Care Gaps That Can Be Closed in the NaviNet Care Gap Response Form

AmeriHealth Caritas
Care is the heart of our work

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Adults' Access to Care (AAP)	Ambulatory or preventive care visit within the measurement year	None
Advance Care Planning (ACP)	Date of service of Advance Care Plan or discussion in the measurement year	None
Blood Pressure < 140/90 Eval — Diastolic Pressure Greater Than or Equal to 90 (CBP/BPD	Most recent/last BP in the measurement year from outpatient setting	None
Breast Cancer Screening (BCS)	Report or visit note documenting: • Mammogram dated on or between October 1 two years prior to the measurement year and December 31 of the measurement year	Documentation of bilateral mastectomy with date of service any time in member's history. Can be unilateral mastectomies with different dates of service.
Care of the Older Adult (COA) — Medication Review	Visit note with: • Medication list and evidence of review by prescribing practitioner/clinical pharmacist in the measurement year • Note can reflect that member is not taking any medications	None

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Care of the Older Adult (COA) — Functional Assessment	Notations for a complete functional status assessment must be in the measurement year and include one of the following: • Notation that activities of daily living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking • Notation that instrumental activities of daily living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances • Result of assessment using a standardized functional status assessment tool, not limited to: - SF-36 - Assessment of Living Skills and Resources (ALSAR) - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale - Bayer ADL (B-ADL) Scale - Barthel Index - Edmonton Frail Scale - Extended ADL (EADL) Scale	None

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Care of the Older Adult (COA) — Functional Assessment (continued)	- Groningen Frailty Index - Independent Living Scale (ILS) - Katz Index of Independence in ADL - Kenny Self-Care Evaluation - Klein-Bell ADL Scale - Kohlman Evaluation of Living Skills (KELS) - Lawton and Brody's IADL scales - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales	None
Care of the Older Adult (COA) — Pain Assessment	Visit note reflecting: · Pain assessment in the measurement year · Can be standardized tool or notation • ***May not be chest pain only***	None
Cervical Cancer Screening (CCS)	Lab/procedure report with date of service documenting one of the following: · Documentation of Pap completed in the measurement year or two years prior · Documentation of hrHPV in the measurement year or four years prior for women at least 30 years of age on date of test · Can be member-reported data/ captured in medical record history as long as result is noted (e.g., Negative or WNL)	Copy of a medical record documenting hysterectomy with no residual cervix

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Child and Adolescent Well-Care Visits (WCV)	Well-child visits within the measurement year	None
Childhood Immunization Status (CISQ) — Lead Screening	Laboratory report or visit note with date of service and results on or before the 2nd birthday.	None
Childhood Immunization Status (CISQ) — DTaP	Immunization record or visit note documenting four DTaP vaccines on or before the 2nd birthday. Do not count a vaccination administered prior to 42 days after birth.	None
Childhood Immunization Status (CISQ) — Hep B Vaccination	Immunization record or visit note documenting three Hep B vaccines before or on the 2nd birthday. One date of service can be newborn vaccine.	None
Childhood Immunization Status (CISQ) — Haemophilus Influenzae Type B (HiB) Vaccine	Immunization record or visit note documenting three HiB vaccines on or before the 2nd birthday. Do not count a vaccination administered prior to 42 days after birth.	None
Childhood Immunization Status (CISQ) — MMR Vaccination (Measles, Mumps, and Rubella (MMR)	Immunization record or visit note documenting MMR vaccine on or between the 1st and 2nd birthdays. History of measles, mumps, or rubella illness prior to 2nd birthday is acceptable.	None

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Childhood Immunization Status (CISQ) — Influenza Vaccine	Immunization record or visit note documenting two influenza vaccines on or before the 2nd birthday. Do not count a vaccination administered prior to six months (180 days) after birth.	None
Childhood Immunization Status (CISQ) — Rotavirus Vaccine	Immunization record or visit note documenting one of the following on or before the 2nd birthday: · 2 doses of the two-dose rotavirus vaccine on different dates of service · 3 doses of the three-dose rotavirus vaccine on different dates of service · 1 dose of the two-dose rotavirus vaccine and two doses of the three-dose rotavirus vaccine	None
Childhood Immunization Status (CISQ) — Varicella Zoster (VZV) Vaccine	Immunization record or visit note documenting VZV vaccine on or between the 1st and 2nd birthdays	None
Childhood Immunization Status (CISQ) — Pneumococcal Conjugate Vaccine (PCV)	Immunization record or visit note documenting four PCV vaccines on or before the 2nd birthday. Do not count a vaccination administered prior to 42 days after birth.	None
Childhood Immunization Status (CISQ) — Inactivated Polio Vaccine (IPV)	Immunization record or visit note documenting three IPV vaccines on or before the 2nd birthday. Do not count a vaccination administered prior to 42 days after birth.	None

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Childhood Immunization Status (CISQ) — Hepatitis A Vaccine	Immunization record or visit note documenting Hep A vaccine on or between the 1st and 2nd birthdays	None
Chlamydia Screening in Women (CHL)	Laboratory report with date of service and results during the measurement year	None
Colorectal Cancer Screening (COL)	Lab/procedure report with date of service documenting one of the following: • FOBT in the measurement year • sDNA in the measurement year or the two years prior • Flexible sigmoidoscopy or CT colonography in the measurement year or the four years prior • Colonoscopy in the measurement year or the nine years prior • Can be member-reported data/ captured in medical record history	None

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Developmental Screening in the First Three Years of Life (DEV-CH)	Children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday during the measurement year: · Ages and Stages Questionnaire — 3rd Edition (ASQ-3) · Parents' Evaluation of Developmental Status (PEDS) — Birth to age 8 · Parent's Evaluation of Developmental Status — Developmental Milestones (PEDS-DM) · Survey of Well-Being in Young Children (SWYC) · Battelle Developmental Inventory Screening Tool (BDI-ST) — Birth to 95 months · Bayley Infant Neurodevelopmental Screen (BINS) — 3 months to age 2 · Brigance Screens-II — Birth to 90 months · Child Development Inventory (CDI) — 18 months to age 6 · Infant Development Inventory — Birth to 18 months	None
Eye Exam for Patients with Diabetes (EED)	Documentation of: · Dilated or retinal eye exam report with date of service and results during the measurement year or the prior year · Results must be from optometrist, ophthalmologist, or AI software	None

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Hemoglobin A1c Control for Patients with Diabetes (HBD)	• Laboratory report with date of service and results for most recent/last A1c during the measurement year • Can be POCT if date and result are clearly documented.	None
Immunizations for Adolescents (IMA) — HPV (Human Papillomavirus)	Immunization record or visit note documenting two HPV immunizations with dates of service at least 146 days apart on or between the 9th and 13th birthdays. Can also be three HPV immunizations on different dates between the 9th and 13th birthdays.	None
Immunizations for Adolescents (IMA) — MCV (Meningococcal)	Immunization record or visit note documenting meningococcal vaccine on or between the 11th and 13th birthdays	None
Immunizations for Adolescents (IMA) — Tdap (Tetanus, diphtheria toxoids and acellular pertussis)	Immunization record or visit note documenting Tdap vaccine on or between the 10th and 13th birthdays	None
Osteoporosis Management	Documentation of one of the following within six months of a fracture: • A bone mineral density (BMD) test • Administered osteoporosis medication	None

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Postpartum Care (PPC)	OB/GYN, prenatal care provider, or PCP visit note with date of service between 7and 84 days after delivery documenting one of the following: · Notation of PP care · Pelvic exam · Eval. of weight, BP, breasts, and abdomen · Perineal or cesarean incision/ wound check · Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders · Glucose screening for women with gestational diabetes · Any one of: infant care, breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/ fatigue, resumption of physical activity, attainment of healthy weight	None
Prenatal Care (PPC)	OB/GYN, prenatal care provider, or PCP (requires a diagnosis of pregnancy) visit note with date of service during first trimester documenting one of the following: · Pregnancy · Basic physical OB exam · Evidence of a prenatal care procedure performed (An ultrasound alone is not considered a visit.)	None

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Transition of Care (TRC) — Medication Reconciliation Post Discharge	Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days) — can be a visit note specifically reflecting hospital follow-up and current medication list.	None
Transition of Care (TRC) — Notification of Inpatient Admission	Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission. Must be present in the outpatient record.	None
Transition of Care (TRC) — Patient Engagement after Inpatient Discharge	Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.	None
Transition of Care (TRC) — Receipt of Discharge Information	Discharge info in outpatient record on day of discharge through two days after discharge. Must include: · Provider of inpatient care · Procedures/treatments · Discharge diagnosis · Current medication list · Test results or notation that no tests are pending · Discharge instructions	None
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) — BMI%	Height, weight, and BMI percentile (can be growth chart) captured within the measurement year	None

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Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) — Nutrition	Counseling for nutrition within the measurement year	None
Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) — Physical Activity	Counseling for physical activity within the measurement year	None
Well-Child Visits in the First 15 Months of Life (W15)	Children who turned 15 months old during the measurement year: Six or more well-child visits	None
Well-Child Visits in the First 30 Months of Life (W30)	Children who turned 30 months old during the measurement year: Two or more well-child visits	None