TRANSFORMING PEDIATRIC PRACTICE

Helping You Reach Your Goals

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HELPING YOU REACH YOUR GOALS

The Pediatric Transforming Clinical Practice Initiative (P-TCPI) is a partnership between the Washington Chapter of the American Academy of Pediatrics, the Washington State Department of Health, and Molina Healthcare. One of only two pediatric-focused Practice Transformation Networks in the country, we offer support to primary care providers in our state to transform their practices to prepare for value-based payment and improve child health outcomes.

P-TCPI goals are aligned with the common measure set and include increasing well child visits and immunization rates, improving behavioral health care, improving asthma management, increasing care coordination and decreasing avoidable use of the emergency room.

As part of the TCPI grant to improve the care of children we started collecting information from practices about how to start caring for your entire practice instead of just those patients coming in on a particular day. This opportunity to learn from each other has been invaluable.

What we have learned is gathered here and will be updated periodically with resources that have been valuable to our participating practices. Please feel free to share suggestions and lessons learned. We hope this resource is helpful and can make this work feel possible instead of overwhelming. Please contact us with any questions.

Beth Harvey, MD, FAAP
Frances Chalmers, MD, FAAP
**Value-Based Payment/Care and Quality Measures**

*Value-Based Payment* (VBP) is the process whereby insurers are gradually moving (over the next 3-4 years) from a system of fee for service/volume based payment to a system that rewards value as defined by the Triple Aim elements of population health, experience and quality of care, and per capita cost. Practitioners will be asked to prove value by meeting certain standardized quality and utilization measure benchmarks in order to earn incentive payments.

The quality measures that are being used in Washington State, the Common Measure Set, were agreed upon by a consensus approach and are based on the broader set of national measures called HEDIS measures. Although the majority are adult focused, the Common Measure Set includes at least 17 measures that pertain to the pediatric age group. They include preventive measures such as Bright Futures-focused well child visits, immunizations, and oral health/fluoride varnish. They also include measures aimed at reducing morbidity from chronic conditions such as asthma and certain mental and behavioral health conditions including ADHD, depression and anxiety and opioid addiction. Closely connected to this are efforts to move toward integration of primary care and behavioral health services with a continuum from improved communication across agencies and improved care coordination to co-located primary care and behavioral health clinicians.

The utilization measures for pediatrics focus on rates of emergency room visits, hospitalizations, and imaging studies, as well as Health Home care coordination services for the most complex pediatric patients.

**How is P-TCPI structured and how does it work to help providers?**

- Each of the nine regions in the state has a P-TCPI team which may include a practice facilitator, physician champion, behavioral health champion, and a regional care facilitator.
- Enrolled practices assess baseline readiness for value based payment and identify specific aims for quality improvement.
- Readiness for achieving success in meeting quality and utilization measure benchmarks is facilitated by learning about empanelment and data analysis both within the practices EMR and the data provided to each clinic by Molina.
- The effectiveness of QI interventions is measured by a variety of means including reviewing internal EMR data as well as data supplied by Molina Healthcare.
- Progress along the continuum towards VBP readiness is measured by the Practice Facilitator meeting with the practice and repeating assessments every 6 months.
- Shared learning happens among providers and clinics at regional meetings and trainings, statewide learning forums on population health and value based care/payment, and through the content of this handbook.

The following chapters in the handbook are a compilation of learnings, successes, challenges and some pitfalls encountered by P-TCPI practices in each of the improvement areas important to moving toward VBP readiness and improved quality of care for our children.
As Washington State moves toward value-based payment for health care, it’s more important than ever for providers/practices to know their patient panels. Discrepancies between the data the managed care organizations (MCOs) are using and what is really happening in a practice will affect performance on quality metrics.

**DETERMINE AN ACCURATE PATIENT PANEL**

- Identify your clinic’s active patient panel by comparing EMR and Payer lists. Larger practices will do this at the provider level; smaller practices might do it only at the practice level.
  - Inactivate patients in your EMR who have moved or changed to a different clinic.
  - Patients on your list who have never been seen at the clinic should be called to confirm they identify you as their PCP, in which case they should be encouraged to come in for a well child visit.

**IMPLEMENT A PROCESS TO MAINTAIN ACCURACY**

- Cleaning up this list will be a large task initially. If maintained on a regular basis, first monthly then quarterly, once fairly accurate this will greatly improve the validity of quality metric reporting and subsequent VBP. The following can help this process.

**MANAGE PROVIDERS’ PATIENT PANEL SIZE**

- Calculate each provider’s (or a smaller practice’s total) ideal panel size and assess whether there is a need for adjustment.
  - Calculate visit capacity which is a provider’s number of days worked per year times the average number of patients seen each day worked.
  - Next calculate visit demand which is the number of patients on a provider’s panel times the average number of visits per year per patient (look at prior year’s data for this number).
  - If demand is greater than capacity (the provider or practice is over-burdened), then changes should be made. These might include:
    - Patients may see another provider for sick visits.
    - Encourage patients to consider changing provider if theirs is often unavailable.
    - Increase provider hours.
    - Close an over-burdened provider’s panel.
    - Hire more providers for the clinic if the entire practice is over-burdened.
USE THE PANEL REPORTS TO INFORM PRACTICE QUALITY IMPROVEMENTS

- Develop panel reports and registries.
  - Use panel-based quality metric reports to drive recall efforts for well child care, immunizations, and chronic disease management.
  - Share quality metric data with providers and ultimately with payers and patients.

For more information on empanelment and how it can inform care quality and VBP readiness, visit PediatricTCPI.org/resources. We’ve posted a spreadsheet to help you make calculations for your own practice and a webinar that provides an in-depth look at empanelment implementation.

DATA MANAGEMENT AND UTILIZATION

Once you are working with an accurate patient panel, your internal data and the data you receive from the Managed Care Organizations can paint a picture of your areas of strength and weakness.

VERIFY YOUR DATA REPORTS

- The MCOs will rely on their own data to determine if you have met quality and utilization measures. You want their data to be accurate.
- Make sure you keep up with the empanelment tasks listed above on a regular basis to make sure your active patient list matches that of the MCO.
- Pay attention to diagnoses used when billing for visits. For example, do not use one of the persistent asthma codes if the patient does not meet criteria. You will be asked to meet certain measures for patients with persistent asthma that you might not do clinically for milder forms of the disease.
- The MCO should be able to give you a list of patients in your practice who fail to meet a measure – spot check that list looking for patients who are not on your panel or who do not have that particular diagnosis. Let the insurer know about these individuals.
- You should be able to generate similar lists from your EMR dashboard regarding the quality and utilization measures. Compare these to what you get from the MCO.
- The above lists can be transferred to an excel format and compared more easily. This takes time. Identify a person on your staff whose job it is to keep up with this task.
IMPLEMENT A PROCESS TO MAINTAIN DATA ACCURACY

- Update records as part of your process for reaching out with well check reminders.
- Keep tabs on patients under 2 years old, and when they come in for their well visits schedule the next visit.
- Recall teens in the spring to remind them to come in over the summer for immunizations or sports physicals.
- Have office staff inactivate patients that move when records requests are received, patients call for records, or if providers know they are moving.
- Make sure when you inactivate in your system that you also inactivate in the immunization information service.

SAMPLE DATA REPORTS FROM MOLINA

The following charts are examples of data reports from Molina. The data is reported using billing data from the prior 12 months on a rolling quarterly basis. The lag from end of data period to report date is about 2-3 months.

This first chart shows cost and utilization data by clinic, region, and state and includes four reporting periods. The columns to the far right titled Barometers show how a group (clinic) compares to its region and to the state. Color codes indicate below average (red), average (yellow), and above average (green) scores for the most current time period. The goals are low ED visits and asthma and gastroenteritis hospitalizations balanced by higher clinic visits.

The second chart is the quality measure chart which lists a clinic’s HEDIS scores for the pediatric transforming clinical practice pediatric quality measures. These measures address preventive services such as immunizations, well child care and oral health care. This chart has no actual data but as you can see from the headings the information you will receive includes the number of patients subject to a measure (the denominator) and the number of those patients who have passed the measure (the numerator). The numerator/denominator ratio is the percentage. For each measure there is a HEDIS benchmark and for the most part the payer gives credit for clinics that meet 75% of that benchmark. The chart also tells you how many patients you need to add to your numerator to reach a goal and you can generate a list of those specific patients for recall.
CLINIC SAMPLE
ACH REGION
Molina Medicaid Pediatrics Cost and Utilization Metrics Overview
Based on claims paid through October 2016

<table>
<thead>
<tr>
<th>COST &amp; UTILIZATION METRICS1</th>
<th>Rolling Year Ending 12-31-13</th>
<th>Rolling Year Ending 10-31-16</th>
<th>Rolling Year Ending 12-31-13</th>
<th>Rolling Year Ending 10-31-16</th>
<th>Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID UTILIZATION</td>
<td>842.6</td>
<td>946.2</td>
<td>842.6</td>
<td>946.2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Available DR Visits/yr/km</td>
<td>8.0</td>
<td>9.7</td>
<td>8.0</td>
<td>9.7</td>
<td>0.0%</td>
</tr>
<tr>
<td>In-NARA Score (Risk Factor)</td>
<td>0.002</td>
<td>0.003</td>
<td>0.002</td>
<td>0.003</td>
<td>0.0%</td>
</tr>
<tr>
<td>FP UTILIZATION</td>
<td>6.7</td>
<td>7.2</td>
<td>6.7</td>
<td>7.2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Asthma-based Admits/yr/km (cohort age 5)</td>
<td>1.6</td>
<td>1.6</td>
<td>1.6</td>
<td>1.6</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pediatric Asthma/admits/yr</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Inpatient Hospital NARA Score (Risk Factor)</td>
<td>0.211</td>
<td>0.211</td>
<td>0.211</td>
<td>0.211</td>
<td>0.0%</td>
</tr>
<tr>
<td>PROFESSIONAL UTILIZATION2</td>
<td>8,526.5</td>
<td>8,526.5</td>
<td>8,526.5</td>
<td>8,526.5</td>
<td>0.0%</td>
</tr>
<tr>
<td>POP Office visits/yr/km</td>
<td>3,602.1</td>
<td>3,602.1</td>
<td>3,602.1</td>
<td>3,602.1</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total imaging/yr</td>
<td>2.3</td>
<td>2.3</td>
<td>2.3</td>
<td>2.3</td>
<td>0.0%</td>
</tr>
<tr>
<td>Professional NARA Score (Risk Factor)</td>
<td>0.197</td>
<td>0.197</td>
<td>0.197</td>
<td>0.197</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total Member Months2</td>
<td>64,103</td>
<td>64,103</td>
<td>64,103</td>
<td>64,103</td>
<td>0.0%</td>
</tr>
<tr>
<td>Member Month % State Total</td>
<td>1.7%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Notes:
1. Utilization rate measures the extent to which a service is used and is calculated as the unit count for 1000 members per year.
2. NARA scores give an indication of how “at-risk” the subpopulation is. Higher NARA scores are associated with higher risk populations.
3. Professional Utilization does not include pharmacy or DME services.
4. Member population consists of Molina members under 21 years of age. Asthma metrics do not include children under the age of 5.

8

2018 HEDIS - PEDIATRIC TCP1
MEASUREMENT YEAR 2017

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Measure Type</th>
<th>Compliant Members</th>
<th>Eligible Members</th>
<th>Current Performance</th>
<th>Current Goal</th>
<th>Previous Year Performance</th>
<th>Max To Reach Goal</th>
<th>Proximity To Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADO - Follow-up Care for Children - Prescribed ACHD Medication - Continuation and Maintenance Phase</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>ADO - Follow-up Care for Children - Prescribed ACHD Medication - Initiation Phase</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>AMR - Asthma Medication Ratio - Age 1 to 18 Ratio &gt; 50%</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>AMR - Asthma Medication Ratio - Age 5 to 11 Ratio &gt; 50%</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>APC - Use of Multiple Concurrent Antipsychotics in Children and Adolescents - Total</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>APC - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>AWC - Adolescent Well Care Visits</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>CAP - Children and Adolescents Access to Primary Care Practitioners - All Members</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>C1 - Childhood Immunization Status - Combination 10 Immunizations</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>IMA - Immunizations for Adolescents - Combination 1 Immunizations</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>MIA - Medication Management for People with Asthma - Age 11 to 18 75% Covered</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>MIA - Medication Management for People with Asthma - Age 5 to 10 75% Covered</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>W2S - Well Child Visits in the First 12 Months of Life - Six or more well child visits</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>W34 - Well Child Visits in the Third Fourth and Sixth Years of Life -</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile Documentation - Total</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition - Total</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
<tr>
<td>WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity - Total</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
<td>H</td>
</tr>
</tbody>
</table>
Making Improvements

Pediatric Transforming Clinical Practice Initiative: Clinical Goals

The goals of P-TCPI align with the common measure set and value-based payment measures to transform clinical practice throughout Washington.

- Improve immunization rates
- Increase well child exams
- Improve asthma outcomes
- Improve behavioral health care and access
- Decrease avoidable ED visits
- Improve coordination of care

Start here!
QUALITY MEASURES

IMMUNIZATIONS

HEDIS Measures

CIS  Childhood Immunization Status  – Combination 10 immunizations
IMA  Immunizations for Adolescents  – Combination 1 immunization

There are two immunization measures you might focus on first.

CIS: Childhood Immunization Status  – Combination 10 immunizations
This measure refers to the percentage of 2-year-olds in your practice who have had all the immunizations scheduled to be given by the 2\textsuperscript{nd} birthday. This measure is also called Combo 10, not to be confused with the older measure, Combo 9 which included both doses of Hepatitis A but no influenza vaccine.

- NCQA detailed definition:
- Denominator: Children who turn 2 years old during the measurement period
- Numerator: Children in the denominator who have had all the scheduled vaccines for that age including 2 doses of influenza and at least one dose of Hepatitis A vaccine
IMA: Immunizations for adolescents – Combination 1 immunizations
This measure refers to the percentage of 13 year olds who have had one Tdap vaccine and one Meningococcal vaccine.

- NCQA detailed definition: [http://www.ncqa.org/portals/0/Immunizations%20for%20Adolescents.pdf](http://www.ncqa.org/portals/0/Immunizations%20for%20Adolescents.pdf)
- Denominator: adolescents who turn 13 years of age during the measurement period
- Numerator: adolescents in the denominator who have had one meningococcal and one Tdap vaccine. Each is measured individually and the two are measured as a combination.

POTENTIAL CHALLENGES TO ACHIEVING IMPROVED IMMUNIZATION STATUS

- Vaccine hesitancy: This is particularly a challenge for the Combo 10 as it requires 2 doses of influenza vaccine by the second birthday.
- Gaps in care
  - Missed well child visits
  - Missed opportunity to vaccinate during an acute care visit

SAMPLE WAYS TO IMPROVE IMMUNIZATION STATUS

- Recommend immunizations using a presumptive first approach, and then adjust to participatory if you encounter resistance.
- Train staff to take advantage of every contact to make certain that patients are up to date, including phone calls and other visits for sickness or injury.
- Consider incorporating questions regarding vaccine status in your visit protocol intake sections.
- Institute patient reminders. Some EMRs can do this through follow up orders at each visit. Use your practice management recall system to help.
- Use diagnosis codes to document reasons for refusal/contraindications.
- Integrate hospital Hepatitis B dose if hospital does not report IIS.
- Use every visit as an opportunity to catch up on immunizations. Include prompts in visit protocols. Train nurses to check status and remind patients/providers of vaccines due.
- Begin offering HPV at 9 and MCV at 10, and begin preparing parents for teen vaccines early - with early uptake they can spread them out and have fewer vaccines on one day.
- Discuss immunization status at morning standup rounds and if indicated permit vaccine to be given if there is time before a provider is available to see the patient.
- Use these trusted vaccine resources to answer parent questions:
  - [http://www.chop.edu/centers-programs/vaccine-education-center](http://www.chop.edu/centers-programs/vaccine-education-center)
There are three well visit measures to focus on first:

1. **W15: Well child visits in the first 15 months of life** – Six or more well child visits
   a. The goal is to get infants and toddlers in for all their scheduled well visits by 15 months of age. You may allow two weeks between visits for catch up. Provide standardized templates to include health education/anticipatory guidance and vaccine information. You may have to do the 15 month visit slightly early and have the patient return to do the HIB vaccine after 15 months. This is because doing the 15 month visit before 15 months of age meets the W15 measure but you can’t do the HIB vaccine at that time.
   b. NCQA detailed definition: [http://www.ncqa.org/portals/0/Well-Child%20Visits%20in%20the%20First%2015%20Months%20of%20Life.pdf](http://www.ncqa.org/portals/0/Well-Child%20Visits%20in%20the%20First%2015%20Months%20of%20Life.pdf)
   c. Denominator: Children on a panel who turn 15 months of age during the measurement period.
d. Numerator: Children in the denominator group who by 15 months of age have had at least 6 well child visits.

2. W34: Well child visits in the third, fourth, fifth and sixth years of life –
   a. The goal is to get 3 to 6 year olds in for annual well child visits.
   b. NCQA detailed definition: [http://www.ncqa.org/portals/0/Well-Child%20Visits%20in%20the%20Third%20Fourth%20Fifth.pdf](http://www.ncqa.org/portals/0/Well-Child%20Visits%20in%20the%20Third%20Fourth%20Fifth.pdf)
   c. Denominator: Children ages three to six years old during the measurement period.
   d. Numerator: Children in the denominator group who have had a well child visit with a PCP during the measurement period.

3. AWC: Adolescent Well Care Visits
   a. The goal is to have adolescents come in for annual well visits.
   b. NCQA Detailed definition: [http://www.ncqa.org/portals/0/Adolescent%20Well-Care%20Visits.pdf](http://www.ncqa.org/portals/0/Adolescent%20Well-Care%20Visits.pdf)
   c. Denominator: Adolescents ages 12 to 21 years of age during the measurement period.
   d. Numerator: Adolescents in the denominator who had at least one well visit with a PCP or OB/GYN during the measurement year. Sports and camp physicals do not count unless the elements of a Bright Futures well visit are included and documented.

POTENTIAL CHALLENGES TO ACHIEVING IMPROVED WELL CHILD VISIT RATES

- Gaps in care
  - Healthy children and adolescents whose families do not realize the value of preventive visits
  - Infrequency of vaccines in the older age group so that one of incentives for well care is lost
  - Social determinants of health: challenges for a family due to parents missing work, children missing school, and transportation issues

- Gaps in data
  - The 2-3 day and 2-4 week well visit are often billed to the mother’s insurance and the baby’s MCO may not credit those visits. Unless identified and pointed out to the MCO the child may be missing two visits in the birth to 15 month period.
SAMPLE WAYS TO IMPROVE WELL CHILD VISIT RATES

✓ Use age-specific standardized templates in your EMR to maximize documentation of Bright Futures elements and to trigger reminders for next well visits.
✓ Start your improvement efforts by determining which patients are behind on their well child visits and call them in. Use your EMR’s recall system.
✓ Look two months ahead to see who is due and call, text, email or mail them to schedule a visit.
✓ Call all no shows.
✓ Consider targeting recalls at different times of year. For example:
  o Call patients with asthma in the late summer and early fall to make sure they get their flu shots and review asthma plans.
  o Target school-age children during the winter and in the spring and summer focus on adolescents.
  o Work to eventually have patients know to schedule a well child visit during the month of their birthday.
✓ Consider turning acute visits into well visits if a patient is behind on their well visit schedule and is not too ill to complete the well visit process.
✓ Post information about the value of preventive well visits on your website and Facebook page.
✓ Engage providers and staff in well visit rate improvement goals.
✓ Elicit parent/family feedback to maximize the value of well visits for families.
ASTHMA

HEDIS Measures

AMR  Asthma Medication Ratio – Age 5 to 11 Ratio > 50%
AMR  Asthma Medication Ratio – Age 12 to 18 Ratio > 50%

These measures only apply to your patients who have had a billed diagnosis of any form of persistent asthma – see codes below.

Asthma Medication Ratio (AMR): Percentage of patients with persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater up until December 31st of the measurement year.

To determine if a patient has met this measure, follow the steps below:
1. For each patient, count the units of controller medications dispensed during the measurement year (one unit = one individual medication lasting 30 days or less).
2. For each patient, count the units of reliever medications dispensed during the measurement year.
3. For each patient, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.
4. For each patient, calculate the ratio of controller medications to total asthma medications using the following formula:
Units of controller Medications (step 1)

Units of Total Asthma Medications (step 3)

**Medication Management for People with Asthma (MMA):** Percentage of patients with persistent asthma who were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. Percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.
2. Percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

The treatment period is the time beginning on the index prescription start date (IPSD) through the last day of the measurement year (Dec. 31st).

To determine if a patient has met this measure, follow the steps below:

1. Identify IPDS. The IPDS is the earliest dispensing event for any asthma controller medication during the measurement year.
2. Treatment period is calculated by counting the days between IPSD and the end of the measurement year.
3. Count the days covered by at least one prescription for an asthma controller medication during the treatment period.
4. Calculate the patient’s proportion of days covered (PDC) using the following equation:

\[
\text{PDC} = \frac{\text{Total Days Covered by a Controller Med. in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}
\]

In this MMA measure, all patients must be prescribed a 30-day supply only (regardless of indications for use like amount of puffs)—this is why this measure is broken up into two sub-measures (50% and 75%).
### Codes to Identify Asthma

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Intermittent Asthma</td>
<td>J45.20, J45.21, J45.22</td>
</tr>
<tr>
<td>Mild Persistent Asthma</td>
<td>J45.30, J45.31, J45.32*</td>
</tr>
<tr>
<td>Moderate Persistent Asthma</td>
<td>J45.40, J45.41, J45.42*</td>
</tr>
<tr>
<td>Severe Persistent Asthma</td>
<td>J45.50, J45.51, J45.52*</td>
</tr>
</tbody>
</table>

* Codes to be used as these two HEDIS measures only regard persistent asthma

### Asthma Controller Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiasthmatic combinations</td>
<td>Dyphylline-guaifenesin</td>
</tr>
<tr>
<td>Antibody inhibitors</td>
<td>Omalizumab</td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>Budesonide-formoterol</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>• Beclomethasone</td>
</tr>
<tr>
<td></td>
<td>• Budesonide</td>
</tr>
<tr>
<td></td>
<td>• Ciclesonide</td>
</tr>
<tr>
<td>Leukotriene modifiers</td>
<td>Montelukast</td>
</tr>
<tr>
<td>Mast cell stabilizers</td>
<td>Cromolyn</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>Aminophylline</td>
</tr>
</tbody>
</table>

### Asthma Reliever Medications

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-acting, inhaled</td>
<td>Albuterol</td>
</tr>
</tbody>
</table>
All plans should be using these exact criteria as these guidelines are explained in the HEDIS specifications guide developed by the National Committee for Quality Assurance (NCQA).

**SAMPLE WAYS TO IMPROVE ASTHMA CARE**

- Create and update action plans.
- Use spirometry to ensure the most accurate measure of lung function.
- Set up prompt in visit protocol to discuss follow up appointment in six months or sooner with parent and order the appointment plus a flu vaccine.
- Recall all asthma patients for influenza vaccine in the fall.
- Use these resources (links provided at PediatricTCPI.org/resources):
  - Spirometry 360 [YouTube video on how to do spirometry effectively:](http://www.spirometry360.org/otherresources/)
  - [Regional Asthma Management & Prevention – Action Plans](http://www.rampasthma.org/info-resources/asthma-action-plans) (multiple languages)
BEHAVIORAL HEALTH

HEDIS Measures

APM  Antipsychotic Monitoring  
ADD  ADHD Follow-up Care

Improve behavioral health and access to care by partnering with local behavioral health care providers. Work with these providers to improve referrals and communication, implement a feedback process and partner to address community needs. There are three questions you need to address in order to improve care:

1. **ACCESS**: How can I get my patient in the door to receive behavioral health care?

2. **ONGOING COMMUNICATION**: How do I know that the referral “stuck” - that my patient and family followed through and received care?

3. **INFORMATION SHARING**: How do I know what happened? How can I learn status, progress, and/or outcome of behavioral health interventions before the patient comes back to my office?

Regular, ongoing communication is the key to answering these questions. You can use our Behavioral Health Toolkit, which can be downloaded at Pediatric TCPI.org/resources, for sample forms to streamline and formalize referral and feedback. Read about one clinic’s efforts to streamline the process [here](http://pediatrictcpi.org/transformation-stories/partnering-improve-behavioral-health-care/).

How to succeed on the HEDIS Measures

1. **APM Antipsychotic monitoring**:
   a. Once every 12 months of antipsychotic use, a child needs to have both Blood sugar measurement (fasting blood sugar or a HbA1c), and Lipid measurement (Either LDL-c or total cholesterol) NCQA detailed definition: Percentage of children aged 1-17 who have had two or more antipsychotic prescriptions filled and at least one metabolic test for glucose or HbA1c, and at least one test for low-density lipoprotein cholesterol (LCL-C) or total cholesterol each year.
SAMPLE WAYS TO IMPROVE ANTIPSYCHOTIC MONITORING

- Inform clinic providers and refill line nurses of intention to monitor labs with antipsychotic prescriptions.
- Set up a refill line “check step” that if refilling an antipsychotic prescription to inform the prescriber of when the last blood sugar/lipid panel was performed.
- Create a reminder system in your clinic’s visit protocols regarding when next labs are due.
- Providers will need to discuss with families the need for lab test monitoring with long term use of these medications, to get their buy-in on the importance of monitoring.

2. ADHD follow-up care: Proportion of children newly diagnosed with ADHD and started on medications who receive in your office:
   a. At least one follow-up appointment in the next 30 days
   b. At least two more follow ups in the next 9 months

*Initiation Measure Details:* Children aged 6-12 years with a prescription dispensed for ADHD medication that had one follow-up visit with a practitioner with prescribing authority during the 30 day initiation phase.

*Continuation Measure Details:* Children aged 6-12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

SAMPLE WAYS TO IMPROVE ADHD FOLLOW-UP CARE

- At the time of making an initial ADHD diagnosis, provider (and front desk staff) plan to schedule a follow up check within 30 days. Set up a system for this in your EMR
- If clinic schedules are blocked out too far in advance to be able to find follow up appointments in 30 days, consider a procedure when a follow up visit gets tentatively scheduled at the time of an ADHD evaluation visit.
- To achieve the goal of 2 more follow up appointments in the next 9 months, try linking an appointment frequency check to medication refills and have follow up visits set up at the time of doing a medication refill.
SAMPLE WAYS TO REDUCE ED UTILIZATION

- Look at your data on avoidable ED utilization diagnoses and clarify whether those patients have been in your clinic. There may be many who are assigned to your practice who have never been in.
- Contact over-utilizers and share your office hours, how to contact you day and night, and start developing a relationship. This provides a good opportunity to help the patient get up to date on immunizations and well child visits.
- Track where your patients are going when you are not in – urgent care, emergency departments, what time of day, what day of the week – and see if you can add office hours to accommodate or change referral pattern and encourage families to call you first.
- Orient all new patients on what your office hours are, how to reach you after hours, and what kinds of conditions you will see urgently (head injury, fractures, lacerations, etc.).
Health homes seek to address complex health issues by offering comprehensive care management, care coordination, health promotion, comprehensive transitional care, and follow-up individual and family support as well as referral to community and social services support. This is a state funded program to pay for an RN or MSW to perform these services in your clinic or at an agency. There is required training that allows for proper documentation and billing/payment for services and referrals of qualifying patients as well as certification of your business as a Care Coordination Organization.

In pediatric practices only certain patients qualify for referral and funding but in larger clinics, this may support 0.5-2 FTE of RN and MSW time. Training and start-up does take several months to partially/fully fund the position. Many hybrid positions can be partially supported by this funding stream and your most complex patients can have tailored support.

Dr. Phyllis Cavens and Dr. Beth Harvey can connect you to training and answer questions. You may also find these health home resources from the State of Washington helpful (links available at PediatricTCPI.org/Resources):

- General Health Home Program Information: https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes
- Health Home Training Materials: https://www.dshs.wa.gov/altsa/washington-health-home-program
- Health Care Authority/DSHS Program Staff: HealthHomes@hca.wa.gov
In order to fulfill the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) measure, the provider must include in the medical record and claims the following information:

BMI percentile documentation or BMI percentile plotted on age-growth chart (height, weight and BMI percentile must be documented). Please keep in mind that it has to be the BMI percentile and not BMI value, as this seems to be a common reason for not counting toward the measure. The codes that must be on the claim need to be selected from the following:
<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI Percentile &lt;5% for age</td>
<td><strong>ICD-10:</strong> Z68.51</td>
</tr>
<tr>
<td>BMI Percentile 5% to &lt;85% for age</td>
<td><strong>ICD-10:</strong> Z68.52</td>
</tr>
<tr>
<td>BMI Percentile 85% to &lt;95% for age</td>
<td><strong>ICD-10:</strong> Z68.53</td>
</tr>
<tr>
<td>BMI Percentile ≥95% for age</td>
<td><strong>ICD-10:</strong> Z68.54</td>
</tr>
</tbody>
</table>

Documentation that PCP or OB/GYN provided counseling for nutrition, provided anticipatory guidance, or referral for nutrition education on the day of the visit. The codes to be used are the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling for nutrition</td>
<td><strong>CPT®:</strong> 97802-97804</td>
</tr>
<tr>
<td></td>
<td><strong>ICD-10:</strong> Z71.3</td>
</tr>
<tr>
<td></td>
<td><strong>HCPCS:</strong> G0270, G0271, G0447, S9449, S9452, S9470</td>
</tr>
</tbody>
</table>

Documentation that PCP or OB/GYN provided counseling for physical activity, provided anticipatory guidance, or referral for physical activity education. The code to be used is the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling for physical activity</td>
<td><strong>ICD-10:</strong> Z71.3</td>
</tr>
</tbody>
</table>
SAMPLE WAYS TO IMPROVE WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY

✓ Make sure your EMR lists the BMI percentile, not just the value. If not, contact your EMR provider and ask them to make changes so that the percentile is available for every patient.
✓ Set up the above CPT and ICD-10 codes in your EMR protocols so the provider is prompted to use them when applicable.
✓ Train your billing staff to ask about these codes for clarification when a similar code is billed.
OTHER OPPORTUNITIES FOR IMPROVEMENT

DENTAL

Washington Dental Service Foundation offers training materials, parent education tools and fluoride varnish samples, along with ongoing technical support. Visit KidsOralHealth.org (http://kidsoralhealth.org/) to learn more, or contact Madlen Caplow mcaplow@deltadentalwa.com or at 206-473-9542 to schedule an in-office training.

DEVELOPMENTAL SCREENING

The Washington Chapter of the American Academy of Pediatrics provides training to providers and office staff on implementing developmental screening through their Great MINDS (http://wcaap.org/programs/great-minds/) program.

NO SHOW POLICIES

If you don’t have a no-show policy, you should adopt one. There are many samples available online. Visit PediatricTCPI.org/Resources to download.

TEAM BUILDING AND WORKFLOW

Pediatric TCPI Practice Facilitators can provide LEAN training to ensure your practice is running as smoothly and efficiently as possible. You may also find this resource from the American Academy of Pediatrics useful: (https://www.aap.org/en-us/professional-resources/practice-transformation/managing-practice/Pages/default.aspx)
GLOSSARY/ACRONYM DEFINITIONS


AMGA list of acronyms: https://www.amga.org/docs/Advocacy/MACRA/AMGA_Acronym_List_05_16.pdf

RESOURCES

Links to these resources can also be found at PediatricTCPI.org/Resources:

Healthier Washington – information on Accountable Communities of Health: https://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach


Common Measure Set, updates focused on pediatrics: http://wahealthalliance.org/updates-to-common-measure-set-focus-on-pediatrics/

Common Measure Set via the Healthier Washington website, related information: https://www.hca.wa.gov/about-hca/healthier-washington/performance-measures

National TCPI Website: https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

WCAAP Pediatric TCPI Website: http://PediatricTCPI.org