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Gaps in Care Resources

Report Tab	Condition	Description of Gap in Care	CC Interventions and Talking Points
F.	Use of High-Risk Medications in Older Adults (DAE)	Patients 66 years of age and older who received two or more of the same high-risk medication in the last 12 reported months.	Reach out to member's primary care provider (PCP) to alert them of high-risk medication Encourage member to bring all medications to PCP appointments Facilitate medication therapy management (MTM) visit
G.	Use of Opioids at High Dosage (HDO)	Patient(s) 18 years of age or older with an average morphine milligram equivalent (MME) >= 90mg/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
H.	Use of Opioids from Multiple Providers (UOP)	Patient(s) 18 years of age or older that filled opioid prescriptions from four or more different prescribers.	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
I.	Follow-Up After Hospitalization for Mental Illness (FUH)	Patient(s) hospitalized for mental illness or intentional self-harm that had a follow-up encounter with a mental health practitioner within 30 days after discharge.	Educate member on the importance of hospital follow-up visit Assist member in scheduling follow-up appointment, and/or finding a mental health provider
J.	Cervical Cancer Screening (CCS)	Women that had appropriate screening for cervical cancer (Medicaid enrollment).	Educate member on the importance of preventive screening Assist member with scheduling preventive screening
K.	Breast Cancer Screening (BCS)	Patient(s) 52 - 74 years of age that had a screening mammogram in last 27 reported months.	Educate member on the importance of preventive screening Assist member with scheduling preventive screening

L.	Comprehensive Diabetes Care (CDC)	Patient(s) 18 - 75 years of age that had a HbA1c test in last 12 reported months.	Educate member on the importance of HbA1c testing Assist member with scheduling preventive screening Investigate any barriers to the member completing needed HbA1c testing
M.	Comprehensive Diabetes Care (CDC)	Patient(s) 18 - 75 years of age with evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	Referral to Diabetes educator Discuss member's goals as they relate to Diabetes Care Outreach to member's PCP to discuss concerns
N.	Comprehensive Diabetes Care (CDC)	Patient(s) 18 - 75 years of age that had an annual screening test for diabetic retinopathy.	Educate member on the importance of preventive screening Provide member with member services phone number for assistance in locating in network provider Assist member with scheduling preventive screening
O.	Medication Management for People With Asthma (MMA)	Patient(s) between 5 and 64 years of age compliant with prescribed asthma controller medication (minimum compliance 50%).	Assess member's understanding of asthma action plan Educate on the importance of medication compliance with asthma Alert PCP to any findings regarding barriers to use of asthma controller medication
P.	Antidepressant Medication Management (AMM)	Patient(s) with major depression who start an antidepressant medication that remained on treatment for at least 6 months (effective continuation phase treatment).	Educate on the importance of medication compliance with antidepressant use
Q.	Osteoporosis Management in Women Who Had a Fracture (OMW)	Women 67 - 85 years of age who were treated or tested for osteoporosis within six months of a fracture.	
R.	Chlamydia Screening in Women (CHL)	Patient(s) 16 - 24 years of age that had a chlamydia screening test in last 12 reported months.	Educate member on the importance of preventive screening

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			Assist member with scheduling preventive screening
S.	Colorectal Cancer Screening (COL)	Patient(s) 50 - 75 years of age that had appropriate screening for colorectal cancer.	Educate member on the importance of preventive screening Assist member with scheduling preventive screening
T.	Adolescent Well-Care Visits (AWC)	Patient(s) 12 - 21 years of age that had one comprehensive well-care visit with a PCP or an OB/GYN in the last 12 reported months.	Educate member on the importance of preventive screening Assist member with scheduling preventive screening
U.	Annual Dental Visit (ADV)	Patient(s) 2 - 20 years of age that had a dental visit during the report period.	Educate member on the importance of preventive dental screenings Provide member services phone number to help with identifying in network provider Assist member with scheduling preventive dental screening
V.	Comprehensive Diabetes Care (CDC)	Patient(s) 18 - 75 years of age that had annual screening for nephropathy or evidence of nephropathy.	Educate member on the importance of preventive Diabetic Screenings Assist member with scheduling preventive Diabetic Screening visit
W.	Medication Management for People With Asthma (MMA)	Patient(s) between the ages of 5 and 64 years compliant with prescribed asthma controller medication (minimum compliance 75%).	Assess member's understanding of asthma action plan Educate on the importance of medication compliance with asthma Alert PCP to any findings regarding barriers to use of asthma controller medication
X.	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Patient(s) with schizophrenia or schizoaffective disorder who were dispensed and remained on antipsychotic medication for at least 80% of their treatment period.	Educate on the importance of compliance with antipsychotic medication

			Alert member mental health provider and/or PCP to any discrepancies in medication compliance Identify any barriers to member taking needed medication.
Y.	Statin Therapy for Patients with Cardiovascular Disease (SPC)	Patient(s) with statin adherence (proportion of days covered) at least 80% during the treatment period.	Educate on the importance of medication compliance Alert PCP to any discrepancies in medication compliance Identify any barriers to member taking needed medication.
Z.	Statin Therapy for Patients with Diabetes (SPD)	Patient(s) with statin adherence (proportion of days covered) at least 80% during the treatment period.	Educate on the importance of medication compliance Alert PCP to any discrepancies in medication compliance Identify any barriers to member taking needed medication.
AA.	Prenatal and Postpartum Care (PPC)	Women that received a prenatal visit in the first trimester or within 42 days of enrollment (including bundled prenatal services).	Educate member on the importance of prenatal care Refer member to Healthy Pregnancy Program
AB.	Comprehensive Diabetes Care (CDC)	Patient(s) 18 - 75 years of age with lab results that have evidence of poor diabetic control, defined as the most recent HbA1c result value greater than 9.0%.	Educate member on the importance of optimal Diabetic Care Engage member in a conversation about what optimal diabetic control looks like for them
AC.	Use of Opioids from Multiple Providers (UOP)	Patient(s) 18 years of age or older that filled opioid prescriptions at four or more different pharmacies.	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

AD.	Comprehensive Diabetes Care (CDC)	Patient(s) with diabetes who had a blood pressure less than 140/90 mm Hg documented in the last 12 months.	Educate member on the importance of blood pressure control for those with diabetes Assist with ordering a home blood pressure monitor and log to track blood pressures
AE.	Prenatal and Postpartum Care (PPC)	Women that received a prenatal visit in the first trimester or within 42 days of enrollment (excluding bundled prenatal services).	Educate member on the importance of prenatal care Refer member to Healthy Pregnancy Program
AF.	Prenatal and Postpartum Care (PPC)	Women that received postpartum care (including bundled postpartum services).	Educate member on the importance of postpartum care Assist member in scheduling postpartum appointments
AG.	Prenatal and Postpartum Care (PPC)	Women that received postpartum care (excluding bundled postpartum services).	Educate member on the importance of postpartum care Assist member in scheduling postpartum appointments
AH.	Prenatal and Postpartum Care (PPC)	Women with second deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment (including bundled prenatal services).	Educate member on the importance of prenatal care Refer member to Healthy Pregnancy Program
AI.	Prenatal and Postpartum Care (PPC)	Women with second deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment (excluding bundled prenatal services).	Educate member on the importance of prenatal care Refer member to Healthy Pregnancy Program
AJ.	Prenatal and Postpartum Care (PPC)	Women with second deliveries that received postpartum care (including bundled postpartum services).	Educate member on the importance of postpartum care Assist member in scheduling postpartum appointments
AK.	Prenatal and Postpartum Care (PPC)	Women with second deliveries that received postpartum care (excluding bundled postpartum services).	Educate member on the importance of postpartum care

			Assist member in scheduling postpartum appointments
AL.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Patient(s) with schizophrenia, schizoaffective disorder or bipolar disorder taking an antipsychotic medication who were screened for diabetes during the report period.	Educate member on the correlation between antipsychotic medication use and incidence of Diabetes Assist member in scheduling needed Diabetic screening.
AM.	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Patient(s) 20 years of age and older that had a preventive or ambulatory care visit during the last 12 months of the report period.	Educate member on the importance of preventive care visits. Assist member in finding PCP Assist member in scheduling preventive care visit
AN.	Controlling High Blood Pressure (CBP) - Part 2	Patient(s) 18 - 85 years of age with hypertension with most recent documented blood pressure less than 140/90 mm Hg.	Educate member on the importance of regular blood pressure monitoring Assist member in scheduling annual preventive care visit

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