PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

2020 Quality Measure Highlight

Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life (W34)

MEASURE DESCRIPTION

The percentage of members 3 - 6 years of age who had one or more well-child visits with a PCP during the measurement year (MY). (**Numerator**)

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

Intent / Importance: A routine check-up with a PCP for children 3 - 6 years of age of the child's overall health and early detection with intervention of vision, speech and language problems. Allows for health teaching and for parents to raise any potential concerns. The child must have the visit during the measurement year, and the child must be 3, 4, 5 **or** 6 as of December 31 of the measurement year.

Coding

Well Child CPT: 99382, 99383, 99392, 99393

Diagnosis Codes: Z00.121, Z00.129

Please Note

- Due to COVID-19, the W34 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 W34 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

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 –** An assessment of specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.

Examples include **"development appropriate for age"**; *ability to hop or balances on one foot, stands on one foot, builds a block tower, throws a ball overhand, or walks upstairs alternating feet.*

- **A mental developmental history –** An assessment of specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop. *Examples include "development appropriate for age"; Neurologic or Psychological or Psych section notation of "normal for age or age appropriate"; ability to speak understandably, make 2-3 sentences, identify colors (e.g., 4 or >), draws person (e.g., 2 or > body parts), copies simple shapes (e.g., circle, square, triangle).*
- **A physical exam.**
- **Health education/anticipatory guidance –** Given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.
  Examples: tobacco exposure, auto safety.

Note: *"Handouts given" during the visit without evidence of a discussion (e.g., AG discussed, AG reviewed) does not meet criteria.*

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.)
3. Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam 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. We may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

<u>Non-Compliant Documentation</u>

1. **Do not** include services rendered via telehealth or during an inpatient or ED visit.
2. Services that are specific to the assessment or treatment of an acute or chronic condition **do not** count toward the measure.
3. The following notations or examples of documentation **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 Tanner Stage/Scale.
  - 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)

- **Physical Exam**
  - Vital signs alone.
- **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.

Exclusion

Members in hospice are excluded from the eligible population.

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.
- 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.