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



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Adults' Access to Care (AAP)	Ambulatory or preventive care visit within the measurement year; an ER visit does not meet criteria.	None
Adult Immunization Status (AIS) — Influenza (1 to 2 doses dependent on vaccine type, age 19 and older)*	Immunization record or visit note documenting administration of influenza vaccine. The date of service must match the vaccine(s) administration date.	None
Adult Immunization Status (AIS) — Pneumococcal (1 dose, age 19 and older)*	Immunization record or visit note documenting administration of adult pneumococcal vaccine. The date of service must match the vaccine(s) administration date.	None
Adult Immunization Status (AIS) — Td/Tdap (1 dose, age 19 and older)*	Immunization record or visit note documenting administration of Td/Tdap. The date of service must match the vaccine(s) administration date.	None
Adult Immunization Status (AIS) — Hep B (2 dose/3 dose, age 19 and older)*	Immunization record or visit note documenting administration of Hep B vaccine. The date of service must match the vaccine(s) administration date.	None
Adult Immunization Status (AIS) — Zoster (1 dose, age 50 and older)*	Immunization record or visit note documenting administration of zoster. The date of service must match the vaccine(s) administration date.	None
Advance Care Planning (ACP)	Date of service of Advance Care Plan or discussion in the measurement year	None

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Blood Pressure < 140/90 Eval—Systolic/Diastolic Pressure Less Than or Equal to 140/90 (CBP/ BPD)	Most recent/last BP in the measurement year from outpatient setting	None
Breast Cancer Screening (BCS)	Members 40 – 74 years of age with documentation or report of 1 or more mammograms 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 function- al 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, ambulation • 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, and 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

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Cervical Cancer Screening (CCS)	Lab/procedure report with date of service documenting one of the following: • 21 – 64 years of age with documentation of Pap completed in the measurement year or two years prior • 30 – 64 years of age with 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. Must specify complete, total, radical, or vaginal hysterectomy.
Child and Adolescent Well-Care Visits (WCV)	Well-child visits within the measurement year for members ages 3 – 21 years old.	None
Childhood Immunization Status (LSC) – Lead Screening (Pb)*	Laboratory report or visit note with date of service and results on or before the 2nd birthday. The date of service must match the vaccine(s) administration date.	None
Childhood Immunization Status (CIS-E) – Diphtheria, Tetanus, Acellular Pertussis (DTaP) Vaccine*	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. The date of service must match the vaccine(s) administration date.	None

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Childhood Immunization Status (CIS) — Hepatitis B (Hep B) Vaccine*	Immunization record or visit note documenting three Hep B vaccines on or before the 2nd birthday. One date of service can be newborn vaccine. The date of service must match the vaccine(s) administration date.	None
Childhood Immunization Status (CIS) — 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. The date of service must match the vaccine(s) administration date.	None
Childhood Immunization Status (CIS) — (Measles, Mumps, and Rubella (MMR) Vaccine*	Immunization record or visit note documenting MMR vaccine on or between the 1st and 2nd birthdays. The date of service must match the vaccine(s) administration date.. History of measles, mumps, or rubella illness prior to 2nd birthday is acceptable.	None
Childhood Immunization Status (CIS) — Influenza (Flu) 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. The date of service must match the vaccine(s) administration date.	None

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Childhood Immunization Status (CIS) — Rotavirus (Rota) Vaccine*	Immunization record or visit note documenting one of the following on or before the 2nd birthday: • Two doses of the two-dose rotavirus vaccine on different dates of service • Three doses of the three-dose rotavirus vaccine on different dates of service • One dose of the two-dose rotavirus vaccine and two doses of the three-dose rotavirus vaccine The date of service must match the vaccine(s) administration date.	None
Childhood Immunization Status (CIS) — Varicella Zoster (VZV) Vaccine*	Immunization record or visit note documenting VZV vaccine on or between the 1st and 2nd birthdays. The date of service must match the vaccine(s) administration date.	None
Childhood Immunization Status (CIS) — Pneumococcal Conjugate (PCV) Vaccine*	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. The date of service must match the vaccine(s) administration date.	None
Childhood Immunization Status (CIS) — Inactivated Polio (IPV) Vaccine*	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. The date of service must match the vaccine(s) administration date.	None

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Childhood Immunization Status (CIS) – Hepatitis A (Hep A) Vaccine*	Immunization record or visit note documenting Hep A vaccine on or between the 1st and 2nd birthdays. The date of service must match the vaccine(s) administration date.	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 and evidence testing was completed for members age 45 – 75 years old 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
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Members age 18 to 64 years old. Laboratory report/POC testing with date of service and results for most recent A1c in MY2026.	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

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Eye Exam for Patients with Diabetes (EED)	Documentation of: • Negative dilated or retinal eye exam in the MY or PY; positive dilated or retinal eye exam in the MY. We can only accept AI software in the MY.	None
Hemoglobin A1c Control for Patients with Diabetes (HBD)Glycemic Status Assessment for Patients with Diabetes (GSD)	• Laboratory report with date of service and results for most recent/last A1c during the measurement year • Can be point-of-care testing (POCT) if date and result are clearly documented.	None
Immunizations for Adolescents (IMA) — Human Papillomavirus (HPV) Vaccine*	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. The date of service must match the vaccine(s) administration date.	None
Immunizations for Adolescents (IMA) — Meningococcal (MCV) Vaccine*	Immunization record or visit note documenting meningococcal vaccine on or between the 11th and 13th birthdays The date of service must match the vaccine(s) administration date.	None

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Immunizations for Adolescents (IMA) — Tetanus, diphtheria toxoids, and acellular pertussis (Tdap) Vaccine*	Immunization record or visit note documenting Tdap vaccine on or between the 10th and 13th birthdays. The date of service must match the vaccine(s) administration date.	None
Oral Evaluation, Dental Services (OED)	Members under the age of 21 years. Dental visit with any dental provider in MY26	None
Osteoporosis Management (OMW)	Documentation of one of the following within 6 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 postpartum care • Pelvic exam • Evaluation of weight, blood pressure, 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 the following: infant care, breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity, attainment of healthy weight	None

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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
Prenatal Immunization Status (PRS) – 1 dose of Influenza and 1 dose Tdap	Immunization record or visit note documenting administration of Influenza (received on or between July 1 of the year prior to the measurement period and the date of delivery) and Tdap (any time during pregnancy or on delivery date). The date of service must match the vaccine(s) administration date.	Deliveries that occurred at less than 37 weeks gestation.
Topical Fluoride for Children (TFC) – 2 Applications	Members 1 to 4 years of age. Fluoride varnish applications in MY. Can only enter one visit at a time.	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

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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
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

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