Health Plan of Nevada
A UnitedHealthcare Company

Provider Resource Guide 2023
HEDIS® Pediatric Measures

Sierra Health and Life
A UnitedHealthcare Company

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

Helpful Hints

Exclusions:

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

Telehealth:
Telehealth is an underutilized method that can be applied to close many gaps in care.

Parent/Guardian Reporting:
Parent/self-reporting is a frequently acceptable method of gap closure if the necessary measure details are documented.

18-21 years of age
Patients in this age group often begin the transition from a pediatrician to an adult provider. To encourage continuity of care, start having conversations with your patient about selecting a new provider and what an adult visit may include.

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

https://healthplanofnevada.com/Provider/HEDIS-Measures

Antibiotic Stewardship

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

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

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

Goal: Reduce overuse of antibiotics

Appropriate Testing for Pharyngitis (CWP)

Patient Population
- Ages 3 years and older
- Pharyngitis diagnosis

Action:
Order a group A streptococcus (strep) test or rapid strep test prior to prescribing antibiotics.

Goal: Reduce overuse of antibiotics

Immunizations

Childhood Immunization Status (CIS)

Patient Population
- Prior to 2 years of age

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

Immunization	Dose(s)
DTaP	4
IPV	3
MMR	1
HiB	3
HepB	3
VZV	1
PCV	4
HepA	1
RV	2 or 3
Influenza	2

Avoiding a delayed immunization schedule will assist in meeting compliance.

Goal: Disease protection

Immunizations for Adolescents (IMA)

Patient Population
- Prior to 13 years of age

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

Immunization	Dose(s)
Meningococcal	1
Tdap	1
HPV	2 or 3

When 1st HPV vaccination is given, consider scheduling next visit for 2nd HPV vaccination after 146 days.

Goal: Disease protection

Well Visits

Child and Adolescent Well-Care Visits (WCV)

Patient Population
- Ages 3-21

Action:
Document and submit coding for well-care visits annually; audio/visual telehealth visits can also count as a well-care visit if documentation supports.

Goal: Build patient/provider relationship and assist youth in maintaining a healthy lifestyle and appropriate development

Well-Child Visits in first 30 Months of Life (W30)

Patient Population
- Ages 0-30 months

Action:
Document and submit coding for six or more well-child visits within the first 15 months of life and two or more visits between 15 and 30 months of age

Goal: Build patient/provider relationship, guide timely vaccination administration, assist in appropriate infant/toddler development

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Patient Population
- Ages 3-17

Action:
- Document BMI percentile, height and weight or plot a BMI growth chart and code for BMI percentile
- Counseling for nutrition (or referral for nutrition education, eating habits, dieting, checklist, member received materials during face-to-face visit, anticipatory guidance for nutrition, weight or obesity counseling)
- Counseling for physical activity (or exercise routine, participation in sports activities, exam for sports participation, checklist, counseling or referral for physical activity, member received materials during face-to-face visit, anticipatory guidance specific to child's physical activity, weight or obesity counseling)

Goal: Maintain healthy weight

Asthma Medication Ratio (AMR)

Patient Population
- Ages 5 - 64
- Diagnosed with persistent asthma

Action:
- Prescribe controllers to patients with persistent asthma
- Refer members to Disease Management for help managing asthma https://healthplanofnevada.com/Member/Disease-Management

Goal: Asthma management

Exclusions: Chronic respiratory conditions (i.e., emphysema, COPD, obstructive chronic bronchitis, cystic fibrosis, acute respiratory failure)

Social Determinants of Health (SDoH) such as food insecurity, homelessness or housing instability, psychosocial circumstances, economic challenges, etc. have been identified as key factors in impacting a patient's health and health outcomes. Coding for these can bring attention to their prevalence and help identify needed resources.

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Diabetes

Patient Population:
- Ages 18 – 75
- Diabetes diagnosis
- Dispensed insulin or hypoglycemics/ antihyperglycemics

Action:
Measure and report values for the following:
- HbA1c
- eGFR
- Urine Albumin-Creatinine Ratio (uACR)
- Albumin/microalbumin and a urine creatinine test (<4 days of each other)
- Repeat BP if either value is >139/89
- Perform a diabetic retinal eye screening or refer to an eye care provider
- Refer members to Disease Management for help managing diabetes https://healthplanofnevada.com/Member/Disease-Management

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Behavioral Health (BH)

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Patient Population
- Ages 6-12
- Dispensed ADHD medication

Action:
- One follow-up visit with a prescribing provider within 30 days of the prescription start date
- At least two follow up visits on different dates with any provider within nine months of the prescription start date

Exclusions: Narcolepsy

Goal: Monitoring of patient to assess response to pharmacotherapy as well as emergence of side effects

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Patient Population
- Ages 6 years and older
- Principal diagnosis of mental illness or intentional self-harm

Action:
- 7-day follow-up for mental illness within 7 days after the ED visit (8 days total)
- 30-day follow-up for mental illness within 30 days after the ED visit (31 days total)

Goal: Ensure proper follow-up care after a mental health ED visit

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Patient Population
- Ages 1-17
- Had two or more antipsychotic prescriptions

Action:
Schedule an annual glucose or HbA1c and LDL-C or other cholesterol test

Goal: Metabolic Monitoring

Antidepressant Medication Management (AMM)

Patient Population
- Ages 18 and older
- Treated with antidepressant medication
- Diagnosis of major depression

Action:
If prescribing an antidepressant, cover 180 days (6 months) of medication and refer to psychiatry to encourage whole-person care

Goal: To relieve or reduce the symptoms of depression

Women's Health

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

Patient Population
- Diagnosed pregnancy

Action:
- Perform and document date of prenatal visit in the 1st trimester
- Indicators of pregnancy: prenatal flow sheet, LMP, EDD, positive pregnancy test result, gravidity and parity, complete obstetrical history, fetal heart tones, measurement of fundus height, prenatal risk assessment and counseling/ education
- Complete depression screening (document test type and score); follow up on positive screenings within 30 days
- Schedule influenza & Tdap vaccinations

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

Chlamydia Screening in Women (CHL)

Patient Population
- Women ages 16-24
- On birth control/Identified as sexually active

Action:
Perform a chlamydia test annually

Goal: Identify chlamydia in sexually active women

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

Patient Population
- Delivery of live birth(s)

Action:
Perform and document a postpartum visit on or between 7–84 days (1-12 weeks) after delivery and one of the following:
- Postpartum care (PP care, PP check, etc.), pelvic exam, evaluation of weight, BP, breasts, and abdomen, perineal or cesarean incision/wound check, screening for depression, anxiety, tobacco use, substance use disorder or pre-existing mental health disorders, glucose screening for women with gestational diabetes, infant care/breast feeding, resumption of intercourse, family planning, sleep/fatigue, resumption of physical activity or attainment of healthy weight
- Complete depression screening (document test type and score); follow up on positive screenings within 30 days

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

Social Determinants of Health (SDoH) such as food insecurity, homelessness or housing instability, psychosocial circumstances, economic challenges, etc. have been identified as key factors in impacting a patient's health and health outcomes. Coding for these can bring attention to their prevalence and help identify needed resources.