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Instructions for the Healthcare Quality Patient Assessment Form (HQPAF)

The Healthcare Quality Patient Assessment Form (HQPAF) program promotes early detection and ongoing assessment of chronic conditions for our clients' Medicare Advantage and Medicaid Managed Care Plan members. The goal of the HQPAF program is to help ensure that these patients receive a complete and comprehensive health assessment at least once per year.

Instructions for Completing the HQPAF

1. **Schedule** a comprehensive exam for the patient listed on the HQPAF or review the document during the patient's next office visit. Complete and return the first page of the HQPAF along with supporting medical record documentation. *On some forms, patient information may extend to the second page. In these instances, you must complete and return both the first page and the second page.*

2. **Document** in the progress note, including clear provider signature & credential(s), patient name, and date of service. Results, referrals and any applicable exclusions must be documented in progress notes and returned with the HQPAF. *Note: Each form must be returned within a certain time frame. Check the HQPAF for the eligible dates of service for submission. Some HEDIS screenings may occur outside the eligible dates of service*

3. **Submit** the applicable pages of the form and progress note(s) to support all chronic conditions and co-morbid factors, documented to the highest level of specificity. Submission options:

Secure Fax Server: 1-877-889-5747 *or*

Traceable Carrier: Attn. Prospective Programs Processing - 1021 Windcross Ct., Franklin, TN 37067

Early Detection of Chronic Illnesses

The Early Detection of Chronic Illness section provides recommendations for screenings for chronic illness(es) based on previously reported risk factors and/or co-morbid conditions. Provider should consider screening for the listed conditions and confirm in progress notes. *Screenings may result in out-of-pocket expense for the patient, depending on health plan benefits.*

Preventive Medicine Screening

The Preventive Medicine Screening section is populated based on HEDIS specifications. Screenings are included if data indicates that screenings are either due or overdue for the patient. Results, referrals and exclusions must be documented in progress notes and returned with HQPAF.

Screening	Criteria for Inclusion
Breast Cancer Screening	No claims for breast cancer screening in current or prior calendar year for women ages 40 – 69 years
Colorectal Cancer Screening	No claims for fecal occult screening in last 12 months; sigmoidoscopy in last 5 years; nor colonoscopy in last 10 years
Cardiovascular Care – Cholesterol Screening	No claims for LDL – C Screening test for members discharged for AMI, CABG, or PCI from 1/1 – 11/1 of prior year, or who had diagnosis of IVD during current or prior calendar year
Glaucoma Screening	No claims for glaucoma screening in last 24 months from eye care professional (i.e., ophthalmologist, optometrist)
Adult Body Mass Index (BMI)	Adults 18 - 74 at each outpatient visit

Care for Older Adults *(This section applies to Special Needs Plans members only)*

Measure	Suggested Action	HEDIS Specification
Advanced Care Planning	Discussion with patient	Evidence of advance care planning during the measurement year. The advanced care plan or documentation of discussion with patient (including date) should be included in medical record. Provider should document in medical record if a member previously executed an advanced care plan
Medication Review	Annual review of medications	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.
Functional Status Assessment	Assess activities of daily living; Instrumental Activities Daily Living; Other Standardized Assessment	At least one functional status assessment during the measurement year. Assessments of ADL or IADL should be documented in medical record. Examples of other standardized assessment includes: SF-36, Assessment of Living Skills & Resources (ALSAR), Barthel ADL Index Physical Self-Maintenance (ADLS) Scale, Bayer Activities of Daily Living (B-ADL) Scale, Barthel Index). Notation that at least 3 of the following 4 were assessed is compliant: Cognitive status, Sensory ability (hearing, vision, speech) or other functional independence (e.g. exercise, ability to perform a job).
Comprehensive Pain Screening	Comprehensive Pain Assessment and/or Pain Management Plan	At least one pain screening or pain management plan during the measurement year. Documentation should include a quantification of pain and determination of how it impacts everyday living. If applicable, describe the pain management plan in the medical record.

Ongoing Assessment & Evaluation

The Ongoing Assessment section provides potential diagnosis information for the patient based on risk factors or comorbid conditions. Providers should assess the patient to determine if the condition currently exists and send supporting documentation in accompanying progress notes.

Managing Chronic Illness(es)

Conditions included in this section have been identified through claims data. Providers should complete the suggested actions or send in medical record documentation that confirms the screening was already completed within the HEDIS specified timeline.

Condition	Suggested Action	HEDIS Specification
Chronic Obstructive Pulmonary Disease (COPD)	Spirometry Test	Spirometry test within 2 years prior or 180 days after initial diagnosis of COPD to confirm new diagnosis of COPD.
Controlled Blood Pressure	Blood Pressure Evaluation	Members diagnosed with hypertension (HTN) to control BP to <140/90 during the measurement year.
Diabetes Mellitus	Blood Pressure Evaluation	BP tested at least annually and controlled to <(130/80) mm Hg
	Nephropathy Screening	Medical attention to nephropathy to occur annually, such as a urine microalbumin test, referral to a nephrologist and/or an ACE/ARB prescription
	LDL-C Screening	LDL-C tested at least annually and controlled to (<100mg/dl)
	Diabetic Eye Exam	Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) annually
	HbA1c Testing	HbA1C tested at least annually, controlled to (<8.0%)
Osteoporosis Management	Bone Density Test (BDT) and/or Prescription Treatment	BDT for females 65+ to check for osteoporosis. For those who experience a fracture, BDT within 6 months or a prescription to treat osteoporosis.
Rheumatoid Arthritis	Prescription Treatment	Those diagnosed with rheumatoid arthritis to receive at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) during the measurement year.

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Medical History Reported to Health Plan

This section is to be retained for your records and is populated based on data received from all providers, including specialists and pharmacies.

Screening	Criteria for Inclusion
Office Visits	A list of the providers the patient has seen at least twice over the course of the previous 24 months is included (outpatient office visits only & some specialties excluded).
ER Visits	List of dates the patient visited an emergency room during the previous 24 months; visit did not result in an admission.
Hospitalizations	A history of hospitalizations the patient has had over the course of the previous 36 months.
Three-Year Condition List	Provides a list of chronic and non-chronic conditions that have been submitted based on claims for the patient within the previous three years. A legend is provided that shows whether diagnosis came from inpatient, provider office or a combination of provider types.
High-Risk Medications	A list of medications according to HEDIS that are considered to have a high risk of serious side effects for patients 65 and older. Please consider whether a safer drug choice is available. Note that the medication list is limited to prescriptions filled using health plan coverage; self-pay prescription data not available.
ACEI or ARB, Statins and Oral Diabetes Medications - Monitored for Patient Adherence	Medications monitored for adherence will be flagged with "GAP " when two or more fill dates present and total "Days Supply" is less than 80% of the total days on the medication type. Consider engaging patient to discuss barriers to taking medication as directed.
Other Prescriptions	Any other prescription medications not in the aforementioned sections.

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Optum does not warrant that this easy reference guide, supplied for informational purposes, is complete, accurate or free from defects; the ICD-9-CM code book is the authoritative reference. Records should reflect a practitioner's clinical "thought process," coding and documenting the status and treatment of all conditions affecting the patient to the most specific level. In 2013, CMS announced an "updated, clinically revised CMS-HCC risk adjustment model" that differs from the proposed model. See: www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2014.pdf, www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf and www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html.