HealthPlan OF SAN MATEO
Healthy is for everyone

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080
tel 650.616.0050
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1
www.hpsm.org

HEDIS® 2021 Measure Details

Controlling High Blood Pressure (CBP)

Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Medical record documentation must include the most recent BP reading (date and result) in the measurement year AFTER the diagnosis of HTN is made.

- 18-85 years: BP control is <140/90 mm Hg

Cervical Cancer Screening (CCS)

Female members 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- 21–64 years of age who had cervical cytology performed within the last 3 years.
- 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Medical record documentation must include the date and result of the cervical cancer screening tests. Members may be excluded with proper documentation of a hysterectomy (with removal of cervix) any time in member's history through 12/31 of the measurement year.

NOTE: Co-testing requires two separate tests. Reflex testing is excluded.

Comprehensive Diabetes Care (CDC)

Members 18-75 with diabetes (Type I and Type 2) who had each of the following:

- Hemoglobin A1c testing
- Eye exam (retinal)
- Medical attention for nephropathy
- BP control <140/90 mm Hg.

Medical record documentation must include:

- Most recent A1c lab test with date and result
- All eye care specialist reports from the measurement year or year prior
- Evidence of attention for nephropathy.
- Most recent blood pressure readings

Colorectal Cancer Screening (COL)

Members 50-75 years of age who had appropriate screening for colorectal cancer.

Medical record documentation must include evidence of one of the following:

- Colonoscopy (within last 10 years)
- FOBT (gFOBT or iFOBT in the measurement year)
- Flexible Sigmoidoscopy (within last 5 years)
- CT colonography during the measurement year or the four years prior to the measurement year
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

Childhood Immunization Status (CIS)

Percentage of children who had all of the required immunizations on or before their 2nd birthday.

Medical record documentation must include:

- One (1) MMR (Measles, Mumps, Rubella)
- One (1) VZV (Varicella)
- One (1) HEP A (Hepatitis A)
- Two (2) Influenza (Influenza; Flu)
- Two or Three (2 or 3) Rotovirus (2-dose Rotarix or 3-dose RotaTeq vaccines)
- Three (3) HEP B (Hepatitis B)
- Three (3) IPV (Polio)
- Three (3) HiB (Haemophilus B)
- Four (4) DTaP (Diptheria, Tetanus, Acellular Pertussis)
- Four (4) PCV (Pneumococcal).

Immunizations for Adolescents (IMA)

Adolescents 13 years of age who received meningococcal, Tdap, and 2 HPV vaccines on or before their 13th birthday.

Medical record documentation must include:

- A note or certificate of immunization indicating the name of the specific antigen and the date of the immunization.
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

Prenatal and Postpartum Care (PPC)

This composite measure aims to provide relevant and comparable data regarding timeliness of prenatal care and postpartum care.

Medical record documentation must include:

- Prenatal Care: Prenatal visit within 42 days of enrollment or during the first trimester.
- Postpartum Care: Post-partum visit within 7-84 days of delivery.

Transition of Care (TRC)

Members 18 years and older with discharges (acute and non-acute inpatient) from January 1-December 1 of the measurement year, who had the following:

- Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Medical record documentation must include:

- Evidence of medication reconciliation AND the date when it was performed.
- Evidence of receipt of notification of inpatient admission that includes evidence of the date when the documentation was received.
- Evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record or be located in structured fields in an EHR.
- Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided within 30 days after discharge. Do not include patient engagement that occurs on the date of discharge.

Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents (WCC)

Members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN with all required components.

Medical record documentation must include:

- Date of service, height, weight, and BMI percentile.
- Counseling for Nutrition
- Counseling for Physical Activity.

Care for Older Adults (COA)

Member 66 years of age and older who had each of the following:

- Advance Care Planning
- Medication Review
- Functional Assessment
- Pain Screening

Medical record documentation must include:

- Evidence of advance care planning during the measurement year
- Both of the following on the same date of service:
  - At least one medication review conducted by a prescribing practitioner or clinical pharmacist.
  - The presence of a medication list in the medical record.
- At least one functional status assessment during the measurement year.
- At least one pain assessment during the measurement year.