

2022 Quality Measure Resource Guide



EmblemHealth and Affiliates are committed to providing high-quality services for the membership we serve.

This reference guide provides a brief overview of national and state quality measures* that evaluate various domains of preventive, acute, and chronic care. We hope that you find this guide useful for the care of our shared members.

The information contained in this guide was compiled in March 2022 and is subject to change as the sources below update their specifications.

*Measures included in this guide are sourced from National Committee for Quality Assurance (NCQA) www.ncqa.org/, Centers for Medicare & Medicaid Services (CMS) <https://www.cms.gov/>, and New York State Department of Health (NYSDOH) www.health.ny.gov/.

NCQA HEDIS specifications and NYS Value Set Directory can be accessed at www.ncqa.org/hedis/measures/.

Please confirm with your EmblemHealth Network Representative to ensure suggested codes are payable per your specific contract.

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Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Description

The percentage of patients 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Numerator/Denominator

Numerator: Patients in the denominator who remain on their prescribed antipsychotic medications for 80% of their treatment period.

Denominator: Patients diagnosed with schizophrenia or schizoaffective disorder during the measurement year.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data and HCPCS codes to calculate the rates.
Eligible Medications	<p>Miscellaneous oral medications</p> <p>Aripiprazole Lurasidone Asenapine Molindone Brexipiprazole Olanzapine Cariprazine Paliperidone Clozapine Quetiapine Haloperidol Risperidone Iloperidone Ziprasidone Loxapine</p> <p>Phenothiazine antipsychotics (oral)</p> <p>Chlorpromazine Prochlorperazine Fluphenazine Thioridazine Perphenazine Trifluoperazine</p> <p>Psychotherapeutic oral combos</p> <p>Amitriptyline-perphenazine</p> <p>Thioxanthenes (oral)</p> <p>Thiothixene</p> <p>Long-Acting Injections</p> <p>Risperidone Aripiprazole Fluphenaz decanoate Haloperidol decanoate Olanzapine Paliperidone palmitate</p>

Exclusion Criteria:

- Diagnosis of dementia.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Patient did not have at least two antipsychotic medication dispensing events.
- Patients 66 years of age or older are either enrolled in an institutional special needs plan (I-SNP) or is living long-term in an institution.
- Patients age 66-80 years of age with frailty AND advanced illness.
- Patients 81 years of age and older with a diagnosis of frailty.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) and medical claims data.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Educate on the importance of medication adherence and common side effects.
- Routinely arrange follow-up visits before the patient leaves the office.
- Refer to a behavioral health specialist if appropriate.
- Consider prescribing a 90-day supply.

All-Cause Readmission (PCR)

Description

For patients 18-64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Numerator/Denominator

Numerator: Patients in the denominator with an acute inpatient or observation stay followed by an unplanned acute inpatient or observation readmission for any diagnosis within 30 days after discharge.

Denominator: Patients 18- 64 years of age with an acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year.

Exclusion Criteria:

- Died during the stay.
- Received hospice or palliative care at any time during the measurement year.
- Had a primary diagnosis of pregnancy.
- Had a primary diagnosis of a condition that originated in the perinatal period.

Additional Measure Information

- Post-discharge planning and care coordination are essential in preventing unplanned readmissions. This measure is based on discharge events.

Documentation Requirements

- Document medication reconciliation (discharge medications reconciled with current medication list) in the patient's medical record.

Telehealth

Telehealth is sufficient for medication reconciliation compliance.



Helpful Tips

- Identify high utilizers and populations at risk.
- Partner with facility to improve care coordination upon discharge.
- Keep open appointments so patients can be seen promptly upon discharge.
- Work with patients and caregivers to ensure they understand discharge care plan, including their new medication regimen.
- Obtain hospital discharge summary and use to schedule post-discharge appointments.
- Contact patients within 3 days of discharge.

Annual Wellness Visit (AWV)

Description

The percentage of patients ages 18 years of age and older who had an annual wellness exam in the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who had an annual wellness exam in the measurement year.

Denominator: Patients 18 years of age and older.

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

Visit includes:

- Physical assessment
- Physical exam
- Laboratory tests
- Immunizations
- Preventive screenings
- Referrals
- Counseling

Codes/Medications for Compliance

Applicable Codes	HCPCS code of G0402, G0438- G0439, or G0468 CPT codes of 99402-99404, 99381-99387, or 99391-99397
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Documentation Requirements

- For Medicare, when billing an Annual Wellness Visit and Annual Physical Exam on the same day, use a modifier code of 25 for the Annual Physical Exam.

Telehealth

Telehealth can be used for compliance.



Helpful Tips

- Send reminders prior to the scheduled appointment date.
- Consider expanding early morning, evening, and weekend hours.
- Provide patient education regarding the importance of preventive health visits and completing the AWV.
- Utilize visit to address behavioral health needs and social determinants of health.
- Visits can be done annually based on calendar year in conjunction with an Annual Physical Exam.
- Telehealth resources may be utilized to reach patients unable to schedule an in- office appointment.
- Review office workflow to ensure time efficiencies.
- Offer block scheduling and/or AWV-specific appointment days.
- Provide patient education and resources regarding management of health conditions.

Annual Dental Visit (ADV)

Description

The percentage of patients ages 2-20 who have had at least one dental visit during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator with one or more visits with a dental provider (DDS, DMD, or certified and licensed dental hygienists) during the measurement year.

Denominator: Patients ages 2-20 as of 12/31 of the measurement year.

Codes/Medications for Compliance

Note: For this measure, all codes will apply. Any visit with a dental provider will count toward this measure.

Applicable Codes	CPT: 99188, D1000-D1999, D0145, D1120, D1208 ICD-10: K02.9 Telehealth CDT: D1330: Oral Hygiene Instructions D1310: Nutritional counseling for control and prevention of oral disease
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Exclusion criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Any preventive service or procedure with a dental care provider.

Telehealth

Telehealth can be used for compliance.



Helpful Tips

- No referral is required.
- Inform family of link of oral health to overall health.
- Encourage routine visits beginning as early as age 1 or first tooth eruption.
- Send parents and/or guardians/patients reminders every six months to schedule for periodic exams, prophylaxis (cleanings), and fluoride treatments.
- Services must be performed by a dental provider (DDS, DMD, or certified and licensed dental hygienists).
- For many one-year-olds, visits will be counted because the specification includes children whose second birthday occurs during the measurement year.
- Schedule next visit before patients leave the office.
- Schedule reminder calls 24 hours before appointment.
- Teledentistry services utilized for dental emergencies will satisfy the ADV measure.

Antidepressant Medication Management (AMM)

Description

The percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment.

Numerator/Denominator

Numerator:

Acute Phase: The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

Continuation Phase: The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Denominator: Patients 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.	
Eligible Medications	Citalopram	Nortriptyline
	Escitalopram	Protriptyline
	Fluoxetine	Trimipramine
	Fluvoxamine	Trazadone
	Paroxetine	Bupropion
	Sertraline	Vilazodone
	Amitriptyline	Vortioxetine
	Amoxapine	Nefazodone
	Clomipramine	Desvenlafaxine
	Desipramine	Duloxetine
	Doxepine	Venlafaxine
	Imipramine	Levomilnacipran
	Isocarboxazid	Selegiline
	Phenelzine	Tranlycypromide
	Maprotiline	Mirtazapine
	Amitriptyline-chlordiazepoxide	
	Amitriptyline-perphenazine	
	Fluoxetine-olanzapine	

Exclusion Criteria:

- Patients who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the Index Prescription Start Date (IPSD) through the IPSD and 60 days thereafter.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filled through pharmacy discount programs will not result in compliance and patients may pay more for their medication than if they used their prescription drug coverage. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Educate patients on medication options benefits and side effects.
- Discuss the importance of continuing medication as prescribed and the risks of stopping medication.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress, reassess symptoms and side effects, and adjust the type or dose of medication if needed.
- Refer to specialist if appropriate.
- Monitor medication prescriptions and do not allow the total gap days to be more than 31 days during the acute phase and 52 days during the continuation phase.

Asthma Medication Ratio (AMR)

Description

The percentage of patients ages 5-64 with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Denominator: Patients ages 5-64 who have persistent asthma during both the measurement year and the year prior.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Eligible Medications	Dyphylline-guaifenesin, Omalizumab, Dupilumab, Benralizumab, Mepolizumab, Reslizumab, Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Formoterol-mometasone, Beclomethasone, Budesonide, Ciclesonide, Flunisolide, Fluticasone, Mometasone, Montelukast, Zafirlukast, Zileuton, Theophylline

Exclusion Criteria:

- Certain patients are excluded, e.g., if they have emphysema, COPD, cystic fibrosis, acute respiratory failure.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Compliance can only be achieved through prescription drug event (PDE) and medical claims data.

Telehealth

Telehealth visits can be used to review, document, and prescribe medication, when appropriate.



Helpful Tips

- Emphasize the important role of controller medications in managing symptoms.
- Create an asthma action plan. Train patients on inhaler technique and encourage use of asthma spacers and peak flow meters.
- Consider prescribing a 90-day supply when appropriate and educate patients on pharmacy auto-refill program.
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).
- Consider more frequent visits until the patient is compliant.
- Encourage patients to receive their annual flu vaccine.

Blood Sugar Control for Patients with Diabetes (HBD)

Description

The percentage of patients 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (<8.0%)
- HbA1c poor control (>9.0%)
- HbA1c control (<=9)

Numerator/Denominator

Numerator: HbA1c control: Patients in the denominator who have an HbA1c level <8.0% or <=9% in the measurement year (most recent HbA1c level is used). Note: The most recent result is the ONLY result that is used to determine compliance.

Denominator: Patients between 18-75 years of age who have diabetes.

Codes/Medications for Compliance

Applicable Codes	HbA1c Lab Test: CPT: 83036, 83037 HbA1c Test Results: CPT II: 3044F, 3046F, 3051F, 3052F
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients with a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes.

Documentation Requirements

- Documentation must include screening results and date of service.

Telehealth

Telehealth not sufficient to complete screening, but documentation in telehealth visit of prior screening will count for compliance. Collect and document history of diabetes care.



Helpful Tips

- Emphasize importance of medication and insulin adherence in managing blood glucose.
- Adjust therapies to improve levels and recommend follow-up visits to monitor results.
- Create a diabetes checklist in your EMR/patient chart to monitor if patients are up to date with recommended screenings.
- The date of the **latest** A1c of the added “measurement” should be submitted. Identify yearly in the year who may need A1c testing; if results are high, you have time for adjustments. Repeat to see if A1c improves.
- Partner with patients to help identify any barriers to effective disease management. Connect patients with care coordinators or other practice staff for available resources.

Breast Cancer Screening (BCS)

Description

The percentage of women 50-74 years of age who have had a mammogram to screen for breast cancer.

Numerator/Denominator

Numerator: Patients in the denominator who have had one or more mammograms between October 1 two years prior to the measurement year and December 31 of the measurement year.

Denominator: Patients 50-74 years of age.

Codes/Medications for Compliance

Applicable Codes	CPT: 77055-77057, 77061-77063, 77065-77067 HCPCS: G0202, G0204, G0206
Exclusion Codes	Z90.13, All palliative care codes

Exclusion Criteria:

- Patients with bilateral mastectomy.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Do not count MRIs, ultrasounds, or biopsies towards the **numerator:** Although these procedures may be indicated for evaluating women at higher risk for breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

Documentation Requirements

- Date of screening and results in medical record. If patient is not sure on exact date, document closest possible timeframe (i.e., month/year).

Telehealth

Telehealth not sufficient to complete screening; only to review and document history of screenings.



Helpful Tips

- Highlight the importance of early detection.
- Discuss common fears about testing.
- Leverage EMR to place a reminder in the patient's chart for when the next screening is due.
- Create "Standing Order" for ease of access.
- Share list of mammogram facilities.
- Partner with community events to increase screening opportunities.
- Increase patient education regarding importance of annual screening.

CAHPS

Description

The annual CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey is an important tool used to capture patient experiences with their doctors and health plan. It is performed by a certified vendor on behalf of the Centers for Medicare & Medicaid Services (CMS).

Survey results can tell us whether we are meeting our patients' needs and if providers are meeting the needs of their patients.

Focusing on the patient experience can improve adherence to care and treatment plans, clinical outcomes, and patient safety. Because health care continues to move toward performance-based care, it is essential to thoroughly understand the patient experience.

CAHPS Health Plan Survey Measures

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Care Coordination
- Flu Vaccine
- Health Plan Customer Service
- Enrollees' Ratings

Documentation Requirements

- CAHPS-related data can be documented in health assessments, surveys, EMRs, and patient self-reporting.



Helpful Tips

- Improve appointment availability.
- Engage patients in shared decision-making.
- Encourage patients to write down what they want to cover during their doctor's visit.
- Discuss any care and treatment received by other doctors.
- Equip patients by providing materials and increased access to helpful information about them managing their health.
- Provide excellent customer service.
- Communicate service standards with all clinical staff and office staff.
- Try to schedule well-visits/routine physicals within 4 weeks and non-urgent sick visits within 48 to 72 hours of request.
- Discuss medication adherence barriers during office visits and ask open-ended questions about concerns related to health benefits, side effects, and cost.

Care for Older Adults (COA)

Description

The percentage of patients 66 years of age and older who had the following during the measurement year:

- One medication review conducted by a prescribing provider or clinical pharmacist and the presence of a medication list in the medical record.
- One pain assessment.
- One functional status assessment.

Numerator/Denominator

Numerator: Number of patients 66 years of age and older that received one medication review, pain assessment, and functional status assessment during the measurement year.

Denominator: Number of patients 66 years of age and older.

Codes/Medications for Compliance

Applicable Codes	Medication List CPTII: 1159F HCPCS: G8427 Medication Review CPT: 90863, 99483, 99605, 99606 CPTII: 1160F Transitional Care Management CPT: 99495, 99496 Functional Status Assessment CPT: 99483 CPTII: 1170F HCPCS: G0438, G0439 Pain Assessment: CPT II: 1125F, 1126F
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Services rendered in an acute inpatient setting.

Documentation Requirements

Medication Review code and Medication List code both must be present for numerator compliance.

Telehealth

Telehealth can be used for compliance.



Helpful Tips

- Patient is not required to be present for medication review.
- Medication review must be completed by a prescribing practitioner or clinical pharmacist.
- Pain assessment may include positive or negative finding for pain.
- May use standardized assessment tools for pain and functional status assessments.
- Components of the functional status assessment may take place during separate visits within the measurement year.
- Take every opportunity to complete assessments when the patient is in the office for any visit type.

Cervical Cancer Screening (CCS)

Description

The percentage of women 21-64 years of age who had an appropriate screening for cervical cancer in the required time frame.

Numerator/Denominator

Numerator: Patients in the denominator who have had one or more cervical cancer screenings in the time frame (depends on age).

Denominator: Women 21-64 years of age.

Codes/Medications for Compliance

Applicable Codes	Cervical Cytology CPT: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175 HCPCS: G0123, G0124, G0141, G0143, G0144, G0147, G0148, P3000, P3001, Q0091 HPV Test CPT: 87620, 87621, 87622, 87624, 87625 HCPCS: G0476
Exclusion Codes	Z90.710, Z90.712, Palliative Care codes, Hospice codes

Exclusion Criteria:

- Patients with hysterectomy with no residual cervix, cervical agenesis, or acquired absence of the cervix.
- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients in hospice.

Additional Measure Information

- Women 21-64 years of age: cervical cytology during the current year or two years prior to the current year (every three years).
- Women 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed during the current year or 4 years prior to the current year (every 5 years).
- Women 30-64 years of age: cervical cytology/HPV co-testing during the current year or 4 years prior to the current year (every 5 years).

Documentation Requirements

- Date cervical cytology was performed.
- Result or finding.

Telehealth

Telehealth not sufficient to complete screening; only to review and document history of screenings.



Helpful Tips

- Highlight the importance of early detection, review barriers and stress importance of yearly screening.
- Place a reminder in the patient's chart for when the next screening is due.
- Conduct test at other visits, e.g., sick visits if opportunity presents.
- If patient has had hysterectomy, document, and code for this condition.
- Flag charts of patients after screening is performed to ensure timely follow-up of results and data capture for compliance.
- Refer patients to OBGYN as applicable.

Child and Adolescent Well-Care Visits (WCV)

Description

The percentage of patients 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN provider during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator with one or more well-care visits during the measurement year.

Denominator: Patients 3-21 years of age as of 12/31 of the measurement year.

Codes/Medications for Compliance

Applicable Codes	Well-Care Visit CPT: 99381-99385, 99391-99395, 99461 HCPCS: G0438, G0439, S0302 ICD-10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2
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Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- Replaces W34 measure.

Documentation Requirements

- Well-child visits must occur with a PCP but does not have to be the assigned PCP.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/.

Telehealth

Telehealth can be used for compliance. (Appropriate CPT code needs to be submitted with GT modifier.)



Helpful Tips

- Conduct or schedule well-care visits when patients present for illnesses, or other events – add modifier for separate and distinct services.
- Document all the required elements of a well-child visit.
- Pre-schedule the next well-visit before the patient leaves the office. Relay the importance of returning even if the child is doing fine.
- Provide health education/anticipatory guidance.
- Take an opportunity to check and administer vaccines that are due at every visit.

Childhood Immunization Status (CIS)

Description

The percentage of patients who have received all recommended vaccines by their 2nd birthday.

Numerator/Denominator

Numerator: Patients in the denominator who have had the following vaccines by their 2nd birthday:

- 4 diphtheria/tetanus/acellular pertussis (DTaP) vaccines.
- 3 polio (IPV) vaccines.
- 1 measles/mumps/rubella (MMR)vaccine†
- 3 haemophilus influenza type B (HiB) vaccines.
- 3 hepatitis B (HepB) vaccines.
- 1 chicken pox (VZV) vaccine.†
- 4 pneumococcal conjugate (PCV) vaccines.

†Must occur between the child's 1st and 2nd birthday.

Denominator: Patients turning 2 years of age during the measurement year.

Codes/Medications for Compliance

Applicable Codes	DTaP: CPT: 90698, 90700, 90723 IPV: CPT: 90698, 90713, 90723 MMR: CPT: 90707, 90710 HIB: CPT: 90644, 90647, 90648, 90698, 90748 Hep B: CPT: 90723, 90740, 90744, 90747, 90748; HCPCS: G0010 VZV: CPT: 90710, 90716 Pneumococcal: CPT: 90670; HCPCS: G0009
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients who had a severe combined immunodeficiency, severe disorder of the immune system, HIV, malignant neoplasm of lymphatic tissue, or intussusception on or before their 2nd birthday.

Documentation Requirements

- Collect and document history of immunizations. Documentation must include vaccine name and date administered.
- Children who had a contraindication for a specific vaccine (Ex.: Anaphylactic reaction, immunodeficiency) are excluded.

Telehealth

Telehealth not sufficient to complete immunizations.



Helpful Tips

- Begin vaccination conversations as early as prenatal appointments.
- Present vaccination as the default option, presuming parents and/or guardians will immunize.
- Provide parents and/or guardians with records of their children's immunizations and ask them to bring the record to each visit.
- Schedule the next appointment at time of checkout and use every office visit as an opportunity to vaccinate.
- Use EMR alerts to stay on schedule.

Chlamydia Screening (CHL)

Description

The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the current year.

Numerator/Denominator

Numerator: Patients in the denominator who have had a chlamydia screening in the measurement year.

Denominator: Women 16-24 years of age identified as sexually active.

Codes/Medications for Compliance

Applicable Codes	Chlamydia Culture CPT: 87110, 87270, 87320, 87490-87492, 87810, 87491
Exclusion Codes	All Hospice codes CPT: 81025, 84702, 84703 Diagnostic Radiology
Medications (as applicable)	Contraceptive Medications as indicated in the HEDIS Medications list.

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients who qualified for the denominator based on a pregnancy test alone and who meet either of the following: pregnancy test and a prescription for Isotretinoin, or pregnancy test and an x-ray on the date of pregnancy test or six days after.

Additional Measure Information

- Women are identified as sexually active through claims/encounter and pharmacy data.

Documentation Requirements

- Date of test and results.

Telehealth

Telehealth not sufficient to complete screening; only to review and document history of screenings.



Helpful Tips

- Discuss safe sex practices and sexually transmitted diseases with patients.
- Highlight the importance of early detection.
- Review/confirm all preventive health screenings at each visit.
- Consider universal urine screening approach as a method to help prevent gaps in test and unidentified sexually active women.
- Consider incorporating chlamydia test into normal process when completing a pap test.

Colorectal Cancer Screening (COL)

Description

The percentage of patients 50-75 years of age who have had an appropriate screening for colorectal cancer within required time frame (depends on screening type).

Numerator/Denominator

Numerator: Patients in the denominator with colorectal cancer screening in required time frame (varies by type of screening).

Additional Numerator Specifications:

- Fecal occult blood test (FOBT): current year.
- Flexible sigmoidoscopy: current year or 4 years prior (5 years).
- Colonoscopy: current year or 9 years prior (10 years).
- CT colonography: current year or 4 years prior (5 years).
- FIT-DNA: current year or 2 years prior (3 years).

Denominator: Patients between 50-75 years of age.

Codes/Medications for Compliance

Applicable Codes	Flexible Sigmoidoscopy: CPT: 45330-45335, 45337-45338, 45340-45342, 45346-45347, 45349-45350; HCPCS: G0104; ICD9: 45.24 Colonoscopy: CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 HCPCS: G0105, G0121 ICD9: 45.22, 45.23, 45.25, 45.42, 45.43 CT Colonography: CPT: 74261-74263 FIT-DNA: CPT: 81528; HCPCS: G0464 FOBT: CPT: 82270, 82274; HCPCS: G0328
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Exclusion Criteria:

- Patients with evidence of colorectal cancer or total colectomy.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Test name.
- Date of test (document any time frame the patient can remember, such as month and year).
- Result (if the documentation is part of “medical history” section, results are not required).

Telehealth

Telehealth not sufficient to complete screening.



Helpful Tips

- Ensure that the patient’s history is updated annually regarding prior colorectal cancer screening test(s).
- Discuss all options for screening including FOBT and FIT-DNA for patients as an alternative to colonoscopy.
- Provide order for testing.
- Highlight the importance of early detection.
- Review/confirm all preventive health screenings at each visit.
- Place a reminder in the patient’s chart for when the next screening is due.
- Discuss fears and concerns with patients and remind them of the importance of screening.

Controlling High Blood Pressure (CBP)

Description

The percentage of patients 18-85 years of age diagnosed with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator/Denominator

Numerator: Patients 18-85 years of age in the denominator with a blood pressure reading of <140/90 Hg during the measurement year.

Denominator: Patients 18-85 years of age diagnosed with hypertension at two or more visits between January 1 of the year prior to the measurement year and June 30 of the measurement year.

Codes/Medications for Compliance

Applicable Codes	Diastolic Blood Pressure: CPT II: 3078F, 3079F, 3080F Systolic Blood Pressure: CPT II: 3074F, 3075F, 3077F
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Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- Blood pressure readings that are patient-reported and/or taken with remote digital monitoring device are reportable.

Documentation Requirements

- Utilize the most recent blood pressure (BP) reading during the measurement year, which must be taken on or after second diagnosis of hypertension. Only the last BP reading taken will be counted towards compliance. Systolic reading must be below 140, and diastolic below 90 for compliance. If multiple BP measurements occur on the same date, the lowest systolic and diastolic BP reading will be counted.

Telehealth

Telehealth can be used for compliance.



Helpful Tips

- If blood pressure reading is high when the patient arrives, re-check at the end of the visit.
- If patient is hypertensive during visit, review medication history and consider modifying treatment plan.
- Schedule a follow-up visit once treatment plan has been initiated.
- Record exact systolic and diastolic values; do not round a result.
- Review diet, medications, exercise regimen, and treatment adherence with the patient at each visit.
- Conduct outreach to patients with hypertension who have not had a follow-up appointment.
- Partner with patients to help identify any barriers to effective management. Connect patients with care coordinators or other practice staff for available resources.
- Encourage patients to use the mail order pharmacy service to save on the cost of medications.

Depression Remission or Response for Adolescents and Adults (DRR-E)

Description

The percentage of patients 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score who had evidence of response or remission within 4-8 months of the elevated score.

- Follow-Up PHQ-9. The percentage of patients who have a follow-up PHQ-9 score documented within 4-8 months after the initial elevated PHQ-9 score.
- Depression Remission. The percentage of patients who achieved remission within 4-8 months after the initial elevated PHQ-9 score.
- Depression Response. The percentage of patients who showed response within 4-8 months after the initial elevated PHQ-9 score.

Numerator/Denominator

Numerator 1: A PHQ-9 total score in the patient's record during the Depression Follow-Up Period.

Numerator 2: Patients who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 score of <5 during the Depression Follow-Up Period.

Numerator 3: Patients who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score being at least 50% lower than the PHQ-9 score associated with the episode, documented during the Depression Follow-Up Period.

Denominator: Patients 12 years of age and older as of the start of the Intake Period who meet all the following criteria:

- A diagnosis of major depression or dysthymia that starts before and overlaps or starts when the PHQ-9 total score of >9 is documented during the Intake Period.

Codes/Medications for Compliance

Applicable Codes	CPT 90791; 90792; 90832-90834; 90836-90839, Behavioral Health Encounter, CPT 99366 Depression Case, Management Encounter
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Exclusion Criteria:

- Patients with any of the following at any time during the intake period or during the measurement period.
 - Bipolar disorder, personality disorder, psychotic disorder, pervasive developmental disorder.
 - Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Patients with a documented result of a depression screening performed using an age-appropriate standardized instrument between May 1 of the year prior to the Measurement Period through December 31 of the Measurement Period.
- Depression Follow-Up Period = 120-240-day period after the episode.

Helpful Tips

- Educate patients regarding the warning signs for depression and advise to seek early treatment.
- Screen patients 12 years of age and older for depression using a standardized instrument and document the result.
- Ensure that patients who screen positive receive follow-up care within 30 days of the positive screen.
- Use web-based platform to capture PHQ-9 results while patient is in waiting room.

Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)

Description

The percentage of patients 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- Depression Screening. The percentage of patients who were screened for clinical depression using a standardized instrument.
- Follow-Up on Positive Screen. The percentage of patients who received follow-up care within 30 days of a positive depression screen finding.

Numerator/Denominator

Numerator 1 & 2:

1. Patients with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the Measurement Period.
2. Patients who received follow-up care on or up to 30 days after the date of the first positive screen.

Denominator 1 & 2:

1. Patients 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.
2. All patients from Numerator 1 with a positive depression screen finding between January 1 and December 1 of the Measurement Period.

Codes/Medications for Compliance

Applicable Codes	CPT 90791; 90792; 90832-90834; 90836-90839, Behavioral Health Encounter, CPT 99366 Depression Case, Management Encounter
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Exclusion Criteria:

- Patients with bipolar disorder in the year prior to the measurement period.
- Patients with depression that starts during the year prior to the Measurement Period.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Numerator 1: Patients with a documented result of a depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the Measurement Period.
- Numerator 2: Patients who received follow-up care on or up to 30 days after the date of the first positive screen. Any of the following on or 30 days after the first positive screen: An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. A dispensed antidepressant medication. Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Telehealth

- Telehealth can be used for follow-up visit with a diagnosis of depression or other behavioral health condition.



Helpful Tips

- Educate patients regarding the warning signs for depression and advise to seek early treatment.
- Screen patients 12 years of age and older for depression using a standardized instrument and document the result.
- Ensure that patients who screen positive receive follow-up care within 30 days of the positive screen.
- Use web-based platform to capture PHQ-9 results while patient is in waiting room.

Developmental Screening in First 3 years

Description

The percentage of patients between 1-3 years of age screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their 1st, 2nd, or 3rd birthday.

Numerator/ Denominator

Numerator: Patients between the ages of 1-3 in the measurement year who were screened.

Denominator: All patients who turn 1, 2, or 3 years of age between January 1 and December 31 of the performance period.

Codes/Medications for Compliance

Applicable Codes	CPT: 96110 For more information, please refer to the American Academy of Pediatrics website: www.aap.org
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Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Documentation must include a standardized developmental screening tool. The following must be included in the patient’s medical record: indication of the standardized tool that was used, the date of the screening, and evidence that the tool was completed and scored.

Telehealth

Telehealth can be used for compliance.

Helpful Tips

- Educate parents and/or guardians to monitor for developmental milestones such as: taking a first step, smiling for the first time, waving “bye bye,” crawling, walking, etc.
- Educate parents and/or guardians on risk factors for developmental delays that include preterm birth, low birth weight, lead exposure, long-lasting health problems or conditions.
- Advise parents and/or guardians that developmental screening tools will not provide a diagnosis but can assist in determining if a child is developing according to standard developmental milestones.
- Establish a “screening champion” in your office. This is anyone in your practice you designate to advocate for developmental screening with parents and/or guardians of young children.
- Refer the child to the appropriate specialist based on screening tool outcomes for follow-up and a more formal evaluation. These specialists can determine if a child needs more help with development: developmental pediatrician, child psychologist, speech-language pathologist, occupational therapist.

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Description

The percentage of patients 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who had an HbA1c test and an LDL-C test performed during the measurement year.

Denominator: Patients 18-64 years of age with schizophrenia or schizoaffective disorder and diabetes.

Codes/Medications for Compliance

Applicable Codes	HbA1c Lab Test CPT: 83036, 83037 HbA1c Test Results CPT II: 3044F, 3046F, 3051F, 3052F LDL-C Lab Test CPT: 80061, 83700, 83701, 83704, 83721 LDL-C Test Results CPT II: 3048F-3050F
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Exclusion Criteria:

- Patients who do not have a diagnosis of diabetes or who were diagnosed with gestational diabetes during the measurement year or the year prior.
- Patients receiving hospice or palliative care at any time during the measurement year.
Documentation Requirements
- The patient must have both lab tests to be compliant in measure. Tests may be performed on the same date or different dates within the calendar year.

Telehealth

Telehealth not sufficient for compliance.



Helpful Tips

- Consider drawing blood in the office or writing a lab script at the time the first prescription is written.
- Involve family and other supports to help patient complete blood work.
- Review results of metabolic testing with patients and discuss importance of coordination of care between behavioral health and primary care providers.
- Utilize hospital reporting data to capture patients with inpatient stay who had metabolic testing.
- Inform behavioral health practitioners of patients still missing medical testing for further discussion during behavioral health visit.
- Leverage provider group/networks willing to grant electronic medical records (EMR) access for medical record review.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Description

The percentage of patients 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who had a glucose test or an HbA1c test performed during the measurement year.

Denominator: Patients 18-64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication during the measurement year.

Codes/Medications for Compliance

Applicable Codes	Glucose Lab Test
	CPT: 80047,80048, 80050, 80053, 80069, 82947, 82950, 82951
	HbA1c Lab Test CPT: 83036, 83037
	HbA1c Test Results
	CPT II: 3044F, 3046F, 3051F, 3052F

Exclusion Criteria:

- Patients with diabetes.
- Patients who had no antipsychotic medications dispensed during the measurement year.
- Patients receiving hospice or palliative care at any time during the measurement year.

Telehealth

Telehealth not sufficient for compliance.



Helpful Tips

- Consider drawing blood in the office or writing a lab script at the time the first prescription is written.
- Involve family and other supports to help patient complete blood work.
- Review results of metabolic testing with patients and discuss importance of coordination of care between behavioral health and primary care providers.
- Behavioral health practitioners: order metabolic screening for patients with limited contact with primary care provider.
- Utilize hospital reporting data to capture patients with inpatient stay who had metabolic testing.
- Inform behavioral health practitioners of patients still missing medical testing for further discussion during behavioral health visit.

Eye Exam for Patient with Diabetes (EED)

Description

The percentage of patients ages 18-75 with diabetes (type 1 or 2) who had a retinal eye exam.

Numerator/Denominator

Numerator: Patients in the denominator who had a retinal or dilated eye exam during the measurement year or a negative retinal eye or dilated eye exam (negative for retinopathy) in the measurement year or year prior.

Denominator: Patients between ages 18-75 who have diabetes.

Codes/Medications for Compliance

Applicable Codes	
	Diabetic Retinal Screening: CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213, 99215, 99242-99245 HCPCS: S0620, S0621, S3000
	Eye Exam with Retinopathy: CPT II: 2022F, 2024F, 2026F
	Eye Exam Without Retinopathy: CPT II: 2023F, 2025F, 2033F
	Diabetic Retinal Screening Negative: CPT II: 3072F

Exclusion Criteria:

- Patients who do not have a diagnosis of diabetes.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Documentation must include screening results and date of service.

- Eye exams must be performed by an optometrist or ophthalmologist.
- A bilateral eye enucleation counts for numerator compliance.
- Eye exams read by an artificial intelligence system count for compliance.

Telehealth

Telehealth not sufficient to complete screening. Detailed history of eye exam found in chart can count towards compliance via telehealth. Collect and document history of diabetes care.



Helpful Tips

- Explain the risk of impaired vision caused by diabetes and the importance of retinal eye exams.
- Ensure results are read by optometrist or ophthalmologist.
- Create a diabetes checklist in your electronic medical records (EMR)/ patient chart to monitor if patients are up to date with recommended screenings.
- Patient blindness is not an exclusion for a diabetic eye exam due to difficulties distinguishing “legally blind” individuals who still need an exam from those “completely blind” who don’t.
- Routine eye exams for glasses, glaucoma or cataracts do not meet measure requirements. It must be a retinal/dilated exam.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Description

The percentage of emergency department (ED) visits among patients 13 years of age and older with a principal diagnosis of substance use disorder (SUD) or any diagnosis of drug overdose for which there was follow-up.

Numerator/Denominator

Numerator: Patients in the denominator with a follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days) and 30 days after the ED visit (31 total days).

Denominator: An ED visit with a principal diagnosis of SUD or any diagnosis of drug overdose on or between January 1 and December 1 of the measurement year where the patient was 13 years of age or older on the date of the visit.

Codes/Medications for Compliance

Applicable Codes	Visit with Principal AOD Abuse or Dependence Diagnosis: CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397
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Applicable Codes	<p>HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917</p> <p>OD Weekly Drug Treatment HCPCS: G2067- G2070, G2072, G2073 HCPCS: G2074-G2077, G2080</p> <p>OD Monthly Office-Based Treatment HCPCS: G2086, G2087</p> <p>E-Visit or Virtual Check-In CPT: 98969-98972, 99421-99444, 99458 HCPCS: G2010, G2012, G2061-G2063</p>
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Exclusion Criteria:

- Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Document SUD diagnosis as primary diagnosis in follow-up visit.

Telehealth

Telehealth visit with principal diagnosis of SUD can be used for compliance.

Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days to help prevent emergency department readmission.
- Make sure the alcohol or other drug abuse (AOD) diagnosis is the primary diagnosis in the follow-up visit.
- Contact patient to confirm they attended follow-up visit.
- Increase utilization of telehealth visits for follow-up care appointments.
- Provide educational opportunities to patients and hospitals around importance of follow-up care appointment post-discharge.

Follow-up After Emergency Department Visit for Mental Illness (FUM)

Description

The percentage of emergency department (ED) visits for patients 6 years of age or older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness.

Numerator/Denominator

Numerator: 7-Day Follow-Up: Patients in the denominator with a follow-up visit with any provider, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit.

30-Day Follow-up: Patients in the denominator with a follow-up visit with a follow-up visit with any provider, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit.

Denominator: Patients 6 years of age and older as of the date of an emergency room visit with a principal diagnosis of mental illness or intentional self-harm.

Codes/Medications for Compliance

Applicable Codes	Visit with Principal Mental Health Diagnosis OR with Principal Intentional self- Harm Diagnosis: CPT: 98960-98962, 99078, 99201-99205,99211-99215, 99241-99245,99341-99345, 99347-99350,99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510
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	<p>HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036,H0037, H0039, H0040, H2000, H2010, H2011, H2013- H2020, T1015</p> <p>UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983</p> <p>E-Visit or Virtual Check-In</p> <p>CPT: 98969-98972, 99421-99423, 99444, 99457</p> <p>HCPCS: G0071, G2010, G2012, G2061-G2063</p> <p>Telephone Visits:</p> <p>CPT: 98966-98968, 99441-99443</p>
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Exclusion criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients that had an ED visit that resulted in an inpatient stay or an ED visit followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 30 days after the ED visit.

Documentation Requirements

- Follow-up visit may occur on the date of the ED visit.

Telehealth

Telehealth with principal diagnosis of mental health disorder can be used for compliance.



Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days to help prevent emergency department readmission.
- Provide educational opportunities to patients and hospitals around continuity of care and importance of follow-up post discharge.
- Make sure the mental health diagnosis is the primary focus of follow-up visit.
- Contact patient to confirm they went to follow-up visit.
- Help assist in coordination of care for behavioral health services.
- Increase utilization of telehealth visits when engaging patient with PCP/behavioral health (BH) provider if in-person visit is unavailable within appropriate time frame.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

Description

The percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among patients 13 years of age and older that result in a follow-up visit within 7 or 30 days of substance use disorder.

Numerator/Denominator

Numerator: Patients in the denominator with a follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder.

Denominator: Patients 13 years of age and older as of the date of discharge, stay, or event with an acute inpatient hospitalization, residential treatment, or detoxification visits for a diagnosis of substance use disorder.

Codes/Medications for Compliance

Applicable Codes	<p>Visit with Principal AOD Abuse or Dependence Diagnosis CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99483, 99510</p> <p>HCPCS: G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, S0201, S9480, S9484, S9485, T1006, T1012, T1015</p>
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Applicable Codes	<p>UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983</p> <p>OD Weekly Non Drug Treatment HCPCS: G2071, G2074-G2077, G2080</p> <p>OD Monthly Office-Based Treatment HCPCS: G2086, G2087</p> <p><i>† Additional codes qualify. See NCQA HEDIS specifications for additional information.</i></p>
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Follow-up visit cannot occur on the same day as discharge.

Telehealth

Telehealth visit with principal diagnosis of SUD can be used for compliance.



Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days of discharge to help prevent readmission.
- Make sure substance use is the primary focus of follow-up visit.
- Contact patient to make sure they went to follow-up visit or need additional support in rescheduling.
- Provide educational opportunities for patients around the importance of follow-up care appointments post-discharge.
- Engage health plans to act as the liaison between entities that have limitations around data sharing.

Follow-Up After Hospitalization for Mental Illness (FUH)

Description

The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider.

Numerator/Denominator

Numerator: Patients who have been hospitalized for treatment and discharged who received a follow-up visit with a behavioral health provider within 7 and 30 days.

Denominator: Patients 6 years of age and older as of the date of an inpatient discharge with a principal diagnosis of mental illness or intentional self-harm.

Codes/Medications for Compliance

Applicable Codes	Follow-up Visit with a Mental Health Provider CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, T1015 UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983 Telephone Visit CPT: 98966-98968, 99441-99443 <i>† Additional codes qualify. See NCQA HEDIS specifications for additional information.</i>
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Exclude discharges followed by readmission or direct transfer to nonacute inpatient care setting within 30 days of follow-up period.

Documentation Requirements

- Follow-up visit cannot occur on the same day as discharge.

Telehealth

Telehealth visit with a mental health provider can be used for compliance.



Helpful Tips

- Help patient schedule a follow-up visit with a health care professional within 7 days of discharge to help prevent readmission.
- Contact patient to make sure they went to follow-up visit or if they need additional support in rescheduling.
- Provide educational opportunities for patients around the importance of follow-up care appointments post discharge.
- Engage health plans to act as the liaison between entities that have limitations regarding data sharing.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Description

The percentage of patients 6-12 years of age newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.

Numerator/Denominator

Numerator:

Initiation Phase:

The percentage of patients with a prescription for ADHD medication who had a follow-up visit with a prescribing provider within 30 days.

Continuation and Maintenance Phase: The percentage of patients who remained on the medication for at least 210 days and who had at least two follow-up visits with a provider within 270 days.

Denominator: Patients 6-12 years of age who were dispensed a newly prescribed ADHD medication.

Codes/Medications for Compliance

Applicable Codes	<p>Behavioral Health Outpatient Visit: CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347 -99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99483, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, T1015</p>
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Applicable Codes	<p>UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0904, 0911, 0914-0917, 0919, 0982, 0983</p> <p>Telephone Visit CPT: 98966-98968, 99441-99443 For One of Two Continuation Phase Visits Only:</p> <p>E-Visit or Virtual Check-In CPT: 98969-98972, 99421-99444, 99458 HCPCS: G2010, G2012, G2061-G2063</p> <p><i>† Additional codes qualify. See NCQA HEDIS specifications for additional information.</i></p>
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Exclusion Criteria:

- Patients with a diagnosis of narcolepsy.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Remove patients who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder during the 30 days after the index prescription start date.

Telehealth

- Telehealth can be used for compliance for acute sub-measure.
- Only one of the two visits can be e-visit or virtual check-in (for continuation and maintenance).



Helpful Tips

- Consider limiting the first prescription to a 21- or 30-day supply.
- Schedule follow-up visit at the time the first prescription is written.
- Schedule follow-up visit to occur before refill is authorized.
- Schedule a 30-, 60- and 180-day follow-up visit from initial visit prescribing ADHD medication.
- Proactively outreach to patients who are at risk for non-adherence.

Immunizations for Adolescents (IMA)

Description

The percentage of patients 13 years of age who have had all required immunizations.

Numerator/Denominator

Numerator: Patients in the denominator who had the following vaccines by their 13th birthday:

- 1 Meningococcal conjugate vaccine
- 1 Tdap vaccine
- 2 or 3 HPV vaccines

Denominator: All patients who turn 13 years of age during the measurement year.

Codes/Medications for Compliance

Applicable Codes	Meningococcal Vaccine: CPT: 90734 Tdap Vaccine: CPT: 90715 HPV Vaccine: CPT: 90649, 90650, 90651
Exclusion Codes	Hospice codes: T80.52XA, T80.52XD, T80.52XS G04.32

Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- Optional exclusion criteria: Anaphylactic reaction, encephalopathy.

Documentation Requirements

- Documentation must include vaccine name and date administered.
- For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

Telehealth

Telehealth not sufficient to complete immunizations. Telehealth is sufficient to review and document history of immunizations.



Helpful Tips

- Present vaccination as the default option, presuming parents and/or guardians will immunize.
- Provide parents and/or guardians with records of their children's immunizations and ask them to bring the record to each visit.
- Schedule the next appointment at time of checkout and use every office visit as an opportunity to vaccinate.
- Use automated text message reminders to outreach parents and/or guardians for scheduling reminders.
- Educate parents and/or guardians about HPV and the HPV vaccine.

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Description

The percentage of patients 13 years of age and older as of a new substance use disorder (SUD) episode that resulted in treatment initiation and engagement.

Numerator/Denominator

Numerator:

Initiation of SUD Treatment: The percentage of new SUD episodes that result in treatment initiation within 14 days.

Engagement of SUD Treatment: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Denominator: Patients 13 years of age and older as of the SUD episode date.

Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- SUD Episode: An encounter during the Intake Period with a diagnosis of SUD.

Telehealth

Telehealth visit with diagnosis that matches denominator event diagnosis can be used for compliance.

Codes/Medications for Compliance

Applicable Codes	<p>The following codes count for compliance for a follow-up visit (for Initiation and Engagement):</p> <p>CPT: 98960-98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99483, 99510</p> <p>HCPCS: G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, G0463, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0022, H0031, H0034-H0037, H0039, H0040, H0047, H2000, H2001, H2010-H2020, H2035, H2036, S0201, S9480, S9484, S9485, T1006, T1012, T101</p> <p>UBREV: 0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983</p> <p>E-Visit or Virtual Check-In</p> <p>CPT: 98969-98972, 99421-99444, 99458</p> <p>HCPCS: G2010, G2012, G2061-G2063</p> <p>Telephone Visit</p> <p>CPT: 98966-98968, 99441-99443</p> <p>ODD Weekly Non Drug Treatment</p> <p>HCPCS: G2071, G2074-G2077, G2080</p>
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Helpful Tips

- Consider using a brief standardized screening tool to guide your diagnosis.
- Schedule follow-up visits upon new SUD diagnosis.
- Involve family and community resources in adherence strategies.
- Consider learning more about “stages of change” and “motivational interviewing” to incorporate into patient care.
- Assist patient in scheduling follow-up care visit and provide support if transportation is needed.
- Provide oversight and support cross-functionally between behavioral health, medical, and care coordination as appropriate.

Initiation of Pharmacotherapy Upon New Episode of Opioid Dependence (POD-N)

Description

The percentage of patients 18 years of age and older who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following a diagnosis of opioid dependence.

Numerator/Denominator

Numerator: Patients in the denominator who initiate pharmacotherapy within 30 days of diagnosis.

Denominator: Patients 18 years of age and older who are diagnosed with opioid abuse or dependence.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data and HCPCS J codes to calculate the rates.
Eligible Medications	Naltrexone <ul style="list-style-type: none">• Oral tablet• Injectable Buprenorphine <ul style="list-style-type: none">• Sublingual tablet• Injection• Implant Buprenorphine/naloxone <ul style="list-style-type: none">• Sublingual tablet• Buccal film• Sublingual film

Exclusion Criteria:

- Exclude patients who had an index visit with a diagnosis of opioid abuse or dependence during the 60 days before the IESD (Index Episode Start Date).
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filed through pharmacy discount programs will not result in compliance and patients may pay more for the medication than if they used their prescription drug coverage. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Ensure pharmacotherapy treatment is started upon diagnosis.
- Consider using a brief standardized screening tool to guide your diagnosis.
- Help patients manage stressors and identify triggers for a return to illicit opioid use.
- Submit claims and encounter data in a timely manner.

Kidney Health Evaluation for Patients with Diabetes (KED)

Description

The percentage of patients 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) **and** a urine albumin-creatinine ratio (uACR) during the measurement year.

Numerator/Denominator

Numerator: Patients 18-85 years of age who received both a kidney evaluation and a uACR. uACR includes a urine albumin-test and a urine creatinine test within 4 days apart.

Denominator: Patients 18-85 years of age with diabetes (type 1 and type 2).

Codes/Medications for Compliance

Applicable Codes	eGFR CPT Codes: 8004, 80048, 80050, 80053, 80069, 82565 Quantitative Urine Albumin Lab Test CPT Code: 82043 Urine Creatine Lab Test CPT Code: 82570
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Exclusion Criteria:

- Patients with evidence of ESRD or dialysis any time during the patient’s history on or prior to the measurement year.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Quality data for this measure is collected from claims. Information can also be captured from medical record if detailed test information is in the chart.

Telehealth

Telehealth not sufficient for compliance.



Helpful Tips

- KED is two separate labs; eGFR (estimated glomerular filtration rate lab test value set) **and** uACR identified by **both** a quantitative urine albumin test (quantitative urine albumin lab test value set) **and** a urine creatinine test (urine creatinine lab test value set) **with** service dates four or less days apart.
- If a patient receives medications, it can also be documented as compliant.
- Please be aware that **both** tests (i.e., eGFR and uACR) need to be performed for compliance.
- Ensure that staff are billing correct codes.

Lead Screening in Children (LSC)

Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their 2nd birthday.

Numerator/Denominator

Numerator: Patients in the denominator who had at least one lead capillary or venous blood test on or before the child's 2nd birthday.

Denominator: Patients who turn 2 years old during the measurement year.

Codes/Medications for Compliance

ApplicableCodes	Lead Test CPT: 83655
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Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- A note indicating the date the test was performed.
- The result or finding.

Telehealth

Telehealth not sufficient for compliance.



Helpful Tips

- Educate parents and/or guardians about the risks of lead poisoning and the importance of screening.
- Identify children at higher risk and screen them earlier when appropriate.
- Ask parents and/or guardians about potential risk factors for lead poisoning such as the age of their home, caregiver occupations and hobbies, use of foods and spices, and hand-to-mouth activity.

Medication Adherence Cholesterol

Description

The percentage of Medicare patients with a prescription for a cholesterol medication (a statin drug) 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Patients in the denominator who fill their cholesterol medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare patients with at least two statin cholesterol prescriptions filled (on unique dates of service) during the year.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. Only statin medications qualify.
Eligible Medications	Fluvastatin, Pitavastatin, Rosuvastatin, Pravastatin, Atorvastatin (+/- Amplodipine), Simvastatin (+/- Ezetimibe, Niacin), Lovastatin (+/- Niacin)

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients with end-stage renal disease (ESRD) are excluded from measure.

Documentation Requirements

- Data from this measure comes from prescription drug event (PDE) data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Medication adherence improves when patients fill a 90-day supply of their prescriptions.
- Consider mail order and enroll in auto-refill.
- Pharmacy medication synchronization (coordinating same-day pick-up for all medications).
- Suggest weekly pillbox for patients with time management concerns.
- Prescribe and encourage generic and less expensive formulary brand medications.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.

Medication Adherence Diabetes

Description

The percentage of Medicare patients who are adherent to their diabetes medications at least 80% or more of the time they are supposed to be taking the medication in the measurement period.

Numerator/Denominator

Numerator: Number of patients ages 18 and older with a prescription for diabetes medication who fill their prescriptions 80% or more of the time they are supposed to be taking their medications.

Denominator: Number of patients 18 years and older during the measurement year with at least two fills on different dates of medication(s) across any of the drug classes.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. Only diabetes medications qualify.
Eligible Medications	Biguanides, DPP- 4 inhibitors, Incretin mimetics, Meglitinides, SGLT2 inhibitors, Sulfonylureas, Thiazolidinediones

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients with an ESRD diagnosis or dialysis coverage dates.
- Patients with one of more prescriptions for insulin.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Medication adherence improves when patients fill a 90-day supply of their prescriptions.
- Consider mail order and assist patients to enroll in auto-refill.
- Pharmacy medication synchronization (coordinating same-day pick-up for all medications).
- Suggest weekly pillbox for patients with time management concerns.
- Prescribe and encourage generic and less expensive formulary brand medications.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.
- Refer to a specialist where appropriate.

Medication Adherence Hypertension

Description

The percentage of Medicare patients with a prescription for a blood pressure medication who fill their prescription 80% or more of the time they are supposed to be taking the medication.

Numerator/Denominator

Numerator: Patients in the denominator who fill their hypertension medication at least 80% or more of the time they are supposed to be taking the medication in the year.

Denominator: Medicare patients with a prescription for a blood pressure medication.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. Only RAS antagonists qualify.
Eligible Medications	ACEI/ARB/direct renin inhibitor ACEI/ARB/direct renin inhibitor combination

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients with an ESRD diagnosis or dialysis coverage dates.
- Patients with one or more prescriptions for sacubitril/valsartan.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Medication adherence improves when patients fill a 90-day supply of their prescriptions.
- Consider mail order and assist patients to enroll in auto-refill.
- Pharmacy medication synchronization (coordinating same-day pick-up for all medications).
- Suggest weekly pillbox for patients with time management concerns.
- Prescribe and encourage generic and less expensive formulary brand medications.
- Discuss medication adherence barriers and ask open-ended questions about concerns related to health benefits, side effects, and cost.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Description

The percentage of children 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Numerator/Denominator

Numerator: Patients who received at least one HbA1c and one LDL-C test within the measurement year. Testing can be done on the same, or different days.

Denominator: Patients 1-17 years of age who had two or more antipsychotic prescriptions.

Codes/Medications for Compliance

Applicable Codes	Glucose Lab Test
	CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951
	HbA1c Lab Test CPT: 83036, 83037
	HbA1c Test Result of Finding CPT II: 3044F-3046F
	Cholesterol Lab Test
	CPT: 81564, 83718, 84478
	LDL-C Lab Test
	CPT: 80061, 83700, 83701, 83704, 83721
	LDL-C Test Result or Finding CPT II: 3048F-3050F

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Consider drawing blood in the office or writing a lab script at the time the first prescription is written.
- Involve family and other supports to help patient complete blood work.
- Review results of metabolic testing with patients and discuss importance of coordination of care between behavioral health and primary care providers.
- Behavioral Health Providers: order metabolic screening for patients with limited contact with primary care provider.
- Utilize hospital reporting data to capture patients with inpatient stay who had metabolic testing.
- Inform behavioral health practitioners of patients still missing metabolic testing for further discussion during behavioral health visit.

Osteoporosis Management in Women Who Had a Fracture (OMW)

Description

The percentage of women 67-85 years of age who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the 6 months after the fracture.

Numerator/Denominator

Numerator: Patients in the denominator who had a BMD test or a prescription to treat osteoporosis in the 6 months after the fracture.

Denominator: Women 67-85 years of age as of December 31 of the measurement year with a fracture.

Codes/Medications for Compliance

Applicable Codes	Bone Mineral Density Tests CPT: 76977, 77078, 77080-77081, 77085-77086 Long-Acting Osteoporosis Medications HCPCS: J0897, J1740, J3489 Osteoporosis Medications HCPCS: J0897, J1740, J3110, J3489
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients who had a bone mineral density (BMD) test during the 730 days (24 months) prior to the episode.
- Patients who had a claim/encounter for osteoporosis therapy during the 365 days (12 months) prior to the episode.
- Patients who received a dispensed prescription or had an active prescription to treat osteoporosis during the 12 months prior to the episode.
- Patients who are enrolled in an institutional SNP (I-SNP) any time during the measurement year.
- Patients living long-term in an institution.

Documentation Requirements

- Bone density reports, dated with results, within 24 months before and/or 6 months after fracture.
- Medication list with osteoporosis medication, within 12 months before or 6 months after the fracture.
- Documentation when osteoporosis medication is administered in your office within 12 months before and/or 6 months after the fracture.

Telehealth

- Telehealth can be used for reviewing, documenting, and prescribing medication, when appropriate.



Helpful Tips

- Ask all female patients 67-85 years of age if they've had a fracture since their last visit.
- Consider writing a prescription for osteoporosis medication at time of fracture.
- If patients are unable or unwilling to have a BMD test, prescribe osteoporosis medications if appropriate.
- Place a reminder in the patient's chart for a BMD test.
- Educate patients on safety and fall prevention.
- Encourage providers to be proactive in scheduling BMD as a preventive tool.

Pharmacotherapy Management of COPD Exacerbation (PCE)

Description

The percentage of COPD exacerbations for patients 40 years of age and older who had an acute inpatient discharge or emergency department (ED) encounter on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications. The eligible population for this measure is based on acute inpatient discharges and ED visits, not on patients.

Numerator/Denominator

Numerator: The number of patients with an acute exacerbation related to COPD who were discharged and were dispensed medications following the discharge with appropriate medications. Two rates are reported for the numerator.

- **Rate 1:** Dispensed prescription for systemic corticosteroid on or 14 days after the acute inpatient discharge or ED visit.
- **Rate 2:** Dispensed prescription for a bronchodilator on or 30 days after the acute inpatient discharge or ED visit.

Denominator: Patients 40 years of age or older as of January 1 of the measurement year discharged from an acute inpatient setting or ED visit with a principal diagnosis of COPD, emphysema, or chronic bronchitis.

Note: Patients can be in the denominator multiple times as measure is based on acute inpatient discharges and ED visits.

Codes/Medications for Compliance

Applicable Codes	COPD ICD-10 Codes: J44.0, J44.1, J44.9 Chronic Bronchitis: ICD-10CM: J41.0, J41.1, J41.8, J42 Emphysema COPD: J44.0, J44.1, J44.9 Chronic Bronchitis: J41.0, J41.1, J41.8, J42 Emphysema: J43.0, J43.1, J43.2, J43.8, J43.9 ICD-10 CM Codes: J43.0-J43.2, J43.8, J43.9 Spirometry CPT Codes: 94010, 94014-94016, 94060, 94070, 94375, 94620
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Had ED visits that result in an inpatient stay.

Medications: Systemic Corticosteroids: Glucocorticoids-Betamethasone, Hydrocortisone, Prednisolone, Triamcinolone, Dexamethasone, Methylprednisolone, Prednisone

Bronchodilators: Anticholinergic Agents: Albuterol- ipratropium, Ipratropium, Umeclidinium, Aclidinium-bromide, Tiotropium; Beta 2-Agonists: Albuterol Formoterol, Olodaterol hydrochloride, Arformoterol, Indacaterol, Pirbuterol Budesonide-formoterol, Levalbuterol, Salmeterol, Fluticasone-salmeterol, Mometasone-formoterol, Umeclidinium-vilanterol, Fluticasone-vilanterol, Metaproterenol; Methylxanthines: Aminophylline, Dyphylline, Dyphylline-guaifenesin, Theophylline, Guaifenesin-theophylline



Helpful Tips

- Contact the patient to schedule a follow-up visit 7-14 days after a discharge from the hospital or ED.
- Remind patients to fill prescriptions for corticosteroids and bronchodilators.
- Document patient's medication and their response to it in their medical record or electronic medical record (EMR).
- Coordinate care with patient's cardiologist and pulmonologist.
- Discuss and deliver a written chronic obstructive pulmonary disease (COPD) action plan to the patient to support self-management and medication adherence.

Postpartum Depression Screening and Follow-Up (PDS-E)

Description

This measure assesses the proportion of deliveries in which patients were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.

Numerator/Denominator

Numerator 1 & 2:

1. Deliveries in which patients had a documented result of a depression screening performed using an age-appropriate standardized instrument during 7 to 84 days following the date of delivery.
2. Deliveries in which patients received follow-up care on or up to 30 days after the date of the first positive screen (31 days total).

Denominator 1 & 2:

1. Deliveries during September 8 of the year prior to the Measurement Period through September 7 of the Measurement Period where the patient also meets the criteria for Participation.
2. All deliveries from Numerator 1 with a positive finding for depression during the 7 to 84 days following the date of delivery.

Codes/Medications for Compliance

Applicable Codes	Prenatal Visit CPT: 99201-99205, 99211-99215, 99241-99245, 99483 HCPCS: G0463, T1015 Stand Alone Prenatal Visit CPT: 99500 HCPCS: H1000, H1001, H1002, H1003, H1004 Postpartum Visit CPT: 57170, 58300, 59430, 99501 HCPCS: G0101 ICD 10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2 Telephone Visit CPT: 98966-98968, 99441-99443 E-Visit or Virtual Check-In CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 HCPCS: G2010, G2012, G2061, G2062, G2063
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Deliveries that occurred at less than 37 weeks gestation.
- Deliveries in which patients were in hospice or using hospice services during the measurement period.

Documentation Requirements

- Any of the following on or up to 30 days after the first positive screen:
 - An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
 - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
 - A behavioral health encounter, including assessment, therapy, collaborative care, or medication management.
 - A dispensed antidepressant medication.
 - Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Telehealth

Telehealth can be used to follow up on positive screening for depression.



Helpful Tips

- Late in pregnancy, discuss the symptoms of postpartum depression and reassure that no shame or stigma should be attached to that diagnosis.
- For patients who have recently delivered a baby, screen for depression using a standardized instrument within 7-84 days following the date of delivery and document the result.
- Ensure that patients who screen positive receive follow-up care within 30 days of the positive screen by flagging charts for follow-up.
- Use web-based platform to capture patient health questionnaire (PHQ)-9 results while patient is in waiting room.

Prenatal and Postpartum Care (PPC)

Description

The percentage of women with a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year who received timely prenatal and postpartum care.

Numerator/Denominator

Numerator: Patients in the denominator with live birth deliveries who had the following completed:

1. Timeliness of Prenatal Care: A prenatal care visit in the 1st trimester.
2. Postpartum Care: A postpartum visit on or between 7 and 84 days after delivery.

Denominator: Patients with a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Codes/Medications for Compliance

Applicable Codes	
	Prenatal Visit CPT: 99201-99205, 99211-99215, 99241-99245, 99483 HCPCS: G0463, T1015
	Stand Alone Prenatal Visit CPT: 99500 HCPCS: 1000, H1001, H1002, H1003, H1004
	Postpartum Visit CPT: 57170, 58300, 59430, 99501 HCPCS: G0101ICD 10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2
	Telephone Visit CPT: 98966-98968, 99441-99443
	E-Visit or Virtual Check-In CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458
	HCPCS: G2010, G2012, G2061, G2062, G2063

Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Non-live births.

Documentation Requirements

- Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP.
- Documentation indicating the woman is pregnant or references to the pregnancy: Documentation in a standardized prenatal flow sheet, or documentation of last menstrual period (LMP), estimated date of delivery (EDD) or gestational age, or a positive pregnancy test result, or documentation of gravidity and parity, or documentation of complete obstetrical history, or documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height.
- Evidence that a prenatal care procedure was performed.
- A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Telehealth

Telehealth can be used for compliance.



Helpful Tips

- Use telephone visits, e-visits, and virtual check-ins to close gaps in timeliness of prenatal care.
- Encourage patients to contact the office as soon as they are aware of pregnancy.
- Ensure staff is aware that patients should be seen within the first trimester when scheduling appointments.
- Place a reminder in the patient's chart for when the postpartum visit is due.
- Encourage patients to also schedule a postpartum visit when scheduling the baby's first wellness visit.

Prenatal Depression Screening and Follow-Up (PND-E)

Description

This measure assesses the proportion of deliveries in which patients were screened for clinical depression while pregnant and if screened positive, received follow-up care.

Numerator/Denominator

Numerator 1 & 2:

1. Deliveries in which patients had a documented result of a depression screening performed during pregnancy, using an age-appropriate standardized instrument.
2. Deliveries in which patients received follow-up care on or up to 30 days after the date of the first positive screen (31 days total).

Denominator 1 & 2:

1. Deliveries during the Measurement Period where the patient also meets the criteria for Participation. (28 days prior to the delivery date through the delivery date)
2. All deliveries from Numerator 1 with a positive finding for depression during pregnancy.

Codes/Medications for Compliance

Applicable Codes	<p>Prenatal Visit CPT: 99201-99205, 99211-99215, 99241-99245, 99483</p> <p>HCPCS: G0463, T1015</p> <p>Stand Alone Prenatal Visit CPT: 99500 HCPCS: H1000, H1001, H1002, H1003, H1004</p> <p>Postpartum Visit CPT: 57170, 58300, 59430, 99501 HCPCS: G0101 ICD 10: Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2</p> <p>Telephone Visit CPT: 98966-98968, 99441-99443</p> <p>E-Visit or Virtual Check-In CPT: 98969, 98970, 98971, 98972, 99421, 99422, 99423, 99444, 99458 HCPCS: G2010, G2012, G2061, G2062, G2063</p>
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Exclusion Criteria:

- Deliveries that occurred at less than 37 weeks gestation.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Any of the following on or up to 30 days after the first positive screen:
 - An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
 - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
 - A behavioral health encounter, including assessment, therapy, collaborative care, or medication management.
 - A dispensed antidepressant medication.
 - Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Telehealth

Telehealth can be used to follow up on positive screening for depression.



Helpful Tips

- Screen pregnant patients for depression using a standardized instrument and document the result.
- Ensure that patients who screen positive receive follow-up care within 30 days of the positive screen by flagging charts for follow-up.
- Use web-based platform to capture patient health questionnaire (PHQ)-9 results while patient is in waiting room.

Social Determinants of Health Screening (SDOH)

Description

The percentage of patients 18 years of age and over who were screened for social determinants of health in the measurement year.

Numerator/Denominator

Numerator: Patients in the denominator who were screened for social determinants of health in the measurement year.

Denominator: Patients 18 years of age and older.

Codes/Medications for Compliance

Applicable Codes	Z-Code Categories: Z55, Z56, Z57, Z59, Z60, Z62, Z63, Z64, Z65, Z91 HCPCS code G9919 – Screening performed and positive. HCPCS code G9920 – Screening performed and negative. <ul style="list-style-type: none">• In conjunction with Z Diagnosis Codes
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Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Social determinants of health data can be documented in health assessments, screening tools, EMRs, patient self-reporting, and submitted claims by anyone on the care team.

Telehealth

Telehealth can be utilized to collect and document SDOH.



Helpful Tips

- Link patients to behavioral health and/or other social service providers.
- Discuss/explain intersection between social determinants of health in relation to preventive and chronic disease care.
- Keep track of and monitor social needs expressed by patients that impact treatment adherence and health outcomes.

Statin Therapy for Patients with Cardiovascular Disease (SPC)

Description

The percentage of males 21-75 years of age and females 40-75 years of age during the measurement year have clinical atherosclerotic cardiovascular disease (ASCVD) that have received and remained adherent to at least one high-intensity or moderate-intensity statin during the measurement year.

Numerator/Denominator

Numerator:

1. Patients in the denominator dispensed at least one high-intensity or moderate-intensity statin during the measurement year.
2. Patients in the denominator that remained on a high-intensity or moderate-intensity statin for 80% of the treatment period.

Denominator: Males 21-75 years of age and females 40-75 years of age during the measurement year, identified as having ASCVD.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates. Only moderate- and high-intensity statin medications qualify.
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Eligible Medications	High-Intensity Statin Therapy Atorvastatin 40-80 mg Amlodipine-atorvastatin 40-80 mg Ezetimibe-simvastatin 80 mg Rosuvastatin 20-40 mg, Simvastatin 80 mg Moderate-Intensity Statin Therapy Atorvastatin 10-20 mg Amlodipine-atorvastatin 10-20 mg Ezetimibe-simvastatin 20-40 mg Fluvastatin 40-80 mg Lovastatin 40 mg, Pitavastatin 2-4 mg Pravastatin 40-80 mg Rosuvastatin 5-10 mg, Simvastatin 20-40 mg
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Exclusion Criteria:

Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

Data from this measure comes from prescription drug event data submitted by drug plans to Medicare. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.

Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Discuss with patient why they are on a statin and stress importance of remaining on statin medication to lower blood cholesterol and manage cardiovascular disease.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress.
- Refer to specialist if appropriate.
- Build quality care alerts in your electronic medial record (EMR).
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).

Statin Therapy for Patients with Diabetes (SPD)

Description

The percentage of patients 40-75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) that have received and remained adherent to at least one high-intensity or moderate-intensity statin during the measurement year.

Numerator/Denominator

Numerator:

1. Patients in the denominator dispensed at least one statin during the measurement year.
2. Patients in the denominator that remained on a statin medication for 80% of the treatment period.

Denominator: Patients 40-75 years of age as of December 31 of the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) .

- advanced illness.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Eligible Medications	Atorvastatin 10-80 mg Amlodipine-atorvastatin 10-80 mg Ezetimibe-simvastatin 10-80 mg Fluvastatin 20-80 mg Lovastatin 10-40 mg Rosuvastatin 5-40 mg Pitavastatin 1-4 mg Pravastatin 10-80 mg Simvastatin 5-80 mg

Exclusion Criteria:

- Pregnancy; In vitro fertilization
- Dispensed at least one prescription for clomiphene
- End-stage renal disease (ESRD) or dialysis
- Cirrhosis
- Myalgia, myositis, myopathy, rhabdomyolysis
- Patients receiving hospice or palliative care at any time during the measurement year.
- Patients 66 years of age or older are either enrolled in an institutional special needs plan (I-SNP) or are living long-term in an institution.
- Patients 66 years of age or older with frailty and

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filled through pharmacy discount programs will not result in compliance. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Educate patients with diabetes of their increased risk of cardiovascular disease and the benefits of statin medication.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress.
- Refer to specialist if appropriate.
- Build quality care alerts in your electronic medial record (EMR).
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).
- Document in the medial record patient conditions that exclude them from taking a statin.

Statin Use in Persons with Diabetes (SUPD)

Description

The percentages of patients 40-75 years of age who were dispensed at least two diabetes medication fills who received a statin medication fill during the measurement period.

Numerator/Denominator

Numerator: Patients in the denominator who received a statin medication fill during the measurement period.

Denominator: Patients with diabetes defined as those who have at least two fills of diabetes medications during the measurement year.

Codes/Medications for Compliance

Applicable Codes	EmblemHealth and Affiliates use medication National Drug Codes (NDCs) from pharmacy data to calculate the rates.
Eligible Medications	Atorvastatin 10-80 mg Amlodipine-atorvastatin 10-80 mg Ezetimibe-simvastatin 10-80 mg Fluvastatin 20-80 mg Lovastatin 10-40 mg Rosuvastatin 5-40 mg Pitavastatin 1-4 mg Pravastatin 10-80 mg Simvastatin 5-80 mg

Exclusion Criteria:

- End-stage renal disease (esrd)
- Rhabdomyolysis and myopathy
- Pregnancy, lactation, fertility
- Liver disease
- Pre-diabetes
- Polycystic ovary syndrome
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Compliance can only be achieved through prescription drug event (PDE) data. Claims that are filled through pharmacy discount programs will not result in compliance and patients may pay more for the statin than if they used their prescription drug coverage. Only final action PDE claims are used to calculate this measure.

Telehealth

Telehealth is not sufficient for compliance.



Helpful Tips

- Remind patients to use their ID card at the pharmacy.
- Educate patients with diabetes of their increased risk of cardiovascular disease and the benefits of statin medication to prevent cardiovascular disease.
- Consider prescribing a 90-day supply when appropriate.
- Schedule follow-up visits to check progress.
- Refer to specialist if appropriate.
- Build quality care alerts in your electronic medical record (EMR).
- Identify and resolve patient-specific adherence barriers (cost, refills, side effects).
- Document in the medical record patient conditions that exclude them from taking a statin.

Transitions of Care (TRC)

Description

The percentage of discharges for patients 18 years of age and older who had each of the following:

1. 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).
2. Receipt of discharge information: documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
3. Patient engagement after inpatient discharge: documentation of patient engagement provided within 30 days after discharge.
4. Medication reconciliation post-discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Numerator/Denominator

Numerator: Notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation within 30 days (office visit, telehealth, home visit).

Denominator: Patients 18 years of age and older who had an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year.

Applicable Codes	CPT Codes: 99495, 99496, 99483 CPT II Code: 1111F
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- Care coordination is important when transitioning from the hospital setting back to home to ensure clear understanding of medication changes, diagnostic testing, and follow-up needs.
- Transitional care management visits using CPT codes 99495 or 99496 count as numerator compliance for patient engagement after discharge and medication reconciliation.

Documentation Requirements

- Receipt of inpatient admission documented in medical record within 3 days of admission.
- Receipt of discharge summary documented in medical record within 3 days of discharge.
- Reconcile discharge medications with current medication list within 30 days of discharge.

Telehealth

Telehealth is sufficient for patient engagement after inpatient discharge and medication reconciliation post-discharge sub measure compliance.



Helpful Tips

- Document receipt of inpatient admission notification with a date stamp.
- Ensure patient's discharge information is comprehensive and complete and used to schedule post-discharge appointments.
- Ensure patient has a follow-up visit within 30 days of discharge.
- Review discharge summary, including new medication regimen with patients and caregivers to ensure they understand diagnosis and care plan.
- Contact patient within 3 days of discharge.
- Ensure patient has all medications and is able to take as prescribed.
- Partner with facility to improve care coordination upon discharge.

Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD) (SPR)

Description

The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.

Numerator/Denominator

Numerator: At least one claim/encounter for spirometry during the 730 days (2 years) prior to the index episode start date through 180 days (6 months) after the index episode start date.

Denominator: Patients 40 years of age and older as of January 1 of the measurement year with a new diagnosis of COPD or newly active COPD.

Codes/Medications for Compliance

Applicable Codes	COPD ICD-10 Codes: J44.0, J44.1, J44.9 Chronic Bronchitis ICD-10CM: J41.0, J41.1, J41.8, J42 Emphysema ICD-10 CM Codes: J43.0-J43.2, J43.8, J43.9 Spirometry CPT Codes: 94010, 94014-94016, 94060, 94070, 94375, 94620
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Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- Document the date of spirometry testing and clear the spirometry results.
- Documented a spirometry test results confirming the COPD diagnosis during the previous two years or six months after the on-set of the episode.



Helpful Tips

- Proper diagnosis is essential to ensure patients receive appropriate short- and long-term treatment. Symptomatic and asymptomatic patients suspected to have COPD should have spirometry testing to document airway limitation and severity.
- Educate newly-diagnosed COPD patients about the importance of spirometry testing.
- Submit timely claims for spirometry testing performed in your office.
- Consider pre-visit chart review and planning to help manage patients' chronic conditions.

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)

Description

The percentage of patients 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

The Measurement Period is divided into three assessment periods with specific dates of service:

- **Assessment Period 1:** January 1–April 30.
- **Assessment Period 2:** May 1–August 31.
- **Assessment Period 3:** September 1–December 31.

Numerator/Denominator

Numerator 1: A PHQ-9 score in the patient’s record during Assessment Period 1.

Numerator 2: A PHQ-9 score in the patient’s record during Assessment Period 2.

Numerator 3: A PHQ-9 score in the patient’s record during Assessment Period 3.

Denominator: Patients 12 years of age and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter that starts during Assessment with a diagnosis of major depression or dysthymia.

Codes/Medications for Compliance

Applicable Codes	CPT 90791; 90792; 90832-90834; 90836-90839, Behavioral Health Encounter, CPT 99366 Depression Case, Management Encounter
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Exclusion Criteria:

- Bipolar disorder, Personality disorder, Psychotic disorder, Pervasive developmental disorder, in hospice or using hospice services.
- Patients receiving hospice or palliative care at any time during the measurement year.

Documentation Requirements

- A bi-directional communication that is face-to-face, phone-based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.

Telehealth

Telehealth can be used for compliance.



Helpful Tips

- Educate patients regarding the warning signs for depression and advise to seek early treatment.
- Ensure that patients, 12 years of age and older with a diagnosis of major depression or dysthymia, are seen for an interactive outpatient visit at a minimum of every 4 months.
- Use web-based platform to capture patient health questionnaire (PHQ)-9 results while patient is in waiting room.

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

Description

The percentage of patients ages 3-17 who had an outpatient visit with a primary care provider (PCP) or OB/GYN, and who had evidence of the following in the measurement year: body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity.

Numerator/Denominator

Numerator: Patients 3-17 years of age who had an outpatient visit with a PCP or OBGYN and had evidence of the following during the measurement year: BMI percentile documentation, counseling for nutrition, and counseling for physical activity.

Denominator: Patients who turn 3-17 years of age in the measurement year and had an outpatient visit with a PCP or OBGYN in the measurement year.

Codes/Medications for Compliance

Applicable Codes	BMI Percentile: ICD10CM: Z68.51-Z68.54 Counseling for Nutrition: CPT: 97802-97804 HCPCS: G0270, G0271, S9449, S9452, S9470 ICD10CM: Z71.3 Counseling for physical activity: HCPCS: S9451, G0447 ICD10CM: Z02.5
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Exclusion Criteria:

- Patients receiving hospice or palliative care at any time during the measurement year.
- Female patients who have a diagnosis of pregnancy during the current year.

Documentation Requirements

- BMI percentile documentation must indicate the height, weight, and BMI percentile, dated during the current or prior year. BMI percentile must include BMI percentile documented as a value (e.g., 85th percentile) or BMI percentile plotted on an age-growth chart.
- Nutritional counseling documentation must include a note indicating the date and at least one of the following: discussion of current nutrition behaviors, checklist indicating nutrition was addressed, counseling or referral for nutrition education, dissemination of educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition.
- Physical activity counseling must include a note indicating the date and at least one of the following: discussion of current physical activity behaviors, checklist indicating physical activity was addressed, counseling or referral for physical activity, dissemination of educational materials on physical activity during a face-to-face visit, anticipatory guidance for physical activity, weight or obesity counseling.

Telehealth

Telehealth can be used to deliver nutrition counseling and weight counseling services.



Helpful Tips

- Contact parents and/or guardians of patients to schedule their visits at least once a year.
- Use sick visits and sports physicals to complete this measure. Include and document all three measure components during a sick visit for a compliant WCC record.
- When counseling for nutrition, discuss proper food intake, healthy eating habits, eating disorders, and issues such as body image.

Well-Child Visits in the First 30 Months of Life (W30)

Description

The percentage of patients who had the following number of well-child visits during the last 15 months:

- **Rate 1:** Well-child visits in the first 15 months during the measurement year: 6 or more well-child visits.
- **Rate 2:** Well-child visits for age 15 months-30 months during the measurement year: 2 or more well-child visits.

Numerator/Denominator (2 sub measures)

Rate 1

Numerator:

Children who turned 15 months old during the measurement year with 6 or more well-child visits on different dates of service.

Denominator:

Patients who turned 15 months old during the measurement year.

Rate 2

Numerator: Patients who turned 30 months old during the measurement year with 2 or more well-child visits on different dates of service.

Denominator: Patients who turned 30 months old during the measurement year.

Codes/Medications for Compliance

Applicable Codes	Well-Care Visit CPT: 99381-99385, 99391-99395, 99461 HCPCS: G0438, G0439, S0302 ICD10: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2
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Exclusion Criteria: Patients receiving hospice or palliative care at any time during the measurement year.

Additional Measure Information

- Replaces W15 measure.

Documentation Requirements

- Well-child visits must occur with a primary care provider (PCP) but does not have to be the PCP assigned.
- This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx)

Telehealth

- Telehealth can be used for compliance. (Appropriate CPT code needs to be submitted with GT modifier.)



Helpful Tips

- Document all the required elements of a well-child visit.
- Pre-schedule the next well visit before the patient leaves the office. Relay the importance of returning even if the child is doing fine.
- Provide health education/anticipatory guidance.
- Take an opportunity to check and administer vaccines that are due at every visit.