2020 OHIC PCMH Cost Management Strategies Survey

This document is intended only to allow practices to prepare their submission for the PCMH Cost Management Strategies survey. To complete this survey, please fill out the online survey.

General Instructions:

- The survey collects information on cost management strategies taken by practices, specifically those focused on Care Coordination or Cost-Effective Use of Services. OHIC collaborated with NCQA to create this requirement. In so doing it built upon an existing NCQA PCMH recognition requirement that addresses cost management.
- Only two categories of practices are required to complete the survey: 1) non-NCQA-recognized practices or 2) practices whose NCQA recognition requirements do not call for annual documentation submission. Practices that are NCQA-recognized PCMHs will be evaluated on this requirement based upon their annual NCQA reporting.
- You can enter in information for five practice sites or less. Practices should submit information for the October 1, 2019 - September 30, 2020 performance period. Practices will be sent a PDF of their submission after completing their survey. Practices will be unable to save partially complete surveys, so practices should gather all of the needed information before entering their survey response.
- For more information, visit http://www.ohic.ri.gov/ohic-reformandpolicy-pcmhinfo.php or contact Cory King (Cory.King@ohic.ri.gov).

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 is 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 2019 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 2019 PCMH Measures Survey. Otherwise, OHIC will assign this practice site with an OHIC PCMH ID Number after reviewing the results of the 2020 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 2019 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
- 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
- In what transformation year is your practice?
    - Year 1: Practice joined CTC (including PCMH Kids) on or after January 1, 2020 or practice is not participating in any formal transformation initiative
    - Year 2: Practice joined CTC (including PCMH Kids) during 2018 or 2019, or independently achieved NCQA PCMH Level 3 recognition during 2018 or 2019
    - Year 3: Practice joined CTC prior to January 1, 2018 or independently achieved NCQA PCMH Level 3 recognition prior to January 1, 2018
- Date Survey Completed

Cost Management Requirement Overview

NCQA 2017 Element

QI 09 (Core): Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship:

- Measures related to care coordination.
- Measures affecting health care costs.

Guidance: The practice has an ongoing quality improvement strategy and process that includes regular review of performance data and evaluation of performance against goals or benchmarks. Review and evaluation offer an opportunity to identify and prioritize areas for improvement, analyze potential barriers to meeting goals and plan methods for addressing the barriers.

OHIC Modification

In meeting NCQA Element QI 09, Rhode Island practices must develop and implement a quality improvement strategy that addresses one of the following menu items, from either the Care Coordination or Cost-Effective Use of Services categories:

Care Coordination:

- Care coordination between facilities (including safe and effective care transitions)
- Care coordination with specialists/other providers
- Care coordination with patient[1]

Cost Effective Use of Services:

- ED utilization
- Inpatient hospital utilization
- Overuse/appropriateness of care (low-value care)
- Pharmaceutical costs (including volume and/or use of high-value pharmaceuticals)
- Specialist referral costs (including volume of referrals and/or referrals to high-value specialists)

Cost Management Requirement Questions

[1] Care coordination with patient refers to measures of successful coordination or communication between members of the care team and the patient. Examples can include, but are not limited to: follow up to ensure ordered lab or imaging tests were completed, follow up to ensure referral has been completed, follow up after patient receipt of abnormal test results, outreach to patients not recently seen that results in an appointment, discussion to reduce % of patients seeing multiple providers (3 or more), follow-up phone calls to check on the patient after an ER visit (or hospitalization), or following up on pediatric visits to after-hours care.

- Did this practice site complete a quality improvement strategy that addresses one of the items from either the Care Coordination or Cost-Effective Use of Services categories? *Please note: active projects should have been implemented at least three months prior to the survey submission date and a completed QI project should be no more than 12 months old as of the survey submission date. There are no guidelines on the length of the time of the project.*
    - Yes
    - No
- Please indicate which menu item(s) on which your quality improvement strategies project is focused (you may select more than one).
    - Care coordination between facilities (including safe and effective care transitions)
    - Care coordination with specialists/other providers
    - Care coordination with patient
    - ED utilization
    - Inpatient hospital utilization
    - Overuse/appropriateness of care (low-value care)
    - Pharmaceutical costs (including volume and/or use of high-value pharmaceuticals)
    - Specialist referral costs (including volume of referrals and/or referrals to high-value specialists)
- Please upload a report or quality improvement worksheet that provides additional detail on your quality improvement strategies project.

Quality Improvement Works

Comprehensive Diabetes Care – Eye Exam

Description:	The percentage of active diabetic patients between 18 and 75 years of age with up to date screening or monitoring for diabetic retinal disease
Age Criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2019 Patient age between 18 as of 12/31/2019 to 75 as of 12/31/2019
Numerator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period who had any of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. • Bilateral eye enucleation anytime during the member's history through the end of the measurement year Please note, documentation in the chart must include one of the following: • A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results. • A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. • Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the patient's history through end of the measurement year. • Documentation of a negative retinal or dilated exam by an eye care professional in the year prior to the measurement year, where results indicate retinopathy was not present (e.g. documentation of normal findings).
Denominator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior. Patients with diabetes are identified in the following ways:

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

	b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. A dispensed dementia medication (Dementia Medications List) 3. Patients in hospice
Look Back Period:	24 months, if negative retinopathy, 12 if positive or unknown
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Comprehensive Diabetes Care – Eye Exam."
    - October 1, 2019 – September 30, 2020
    - Other (Please Specify)
- Enter the numerator for "Comprehensive Diabetes Care – Eye Exam."
- Enter the denominator for "Comprehensive Diabetes Care – Eye Exam."

Comprehensive Diabetes Care: HbA1c Control (<8)

Description:	The percentage of active diabetic patients between 18 and 75 years of age whose most recent HbA1C value was less than 8
Age Criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2019 Patient age between 18 as of 12/31/2019 to 75 as of 12/31/2019
Numerator Statement:	Active diabetic patients between 18 and 75 years of age at the end of the measurement period whose most recent HbA1C value in the measurement year was less than 8
Denominator Statement:	Active patients with diabetes between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior. Patients with diabetes are identified in the following ways: 2. Encounter-based – Members who met any of the following criteria during the measurement year or the year prior to the measurement year: a. At least two outpatient visits (Outpatient Value Set, Telephone Visits Value Set, Online Assessments Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Only one of the two visits may be a telehealth visit, a telephone visit or an online assessment. Identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit. Use the code combinations below to identify telephone visits and online assessments: o A telephone visit (Telephone Visits Value Set) with a diagnosis of diabetes (Diabetes Value Set) o An online assessment (Online Assessments Value Set) with any diagnosis of diabetes (Diabetes Value Set) 3. Pharmacy Data: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior (Diabetes Medications List). Note that Glucophage/metformin as a solo agent is NOT included because it is used to treat conditions other than diabetes; patients with diabetes on these medications are identified through diagnosis codes only.
Acceptable Exclusions:	1. Patients who do not have a diagnosis of diabetes (Diabetes Value Set) in any setting during the measurement year or year prior AND who had a diagnosis included in the Diabetes Exclusions

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

- Please indicate for what performance period you are reporting data for "Comprehensive Diabetes Care – HbA1c Control (<8)."
    - October 1, 2019 – September 30, 2020
    - 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

Description:	The percentage of active patients between 18 and 85 years who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-85 years of age whose BP was <140/90 mm Hg
Age Criteria:	Eligible population is determined as 18 or 85 at the end of the measurement period. Example: Measurement period end date 12/31/2019 Patient age between 18 as of 12/31/2019 to 85 as of 12/31/2019
Numerator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-85 years of age whose most recent BP reading during the measurement year, on or after the second diagnosis of hypertension, (hypertension diagnosis may be established prior to the measurement year if patient has already had two dates of service with a hypertension diagnosis) was <140/90 mm Hg
Denominator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period. Active hypertension patients are identified as patients who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or year prior to the measurement year (count services that occur over both years). Only one of the two visits may be a telephone visit, an online assessment or telehealth visit. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with or without a telehealth modifier with any diagnosis of hypertension (Essential Hypertension Value Set) • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • An online assessment (Online Assessment Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set)
Acceptable Exclusions:	1. Patients 81 years of age and older as of December 31st of the measurement year with frailty (Frailty Value Set) during the measurement year. 2. Patients 66-85 as of December 31st of the measurement year with frailty (Frailty Value Set) AND advanced illness during the measurement year. To identify members with advanced illness, any of the following during the measurement year or the year prior, meet the criteria: a. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute

	Inpatient Value Set) on different dates of service with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. b. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) c. A dispensed dementia medication (Dementia Medications List) 3. Patients with ESRD (ESRD Value Set: ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis. (optional) 4. Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year (optional) 5. Patients who had a non-acute inpatient admission during the measurement year. (This exclusion is much more feasible for a health plan to apply than a practice). To identify non-acute inpatient admissions: a. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). b. Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim. c. Identify the discharge date for the stay. 6. Patients in hospice
BP Documentation:	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension (hypertension diagnosis may be established prior to the measurement year if patient has already had two dates of service with a hypertension diagnosis). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP reading is recorded during the measurement year, assume that the patient is "not controlled." BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider. ***Note:*** *Member-reported results to the provider from a remote monitoring device are not acceptable.* Coding tip: HEDIS does allow ambulatory BP monitoring (CPT 93784,93788 and 93790) and analysis of electronic data (99091) to qualify as measurement methodologies.
Look Back Period:	12 months
Source:	HEDIS®

- Please indicate for what performance period you are reporting data for "Controlling High Blood Pressure."
    - October 1, 2019 – September 30, 2020
    - Other (Please Specify)
- Enter the numerator for "Controlling High Blood Pressure."
- Enter the denominator for "Controlling High Blood Pressure."

Pediatric Measures

Adolescent Well Care Visits

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

- Please indicate for what performance period you are reporting data for "Adolescent Well Care Visits."
    - October 1, 2019 – September 30, 2020
    - 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

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

	3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s). 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above Current recommended tools that meet these criteria: 1. Ages and Stages Questionnaire (ASQ) - 2 months – 5 years 2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3) 3. Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth – 95 months 4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months – 2 years 5. Brigance Screens-II – Birth – 90 months 6. Child Development Inventory (CDI) - 18 months–6 years 7. Infant Development Inventory – Birth – 18 months 8. Parents' Evaluation of Developmental Status (PEDS) – Birth – 8 years 9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) 10. Survey of Wellbeing of Young Children (SWYC) Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Denominator Statement:	Active patients who have been seen by the primary care clinician at the PCMH in the previous 12 months who meet the following eligibility requirement based on child's age at end of measurement year • **Denominator 1**: Active Patients who turn 1 during measurement year • **Denominator 2**: Active Patients who turn 2 during measurement year • **Denominator 3**: Active Patients who turn 3 during measurement year • **Denominator 4**: All Active Patients who turn 1, 2, or 3 the measurement year, i.e., the sum of denominators 1, 2, and 3
Acceptable Exclusions:	None

Look Back Period:	Screenings must be completed prior to the patient's birthdate. In order to account for patients with birthdates at the beginning of the measurement year, reports should account for these encounters accordingly and place a lookback period on the patient's DOB rather than the measurement period. In order to account for age appropriate screenings, this look back should not exceed a 6 month lookback from the DOB in order to avoid erroneously counting developmental screenings used for prior years of age. Example: Patient 1 DOB: 1/15/2019 Patient 2 DOB: 5/31/2019 Measurement period for both Patient 1 and 2: 1/1/2019 – 12/31/2019 Lookback period for Patient 1: 7/15/2018 -1/14/2019 Lookback period for Patient 2: 11/15/2018 – 5/30/2019
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, 2019 – September 30, 2020
    - 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

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
Acceptable Exclusions:	None
Look Back Period:	12 months
Source:	HEDIS® (modified by OHIC to obtain data through KIDSNET. OHIC is working with RIDOH and KIDSNET to obtain data for this measure on behalf of practices. HEDIS limits the population to Medicaid-only. KIDSNET has adapted the measure specification to apply to all children, regardless of insurance type, and defines the active patient using its attribution methodology rather than that of the practice site. KIDSNET attributes patients based on the provider who delivered the last vaccination.)

- 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

Weight Assessment and Counseling for Nutrition and Physical Activity

Description:	Percentage of active patients 3-17 years of age who had an outpatient visit in the last twelve months with a primary care clinician of the PCMH who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation, • Counseling for nutrition, AND • Counseling for physical activity
Age Criteria:	Eligible population is determined as 3-17 at the end of the measurement year. Example: Measurement period end date 12/31/2019 Patient age between 3 as of 12/31/2019 to 17 as of 12/31/2019
Numerator Statement:	Patients in the denominator who had evidence of a body mass index (BMI) percentile documentation, counseling for nutrition, AND counseling for physical activity during the measurement year • BMI percentile: documentation must include height, weight, and BMI percentile during the measurement year. The height, weight, and BMI must be from the same data source. o Either of the following meets criteria for BMI percentile: ▪ BMI percentile, or ▪ BMI percentile plotted on age-growth chart o Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). o Practices may utilize the BMI Percentile Value Set as a mechanism to achieve this component of the measure. • Counseling for nutrition: documentation of counseling for nutrition or referral for nutrition education during the measurement year. Documentation must include a note indicating the date and at least one of the following: o Discussion of current nutrition behaviors (e.g. eating habits, dieting behaviors) o Checklist indicating nutrition was addressed o Counseling or referral for nutrition education o Patient received educational materials on nutrition during a face to face visit o Anticipatory guidance for nutrition o Weight or obesity counseling Practices may utilize the Nutrition Counseling Value Set as a mechanism to achieve this component of the measure, but still must meet the above documentation requirements.

	• Counseling for physical activity: documentation of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following: o Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation) o Checklist indicating physical activity was addressed o Counseling or referral for physical activity o Patient received education materials on physical activity during face to face visit o Anticipatory guidance for physical activity o Weight or obesity counseling Practices may utilize the Physical Activity Counseling Value Set as a mechanism to achieve this component of the measure, but still must meet the above documentation requirements. Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.
Denominator Statement:	All active patients 3-17 at the end of the measurement year with a documented encounter during the measurement year
Acceptable Exclusions:	• Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year • Patients in hospice
Look Back Period:	12 months
Source:	HEDIS® (modified by OHIC to become an "all-or-nothing" measure, including the three sub-measures)

- Please indicate for what performance period you are reporting data for "Weight Assessment and Counseling for Nutrition and Physical Activity."
    - October 1, 2019 – September 30, 2020
    - Other (Please Specify)
- Enter the numerator for "Weight Assessment and Counseling for Nutrition and Physical Activity."
- Enter the denominator for "Weight Assessment and Counseling for Nutrition and Physical Activity."