Overarching Principles and Definitions	
Active Patients:	Outpatients seen by a primary care clinician of the PCMH anytime within the last 24 months Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA), and Certified Nurse Practitioner (CNP). The following are the eligible CPT/HCPCS office visit codes for determining Active Patient status: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490, 99495-99496, G0402; G0438-G0439 Acceptable Exclusions: Patients who have left the practice, as determined by one or more of the following: 1. Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice 2. Patient has passed away 3. Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person 4. Patient has been discharged according to practice's discharge policy
Outpatient Visit Criteria:	Please refer to the HEDIS® Outpatient Value Set.
Encounter Types:	In addition to following CPT/HCPCS code level of service guidelines to establish an eligible population, report writers should ensure encounter types are limited to include only face to face encounter types for those measures requiring a face to face encounter. Example: Depression screening: Patient turns 18 in July 2017. In the record they have two "encounters" in 2017 – a well visit in April and a nurse care manager phone call in August. Failure to limit encounter types correctly could result in the nurse care manager visit erroneously triggering this patient in the eligible population.
Practices using shared EHR systems:	Denominator calculation are based upon encounters in the PCMH unless otherwise specified. Numerator events may be from any source (e.g. a recorded BMI or lab value).
Value Set Information:	HEDIS® measures reference Value Sets are available for download at store.ncqa.org under the search term: "Quality Rating System (QRS) HEDIS® Value Set Directory." See attached "Instructions for Obtaining "2017 Quality Rating System (QRS) HEDIS® Value Set Directory."

Measure:	Adult BMI Assessment (ABA)
Description:	The percentage of patients 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented using the age acceptable format (percentile versus numeric) during the measurement year or the year prior by any provider
Age criteria:	Eligible population is determined as 18 as of the beginning of the year prior to the measurement year and 74 as of the last day of the measurement year. **Example:** Measurement year 2016 18 as of 1/1/2015 74 as of 12/31/2016 Note: An added age criteria must be applied to determine if the correct format was used for the patient's age at the time of the visit. Since only one recording is required and multiple will likely occur during the reporting period, reporting on the most recent value is easiest.
Numerator Statement:	For patients 20 years of age or older on the date of service, BMI (BMI Value Set) documented during the measurement year or the year prior to the measurement year For patients younger than 20 years of age on the date of service, BMI percentile (BMI Percentile Value Set) documented during the measurement year or the year prior to the measurement year Documentation must include not only the BMI Value or Percentile, but also height and weight.
Denominator Statement:	Patients meeting the above age criteria who had an outpatient visit defined by Outpatient Visit Criteria during the measurement year or the year prior
Acceptable Exclusions:	• Patients with a diagnosis of pregnancy (refer to HEDIS® Pregnancy Value Set) during the measurement year of the year prior to the measurement year • Outpatient visit codes 99324-99337; 99341-99350; 99495-99496 due to lack of ability to measure height and weight in home setting • Patients in hospice
Look back Period:	24 months
Source:	HEDIS®

Measure:	Preventive Care and Screening: Screening for Clinical Depression and Follow Up Plan (Adapted for adult population)
Description:	The percentage of active patients 18 years of age and older screened for clinical depression using an age appropriate standardized tool AND, if positive follow up plan is documented on the date of the screen
Age criteria:	Eligible population is determined as 18 at the date of encounter. **Example 1:** Patient turns 18 on 4/15/2016 Date of encounter 4/12/2016 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 4/15/2016 Date of encounter 6/12/2016 Patient is IN denominator
Numerator Statement:	Active patients 18 years of age and older at the date of encounter screened for clinical depression at least once during the measurement period using an age appropriate standardized tool AND, if positive, follow up plan is documented on the date of the screen
Denominator Statement:	Active patients 18 years of age and older on the date of encounter. Encounter must meet the outpatient visit criteria
Acceptable Exclusions:	1. Patient has active diagnosis of depression 2. Patient has a diagnosed bipolar disorder 3. Patient has a diagnosis of dementia
Follow-Up Plan Requirements:	Documented follow-up for a positive depression screening must include one or more of the following: 1. Additional evaluation for depression (e.g. continuation to PHQ-9 if PHQ-2 is abnormal) 2. Suicide Risk Assessment 3. Referral to a practitioner who is qualified to diagnose and treat depression 4. Pharmacological interventions 5. Other interventions or follow-up for the diagnosis or treatment of depression
Adult Screening Tools:	Acceptable tools include the Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2. The tool used must be documented in the record.
Look back Period:	12 months
Source:	NQF 0418:3148 CMS

Measure:	Comprehensive Diabetes Control: HbA1C Control (<8)
Description:	The percentage of active diabetic patients between 18 and 75 years of age whose most recent HbA1C value was less than 8
Age criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2016 Patient age between 18 as of 12/31/2016 to 75 as of 12/31/2016
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 diabetic patients 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
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 who joined the practice less than 6 months prior to the end of the measurement period 3. Patients in hospice
Identifying Diabetics:	Practices may identify diabetics in multiple ways including problem lists, encounter diagnoses, and/or active medications.
Diabetics without A1C Documented:	If no A1C reading was rendered during the measurement year, patient counts as non-adherent.
Look back Period:	12 months
Source:	HEDIS®

Measure:	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 18-59 years of age whose BP was <140/90 • Patients 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Patients 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
Age criteria:	Eligible population is determined as 18 or 85 at the end of the measurement period. Example: Measurement period end date 12/31/2016 Patient age between 18 as of 12/31/2016 to 85 as of 12/31/2016
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 18-59 years of age whose BP was <140/90 mm Hg • Patients 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Patients 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
Denominator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period. Patients are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) or active problem list diagnosis during the first six months of the measurement year.
Acceptable Exclusions:	1. 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. 2. Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year 3. 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.

	4. Patients in hospice 5. Medicare patients 65 years of age and older living long-term in institutional settings
BP Documentation:	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP reading is recorded during the measurement year, assume that the patient is "not controlled."
Look back Period:	12 months
Source:	HEDIS®

Measure:	Preventive Care and Screening: Tobacco Cessation Intervention
Description:	The percentage of active patients 18 years and older and who were screened for tobacco use one or more times within 24 months AND who received cessation counseling if identified as a tobacco user
Age criteria:	Eligible population is determined as 18 at the date of encounter **Example 1:** Patient turns 18 on 4/15/2016 Date of encounter 4/12/2016 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 4/15/2016 Date of encounter 6/12/2016 Patient is IN denominator
Numerator Statement:	All active patients 18 and older at the date of encounter who were screened for tobacco use at least once within 24 months and were either identified as a non-smoker OR identified as a smoker AND received tobacco cessation intervention
Denominator Statement:	All active patients 18 and older at the date of encounter with at least two visits (see Outpatient Visit criteria) **OR** one preventive visit during the measurement period
Acceptable Exclusions:	None
Tobacco Use and Intervention Definitions:	Tobacco Use – Includes use of any type of tobacco Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy
Patients Not Assessed:	If tobacco use status of patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure.
Look back Period:	There are two different lookback period for this measure: • Documentation of cessation counseling – 24 month look back from most recent office visit • Count of encounters – 24-month look back from end of measurement period to determine if patient has been seen twice for any type of visit or for one preventive visit
Source:	NQF 0028:3225 PCPI Foundation

Measure:	Well Child Counseling: Weight Assessment and Counseling for Nutrition and Physical Activity
Description:	Percentage of active patients 3-17 years of age who had an outpatient visit in the last twelve months with a primary care clinician of the PCMH who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation, • Counseling for nutrition, AND • Counseling for physical activity
Age criteria:	Eligible population is determined as 3-17 at the end of the measurement year. Example: Measurement period end date 12/31/2016 Patient age between 3 as of 12/31/2016 to 17 as of 12/31/2016
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 educations materials on nutrition during a face to face visit o Anticipatory guidance for nutrition o Weight or obesity counseling o Documentation related to a member's "appetite" does not meet criteria for Counseling for nutrition. o Practices may utilize the Nutrition Counseling Value Set as a mechanism to achieve this component of the measure.

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

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

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

	4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above Current recommended tools that meet these criteria: 1. Ages and Stages Questionnaire (ASQ) - 2 months – 5 years 2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3) 3. Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth – 95 months 4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months – 2 years 5. Brigance Screens-II – Birth – 90 months 6. Child Development Inventory (CDI) - 18 months–6 years 7. Infant Development Inventory – Birth – 18 months 8. Parents' Evaluation of Developmental Status (PEDS) – Birth – 8 years 9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) 10. Survey of Wellbeing of Young Children (SWYC) Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Denominator Statement:	Active patients who have been seen by the primary care clinician at the PCMH in the previous 12 months who meet the following eligibility requirement based on child's age at end of measurement year • **Denominator 1**: Active Patients who turn 1 during measurement year • **Denominator 2**: Active Patients who turn 2 during measurement year • **Denominator 3**: Active Patients who turn 3 during measurement year • **Denominator 4**: All Active Patients who turn 1, 2, or 3 the measurement year, i.e., the sum of denominators 1, 2, and 3
Acceptable Exclusions:	None
Look back Period:	Screenings must be completed prior to the patient's birthdate. In order to account for patients with birthdates at the beginning of the measurement year, reports should account for these encounters accordingly and place a lookback period on the patient's DOB rather than the measurement period. In order to account for age appropriate screenings, this look back should not exceed a 6 month lookback from the DOB in order to avoid erroneously counting developmental screenings used for prior years of age. Example: Patient 1 DOB: 1/15/2013 Patient 2 DOB: 5/31/2013 Measurement period for both Patient 1 and 2: 1/1/2016 – 12/31/2016 Lookback period for Patient 1: 7/15/2015 -1/14/2016

	Lookback period for Patient 2: 11/15/2015 – 5/30/2016
Source:	Oregon Pediatric Improvement Partnership at Oregon Health and Science University (OHSU)

Measures to be Newly Reported October 2018

Measure:	Adolescent Well Care Visit - PEDIATRIC
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
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®

Measure:	Colorectal Cancer Screening
Description:	The percentage of active patients 50 to 75 years of age who received an acceptable colorectal cancer screening.
Age criteria:	Eligible population is determined as patients 51 to 75 years of age at the end of the measurement period. (Description states 50 since someone could be 50 throughout the measurement year and not turn 51 until the last day of the measurement period).
Numerator Statement:	Active patients 51 to 75 at the end of the measurement period who received an acceptable colorectal screening during the identified lookback period (See below).
Denominator Statement:	Active patients 51-75 at the end of the measurement period.

Acceptable Exclusions:	• Either of the following at any time in the member's history through the end of the measurement period:
	  ○ Colorectal cancer
	  ○ Total colectomy
	• Patient is in hospice
	• Medicare patients 65 years of age and older living long-term in institutional settings

Look back Period:	Varies based on test performed: • Fecal occult blood test during the measurement year • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year • Colonoscopy during the measurement year or the nine years prior to the measurement year • CT colonography during the measurement year or the four years prior to the measurement year • FIT-DNA test during measurement year or the two years prior to the measurement year
Medical Record Documentation:	See guidance note below. Claims based information can be used to initiate patient outreach to meet the patient reported requirement.
Source:	HEDIS®

Guidance ***Numerator***

NOTE:

- ***FOBT includes:*** *ColoCARE, Coloscreen, EZ Detect, Fecal Immunochemical Tests (FIT), Fecal occult blood test, flushable reagent pads, flushable reagent stool blood test, guiac smear test, Hemoccult, Seracult, stool occult blood test*
- ***Do not count digital rectal exams*** *(++DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE*
- ***Documentation in the medical record must include both of the following:*** *A note indicating the date the colorectal cancer screening was performed AND the result or findings*
- ***Documentation*** *of 'normal' or 'abnormal' is acceptable*
- ***Patient Reported Requirement:*** *Date (year) and type of test AND result/finding*
- ***Documentation of colorectal cancer screening*** *may be completed during a telehealth encounter*

Measure:	Comprehensive Diabetes Care – Eye Exam (Retinal)
Description:	The percentage of active diabetic patients (type 1 and 2) between 18 and 75 years of age who had an eye screening 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 12/31/2016 Patient age between 18 as of 12/31/2016 to 75 as of 12/31/2016
Numerator Statement:	Active diabetic patients (type 1 and 2) between 18 and 75 years of age who had an eye screening for diabetic retinal disease. Screenings include the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the measurement year regardless of retinopathy status. • A **negative** (for retinopathy) retinal or dilated eye exam by an eye care professional in the year prior to the measurement year. • Bilateral eye enucleation at any point up to and including the last day of the measurement year
Denominator Statement:	Active diabetic patients 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
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 who joined the practice less than 6 months prior to the end of the measurement period 3. Patients in hospice
Medical Record Documentation:	As a best practice, documentation of results should be documented within the patient's chart. This is a requirement for CMS reporting through MSSP and Nextgen contracts.
Identifying Diabetics:	Practices may identify diabetics in multiple ways including problem lists, encounter diagnoses, and/or active medications.
Look back Period:	12 months for eye exam, regardless of result. 24 months for negative eye exam.
Source:	HEDIS®

Guidance ***Numerator***

NOTE:

- ***Patient Reported Requirement:*** *Date (year) and result/finding*
- ***If an endocrinologist or PCP performs the appropriate imaging*** *in their office and the results are reviewed by an eye care professional (optometrist or ophthalmologist) during the measurement period or the year prior to the measurement period (if negative for retinopathy) then it is eligible for use in reporting*
- ***If the eye exam is not performed or reviewed by an ophthalmologist*** *or optometrist, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist*
- ***Documentation of diabetic retinal disease screening*** *may be completed during a telehealth encounter*