HEDIS® RESOURCE GUIDE

— Adult —

WellCare® Health Plans

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2017 ADULT PREVENTIVE HEALTH CARE GUIDELINES FOR PROVIDERS

The best practice recommendations detailed below represent services that are considered medically necessary by WellCare for the prevention of certain diseases and medical conditions in adults. WellCare strongly recommends that all members receive the necessary preventive services, leading to improved health care quality and outcomes.

FREQUENCY OF PHYSICAL EXAMINATION

All members should visit their physician on a regular basis. A baseline physical exam visit should occur for all new non-pregnant adult members regardless of age, within the first 90 days of enrollment. ***Pregnant members should be seen within the first 14 days of enrollment.*** Recommendations for periodic health exam visits for asymptomatic adults include:

- **Ages 18 to 39 years:** Exam frequency: every 1 to 3 years (Annual Pap smears are indicated for females unless 3 consecutive normal smears, allowing Pap smears every 3 years. Note: In some markets, 21 to 39 years.)
- **Ages 40 to 64 years:** Exam Frequency: every 1 to 2 years based on risk factors
- **Ages 65 and Over:** Exam frequency: every year

Age	Screening	Frequency
• 18 and older	Blood Pressure, Height, Body Mass Index (BMI), Alcohol Use	Annually, 18-21 years. After 21, every 1-2 years or per PCP recommendations
• Adults 21 years of age and older, especially if at high risk	Cholesterol	Every 5 years (More frequent if elevated)
• Female 21 years of age and older	Pap Smear and Chlamydia	Every 1-3 Years or per PCP's recommendations
• Female 40 years and older	Mammography	Every 1-2 years
• 50 years and older • 50 years and older	Colorectal Hearing Screening	Periodically depending upon test Periodically
• Female > 65 years old, or > 60 years at risk • 65 years and older, or younger for those that have diabetes or other risk factors	Osteoporosis (Bone Mass Measurement) Vision including a Glaucoma or Diabetic Retinal exam as needed	Every two years or per PCP's recommendations Every two years for routine exams or annual if diabetic or other risk factors

WellCare's 2015 Adult Preventive Health Care Guidelines for Providers, Page 1, Original Effective Date: 2/2008, Last Revised: 9/17/2015

HEPATITIS C TESTING

Due to a steady increase in deaths among individuals born between 1945 and 1965 ("baby boomers"), testing for hepatitis C is recommended for those born during this time. Baby boomers are five times more likely than other American adults to be infected; over 75% of American adults with hepatitis C are baby boomers. New treatments are available which can cure up to 75% of hepatitis C cases.

Immunization* (see attached schedule)	
Tetanus-Diphtheria and acellular pertussis (Td/Tdap)	18 years and older, Tdap: Substitute 1-time dose of Tdap for Td then boost with Td every 10 years
Varicella (VZV)	All adults without evidence of immunity to varicella should receive 2 doses of single- antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose.
Measles, Mumps, Rubella (MMR)	Adults born during or after 1957 should receive 1-2 doses
Pneumococcal polysaccharide (PPSV)	65 years of age and older, all adults who smoke or have certain chronic medical conditions – 1 dose, may need a 2nd dose if identified at risk.
Seasonal Influenza	All adults annually
Hepatitis A Vaccine (HepA)	All unvaccinated individual with chronic liver disease and persons who receive clotting factor concentrates, persons traveling internationally to areas with high or intermediate endemicity of hepatitis A, or unvaccinated persons who anticipate close contact with an international adoptee, or those with certain high-risk behaviors.
Hepatitis B vaccine (HepB)	Adults at risk, 18 years of age and older – 3 doses
Meningococcal conjugate vaccine (MCV)	College freshmen living in dormitories not previously vaccinated with MCV and others at risk, 18 years of age and older – 1 dose. Meningococcal polysaccharide vaccine is preferred for adults aged ≥ 56 years.
Human Papillomavirus (HPV)**	*For eligible members through 26 years of age (three dose series)
Zoster	Age 60 and older 1 dose
Haemophilus Influenza type b (Hib)	For eligible members who are at high-risk and who have not previously received Hib vaccine (1 dose)

*(Source: **CDC, 2015**)*
WellCare's 2015 Adult Preventive Health Care Guidelines for Providers, Page 2, Original Effective Date: 2/2008, Last Revised: 9/17/2015
** Unless there is a medical reason not to get a specific vaccine. **Subject to individual state coverage.*

PREVENTION

- Discuss aspirin to prevent cardiovascular events.
  - Men – 40 years and older periodically
  - Women – 50 years and older periodically
- Discuss the importance of preventive exams (e.g., mammograms and breast self-examination for women at high risk and who have family history.)
- Discuss prostate-specific antigen (PSA) test and rectal exam for men after 40 years old per PCP discretion.

COUNSELING

- Calcium intake: 1,000mg/day (women ages 18-50 years old), 1200-1500 mg/day (women >50 years).
- Folic Acid: 0.4 mg/day (women of childbearing age); the same dosage is recommended for women who are not currently trying to conceive. Women who have given birth to a child with Neural Tube Defects (NTD) should take 4 mg daily.
- Breastfeeding: For pregnant women and women after childbirth.
- Tobacco cessation, drug and alcohol use, STDs and HIV, nutrition, physical activity, sun exposure, oral health, and injury prevention.
  - Medication list
  - Advance directives

WellCare's 2015 Adult Preventive Health Care Guidelines for Providers, Page 2, Original Effective Date: 2/2008, Last Revised: 9/17/2015

Recommended Adult Immunization Schedule—United States - 2016

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended immunization schedule for adults aged 19 years or older, by vaccine and age group[1]

VACCINE ▼ / AGE GROUP ▶	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza*,[2]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap)*,[3]	Substitute Tdap for Td once, then Td booster every 10 yrs					
Varicella*,[4]	2 doses					
Human papillomavirus (HPV) Female*,[5]	3 doses					
Human papillomavirus (HPV) Male*,[5]	3 doses					
Zoster[6]					1 dose	
Measles, mumps, rubella (MMR)*,[7]	1 or 2 doses depending on indication					
Pneumococcal 13-valent conjugate (PCV13)*,[8]	1 dose					
Pneumococcal 23-valent polysaccharide (PPSV23)[8]	1 or 2 doses depending on indication					1 dose
Hepatitis A*,[9]	2 or 3 doses depending on vaccine					
Hepatitis B*,[10]	3 doses					
Meningococcal 4-valent conjugate (MenACWY) or polysaccharide (MPSV4)*,[11]	1 or more doses depending on indication					
Meningococcal B (MenB)[11]	2 or 3 doses depending on vaccine					
Haemophilus influenzae type b (Hib)*,[12]	1 or 3 doses depending on indication					

*Covered by the Vaccine Injury Compensation Program

- Recommended for all persons who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection; zoster vaccine is recommended regardless of past episode of zoster
- Recommended for persons with a risk factor (medical, occupational, lifestyle, or other indication)
- No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the America College of Physicians (ACP), the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse-Midwives (ACNM).

Figure 2. Vaccines that might be indicated for adults aged 19 years or older based on medical and other indications[1]

VACCINE ▼ / INDICATION ▶	Pregnancy	Immuno-compromising conditions (excluding HIV infection)[4,6,7,8,13]	HIV infection CD4+ count (cells/μL)[4,6,7,8,13] < 200	HIV infection CD4+ count (cells/μL)[4,6,7,8,13] ≥ 200	Men who have sex with men (MSM)	Kidney failure, end-stage renal disease, on hemodialysis	Heart disease, chronic lung disease, chronic alcoholism	Asplenia and persistent complement component deficiencies[8,11,12]	Chronic liver disease	Diabetes	Healthcare personnel
Influenza*,[2]	1 dose annually										
Tetanus, diphtheria, pertussis (Td/Tdap)*,[3]	1 dose Tdap each pregnancy	Substitute Tdap for Td once, then Td booster every 10 yrs									
Varicella*,[4]	Contraindicated			2 doses							
Human papillomavirus (HPV) Female*,[5]		3 doses through age 26 yrs				3 doses through age 26 yrs					
Human papillomavirus (HPV) Male*,[5]		3 doses through age 26 yrs				3 doses through age 21 yrs					
Zoster[6]	Contraindicated				1 dose						
Measles, mumps, rubella (MMR)*,[7]	Contraindicated			1 or 2 doses depending on indication							
Pneumococcal 13-valent conjugate (PCV13)*,[8]		1 dose									
Pneumococcal polysaccharide (PPSV23)[8]	1, 2, or 3 doses depending on indication										
Hepatitis A*,[9]	2 or 3 doses depending on vaccine										
Hepatitis B*,[10]	3 doses										
Meningococcal 4-valent conjugate (MenACWY) or polysaccharide (MPSV4)*,[11]	1 or more doses depending on indication										
Meningococcal B (MenB)[11]	2 or 3 doses depending on vaccine										
Haemophilus influenzae type b (Hib)*,[12]	3 doses post-HSCT recipients only	1 dose									

*Covered by the Vaccine Injury Compensation Program

- Recommended for all persons who meet the age requirement, lack documentation of vaccination, or lack evidence of past infection; zoster vaccine is recommended regardless of past episode of zoster
- Recommended for persons with a risk factor (medical, occupational, lifestyle, or other indication)
- No recommendation
- Contraindicated

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly recommended for adults aged ≥19 years, as of February 2016. For all vaccines being recommended on the Adult Immunization Schedule: a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/hcp/acip-recs/index.html). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Footnotes—Recommended Immunization Schedule for Adults Aged 19 Years or Older: United States, 2016

1. Additional information
- Additional guidance for the use of the vaccines described in this supplement is available at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- Information on vaccination recommendations when vaccination status is unknown and other general immunization information can be found in the General Recommendations on Immunization at www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm.
- Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) is available at wwwnc.cdc.gov/travel/destinations/list.
- Additional information and resources regarding vaccination of pregnant women can be found at www.cdc.gov/vaccines/adults/rec-vac/pregnant.html.

2. Influenza vaccination
- Annual vaccination against influenza is recommended for all persons aged ≥6 months. A list of currently available influenza vaccines can be found at http://www.cdc.gov/flu/protect/vaccine/vaccines.htm.
- Persons aged ≥6 months, including pregnant women, can receive the inactivated influenza vaccine (IIV). An age-appropriate IIV formulation should be used.
- Intradermal IIV is an option for persons aged 18 through 64 years.
- High-dose IIV is an option for persons aged ≥65 years.
- Live attenuated influenza vaccine (LAIV [FluMist]) is an option for healthy, non-pregnant persons aged 2 through 49 years.
- Recombinant influenza vaccine (RIV [Flublok]) is approved for persons aged ≥18 years.
- RIV, which does not contain any egg protein, may be administered to persons aged ≥18 years with egg allergy of any severity; IIV may be used with additional safety measures for persons with hives-only allergy to eggs.
- Health care personnel who care for severely immunocompromised persons who require care in a protected environment should receive IIV or RIV; health care personnel who receive LAIV should avoid providing care for severely immunosuppressed persons for 7 days after vaccination.

3. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination
- Administer 1 dose of Tdap vaccine to pregnant women during each pregnancy (preferably during 27–36 weeks' gestation) regardless of interval since prior Td or Tdap vaccination.
- Persons aged ≥11 years who have not received Tdap vaccine or for whom vaccine status is unknown should receive a dose of Tdap followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter. Tdap can be administered regardless of interval since the most recent tetanus or diphtheria-toxoid-containing vaccine.
- Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series including a Tdap dose.
- For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second.
- For incompletely vaccinated (i.e., less than 3 doses) adults, administer remaining doses.
- Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (see footnote 1).

4. Varicella vaccination
- All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
- Vaccination should be emphasized for those who have close contact with persons at high risk for severe disease (e.g., health care personnel and family contacts of persons with immunocompromising conditions) or are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
- Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health care facility. The second dose should be administered 4–8 weeks after the first dose.
- Evidence of immunity to varicella in adults includes any of the following:
  - documentation of 2 doses of varicella vaccine at least 4 weeks apart;
  - U.S.-born before 1980, except health care personnel and pregnant women;
  - history of varicella based on diagnosis or verification of varicella disease by a health care provider;
  - history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health care provider; or
  - laboratory evidence of immunity or laboratory confirmation of disease.

5. Human papillomavirus (HPV) vaccination
- Three HPV vaccines are licensed for use in females (bivalent HPV vaccine [2vHPV], quadrivalent HPV vaccine [4vHPV], and 9-valent HPV vaccine [9vHPV]) and two HPV vaccines are licensed for use in males (4vHPV and 9vHPV).
- For females, 2vHPV, 4vHPV, or 9vHPV is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 26 years, if not previously vaccinated.
- For males, 4vHPV or 9vHPV is recommended in a 3-dose series for routine vaccination at age 11 or 12 years and for those aged 13 through 21 years, if not previously vaccinated. Males aged 22 through 26 years may be vaccinated.
- HPV vaccination is recommended for men who have sex with men through age 26 years who did not get any or all doses when they were younger.
- Vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years who did not get any or all doses when they were younger.
- A complete HPV vaccination series consists of 3 doses. The second dose should be administered 4–8 weeks (minimum interval of 4 weeks) after the first dose; the third dose should be administered 24 weeks after the first dose and 16 weeks after the second dose (minimum interval of 12 weeks).
- HPV vaccines are not recommended for use in pregnant women. However, pregnancy testing is not needed before vaccination. If a woman is found to be pregnant after initiating the vaccination series, no intervention is needed; the remainder of the 3-dose series should be delayed until completion or termination of pregnancy.

6. Zoster vaccination
- A single dose of zoster vaccine is recommended for adults aged ≥60 years regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the U.S. Food and Drug Administration for use among and can be administered to persons aged ≥50 years, ACIP recommends that vaccination begin at age 60 years.
- Persons aged ≥60 years with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.

7. Measles, mumps, rubella (MMR) vaccination
- Adults born before 1957 are generally considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.

Measles component:
- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
  - are students in postsecondary educational institutions,
  - work in a health care facility, or
  - plan to travel internationally.
- Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type during 1963–1967 should be revaccinated with 2 doses of MMR vaccine.

Mumps component:
- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who:
  - are students in a postsecondary educational institution,
  - work in a health care facility, or
  - plan to travel internationally.
- Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health care facility) should be considered for revaccination with 2 doses of MMR vaccine.

Rubella component:
- For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health care facility.

Health care personnel born before 1957:
- For unvaccinated health care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.

8. Pneumococcal vaccination
- General information
  - Adults are recommended to receive 1 dose of 13-valent pneumococcal conjugate vaccine (PCV13) and 1, 2, or 3 doses (depending on indication) of 23-valent pneumococcal polysaccharide vaccine (PPSV23).
  - PCV13 should be administered at least 1 year after PPSV23.
  - PPSV23 should be administered at least 1 year after PCV13, except among adults with immunocompromising conditions, anatomical or functional asplenia, cerebrospinal fluid leak, or cochlear implant, for whom the interval should be at least 8 weeks; the interval between PPSV23 doses should be at least 5 years.
  - No additional dose of PPSV23 is indicated for adults vaccinated with PPSV23 at age ≥65 years.
  - When both PCV13 and PPSV23 are indicated, PCV13 should be administered first; PCV13 and PPSV23 should not be administered during the same visit.
  - When indicated, PCV13 and PPSV23 should be administered to adults whose pneumococcal vaccination history is incomplete or unknown.
- Adults aged ≥65 years (immunocompetent) who:
  - have not received PCV13 or PPSV23: administer PCV13 followed by PPSV23 at least 1 year after PCV13.
  - have not received PCV13 but have received a dose of PPSV23 at age ≥65 years: administer PCV13 at least 1 year after PPSV23.
  - have not received PCV13 but have received 1 or more doses of PPSV23 at age <65 years: administer PCV13 at least 1 year after the most recent dose of PPSV23. Administer a dose of PPSV23 at least 1 year after PCV13 and at least 5 years after the most recent dose of PPSV23.
  - have received PCV13 but not PPSV23 at age <65 years: administer PPSV23 at least 1 year after PCV13.
  - have received PCV13 and 1 or more doses of PPSV23 at age <65 years: administer PPSV23 at least 1 year after PCV13 and at least 5 years after the most recent dose of PPSV23.
- Adults aged ≥19 years with immunocompromising conditions or anatomical or functional asplenia (defined below) who:
  - have not received PCV13 or PPSV23: administer PCV13 followed by PPSV23 at least 8 weeks after PCV13. Administer a second dose of PPSV23 at least 5 years after the first dose of PPSV23.
  - have not received PCV13 but have received 1 dose of PPSV23: administer PCV13 at least 1 year after the PPSV23. Administer a second dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the first dose of PPSV23.

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Footnotes—Recommended Immunization Schedule for Adults Aged 19 Years or Older: United States, 2016

- have not received PCV13 but have received 2 doses of PPSV23: administer PCV13 at least 1 year after the most recent dose of PPSV23.
- have received PCV13 but not PPSV23: administer PPSV23 at least 8 weeks after PCV13. Administer a second dose of PPSV23 at least 5 years after the first dose of PPSV23.
- have received PCV13 and 1 dose of PPSV23: administer a second dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the first dose of PPSV23.
- If the most recent dose of PPSV23 was administered at age <65 years, at age ≥65 years, administer a dose of PPSV23 at least 8 weeks after PCV13 and at least 5 years after the last dose of PPSV23.
- Immunocompromising conditions that are indications for pneumococcal vaccination are: congenital or acquired immunodeficiency (including B- or T-lymphocyte deficiency, complement deficiencies, and phagocytic disorders excluding chronic granulomatous disease), HIV infection, chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, multiple myeloma, solid organ transplant, and iatrogenic immunosuppression (including long-term systemic corticosteroids and radiation therapy).
- Anatomical or functional asplenia that are indications for pneumococcal vaccination are: sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, and splenectomy. Administer pneumococcal vaccines at least 2 weeks before immunosuppressive therapy or an elective splenectomy, and as soon as possible to adults who are newly diagnosed with asymptomatic or symptomatic HIV infection.

- Adults aged ≥19 years with cerebrospinal fluid leaks or cochlear implants: administer PCV13 followed by PPSV23 at least 8 weeks after PCV13; no additional dose of PPSV23 is indicated if aged <65 years. If PPSV23 was administered at age <65 years, at age ≥65 years, administer another dose of PPSV23 at least 5 years after the last dose of PPSV23.
- Adults aged 19 through 64 years with chronic heart disease (including congestive heart failure and cardiomyopathies, excluding hypertension), chronic lung disease (including chronic obstructive lung disease, emphysema, and asthma), chronic liver disease (including cirrhosis), alcoholism, or diabetes mellitus, or who smoke cigarettes: administer PPSV23. At age ≥65 years, administer PCV13 at least 1 year after PPSV23, followed by another dose of PPSV23 at least 1 year after PCV13 and at least 5 years after the last dose of PPSV23.
- Routine pneumococcal vaccination is not recommended for American Indian/Alaska Native or other adults unless they have an indication as above; however, public health authorities may consider recommending the use of pneumococcal vaccines for American Indians/Alaska Natives or other adults who live in areas with increased risk for invasive pneumococcal disease.

9. Hepatitis A vaccination

- Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
  - men who have sex with men;
  - persons who use injection or noninjection illicit drugs;
  - persons working with HAV-infected primates or with HAV in a research laboratory setting;
  - persons with chronic liver disease and persons who receive clotting factor concentrates;
  - persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (see footnote 1); and
  - unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity of hepatitis A (see footnote 1). The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
- Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30 followed by a booster dose at 12 months.

10. Hepatitis B vaccination

- Vaccinate any person seeking protection from hepatitis B virus (HBV) infection and persons with any of the following indications:
  - sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than 1 sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection drug users; and men who have sex with men;
  - health care personnel and public safety workers who are potentially exposed to blood or other infectious body fluids;
  - persons who are aged <60 years with diabetes as soon as feasible after diagnosis; persons with diabetes who are aged ≥60 years at the discretion of the treating clinician based on the likelihood of acquiring HBV infection, including the risk posed by an increased need for assisted blood glucose monitoring in long-term care facilities, the likelihood of experiencing chronic sequelae if infected with HBV, and the likelihood of immune response to vaccination;
  - persons with end-stage renal disease (including patients receiving hemodialysis), persons with HIV infection, and persons with chronic liver disease;
  - household contacts and sex partners of hepatitis B surface antigen–positive persons, clients and staff members of institutions for persons with developmental disabilities, and international travelers to regions with high or intermediate levels of endemic HBV infection (see footnote 1); and
  - all adults in the following settings: STD treatment facilities, HIV testing and treatment facilities, facilities providing drug abuse treatment and prevention services, health care settings targeting services to injection drug users or men who have sex with men, correctional facilities, end-stage renal disease programs and facilities for chronic hemodialysis patients, and institutions and nonresidential day care facilities for persons with developmental disabilities.
- Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered at least 1 month after the first dose; the third dose should be administered at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule may be used, administered on days 0, 7, and 21–30, followed by a booster dose at 12 months.
- Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 mcg/mL (Recombivax HB) administered on a 3-dose schedule at 0, 1, and 6 months or 2 doses of 20 mcg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

11. Meningococcal vaccination

- General information
  - Serogroup A, C, W, and Y meningococcal vaccine is available as a conjugate (MenACWY [Menactra, Menveo]) or a polysaccharide (MPSV4 [Menomune]) vaccine.
  - Serogroup B meningococcal (MenB) vaccine is available as a 2-dose series of MenB-4C vaccine (Bexsero) administered at least 1 month apart or a 3-dose series of MenB-FHbp (Trumenba) vaccine administered at 0, 2, and 6 months; the two MenB vaccines are not interchangeable, i.e., the same MenB vaccine product must be used for all doses.
  - MenACWY vaccine is preferred for adults with serogroup A, C, W, and Y meningococcal vaccine indications who are aged ≤55 years, and for adults aged ≥56 years: 1) who were vaccinated previously with MenACWY vaccine and are recommended for revaccination or 2) for whom multiple doses of vaccine are anticipated; MPSV4 vaccine is preferred for adults aged ≥56 years who have not received MenACWY vaccine previously and who require a single dose only (e.g., persons at risk because of an outbreak).
  - Revaccination with MenACWY vaccine every 5 years is recommended for adults previously vaccinated with MenACWY or MPSV4 vaccine who remain at increased risk for infection (e.g., adults with anatomical or functional asplenia or persistent complement component deficiencies, or microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*).
  - MenB vaccine is approved for use in persons aged 10 through 25 years; however, because there is no theoretical difference in safety for persons aged >25 years compared to those aged 10 through 25 years, MenB vaccine is recommended for routine use in persons aged ≥10 years who are at increased risk for serogroup B meningococcal disease.
  - There is no recommendation for MenB revaccination at this time.
  - MenB vaccine may be administered concomitantly with MenACWY vaccine but at a different anatomic site, if feasible.
  - HIV infection is not an indication for routine vaccination with MenACWY or MenB vaccine; if an HIV-infected person of any age is to be vaccinated, administer 2 doses of MenACWY vaccine at least 2 months apart.
- Adults with anatomical or functional asplenia or persistent complement component deficiencies: administer 2 doses of MenACWY vaccine at least 2 months apart and revaccinate every 5 years. Also administer a series of MenB vaccine.
- Microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*: administer a single dose of MenACWY vaccine; revaccinate with MenACWY vaccine every 5 years if remain at increased risk for infection. Also administer a series of MenB vaccine.
- Persons at risk because of a meningococcal disease outbreak: if the outbreak is attributable to serogroup A, C, W, or Y, administer a single dose of MenACWY vaccine; if the outbreak is attributable to serogroup B, administer a series of MenB vaccine.
- Persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic: administer a single dose of MenACWY vaccine and revaccinate with MenACWY vaccine every 5 years if the increased risk for infection remains (see footnote 1); MenB vaccine is not recommended because meningococcal disease in these countries is generally not caused by serogroup B.
- Military recruits: administer a single dose of MenACWY vaccine.
- First-year college students aged ≤21 years who live in residence halls: administer a single dose of MenACWY vaccine if they have not received a dose on or after their 16th birthday.
- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years): may be vaccinated with a series of MenB vaccine to provide short-term protection against most strains of serogroup B meningococcal disease.

12. *Haemophilus influenzae* type b (Hib) vaccination

- One dose of Hib vaccine should be administered to persons who have anatomical or functional asplenia or sickle cell disease or are undergoing elective splenectomy if they have not previously received Hib vaccine. Hib vaccination 14 or more days before splenectomy is suggested.
- Recipients of a hematopoietic stem cell transplant (HSCT) should be vaccinated with a 3-dose regimen 6–12 months after a successful transplant, regardless of vaccination history; at least 4 weeks should separate doses.
- Hib vaccine is not recommended for adults with HIV infection since their risk for Hib infection is low.

13. Immunocompromising conditions

- Inactivated vaccines (e.g., pneumococcal, meningococcal, and inactivated influenza vaccines) generally are acceptable and live vaccines generally should be avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at www.cdc.gov/vaccines/hcp/acip-recs/index.html.

TABLE. Contraindications and precautions to commonly used vaccines in adults [1*†]

Vaccine	Contraindications	Precautions
Influenza, inactivated (IIV)[2]	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of any influenza vaccine; or to a vaccine component, including egg protein	• Moderate or severe acute illness with or without fever • History of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination • Adults with egg allergy of any severity may receive RIV; adults with hives-only allergy to eggs may receive IIV with additional safety measures[2]
Influenza, recombinant (RIV)	• Severe allergic reaction (e.g., anaphylaxis) after previous dose of RIV or to a vaccine component. RIV does not contain any egg protein[2]	• Moderate or severe acute illness with or without fever • History of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination
Influenza, live attenuated (LAIV)[2,3]	• Severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine, or to a previous dose of any influenza vaccine • In addition, ACIP recommends that LAIV not be used in the following populations: — pregnant women — immunosuppressed adults — adults with egg allergy of any severity — adults who have taken influenza antiviral medications (amantadine, rimantadine, zanamivir, or oseltamivir) within the previous 48 hours; avoid use of these antiviral drugs for 14 days after vaccination	• Moderate or severe acute illness with or without fever. • History of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination • Asthma in persons aged 5 years and older • Other chronic medical conditions, e.g., other chronic lung diseases, chronic cardiovascular disease (excluding isolated hypertension), diabetes, chronic renal or hepatic disease, hematologic disease, neurologic disease, and metabolic disorders
Tetanus, diphtheria, pertussis (Tdap); tetanus, diphtheria (Td)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component • For pertussis-containing vaccines: encephalopathy (e.g., coma, decreased level of consciousness, or prolonged seizures) not attributable to another identifiable cause within 7 days of administration of a previous dose of Tdap, diphtheria and tetanus toxoids and pertussis (DTP), or diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine	• Moderate or severe acute illness with or without fever • Guillain-Barré Syndrome within 6 weeks after a previous dose of tetanus toxoid-containing vaccine • History of Arthus-type hypersensitivity reactions after a previous dose of tetanus or diphtheria toxoid-containing vaccine; defer vaccination until at least 10 years have elapsed since the last tetanus toxoid-containing vaccine • For pertussis-containing vaccines: progressive or unstable neurologic disorder, uncontrolled seizures, or progressive encephalopathy until a treatment regimen has been established and the condition has stabilized
Varicella[3]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component • Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, or long-term immunosuppressive therapy,[4] or patients with human immunodeficiency virus [HIV] infection who are severely immunocompromised) • Pregnancy	• Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)[5] • Moderate or severe acute illness with or without fever • Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination
Human papillomavirus (HPV)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever • Pregnancy
Zoster[3]	• Severe allergic reaction (e.g., anaphylaxis) to a vaccine component • Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, or long-term immunosuppressive therapy,4 or patients with HIV infection who are severely immunocompromised) • Pregnancy	• Moderate or severe acute illness with or without fever • Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) 24 hours before vaccination; avoid use of these antiviral drugs for 14 days after vaccination
Measles, mumps, rubella (MMR)[3]	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component • Known severe immunodeficiency (e.g., from hematologic and solid tumors, receipt of chemotherapy, congenital immunodeficiency, or long-term immunosuppressive therapy,[4] or patients with HIV infection who are severely immunocompromised) • Pregnancy	• Moderate or severe acute illness with or without fever • Recent (within 11 months) receipt of antibody-containing blood product (specific interval depends on product)[5] • History of thrombocytopenia or thrombocytopenic purpura • Need for tuberculin skin testing[6]
Pneumococcal conjugate (PCV13)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component, including to any vaccine containing diphtheria toxoid	• Moderate or severe acute illness with or without fever
Pneumococcal polysaccharide (PPSV23)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever
Hepatitis A	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever
Hepatitis B	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever
Meningococcal, conjugate (MenACWY); meningococcal, polysaccharide (MPSV4)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever
Meningococcal serogroup B (MenB)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever
Haemophilus influenzae Type b (Hib)	• Severe allergic reaction (e.g., anaphylaxis) after a previous dose or to a vaccine component	• Moderate or severe acute illness with or without fever

1. Vaccine package inserts and the full ACIP recommendations for these vaccines should be consulted for additional information on vaccine-related contraindications and precautions and for more information on vaccine excipients. Events or conditions listed as precautions should be reviewed carefully. Benefits of and risks for administering a specific vaccine to a person under these circumstances should be considered. If the risk from the vaccine is believed to outweigh the benefit, the vaccine should not be administered. If the benefit of vaccination is believed to outweigh the risk, the vaccine should be administered. A contraindication is a condition in a recipient that increases the chance of a serious adverse reaction. Therefore, a vaccine should not be administered when a contraindication is present.

2. For more information on use of influenza vaccines among persons with egg allergies and a complete list of conditions that CDC considers to be reasons to avoid receiving LAIV, see CDC. Prevention and control of seasonal influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP) — United States, 2015–16 Influenza Season. *MMWR* 2015;64(30):818-25.

3. LAIV, MMR, varicella, or zoster vaccines can be administered on the same day. If not administered on the same day, live vaccines should be separated by at least 28 days.

4. Immunosuppressive steroid dose is considered to be ≥2 weeks of daily receipt of 20 mg of prednisone or the equivalent. Vaccination should be deferred for at least 1 month after discontinuation of such therapy. Providers should consult ACIP recommendations for complete information on the use of specific live vaccines among persons on immune-suppressing medications or with immune suppression because of other reasons.

5. Vaccine should be deferred for the appropriate interval if replacement immune globulin products are being administered. See CDC. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2011;60(No. RR-2). Available at www.cdc.gov/vaccines/pubs/pinkbook/index.html.

6. Measles vaccination might suppress tuberculin reactivity temporarily. Measles-containing vaccine may be administered on the same day as tuberculin skin testing. If testing cannot be performed until after the day of MMR vaccination, the test should be postponed for at least 4 weeks after the vaccination. If an urgent need exists to skin test, do so with the understanding that reactivity might be reduced by the vaccine.

* Adapted from CDC. Table 6. Contraindications and precautions to commonly used vaccines. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices. MMWR 2011;60(No. RR-2):40–41 and from Hamborsky J, Kroger, A, Wolfe C, eds. Appendix A. Epidemiology and prevention of vaccine preventable diseases. 13th ed. Washington, DC: Public Health Foundation, 2015. Available at www.cdc.gov/vaccines/pubs/pinkbook/index.html.

† Regarding latex allergy, consult the package insert for any vaccine administered.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

ADULT HEDIS MEASURES

This document outlines the required medical record documentation needed to demonstrate compliance with adult HEDIS measures. This information is from "2017 Technical Specifications for Health Plans."

Measure	Description	Required Documentation	Key Notes
Adult BMI Assessment	Members ages 18-74 who had an outpatient visit and whose BMI was documented in current or previous year.	• Documentation of weight and BMI value for 20 and older • Documentation of height, weight and BMI percentile (must be from the same data source) for younger than 20	Notations or examples of documentation that are considered "negative findings" and do not count as numerator compliant include: • No BMI or BMI percentile documented in medical record or plotted on age-growth chart. • Notation of weight only
Breast Cancer Screening	Women ages 50-74 who had a screening mammogram in the current or previous year.	• A note indicating the date the test was performed, and the result or finding	This measure evaluates **primary** screening. Unable to count biopsies, breast ultrasounds, MRIs or diagnostic screenings because they are not appropriate methods for primary breast cancer screening.
Cervical Cancer Screening	Women ages 21-64 who received one or more Pap tests to screen for cervical cancer in the current year or the 2 previous years: • Women ages 21-64 who had cervical cytology performed every 3 years • Women ages 30-64 who had cervical/ human papillomavirus	• A note indicating the date the test was performed, and the result or finding	• Labs that indicate the sample was inadequate or "no cervical cells were present" cannot be counted • Biopsies cannot be counted • Documentation of "Hysterectomy" alone cannot be counted because it is not sufficient evidence the cervix was removed.
Chlamydia Screening	Women ages 16-24 who were identified as sexually active and who had at least one test for chlamydia in the current year.	• A note indicating the date the test was performed, and the result or finding	
Colorectal Cancer Screening	Members ages 50-75 who had appropriate screening for colorectal cancer.	• A note indicating the date the test was performed. A result is not required if the documentation is clearly part of the medical history section of the record. If it is not clear, the result or finding must also be present. • FOBT or FIT in current year, **or** • Flexible sigmoidoscopy in current year or the 4 years prior, **or** • Colonoscopy in current year or the 9 years prior	• Digital rectal exams do not count A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed counts. • For pathology reports that do not indicate the type of screening and for incomplete procedures: • Evidence that the scope advanced beyond the splenic flexure counts for a completed colonoscopy. • Evidence that the scope advanced into the sigmoid colon counts for a completed flexible sigmoidoscopy.

Measure	Description	Required Documentation	Key Notes
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Adults 40 and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	• A note indicating the date the spirometry test was performed, and the result or finding	
Care for Older Adults	Adults 66 and older who had each of the following in the current year: • Advance care planning • Medication review • Functional status assessment • Pain screening	1) Advance Care Planning: • The presence of an advance care plan (ACP) such as advance directive (e.g., living will, health care power of attorney, health care proxy) or actionable medical orders (e.g., POLST, Five Wishes) **or** • Documentation of an advance care planning **discussion** with the provider ***and*** the date when it was discussed. The documentation of the discussion must be in the measurement year, **or** • Notation that the member previously executed an advance care plan. 2) Medication Review: • A medication list in the medical record, ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed. • Documentation that the member is not taking any medication and the date when it was noted. 3) Functional Status Assessment: • Notation that Activities of Daily Living (ADL) were assessed • Notation that Instrumental Activities of Daily Living (IADL) were assessed • Result of assessment using a standardized functional status assessment tool • Notation that at least three of the following four components were assessed: – Cognitive status – Ambulation status – Sensory ability (hearing, vision, speech) – Other functional independence (exercise, ability to perform job) 4) Pain Screening: • Documentation that the patient was assessed for pain (which may include positive or negative findings for pain) and the date when it was performed. Include results of assessment using a standardized pain assessment tool.	Examples of ACP discussion: • The provider must note in the medical record the discussion or initiation of a discussion by the provider. Documentation that a provider asked the member if an ACP was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion. • Oral statements regarding ACPs may include conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Or, patient designation of an individual who can make decisions on their behalf. Evidence of oral statements must be noted in the medical record during the measurement year. • A review of side effects for a single medication at the time of prescription alone is not sufficient. • For ADLs, note that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, or walking. • For IADLs, may assess at least four of the following: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, or handling finances. • A functional status assessment limited to an acute or single condition, event or body system does not meet criteria for a comprehensive functional status assessment. • The components of the functional status assessment may take place during separate visits within the measurement year. • Unable to count notation of pain management plan alone or pain treatment plan alone. • Screening for chest pain alone or documentation of chest pain alone does not meet criteria.

Measure	Description	Required Documentation	Key Notes
Controlling High Blood Pressure	Adults ages 18-85 who had a diagnosis of hypertension and whose BP was adequately controlled, (ages 18-59 BP< 140/90, ages 60-85 with diabetes BP< 140/90, ages 60-85 without diabetes BP<150/90) during the current year.	• Documented confirmation that the member had an HTN diagnosis on or before June 30, in current year in the medical record (problem list, office visit, discharge summary, etc.). • There must be documentation of one of the following: Hypertension, HTN, High BP (HBP), Elevated BP (-BP), Borderline HTN, Intermittent HTN, History of HTN, Hypertensive vascular disease (HVD), Hyperpiesia, or Hyperpiesis. • Notation of the most recent BP in the medical record	• BPs taken during an acute inpatient stay, ER visit, an office visit in which a procedure is being performed (sigmoidoscopy, mole removal, etc.), surgical procedure, or major diagnostic procedure (stress test, radiology procedure, endoscopy, etc.) do not count. • Documentation of member reported BP readings do not count. • When confirming the diagnosis of HTN, the intent is to identify the date when the provider became aware of the HTN diagnosis and documented the diagnosis of HTN in the medical record (versus the time the patient acquired hypertension). • Problem lists generally indicate established conditions. If a problem list is found in an office visit note, it will be considered a dated problem list and the date of the visit will be used. • Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the only notations of HTN in the medical record.

Measure	Description	Required Documentation	Key Notes
Comprehensive Diabetes Care	Adults ages 18-75 with diabetes (type 1 and type 2) who had: • HbA1c screening • Dilated eye exam • Attention for nephropathy • Controlled BP (<140/90)	• Notation of the most recent HbA1c screening and result performed in current year • HbA1c screening may include: A1c, HbA1c, HgbA1c, Hemoglobin A1c, Glycohemoglobin A1c, Glycohemoglobin, Glycated hemoglobin, Glycosylated hemoglobin. • A retinal or dilated eye exam by an optometrist or ophthalmologist in current year, or a *negative* retinal or dilated exam (negative for retinopathy) done by an optometrist or ophthalmologist in **previous year**. Documentation must include who completed the procedure or reviewed the results, the date of when the procedure was done and the results. • A nephropathy screening test – the date when a urine microalbumin test was performed and the result, or evidence of nephropathy (visit to nephrologist, renal transplant, positive urine macroalbumin test, or prescribed ACE/ARB therapy) • Notation of the most recent BP in the medical record	• BPs taken during an acute inpatient stay, ER visit, an office visit in which a procedure is being performed (sigmoidoscopy, mole removal, etc.), surgical procedure, or major diagnostic procedure (stress test, radiology procedure, endoscopy, etc.) do not count. • Documentation of member reported BP readings do not count. • Documentation does not specifically have to state "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria. • The intent of the eye exam indicator is to ensure that members with evidence of any type of retinopathy have an eye exam annually, while those who remain free of retinopathy (i.e., the retinal exam was negative for retinopathy) are screened every other year. • Blindness is not an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam and those who are completely blind and therefore do not require an exam.
Annual Monitoring for Patients on Persistent Medications	Adults ages 18 and older who received at least 180 treatment days of an ACE or ARB, digoxin, and diuretic in current year and had at least one therapeutic monitoring event in current year.	ACE/ARB, Digoxin, and Diuretic Agents • A lab panel performed in current year and the result, or a serum potassium and serum creatinine performed in current year and the result. • For members on digoxin, at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year.	To increase compliance, consider using standing orders to get labs done.

Measure	Description	Required Documentation	Key Notes
Medication Reconciliation Post-Discharge	Adults ages 18 and older who were discharged from January 1–December 1, in the current year for whom medications were reconciled by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. (31 total days)	• Documentation must include evidence of medication reconciliation and the date when it was performed • Notation that the medications prescribed or ordered upon discharge were reconciled with the current medications (in the outpatient record), or • A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications, or • Notation that no medications were prescribed or ordered upon discharge	Only documentation in the outpatient chart counts, but an outpatient visit is not required. Documentation may include any of the following: • Current and discharge medications were reconciled by the provider. • Current medications with a note referencing the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications). • A note that both the current medication list and a discharge medication list were reviewed on the same date of service. • Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. • A discharge summary that notes the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days). • Notation that no medications were prescribed or ordered upon discharge.
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	Members 18-64 with schizophrenia or bipolar who were dispensed an antipsychotic medication and had a diabetes screening test.	• A note indicating the date of glucose test or HbA1c during the measurement year	To increase compliance, consider using standing orders to get labs done
Diabetes Monitoring for People with Diabetes and Schizophrenia	Members 18-64 with schizophrenia and diabetes who had both an LDL-C and HbA1c during the measurement year.	• A note indicating the date of LDL-C and HbA1c during the measurement year	To increase compliance, consider using standing orders to get labs done
Cardiovascular Disease Monitoring for People with Cardiovascular Disease and Schizophrenia	Members 18-64 with schizophrenia and cardiovascular disease who had an LDL-C during the measurement year.	• A note indicating the date of LDL-C during the measurement year	To increase compliance, consider using standing orders to get labs done
Statin Therapy for Patients With Cardiovascular Disease	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year with clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy and remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.	• Notation of the high or moderate-intensity statin medication and date prescribed	

Measure	Description	Required Documentation	Key Notes
Statin Therapy for Patients With Diabetes	The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy and remained on any intensity statin medication for at least 80% of the treatment period.	• Notation of any intensity statin medication and date prescribed	
First Year Measure **Follow-Up After Emergency Department (ED) Visit For Mental Illness**	Members 6 years of age and older who had an ED visit with a principal diagnosis of mental illness and who had outpatient visit, an intensive outpatient encounter or partial hospitalization with any practitioner within 30 days and 7 days after the ED visit.	Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit	If the member's appointment does not occur within the first 7 days post-ED visit, please schedule the appointment to occur within 30 days post-ED visit.
First Year Measure **Follow-Up After Emergency Department Visit For Alcohol And Other Drug Dependence**	Members 13 years of age and older who had an ED visit with a principal diagnosis of alcohol or other drug (AOD) dependence and who outpatient visit, an intensive outpatient encounter or partial hospitalization with any practitioner within 30 days and 7 days after the ED visit.	Two rates are reported: • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit. • The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.	If the member's appointment does not occur within the first 7 days post-ED visit, please schedule the appointment to occur within 30 days post-ED visit.
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)	The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who have a PHQ-9 tool administered at least once during a four-month period	Two rates are reported. • ECDS Coverage. For those members 12 and older with a diagnosis of major depression or dysthymia for whom a health plan can receive any electronic clinical quality data. • Utilization of PHQ-9. The percentage of PHQ-9 utilization. Members with a diagnosis of major depression or dysthymia whose measure data are reportable using ECDS and, had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.	• Selection of the appropriate assessment should be based on the age of the member. – PHQ-9: For 13 years of age and above. – PHQ-9 Modified for Teens: For ages 12–18. • The PHQ-9 assessment does not need to occur during a face-to-face encounter; for example, it can be completed over the telephone or through a Web-based portal
First Year Measure **Depression Remission or Response for Adolescents and Adults (DRR)**	Members 12 years and older with a diagnosis of depression and an elevated PHQ-9 score who had a response or remission within 5-7 months of the elevated score.	Four rates are reported: • ECDS Coverage: Members for whom a health plan can receive any electronic clinical quality data. • Follow-Up PHQ-9: Members who have a documented PHQ-9 score in the ECDS during the depression follow-up period. • Depression Remission: Members who achieve remission of depression symptoms as noted by a PHQ-9 depression response score of <5 recorded in the ECDS during the depression follow-up period. Must be the most recent score recorded. • Depression Response: Members who indicate a response to depression treatment as noted by a PHQ-9 depression response score at least 50% lower than the PHQ-9 score associated with the Index Episode Start Date (IESD), recorded in the ECDS during the depression follow-up period. Must be the most recent score recorded.	• Selection of the appropriate assessment should be based on the age of the member. – PHQ-9: For 13 years of age and above. – PHQ-9 Modified for Teens: For ages 12–18. • The PHQ-9 assessment does not need to occur during a face-to-face encounter; for example, it can be completed over the telephone or through a Web-based portal. • (IESD) recorded in the ECDS during the depression follow-up period. Must be the most recent score recorded.

PREGNANCY HEDIS MEASURES

This document outlines the required medical record documentation needed to demonstrate compliance with pregnancy related HEDIS measures. This information is from "2017 Technical Specifications for Health Plans."

Measure	Description	Required Documentation
Timeliness of Prenatal Care	Women who had a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment with the health plan	• Prenatal care visit to an OB/GYN, midwife, family practitioner, or PCP. For visits to a PCP or family practitioner, the diagnosis of pregnancy must be present. The medical record must include the date the visit occurred and at least one of the following: – A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height – Evidence that a prenatal care procedure was performed such as an OB lab panel, TORCH antibody panel, ABO/Rh blood typing, or ultrasound – A Pap test alone does not count as a prenatal care visit for the Timeliness of Prenatal Care rate. A colposcopy alone does not count. – Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count – Documentation of LMP or EDD in conjunction with prenatal risk assessment and counseling/education or complete obstetrical history – EDD must be on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Frequency of Ongoing Prenatal Care	Women who had a live birth that had the expected number of prenatal visits, using ACOG's recommended schedule of visits	• Must identify gestational age at birth from the hospital record or birth certificate. • Prenatal care visits to an OB/GYN, midwife, family practitioner, or PCP. For visits to a PCP or family practitioner the diagnosis of pregnancy must be present. The medical record must include the date the visit occurred and at least one of the following: – A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height – Evidence that a prenatal care procedure was performed such as an OB lab panel, TORCH antibody panel, ABO/Rh blood typing, or ultrasound – Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count – Documentation of LMP or EDD in conjunction with prenatal risk assessment and counseling/education or complete obstetrical history
Postpartum Care	Women who had a live birth and had a postpartum visit on or between 21 and 56 days after delivery	• Postpartum visit to an OB/GYN practitioner or midwife, family practitioner, or other PCP on or between 21 and 56 days after delivery. The medical record must include the date the visit occurred and at least one of the following: – Pelvic exam, **or** – Evaluation of weight, BP, breasts (notation of "breastfeeding" counts) and abdomen, or – Notation of postpartum care, including but not limited to: "postpartum care," "PP care," "PP check," "6 week check" or completion of a preprinted "postpartum care" form – A Pap test alone is acceptable for the Postpartum Care rate. A colposcopy alone does not count.

HOW TO BE A QUALITY STAR

WHAT IS THE MEDICARE STAR RATING?

The Medicare star rating system was created by the Centers for Medicare & Medicaid Services (CMS) and evaluates the relative quality of private health plans offered to Medicare beneficiaries. CMS scores Medicare health plans on a one-to-five star scale, with five stars representing the highest quality. Members can use these ratings as a way to gauge the quality of care, ease of access to care, provider responsiveness and beneficiary satisfaction of the health plan.

QUICK REMINDERS TO HELP YOU BOOST YOUR RATINGS…

Don't keep your patients waiting too long

- Has the member been in the waiting room for more than 30 minutes?

Getting to know your patients' special needs

- Accommodate those who are frail/elderly or non-English speaking

Keep in touch with patients

- Make sure each patient has an annual wellness visit and preventive screenings
- Allow extra time during appointments for questions and answers
- Reach out to patients who have not been seen

Scheduling appointments appropriately

- Urgent – less than 24 hours
- Non-urgent – within one week
- Routine/preventive – within one month

Schedule these important screenings as needed

- Colorectal cancer screening
- Diabetes care
- Breast cancer screening
- Controlling hypertension

WHY IS THE MEDICARE STAR RATING SYSTEM IMPORTANT?

Star ratings are available to:

- Help members make health plan decisions
- Increase premium dollars, rewarding strong performance for physicians affiliated with Independent Physician Associations (IPAs)
- Provide richer benefits for members
- Allow WellCare to expand

2017 MEDICARE STAR MEASURES

DOMAIN 1: Staying Healthy, Screening, Tests and Vaccines	DOMAIN 2: Managing Chronic (Long Term) Conditions	DOMAIN 3: Member Experience with Health Plan	DOMAIN 4: Member Complaints, Problems Getting Services & Improvement in the Health Plan's Performance	DOMAIN 5: Health Plan Customer Service	PART D MEASURES
Adult BMI Assessment	Care of Older Adults-Functional Status Assessment	Care Coordination	Beneficiary Access and Performance Problems	Call Center-Foreign Language Interpreter & TTY/TDD Availability	Appeals Auto Forward
Annual Flu Vaccine	Care of Older Adults-Medication Review	Customer Service	Complaints about the Health Plan	Plan Makes Timely Decision About Appeals	Appeals Upheld
Breast Cancer Screening	Care of Older Adults-Pain Screening	Getting Appointments and Care Quickly	Health Plan Quality Improvement	Reviewing Appeals Decisions	Beneficiary Access and Performance Problems
Colorectal Cancer Screening	Controlling Blood Pressure	Getting Needed Care	Members choosing to Leave the Plan		Call Center-Foreign Language Interpreter & TTY/TDD Availability
Improving or Maintaining Mental Health	Diabetes Care-Blood Sugar Controlled	Overall Rating of Health Care Quality			Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Review (CMR)
Improving or Maintaining Physical Health	Diabetes Care-Eye Exam	Overall Rating of Health Plan			Complaints about the Drug Plan
Monitoring Physical Activity	Diabetes Care-Kidney Disease Monitoring				Drug Plan Quality Improvement
	Osteoporosis Management in Women Who Had a Fracture				Getting Needed Prescription Drugs
	Plan All-Cause Readmissions				High-Risk Medication
	Reducing the Risk of Falling				Medication Adherence for Cholesterol (Statins)
	Rheumatoid Arthritis Management				Medication Adherence for Hypertension (RAS Antagonists)
	Special Needs Plan (SNP) Care Management				Medication Adherence for Diabetes Medication
					Members Choosing to Leave the Plan
					MPF (Medicare Plan Finder) Price Accuracy
					Rating of Drug Plan

PHARMACY TIP SHEET FOR MEDICARE PART D (PRESCRIPTION DRUG PLANS)

The Centers for Medicare & Medicaid Services (CMS) monitors "Part D Performance Metrics" for Prescription Drug Plans (PDPs). Here are tips for Medicare prescribers:

Drug Prices: Help Medicare members to avoid or delay entry into the Part D "donut hole" by prescribing lower-cost generic medications.

High-Risk Medication: For plan members 65 and older, limit or avoid prescriptions for certain drugs with a high risk of side effects when there may be safer drug choices.

The most commonly prescribed high-risk medications in the elderly include:

- Muscle relaxants (carisoprodol, cyclobenzaprine, and methocarbamol)
- Chronic use (> 90 days/year) of non-benzodiazepine hypnotics [Ambien® (zolpidem), Sonata® (zaleplon), and Lunesta® (eszopiclone)]
- Antihistamines (hydroxyzine and promethazine)
- Oral estrogens (Premarin®)

Adherence measures:

CMS gauges Plans' performance via multiple quality and performance measures to allow beneficiaries to make informed decisions about their healthcare. Adherence to maintenance medications is one of these measures and is reported as three separate measures:

- Adherence with diabetes medications
  - –Biguanides, Sulfonylureas, Thiazolidinediones, DPP-IV inhibitors, Incretin Mimetics, and Meglitinides
- Adherence with hypertension medications
  - –ACE Inhibitors, ARBs, Direct Renin Inhibitors
- Adherence with cholesterol Medications
  - –Statins

Ways to Improve Adherence:

- Engage your patient in a discussion about adherence and identify their barriers
- Discuss ways to improve compliance – creating a routine, use of pillboxes, etc.
- If cost is an issue – consider generics in the same class
- Help members understand why they take each medication
- Write 90-day supplies for patients who are stable at their current dose
- Consider writing for multiple refills
- Reduce pill burden if appropriate

For more pharmacy-related information including the Medicare formulary and links to request or appeal drug coverage, please visit **www.WellCare.com**. Select your state, followed by Medicare Providers, then Pharmacy.

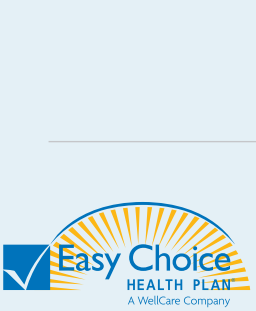
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®)

CAHPS is a survey asking members and consumers to report on and evaluate their experiences with health care. This covers topics that are important to consumers and focuses on aspects of quality that consumers are best qualified to assess. Some of these topics are the communication skills of providers as well as ease of access to health care services. Your patients will be asked to evaluate you, the PCP, on the following topics:

- How often did your doctor listen carefully to you?
- How often did your doctor show respect for what you had to say?
- How often did your doctor spend enough time with you?
- Care Coordination between PCP and Specialists
- Getting Appointments and Care Quickly
- Ease of Getting Needed Care/Seeing Specialists
- Advising Smokers to Quit
- Flu Vaccinations

All CAHPS surveys are in the public domain, which means anyone can download and use these surveys to assess experience with care. Users of CAHPS surveys include patients and consumers, quality monitors and regulators, provider organizations, health plans, community collaboratives, and public and private purchasers of health care. These individuals use the survey results to inform their decisions and to improve the quality of health care services. For more information regarding CAHPS/HOS, please refer to our Quick Reference Guide located at www.wellcare.com under Provider Resources.

CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).



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