**PCMH-Kids, RI Care Transformation Collaborative (CTC)**

**Pediatric Clinical Quality Measures (CQM) Strategy Checklist** (v1.17)

(Based on CTC/OHIC document: “December 2018 CTC/OHIC Measure Specifications”)

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Healthcentric Advisors, together with CTC, has developed this checklist to assist practices in achievement of clinical quality measure (CQM) reporting for CTC. This is not an exhaustive plan, but rather a guide to help navigate the requirements. Use this checklist as supplement to: “December 2018 CTC/OHIC Measure Specifications".

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| **Practice Name:** |  |
| **Reviewed Check list with name/s):** |  **Date(s) Reviewed:** |
| **Practice Facilitator(s):** | Putney Pyles (ppyles@healthcentricadvisors.org), Vicki Crowningshield (vcrowningshield@healthcentricadvisors.org), Suzanne Herzberg (Suzanne\_Herzberg@brown.edu), Jayne Daylor (sdaylor@cox.net) |
| **Current NCQA Level / Expiration:**  |  **EHR Vendor/ Version:** |
|  | **Important Steps** | **Notes/ Planning / Timeline** |
| [ ]  | **Define roles, responsibilities and processes for**:* Practice to check with System of Care/ACO to determine what support will be provided to practice (ex. NCQA support)
* Attend Practice Reporting & Transformation Meetings to stay current on project expectations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Develop and generate EHR reports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Report to CTC quarterly on quality measures and high-risk patient engagement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Disseminate results within practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Use results to drive quality improvement activities within practice
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| [ ]  | **Understand measure definitions:*** Review Measures
* Examine EHR reporting capabilities/ or pursue external vendor
* Identify and address any problems with EHR reporting capabilities
* Develop reports – run test reports and examine for accuracy
* First time submission: generate reports prior to 1st reporting deadline; meet with practice facilitator to discuss how report was generated to insure correct application of measurement specifications
* Following quarterly data submission to CTC, review performance with practice facilitator to compare against defined benchmarks for each measure and identify areas for improvement (examples: does a workflow need to be changed, is documentation happening consistently and correctly). Strategize on methods for improvement – PDSA, re-education of staff, etc.
 | Any questions about quality measure specifications, please contact your practice facilitator.January 15, 2020 is first reporting deadline for practices in Cohort 3. Recommendation is to run test report on all measures in November 2019 to review results -> opportunity to identify gaps in data, run exception reports, as needed, based on what results demonstrate. |
| [ ]  | **Reporting Requirements*** Submit data on quality measures and high risk patient engagement for each quarter. Due dates: January 15th, April 15th, July 15th, October 15th
* Submit performance data and quality improvement data to OHIC via their portal ([www.ohic.ri.gov](http://www.ohic.ri.gov)) by October 15th annually. **Note:** OHIC will require that practices submit a base line report starting Oct 15, 2019. Practices will want to generate initial reports on PCMH Measurement requirements in September 2019
 | For questions regarding data submission to CTC, please reach out to your practice facilitator or Carolyn Karner: ckarner@ctc-ri.orgFor questions regarding data submission to OHIC, please reach out to your practice facilitator.  |
| [ ]  | **Timeline for required Quarterly Submission of quality measures:** *(use rolling quarters)*Due 1/15/2020; Q4 2019 (data from 10/1/2019 ending 12/31/19)Due 4/15/2020; Q1 2020 (data from 1/1/2020 ending 3/31/20)Due 7/15/2020; Q2 2020 (data from 4/1/20 ending 6/30/20)Due 10/15/2020; Q3 2020 (data from 6/1/20 ending 9/30/20)Due 1/15/2021; Q4 2020 (data from 10/1/20 ending 12/31/20)Due 4/15/2021; Q1 2021 (data from 1/1/21 ending 3/31/21)Due 7/15/2021; Q2 2021 (data from 4/1/21 ending 6/30/21)Due 10/15/2021; Q3 2021 (data from 6/1/21 ending 9/30/21)Due 1/15/2022; Q4 2021 (data from 10/1/21 ending 12/31/21)Due 4/15/2022; Q1 2022 (data from 1/1/22 ending 3/31/22)Due 7/15/2022; Q2 2022 (data from 4/1/22 ending 6/30/22) | \*Practices need to formally ask for an extension if not able to report data; such an extension MUST be APPROVED by CTC. Please contact the following people in the event of such a request: Andrea Galgay (Practice Reporting): agalgay@ripcpc.comPatty Kelly-Flis (Practice Reporting): pkelly-flis@welloneri.org |
| **PCMH-Kids Clinical Quality Measures (CQMs)** |
| Note: These measure definitions are based on the NQF and/or HEDIS measure definitions but are not exactly the same as the quality measures required for Meaningful Use. EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the EHR report may result in duplication of patients.  |
| **Measure**  | **Helpful Tips**  | **Notes/ Planning / Timeline** **Where Captured in EHR?** |
| [ ]   | **Active Patient criteria –** same definition for ALL measures – refer to *December 2018 CTC/OHIC Measure Specification* document (Spec Doc.) for additional detailsPatient seen by a primary care clinician of the PCMH anytime within the last 24 months. (outpatient visit) | **Helpful Tip:**  Important to “clean” up your data and ensure that you are reporting on your active patients. Be sure to review your lists regularly with your providers (annotate properly who is deceased, or transferred out according to the active patient definition). This will yield more accurate results with your quality data.Refer to pg. 1 of *December 2018 CTC/OHIC Measure Specifications* document for: CPT office visit codes, acceptable exclusions, outpatient visit criteria and encounter types.  |  |
| [ ]  | **Well-Child Counseling: Weight Assessment and Counseling for Nutrition and Physical Activity – Ages 3-17 (HEDIS)****Contract Measure*** BMI % documentation
* Counseling for nutrition, **AND**
* Counseling for physical activity
* Look Back Period: 12 months
* Targets:

Baseline (Year 1): First report due January 15, 2020Target for PY 1 (Year 2) will be set based on Q1 2021 reportingTarget for PY 2 (Year 3) will be set based on Q1 2022 reporting  | **Helpful Tips:** Numerator:BMI percentile documentation must include height, weight and BMI % from the same data source.Counseling for nutrition must include documentation of counseling or referral for nutrition education during measurement year. Counseling for physical activity must include documentation of counseling or referral for physical activity during measurement year.Denominator: All patients 3-17 at end of measurement year with documented encounter during measurement year | Reporting guidance: credit for this measure is given when both BMI and evidence of counseling (for physical activity and nutrition) are documented in the EHR.In some EHRs, the WCC templates have been built to include language pertaining to nutrition and physical activity counseling, and in some EHRs, documentation is added to the template during or after the visit. Please talk with your facilitator if you have questions regarding documentation for this measure.  |
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| [ ]   | **Developmental Screening in the First Three Years of Life – Ages 0-3 (Oregon Pediatric Improvement Partnership at Oregon Health and Science University)****Contract Measure*** Children ages 0-3 screened at well visits for risk of developmental, behavioral and social delays using standardized tool
* Recommended screening ages: 9, 18 and 24 or 30 months
* Look Back Period: Screenings must be completed prior to the patient’s birthdate. In order to account for patients with birthdates at the beginning of the measurement year, reports should account for these encounters accordingly and place a lookback period on the patient’s DOB rather than the measurement period. In order to account for age appropriate screenings, this look back should not exceed a 6-month lookback from the DOB in order to avoid erroneously counting developmental screenings used for prior years of age.
* Targets:

Baseline (Year 1): First report due January 15, 2020Target for PY 1 (Year 2) will be set based on Q1 2021 reportingTarget for PY 2 (Year 3) will be set based on Q1 2022 reporting  | **Helpful Tips:** Documentation required to meet measure: Note indicating date of screening, the tool used and evidence of screening result or score. Acceptable evidence-based tools: Ages and Stages Questionnaire (ASQ) - 2mos-5yrs, Ages and Stages Questionnaire – 3rd Edition (ASQ-3), Battelle Developmental Inventory Screening (BDI-ST) – Birth-95mos, Bayley Infant Neuro-developmental Screen (BINS) – 3mos-2yrs, Brigance Screens-II – Birth-90mos, Child Development Inventory (CDI) – 18mos-6yrs, Parents’ Evaluation of Development Status (PEDS) – Birth-8yrs, Parents’ Evaluation of Developmental Status – Developmental Milestones (PEDS-DM), Survey of Wellbeing of Young ChildrenNumerator: All active patients who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthdayDenominator: Sum of all active patients seen by PCP in previous 12 months who turned 1, 2 or 3 during measurement year |  |
| [ ]   | **Adolescent Well Care Visit – ages 12-21 (HEDIS)****Contract Measure*** The percentage of active patients 12-21 with a documented well visit during measurement year
* Look back Period: 12 months
* Targets:

Baseline (Year 1): First report due January 15, 2020Target for PY 1 (Year 2) will be set based on Q1 2021 reportingTarget for PY 2 (Year 3) will be set based on Q1 2022 reporting  | **Helpful Tips:** Numerator: All active patients 12-21 at end of measurement year with a note indicating a visit to a PCP or OBGYN, the date of the well visit and evidence of all of the following: health and development history (physical and mental), a physical exam, health education/anticipatory guidanceDenominator: All active patients 12-21 years of age at the end of the measurement yearCodes to identify Adolescent Well-Care Visits: CPT: 99383-99385; 99393-99395 ICD-10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9  |  |