2020 Quality Measure Highlight

Adolescent Well-Care Visits (AWC)

MEASURE DESCRIPTION

The percentage of members 12 - 21 years of age who had at least one comprehensive well-care visit with a PCP (PCP does not have to be assigned to the member) or an OB/GYN practitioner during the measurement year **(Numerator)**.

Measure Type: Hybrid (medical record / claims / encounter) a systematic sample drawn from the eligible population (**Denominator**).

Coding

Well Child CPT: 99384, 99385, 99394, 99395

Diagnosis Codes: Z00.00, Z00.01, Z00.121, Z00.129

Intent / Importance: Routine physicals for adolescents provide an opportunity for health education and age appropriate screening. They are also a time for adolescents and parents to raise any potential concerns. Adolescents benefit from an annual preventive health care visit that addresses the physical, emotional and social aspects of their health. This is a time of transition between childhood and adult life and is accompanied by dramatic changes and increased risk for accidents, homicide and suicide, which are the leading causes of adolescent deaths. Sexually transmitted infections, substance use, pregnancy and antisocial behavior are important causes of physical, emotional and social adolescent problems.

Please Note

- Due to COVID-19, the AWC measure is not part of the revised 2020 PCP QIP measurement set. It will likely be part of the 2021 PCP QIP measurement set.
- Data on AWC performance will continue to be available in eReports and the Partnership Quality Dashboard.
- For more information, please refer to the PCP QIP webpage, or contact the QIP Team at QIP@partnershiphp.org.

For additional information regarding the specifications for this measure feel free to email us: QIP@partnershiphp.org

References: National Committee on Quality Assurance (NCQA) HEDIS® 2020 Vol 2 Technical Specifications for Health Plans; NCQA HEDIS 2018 Vol 1 Narrative. HEDIS® is a registered trademark of NCQA.

Compliant Documentation

1. Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of ***all*** the following:

   - **A health history –** An assessment of the member's history of disease or illness. It can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history. *Examples of health history could be: allergies, medications, and immunizations (documented on different dates of service as long as **all** are documented within the measurement year); mother states siblings have ADHD, aunt has a history of seizures, father is asthmatic recently treated for shingles.
   - **A physical developmental history –** Developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult. Examples include **"development appropriate for age"**; skates, rides bike, body changes associated with puberty, physical maturity and reproductive growth leveling off and ending, firmer sense of sexual identity, more agile and coordinated, making it easier to do things like type on a keyboard or build complex projects. Developing visual-spatial coordination needed to help judge distance and speed and react quickly when learning to drive.
   - **A mental developmental history –** Includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult. Examples include **"development appropriate for age"**; neurologic or psychological or psych section notation of "normal for age or age appropriate"; concrete operational stage (age of relational thinking and concrete concepts), develop abstract thinking and logic, abstract thought established – future oriented, plan and pursue long range goals. Write with complexity about a variety of content areas (science, social studies, literature), take other opinions into account but make their own decisions.
   - **A physical exam.**
   - **Health education/anticipatory guidance –** Provided by the health care provider to the member and/or parents or guardians in anticipation of emerging issues that a member and family may face. Examples: tobacco exposure, avoiding alcohol, avoiding inhalants, auto safety.

2. Preventive services can be completed during well-child visits and during acute visits, as appropriate. Well-child preventive services count toward the measure, regardless of the primary intent of the visit.
   For acute care visits, services that are specific to the assessment or treatment of the acute or chronic condition related to that visit cannot count toward the measure. (These services are considered diagnostic or therapeutic, not preventative.)

Compliant Documentation (continued)

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3. Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.
4. Count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure. (See page 1 measure description.)
5. Documentation of "Tanner Stage/Scale" meets criteria for Physical Developmental History for this measure.

Non-Compliant Documentation

Do not include services rendered via telehealth or during an inpatient or ED visit.

1. Services that are specific to the assessment or treatment of an acute or chronic condition **do not** count toward the measure.
2. The following notations or examples of documentation that **do not** count as numerator compliant:
   - **Health History**
     - Notation of allergies or medications or immunization status **alone**. If all three (allergies, medications, immunization status) are documented it meets criteria.
     - Family health history is noted while performing the assessment and it is related to the reason for the child's acute or chronic condition (e.g., child is being assessed for difficulty breathing and wheezing, and part of the assessment notation includes the mother stating she and the child's sister have asthma).
   - **Physical Developmental History**
     - Notation of "appropriate for age" without specific mention of development.
     - Notation of "well developed/nourished/appearing."
     - Notation of "well developed."
   - **Mental Developmental History**
     - Notation of "appropriately responsive for age."
     - Notation of "neurological exam."
     - Notation of "well developed."

Non-Compliant Documentation (continued)

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- **Physical Exam**
  - Vital signs alone.
- Visits where care is limited to OB/GYN topics (e.g., prenatal or postpartum care). The purpose of including visits with OB/GYNs is to allow that practitioner type to perform the adolescent well-care visit requirements. It is not the measure's intent to allow care limited to OB/GYN topics to be a substitute for well-care**Health Education/Anticipatory Guidance**
  - Information regarding medications or immunizations or their side effects. (Consider if instructions could also be given to the parent of another child to guide them in their child's upcoming development.)
  - "Handouts given" during the visit without evidence of a discussion (e.g., Anticipatory Guidance [AG] discussed, AG reviewed).

Exclusion

Members in hospice are excluded from the eligible population.

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Best and Promising Practices

Use acute visits to cover one or more of the five areas of assessment.

- Ensure proper documentation of all components in the medical record for each visit where preventive services are addressed.
  - Documentation of “development appropriate for age” satisfies both physical and mental development.
  - Documentation of anticipatory guidance can be found on the Staying Healthy Assessment (SHA).
- Place next well-child visit sticker on health card. Schedule next appointment before the member/patient leaves the office or while “waiting” to be seen by the provider (e.g., in the exam room).
- Actively pursue missed appointments within 48 hours with reminder call by staff member.
- Use standardized templates in EHRs to guide providers and staff through the visit to ensure all components were met and documented.
- Offer extended evening or weekend hours.
- Identify and address barriers to care (transportation, language, cultural beliefs). Partner with established community agencies, schools, after-school programs, faith-based organizations.
- Offer extended evening or weekend hours.
- Health history can be obtained by documenting review of allergies, medications, immunizations, chronic illnesses, standardize practice to review on each visit.
- Submit claims and encounter data within 90 days of service. Use complete and accurate codes to capture services completed.

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