12 months of approved claims. It does not include maternity, newborn, neonatal, ER or observation visits up to 23 hours.

Select the *Population* tab and the option for **Inpatient Admissions**. The total count of Inpatient Admissions per patient appears under the *Inpatient Admissions* column.



Report Date

The Report Date displays in the upper right of the *Population* view. Select the date next to Report Date to see the refresh frequency and refresh status.



The Report Refresh Frequency statuses are defined below:

- Green check: refresh has completed per frequency schedule
- Red X: refresh has not completed per frequency schedule

Data columns

The data columns that display in this view are described in the table here.

Note: If you need more information about the columns that are not unique to this view (e.g., Patient, Attributed Provider), refer to the *Attributed Patients view* section of this guide.

Column	Description
Actions ☰	Select to access specific actions/functions in PCMS
Patient 360 LPR	Launches the Patient 360 LPR for the associated patient, where available
Patient	The full name (last name, first name), gender, age and DOB of the patient
Attributed Provider	The full name (Last name, First name) of the primary care provider to whom the patient is attributed
Organization	The provider organization (tied to tax identification number) assigned to the patient
Prospective Risk Score	A score reflecting the patient's relative risk of future health care cost and use over the next 12 months
Inpatient Admissions	The number of admissions identified from claims for a patient in the past 12 rolling months
Last Inpatient Admission	The date of the most recent admission identified from claims for a patient in the past 12 rolling months
Clinical Programs	Information regarding participation in referrals and/or association with Clinical Programs

Inpatient Admissions details

Select the information icon next to the number in the *Inpatient Admissions* column to display details about the inpatient admissions associated with the patient in the past 12 months, including:

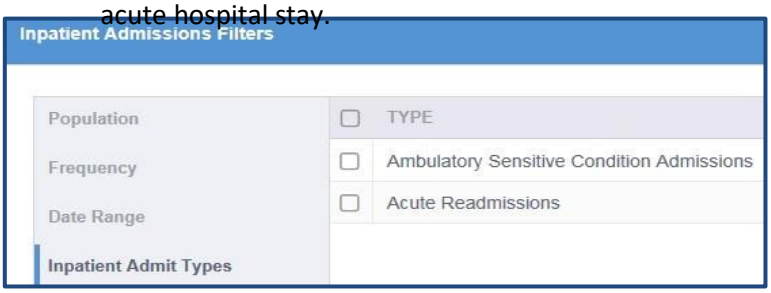
- Admit date
- Discharge date
- Actual length of stay
- Name
- Primary diagnosis
- New-to-view icon: The green circle with a white cross indicates the inpatient admission was newly added to the view in the past seven calendar days
- Ambulatory Sensitive Condition inpatient admission: The yellow hazard icon indicates the inpatient admission was tied to an ambulatory sensitive condition primary diagnosis
- Readmission: The red circle with an exclamation point indicates an inpatient admission that is considered a readmission based on unplanned acute readmission to a hospital within 30 days of being discharged from an initial acute inpatient stay

Using Inpatient Admissions information

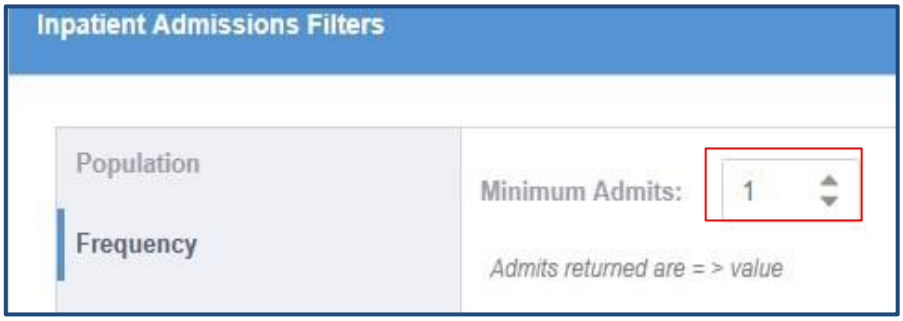
To filter by types of inpatient admissions, frequency, date range or a combination, open the *Filters* panel to select from the filtering options:

- Inpatient Admit Types

- Ambulatory Sensitive Condition Admissions: Returns a list of patients who had at least one Inpatient Admission with an ambulatory sensitive condition primary diagnosis in the past 12 rolling months.
- Acute Readmissions: Returns a list of patients with at least one acute readmission in the past 12 rolling months. Select the downward arrow to the far right of the *Inpatient Admit Types* filter to expand the list. Inpatient Admissions are considered readmissions based on unplanned acute readmissions to the hospital within 30 days of being discharged from initial acute hospital stay.



- Frequency: Use the arrows to enter a value from 1-10 to return a list of patients who meet the minimum frequency of inpatient admissions specified, during the past 12 rolling months.



- Date Range: Enter a date range to filter the specific time period of inpatient admissions you would like to filter by.

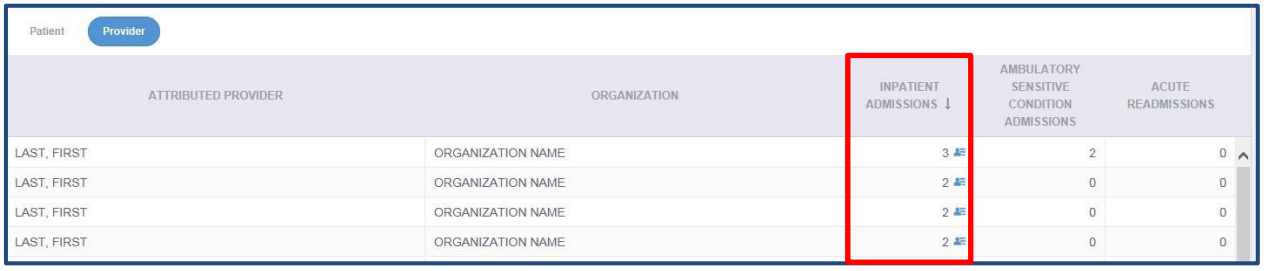
Select **Update** to update the filters or **Reset** to remove the filters.

Filter by Patient or Provider

The *Patient* list or *Provider* list options can be found in the upper left corner of the patient list view. The default is *Patient* list, but users can also choose the *Provider* radio button. It displays the providers who have patients with Inpatient Admissions. Users can use this field to identify which physician has the most admissions. Select the icon to the right of the **Inpatient Admissions** column to produce a list of all patients for that provider.

The following table defines the columns in the provider view.

Column	Description
Attributed Provider	The full name (Last name, First name) of the primary care provider to whom the patient is attributed
Organization	The provider organization (tied to tax identification number) assigned to the patient
Inpatient Admissions	The number of admissions identified from claims for a patient in the past 12 rolling months
Ambulatory Sensitive Condition Admissions	The total number of inpatient admissions with an ambulatory sensitive condition primary diagnosis in the past 12 rolling months
Acute Readmissions	The total number of readmissions in the past 12 rolling months



Ambulatory Care Sensitive Admission Condition Summary Chart

The Ambulatory Care Sensitive Admissions by Condition Chart (ACSC) is displayed in the Inpatient Admissions view when selected in the drop down menu.

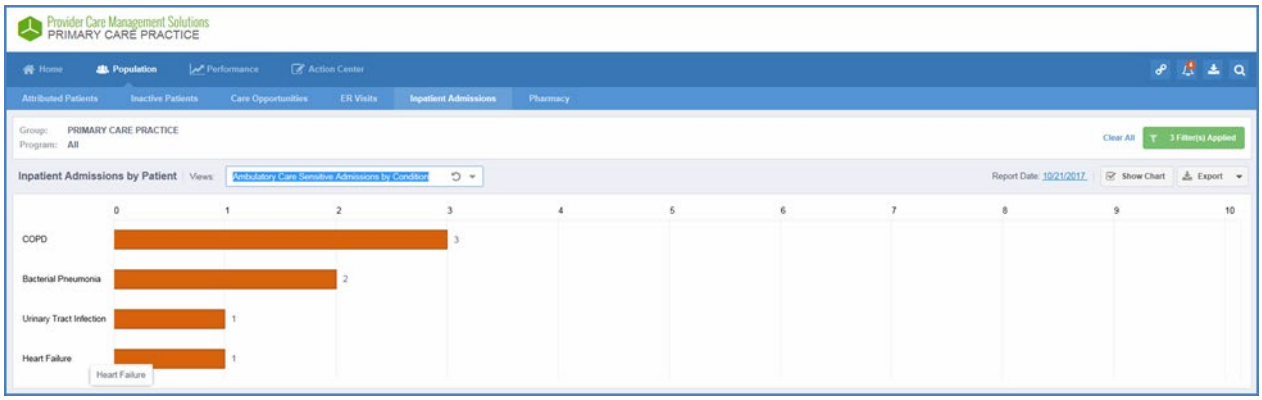
The default chart displays at the group level and displays patients with ambulatory care sensitive condition (ACSC) primary diagnoses, grouped by Ambulatory care Sensitive Condition (ACSC) type. The counts represent Inpatient Admissions, not patient counts.

When the chart is selected, from the drop down, the Show Chart button is activated to enable the user to view the chart and the corresponding patient list or just the patient list.

The user may select a diagnosis category. The chart refreshes to display the diagnosis selected and the other

diagnosis category bars gray out. The patient grid updates to include patients who have an ACSC Admission in the selected diagnosis category. The information icon pop up will include all ACSCs associated with the patient.

When using global filters, the ACSC Diagnosis Admissions by Condition categories re-display based on the program and LOB at the group level. The categories returned are based on the available data for the individual organization that is filtered. The displayed list and visit counts vary.



The Chart cannot be exported in Excel, only in PDF. When exporting in PDF, the user has the option to export the patient list and/or chart – one PDF for the patient list and one for the chart.

Frequently Asked Questions: Inpatient Admissions View

Q1: What is the difference between the inpatient authorization filter and the Inpatient Admissions view?

A1: Inpatient authorization data is sourced from internal utilization management and is more "real time" vs. inpatient admissions data as this is claims based. The intent of these reports is different as well. For example, inpatient authorization data allows practices to identify "early on" in the admission process, allowing for proactive collaboration with hospital discharge planning and follow up. The inpatient admissions report allows providers to identify utilization patterns over a rolling 12-month period for identification of potential improvement opportunities or strategies for high-risk case management.

Q2: What are ambulatory sensitive condition admissions?

A2: Ambulatory sensitive condition metrics looks at those conditions, based on certain diagnoses that could have potentially been treated in a lesser care setting and avoided a hospitalization. Below is a list of conditions considered ambulatory sensitive admissions. If you would like a reference list of code specifications used in this measure, please contact your health plan representative.

- Asthma-Pediatric (> = 2 years old but < 18 years old)
- Gastroenteritis-Pediatric (> = 2 years old but < 18 years old)
- Angina-Adult (> = 18 years old)
- Asthma & Bronchitis-Adult (> = 18 years old)
- COPD-Adult (> = 18 years old)
- Diabetes-Adult (> = 18 years old)
- Heart Failure-Adult (> = 18 years old)
- Hypertension-Adult (> = 18 years old)
- Bacterial Pneumonia-Adult (> = 18 years old)
- UTI-Adult (> = 18 years old)
- Dehydration-Adult (> = 18 years old)

Q3: Are readmissions specific to certain diagnoses?

A3: No, readmissions are considered any unplanned all cause readmission within 30 days of being discharged from a prior acute hospital admission. Indicator types that are not included are:

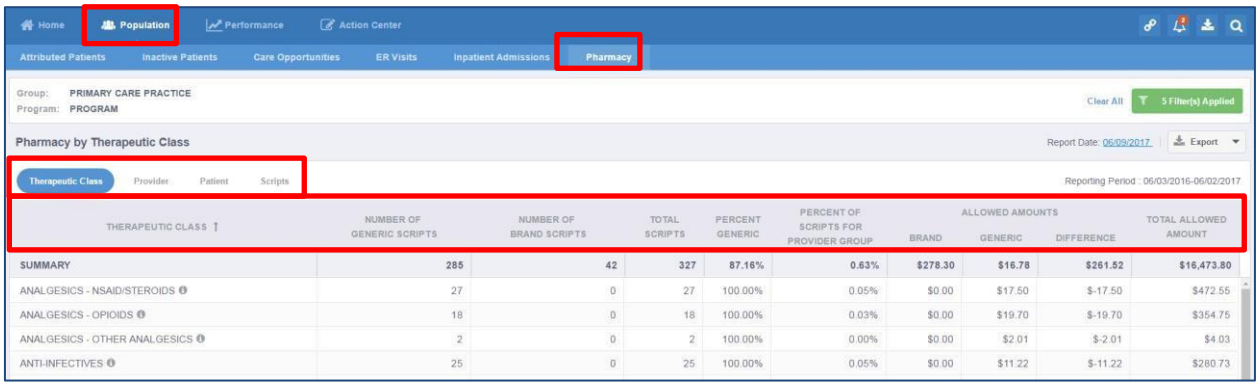
- Admission and DC date are the same
- Patient died during admission stay
- Principal diagnosis of pregnancy
- Principal diagnosis of perinatal conditions
- Principal initial diagnosis of chemotherapy or rehabilitation
- First readmission within 30 days of transplant.

Q4: Is it the admitting or discharge diagnosis that displays in the inpatient admissions view?

A4: It is the primary admitting diagnosis. It was noted during data profiling the discharge diagnosis field was populating "NA" from admissions claims, rendering our inability to capture discharge diagnosis in the claim.

Pharmacy Report View

The Pharmacy Report gives a provider the ability to view pharmacy data, including cost and drug utilization metrics. This report is available to users with clinical access. This report is designed to offer users support for care coordination, population health management and can help support patient safety, medication adherence, and managing total cost of care.



Note: HIV drugs and drugs specifically indicated for substance and alcohol abuse treatment are excluded from this report, including cost of these agents due to special considerations related to sensitivity

Filters

The report will be available in four different views, selected with radio buttons. Choosing the view will determine the columns displayed. Hovering over column titles will show definitions, and each column is sortable.

Columns

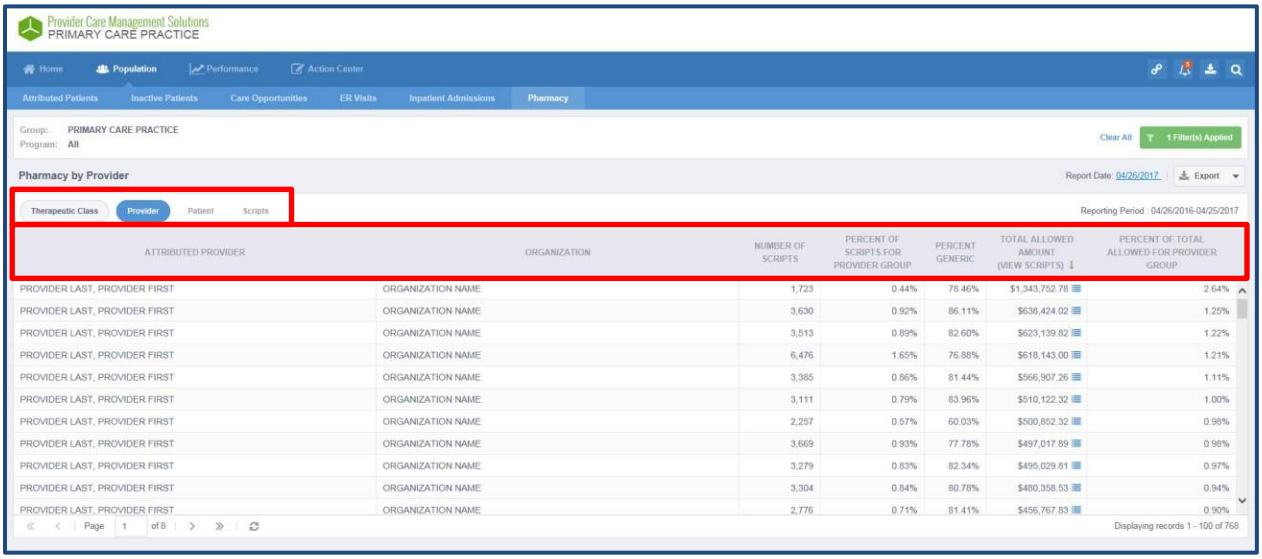
Therapeutic Class View

This view is organized by Therapeutic Drug Class, with one row for each Drug Class. Click on the info icon to see a breakdown for each NDC Code assigned to the Therapeutic Drug Class. The default sort is by Therapeutic Class column in ascending order.

The information icon pop-up in the Therapeutic Class column displays: NDC, GPI, Drug Name, Label Name, Generic, Number of Scripts (default sort column in pop up) and Percent of Scripts within Therapeutic Class for the Provider Group. Hovering over the column headers provides a description for the content represented.

Columns	Description
Therapeutic Class	Represents the drug Categories based on the Generic Product Indicator
Number of Generic Scripts	Represents the number of generic prescriptions dispensed in the specified therapeutic class.
Number of Brand Scripts	Represents the number of brand prescriptions dispensed in the specified therapeutic class
Total Scripts	Represents the total number of prescriptions dispensed in the specified therapeutic class
Columns	**Description**
Percent Generic	Represents the percentage of dispensed prescriptions that were generic
Percent of Scripts for Provider	Represents the number of prescriptions in this class as a percentage of the total prescriptions
Allowed Amounts Generic	Represents the average allowed amount of a generic prescription in the specified therapeutic class
Allowed Amounts Brand	Represents the average allowed amount of a brand prescription in the specified therapeutic class
Allowed Amounts Difference	Represents the difference between the average allowed amount for a brand prescription and the average allowed amount for a generic prescription in the specified therapeutic class

Provider View



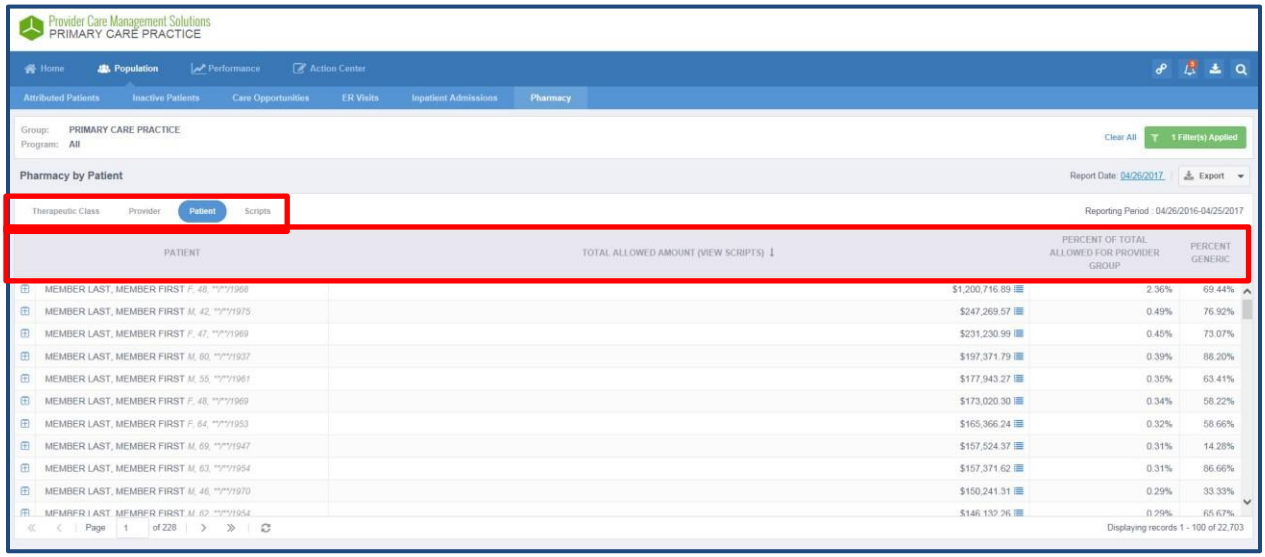
This view is organized by individual Attributed Provider, with one row for each Provider. Click on the View Scripts icon to drill into the scripts view for the selected Provider. The default view is Total Allowed

Amount (View Scripts) in descending order.

The icon in the Total Allowed Amount (View Scripts) allows user to certify a need to view sensitive clinical information and view the Scripts View for the Provider selected. To remove the single provider filter; reset filters or remove the Organizations filter in the green navigation bar.

Column	Description
Attributed Provider	Either the full name (Last, First) of the primary care provider or the name of the primary Organization assigned to a patient.
Column	**Description**
Organization	The name of organization
Number of Scripts	The number of scripts
Percent of Scripts for Provider	The number of prescriptions for this provider as a percentage of the total prescriptions
Percent Generic	The percentage of dispensed prescriptions that were generic
Total Allowed Amount (view scripts)	The total allowed amount for all the provider's prescriptions
Percent of Total Allowed for Provider Group	The allowed amount for the specified provider as a percentage of the total allowed amount

Patient View

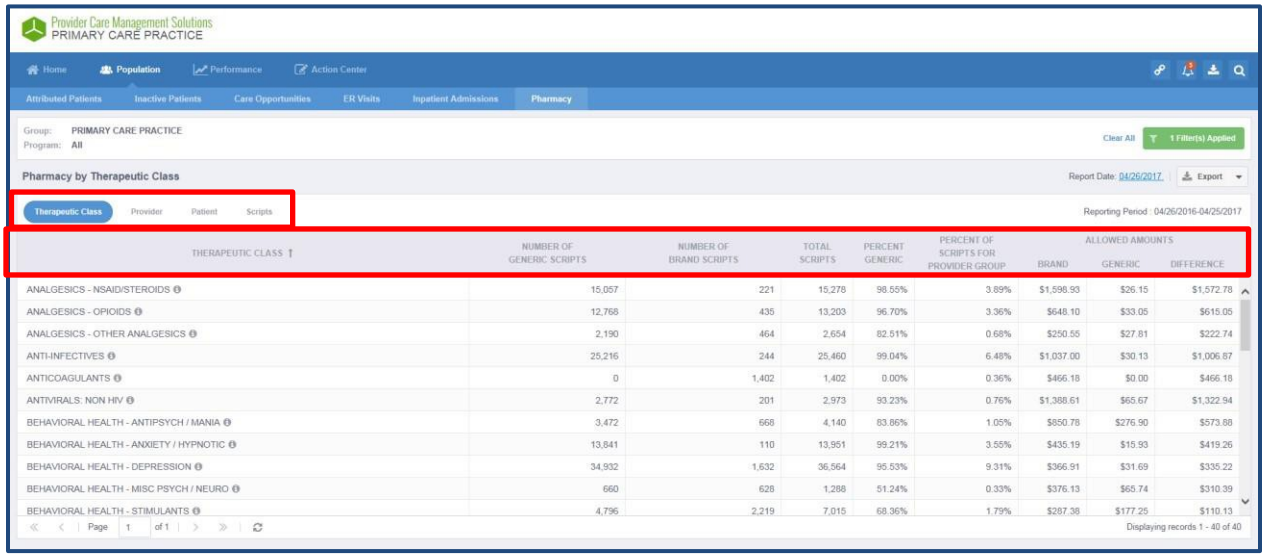


This view is organized by Patient, with one row for each Patient. Click on the View Scripts icon to drill into the scripts view for the selected Patient. The default view is by Total Allowed Amount (View scripts) column in a descending order.

The icon in the Total Allowed Amount (View Scripts) allows the user to certify a need to view sensitive clinical information and view the Scripts View for the Patient selected. To remove the single patient filter; reset filters or remove the patient filter in the green navigation bar.

Column	Description
Patient	Represents the full name (Last, First) of the attributed patient.
Total Allowed Amount (View Scripts)	Represents the total allowed amount for all the member's prescriptions
Column	**Description**
Percent of Total Allowed for Provider	Represents the allowed amount for the specified member as a percentage of the total allowed amount
Percent Generic	Represents the percentage of dispensed prescriptions that were generic

Scripts View



This view is organized by Brand Name, with one row for each specific prescription. The user must certify a need to view sensitive clinical information to see data in this view. HIV, Drug and Alcohol Abuse drugs will be excluded from this view for privacy reasons. The default view is the Drug name column in ascending order.

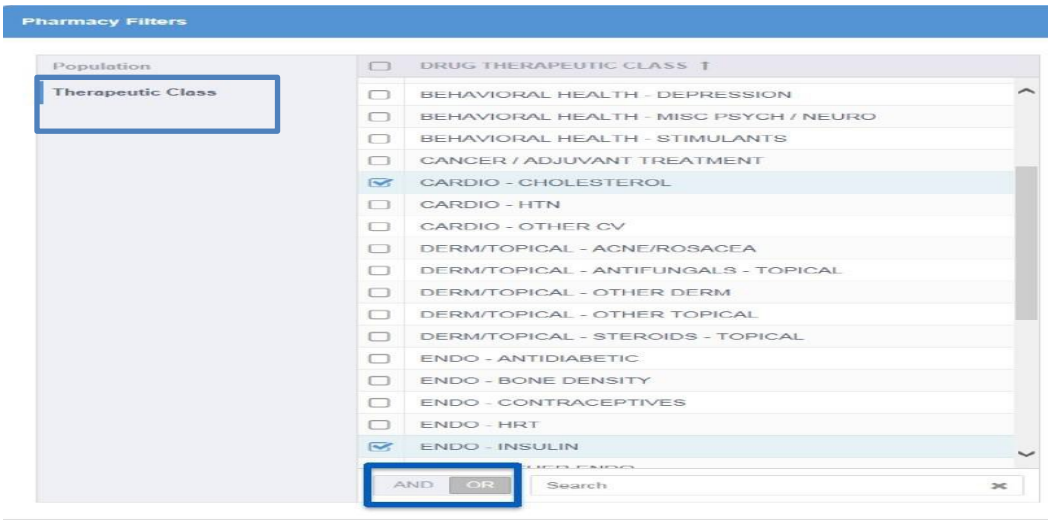
To search for a specific drug, enter the drug name in the Enter Drug Name search box in the upper right corner. You can enter one character in the search field to begin your search.

Example: Entering the letter 'C' and all drugs beginning with the letter C display.

Column	Description
NDC	Represents the National Drug Code
Drug Name	Represents the product drug name of the dispensed drug
Label Name	Represents the complete label name of the dispensed drug
Patient	Represents the full name (Last, First) of the attributed patient.
Prescribing Provider	Represent the name of the provider who issued the prescription
Attributed Provider	Represents either the full name (Last, First) of the primary Practitioner, or the name of the primary Organization assigned to a patient.
Therapeutic Class	Represents the drug Categories based on the Generic Product Indicator
Generic	Represents the dispensed prescription was either generic or brand
Formulary	Represents if the dispensed prescription was on formulary for the member
Mail	Represents if the prescription was dispensed through mail order service
New Script	Represents if the prescription was a new prescription
Fill Date	Represents date the prescription was filled
Days' Supply	Represents the number of days' supply dispensed
GPI	Represents the Generic Product Indicator
Allowed Amount	Represents the total payment for the prescription, including the amount Anthem pays and the amount owed by the member.

Advanced Filters – Pharmacy Report

Users can filter by Drug Class and using the "and/or" option by using the Global Filters Panel.



Using the Pharmacy Report

Purpose and Description: The Pharmacy report is intended to display pharmacy data in a variety of ways to assist in managing drug utilization. The goal of the report is to help primary care providers in managing drug utilization by providing claims data on medications.

This information may help identify brand vs generic prescribing across all providers in an organization, identify potential opportunities to improve patient understanding of medication adherence, and open discussion with patients on generic drugs and therapeutic substitution providing the same quality and outcomes as brand.
Report Frequency: Daily

Sample Use Case: Care Management- Medication Adherence
Dr. Carney's office keeps a registry of patients who have hypertension. The Care Management team uses the Pharmacy Report monthly and cross references it to the Hypertension registry to check on drugs prescribed and filled.

Jose, the care coordinator finds three patients from their registry on the Pharmacy report, but there are no claims for antihypertensive agents for these patients. Using the patient view, he finds the patients and clicks on the icon to get medication details for the patient. He then develops a plan with the providers to reach out to these patients, assess their treatment med adherence and address any barriers. The data is shared with the Performance Improvement team as well. They begin work with the providers to look at resources to help patients who need assistance.

Sample Use Case: Population Management- costs
The provider group has decided to look at antiulcer drug utilization and decides to look at the providers prescribing antiulcer medications.

In the Provider tab, the user filters by antiulcer global filters and sorts the grid by number of scripts highest to lowest. They then look at the providers' percent generic and total allowed amount for antiulcer drug class.

The user can drill down into the "script" view for the provider and identify the costs differences between

generic antiulcer medications such as the proton pump inhibitors. Selecting the View Scripts icon shows further detail:

There are 4 generic proton pump inhibitors with varying costs[1]

- Esomeprazole costs approximately $206/30days
- Lansoprazole costs approximately $127.31 for 30 days
- Omeprazole costs approximately $14.70 for 30 days
- Pantoprazole costs approximately $4.55 for 30 days

One of the providers with high volume of scripts, lower generic percent and higher total allowed costs for antiulcer medications had 18 scripts for esomeprazole with estimated costs of $8,428.84. In this instance, choosing a cost effective alternative could create significant savings and potentially provide the same clinical outcomes

Sample Use Case: Care Management- Patient Safety
Using the Patient view, Mary, Dr. Carney's Care Manager, sorts on Opioids using the global filters. The default view lists the patients with the highest cost for opioid scripts at the top. She notes a patient she is not working with specifically is at the top.

Clicking on the icon and certifying a need to view sensitive clinical information, Mary is able to see the detail around the patient's opioid prescriptions. She notes who the prescribing physician is to determine the provider or providers responsible for the prescriptions. Analysis reveals that the patient received three different opioid analgesics from five different providers during the time period. She uses P360 to view other care the member received during the time period (e.g. specialist care, ER, admissions). The member visited the ER twice for relatively minor concerns.

The care coordinator and the physician create a plan to ask the member to come in for an office visit where they will review the member's prescriptions and make an assessment.

Sample Use Case: Population Health – generic project

Dr. Carney's office is promoting a brand to generic conversion campaign to potentially switch specific brand name medications to generic alternative options. The providers would like to begin with hypertension medications.

The team reviews the Pharmacy report therapeutic class view to determine the percent generic and find it is under 80% with 300 brand prescriptions. The information on specific hypertension medications can be obtained in the popup including the drug name, the number of scripts and whether it is a and generic or brand medication

The Performance Improvement (PI) Team works with the physician to develop a PI plan to determine which patients can be switched to the generic alternative within the next six months. The plan is to report cost savings using the allowed amounts column data to the providers and the performance improvement team at that time.

1 Costs for illustrative purposes only.

Frequently Asked Questions- Pharmacy Report

Q1: Where do the Therapeutic Classes categories come from?

A1: The pharmacy report is currently broken down into 40 Therapeutic classes grouped by generic product index codes. These codes identify medications by therapeutic class. The therapeutic classes in the pharmacy report were created by Anthem and they are not nationally defined groupings of drugs.

Q2: How are the generic drugs selected for the report?

A2: Generic drugs must be considered equivalent to the brand name medication and must have the same active ingredient, strength, dosage form and route of administration

Q3: What is used if there is no generic drug available for a brand drug?

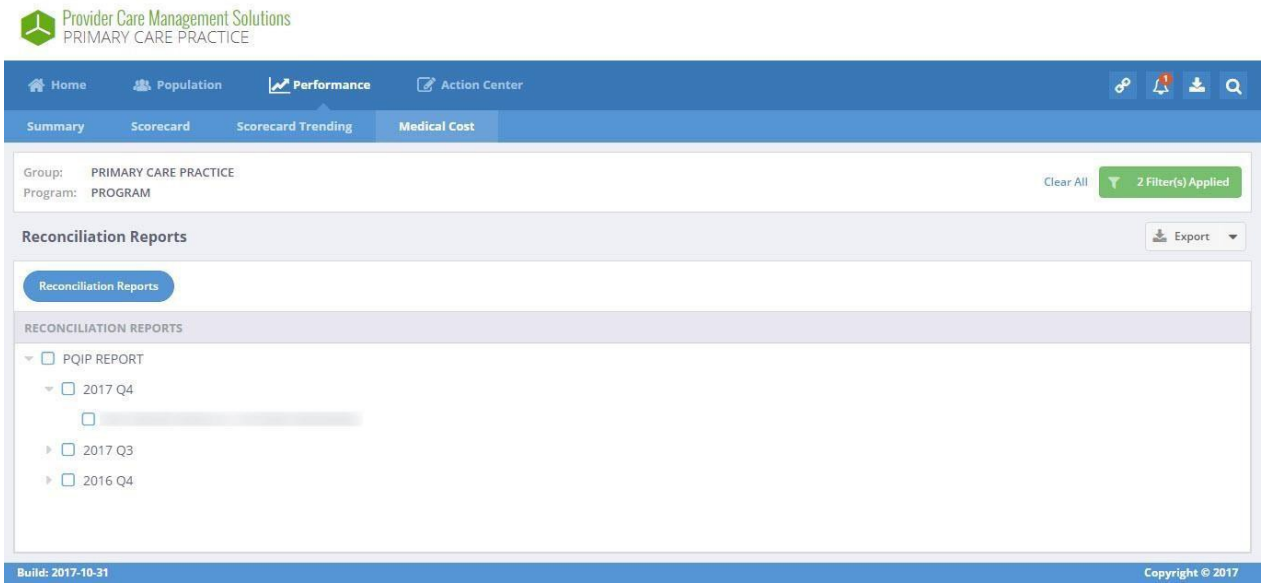
A3: Not all brand name medications have a generic equivalent. Generic agents from the same drug class may be effectively used instead of the brand agent, despite being a different chemical entity

Program-specific Reconciliations

Program financial reconciliations, if applicable, are expected to be in PCMS in late Q4 2017.

Accessing Reconciliations

Reconciliations are available in the PCMS Performance tab under the Medical Cost view. Financial reconciliations will be delivered through the PCMS Performance tab. Users authorized to review the reconciliation data must be registered in Provider Online Reporting (POR) by the practice Availity Administrator as a designated financial user for PCMS. Please refer to the Guide to Register for PCMS for more information on about registering users in Provider Online Reporting (POR). Please reach out to your Health Plan representative for guidance regarding access to financial reporting data for your alternative payment model (i.e., value-based payment program).



Automated referrals

You can refer a patient for a health plan Care Management program, subject to benefit coverage and eligibility, through the PCMS application. The steps for submitting a referral are outlined below. Please note that the success of a patient's participation in a clinical program is strongly correlated to their PCP discussing the value of the program in advance of submitting the referral.

Submitting referrals to health plan Care Management

1. Select **Actions** (☰) located to the left of a patient's name.

   Notes: Only patients eligible for referrals have the menu icon (☰) option.

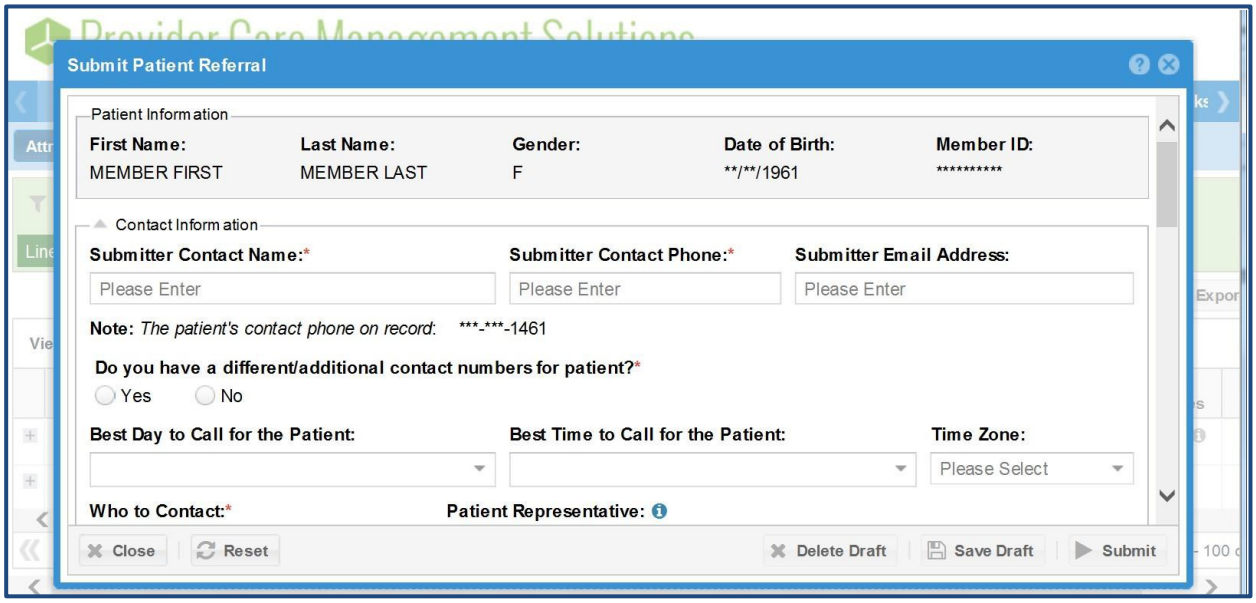
   a) The *Action* column is located between the row expander icon and the patient name.

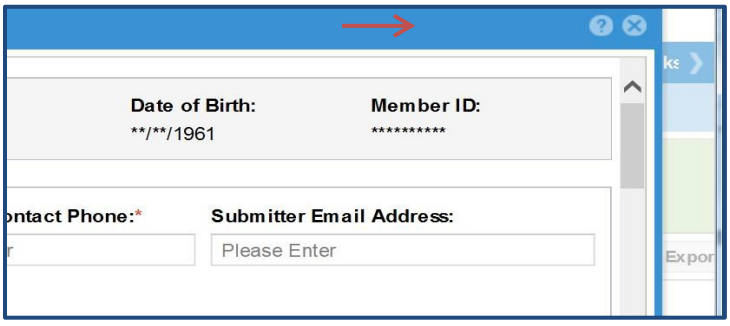
   b) The *Action* column offers a menu to initiate actions, including *Refer to Clinical Programs*."

   c) Hovering over the *Action* column displays *Click for Actions*.

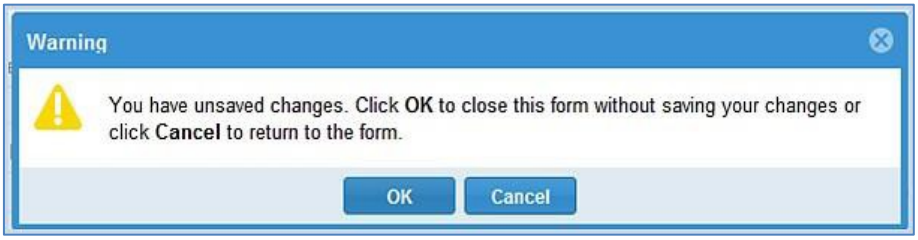
2. Select Refer to Clinical Programs. The referral form window displays with the patient's information populated in the header.



3. Complete all required fields on the form. For field-by-field instructions, select the question mark in the top right of the form.



Note: If closing the form prior to submitting, a warning window appears. Select **OK** to close without saving or **Cancel** to return to the form to save changes:



4. Select **Submit** in the lower right of the form to submit the referral to Care Management. **Note:** If closing the form prior to submitting, a warning window appears. Select **OK** to close without saving or **Cancel** to return to the form to save changes.

Tips

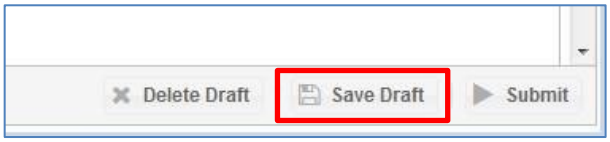
- Required fields are identified with a red asterisk. When **Submit** is selected, a prompt appears and provider is prompted to complete any required fields that were not completed.
- Users can add up to three alternate phone numbers by selecting the plus sign for additional fields.
- Users can tab through the fields.
- Users can add multiple days and times to call and can select **X** to remove a selection from those fields.
- Select the print icon in the upper right to print the referral form as a PDF.
- The user can expand or collapse each of the three sections of the form:
    - Contact Information
    - Referral Details
    - Clinical Information

In the example below, the **Contact Information** and **Referral Details** sections are collapsed.

Saving draft referrals

Users may save a draft of a referral to complete it at a later time.

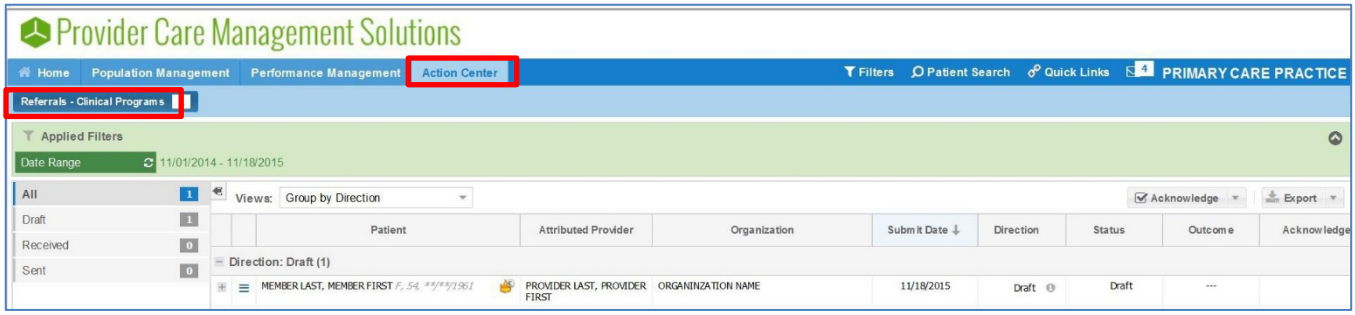
1. Follow steps 1 through 3 to the process of creating/submitting a referral (above).
2. Select **Save Draft** in the lower right of the form to save the draft.



Once a draft is saved, the **Delete Draft** option is available.

A dialog box appears, confirming that the referral has been saved and offering a unique reference number for the referral.

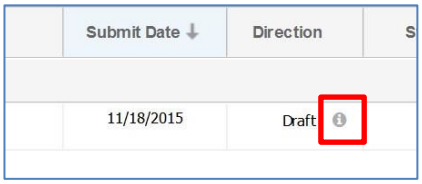
The draft referral is saved to a *Draft* folder in ***Action Center*** > ***Referrals*** – ***Clinical Programs***.



3. To complete the draft, locate the draft via the ***View Referrals*** action or in the ***Action Center***. Select the information icon in the ***Direction*** column and complete the referral per steps outlined above.

Provider views results of referrals

Users may view the status/results of referrals submitted to health plan Care Management via PCMS in the last 12 months. Referral updates are received in PCMS from health plan Care Management multiple times per day.



Referral status is available in multiple ways:

1. From the ***Action Center*** tab for individual patient's statuses.

2. From the information icon in the ***Clinical Programs*** column under ***Referrals > Clinical Programs*** for an aggregated view.
3. From the *Action* column in the *Population* tabs for Attributed Patients, Inactive Patients, Care Opportunities or ER Visits.
4. In the *Action Menu* tab: select *View Referrals – Clinical Programs*. The following explains each outcome for the ***In Progress*** status.

The following explains each outcome for the ***Complete*** status.

Outcome/result	Explanation
Submitted	Waiting to be processed
Pending Outreach	Referral is being processed in health plan Care Management systems
Research	Two-week recycle – referral in process of retrying for 14 days due to corrections or timing issues with membership/eligibility updates/synching
Not Available	Referral being processed on legacy medical management systems
Member Not Eligible	Health plan Care Management system does not show program eligibility for management
Member Not Found	Health plan Care Management system does not match member from PCMS
Engaged	Patient is engaged with Care Management – active outreach by health plan Care Management with patient who is actively participating
On Demand/DM Passive	Patient has a case with health plan Care Management but is not actively engaged. This may mean patient is getting mailers/newsletters, but not active outreaches by a nurse; patient may have requested to be on demand or may be low risk for condition management
Unable to Reach	Case closed based on unsuccessful attempts to patient
Expired (Deceased)	Patient is deceased
Member Prefers No Outreach	Patient declined to participate in health plan Care Management program
"Do Not Call" Member	Patient has requested to be on *Do Not Call* list for health plan Care Management

Provider notifications

The ***Action Center*** in PCMS notifies users of referrals where action is needed. The user selects ***Action Center*** tab and ***Referrals – Clinical Programs*** and receives a list of patient referrals sent in the last 12 months.

Note: If multiple referrals were sent for a particular patient, that patient appears on the list multiple times.

Folders appear on the top left for:

- All
- Draft
- Received (for future use)
- Sent

Providers have the option to group by:

- Attributed Provider
- Direction
- Organization
- Outcome
- Status
- Sort by Date

Protect sensitive information

Clinically sensitive patient information may be contained on the referral form from providers to health plan Care Management. PCMS provides safeguards to prevent users from viewing this information inappropriately.

When a user views referral form details, a dialog box appears with the option to view sensitive information or not to view sensitive information.

Option to view sensitive information – attestation

To view sensitive information, the provider must accept conditions and select **Continue with Sensitive Information**. The user must accept the conditions once per session for each patient.

Example: A provider attests to patient Mary Jones at 10:10 a.m. They view details and close that window. The provider views another patient, then in the same session, returns to view details for Mary Jones. Provider will not be prompted for attestation.

Each time a provider attests, an audit log is created that includes:

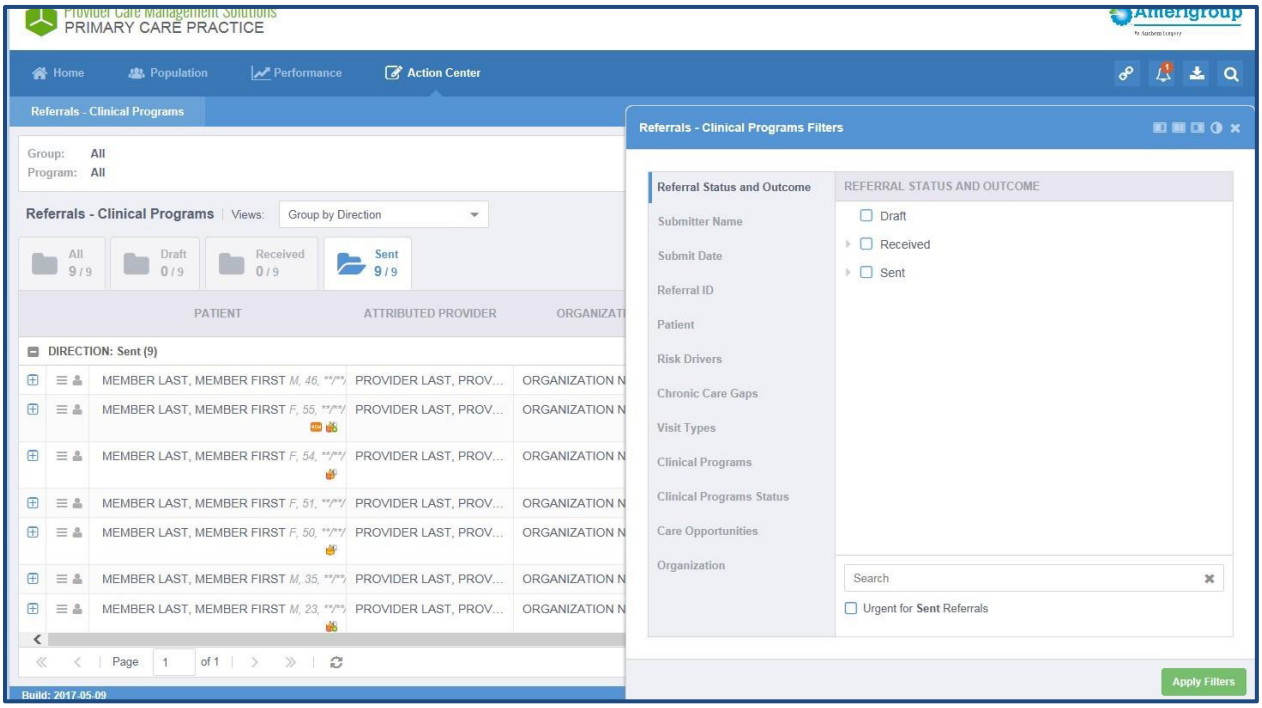
- Provider
- When the record was viewed
- Which patient
- What they viewed

Option to not view sensitive information

Provider selects **Continue without Sensitive Information**. The sensitive information in the ***Notes*** fields, the *Reason* fields and the PHQ2 and PHQ9 scores on the referral form display as asterisks (***), representing sensitive patient information that has been masked.

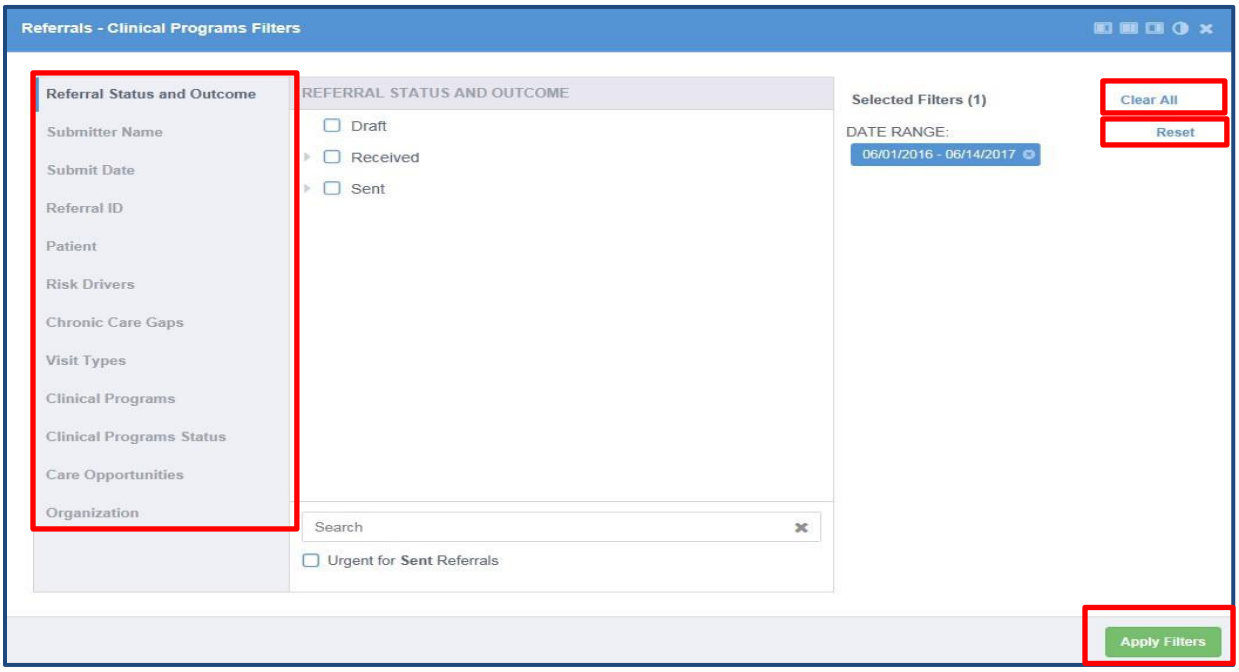
Filter for referral details

Users may select the **Filters** icon at the top of the page to filter at the *Patient* view for referral details. A *Filter* panel appears over the content. The filter panel can be pinned so that all content is shifted to the left for easier viewing.



The ***Filters*** icon allows users to filter by the following fields for the *Patient* referrals:

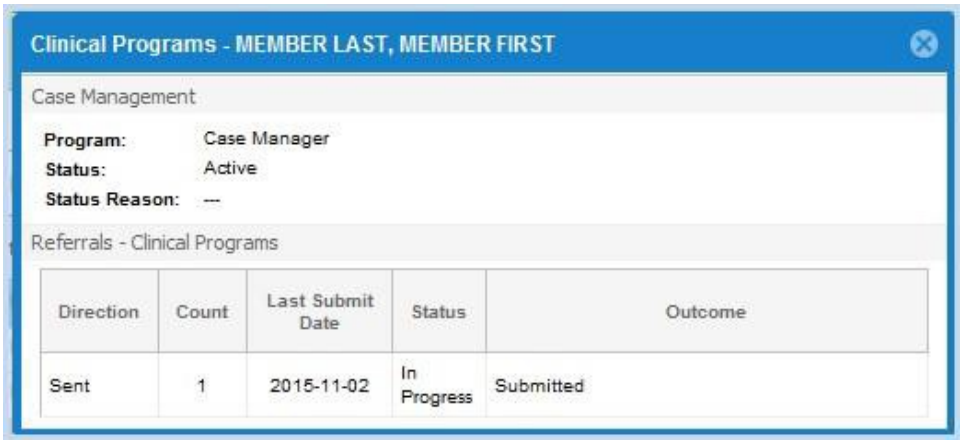
- Referral Status and Outcome
- Submitter Name
- Submit Date
- Referral ID
- Patient
- Organization
- Visit Types
- Clinical Programs
- Clinical Programs Status
- Care Opportunities



Select **Clear** to remove the filters or **Apply filters** to update the filters.

Clinical Program Care Management/Disease Management information and referrals can be viewed from the ***Population*** *Attributed Patients, Care Opportunities* and *ER Visits* and *Inpatient admission* views and from the ***Action Center*** tab. To view, select the information icon in the *Clinical Program* column.

Below is an example of a view from the *Clinical Program* column.



Export Referral Details

When an **Export** is completed from one of the 4 Population pages below, only the number of sent and received referrals is exported:

- Attributed Patients
- Care Opportunities
- ER Visits
- Inpatient Admissions

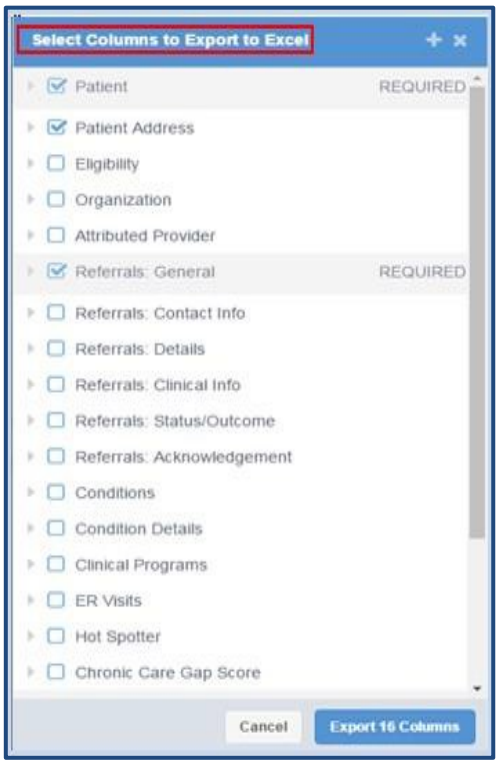
Note: Referrals received displays as dashes (---) at this time.

To **Export** from Population Inactive Patients, select **Referrals – Clinical Programs**. Only the number of Referrals sent is exported.

For more extensive export options, providers can click on the **Export** icon in the **Action Center** tab.

An export dialogue opens to select which columns to include in the export. Some export columns are pre-selected. The selected columns are exported by row per patient, per referral.

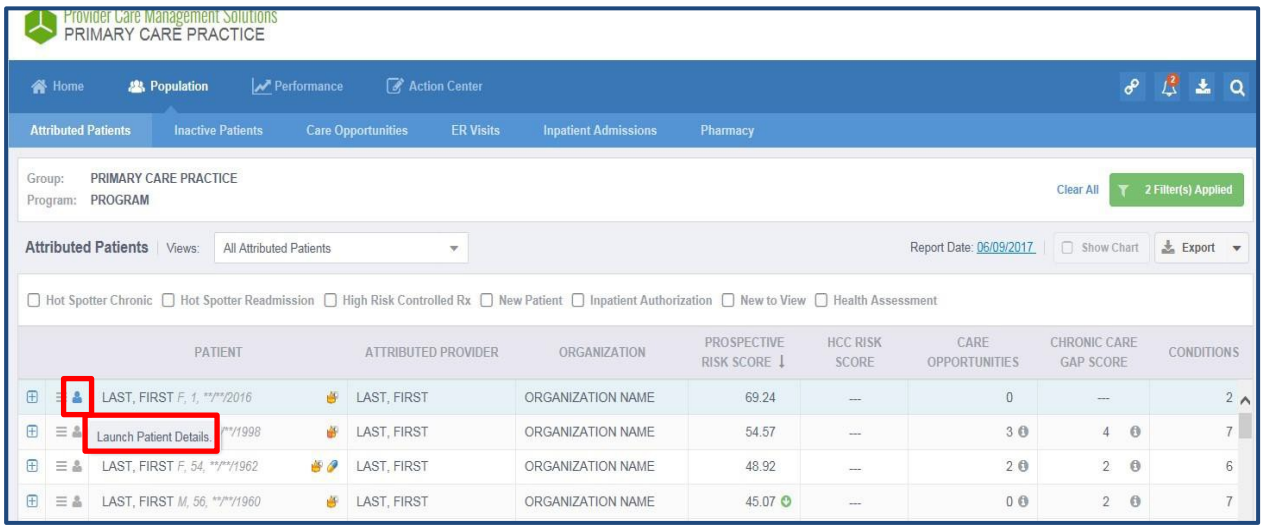
The export indicates the filters that were active at the time of export.



The Patient 360 LPR Longitudinal Patient Record in PCMS

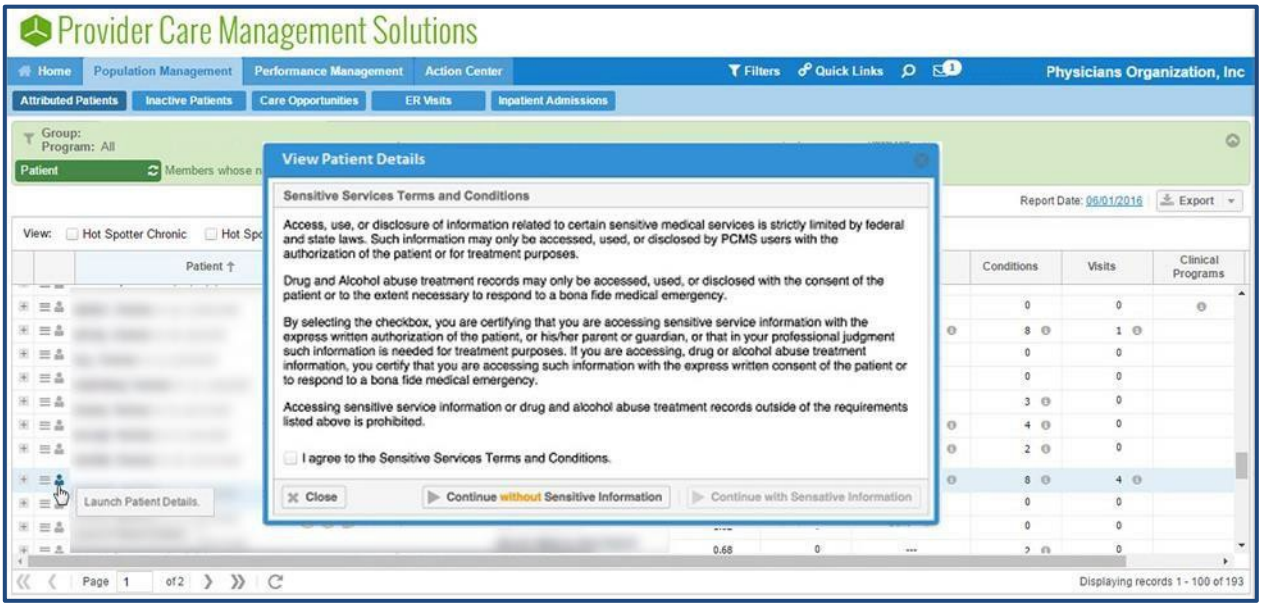
Accessing the P360 LPR in PCMS

1. Select the P360 LPR icon to the left of the patient name to *Launch Patient Details*.



2. Select the *Continue Without Sensitive Information* button to continue without these details in the LPR. Select the *I agree to the sensitive Services Terms and*

Conditions checkbox and then select the *Continue With Sensitive Information* button to see these details in the LPR.



3. After selecting the patient icon, ( ) the application will prompt the user to select whether or not to display sensitive information.

Note: It is important that the user to completely close out of browser (not just a tab) to close out of PCMS session and clear sensitive history. PCMS will automatically close out after 15 minutes of inactivity for security purposes.

A reminder to close browsers is included in the *View Patient Details* window under the *Terms and Conditions* (see below).

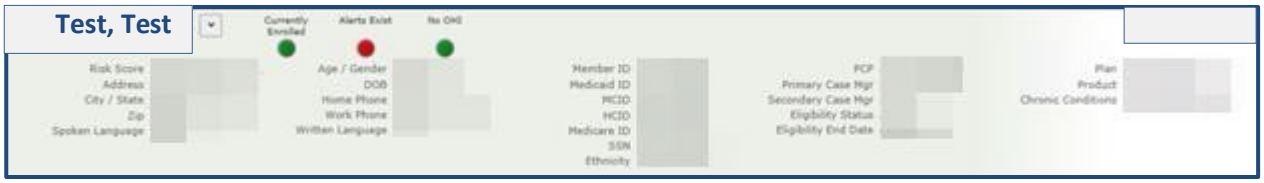
After selecting **Continue without sensitive information** or **Continue with sensitive information**, the member LPR (longitudinal patient record) will appear.

Reading the P360 LPR in PCMS

The P360 LPR includes multiple tabs of data for each patient record. A screen shot describing each tab is presented below in the order shown in the tool, designed to help you navigate these details and find specific medical information about patients attributed to you.

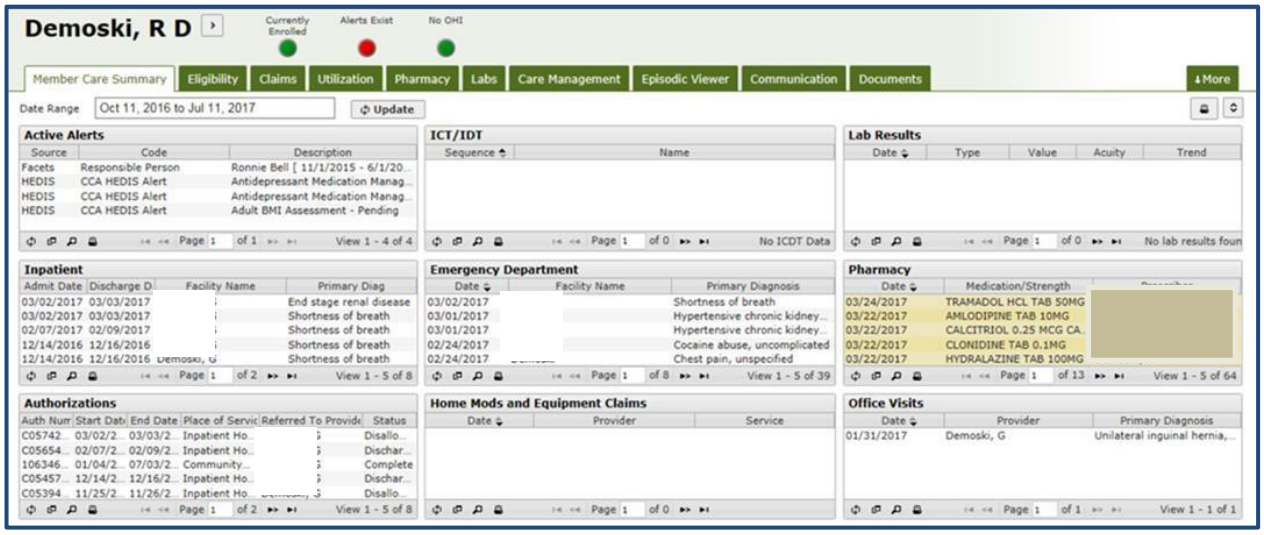
Patient banner

At the very top of the LPR is the patient banner. The banner displays all of the demographic information we have on file for that patient.



Member Care Summary

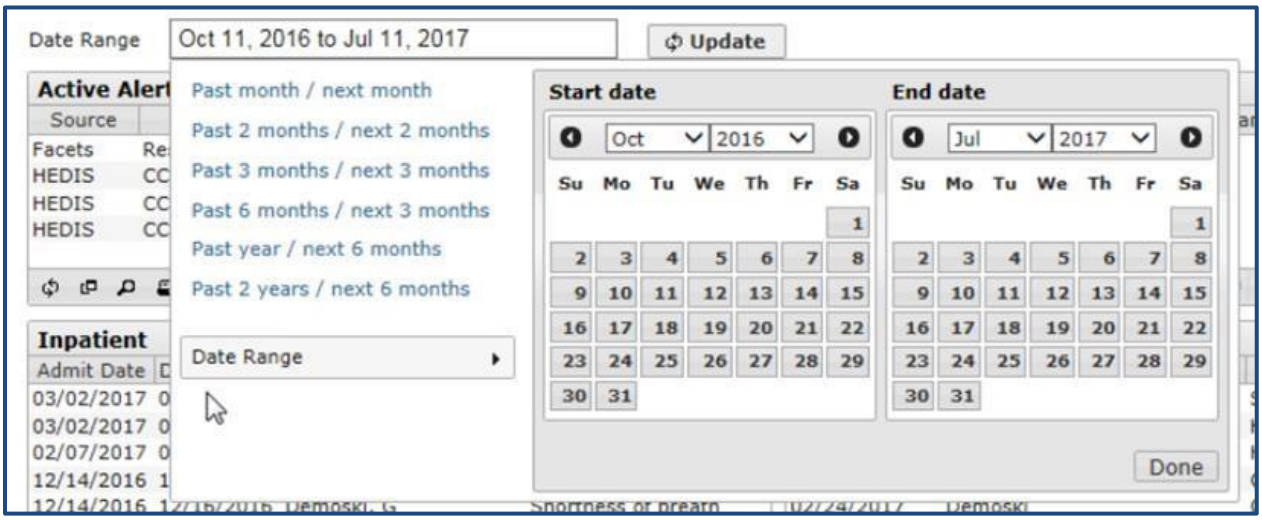
The Member Summary page is a condensed view of the most recent claims from each of the tabs. This page summarizes important aspects of the patient's care, such as active alerts for HEDIS care gaps, immunization and lab records, emergency department visits, inpatient stays and office visits.



Date Range

At the top of the following tabs displayed below, there is a *Date Range* field that can be modified based on the time period available defined in each tab displayed within this document. The default date range is six months.

When clicking in the date range field a drop down will display shortcuts to predefined date ranges:



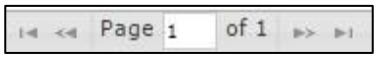
Selecting the last option, “date range” will open up two calendars allowing customization of start and end date.

Reload Grid:  This option will reload the grid either with the same data or new data.

Expand Grid:  This option will expand the selected grid into a full screen view

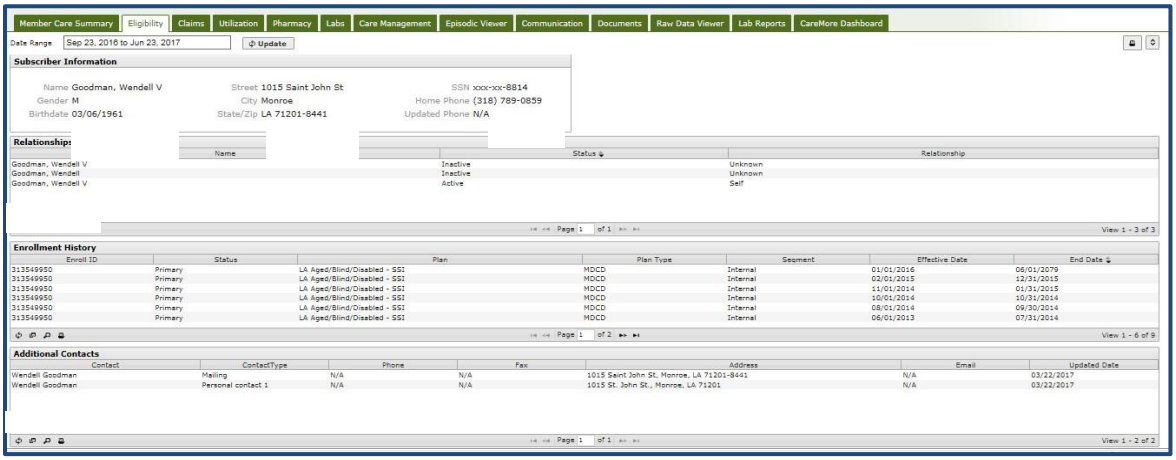
Search Grid:  This option allows the user to search the selected grid for specific data values.

Print grid:  This option allows the user to print the current grid.

Page option:  The page option will allow the user to move through the selected grid. The user can jump to the end of the date or move through each page of the grid. This option works well when the user selects the “Expand Grid” option.

Eligibility

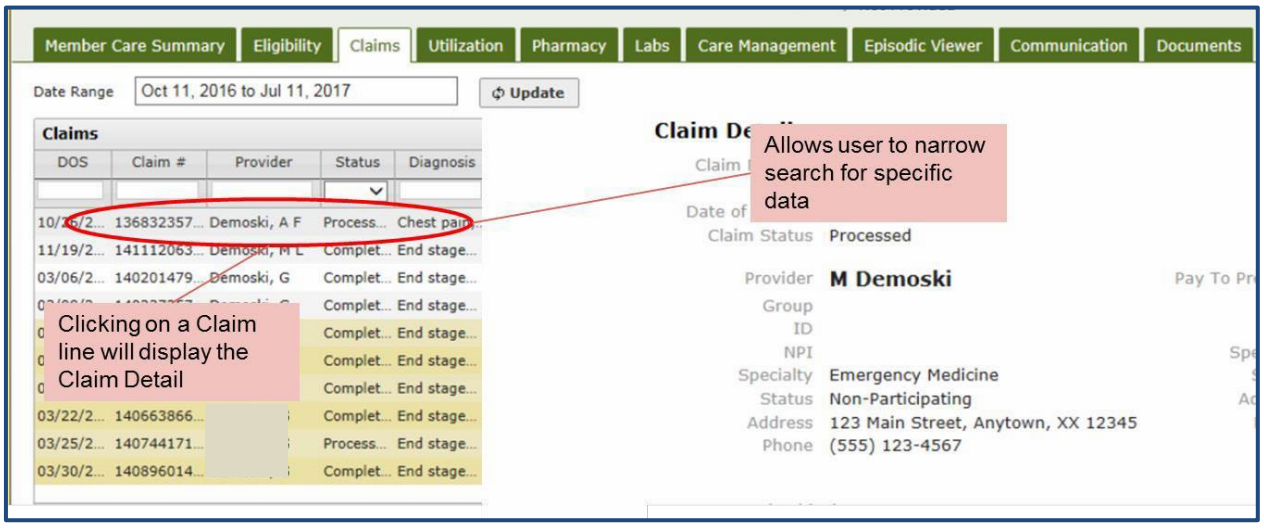
The *Eligibility history* displays current and/or previous coverage information.



The Additional Contacts section located at the bottom of the screen contains more information about other contacts the member has provided. It displays contact information from the Care Management application that has been collected about the member. It would typically include an alternate phone number that may not be present in the enrollment system.

Claims

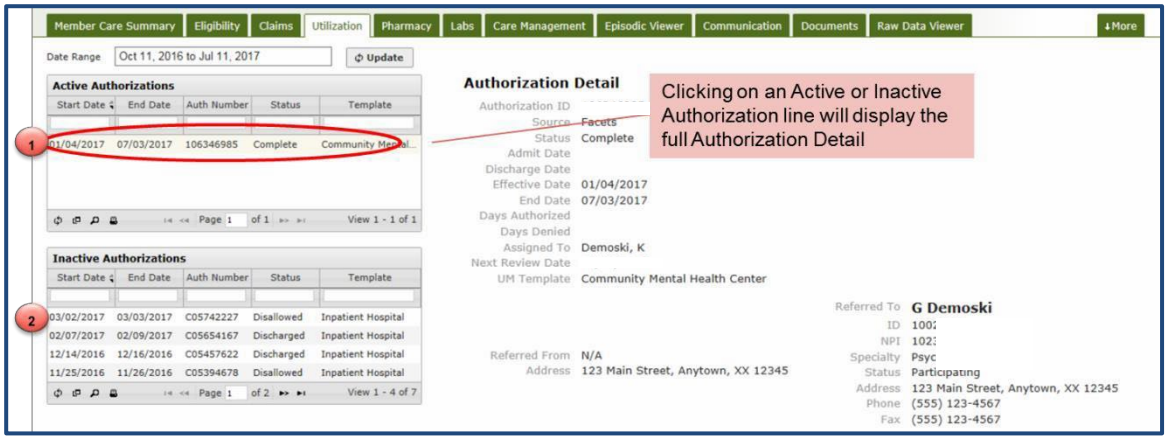
The Claims tab shows claim details for up to two years, including claim status, assigned diagnoses and services rendered.



Utilization

The *Utilization* tab provides details about active and inactive authorizations on file for the patient for up to two years. Selecting on an Active or Inactive Authorization line will display the full Authorization Detail.

- Active authorizations: Authorizations for which the member is currently receiving care.
- Inactive authorizations: Authorizations that have expired or for which care has already been rendered.



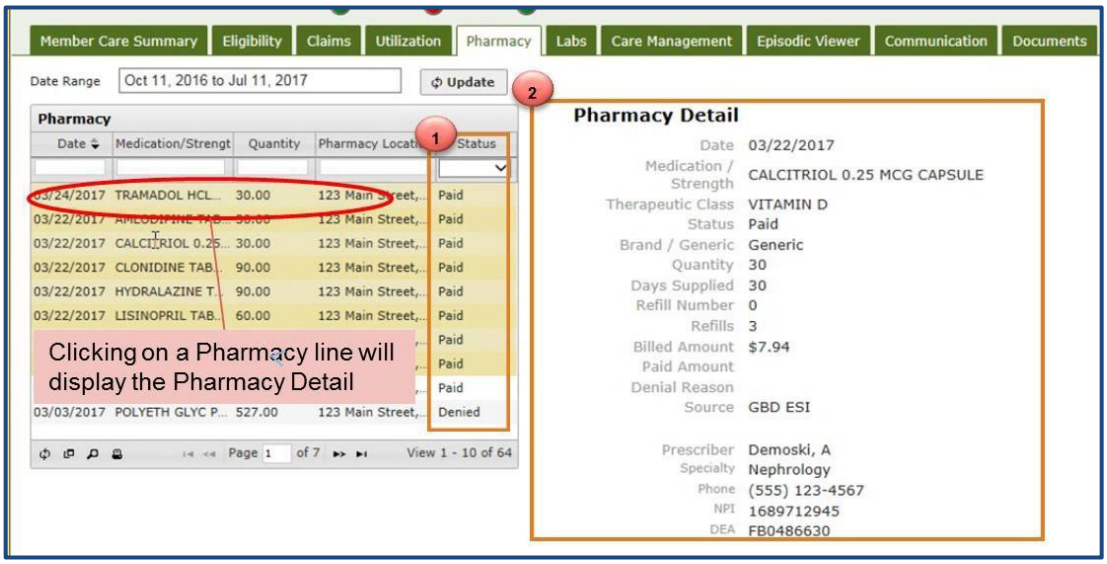
Pharmacy

The *Pharmacy* tab includes all the pharmacy information associated with claims we have received. Sensitive information is not displayed.

The pharmacy tab includes all the pharmacy information from Express Scripts (ESI) and a few other third party pharmacies.

Status: Status of the specified pharmacy transaction.

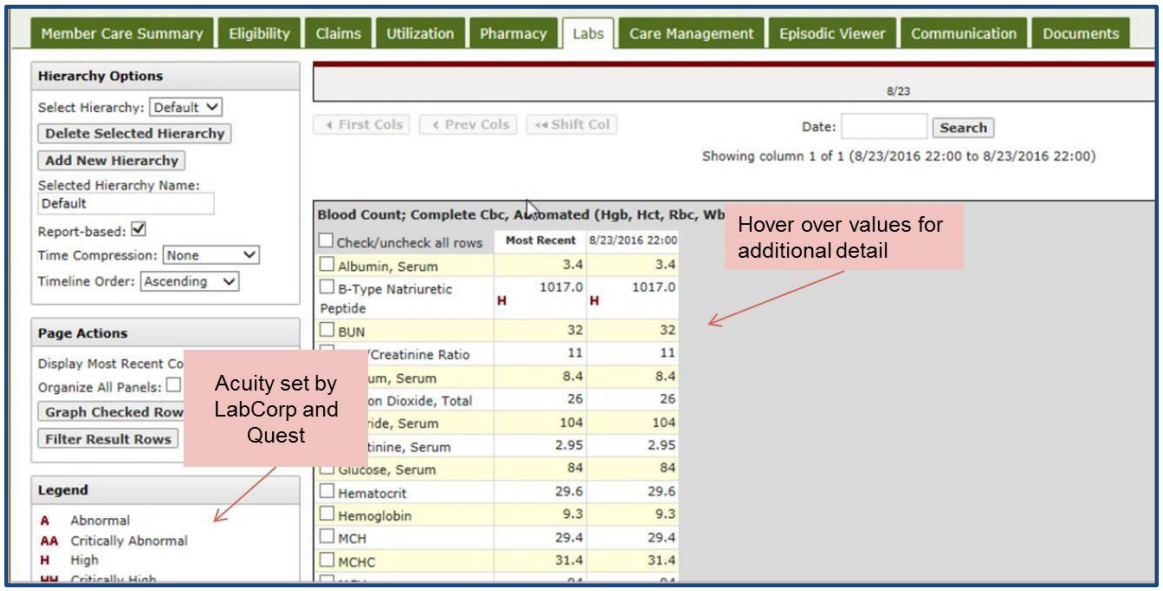
Pharmacy Detail: Details of the selected pharmacy item, including the medication quantity, days supplied, prescribing physician and pharmacy location.



Labs

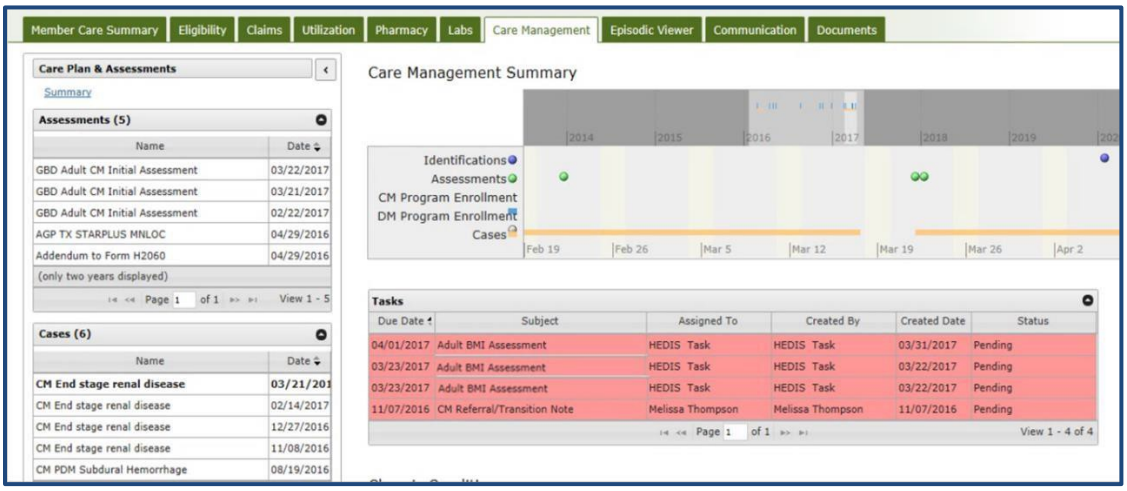
The *Labs* tab include all the lab information from Quest and LabCorp that we have received.

This tab allows for tracing and trending specific lab results along with seeing lab results that fall outside of the normal ranges.

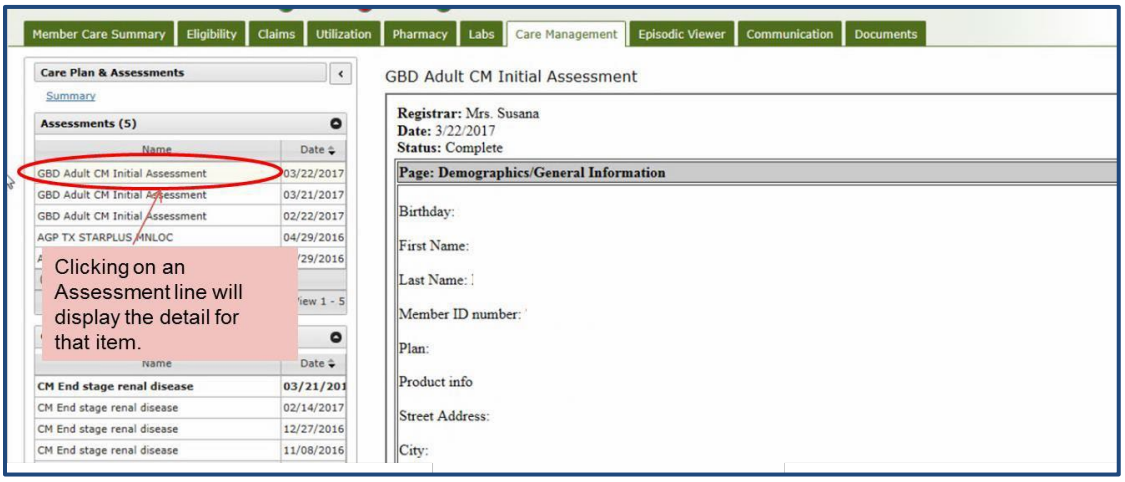


Care Management

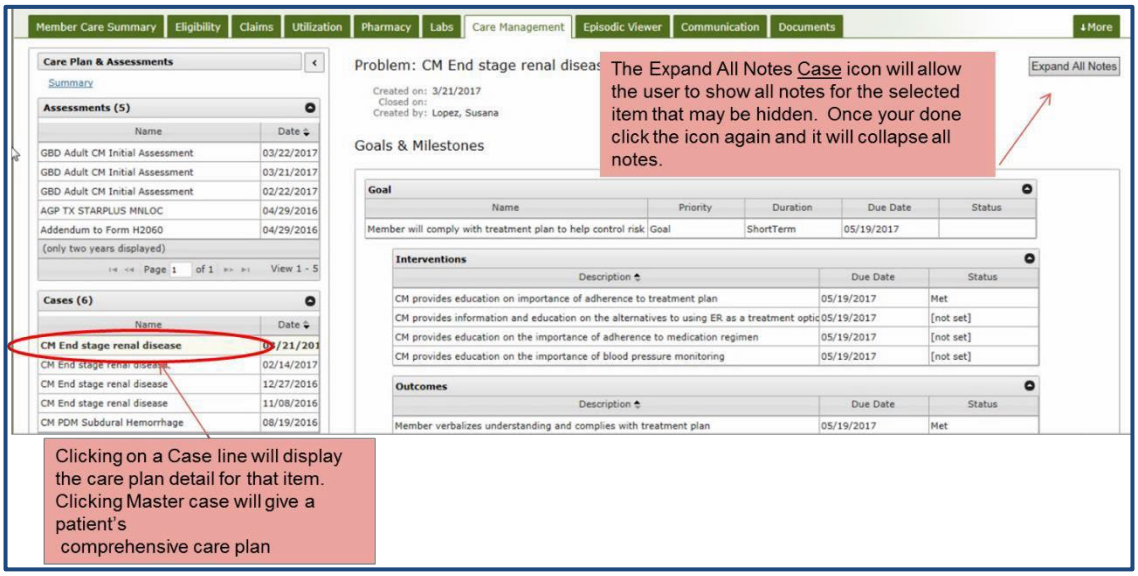
All *Care Management* activities are below, including assessments, care plan (cases) goals and initiatives.



Assessments: All assessments questions and answers recently completed by the member and the assigned Care Manager

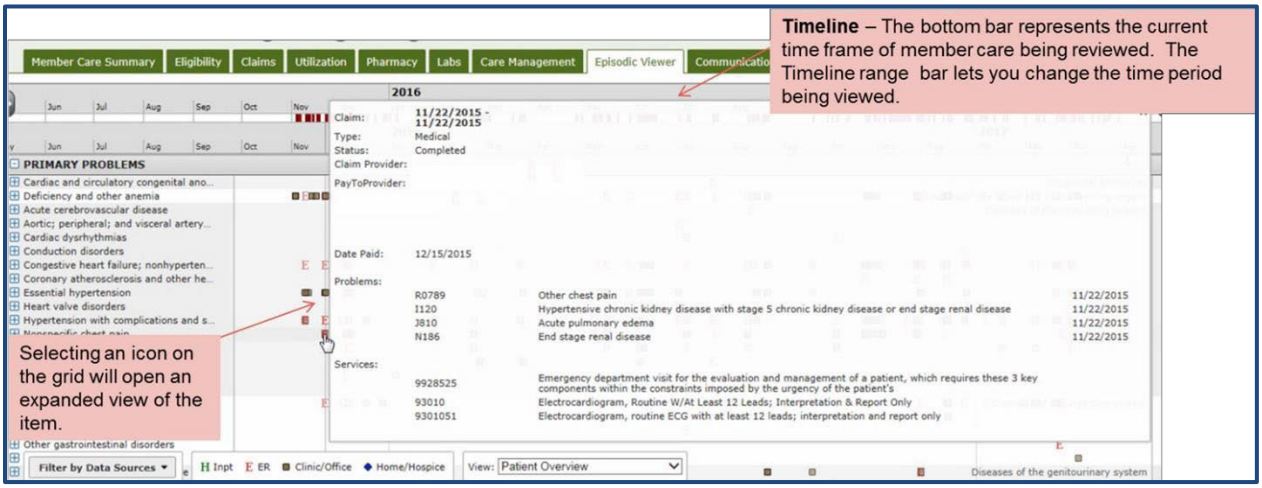


Case Management Cases: Notes on the member's care plan, goals, milestones and outcomes.



Episodic Viewer

The Episodic Viewer is a graphical representation of the data displayed in the Member Care Summary, Claims, Utilization and Labs. Each event is represented by a specific encounter (e.g. hospital, ER) with drill down to the specifics of each encounter.



Communication

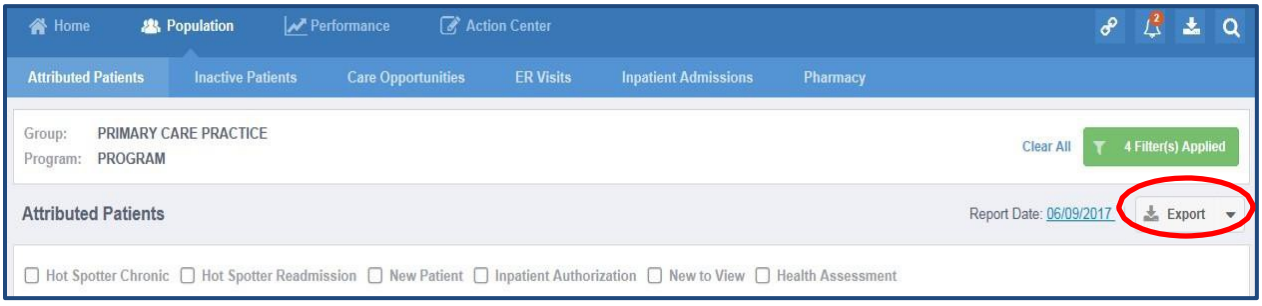
The communication tab will display communication details with member, member representative, and/or provider about member's care.

Documents

The Documents tab displays the documents received by the Health Plan from providers. Please contact your Network or Health Plan Representative for more information. Clinical Documents can include but are not limited to: CCDAs (Consolidates Clinical Data Architecture), Progress notes, Assessments, Discharge Summaries and Emergency Department Notes/Reports.

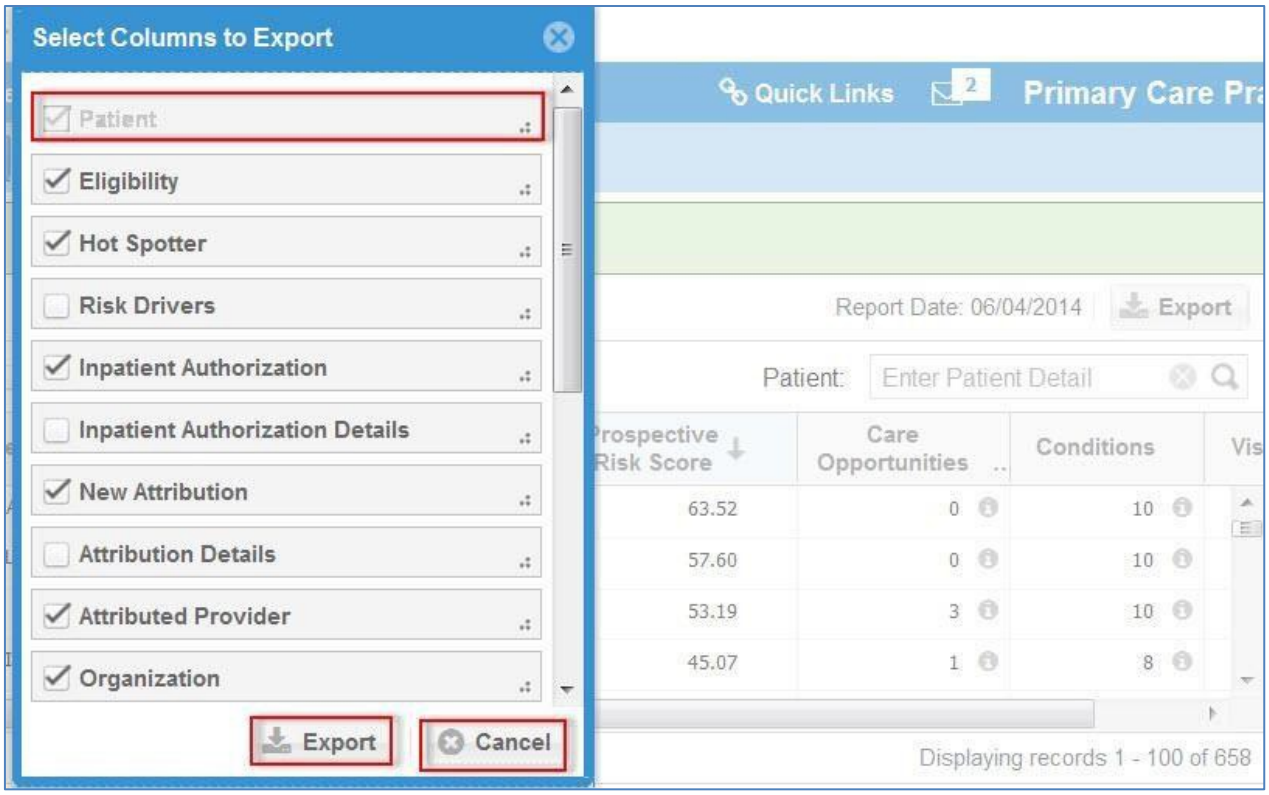
Export a Report

Data can be exported from PCMS into a PDF or Excel format in any view where the **Export** button displays.



Select which columns to include in the export. Some columns are preselected but can be deselected. Greyed-out columns cannot be deselected. The greyed-out data will be included in the report by default. Select **Cancel** at any time to exit out of the *Export* function.

Note: There are known limitations on the number of rows that can be exported from PCMS. Please use filters to narrow the data set.



Exporting large amounts of data

Exporting large amounts of data will trigger the alert shown below.

Continue with the export by selecting **Yes**. Selecting **No** will simply cancel the export.

Note: PCMS allows exports up to 200,000 rows of data in Excel. Please use filters to narrow the data set. Selecting **Yes** will trigger the message below. Users can continue to use the application while the data is exporting. Once the data is done exporting, an *Excel Open/Save* window will display.

Optional: Steps to prepare your Excel spreadsheet

Download your export by clicking on the small Export icon at the top right of the screen. A small numeral will indicate exports ready to open.

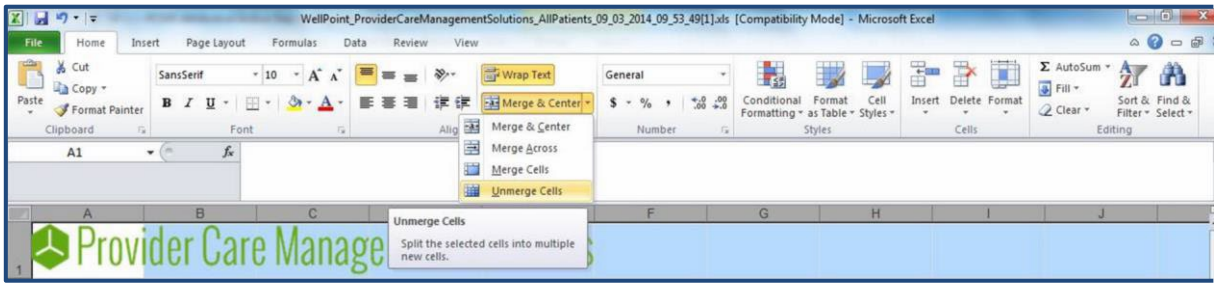
Click the icon to view exports. The popup will list the exports available. Select the export icon next to the submitted file to open and or save and print. Once the download is completed, the report is removed from the pop-up menu. The system will store exports for 12 hours from the time they become available.

Choose the Cancel button at any time to exit out of Export.

Prep the Excel worksheet by selecting the upper left corner of spreadsheet to highlight the entire sheet.

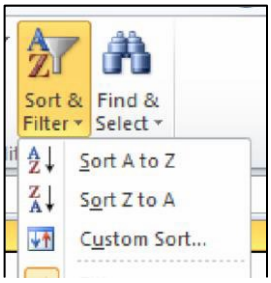
Select the **Merge and Center** drop-down arrow and select **Unmerge Cells**.

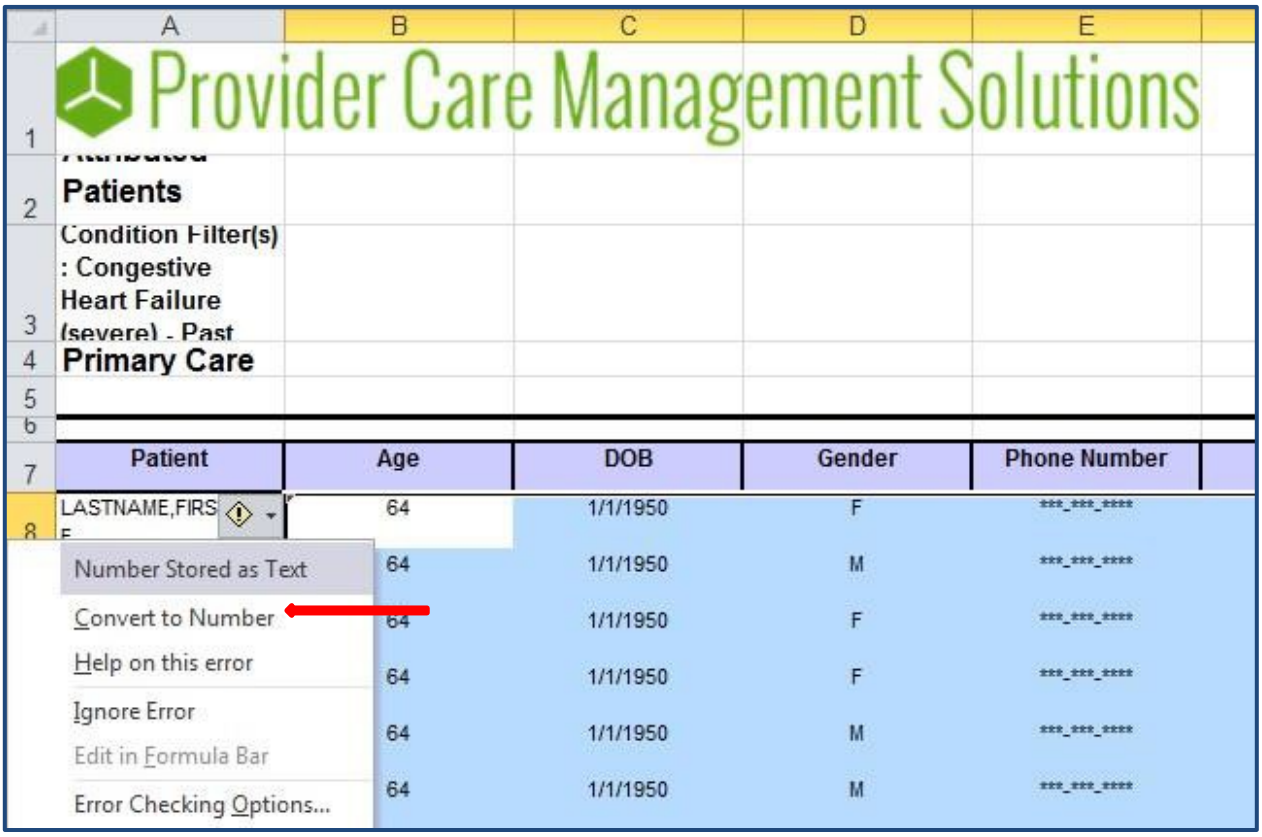
Hint: You may have to enable editing or save the Excel worksheet to your desktop or other drive.



Delete any columns that are blank. Cells that contain numbers have been exported from PCMS into Excel as text and not as numerical values. These **must** be converted to numbers. To do this, select the first cell of the report data that includes a number and then highlight the remaining cells in the sheet by pressing the **Control** and **Shift** keys while pushing the down and right arrow keys.

Scroll back to top of report data and locate the cell with a yellow box/exclamation point. Select the drop-down arrow and select **Convert to Number**.



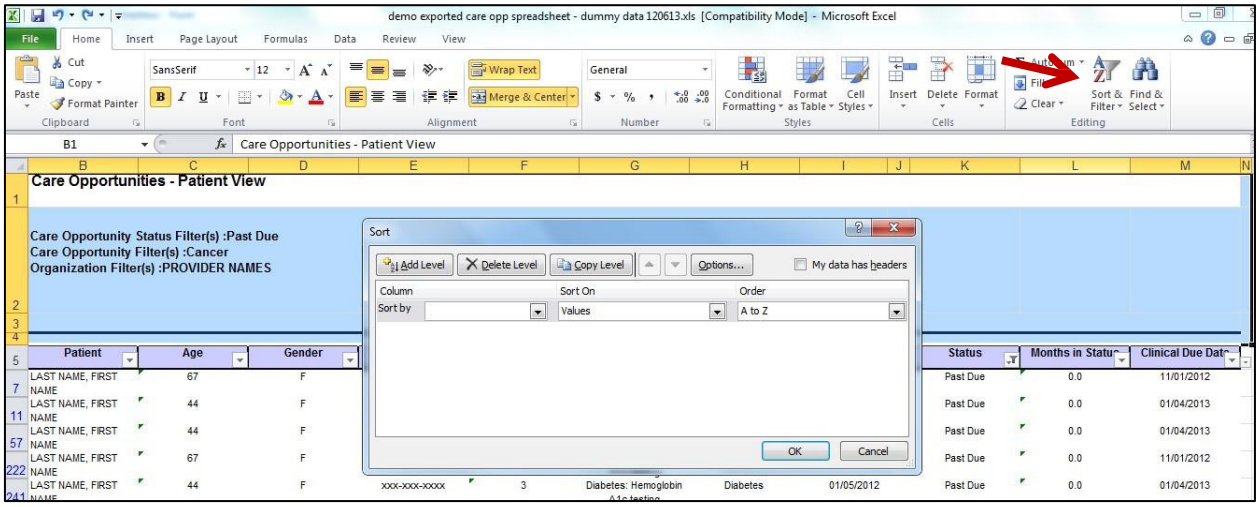


Now, all cells with numbers will be numerical values rather than text. You should not see any more green triangles in the corner of each cell.

Filter using column headers

1. Select the row with column headers.
2. Select the filtering option.
3. Use the filters to view preferred data.

Sort using columns



1. Highlight the first four rows, right-click and select **Delete row**.
2. Select **Sort & Filter** from the ribbon at the top of the worksheet and custom sort to your preference by choosing from the **Sort by** drop-down lists.

Export glossary

This glossary identifies the data that is exported when specific columns are selected within each view.
Notes:

1. There are known limitations on the numbers of rows that can be exported from PCMS. Please use filters to narrow the data set.
2. All filter and search criteria will be included in export headers.

Attributed Patients view

Columns to export

This section identifies the data that is exported to Excel when a specific column in the *Attributed Patients* view is selected.

Select and drag the column name to place the columns that will be included on the report in a particular order. The overall number of columns selected will affect the look of the PDF.

Below is a list of columns that can be exported to Excel.

Patient
Patient is preselected. The following patient data is exported:

- Last Name
- First Name
- Age
- Date of Birth
- Gender (M or F)
- Member Address (dashes (--) indicates address is not available)
    - Member Street
    - Member City
    - Member State
    - Member ZIP code
- Phone number

Eligibility
The following additional patient data is exported when the *Eligibility* column is selected:

- Member ID
- Line of business
- Product
- Home Plan Parent Company
- Home Plan Name

Hot Spotter
The following indicators are exported when the *Hot Spotter* column is selected:

- Hot Spotter Chronic (Y, Y-New or N)
- Months as Hot Spotter Chronic (number of months)
- Readmission Hot Spotter (Y, Y-New or N) **Chronic Care Gap Score**
- Score for Open Risk Drivers

Risk Drivers
The following data is exported when the *Risk Drivers* column is selected:

- Hot Spotter Risk Drivers
- Hot Spotter Chronic
- Hot Spotter Readmission

Inpatient Authorization
The following indicators are exported when the *Inpatient Authorization* column is selected:
inpatient Authorization (Y, Y-New or N)

Inpatient Authorization Details
The following Inpatient Authorization data is exported when the *Inpatient Authorization Details* column is selected:

- Inpatient Facility
- Length of Stay
- Admission Date
- Discharge Date
- Admitting Diagnosis
- Readmission Risk

Clinical Programs
The following Case Management and Disease Management data is exported when the *Clinical Programs* column is selected:

- CM/DM Contact Name (primary)
- CM/DM Contact Phone (primary)
- /DM Contact Name (secondary)
- CM/DM Contact Phone (secondary)
- CM Program Name
- CM Program Status
- CM Program Status Reason
- DM Program Name
- DM Program Status
- DM Program Status Reason

New Attribution
The following indicators are exported when the *New Attribution* column is selected: New Attribution (Y or N)

Attributed Provider
The following data is exported when the *Attributed Provider* column is selected:

- Attributed Provider Name
- Attributed Provider Address (dashes (--) indicates address is not available)
    - Provider Street
    - Provider City
    - Provider State
    - Provider ZIP code
- NPI of Attributed Provider
- Provider Specialty

Attribution Details
The following attribution data is exported when the *Attribution Details* column is selected:

- Attribution Date
- Months Attributed
- Attribution Method

Organization
The following data is exported when the *Organization* column is selected:

- Organization Name of Attributed Provider
- Organization TIN

Risk Score
The following patient data is exported when the *Prospective Risk Score* column is selected:
Prospective Risk Score

Care Opportunities
The following patient data is exported when the *Care Opportunities* column is selected:
Number of Care Opportunities

Conditions
The following patient data is exported when the *Conditions* column is selected:
Number of Conditions

Condition Details
The following patient data is exported when the *Condition Details* column is selected: Condition Details

Visits
The following patient data is exported when the *Visits* column is selected:
Number of Visits

Attributed Provider Visits
The following patient data is exported when the *Attributed Provider Visits* column is selected:

- Attributed PCP Last Visit Date
- Attributed PCP Number of Visits

ER Visits
The following patient data is exported when the *ER Visits* column is selected:

- ER Visits (Y, Y-New or N)
- ER Last Visit Date
- ER Number of Visits

Inpatient Visits
The following patient data is exported when the *Inpatient Visits* column is selected:

- Inpatient Last Visit Date
- Inpatient Number of Visits

Other PCP Visits
The following patient data is exported when the *Other PCP Visits* (primary care visits not for the

attributed PCP) column is selected:

- Last Visit Date
- Number of Visits

Outpatient Visits
The following patient data is exported when the *Outpatient Visits* column is selected:

- Outpatient Last Visit Date
- Outpatient Number of Visits

Specialists Visits
The following patient data is exported when the *Specialist Visits* column is selected:

- Last Visit Date
- Number of Visits

Urgent Care Visits
The following patient data is exported when the *Urgent Care Visits* column is selected:

- Urgent care Last Visit Date
- Urgent care Number of Visits

Referrals – Clinical Programs
The following patient data is exported when the *Referrals – Clinical Programs* column is selected:

- Number of Referrals Received
- Number of Referrals Sent

Inactive Patient view

Columns to export

This section identifies data that can be exported to Excel or PDF when you select specific column(s) in the *Inactive Patient* view.

Drag the columns up or down to define the placement of the columns in the export. The additional selection of columns will impact the look of the PDF.

Below is a list of columns that can be exported to Excel.

Patient
Patient is preselected. The following patient data is exported:

- Last Name
- First Name
- Age
- Date of Birth
- Gender (M or F)
- Member Address (dashes (--) indicates address is not available)
    - Member Street
    - Member City
    - Member State
    - Member ZIP code
- Phone number

Eligibility
The following additional patient data is exported when the *Eligibility* column is selected:

- Member ID
- Line of business
- Product

Attribution Provider
The following data is exported when the *Attributed Provider* column is selected:

- Attributed Provider Name
- Attributed Provider Address (dashes (--) indicates address is not available)
    - Provider Street
    - Provider City
    - Provider State
    - Provider ZIP code
- NPI of Attributed Provider
- Provider Specialty

Organization
The following data is exported when the *Organization* column is selected:

- Organization name of Attributed Provider
- Organization TIN

Months Attributed
The following data is exported when the *Months Attributed* column is selected:
Number of Months Attributed

Attribution End Date
The following data is exported when the *Attribution End Date* column is selected:
Attribution End Date

Attribution End Reason
The following data is exported when the *Attribution End Reason* column is selected: Attribution End Reason

Referrals – Clinical Programs
The following patient data is exported when the *Referrals – Clinical Programs* column is selected: Number of Referrals Sent

Care Opportunities Patient view

Columns to export
This section identifies data that can be exported to Excel or PDF when a specific column(s) in the *Care Opportunities* patient view is selected.

Below is a list of the columns that can be exported to Excel.

Patient
Patient is preselected. The following patient data is exported:

- Last Name
- First Name
- Age

- Date of Birth
- Gender (M or F)
- Member Address (dashes (--) indicates address is not available)
    - Member Street
    - Member City
    - Member State
    - Member ZIP code
- Phone number

Eligibility
The following additional patient data is exported when the *Eligibility* column is selected:

- Member ID
- Line of business
- Product
- Home Plan Parent Company
- Home Plan Name

Hot Spotter
The following data is exported when the *Hot Spotter* column is selected:

- Chronic Hot Spotter (Y, Y-New or N)
- Readmission Hot Spotter (Y, Y-New or N)

Inpatient Authorization
The following indicators are exported when the *Inpatient Authorization* column is selected:
Inpatient Authorization (Y, Y-New or N)

Clinical Programs
The following Case Management and Disease Management data is exported when the *Clinical Programs* column is selected:

- CM/DM Contact Name (primary)
- CM/DM Contact Phone (primary)
- CM/DM Contact Name (secondary)
- CM/DM Contact Phone (secondary)
- CM Program Name
- CM Program Status
- CM Program Status Reason
- DM Program Name
- DM Program Status
- DM Program Status Reason

New Attribution
The following indicators are exported when the *New Attribution* column is selected:
New Attribution (Y or N)

Attributed Provider
The following data is exported when the *Attributed Provider* column is selected:

- Attributed Provider Name
- Attributed Provider Address (dashes (--) indicates address is not available)
    - Provider Street

    - Provider City
    - Provider State
    - Provider ZIP code
- NPI of Attributed Provider
- Provider Specialty

Organization
The following data is exported when the *Organization* column is selected:
- Organization name of Attributed Provider
- Organization TIN

Prospective Risk Score
The following data is exported when the *Prospective Risk Score* column is selected:
Prospective Risk Score

Total Care Opportunities
The following data is exported when the *Prospective Risk Score* column is selected: Total number of Care Opportunities

Care Opportunity
Care Opportunity is preselected. The following patient data is exported:
- Care Opportunity Measure Name
- Condition
- Last Date of Compliance
- Status
- Number of Months in Status
- Clinical Due Date

Referrals – Clinical Programs
The following patient data is exported when the *Referrals – Clinical Programs* column is selected:
Number of Referrals Received
Number of Referrals Sent

Care Opportunities Provider view

Columns to export
This section identifies data that can be exported to Excel or PDF when a specific column(s) in the *Care Opportunities* provider view is selected.

You can drag the columns up or down to define the placement of the columns in the export. The additional selection of columns will affect the look of the PDF.

Below is a list of the columns that can be exported to Excel.

Provider
Provider is preselected. The following provider data is exported:
- Attributed Provider Name
- NPI of Attributed Provider

Organization

The following provider data is exported when the *Organization* column is selected:

- Organization Name of Attributed Provider
- Organization TIN

Condition

The following data is exported when the *Condition* column is selected:

- Condition tied to the open Care Opportunity
- Care Opportunity Measure

Past Due

The following data is exported when the *Past Due* column is selected:
Number of patients with past due open Care Opportunities

Due in 30 Days

The following data is exported when the *Due in 30 Days* column is selected: Number of patients who have open Care Opportunities due in 30 days

Due in 60 Days

The following data is exported when the *Due in 60 Days* column is selected: Number of patients who have open Care Opportunities due in 60 days

Due in Calendar Year

The following data is exported when the *Due in Calendar Year* column is selected: Number of patients who have open Care Opportunities due in the calendar year

Total

The following data is exported when the *Total* column is selected: Total number of patients with completed or closed Care Opportunities

Completed

The following data is exported when the *Completed* column is selected: Total number of patients with completed or closed Care Opportunities

ER Visits view

Columns to export

This section identifies data that can be exported to Excel or PDF when a specific column(s) in the *ER Visits* view is selected.

Drag the columns up or down to define the placement of the columns in the export. The additional selection of columns will affect the look of the PDF.

Below is a list of the columns that can be exported to Excel.

Patient is preselected. The following patient data is exported:

- Last Name
- First Name
- Age
- Date of Birth
- Gender (M or F)

- Member Address (dashes (--) indicates address is not available)
    - Member Street
    - Member City
    - Member State
    - Member ZIP code
- Phone number

Eligibility
The following additional patient data is exported when the *Eligibility* column is selected:

- Member ID
- Line of business
- Product
- Home Plan Parent Company
- Home Plan Name

Hot Spotter
The following indicators are exported when the *Hot Spotter* column is selected:

- Hot Spotter Chronic (Y, Y-New or N)
- Months as Hot Spotter Chronic (number of months)
- Readmission Hot Spotter (Y, Y-New or N) **Chronic Care Gap Score**
- Score for Open Risk Drivers

Risk Drivers
The following data is exported when the *Risk Drivers* column is selected: Hot Spotter Risk Drivers

Inpatient Authorization
The following indicators are exported when the *Inpatient Authorization* column is selected: Inpatient Authorization (Y, Y-New or N)

Inpatient Authorization Details
The following Inpatient Authorization data is exported when the *Inpatient Authorization Details* column is selected: Inpatient Facility

- Length of Stay
- Admission Date
- Discharge Date
- Admitting Diagnosis
- Readmission Risk

Clinical Programs
The following Case Management and Disease Management data is exported when the *Clinical Programs* column is selected:

- CM/DM Contact Name (primary)
- CM/DM Contact Phone (primary)
- CM/DM Contact Name (secondary)
- CM/DM Contact Phone (secondary)
- CM Program Name
- CM Program Status
- CM Program Status Reason

- DM Program Name
- DM Program Status
- DM Program Status Reason

New Attribution
The following indicators are exported when the *New Attribution* column is selected:
New Attribution (Y or N)

Attributed Provider
The following data is exported when the *Attributed Provider* column is selected:
- Attributed Provider Name
- Attributed Provider Address (dashes (--) indicates address is not available)
    - Provider Street
    - Provider City
    - Provider State
    - Provider ZIP code
- NPI of Attributed Provider
- Specialty Provider

Attribution Details
The following attribution data is exported when the *Attribution Details* column is selected:
- Attribution Date
- Months Attributed
- Attribution Method

Organization
The following data is exported when the *Organization* column is selected:
- Organization Name of Attributed Provider
- Organization TIN

Risk Score
The following patient data is exported when the *Prospective Risk Score* column is selected:
Prospective Risk Score

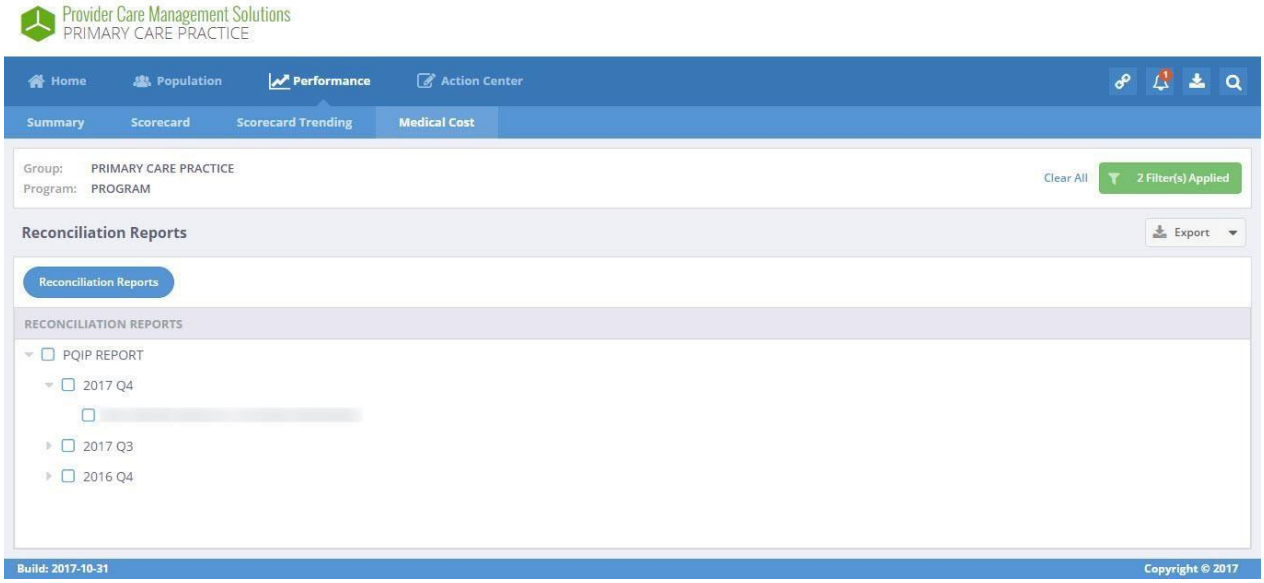
ER Visits
The following data is exported when the *Visits* column is selected:
- ER Visits (Y or Y-New)
- Number of ER visits
- Last Visit Date

ER Visit Details
The *Visit Details* column is preselected. The following data is exported:
- Visit date
- Day of week
- Facility name
- Potentially avoidable ER visit (Y or N)
- Primary diagnosis
- Secondary diagnosis 1
- Secondary diagnosis 2

- Secondary diagnosis 3

Referrals – Clinical Programs
The following patient data is exported when the *Referrals – Clinical Programs* column is selected:

- Number of Referrals Received
- Number of Referrals Sent



Inpatient Admissions view

Columns to export

This section identifies data that can be exported to Excel or PDF when a specific column(s) in the *Inpatient Admissions* view is selected.

Drag the columns up or down to define the placement of the columns in the export. The additional selection of columns will affect the look of the PDF.

Below is a list of the columns that can be exported to Excel.

Patient is preselected. The following patient data is exported:

- Last Name
- First Name
- Age
- Date of Birth
- Gender (M or F)
- Member Address (dashes (--) indicates address is not available)
    - Member Street
    - Member City
    - Member State
    - Member ZIP code
- Phone number

Eligibility
The following additional patient data is exported when the *Eligibility* column is selected:

- Member ID
- Line of business
- Product
- Home Plan Parent Company
- Home Plan Name

Hot Spotter
The following indicators are exported when the *Hot Spotter* column is selected:
- Hot Spotter Chronic (Y, Y-New or N)
- Months as Hot Spotter Chronic (number of months)
- Readmission Hot Spotter (Y, Y-New or N) **Chronic Care Gap Score**
- Score for Open Risk Drivers

Risk Drivers
The following data is exported when the *Risk Drivers* column is selected: Hot Spotter Risk Drivers

Inpatient Authorization
The following indicators are exported when the *Inpatient Authorization* column is selected: Inpatient Authorization (Y, Y-New or N)

Inpatient Authorization Details
The following Inpatient Authorization data is exported when the *Inpatient Authorization Details* column is selected:
- Inpatient Facility
- Length of Stay
- Admission Date
- Discharge Date
- Admitting Diagnosis
- Readmission Risk

Clinical Programs
The following Case Management and Disease Management data is exported when the *Clinical Programs* column is selected:
- CM/DM Contact Name (primary)
- CM/DM Contact Phone (primary)
- CM/DM Contact Name (secondary)
- CM/DM Contact Phone (secondary)
- CM Program Name
- CM Program Status
- CM Program Status Reason
- DM Program Nam
- DM Program Status
- DM Program Status Reason

New Attribution
The following indicators are exported when the *New Attribution* column is selected: New Attribution (Y or N)

Attributed Provider
The following data is exported when the *Attributed Provider* column is selected:

- Attributed Provider Name
- Attributed Provider Address (dashes (--) indicates address is not available)
    - Provider Street
    - Provider City
    - Provider State
    - Provider ZIP code
- NPI of Attributed Provider
- Specialty Provider

Attribution Details
The following attribution data is exported when the *Attribution Details* column is selected:

- Attribution Date
- Months Attributed
- Attribution Method

Organization
The following data is exported when the *Organization* column is selected:

- Organization Name of Attributed Provider
- Organization TIN

Risk Score
The following patient data is exported when the *Prospective Risk Score* column is selected: Prospective Risk Score

Inpatient Admission
The following patient data is exported when the *Inpatient Admissions* column is selected:

- Inpatient admissions (Y or N)
    - Inpatient Number of Admissions
    - Last Inpatient Admission
- Inpatient Admit Details
    - Admit Date
    - Discharge Date
    - Length of Stay
    - Facility Name
    - Ambulatory Sensitive Condition (Y or N)
    - Acute Readmission (Y or N)
    - Admitting Diagnosis
    - Secondary Diagnosis 1
    - Secondary Diagnosis 2

Referrals – Clinical Programs
The following patient data is exported when the *Referrals – Clinical Programs* column is selected:

- Number of Referrals Received
- Number of Referrals Sent

Appendix 1: Table of Conditions

Priority	Condition	Rule friendly name	Rule description
1	CHF	CHF PMH	Identifies members with a past medical history of congestive heart failure (CHF)
2	Diabetes mellitus	Diabetes mellitus PMH	Identifies members with a history of DM (type 1 or 2)
3	CHD	CHD PMH	Identifies patients with coronary heart disease CHD)
4	Hypertension	Hypertension PMH	Identifies patient with HTN
5	COPD American Thoracic Society Criteria	COPD ATS PMH	Identifies members who probably have COPD according to the American Thoracic Society definition. 'COPD' Chronic Bronchitis_PMH"; OR"_Emphysema_PMH"
6	Asthma	Asthma PMH	Identifies patients who have asthma
7	Migraine	Migraine PMH	Identifies members with a past medical history of migraine headaches
8	Hyperlipidemia	Lipid PMH	Identifies members with hyperlipidemia
9	Smoking history	Smoking history PMH	Identifies members with medical, Rx, and/or HRA claims suggestive of a history of cigarette smoking
10	Depression	Depression PMH	Identifies members with depression
11	Hospice	Hospice history PMH	Identifies members with a history of hospice services over the past year
12	Vulnerable Elder	Vulnerable Elder PMH	Identifies patients >=75 or ages 65-74 with recent hospitalization, physical therapy or functional impairment diagnosis in past 6 months

Priority	Condition	Rule friendly name	Rule description
13	Atrial fibrillation	Atrial fibrillation PMH	Identifies members with a past medical history of atrial fibrillation (Afib)
14	Fatigue or Somnolence	Fatigue or Somnolence PMH	Identifies patients with claims fatigue or somnolence
15	Obstructive Sleep Apnea (OSA)	Obstructive Sleep Apnea (OSA) PMH	Identifies patients with claims for Obstructive Sleep Apnea
16	Osteoporosis	Osteoporosis PMH	Identifies patients with a diagnosis of osteoporosis
17	DVT lower extremity	DVT lower extremity PMH	Identifies patients with claims for Lower Extremity Deep Vein Thrombosis - DVT
18	DVT PE	DVT PE PMH	Identifies patient with DVT & PE
19	Bipolar	Bipolar PMH	Identifies members with a history of bipolar disorder
20	Dementia	Dementia PMH	Identifies members with a history of dementia
21	Schizophrenia	Schizophrenia PMH	Identifies members with a history of schizophrenia
22	CVA	CVA PMH	Identifies patients with a PMH of CVA
23	Seizure	Seizure PMH	Identifies members who have a seizure disorder
24	Proteinuria	Proteinuria PMH	Identifies individuals with Proteinuria
25	Kidney- CKD	Chronic Kidney Disease (CKD) - Past Medical History	Identifies patients with claims for CKD,codes for ESRD Services
26	Obesity	Obesity PMH	Identifies members >= 18 years-old with a past medical history of obesity (BMI >= 30 kg/m2) Most recent HRA claims for 'BodyMassIndex_HRA' >= 30 kg/m2

Priority	Condition	Rule friendly name	Rule description
27	Overweight or heavier (BMI>=25)	Overweight or heavier (BMI>=25)	Identifies patients with claims with most recent value of BodyMassIndex_HRA >= 25.0; OR Has >=1 claim for overweight or obesity
28	Pregnancy now	Pregnancy now PMH	Identifies pregnant female members
29	Colorectal cancer	Colorectal cancer PMH	Identifies adult members with a diagnosis of colorectal cancer
30	Breast cancer	Breast cancer PMH	Identifies members with a history of breast cancer
31	High Risk Breast Cancer	High Risk Breast Cancer PMH	Women only; claims for Genetic susceptibility for BrCa
32	Prostate cancer	Prostate cancer past medical history	Identifies patients with history of prostate cancer anytime in the past
33	Recent cancer	Recent cancer PMH	Identifies patients with claims for cancer
34	Melanoma	Melanoma PMH	Identifies patients with claims for melanoma
35	Cirrhosis (chronic liver)	Cirrhosis - Past Medical History	Identifies patients with claims for cirrhosis
36	Rheumatoid Arthritis	Rheumatoid arthritis PMH	Identifies adult patients with a history of Rheumatoid Arthritis (RA)

Appendix 2: Table of Readmission Risk Drivers

Driver type	Risk drivers that display on report	Definition	Data source
Readmission Risk Model	Demographic Risk	Age, Gender	Membership
Readmission Risk Model	Co morbidities	Charlson Comorbidity Index	1 year claims prior to index admission
Readmission Risk Model	High Medical care Utilization	Based on the # of inpatient, ER, Outpatient, urgent care & office visits in prior 12 months	

Driver type	Risk drivers that display on report	Definition	Data source
Readmission Risk Model	Recent High Risk Utilization	UM review in last 90 days (includes requests that are urgent, emergent, elective, acute)	90 Days UM History prior to Index Admission
Readmission Risk Model	Admit Diagnosis	Current admit has primary diagnosis of Heart Disease, Psychoses, Malignant Neoplasm	Current UM Admission
Readmission Risk Model	Unplanned Admit	Classification of current admit is urgent or emergent	
Readmission Risk Model	Medical Service Classification	Members admitted for medical services are more likely to have an unplanned readmission than members with surgical admissions	
Readmission Risk Model	Length of Stay	Approved days of current admission	
Readmission Risk Model	Future Risk Score	Predicted utilization of medical/RX services in the next 12 months based on the DxCG risk solutions model	DXCG Risk Score
Care Gap	No MD Visit Claims 6 mos.	No Usual Source of Care: identifies members who have not had claims for a face to face office visit in the past 6 mos.	RHI Rules
Care Gap	Rx Non-Compliance 6 mos.	Rx Non-Compliance: identifies members who have filled chronic condition medical prescriptions less than 80% of the time in the past 6 mos.	RHI Rules
Care Gap	Claims for > 10 Rx 4 mos.	Polypharmacy: identifies members who have had claims for more than 10 medications in the past 4 mos.	RHI Rules

Appendix 3: Table of Chronic Care Gaps

Condition	Care gap	Definition	Why it's important
ASTHMA	Asthma needs 6-month follow up	Identifies members at least 18 years old with asthma who need 6-month follow-up.	A follow-up visit to review medication and treatment options can prevent future complications.

Condition	Care gap	Definition	Why it's important
ASTHMA	Asthma recent ER visit needs follow up	Identifies members at least 18 years old with asthma who were seen in the ED for asthma 3 to 9 months before the run date and who have not had a follow-up office visit between the ED visit and the run date	A follow-up visit to review medication and treatment options can prevent future ER visits.
ASTHMA	Asthma beta blocker warning	Identifies members at least 18 years old whose asthma might be exacerbated by taking nonselective beta blocker medication as treatment for other medical conditions.	Beta blockers can make asthma symptoms worse.
ASTHMA	Zileuton needs LFT	Identifies members at least 18 years old who recently started taking zileuton and need a 3month liver function test. Requires pharmacy eligibility.	This drug is associated with hepatotoxicity. Periodic evaluation of liver function is recommended.
ASTHMA	Asthma recent hospital visit needs follow up	Identifies members at least 18 years old with asthma who were hospitalized for asthma and who have not had a follow-up office visit.	A follow-up visit to review medication and treatment options can prevent future hospital visits.
ASTHMA	Asthma med erratic refill 6 months	Identifies members at least 18 years old with asthma who are taking steroid inhalants less than 80% of the time. Requires pharmacy eligibility.	Compliance with drug therapy can help prevent exacerbations and improve outcomes.
ASTHMA	Asthma persistent needs 4-month follow-up for child	Identifies members age 5-17 years with asthma who need 4month follow-up.	A follow-up visit to review medication and treatment options can prevent future complications.

Condition	Care gap	Definition	Why it's important
ASTHMA	Asthma new diagnosis needs initial spirometry	Identifies members at least 18 years old with a new asthma diagnosis who did not have a spirometry test between 30 and 90 days after the initial diagnosis of asthma.	Spirometry is needed to provide a baseline for comparison and establish an accurate diagnosis.
ASTHMA	Asthma needs periodic spirometry	Identifies members at least 18 years old with asthma who have not had a spirometry test within the past 2 years.	Regular periodic assessment of pulmonary function is recommended for monitoring the effectiveness of therapy and disease progression.
ASTHMA	Asthma med recently discontinued	Identifies members at least 18 years old who filled prescriptions for asthma controller medication (such as inhaled corticosteroids) regularly in the last year but who have no claims for them in the last 60 days. Requires pharmacy eligibility.	These drugs can help achieve and maintain control of persistent asthma.
ASTHMA	Asthma persistent needs controller medication	Identifies members at least 18 years old with persistent asthma who are not on a controller medication. Requires pharmacy eligibility.	These drugs can help achieve and maintain control of persistent asthma.
ASTHMA/ COPD	Asthma or COPD overuse of rescue inhaler	Identifies members at least 18 years old with asthma or COPD who appear to be overusing their beta-2 agonists. Requires pharmacy eligibility.	Excessive utilization of rescue medication suggests poor control of disease and need for more aggressive use of controller medications.
CHD	CAD anti-inflammatory COX2 risk advisory	Identifies members at least 18 years old with a prior history of coronary artery disease who are currently taking a COX-2 inhibitor.	COX-2 inhibitors increase risk for cardiovascular events by selectively reducing vascular prostacyclin synthesis without disrupting COX-1-derived thromboxane synthesis in platelets.

Condition	Care gap	Definition	Why it's important
CHD	CHD med erratic refill 6 months	Identifies members at least 18 years old who filled prescriptions for coronary heart disease medication less than 80% in the last 6 months. Requires pharmacy eligibility.	Compliance with drug therapy will help prevent exacerbations and improve outcomes.
CHD	CHD needs annual followup visit	Identifies members at least 18 years old with coronary heart disease who have not had an office visit within the past 12 months.	Annual follow-up visits to review medication and treatment options can prevent future complications.
CHD	CHD recent ER visit needs follow up	Identifies members at least 18 years old with coronary heart disease (CHD) who were seen in the ED for CHD 3 to 9 months before the run date and did not have a follow-up office visit between the ED visit and the run date.	A follow-up visit to review medication and treatment options can prevent future ER visits.
CHD	CHD and migraine med warning	Identifies members at least 18 years old with heart disease who take sumatriptan or ergotamine, which could exacerbate angina and ischemia. Requires pharmacy eligibility.	These drugs are contraindicated for patients with heart disease.
CHD	CHD recent hospital visit needs follow up	Identifies members at least 18 years old with coronary heart disease (CHD) who were hospitalized for CHD 3 to 9 months before the run date and did not have a follow-up office visit between the hospital visit and the run date.	A follow-up visit to review medication and treatment options can prevent future hospital visits.
CHD	CHD on short-acting nifedipine	Identifies members at least 18 years old with coronary heart disease who have taken a short acting nifedipine.	Short acting nifedipine has been associated with increased risk of major cardiovascular events.

Condition	Care gap	Definition	Why it's important
CHD	CHD med recently discontinued	Identifies members at least 18 years old with heart disease who were filling prescriptions for medication regularly in the last year but who have no claims for them in the last 60 days. Requires pharmacy eligibility.	These patients may have stopped taking their heart disease medication.
CHD	CHD may benefit from statin	Identifies members 21-74 years old with recent MI, stent, PTCA or coronary syndrome (angina, impending infarction, preinfarction angina/syndrome, or unstable angina) who are not currently receiving a statin. Excludes those with contraindications to statin therapy and/or ESRD or severe congestive heart failure, for whom available data do not support therapy. Requires pharmacy eligibility.	Statins are strongly indicated as treatment of CHD and are proven to decrease cardiovascular events.
CHD	Drug-eluting stent no antiplatelets	Identifies members at least 18 years old with a drug-eluting stent procedure between 3 and 1 month ago (setting the most recent procedure as the onset date) who have no claims for an antiplatelet prescription at least 30 days following coronary stent placement. Requires pharmacy eligibility.	Antiplatelet therapy following stent placement is essential to prevent rethrombosis.
CHD	Myocardial infarction needs beta blocker	Identifies members at least 19 years old with a history of heart attack who are not taking beta blocker medication. Requires pharmacy eligibility.	Sustained therapy with beta blockers following MI reduces risk of subsequent coronary events.
CHF	CHF med erratic refill 6 months	Identifies members at least 18 years old with heart failure who have taken heart failure medication less than 80% of the time. Requires pharmacy eligibility.	Adherence with drug therapy will help prevent exacerbations and improve health outcomes.

Condition	Care gap	Definition	Why it's important
CHF	CHF needs 6-month follow up	Identifies members at least 18 years old with heart failure who need 6-month follow-up.	A follow-up visit to review medication and treatment options can prevent future complications.
CHF	CHF recent ER visit needs follow up	Identifies members at least 18 years old with congestive heart failure (CHF) who were seen in the ED for CHF 3 to 9 months before the run date and did not have a follow-up office visit between the ED visit and the run date.	A follow-up visit to review medication and treatment options can prevent future ER visits.
CHF	CHF norpace interaction	Identifies members at least 18 years old with heart failure who take disopyramide. Requires pharmacy eligibility.	This drug is contraindicated in patients with heart failure.
CHF	CHF high sodium med	Identifies members at least 18 years old with heart failure who are on high sodium content drugs (sodium and sodium salts alginate bicarbonate, biphosphate, citrate, phosphate, saliclate, and sulfate). Requires pharmacy eligibility.	These high sodium drugs can worsen fluid retention for heart failure patients.
CHF	CHF itraconazole interaction	Identifies members at least 18 years old with heart failure who have a supply of itraconazole in the past 30 days.	This drug is contraindicated in patients with heart failure.
CHF	Digoxin needs annual K and SCr test	Identifies members at least 18 years old who have taken digoxin in the last year and need serum potassium and creatinine tests.	Declining kidney function, especially in the elderly, can lead to decreased renal clearance of digoxin and subsequent digoxin toxicity.
CHF	CHF recent hospital visit needs follow up	Identifies members at least 18 years old with congestive heart failure (CHF) who were hospitalized for CHF 3 to 9 months before the run date and did not have a follow-up office visit between the hospital visit and the run date.	A follow-up visit to review medication and treatment options can prevent future hospital visits.

Condition	Care gap	Definition	Why it's important
CHF	CHF on digoxin with high level	Identifies members at least 18 years old with CHF who have a digoxin level greater than 1.2 ng/L.	A recent blood test suggests the drug level for digoxin is higher than it should be. Digoxin has a high risk of significant toxicity at levels close to the therapeutic range.
CHF	CHF with NSAID use	Identifies members at least 18 years old with a history of congestive heart failure who are using a NSAID.	NSAIDs can cause sodium and water retention and blunt the effects of diuretics. Several observational cohort studies have revealed increased morbidity and mortality in patients with HF using either nonselective or selective NSAIDs.
CHF	Heart failure on digoxin with low level	Identifies members at least 18 years old with heart failure who are taking digoxin and who have a digoxin level below 0.5 ng/mL. The recommended range is 0.5-1.0 ng/mL.	The drug level for digoxin is lower than the therapeutic range.
CHF	CHF med recently discontinued	Identifies members at least 18 years old who filled prescriptions for heart failure medication regularly in the last year but who have no claims for them in the last 60 days. Requires pharmacy eligibility.	Adherence with drug therapy will help prevent exacerbations and improve health outcomes.
CHF	Heart Failure Medication Recommendation (ACE/ARB)	Identifies members at least 18 years old with heart failure who are not taking an ACE inhibitor or an ARB, which might benefit their condition. Requires pharmacy eligibility.	In patients with a history of MI or ACS and reduced EF, ACE inhibitors should be used to prevent symptomatic HF and reduce mortality. In patients intolerant of ACE inhibitors, ARBs are appropriate unless contraindicated.
CHF	Beta Blocker Recommendation (Heart Failure)	Identifies members at least 18 years old with heart failure who have not filled a prescription for a beta blocker over the past 30 days. Excludes those with diastolic heart failure. Requires pharmacy eligibility.	Adding beta blockers in cases of heart failure has been shown to improve outcomes.

Condition	Care gap	Definition	Why it's important
CHF	CHF severe no aldosterone antagonist	Identifies members at least 18 years old with a history of severe heart failure who do not have a prescription for an aldosterone antagonist in the past 60 days. Requires pharmacy eligibility.	Adding aldosterone antagonists in cases of severe heart failure has been shown to improve outcomes.
CHF/HTN	Diuretic needs annual K and SCr test	Identifies members at least 18 years old who have taken a diuretic in the last year and need serum potassium and creatinine tests.	Diuretic use might cause electrolyte imbalance and therefore requires monitoring.
COPD	COPD needs 6-month follow up	Identifies members at least 18 years old with COPD who need a 6-month follow-up visit.	A follow-up visit to review medication and treatment options can prevent future complications.
COPD	COPD recent ER visit needs follow up	Identifies members at least 18 years old with COPD who were seen in the ED for COPD 3 to 9 months before the run date and did not have a follow-up office visit between the ED visit and the run date.	A follow-up visit to review medication and treatment options can prevent future ER visits.
COPD	COPD needs spirometry	Identifies members 42 or older with a new COPD diagnosis who need spirometry.	Spirometry is needed to provide a baseline for comparison and establish an accurate diagnosis.
COPD	COPD recent hospital visit needs follow up	Identifies members at least 18 years old with COPD who were hospitalized for COPD 3 to 9 months before the run date and did not have a follow-up office visit between the hospital visit and the run date.	A follow-up visit to review medication and treatment options can prevent future ER visits.
COPD	COPD med erratic refill 6 months	Identifies members at least 18 years old with COPD who are taking inhaled COPD controllers (steroid inhalers, inhaled anticholinergics, and inhaled long acting beta 2 agonists) less than 80% of the time. Requires pharmacy eligibility.	These patients may have stopped taking their COPD controller medication. Improving medication adherence among individuals with COPD is critical to improving patient outcomes.

Condition	Care gap	Definition	Why it's important
COPD	COPD med recently discontinued	Identifies members at least 18 years old with COPD who have not taken their controller medication, such as long-acting inhaled bronchodilators in the past 60 days. Requires pharmacy eligibility.	These patients may have stopped taking their COPD controller medication. Improving medication adherence among individuals with COPD is critical to optimizing patient outcomes.
COPD	COPD Medication Recommendation	Identifies members at least 18 years old with COPD who may be overusing short-acting beta-2 agonist inhalers (eg albuterol) and who have no claims for long- acting controller medications for the past 4 months. Requires pharmacy eligibility.	Short-acting beta-2 agonist inhalers offer only temporary relief from symptoms and do not correct the underlying inflammation. Overuse of a ß2agonists indicates the need for an anti-inflammatory controller medication.
DIABETES	Diabetes med erratic refill 6 months	Identifies members at least 18 years old with diabetes mellitus (DM) who are taking their oral medication for DM less than 80% of the time. Requires pharmacy eligibility.	These patients may not be taking their diabetes medication regularly.
DIABETES	Diabetes needs annual retina exam	Identifies members at least 18 years old with diabetes who have not had an annual eye exam.	Diabetes can cause vision loss and blindness. Regular monitoring for retinopathy allows for early detection and intervention.
DIABETES	Diabetes needs HbA1c every 6 months	Identifies members at least 18 years old with diabetes who need a 6-month HbA1c test.	Regular HbA1c tests can assess whether a patient's glycemic levels are under control.
DIABETES	Diabetes needs annual urine protein screen	Identifies members at least 18 years old with diabetes (and no history of renal disease) who need a urine microalbumin test.	Diabetes can cause kidney disease. Regular monitoring for proteinuria allows for early detection and intervention.
DIABETES	Medication Advisory: ACE/ARB for Diabetic with Heart Disease	Identifies members at least 18 years old with diabetes and coronary heart disease who are not taking an ACE inhibitor or an ARB. Requires pharmacy eligibility.	ACE inhibitors have been shown to reduce major CVD events in patients with diabetes, supporting their use in patients with diabetes and CHD.
DIABETES	Diabetes and CKD on glimepiride	Identifies members at least 18 years old with diabetes and chronic renal failure who are taking glimepride. These members may require a dosage adjustment of glimepiride.	These members may require a dosage adjustment of glimepiride.

Condition	Care gap	Definition	Why it's important
DIABETES	Diabetes and CKD on metformin	Identifies members at least 18 years old with diabetes on metformin who have stage 3 through 5 chronic kidney disease.	Metformin is contraindicated in patients with stage 3-5 CKD.
DIABETES	Diabetes need 6-month follow-up visit	Identifies members at least 18 years old with diabetes who need a 6-month follow-up visit.	A follow-up visit to review medication and treatment options can prevent future complications.
DIABETES	Diabetes recent ER visit needs follow up	Identifies members at least 18 years old with diabetes who were seen in the ED for diabetes 3 to 9 months before the run date and did not have a followup office visit between the ED visit and the run date.	A follow-up visit to review medication and treatment options can prevent future ER visits.
DIABETES	Diabetes with CHF on a TZD med	Identifies members at least 18 years old with heart failure and diabetes who are taking TZDs, a contraindicated class of medications.	Thiazolinediones are contraindicated in patients with heart failure.
DIABETES	Diabetes screening for high-risk groups	Identifies members at least 18 years old with hypertension who need diabetes screening.	Patients with hypertension are at a higher risk for diabetes.
DIABETES	Diabetes recent hospital visit needs follow up	Identifies members at least 18 years old with diabetes who were hospitalized for diabetes 3 to 9 months before the run date and did not have a follow-up office visit between the hospital visit and the run date.	A follow-up visit to review medication and treatment options can prevent future hospital visits.
DIABETES	Gestational diabetes postpartum screening	Identifies women who delivered between 6 and 12 months ago and who were diagnosed with gestational diabetes within 9 months before delivery. These members should be screened for diabetes mellitus postpartum. Members with no claims for fasting blood sugar, glucose tolerance test, or HbA1c test since delivery are identified.	Patients with gestational diabetes should be screened for diabetes postpartum.
DIABETES	Diabetes uncontrolled high A1c	Identifies members at least 18 years old with diabetes who have an A1c (HbA1c) levels over 7.0%.	These patients have uncontrolled diabetes, which may require more aggressive therapeutic intervention.

Condition	Care gap	Definition	Why it's important
DIABETES	Fasting blood sugar 126 or greater needs follow up	Identifies members at least 18 years old without a previous diagnosis of diabetes who had a most recent lab result for a fasting blood sugar of at least 126 mg/dL from 90 to 365 days ago. Excludes members with a history of diabetes.	These patients may have diabetes and may require confirmatory tests and intervention.
DIABETES	TZD and high ALT	Identifies members at least 18 years old with an active prescription for a thiazolidinedione who have a most recent ALT above 120 U/L.	Thiazolidinediones can affect liver function.
DIABETES	Metformin needs annual creatinine test reminder for elderly patients	Identifies members 80 years old or older who are taking metformin and need an annual serum creatinine test.	Monitoring declining kidney function in elderly patients allows for reduction of the dose of metformin.
DIABETES	Diabetes on insulin no evidence of self-monitoring	Identifies members at least 18 years old with diabetes on insulin who do not have evidence of proper selfmonitoring blood glucose testing. Requires pharmacy eligibility.	These patients have diabetes treated with insulin and may not be monitoring blood glucose levels regularly.
DIABETES	Diabetes >=40 y/o LDL >=70 mg/dL no Statin	Identifies members age 40-74 years old with diabetes who have a recent LDL lab result greater than or equal to 70 mg/dL. Excludes those with coronary heart disease (these members are covered by rule CC4_CHD_no statin), LDL greater than or equal to 190 mg/dL (these members are covered by rule CC4_LDL >=190 mg/dL no Statin), and contraindications to statin therapy and/or ESRD or severe congestive heart failure, for whom available data do not support therapy. Requires pharmacy eligibility.	These patients may be at a higher risk for developing atherosclerotic cardiovascular disease.

Condition	Care gap	Definition	Why it's important
DIABETES	Diabetes HbA1c >= 9 and >= 2 oral agents no insulin	Identifies members at least 18 years old with diabetes who have taken 3 oral treatments and still have HbA1c greater than 8. These members should consider trying insulin. Requires pharmacy eligibility.	These members should consider trying insulin.
DIABETES	Diabetes pramlintide no insulin	Identifies members at least 18 years old with diabetes who are taking pramlintide and not insulin. Pramlintide should only be used with insulin. Requires pharmacy eligibility.	Pramlintide should only be used with insulin.
DIABETES	Diabetes TZD no prior metformin	Identifies members at least 18 years old with type 2 diabetes who are taking a thiazolinedione but not metformin. Requires pharmacy eligibility.	Metformin, if not contraindicated and if tolerated, is the preferred initial pharmacological agent for type 2 diabetes. Metformin may have fewer side effects than thiazolinediones.
DIABETES	Diabetes med recently discontinued	Identifies members 18 years or older with diabetes mellitus (DM) who were regularly taking DM meds over the last year and are not currently taking insulin, who have no claims for DM meds over the last 60 days.	These patients may have stopped taking their diabetes medication.
HTN	HTN med erratic refill	Identifies the drug compliance pattern (<80% adherence) for members at least 18 years old with hypertension currently on antihypertensive medication. Requires pharmacy eligibility.	These patients may not be taking their antihypertensive medication regularly.
HTN	HTN needs 6-month follow up	Identifies members at least 18 years old with hypertension who need a 6-month follow-up visit.	Regular follow-up visits to review medication and treatment options can prevent future complications.

Condition	Care gap	Definition	Why it's important
HTN	HTN recent hospital visit needs follow up	Identifies members at least 18 years old with hypertension who were hospitalized for hypertension 3 to 9 months before the run date and did not have a follow-up office visit between the hospital visit and the run date.	Regular follow-up visits to review medication and treatment options can prevent future complications.
HTN	HTN recent ER visit needs follow up	Identifies members at least 18 years old with hypertension who were seen in the ED for hypertension 3 to 9 months before the run date and did not have a follow-up office visit between the ED visit and the run date.	Regular follow-up visits to review medication and treatment options can prevent future complications.
HTN	HTN needs annual K and SCr test	Identifies members at least 18 years old with hypertension who have not had test for creatinine or potassium in the last 12 months.	Monitoring of serum creatinine and potassium levels is important, as hypertension as well as some antihypertensive medications can affect renal function.
HTN	HTN and gout avoid thiazides	Identifies members at least 18 years old with hypertension and gout who have taken a thiazide.	Thiazide diuretics decrease urate excretion and can lead to exacerbation of gout.
HTN	HTN med recently discontinued	Identifies members at least 18 years old with hypertension who were filling prescriptions for medication regularly in the last year but who have no claims for them in the last 60 days. Requires pharmacy eligibility.	These patients may have stopped taking their antihypertensive medication.
HTN	HTN new no HCTZ Diuretic, ACE/ARB or CCB	Identifies members at least 18 years old with a new diagnosis of hypertension (and no major comorbidities) who are taking hypertension medication but have not tried a thiazide-type diuretic, calcium channel blocker, ACE inhibitor, or ARB. Requires pharmacy eligibility.	Patients with hypertension may benefit from one of these medications.

Condition	Care gap	Definition	Why it's important
MIGRAINE	Migraine needs prophylactic med	Identifies members at least 18 years old with migraine headaches who frequently treat acute headaches and who are not taking medication to prevent migraines. Requires pharmacy eligibility.	Prophylactic medication can prevent migraines, improving a patient's quality of life.
OBESITY	Overweight with fatigue needs obstructive sleep apnea screening	Identifies members at least 18 years old with a BMI of at least 25 and claims for fatigue or somnolence who have not had an obstructive sleep apnea screening in the last 12 months.	Obstructive sleep apnea can lead to fatigue and cause serious complications.
OBESITY	Obesity in youth needs follow up	Identifies members younger than 21 years with a history of obesity who have had not had an outpatient face-to-face visit with a physician in the past 6 months.	Obesity can cause several serious health problems, including diabetes and hypertension.
OTHER	Cholesterol test reminder	Identifies members at least 18 years old with hyperlipidemia who have not had a lipid level test in the last 12 months.	Regular lipid testing should be performed to monitor therapeutic response and medication adherence.
OTHER	Lipid med needs 8 week or 3-month follow up	Identifies members at least 18 years old newly started on lipid lowering medications who have not had an office visit since starting therapy. Requires pharmacy eligibility.	Regular follow-up visits to review medication and treatment options can prevent future complications.
OTHER	ACE or ARB needs annual K and SCr test	Identifies members at least 18 years old who have taken an ACE inhibitor or ARB for a year and need annual serum potassium and creatinine test.	ACE inhibitor or ARB can affect creatinine or potassium levels and monitoring of electrolyte and serum creatinine levels is recommended.
OTHER	Dementia new needs TSH, B12, and thiamine testing	Identifies members at least 50 years old newly diagnosed with dementia who have not received TSH, B12, and thiamine testing within 3 months after diagnosis.	Evidence supports thyroid function and B12 level testing in the routine initial evaluation of patients with suspected dementia.

Condition	Care gap	Definition	Why it's important
OTHER	PCOS, on TZD, and Category X drug needs contraception women	Identifies members age 18-55 with polycystic ovaries placed on TZD treatment (that can also restore fertility) who are also taking a Category X drug with no record of contraception in the last 6 months.	TZDs can restore fertility to patients with PCOS. It is important to stop taking Category X drugs, which can cause birth defects.
OTHER	RHI LDL >=190 mg/dL no Statin	Identifies members age 21-74 years with a most recent LDL lab greater than or equal to 190 mg/dL, who have no claims for statin therapy. Requires pharmacy eligibility.	Patients with LDL >= 190 mg/dL are identified as having major statin benefit by the ACC/AHA guideline on the treatment of blood cholesterol.
OTHER	Age 45 or older needs diabetes screening	Identifies members 46 years old who have not had diabetes screening (fasting blood sugar, random blood sugar, glucose tolerance test, HbA1c) anytime during the last 2 years.	The American Diabetes Association recommends screening for asymptomatic individuals at age 45 (with subsequent intervals of 3 years).