Overarching Principles and Definitions	
Active Patients:	Patients seen by a primary care clinician of the PCMH anytime within the last 24 months Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA), and Certified Nurse Practitioner (CNP). The following are the eligible CPT/HCPCS office visit codes for determining Active Patient status: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490, 99495-99496, G0402; G0438-G0439 Acceptable Exclusions: Patients who have left the practice, as determined by one or more of the following: 1. Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice 2. Patient has passed away 3. Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person 4. Patient has been discharged according to practice's discharge policy
Outpatient Visit Criteria:	Please refer to the current year HEDIS® Outpatient Value Set.
Encounter Types:	In addition to following CPT/HCPCS code level of service guidelines to establish an eligible population, report writers should ensure encounter types are limited to include only face to face encounter types for those measures requiring a face to face encounter. Example: Depression screening: Patient turns 18 in July. In the record they have two "encounters" during the measurement year – a well visit in April and a nurse care manager phone call in August. Failure to limit encounter types correctly could result in the nurse care manager visit erroneously triggering this patient in the eligible population.
Practices using shared EHR systems:	Denominator calculations are based upon encounters in the PCMH unless otherwise specified. Numerator events may be from any source (e.g. a recorded BMI or lab value).
Value Set Information:	HEDIS® measures reference Value Sets, which are available for download at store.ncqa.org under the search term: "Quality Rating System (QRS) HEDIS® Value Set Directory." See attached "Instructions for Obtaining "2018 Quality Rating System (QRS) HEDIS® Value Set Directory."

Adult Measures

Measure:	Adult BMI Assessment (ABA)
Description:	The percentage of patients 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented using the age acceptable format (percentile versus numeric) during the measurement year or the year prior by any provider
Age criteria:	Eligible population is determined as 18 as of the beginning of the year prior to the measurement year and 74 as of the last day of the measurement year. **Example:** Measurement year 2018 18 as of 1/1/2017 74 as of 12/31/2018 Note: An added age criteria must be applied to determine if the correct format was used for the patient's age at the time of the visit. Since only one recording is required and multiple will likely occur during the reporting period, reporting on the most recent value is easiest.
Numerator Statement:	For patients 20 years of age or older on the date of service, BMI (BMI Value Set) documented during the measurement year or the year prior to the measurement year For patients younger than 20 years of age on the date of service, BMI percentile (BMI Percentile Value Set) documented during the measurement year or the year prior to the measurement year Documentation must include not only the BMI Value or Percentile, but also height and weight.
Denominator Statement:	Patients meeting the above age criteria who had an outpatient visit defined by Outpatient Visit Criteria during the measurement year or the year prior
Acceptable Exclusions:	• Patients with a diagnosis of pregnancy (refer to HEDIS® Pregnancy Value Set) during the measurement year of the year prior to the measurement year
Look back Period:	24 months
Source:	HEDIS®

Measure:	Preventive Care and Screening: Screening for Clinical Depression and Follow Up Plan (Adapted for adult population)
Description:	The percentage of active patients 18 years of age and older screened for clinical depression using an age appropriate standardized tool AND, if positive follow up plan is documented on the date of the screen
Age criteria:	Eligible population is determined as 18 at the date of encounter. **Example 1:** Patient turns 18 on 4/15/2018 Date of encounter 4/12/2018 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 4/15/2018 Date of encounter 6/12/2018 Patient is IN denominator
Numerator Statement:	Active patients 18 years of age and older at the date of encounter screened for clinical depression at least once during the measurement period using an age appropriate standardized tool AND, if positive, follow up plan is documented on the date of the screen
Denominator Statement:	Active patients 18 years of age and older on the date of encounter. Encounter must meet the outpatient visit criteria
Denominator Exclusions:	1. Patient has active diagnosis of depression 2. Patient has a diagnosed bipolar disorder
Denominator Exceptions:	1. Patient refuses to participate 2. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status 3. Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
Follow-Up Plan Requirements:	Documented follow-up for a positive depression screening must include one or more of the following: 1. Additional evaluation for depression (e.g. continuation to PHQ-9 if PHQ-2 is abnormal) 2. Suicide Risk Assessment 3. Referral to a practitioner who is qualified to diagnose and treat depression 4. Pharmacological interventions 5. Other interventions or follow-up for the diagnosis or treatment of depression

Adult Screening Tools:	Acceptable tools include the Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2. The tool used must be documented in the record.
Look back Period:	12 months
Source:	NQF 0418:3148 CMS eMeasure Version number 6.3.000

Measure:	Comprehensive Diabetes Control: HbA1C Control (<8)
Description:	The percentage of active diabetic patients between 18 and 75 years of age whose most recent HbA1C value was less than 8
Age criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2018 Patient age between 18 as of 12/31/2018 to 75 as of 12/31/2018
Numerator Statement:	Active diabetic patients between 18 and 75 years of age at the end of the measurement period whose most recent HbA1C value in the measurement year was less than 8
Denominator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior. Patients with diabetes are identified in the following ways: 1. Encounter-based – Members who met any of the following criteria during the measurement year or the year prior to the measurement year: a. At least two outpatient visits (Outpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Only one of the two visits may be a telehealth visit, a telephone visit or an online assessment. Identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit. Use the code combinations below to identify telephone visits and online assessments: o A telephone visit (Telephone Visits Value Set) with a diagnosis of diabetes (Diabetes Value Set) o An online assessment (Online Assessments Value Set) with any diagnosis of diabetes (Diabetes Value Set) 2. Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior (Diabetes Medications List). Note that Glucophage/metformin as a solo agent is NOT included because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
Acceptable Exclusions:	1. Patients who do not have a diagnosis of diabetes (Diabetes Value Set) in any setting during the measurement year or year prior AND who had a diagnosis included in the Diabetes Exclusions Value Set during the measurement year or year prior. (Historically, these exclusions were limited to gestational and steroid induced diabetes, but the exclusion

	value set includes additional conditions focused heavily on diabetes caused by an underlying condition). 2. Patients 66 and older as of December 31st of the measurement year with frailty (Frailty Value Set) AND advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. A dispensed dementia medication (Dementia Medications List) 3. Patients in hospice
Diabetics without A1C Documented:	If no A1C reading was rendered during the measurement year, patient counts as non-adherent.
Look back Period:	12 months
Source:	HEDIS®

Measure:	Comprehensive Diabetes Control: Eye Exam (retinal) performed
Description:	The percentage of active diabetic patients between 18 and 75 years of age with up to date screening or monitoring for diabetic retinal disease
Age criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2018 Patient age between 18 as of 12/31/2018 to 75 as of 12/31/2018
Numerator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period who had any of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilateral eye enucleation anytime during the member's history through the end of the measurement year Please note, documentation in the chart must include one of the following: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results. • A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. • Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the patient's history through end of the measurement year. • Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (e.g. documentation of normal findings).
Denominator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior. Patients with diabetes are identified in the following ways: 1. Encounter-based – Members who met any of the following criteria during the measurement year or the year prior to the measurement year: a. At least two outpatient visits (Outpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes

	Value Set). Only one of the two visits may be a telehealth visit, a telephone visit or an online assessment. Identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit. Use the code combinations below to identify telephone visits and online assessments: o A telephone visit (Telephone Visits Value Set) with a diagnosis of diabetes (Diabetes Value Set) o An online assessment (Online Assessments Value Set) with any diagnosis of diabetes (Diabetes Value Set) 2. Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior (Diabetes Medications List). Note that Glucophage/metformin as a solo agent is NOT included because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
Acceptable Exclusions:	1. Patients who do not have a diagnosis of diabetes (Diabetes Value Set) in any setting during the measurement year or year prior AND who had a diagnosis included in the Diabetes Exclusions Value Set during the measurement year or year prior. (Historically, these exclusions were limited to gestational and steroid induced diabetes, but the exclusion value set includes additional conditions focused heavily on diabetes caused by an underlying condition). 2. Patients 66 to 75 as of December 31st of the measurement year with frailty (Frailty Value Set) AND advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. A dispensed dementia medication (Dementia Medications List) 3. Patients in hospice
Look back Period:	24 months, if negative retinopathy, 12 if positive or unknown
Source:	HEDIS®

Measure:	Controlling High Blood Pressure - Note SIGNIFICANT CHANGES
Description:	The percentage of active patients between 18 and 85 years who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-85 years of age whose BP was <140/90 mm Hg
Age criteria:	Eligible population is determined as 18 or 85 at the end of the measurement period. Example: Measurement period end date 12/31/2018 Patient age between 18 as of 12/31/2018 to 85 as of 12/31/2018
Numerator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-85 years of age whose most recent BP reading during the measurement year, on or after the second diagnosis of hypertension, (hypertension diagnosis may be established prior to the measurement year if patient has already had two dates of service with a hypertension diagnosis) was <140/90 mm Hg
Denominator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period. Active hypertension patients are identified as patients who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or year prior to the measurement year (count services that occur over both years). Only one of the two visits may be a telephone visit, an online assessment of telehealth visit. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with or without a telehealth modifier with any diagnosis of hypertension (Essential Hypertension Value Set) • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • An online assessment (Online Assessment Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set)
Acceptable Exclusions:	1. Patients 81 years of age and older as of December 31st of the measurement year with frailty (Frailty Value Set) during the measurement year. 2. Patients 66-85 as of December 31st of the measurement year with frailty (Frailty Value Set) AND advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value

	Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. A dispensed dementia medication (Dementia Medications List) 3. Patients with ESRD (ESRD Value Set: ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis. 4. Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year 5. Patients who had a non-acute inpatient admission during the measurement year. (This exclusion is much more feasible for a health plan to apply than a practice). To identify non-acute inpatient admissions: a. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). b. Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim. c. Identify the discharge date for the stay. 6. Patients in hospice
BP Documentation:	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension (hypertension diagnosis may be established prior to the measurement year if patient has already had two dates of service with a hypertension diagnosis). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP reading is recorded during the measurement year, assume that the patient is "not controlled."
Look back Period:	12 months
Source:	HEDIS®

Measure:	Preventive Care and Screening: Tobacco Cessation Intervention
Description:	The percentage of active patients 18 years and older and who were screened for tobacco use one or more times within 24 months AND who received cessation counseling if identified as a tobacco user
Age criteria:	Eligible population is determined as 18 at the date of encounter **Example 1:** Patient turns 18 on 4/15/2018 Date of encounter 4/12/2018 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 4/15/2018 Date of encounter 6/12/2018 Patient is IN denominator
Numerator Statement:	All active patients 18 and older at the date of encounter who were screened for tobacco (all forms including smokeless) use at least once within 24 months and were either identified as a non-smoker OR identified as a smoker AND received tobacco cessation intervention
Denominator Statement:	All active patients 18 and older at the date of encounter with at least two visits (see Outpatient Visit criteria) **OR** one preventive visit during the measurement period
Denominator Exclusions:	None
Denominator Exceptions:	Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)
Tobacco Use and Intervention Definitions:	Tobacco Use – Includes use of any type of tobacco Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy
E-Cigs	Per measure: "As noted in a recommendation statement from the USPSTF, the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) including electronic cigarettes for tobacco cessation. Additionally, ENDS are not currently classified as tobacco in the recent evidence review to support the update of the USPSTF recommendation given that the devices do not burn or use tobacco leaves. In light of the current lack of evidence, the measure does not currently capture e-cigarette usage as either tobacco use or a cessation aid."
Patients Not Assessed:	If tobacco use status of patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure.
Look back Period:	There are two different lookback period for this measure: • Documentation of cessation counseling – 24 month look back from most recent office visit

	• Count of encounters – 24 month look back from end of measurement period to determine if patient has been seen twice for any type of visit or for one preventive visit
Source:	NQF 0028 CMS 138v7 population 3 (populations 1 and 2 will not be reported separately as the measure suggests)

Measure:	Colorectal Cancer Screening
Description:	The percentage of active patients 50 to 75 years of age who had an appropriate screening for colorectal cancer.
Age criteria:	Eligible population is determined as patients 51 to 75 years of age at the end of the measurement period. (Description states 50 since someone could be 50 throughout the measurement year and not turn 51 until the last day of the measurement period).
Numerator Statement:	Active patients 51 to 75 at the end of the measurement period who received an acceptable colorectal screening during the identified lookback period (See below).
Denominator Statement:	Active patients 51-75 at the end of the measurement period.
Acceptable Exclusions:	• Either of the following at any time in the member's history through the end of the measurement period: • Colorectal cancer • Total colectomy • Patients 66 to 75 as of December 31st of the measurement year with frailty (Frailty Value Set) AND advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. o At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) o A dispensed dementia medication (Dementia Medications List)
Look back Period:	Varies based on test performed: • Fecal occult blood test during the measurement year (FOBT Value Set) • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year (Flexible Sigmoidoscopy Value Set) • Colonoscopy during the measurement year or the nine years prior to the measurement year (Colonoscopy Value Set) • CT colonography during the measurement year or the four years prior to the measurement year (CT Colonography Value Set) • FIT-DNA (Cologuard) test during measurement year or the two years prior to the measurement year (FIT-DNA Value Set)

Medical Record Documentation:	If a copy of the actual procedure/test/lab result is not present, documentation in the medical record must include a note indicating the date when the colorectal screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If that is not clear, the result finding must be present (this ensures the screening was performed and not merely ordered). A pathology report that indicates the type of screening meets the criteria. For pathology reports that do not indicate the type of screening and for incomplete procedures: • Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy. • Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy. There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance. • If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. • If the medical record does not indicate the type of test and the number of returned samples is specified, the member meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion. • FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the member meets the screening criteria, regardless of how many samples were returned. • If the medical record indicates that a gFOBT was done, follow the scenarios below. – If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator. – If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator. – If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria. Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.
Source:	HEDIS®

Pediatric Measures

Measure:	Well Child Counseling: Weight Assessment and Counseling for Nutrition and Physical Activity
Description:	Percentage of active patients 3-17 years of age who had an outpatient visit in the last twelve months with a primary care clinician of the PCMH who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation, • Counseling for nutrition, AND • Counseling for physical activity
Age criteria:	Eligible population is determined as 3-17 at the end of the measurement year. Example: Measurement period end date 12/31/2018 Patient age between 3 as of 12/31/2018 to 17 as of 12/31/2018
Numerator Statement:	Patients in the denominator who had evidence of a body mass index (BMI) percentile documentation, counseling for nutrition, **AND** counseling for physical activity during the measurement year • BMI percentile: documentation must include height, weight, and BMI percentile during the measurement year. The height, weight, and BMI must be from the same data source. o Either of the following meets criteria for BMI percentile: ▪ BMI percentile, or ▪ BMI percentile plotted on age-growth chart o Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). o Practices may utilize the BMI Percentile Value Set as a mechanism to achieve this component of the measure. • Counseling for nutrition: documentation of counseling for nutrition or referral for nutrition education during the measurement year. Documentation must include a note indicating the date and at least one of the following: o Discussion of current nutrition behaviors (e.g. eating habits, dieting behaviors) o Checklist indicating nutrition was addressed o Counseling or referral for nutrition education o Patient received educational materials on nutrition during a face to face visit o Anticipatory guidance for nutrition o Weight or obesity counseling Practices may utilize the Nutrition Counseling Value Set as a mechanism to achieve this component of the measure, but still must meet the above documentation requirements.

	• Counseling for physical activity: documentation of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following:
	  ○ Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
	  ○ Checklist indicating physical activity was addressed
	  ○ Counseling or referral for physical activity
	  ○ Patient received education materials on physical activity during face to face visit
	  ○ Anticipatory guidance for physical activity
	  ○ Weight or obesity counseling
	Practices may utilize the Physical Activity Counseling Value Set as a mechanism to achieve this component of the measure, but still must meet the above documentation requirements.
	
	Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.

Denominator Statement:	All active patients 3-17 at the end of the measurement year with a documented encounter during the measurement year
Acceptable Exclusions:	• Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year • Patients in hospice
Look back Period:	12 months
Source:	HEDIS®

Measure:	Developmental Screening in the First Three Years of Life
Description:	The percentage of active patients screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.
Age criteria:	Children who turn 1, 2, or 3 years of age during the measurement year.
Numerator Statement:	The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening in the first, second, and third years of life. The measure is based on three, age-specific indicators. Numerators 1-3 are for your understanding of the measures. Only Numerator 4 is required to report to PCMH-Kids. • **Numerator 1**: Children in Denominator 1 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday • **Numerator 2**: Children in Denominator 2 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their first and before or on their second birthday • **Numerator 3**: Children in Denominator 3 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their second and before or on their third birthday • **Numerator 4**: Children in Denominator 4 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthday, i.e., the sum of numerators 1, 2, and 3. Documentation in the medical record must include all of the following: • A note indicating the date on which the test was performed, and • The standardized tool used (see below), and • Evidence of a screening result or screening score Tools must meet the following criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional. 2. Established Reliability: Reliability scores of approximately 0.70 or above 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

	4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above Current recommended tools that meet these criteria: 1. Ages and Stages Questionnaire (ASQ) - 2 months – 5 years 2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3) 3. Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth – 95 months 4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months – 2 years 5. Brigance Screens-II – Birth – 90 months 6. Child Development Inventory (CDI) - 18 months–6 years 7. Infant Development Inventory – Birth – 18 months 8. Parents' Evaluation of Developmental Status (PEDS) – Birth – 8 years 9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) 10. Survey of Wellbeing of Young Children (SWYC) Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Denominator Statement:	Active patients who have been seen by the primary care clinician at the PCMH in the previous 12 months who meet the following eligibility requirement based on child's age at end of measurement year • **Denominator 1**: Active Patients who turn 1 during measurement year • **Denominator 2**: Active Patients who turn 2 during measurement year • **Denominator 3**: Active Patients who turn 3 during measurement year • **Denominator 4**: All Active Patients who turn 1, 2, or 3 the measurement year, i.e., the sum of denominators 1, 2, and 3
Acceptable Exclusions:	None
Look back Period:	Screenings must be completed prior to the patient's birthdate. In order to account for patients with birthdates at the beginning of the measurement year, reports should account for these encounters accordingly and place a lookback period on the patient's DOB rather than the measurement period. In order to account for age appropriate screenings, this look back should not exceed a 6 month lookback from the DOB in order to avoid erroneously counting developmental screenings used for prior years of age. Example: Patient 1 DOB: 1/15/2018 Patient 2 DOB: 5/31/2018

	Measurement period for both Patient 1 and 2: 1/1/2018 – 12/31/2018 Lookback period for Patient 1: 7/15/2017 -1/14/2018 Lookback period for Patient 2: 11/15/2017 – 5/30/2018
Source:	Oregon Pediatric Improvement Partnership at Oregon Health and Science University (OHSU)

Measure:	Adolescent Well Care Visit
Description:	The percentage of active patients 12-21 years of age with a documented well child encounter during the measurement year
Age criteria:	Active patients 12-21 years of age at the end of the measurement year.
Numerator Statement:	Active patients 12-21 years of age at the end of the measurement year with a note indicating a visit to a PCP or OBGYN, the date of well visit, and evidence of all of the following: • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance *If standard preventive visit templates consistently incorporate the above information, practices may simply use encounter information to verify compliance.*
Denominator Statement:	Active patients 12-21 years of age at the end of the measurement year
Acceptable Exclusions:	None
Codes to identify Adolescent Well-Care Visits	CPT: 99383-99385; 99393-99395 ICD-10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9
Look back Period:	12 months
Source:	HEDIS®