2022 OHIC PCMH Quality Measures and Integrated Behavioral Health Reporting

This document is intended only to allow practices to prepare their submission for the PCMH Quality Measures and Integrated Behavioral Health Reporting survey. To complete this survey, please fill out the online survey, or contact Cory King at OHIC (Cory.King@ohic.ri.gov) for an Excel template to use in lieu of the online survey.

Practices required to submit data:

- All practices are required to indicate their Accountable Care Organization or Accountable Entity (ACO/AE) affiliation and answer the Behavioral Health Integration survey questions. Starting in 2022 only practices not affiliated with an ACO/AE are required to complete the PCMH Quality Measures and Practice Transformation components of the survey.

General Instructions:

- In 2022, OHIC has make the following changes to this survey: (1) edited to reflect that only practices not affiliated with an ACO/AE are required to complete the Quality Measures component of the survey, (2) updated to indicate that *Colorectal Cancer Screening* will be a reporting-only measure in 2022 due to significant specification changes in measurement year (MY) 2022, (3) updated to indicate that *Controlling High Blood Pressure* is transitioning back to a performance-based measure in 2022 and (4) updated measure specifications and dates to align with the national versions of these specifications.
- Practices not affiliated with an ACO/AE should submit quality measure data for the October 1, 2021 – September 30, 2022 performance period. Practices should only submit data for an alternate performance period if they are unable to pull data for the desired period.
- If practices are submitting data through the online survey, they will be sent a PDF of their submission after completing the survey. Practices will be unable to save partially complete surveys, so practices should gather all of the needed data before entering their survey response.
- Practices should complete the online survey if they are entering data for five practice sites or less. If practices are entering in information for more than five practices, they can either:
    - Fill out the survey as many times as needed in order to enter in information for all practice sites (e.g., a seven-site practice can fill out the survey twice and include data for five sites the first time and two sites the second time), or
    - Contact Cory King for an Excel template to use in lieu of the online survey.
- As a reminder, practices can use telehealth encounters when reporting data for the PCMH Measure Set:
    - ***Practices can apply telehealth encounters for numerator compliance or for identifying patient populations (denominator compliance), even if the***

specification says otherwise, when reporting data for the PCMH Measure Set for the 10/1/2021 – 9/30/2022 measurement period. Practices, however, are not required to include telehealth encounters when reporting data.

- ***Please note that for 2022, OHIC it maintaining the 2021 methodology for assessing practice performance against the PCMH Measure Set due to the anticipated ongoing impact of COVID-19 on quality measure performance.*** Practices must meet a high-performance benchmark (which has been adjusted to account for COVID-19) or demonstrate improvement over the October 1, 2020 - September 30, 2021 performance period (there is no three-percentage point improvement threshold for 2022). For more information, visit OHIC's PCMH web page.

Practice Site Information:

- Please fill out your contact information.
  - First Name
  - Last Name
  - Title
  - Email Address
  - Phone Number
- Please fill out the contact information for the practice site. If your practice site was a CTC-RI participant, please use the same site name as employed in your CTC-RI data submissions.
  - Name of Practice Site
  - Street Address
  - City
  - State
  - Zip
  - Site Contact Person's Name
  - Site Contact Person's Email Address
  - Phone Number
  - Fax Number
- Did this practice site respond to the OHIC 2021 PCMH Measures Survey? *You will be prompted to enter the practice site's OHIC PCMH ID Number if the practice site did respond to the OHIC 2021 PCMH Measures Survey. Otherwise, OHIC will assign this practice site with an OHIC PCMH ID Number after reviewing the results of the 2022 PCMH Measures Survey.*
  - Yes
  - No
  - [*If yes*] What is the OHIC PCMH ID Number for this practice site? *A practice site has an OHIC PCMH ID Number if it has previously responded to the OHIC 2021 PCMH Measures Survey. See the bottom of this web page for more information: http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php.*
- For what health plans is your practice site a contracted provider (*check all that are applicable*)?
  - Blue Cross Blue Shield of Rhode Island
  - Neighborhood Health Plan of Rhode Island

    - Tufts Health Plan
    - UnitedHealthcare
- With which ACO/AE is this practice site affiliated? (**Note:** All practices are required to answer the Integrated Behavioral Health Reporting questions in this survey, but only practices not affiliated with an ACO/AE are required to complete the PCMH Quality Measures and Practice Transformation components of this survey)
    - Blackstone Valley Community Health Center
    - Coastal Medical
    - Integra Community Care Network
    - Integrated Healthcare Partners
    - Lifespan
    - Providence Community Health Centers
    - Prospect CharterCARE
    - Thundermist Health Center
    - Not affiliated with an ACO/AE
- What is the Tax Identification Number (TIN) for this practice site?
- What are the NPI numbers for all clinicians at this site managing a patient panel (*list each MD's, NP's, PA's*)?
- Which of the below specialties best indicates the primary care specialty(ies) of this practice site?
    - Internal Medicine, Family Practice, or General Practice
    - Pediatric Practice
    - Both
- Are more than 50% of your practice site's patients covered by Medicaid or uninsured?
    - Yes
    - No
- Is your practice site currently recognized as a PCMH by NCQA?
    - Yes
    - No
- *If no*, did your practice participate in CTC-RI's PCMH transformation program through June 2020 or CTC RI's PCMH-Kids through June 2022 to support PCMH recognition or another formal transformation initiative?
    - Yes
    - No
- Date Survey Completed

Behavioral Health Integration

Please answer the following questions about what your practice site is doing to integrate behavioral health and to capture depression screening and follow-up electronically.

- Has the practice received the NCQA Behavioral Health Distinction, or is the practice receiving facilitated assistance from a formal program designed to assist primary care practices in achieving the NCQA Behavioral Health Distinction?[1]
    - Yes
    - No
- Does the practice currently, or did the practice participate in and successfully complete the CTC Integration Behavioral Health Program?
    - Yes
    - No
- If you answered "no" to the previous two questions, has the practice completed a behavioral health integration self-assessment tool AND developed an action plan for improving its level of integration? Self-assessment tools include, but are not limited to: Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration, the PCBH Implementation Kit, and the Maine Health Access Foundation Site Self-Assessment.
    - Yes
    - No
- Does the integrated behavioral health practice site have a different name than the reporting practice sites?
    - Yes
    - No
- [*If yes*] What is the name of the integrated behavioral health practice site?
- [*If yes*] What is the TIN of the integrated behavioral health practice site?

[1] Definition of "Formal program:" A formal program consists of a structured training or support program for primary care providers and/or behavioral health providers with a pre-defined curriculum and technical assistance and designed to systematically build the skills within the practice with a goal of pursuing and attaining NCQA Behavioral Health Distinction.

Adult Measures

Colorectal Cancer Screening[2]

Updates to Measure Specifications:	• Updated Value Set references to align with the HEDIS MY 2022 Value Set Dictionary. • Clarified that patients in hospice are a required exclusion. • Revised age range from 50-75 years of age to 45-75 years of age • Changed references of "FIT-DNA test" to "stool DNA (sDNA) with FIT test" in the numerator.
Description:	The percentage of active patients 45 to 75 years of age who had an appropriate screening for colorectal cancer.
Age Criteria:	Eligible population is determined as patients 46 to 75 years of age at the end of the measurement period. (Description states 45 since someone could be 45 throughout the measurement year and not turn 46 until the last day of the measurement period).
Numerator Statement:	Active patients 46 to 75 at the end of the measurement period who received an acceptable colorectal screening during the identified lookback period (See below).
Denominator Statement:	Active patients 46-75 at the end of the measurement period.
Required Exclusions:	Exclude patients who meet any of the following criteria anytime during the measurement year: • Patients in hospice • Patients receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set)
Acceptable Exclusions:	Either of the following at any time in the patient's history through the end of the measurement period: • Colorectal cancer (Colorectal Cancer Value Set) • Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set) • Patients 66 to 75 as of December 31st of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) AND advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (this

[2] Due to the significant specification changes for MY 2022, *Colorectal Cancer Screening* will be a reporting-only measure for 2022.

	exclusion is much more feasible for a health plan to apply than a practice) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify nonacute inpatient discharges: ▪ Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ▪ Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). ▪ Identify the discharge date for the stay. o At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) o At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim o A dispensed dementia medication (Dementia Medications List)
Look Back Period:	Varies based on test performed: • Fecal occult blood test during the measurement year (FOBT Value Set) • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year (Flexible Sigmoidoscopy Value Set) • Colonoscopy during the measurement year or the nine years prior to the measurement year (Colonoscopy Value Set) • CT colonography during the measurement year or the four years prior to the measurement year (CT Colonography Value Set) • Stool DNA (sDNA) with FIT test during measurement year or the two years prior to the measurement year
Medical Record Documentation:	If a copy of the actual procedure/test/lab result is not present, documentation in the medical record must include a note indicating the date when the colorectal screening was performed. A result is not required if the documentation is clearly part of the "medical history" section of the record. If that is not clear, the result finding must be present (this ensures the screening was performed and not merely ordered). A pathology report that indicates the type of screening meets the criteria and the date when the screening was performed meets criteria. For pathology reports that do not indicate the type of screening and for incomplete procedures: • Evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.

	• Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy. There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (FIT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine patient compliance. • If the medical record does not indicate the type of test and there is no indication of how many samples were returned, assume the required number was returned. The patient meets the screening criteria for inclusion in the numerator. • If the medical record does not indicate the type of test and the number of returned samples is specified, the patient meets the screening criteria only if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the patient does not meet the screening criteria for inclusion. • FIT tests may require fewer than three samples. If the medical record indicates that an FIT was done, the patient meets the screening criteria, regardless of how many samples were returned. • If the medical record indicates that a gFOBT was done, follow the scenarios below. – If the medical record does not indicate the number of returned samples, assume the required number was returned. The patient meets the screening criteria for inclusion in the numerator. – If the medical record indicates that three or more samples were returned, the patient meets the screening criteria for inclusion in the numerator. – If the medical record indicates that fewer than three samples were returned, the patient does not meet the screening criteria. Do not count digital rectal exams (DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE.
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Colorectal Cancer Screening."
    - October 1, 2021 – September 30, 2022
    - Other (Please Specify)
- Enter the numerator for "Colorectal Cancer Screening."
- Enter the denominator for "Colorectal Cancer Screening."

Eye Exam for Patients with Diabetes

Updates to Measure Specifications:	• Revised measure title from "Comprehensive Diabetes Eye Care: Eye Exam" to "Eye Exam for Patients with Diabetes". • Updated Value Set references to align with the HEDIS MY 2022 Value Set Dictionary. • Clarified that patients in hospice are a required exclusion. Revised optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions. • **Updated the example Age Criteria to align with the OHIC PCMH Measure performance period.**
Description:	The percentage of active diabetic patients (type 1 and type 2) between 18 and 75 years of age who had a retinal eye exam.
Age Criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2022 Patient age between 18 as of 12/31/2022 to 75 as of 12/31/2022
Numerator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period who had any of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year • Bilateral eye enucleation anytime during the patient's history through the end of the measurement year Please note, documentation in the chart must include one of the following: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results. • A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist OR by a system that provides an artificial intelligence interpretation. • Evidence that the patient had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the patient's history through end of the measurement year.

	• Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (e.g. documentation of normal findings).
Denominator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior. Patients with diabetes are identified in the following ways: 1. Encounter-based: Patients who met any of the following criteria during the measurement year or the year prior to the measurement year: a. At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) WITHOUT telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) b. At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim 2. At least two outpatient visits (Outpatient Value Set,), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) WITHOUT telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) or nonacute inpatient discharges on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior (Diabetes Medications List). Note that Glucophage/metformin as a solo agent is NOT included because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
Required Exclusions:	Exclude patients who meet any of the following criteria anytime during the measurement year: 1. Patients who do not have a diagnosis of diabetes (Diabetes Value Set) in any setting during the measurement year or year prior AND who had a diagnosis included in the Diabetes Exclusions Value Set during the measurement year or year prior. (Historically, these exclusions were limited to gestational and steroid induced diabetes, but the exclusion value set includes additional conditions focused heavily on diabetes caused by an underlying condition). 2. Patients receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

	3. Patients in hospice
Acceptable Exclusions:	1. Patients 66 to 75 as of December 31st of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) AND advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (this exclusion is much more feasible for a health plan to apply than a practice) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify nonacute inpatient discharges: i. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ii. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). iii. Identify the discharge date for the stay. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim d. A dispensed dementia medication (Dementia Medications List)
Look Back Period:	24 months, if negative retinopathy, 12 if positive or unknown
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Comprehensive Diabetes Care – Eye Exam."
    - October 1, 2021 – September 30, 2022
    - Other (Please Specify)
- Enter the numerator for "Comprehensive Diabetes Care – Eye Exam."
- Enter the denominator for "Comprehensive Diabetes Care – Eye Exam."

HbA1c Control for Patients with Diabetes (<8)

Updates to Measure Specifications:	• Updated Value Set references to align with the HEDIS MY 2022 Value Set Dictionary. • Revised measure title from "Comprehensive Diabetes Eye Care: HbA1c Control (<8)" to "HbA1c Control for Patients with Diabetes (<8)". • Clarified that patients in hospice are a required exclusion. • Revised optional exclusions for polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes to be required exclusions.
Description:	The percentage of active diabetic patients (type 1 and type 2) between 18 and 75 years of age whose most recent HbA1c value was less than 8
Age Criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2021 Patient age between 18 as of 12/31/2021 to 75 as of 12/31/2021
Numerator Statement:	Active diabetic patients (type 1 and type 2) between 18 and 75 years of age at the end of the measurement period whose most recent HbA1C value in the measurement year was less than 8
Denominator Statement:	Active patients with diabetes (type 1 and type 2) between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior. Patients with diabetes are identified in the following ways: 1. Encounter-based: Patients who met any of the following criteria during the measurement year or the year prior to the measurement year: a. At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) WITHOUT telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) b. At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim 2. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) WITHOUT telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) or nonacute inpatient discharges on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior

	(Diabetes Medications List). Note that Glucophage/metformin as a solo agent is NOT included because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
Required Exclusions:	1. Patients receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. 2. Patients who do not have a diagnosis of diabetes (Diabetes Value Set) in any setting during the measurement year or year prior AND who had a diagnosis included in the Diabetes Exclusions Value Set during the measurement year or year prior. (Historically, these exclusions were limited to gestational and steroid induced diabetes, but the exclusion value set includes additional conditions focused heavily on diabetes caused by an underlying condition). 3. Patients in hospice.
Acceptable Exclusions:	4. Patients 66 and older as of December 31st of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) AND advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (this exclusion is much more feasible for a health plan to apply than a practice) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify nonacute inpatient discharges: i. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ii. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). iii. Identify the discharge date for the stay. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim d. A dispensed dementia medication (Dementia Medications List)

Diabetics without A1C Documented:	If no A1c reading was rendered during the measurement year, patient counts as non-adherent.
Look Back Period:	12 months
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Comprehensive Diabetes Care – HbA1c Control (<8)."
    - October 1, 2021 – September 30, 2022
    - Other (Please Specify)
- Enter the numerator for "Comprehensive Diabetes Care – HbA1c Control (<8)."
- Enter the denominator for "Comprehensive Diabetes Care – HbA1c Control (<8)."

Controlling High Blood Pressure[3]

Updates to Measure Specifications:	• Updated Value Set references to align with the HEDIS MY 2022 Value Set Dictionary. • Clarified that hospice patients are a required exclusion. • Clarifications to the numerator of the Hybrid Specifications: BP readings taken by the patient are eligible for use in reporting, ranges and thresholds do not meet criteria, and "average BP" of 139/70 is eligible for use.
Description:	The percentage of active patients between 18 and 85 years who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria: • Patients 18-85 years of age whose BP was <140/90 mm Hg
Age Criteria:	Eligible population is determined as 18 or 85 at the end of the measurement period. Example: Measurement period end date 12/31/2021 Patient age between 18 as of 12/31/2021 to 85 as of 12/31/2021
Numerator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-85 years of age whose most recent BP reading during the measurement year, on or after the second diagnosis of hypertension, (hypertension diagnosis may be established prior to the measurement year if patient has already had two dates of service with a hypertension diagnosis) was <140/90 mm Hg
Denominator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period. Active hypertension patients are identified as patients who had at least two visits on different dates of service with a diagnosis of hypertension during the year prior to the measurement year and the first half of the measurement year (e.g., if the measurement year was January 1, 2020 to December 31, 2020, one would consider visits from January 1, 2019 to June 30, 2020). Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • An e-visit or virtual check-in (Online Assessment Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set)

[3] *Controlling High Blood Pressure* was a reporting-only measure in 2021 due to significant specification changes, but is transitioning back to being a performance-based measure for 2022.

Required Exclusions:	1. Patients receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. 2. Patients in hospice
Acceptable Exclusions:	1. Patients receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year. 2. Patients 81 years of age and older as of December 31st of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year. 3. Patients 66-85 as of December 31st of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) AND advanced illness during the measurement year. To identify patients with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (this exclusion is much more feasible for a health plan to apply than a practice)on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify nonacute inpatient discharges: i. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). ii. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). iii. Identify the discharge date for the stay. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim d. A dispensed dementia medication (Dementia Medications List) 3. Patients with ESRD (ESRD Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.

	4. Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. 5. Patients who had a non-acute inpatient admission during the measurement year. (This exclusion is much more feasible for a health plan to apply than a practice). To identify non-acute inpatient admissions: a. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). b. Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim. c. Identify the discharge date for the stay.
BP Documentation:	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension (hypertension diagnosis may be established prior to the measurement year if patient has already had two dates of service with a hypertension diagnosis). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP reading is recorded during the measurement year, assume that the patient is "not controlled." Do not include BP readings: • Taken during an acute inpatient stay or an ED visit. • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. • Taken by the patient using a non-digital device such as with a manual blood pressure cuff and a stethoscope. Coding tip: The most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) may be taken during an outpatient visit (Outpatient Without UBREV Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year. As stated above, self-reported BP readings recorded during a telephone visit, e-visit or virtual check-in must rely on a digital device and cannot be recorded using a non-digital device such as a manual blood pressure cuff.
Look Back Period:	12 months
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Controlling High Blood Pressure."
    - October 1, 2021 – September 30, 2022

    - Other (Please Specify)
- Enter the numerator for "Controlling High Blood Pressure."
- Enter the denominator for "Controlling High Blood Pressure."

Pediatric Measures

Child and Adolescent Well Care Visits (Adolescent Age Ranges Only)

Updates to Measure Specifications:	• **Clarified that** hospice patients **are a required exclusion.**
Description:	The percentage of active patients 12-21 years of age with at least one documented, comprehensive well-care visit during the measurement year
Age Criteria:	Active patients 12-21 years of age at the end of the measurement year.
Numerator Statement:	Active patients 12-21 years of age at the end of the measurement year with a note indicating a visit to a PCP or OBGYN, the date of well visit, and evidence of all of the following: • A health and developmental history (physical and mental) • A physical exam • Health education/anticipatory guidance *If standard preventive visit templates consistently incorporate the above information, practices may simply use encounter information to verify compliance.*
Denominator Statement:	Active patients 12-21 years of age at the end of the measurement year
Required Exclusions:	1. Patients in hospice
Acceptable Exclusions:	None
Codes to Identify Adolescent Well-Care Visits	CPT: 99383-99385; 99393-99395 ICD-10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.2, Z00.3, Z02.5, Z02.79, Z02.81
Look Back Period:	12 months
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Adolescent Well Care Visits."
    - October 1, 2021 – September 30, 2022
    - Other (Please Specify)
- Enter the numerator for "Adolescent Well Care Visits."
- Enter the denominator for "Adolescent Well Care Visits."

Developmental Screening in the First Three Years of Life

Updates to Measure Specifications:	• Updated the example Age Criteria to align with the OHIC PCMH Measure Set performance period.
Description:	The percentage of active patients screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.
Age Criteria:	Children who turn 1, 2, or 3 years of age during the measurement year.
Numerator Statement:	The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening in the first, second, and third years of life. The measure is based on three, age-specific indicators. Numerators 1-3 are for your understanding of the measures. Only Numerator 4 is required to report to PCMH-Kids. • **Numerator 1**: Children in Denominator 1 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday • **Numerator 2**: Children in Denominator 2 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their first and before or on their second birthday • **Numerator 3**: Children in Denominator 3 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their second and before or on their third birthday • **Numerator 4**: Children in Denominator 4 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthday, i.e., the sum of numerators 1, 2, and 3. Documentation in the medical record must include all of the following: • A note indicating the date on which the test was performed, and • The standardized tool used (see below), and • Evidence of a screening result or screening score Tools must meet the following criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.

	2. Established Reliability: Reliability scores of approximately 0.70 or above. 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s). 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above. The following tools meet these criteria and are included in the Bright Futures Recommendations for Preventive Care, which reference the updated January 2020 AAP statement "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening": 1. Ages and Stages Questionnaire - 3rd Edition (ASQ-3) 2. Parents' Evaluation of Developmental Status (PEDS) – Birth – 8 years 3. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) 4. Survey of Wellbeing of Young Children (SWYC) Note: The 2020 AAP statement provides descriptive information about the screening tool properties that may be useful for organizations to consider in designing their policies. The following list of tools meet the criteria included in these specifications, but (a) were not included in either the revised January 2020 AAP statement or the original AAP statement on developmental screening recommendations from 2006 and (b) are not frequently used by primary care providers in the context of routine well-child care: 1. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months 2. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2 3. Brigance Screens-II - Birth to 90 months 4. Child Development Inventory (CDI) - 18 months to age 6 5. Infant Development Inventory - Birth to 18 months Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

	Tools listed above: The tools listed above are examples of tools cited by Bright Futures in its Recommendations for Primary Care, which are informed by the 2006 and the 2020 AAP statements on developmental screening. Organizations may utilize additional tools not listed here as long as they meet the criteria outlined in the specifications.
Denominator Statement:	Active patients who have been seen by the primary care clinician at the PCMH in the previous 12 months who meet the following eligibility requirement based on child's age at end of measurement year • **Denominator 1**: Active Patients who turn 1 during measurement year • **Denominator 2**: Active Patients who turn 2 during measurement year • **Denominator 3**: Active Patients who turn 3 during measurement year • **Denominator 4**: All Active Patients who turn 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3
Acceptable Exclusions:	None
Look Back Period:	Screenings must be completed prior to the patient's birthdate. In order to account for patients with birthdates at the beginning of the measurement year, reports should account for these encounters accordingly and place a lookback period on the patient's DOB rather than the measurement period. In order to account for age appropriate screenings, this look back should not exceed a 6 month lookback from the DOB in order to avoid erroneously counting developmental screenings used for prior years of age. Example: Patient 1 DOB: 1/15/2022 Patient 2 DOB: 5/31/2022 Measurement period for both Patient 1 and 2: 10/1/2021 – 9/30/2022 Lookback period for Patient 1: 7/15/2021 -1/14/2022 Lookback period for Patient 2: 11/15/2021 – 5/30/2022
Source:	Oregon Pediatric Improvement Partnership at Oregon Health and Science University (OHSU)

- Please indicate for what performance period you are reporting data for "Developmental Screening in the First Three Years of Life."
    - October 1, 2021 – September 30, 2022
    - Other (Please Specify)
- Enter the numerator for "Developmental Screening in the First Three Years of Life."
- Enter the denominator for "Developmental Screening in the First Three Years of Life."

Lead Screening in Children

Updates to Measure Specifications:	• Clarified that patients in hospice are a required exclusion.
OHIC Note:	To report performance on this measure to OHIC, practices can either: 1. grant the Rhode Island Department of Health (RIDOH) permission to share practice performance on this measure from KIDSNET directly with OHIC, or 2. report performance using the specifications listed below. Practices will have the ability to choose either option when completing the OHIC PCMH Measures Survey.
Description:	The percentage of active patients two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
Age Criteria:	Active patients who turn two years of age during the measurement year.
Numerator Statement:	Active patients who turn two years of age during the measurement year with at least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday. Documentation must include both of the following: • A note indicating the date the test was performed. • The result or finding.
Denominator Statement:	Active patients who turn two years of age during the measurement year
Required Exclusions:	1. Patients in hospice
Acceptable Exclusions:	None
Look Back Period:	12 months
Source:	HEDIS® (HEDIS limits the population to Medicaid-only. OHIC has adapted the measure specification to apply to all children, regardless of insurance type.)

- Does this practice site give RIDOH permission to release practice-level lead screening data to OHIC for the purposes of assessing whether the practice met the performance improvement requirement of OHIC's PCMH definition?
    - Yes
    - No
    - [*If yes*] What is your Rhode Island KIDSNET Practice ID?
    - [*If no*] Please indicate for what performance period you are reporting data for "Lead Screening in Children."
        - October 1, 2021 – September 30, 2022
        - Other (Please Specify)

- [*If no*] Enter the numerator for "Lead Screening in Children."
- [*If no*] Enter the denominator for "Lead Screening in Children."