Medica

Gaps in Care Report Resource & Talking Points
MSHO, MSC+, SNBC, I-SNBC

The Gaps in Care Report is a tool for Care Coordinators to use to facilitate conversations with members about access to needed care and barriers that may be interfering with them achieving optimal health. It identifies members who, based on claims data, have a gap in care such as an overdue screening or missed medication fills.

Timing: The Gaps in Care Report described below is provided to Agency and County delegates on a quarterly basis around the 15th of the month following the end of the quarter. The report is shared via SharePoint. Note: Care System delegates receive a separate gaps in care report that is reviewed at partnership meetings.

Applicability/Products: This Gaps in Care Report includes members in all products: MSHO, MSC+, SNBC, and I-SNBC. However, certain measures apply only to the SNBC/I-SNBC population. They are indicated with an asterisk (*) in the table below.

Process upon Receipt of Report: (1) Delegate representative matches the names on the Gaps in Care Report to the assigned Care Coordinator and distributes for review; (2) Care Coordinators review the report and make note of members with a gap. Care Coordinators should use their knowledge of the member and their clinical judgment to determine appropriate follow-up with identified members. It is best practice to address gaps in care at a minimum at the six-month follow-up and annual assessment.

Additional Resources: In addition to the talking points in the table below, you can find additional resources on preventive care and chronic condition management on the Care Coordination Hub in the Templates, tools, and additional resources section of the Care coordination resources page for each product (e.g., >Care Coordination Hub>Care Coordination resources/Medica DUAL Solution®>Templates, tools, and additional resources>Gaps in Care). Additional resources on depression in Seniors are located on the MSHO and MSC+ Care coordination resources pages under Tools and Forms (>Templates, tools, and additional resources >Tools and Forms >Health Improvement Programs). Topics with additional resources on the Care Coordination Hub are identified in the table below.

Measure Abbreviation	Measure Name	Description of Gap	Recommended Care Coordinator Interventions/Talking Points	Additional Resources on Care Coordination Hub
BCS	Breast Cancer Screening	Women aged 52-74 years who have not had a screening mammogram in accordance with national preventive care guidelines	• Educate member on the importance of preventive cancer screenings. • Help address any barriers member is facing related to completing breast cancer screening. • Assist member with scheduling a screening mammogram. • **Note:** Preventive care guidelines recommend starting routine breast cancer screening at age 50; however, the Gaps in Care Report focuses on women age 52+.	Paper Clip Document - Breast Cancer Screening
CCS*	Cervical Cancer Screening	Women aged 21-64 years who have not have not completed cervical cancer screening in accordance with national preventive care guidelines (recommended timeframes differ depending on the type of screening).	• Educate member on the importance of preventive cancer screenings. • Help address any barriers member is facing related to completing cervical cancer screening. • Assist member with scheduling cervical cancer screening.	
COL	Colorectal Cancer Screening	Members aged 50-75 years who have not completed colorectal cancer screening in accordance with national preventive care guidelines (recommended timeframes differ depending on the type of screening).	• Educate member on the importance of preventive cancer screenings. • Help address any barriers member is facing related to completing colorectal cancer screening. • Assist member with scheduling a colorectal cancer screening. • **Note:** Preventive care guidelines now recommend starting routine colorectal cancer screening at age 45; however, the Gaps in Care Report focuses on members age 50+.	Paper Clip Document - Colorectal Cancer Screening
CHL*	Chlamydia Screening in Women	Women aged 16-24 years who have not had chlamydia screening in accordance with national preventive care guidelines (in the last 12 reported months)	• Educate member on the importance of preventive screening Help address any barriers member is facing related to completing chlamydia screening. • Assist member with scheduling chlamydia screening.	
CDC - HbA1C Testing	Comprehensive Diabetes Care – HbA1c Testing	Members aged 18-75 years with a diagnosis of diabetes mellitus who have not had an HbA1c test in the last 12 reported months	• Educate member on the importance of preventive diabetic screenings, including an annual HbA1C test, for managing diabetes. • Help address any barriers member is facing related to completing HbA1c screening. • Assist member with scheduling a preventive diabetic screening visit, to include HbA1c screening.	Paper Clip Document - Diabetes

*Applicable only to SNBC & I-SNBC members

Measure Abbreviation	Measure Name	Description of Gap	Recommended Care Coordinator Interventions/Talking Points	Additional Resources on Care Coordination Hub
EED	Eye Exam for Patients with Diabetes (formally called CDC - Retinal Eye Exam)	Members aged 18-75 years with a diagnosis of diabetes mellitus who have not had an annual screening test for diabetic retinopathy	• Educate member on the importance of preventive diabetic screenings, including regular retinal or dilated eye exams to screen for eye damage that can result from diabetes. Help member identify an in-network eye provider (optometrist or ophthalmologist) or connect them to Member Services to do so. • Help address any barriers member is facing related to completing a retinal or dilated eye exam. • Assist member with scheduling a retinal or dilated eye exam.	Paper Clip Document - Diabetes
KED	Kidney Health Evaluation for Patients with Diabetes	Members aged 18-85 years with a diagnosis of diabetes mellitus who have not received an annual kidney health evaluation (an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR))	• Educate member on the importance of preventive diabetic screenings, including an annual evaluation of their kidney health to look for potential kidney damage that can result from diabetes. • Help address any barriers member is facing related to completing an annual kidney health evaluation. • Assist member with scheduling a preventive diabetic screening visit, to include a kidney health evaluation.	Paper Clip Document - Diabetes
SUPD	Statin Use in Persons with Diabetes	Members aged 40-75 years who were dispensed at least two diabetes medication fills during the year but have not received a statin medication fill.	• Educate the member that to lower the risk of heart disease, most people with diabetes should take cholesterol medication. • Recommend the member talk with their PCP about whether a statin is appropriate for them.	
SPC - Received	Statin Therapy for Patients with Cardiovascular Disease - Received	Males aged 21-75 years and females aged 40-75 who have clinical atherosclerotic cardiovascular disease (heart disease) but have not been dispensed at least one high-intensity or moderate-intensity statin medication during the year.	• Educate the member that statins are cholesterol-lowering drugs that can be effective in treating high cholesterol. • Recommend the member talk with their PCP about whether a statin is appropriate for them.	

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SPC - Adherence	Statin Therapy for Patients with Cardiovascular Disease - Adherence	Males aged 21-75 years and females aged 40-75 years who have clinical atherosclerotic cardiovascular disease (heart disease), were dispensed a high-intensity or moderate-intensity statin medication but have not remained on a statin medication for 80% or more of the treatment period (i.e., adherence is below the recommended threshold of proportion of days covered >=80%).	• Educate the member that cholesterol medication is important in lowering the risk of heart disease. • Help address any barriers member is facing related to taking needed medication. • Refer to MTM, if appropriate. • Alert PCP to any issues member is having with the medication.	Paper Clip Document - Hyperlipidemia Statins Adherence
AMR*	Asthma Medication Ratio	Members aged 5-64 years identified as having persistent asthma whose ratio of controller medications to total asthma medications is less than 0.50 during the measurement year.	• Assess member's understanding of their asthma action plan. Educate member on the importance of compliance with controller medications. • Alert PCP to any issues member is having with their asthma controller medication.	
AMM - Continuation	Antidepressant Medication Management	Members aged 18 years and older with a diagnosis of major depression who are being treated with antidepressant medication but have not remained on an antidepressant for at least 180 days (6 months).	• Educate the member that it can take an antidepressant 6-8 weeks or more to work, so it is important to continue to take the medication even if they don't experience a change in symptoms right away. • It is also important not to stop taking the medication without talking to their doctor first. • Members should talk to their doctor if they think side effects are too troublesome or the medicine doesn't seem to be working. Their doctor may try a different dose or a different drug. • Help address any barriers member is facing related to taking needed medication. • Refer to MTM, if appropriate. • Alert PCP to any issues member is having with the medication.	• Paper Clip Document - Depression • Depression Management Talking Points for Care Coordinators (focused on Seniors) • Depression Management Tip Sheet for Members (focused on Seniors)

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Measure Abbreviation	Measure Name	Description of Gap	Recommended Care Coordinator Interventions/Talking Points	Additional Resources on Care Coordination Hub
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Members aged 18 years and older with a diagnosis of schizophrenia or schizoaffective disorder who were dispensed an antipsychotic medication but have not remained on it for at least 80% of their treatment period (i.e., adherence is below the recommended threshold of proportion of days covered >=80%).	• Educate the member on the importance of taking their antipsychotic medication as prescribed to help manage their schizophrenia or schizoaffective disorder. • Help address any barriers member is facing related to taking needed medication. • Refer to MTM, if appropriate. • Alert PCP and/or member's mental health provider to any issues member is having with the medication.	
SSD*	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	Members aged 18-64 years with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and have not had a diabetes screening test during the measurement year.	• Educate member on the importance of annual diabetic screening for individuals taking antipsychotic medications because these medications can increase the risk of developing diabetes. • Help address any barriers member is facing related to getting a diabetic screening. • Assist member in scheduling diabetic screening.	
HDO	Use of Opioids at High Dosage	Members aged 18 years and older with an average morphine milligram equivalent (MME) >= 90 mg/day during the treatment period.	• Reach out to member's PCP to alert them of high-risk medication. • Encourage member to bring all medications to PCP appointments. • Facilitate MTM visit.	

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