OPTUM™

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 annual assessment.

Instructions for Completing the HQPAF

1. **Schedule** an annual assessment 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. It is important that you utilize your patient's HQPAF during the point of care. 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. *Note: Certain types of procedures, including screenings and labs, may result in out-of-pocket expenses for the patient, depending on health plan benefits.*

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:
Optum - Attn. Prospective Programs Processing - 7105 Moores Lane - Brentwood, TN 37027

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.

Preventive Medicine Screening

The Preventive Medicine Screening section is populated based on HEDIS (Healthcare Effectiveness Data and Information Set)* 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	Screening is recommended for female patients age 50 – 74 who have not had a mammogram in the 27 months prior to 12/31 of the current year.
Colorectal Cancer Screening	Screening is recommended for patients age 50-75, who have not had any of the following: • FOBT in the current calendar year • Flexible Sigmoidoscopy in the current or 4 previous calendar years • Colonoscopy in the last 10 calendar years
Cardiovascular Care – Cholesterol Screening	Screening is recommended for patients discharged alive for AMI, CABG, or PCI from 01/01 - 11/01 of prior year or who had diagnosis of IVD during current or prior calendar year. LDL-C control is < 100 mg/dL
Glaucoma Screening	Screening is recommended for patients over 67, who have not had a glaucoma screening by an optometrist or an ophthalmologist in the current or previous calendar year
Adult Body Mass Index (BMI)	Screening is recommended for all patients age 18-74. *Documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year.*

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

Measure	Suggested Action	HEDIS Specification
Advanced Care Planning	Discussion with patient	Recommended during the calendar year for adults 66 years and older. 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	Recommended that adults 66 years and older have an annual review all medications (prescriptions, OTC, herbal/supplemental therapies)
Functional Status Assessment	Assess activities of daily living (ADL); instrumental activities daily living (IADL); other standardized assessment	Recommended that adults 66 years and older have 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	Recommended that adults 66 years and older have 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	Patients 40 years and older with a new diagnosis of COPD or newly active COPD should receive appropriate spirometry testing to confirm the diagnosis (within 180 days of first COPD diagnosis)
Controlled Blood Pressure	Blood Pressure Evaluation	Patients with diagnosis of high blood pressure who receive treatment and are able to maintain a healthy pressure (<140/90) during the calendar 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. Screening is recommended for patients with diabetes, age 18-75, who have not had a diabetic nephropathy screening in the current calendar year. *Patients seeing a nephrologist, or currently diagnosed with nephropathy are excluded.*

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Managing Chronic Illness(es) *(continued)*

Condition	Suggested Action	HEDIS Specification
Diabetes Mellitus	LDL-C Screening	Test is recommended for patients with diabetes, age 18-75, who have not had an LDL cholesterol screening in the current calendar year. LDL-C control is < 100 mg/dL
	Diabetic Eye Exam	Exam is recommended for patients with diabetes, age 18-75, who have not had a glaucoma screening by an optometrist or an ophthalmologist in the current calendar year
	HbA1c Testing	Test is recommended for patients with diabetes, age 18-75, who, in the current calendar year: • have an HbA1c result over 8% or • have not had an HbA1c test *Stars measure defines HbA1c levels >9.0% as poorly controlled.*
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

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)
Date of Last Annual Exam ____/____/____	Allows immediate identification of patients who are overdue for an annual exam by providing the date of the patient's last annual exam as well as the name of the treating provider. *Note: Annual Exam identified using Optum's definition.*
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.
Diabetes Treatment	Alerts providers if patients who are both diabetic and hypertensive are missing an Rx for either condition
Other Prescriptions	Any other prescription medications not in the aforementioned sections

*All HCCs listed reflect CMS HCC Model V22.

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