Senior Whole Health
BY MOLINA HEALTHCARE

QUALITY INSIDER NEWSLETTER

2025

Christopher A. Post, MD
Chief Medical Officer

Opening remarks

The annual Quality Insider newsletter provides information and resources to support providers in efforts to improve the quality of care for our members. Senior Whole Health, LLC (SWH) appreciates the strong partnership with our provider network that contributes to successful quality improvement efforts.

HEDIS® updates

Performance on Healthcare Effectiveness Data and Information Set (HEDIS®) measures contributes significantly to the annual star ratings from the Centers for Medicare and Medicaid Services (CMS) and demonstrates the quality of the health care received, and the quality of the health plan. HEDIS® results also help to identify priority areas of focus for interventions focused on quality improvement. HEDIS® data collection occurs throughout the year and results in annual HEDIS® ratings for multiple measures.

Provider involvement in quality improvement efforts is vital for closing care gaps and improving health outcomes. Key reasons for partnering with SWH include:

- **Better patient outcomes** – patients receiving timely and effective care leads to improved health.
- **Higher patient satisfaction** – meeting care standards builds patient trust and engagement.
- **Regulatory compliance** – helps meet standards set by healthcare regulators and accrediting bodies.
- **Cost savings** – preventing issues reduces expensive complications and hospital visits.
- **Value-based payments** – closing care gaps means better performance, potentially leading to increased reimbursement for SWH and providers.
- **Improved performance metrics** – boosts provider ratings and reputations.
- **Population health management** – improves care for entire patient groups and communities.
- **Professional growth** – encourages up-to-date practices and teamwork among providers.

We will be working closely with providers throughout 2025 to close care gaps. HEDIS® data and gap lists for SWH members with gaps in care will be shared and meetings scheduled with our Provider Engagement team to discuss progress. Based on performance in 2024, the priority HEDIS® measures in 2025 include:

Colorectal cancer screening (COL):

SWH offers members options for getting recommended screenings for colorectal cancer. In an effort to close gaps in care, Molina Healthcare partners with Exact Sciences and Let's Get Checked in order to assist SWH members due for cancer screenings. By offering screenings through home lab kits, we hope to reach members who may avoid visits to the doctor or who may be unable to leave their homes. SWH nurse care managers provide support to complete the home tests and get them back to the lab. SWH also partners with Care Connections to provide Cologuard kits to members due for colorectal cancer screening. SWH providers receive notification and lab results once a test has been successfully completed and resulted. Please be on the lookout for lab results from these important screenings.

Controlled blood pressure (CBP):

SWH works with providers and clinical staff to control blood pressure for our members with hypertension. SWH provides education and support to members with high blood pressure through various activities, including:

- SWH disease management program for eligible members with hypertension
- CBP focus workgroups in the community with blood pressure screenings and education by SWH nurse care managers and other partners
- Infographic educational flyers in multiple languages on several topics related to high blood pressure

According to the National Center for Health Statistics (NCHS), between August 2021 through August 2023, the prevalence of hypertension in adults was 47.7%. Prevalence among adults aged 60 and older was 71.6%. During that time, only 20.7% of adults with hypertension had blood pressure controlled to less than 130/80 mm Hg, and 51.2% of adults with hypertension were taking medication to lower blood pressure. [1]

Please review the following helpful tips to support your patients with hypertension:

- Prescribe automated home blood pressure cuffs and provide education on home use
- Check in with high-risk patients for home readings on a planned schedule
- Remind patients to take their blood pressure medications before scheduled appointments and reinforce the importance of adherence
- Recheck blood pressure at the end of a visit if initial blood pressure is high
- Ensure sphygmomanometers are calibrated at least annually
- Provide nutrition education and resources for patients
- Utilize current clinical practice guideline recommendations to guide treatment
- Promote smoking cessation programs to patients who smoke
- Encourage patients to use their Silver & Fit exercise benefit
- Refer eligible members to the SWH disease management program

[1] Fryar CD, Kit B, Carroll MD, Afful J. Hypertension prevalence, awareness, treatment, and control among adults age 18 and older: United States, August 2021–August 2023. NCHS Data Brief, no 511. Hyattsville, MD: National Center for Health Statistics. 2024.
DOI: **dx.doi.org/10.15620/cdc/164016**.

Plan all-cause readmissions (PCR):

SWH is focused on reducing hospital readmission rates. According to data from the National Readmission Database (NRD), approximately 20% of patients discharged from the hospital end up readmitted within 30 days (Wang and Zhu 2022) [2]. Access to follow-up care post-discharge is a key component to reducing readmission during transitions of care. Tips to avoid unplanned readmissions include:

- Strong communication with inpatient medical team during your patient's hospitalization
- Scheduling follow-up appointments within 7 days of discharge per SWH model of care
- Outreach patient to check in once notification of discharge has been received
- Include SWH nurse care managers in discussions for high-risk patients
- Refer patients to home care services for a home safety evaluation and medication review if indicated
- Communicate with the pharmacy if needed for safe post-discharge medication reconciliation

Please review the **Guide for Reducing Disparities in Readmissions** from the CMS Office of Minority Health using this link: **CMS.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf**. The guide provides information on the importance of advancing equity through primary care provider involvement during hospitalizations and transitions of care.

Breast cancer screening (BCS):

The U.S. Preventive Services Task Force (USPSTF) recommends mammography for breast cancer screening every two years in women aged 40 to 74. Clinical judgement should be used for breast cancer screening in women aged 75 and above (USPSTF 2024) [3]. Please encourage your patients due for screening to schedule a mammogram. For help scheduling an appointment and transportation if needed, please ask members to call SWH Member Services.

Medication reconciliation (TRC-MRP):

Medication reconciliation during transitions of care is one of the 2024 Ambulatory Health Care National Patient Safety Goals from the Joint Commission. Improving rates of medication reconciliation post-discharge is a high priority HEDIS® measure. Reconciling medications during transitions of care is a complex process involving numerous stakeholders. Providers and pharmacists are key to ensuring that patients engage in safe medication practices upon discharge from an inpatient setting.

The Medications at Transitions and Clinical Handoffs (MATCH) Toolkit was created by the Agency for Healthcare Research and Quality (AHRQ) to assist providers and patients. You can find information in this valuable resource promoting medication safety by using this link: **Ahrq.gov/patient-safety/settings/hospital/match/index.html**.

Glycemic status assessment in patients with diabetes (GSD):

Controlling Hemoglobin A1c (HbA1c) in patients with diabetes is a high priority HEDIS® measure for SWH members. The HEDIS® measure name was updated in 2024 to Glycemic Status Assessment in Patients with Diabetes (GSD). Diabetes is one of the top diagnoses among SWH members. We would like to partner with providers to focus on providing education and monitoring for controlling HbA1c among SWH members with diabetes. Tips to improve HEDIS® scores and results for patients with diabetes include:

- Conduct HbA1c testing at least 2X/year, and bill for point of care (POC) testing
- Assess patient understanding of condition and treatments
- Reinforce importance of medication adherence
- Monitor diabetes therapy and adjust as needed throughout the year to improve results
- Prescribe statin therapy to diabetics aged 40 to 75 years
- Refer eligible members to SWH Diabetes Disease Management program if appropriate
- Complete annual eye exams and kidney health evaluations for diabetic members

[2] Wang S, Zhu X. Nationwide hospital admission data statistics and disease-specific 30-day readmission prediction. Health Inf Sci Syst. 2022 Sep 2;10(1):25. doi: 10.1007/s13755-022-00195-7. PMID: 36065327; PMCID: PMC9439279.

[3] US Preventive Services Task Force (USPSTF). (2024). Breast Cancer Screening: Final Recommendations Statement. Retrieved from **uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening#bcei-recommendation-title-area**

Osteoporosis management in women who had a fracture (OMW):

Management of osteoporosis for women who suffer a fracture is a time sensitive HEDIS® measure. To improve HEDIS® ratings for this measure, women must have a bone marrow density (BMD) test within 180 days of the date of their fracture, or they must have an eligible prescription that is filled within 180 days of the date of their fracture to be compliant. SWH partners with Care Connections to provide screenings and preventive care services to Medicare members. In order to improve HEDIS® rates for OMW, Care Connections will be conducting portable bone density testing in eligible members in their homes. Results will be shared with primary care providers to help guide treatment if needed. Eligible medications for osteoporosis treatment to satisfy HEDIS® requirements include:

Bisphosphonates: Alendronate; Alendronate-cholecalciferol; Ibandronate; Risedronate; Zoledronic acid
Others: Abaloparatide; Denosumab; Raloxifene; Romosozumab; Teriparatide

Some tips for addressing this HEDIS® measure with your female patients with a fracture include:

- Reinforce the importance of fall prevention with patients
- Include assessment of recent fractures during scheduled appointments
- Schedule patients for osteoporosis screenings on regular schedule
- Order bone density testing on all women who have had a fracture or prescribe an eligible medication to prevent osteoporosis within six months of the event
- Share medical records with SWH if patients have had BMD testing

Follow-up after ED visit for people with multiple high-risk chronic conditions (FUM):

A visit to the emergency department in patients with high-risk medical conditions can lead to hospitalization. Chronic conditions for HEDIS® purposes include:

- COPD, asthma or unspecified bronchitis
- Alzheimer's disease and related disorders
- Chronic kidney disease
- Depression
- Heart failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

It is vital that patients with any of the above conditions who are seen in the ED receive a follow-up visit within seven days of the event. To improve overall outcomes and HEDIS® scores, providers should:

- Monitor notifications of ED visits and admissions and be proactive in scheduling patients for follow-up post-ED for each event, unless visits occur within eight days of each other. Assess if the patient has barriers to getting to appointments. Contact Member Services for assistance if needed.
- Conduct a medication review during every encounter to assess home medication safety.
- Ensure any behavioral health follow-up is scheduled with a mental health provider.

Kidney health evaluation for patients with diabetes (KED):

Approximately 1 in 3 adults with diabetes may have chronic kidney disease. Managing diabetes and keeping blood sugar in control can promote kidney health and reduce the negative impact diabetes can have on the kidneys. [4] SWH is working to improve HEDIS® ratings for this measure. Molina Healthcare, Inc. supports our local efforts by providing home lab kit testing through Let's Get Checked for targeted members due for kidney screening related to diabetes. All lab results for tests completed successfully are shared with providers. Please support our efforts to improve rates of annual testing to help detect and prevent kidney disease in our diabetic patients.

You can find more information on the importance of this endeavor here:
CDC.gov/kidney-disease/media/pdfs/CKD-Factsheet-H.pdf.

HEDIS® and CAHPS® resources for providers

SWH provides HEDIS® and CAHPS® tip sheets for our network providers. The HEDIS® tip sheets contain the required HEDIS® codes that must be documented in claims in order to close care gaps. The tip sheets also contain valuable information including eligibility and exclusion criteria, as well as tips on best practices for providers. Please utilize the HEDIS® tip sheets to ensure that accurate coding is used when billing for services.

The CAHPS® tip sheets contain sample survey questions and helpful tips on improving member experience and satisfaction for multiple measures, including:

- Care coordination
- Getting appointments and care quickly
- Getting needed care
- Getting how well doctors communicate
- Medical assistance with smoking cessation
- Rating of health care, PCP, and specialist

Please review the tip sheets available under the Quality section on the SWH provider website:
MolinaHealthcare.com/providers/ma/swh/resources/quality.aspx.

HEDIS® and CAHPS® tip sheets can also be found in the Payer Spaces/Resources section of the Senior Whole Health Availity portal using this link: **Apps.availity.com/public/apps/home/#!/**.

You must be registered with the Availity portal for access. To register for Availity, go here:
Availity.com/Essentials-Portal-Registration.

Please encourage members to contact SWH Member Services to help schedule screening appointments and transportation if needed at **(888) 794-7268 (TTY: 711)**, 7 days a week, 8 a.m. to 8 p.m., local time.

Culturally and linguistically appropriate services

SWH offers resources to providers promoting culturally and linguistically appropriate services (CLAS), including provider training. The Office of Minority Health from the U.S. Department of Health & Human Services provides valuable information and provider trainings through **Think Cultural Health – A Provider's Practical Guide to Culturally Competent Care**. SWH encourages network providers to register for an account and participate in trainings to promote health equity. You can find the link and information on additional resources here:
MolinaHealthcare.com/providers/ma/swh/health/cme.aspx.

SWH would like to share the link to Resources for Integrated Care (RIC), a CMS-sponsored resource for providers and others working with D-SNP members. You can find information on this and other provider resources here:
MolinaHealthcare.com/providers/ma/swh/resources/training.aspx

SWH Performance Improvement project update

The MassHealth Comprehensive Quality Strategy requires managed care health plans to participate in Performance Improvement Projects (PIPs) on an ongoing basis. These PIPs rely on partnership with our network providers and internal stakeholders to collaborate on interventions throughout each project's three year cycle. The Island Peer Review Organization (IPRO) is the external quality review organization (EQRO) mandated by CMS to oversee PIP activities and data validation as part of their quality review.

[4] Centers for Disease Control and Prevention. Chronic Kidney Disease in the United States, 2023. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2023.

The PIP topics for the current three year cycle, spanning 2024 to 2026, include:

- Controlling high blood pressure (CBP)
- Transitions of care – medication reconciliation post-discharge

SWH Quality is implementing interventions aimed at improving rates of controlled blood pressure and improving rates of medication reconciliation post-discharge for SWH members. Member and provider engagement during PIP activities are key components of success.

Data is collected throughout the PIP cycle to demonstrate measurable improvement on HEDIS® performance for these topics. Intervention tracking measures (ITMs) are monitored routinely, and ITM performance data is reported to IPRO on a quarterly basis.

Through Joint Operational Committee (JOC) meetings and sharing of gap lists, SWH aims to collaborate with providers to close gaps in care for these measures. Progress throughout the PIP cycle is monitored and evaluated, with small tests of change conducted to determine viability of interventions and potential new activities needed to meet performance goals. Please support these projects and collaborate with SWH if your practice is contacted to participate in these efforts to improve the quality of care for SWH members.

Providers impacting measures to advance quality improvement

Reaching out to non-engaged members on your panel

Why it matters: Engaging non-active members helps close care gaps, improves preventive care compliance and ensures better health outcomes.

How to implement:

- Use patient lists and risk stratification tools to identify individuals overdue for screenings, immunizations or follow-up visits.
- Employ outreach strategies like phone calls, texts or patient portal messages to encourage appointment scheduling.
- Collaborate with care coordinators or case managers to assist high-risk or hard-to-reach members.

Setting up supplemental data feeds

Why it matters: Supplemental data provides a more complete picture of patient care, helping to capture services performed outside your practice and improving quality measure reporting.

How to implement:

- Work with health plans or health information exchanges (HIEs) to integrate electronic health record (EHR) data.
- Ensure coding and documentation practices align with measure requirements (e.g., HEDIS®, star ratings).
- Monitor data submissions to ensure accuracy and timely updates.

Other potential activities

Improving preventive care compliance:

- Implement standing orders for vaccinations, screenings and routine labs.
- Educate patients on the benefits of preventive care.

Promoting health education:

- Provide targeted education for patients with chronic conditions such as diabetes or hypertension to improve self-management.

Leveraging technology:

- Use telehealth services to reach patients who face barriers to in-person visits.
- Adopt predictive analytics to identify and intervene with at-risk patients.

Collaborating with community resources:

- Connect patients with local resources (e.g., transportation, meal programs) to address social determinants of health that impact care.

Clinical practice and preventive health guidelines

SWH reviews clinical practice and preventive health guidelines each quarter. Updates to existing guidelines and the adoption of new guidelines are conducted through established committee reviews, with changes communicated to providers via fax and on our provider website. We ask network providers to utilize these guidelines to help guide care of our members.

Links to current practice guidelines approved by the SWH Medical Advisory Committee can be found in the Health Resources section of our website located at: **MolinaHealthcare.com/providers/ma/swh/home.aspx**.

SWH Member Advisory Committee

The Center for Medicare and Medicaid Services (CMS) requires Dual Eligible Special Needs Plans (D-SNPs) to establish and maintain a Member Advisory Committee in order to obtain member feedback and involve them in plan governance. The member perspective allows D-SNP plans to identify potential barriers and work to make improvements to benefits and programming.

- The Member Advisory Committee meets quarterly and is open to all SWH members and/or caregivers. Staff from various departments are present to hear from members and to answer any member questions.
- Meeting topics include but are not limited to: health management programs, benefit education, pharmacy/medication topics, ombudsman reports and obtaining feedback on enhancing the member experience.
- Meetings are currently conducted virtually using a computer or telephone. Members receive pre-meeting instructions, telephonic support and interpreters as needed. In-person meetings may be held in the future if members are able to attend, with SWH providing transportation and other support needed.

If you know a SWH member and/or a caregiver that may be interested in joining our Member Advisory Committee, please have them contact SWH Member Services at: **(888) 794-7268 (TTY: 711)** from 8 a.m. to 8 p.m., 7 days a week.

SWH member support focus workgroups

SWH works in the community to deliver in-person education on the importance of controlling blood pressure. Educational sessions led by SWH nurse care managers include information on how to check blood pressure, tracking blood pressure, dietary recommendations, and medication adherence. Staff from the clinical, quality and sales departments are present at these events to provide information and support to members and others who attend. Interpreter services are available if needed. Examples of the education presented include:

- Healthy habits such as taking your blood pressure and keeping a daily log to share with your doctor
- Understanding how to accurately take your blood pressure, what your healthy range is and when to call your doctor for abnormal readings
- Tools and tips on how to maintain healthy blood pressure

Please feel free to contact Senior Whole Health for more information.

Member Incentive Program offered by SWH

SWH would like to share information on our Healthy Actions Member Incentive Program available to all SWH members. Members completing targeted screenings can earn reward dollars, which are placed on their Healthy You over-the-counter cards. Members must complete and then attest to the screenings through mail, email, texting and/or IVR campaigns. Information was sent to members early in 2025. We would appreciate your help in promoting this program to you SWH patients! The screenings and reward amounts earned include:

Screening	Reward amount
Annual wellness visits	$125
Breast cancer screening	$75
Colon cancer screening	$75
Comprehensive diabetes screenings	$75
Flu vaccine	$25
Maximum potential incentive	**$375**

You can find more information on this valuable program here: **MolinaHealthcare.com/members/ma/en-us/mem/Medicare/Healthy-Actions-Rewards-Program.aspx.**

Access to electronic medical records

SWH works with network providers to establish access to electronic health records (EHR). Shared EHR access improves interoperability across settings and reduces burden on providers related to completing complicated forms or waiting for information to complete timely prior authorizations. Other benefits include improved access to care for patients, and cost savings due to efficiency and reduced time spent on administrative tasks. Please work with our network team on establishing these connections to better support care of our members. To set up EMR access with SWH, please contact Alisha Ely, RN at **(614) 516-4621**.

SDS (Supplemental Data Source) file exchange

SWH works with providers in our network to establish a supplemental data source (SDS) file exchange. Establishing an SDS connection allows for sharing of comprehensive data beyond administrative claims, improving efficiency and reducing administrative burden on providers. Other benefits of an SDS file exchange include:

- Reduces need for office staff to participate in HEDIS® manual record retrieval
- Allows health plan to securely download what is needed for HEDIS® data
- Increases data transparency between providers and SWH
- Supports HEDIS® through increased access to data, improving rates of gap closure
- Allows for HIPAA compliance through secure exchange of PHI (Personal Health Information)
- Supplemental data can be extracted year-round

Please be on the lookout for communications from the SWH Quality team related to this project.

Vaccinations for SWH members

SWH monitors flu, COVID, RSV, and pneumococcal vaccination rates among SWH members and provides education and support to improve vaccine access. With a goal of preventing illness and complications of respiratory infections such as influenza, SWH works with community partners to set up mobile vaccination clinics and encourage providers to strongly encourage patients to get vaccinated. The 2024/2025 flu season showed a significant increase in respiratory illness rates from previous years. We encourage providers to start discussing vaccinations early in the season and provide education for your SWH patients with vaccine hesitancy. Cultural beliefs may be a factor with members who decline to be vaccinated. Culturally sensitive education and the use of motivational interviewing can make the difference to get members vaccinated. Please review our motivational interviewing resource located in the Availity portal in the Payer Spaces section under Resources. You can find more information on current respiratory illness prevalence here: **Mass.gov/info-details/viral-respiratory-illness-reporting**.

Find up-to-date information on the recommended adult immunization schedule for adults from the Centers for Disease Control and Prevention (CDC) here: **CDC.gov/vaccines/hcp/imz-schedules/adult-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html**.

Collaboration on Transitions of Care (TRC) HEDIS® measure

SWH Quality oversees quality improvement efforts to improve outcomes for our members. Strong performance on HEDIS® measures demonstrates high quality care to members and helps in attaining higher star ratings for our plan.

Transitions of care is a critical area of focus for SWH to reduce adverse events and ensure members are discharged safely with appropriate education and follow-up. The SWH clinical program includes a transition of care (TOC) team of dedicated nurse care managers tasked with identifying and assessing all members being discharged from an inpatient setting. Providers in our network play an integral part in this process. One piece of the transitions of care process includes data collection to monitor and report performance on the Transitions of Care (TRC) HEDIS® measure. Sub-measures in the TRC measure include:

- Notification of Inpatient Admission
- Receipt of Discharge Information
- Patient Engagement After Inpatient Discharge
- Medication Reconciliation Post-Discharge

SWH is currently focused on improving performance on the top two sub-measures using a collaborative approach to retrieve appropriate documentation to meet HEDIS® requirements. HEDIS® reporting requires SWH to:

1. Submit documentation data of the primary care provider's receipt of notification of an inpatient admission on the day of admission through two days after the admission (three total days)
2. Submit documentation data of the primary care provider's receipt of discharge information on the day of discharge through two days after the discharge (three total days).

SWH is working to identify strategies to obtain this important information from network providers efficiently and timely. Given the challenges with ongoing manual retrieval of this type of data for individual patients, SWH is requesting help from providers by granting SWH access to electronic health records to facilitate retrieval of this information.

Please be on the lookout for more communications about this important endeavor. We appreciate your support of our quality efforts and attention to the regulatory requirements from CMS.