CMS Quality Improvement Workshop Series
QI 101
Webinar 1: Getting Started

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Agenda

- Welcome and Introductions
- Purpose and Learning Objectives
- Overview of the Workshop Curriculum
- Quality Improvement
- Introduction to the Model for Improvement
- Improvement Process
- A QI Case Study
- Question and Answer
- Preview of Next QI Webinar
Purpose and Learning Objectives

Purpose

• Enable state Medicaid programs to apply quality improvement (QI) to improve child and adult health care quality outcomes

Learning Objectives

• Participants will learn the basic tasks to conduct a QI project
• Participants will learn the three questions in The Model for Improvement
• Participants will identify at least two considerations for how to pick a QI project in order to answer the first question in the Model for Improvement:
  • “What are we trying to accomplish?”
Overview of the Workshop Curriculum

• QI 101: Establishing the QI Foundation
  • Webinar 1: Getting Started – provides a broad overview of QI fundamentals and introduction to “The Model for Improvement”
  • Webinar 2: The QI Framework – provides a structured approach for planning and monitoring the impact of QI efforts
  • Webinar 3: Preparing for and Implementing Change

• QI 201: Application of the QI Methods
  • A series of three webinars with hands-on practice
  • Enables states to undertake a QI project with support
Quality Improvement
Quality Improvement & The Know-Do Gap

What we know

Yesterday                                Today                                Tomorrow

What we do
Going From ‘What We Know’ to ‘What We Do’

Leading,
Building Will

Ideas for Systems Improvement
Driver Diagram

Executing and Spreading Change
Strategies, Testing and Measurement

Medicaid/CHIP
Health Care Quality Measures
The Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act

Plan

Study

Do

Source: Associates in Process Improvement
The Improvement Process

**PLAN**
- Task 1: Identify a QI Project
- Task 2: Engage Stakeholders
- Task 3: Organize the Effort
- Task 4: Create the Aim, Measures, and Changes

**DO**
- Task 5: Start Your Project

**STUDY**
- Task 6: Assess Outcomes

**ACT**
- Task 7: Develop Response Based on QI Outcomes
Identify a QI Project

- What does data tell you?
- How do you compare to others?
- What is the gap between what is possible and where you are? How are you performing now?
- Are there glaring health disparities?
- Is this a reasonable place to save money and improve outcomes?
- Other concerns:
  - How interested or engaged are your public constituents? Your key partners?
  - How aligned is this improvement project with the strategic priorities of your agency, the governor, or the secretary? If not, how might you make the case for improvement?
Useful Data in Selecting a QI Project

- Medicaid and CHIP program expenditure data (top diagnosis, utilization, cost drivers)
- Child and Adult Core Set measures (past performance)
- Claims/encounter data, health record reviews
- Pharmacy data analysis
- Referral patterns and supply driven demand
Secretary’s Annual Report on the Quality of Care for Children in Medicaid and CHIP

### Appendix Table E.1 (continued)

| State       | Number of Measures Reported by State | Preventative and Routine Care Timeliness (PRT) (b) | Frequency of Ongoing Preventive Care (c) | Percentage of Live Birth Weight Less Than 2,500 Grams (d) | Cesarean Rate for Non-Low Risk Single Varies (Low-Risk First Birth Woman (64)) | Childhood Immunizations Status (e) | Immunization Assessment for Children and Adolescents (f) | Developmental Screening in the First Three Years of Life (g) | Chlamydia Screening (h) | Well Child Visits in the 3rd, 4th, and 6th Years of Life (i) | Well Child Visits in the 1st, 2nd, and 5th Year of Life (j) | Adolescence Well-Care Visits (k) | Percentage of Eligibles who Received Preventive Dental Services (l) | Appropriate Testing for Children with Phenylketonuria (m) | Appropriate Testing for Children with Hemoglobin (n) | Appropriate Testing for Children with Cystic Fibrosis (o) | Appropriate Testing for Children with Asthma (p) | Appropriate Testing for Children with Diabetes (q) | Annual Percentage of Medicaid Patients (4-20 years old) with 1 or More Ambulatory Measures (r) | Annual Percentage of Medicaid Patients (2-20 years old) with 1 or More Ambulatory Measures (s) | Follow-Up Care for Children Prescribed Anti-Depressant-Deficit Hyperactivity Disorder (t) | Annual Pediatric Hemoglobin A1C Testing (u) | Follow-Up After Hospitalization for Mental Illness (v) |
|-------------|-------------------------------------|-----------------------------------------------|------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------|-------------------------------------------------------|-----------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------|
| Vermont     | 7                                   | X                                             | X                                        | X                                                      | X                                                                              | X                                | X                                                      | X                                                     | X                                 | X                                                        | X                                                      | X                                                      | X                                                        | X                                                      | X                                                  | X                                                  |
| Virginia    | 11                                  | X                                             | X                                        | X                                                      | X                                                                              | X                                | X                                                      | X                                                     | X                                 | X                                                        | X                                                      | X                                                      | X                                                        | X                                                      | X                                                  | X                                                  |
| Washington  | 10                                  | X                                             | X                                        | X                                                      | X                                                                              | X                                | X                                                      | X                                                     | X                                 | X                                                        | X                                                      | X                                                      | X                                                        | X                                                      | X                                                  | X                                                  |
| West Virginia | 16                                    | X                                             | X                                        | X                                                      | X                                                                              | X                                | X                                                      | X                                                     | X                                 | X                                                        | X                                                      | X                                                      | X                                                        | X                                                      | X                                                  | X                                                  |
| Wisconsin   | 14                                  | X                                             | X                                        | X                                                      | X                                                                              | X                                | X                                                      | X                                                     | X                                 | X                                                        | X                                                      | X                                                      | X                                                        | X                                                      | X                                                  | X                                                  |

### Appendix Table E.4. Percentage of Children Receiving Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, as Reported by States in their FY 2011 CARTS Reports (n=47)

<table>
<thead>
<tr>
<th>State</th>
<th>Methodology</th>
<th>Date Range</th>
<th>Medicaid</th>
<th>CHIP</th>
<th>CHIP Program Type</th>
<th>Sample Size</th>
<th>Administrative</th>
<th>Hybrid</th>
<th>Percentage of Children Receiving 1+ Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life</th>
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<tr>
<td>Alabama</td>
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<td>Jan-10 - Dec-10</td>
<td>X</td>
<td>X</td>
<td>Separate</td>
<td>7,343</td>
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<td>Arizona</td>
<td>HEDIS 2011</td>
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<td>X</td>
<td>Expansion</td>
<td>3,603</td>
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<td>75.5</td>
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<tr>
<td>Arkansas</td>
<td>HEDIS 2010</td>
<td>Oct-09 - Sep-10</td>
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<td>Separate</td>
<td>88,106</td>
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<td>California</td>
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<td>Combination</td>
<td>115,975</td>
<td>X</td>
<td>74.0</td>
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**Questions:**
- What measures is your state reporting?
- Where does your state fall?
Engage Stakeholders

- Stakeholders help build and maintain will for improvement
- Stakeholders help with executing a QI project
- Various ways and levels at which to continually engage stakeholders
  - Town hall meetings
  - Task forces
  - Advisory committees
• Identify who influences the desired outcomes and bring them into the room
  • Who does the state depend on to make this improvement? (e.g., payers, providers, hospitals)
  • Who depends on the state to make this improvement? (e.g., constituents, Secretary, Governor)
PLAN: Task 2

Potential Stakeholders

- Medicaid/CHIP
- Title V
- Plans
- Community Groups
- Education
- Health
- IT
- Admin. and Financial
- Public
- Providers
- Payors
Organize the Effort:
QI Project Team Composition

• State-led QI project teams should include representation from:
  • Lead agency
  • Partner agencies/other payers serving the population
  • Key providers/entities serving the population
• Teams may also include representation from:
  • Clinician community
  • Families
  • Patients
  • Community-based organizations
Create the Aim, Measures, and Changes

- Set data-driven aim and goals
- Answer the 3 Questions in the Model for Improvement:
  - Aim: What are we trying to accomplish?
  - Measure: How will we know that a change is an improvement?
  - Changes: What change can we make that will result in an improvement?
Aim:

• We are organizing 20 clinics in the metro area and 20 rural clinics, along with their hospital partners, to reduce obstetrical inductions for women prior to 39 weeks by 50 percent or more. We will accomplish this by February 14, 2014

Measures:

• Outcome measures: Rate of inductions prior to 39 weeks without medical indication
• Process measures: Bundle compliance rates for elective and augmentation inductions
• Balancing measures: Family/staff satisfaction

Changes:

• Elective induction bundle, augmentation bundle, instrument delivery bundle
Example of Data-Driven Aim 2

Aim:
By February 2014, reduce early inductions prior to 39 weeks by 80 percent or more by adoption of related Medicaid policies and programs, aligning payment, and regulation (revising conditions of participation to include key changes).

Measures:
Outcome: Percent of births induced without indication prior to 39 weeks
Process: Proportion of births in state with hard stop policies
Balancing: Family/staff satisfaction

Changes:
New policies, pay-for-performance
Questions?
Develop Change Ideas
Integrated with Driver Diagram

- Data from Secretary’s report - what states have outstanding performance and how did they achieve this?
- Literature
- Experts
- People on front line with experience and knowledge of processes
- Innovators who have achieved exceptional results
Global Goal: Improve utilization and quality of inter-conception care among women who have experienced a Medicaid financed birth that resulted in an adverse pregnancy outcome.

Smart Aim: Improve percent of Medicaid-eligible women receiving Post Partum and Family Planning visits by 20 percent by December 2013.

Key Drivers

- **Eligibility**
- **Program Design**
- **Data Driven & QI Processes**
- **Medicaid Admin & Payment**
- **Provider Practices**
- **Consumer Outreach**

Secondary Drivers

- **1115 Waiver (“Interpregnancy”)**
- **Optional eligibility for women**
- **ACA Medicaid expansion (January 2014 and beyond)**
- **Plan to enroll those eligible**

- **Targeted Case Management for women < 90% FPL**
- **Administrative Case Management for > 90% - 200% FPL**
- **PCMH and HH focus on women with chronic health conditions**
- **Integrated delivery systems with standardized reproductive measures**
- **Innovation grants & projects**

- **Medicaid and Vital Stats Linkages with meaningful feedback**
- **Tracking high risk women across systems**
- **Develop QI capacity for this population among Providers**
- **Develop Perinatal Quality Collaboratives to disseminate best practice**

- **Medicaid Billing “Mythbusting” and code development**
- **Reimbursement for Inter Conception Care (ICC) (And PCC)**
- **Managed Care Plan Contract language development**
- **Address Contraception Care barriers within Medicaid**
- **Incentives for reproductive health planning measures (Adol WCC, PPV)**

- **Education: Medicaid Provider Manuals & Guidance**
- **Screening Tools/ New apps/ IT innovation**
- **Focus on high risk adolescent women and post-partum (Pre conception and Inter conception Care)**
- **Systems integration & Coordination**

- **Screening tools for consumers at risk for poor birth outcomes**
- **Informational materials & social marketing campaign**
- **Pre and Inter Conception Care Outreach**
- **Patient engagement strategies**
Start Your Project

- Launch your team
- Manage the process
- Conduct PDSAs
- Collect and review data
- Monitor changes
Assess Outcomes

• Review documented improvement efforts
• Do the data exceed or fall short of the aim?
• Were the desired outcomes achieved?
  • For example:
    • Reduced inductions between 36 and 38 weeks
    • Reduced neonatal days
    • Decreased cost of care
Percent distribution of Ohio* full term and near term births, by month
January 2006 to May 2010

Since OPQC inception, 9,000 expected near-term births statewide were delayed to full-term.

Averages were calculated from the initial 24 months, January 2006 to December 2007.

*Data from Ohio Perinatal Quality Collaborative, CMS Neonatal Outcomes Improvement Project
Develop Response Based on QI Outcomes

• Are the results generalizable to other settings, populations, locales?

• Do adaptations need to be made to ensure similar effectiveness in other settings?
  • For other populations?
  • In other locales?

• How will the QI project move from the improvement teams to all possible sites where improvement is needed?
  • What additional resources might other sites need?
  • What policy and payment changes can be implemented?
If Desired Outcomes NOT Achieved: Analysis of Barriers and Next Steps

- What were the barriers to success?
- Were the barriers within or outside of the implementation team’s control?
- How might the strategy be modified to achieve desired outcomes?
- What recommendations could be made for moving forward?
A QI Case Study

- Aims
- Organization
- Changes
- Results
Question 1 in Model for Improvement: What are we trying to accomplish?

Aim should be “S-M-A-R-T”

Specific
Measureable
Attainable
Relevant
Time bound

Aim

In one year, reduce by 60% the number of women in Ohio of 36.1 to 38.6 weeks gestation for whom initiation of labor or caesarean section is done in absence of appropriate medical or obstetric indication (scheduled delivery)
To accomplish results who are the stakeholders?

- In order to reduce inductions between 36 and 38 weeks, who would the state need to include?
  - Medicaid plans and payers
  - Providers
  - Hospitals (obstetric and neonatal units)
  - Community partner
- Who has a shared interest in improved outcomes?
  - Women who are constituents
  - WIC
  - Title V
  - Medical societies and associations
  - Others?
Question 2: How Will We Know a Change is an Improvement? Baseline Data

Percent distribution of Ohio full term and near term births, by month
January 2006 to September 2008 (pre-OPQC)

*Data from Ohio Perinatal Quality Collaborative, CMS Neonatal Outcomes Improvement Project*
Question 2: How will we know a change is an improvement?

Results

Percent distribution of Ohio* full term and near term births, by month
January 2006 to May 2010

Since OPQC inception, 9,000 expected near-term births statewide were delayed to full-term.

Averages were calculated from the initial 24 months, January 2006 to December 2007.

*Data from Ohio Perinatal Quality Collaborative, CMS Neonatal Outcomes Improvement Project
Example: Ohio Driver Diagram

**Goal:** Assure that all induction of labor or caesarean sections on women who are not in labor occur only when obstetrically or medically indicated.

### Secondary Drivers
- Inform consumers of risk/benefits of deliveries < 39 weeks
- Communicate to patient/clinic/hospital ultrasound results
- Promote need for early dating to practitioners and consumers
- Public awareness campaign

### Primary Drivers

**Project Aim:** In one year, reduce by 60%, the number of women in Ohio of 36.1 to 38.6 weeks gestation for whom induction of labor or caesarean section is done in absence of appropriate medical or obstetric indication (Scheduled delivery)

- **Awareness of risks & expected benefit of near-term delivery by patients and consumers**
  - Inform consumers of risk/benefits of deliveries < 39 weeks
  - Communicate to patient/clinic/hospital ultrasound results
  - Promote need for early dating to practitioners and consumers
  - Public awareness campaign

- **Dating criteria: optimal estimation of gestational age**
  - Promote need for early dating to practitioners and consumers
  - Promote sonography < 20 weeks to establish dates
  - Document criteria used to establish EDC
  - Appropriate use of fetal maturity testing
  - Empower nurses/schedulers to require dating criteria
  - Identify a specific contact for authorization dispute re: dating
  - Provide patient with hard copy results of ultrasound

- **Hospital and physician practice policies that facilitate ACOG criteria**
  - Empower nurses/schedulers to require dating criteria
  - Document rationale and risk/benefit for scheduled deliveries at 36.1 to 38.6 weeks gestation
  - Document discussion with patient about the above
  - Both patient and MD sign consent statement for scheduled delivery between 36.1 and 38.6 weeks
  - Physician awareness campaign: what are the reason(s) for scheduled delivery?
  - Maximize access to Delivery and OR for optimal scheduling
  - Facilitate scheduling policies that respect ACOG criteria

- **Awareness of risks & expected benefit of near-term delivery by clinician**
  - Prenatal caregivers receive feedback from postnatal caregivers about neonatal outcomes of scheduled deliveries
  - Ensure complete and accurate handoffs OB/Ob and OB/Peds
  - Document discussion with patient about risks/benefits of near-term delivery
  - Promote need for early dating to practitioners and consumers

- **Culture of safety and improvement**
  - Continuous monitoring of data & discussion of this effort in staff/division meetings
  - Project outcomes posted on units and websites
  - Develop ways to include staff and physician input about communications and handoffs
  - Connect with organizational initiatives on safety and use existing approaches as possible
  - Empower nurses/schedulers to require dating criteria

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**Medicaid/CHIP Health Care Quality Measures**
Question 3: What changes can we make to bring about improvement?

- Use a driver diagram to organize theory and ideas for improvement:
  - Primary Drivers: Major processes, operating rules, or structures that will contribute to moving toward the aim
  - Secondary Drivers: Elements or portions of the primary drivers. The secondary drivers are system components necessary in order to impact primary drivers, and thus reach project aim
  - Specific Changes: Concrete actionable ideas to take to testing
  - Measures can be indicated on the driver diagram as it becomes more mature
Recap of Learning Objectives

• Participants will learn the basic tasks to conduct a QI project
• Participants will learn the three questions in The Model for Improvement
• Participants will identify at least two considerations for how to pick a QI project in order to answer the first question in the Model for Improvement:
  • “What are we trying to accomplish?”
Additional Resources

• 2012 Secretary’s Report:

  Model for Improvement:
  http://www.apiweb.org/API_home_page.htm

• Ohio Perinatal Quality Collaborative: https://opqc.net/

• Perinatal Quality Collaborative of North Carolina:
  http://www.pqcnc.org/

• Neonatal Outcomes Improvement Project – Nine Interventions:
  http://www.nichq.org/expert_services/sample_projects/neonatal_outcomes_improvement/nine_interventions.html
Questions?
Jointly sponsored by Tufts University School of Medicine and National Initiative for Children’s Healthcare Quality

Accreditation

Physicians

• This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of Tufts University School of Medicine (TUSM) and National Initiative for Children’s Healthcare Quality. TUSM is accredited by the ACCME to provide continuing medical education for physicians.
• TUSM designates this enduring material for a maximum of .75 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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• Tufts University School of Medicine Office of Continuing Education is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s COA.
• This activity provides .75 Contact Hours for nurses.

Requirements for Successful Completion

• To receive CE credit, participants must register, view the content and complete the evaluation. Certificates will be available electronically 6-8 weeks after successful completion of the activity.

Disclosure of Relevant Financial Relationships with Commercial Interests

• All faculty course directors, planning committee members and others in a position to control the content of an educational activity are required to disclose to the audience any relevant financial relationships with commercial interests. Conflicts of interest resulting from a relevant financial relationship are resolved prior to the activity during the content review. No relevant financial relationships are held by any of the planners, presenters, or TUSM OCE staff.
Continuing Education

• Continuing education (CE) is provided jointly through Tufts University School of Medicine Office of Continuing Education and the National Initiative for Children’s Healthcare Quality

• CE credit available for this three-part webinar series includes:
  • .75 AMA PRA Category 1 Credits™
  • .75 Contact Hours for nurses
  • Certificate of participation

• Attendance at all three webinars is required to receive full credit
  • Sign in for Webinar 1: http://www.cvent.com/d/bcqfh9

• Certificates will be available electronically 6 – 8 weeks after successful completion of webinar 3
Next Webinar in the QI Workshop Series

• QI 101, Webinar 2: Continuing the Quality Framework Discussion
• When: April 5, 2013 at 2:00pm ET
• Purpose:
  • Build upon content in today’s session
  • Orient states to a structured QI approach for planning and monitoring the impact of their QI efforts

**REMINDER: Please complete Online Session Evaluation and Expression of Interest for the QI 201 Series**
Thank You for Participating in Today’s Webinar!

Please complete the evaluation as you exit the webinar.
Appendix

• Defining QI
• Roles and Responsibilities for QI Project
• Core Set of Children’s Health Care Quality Measures
• Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid
Defining Quality Improvement
What is Quality of Care?

“The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

— Institute of Medicine, 1990
Six Aims for Improvement

Safe — Avoid injuries to patients from the care that is intended to help them. Safety must be at the forefront of patient care.

Effective — Match care to science; avoid overuse of ineffective care and underuse of effective care.

Patient-Centered — Honor the individual and respect choice. Each patient’s culture, social context and specific needs deserve respect, and the patient should play an active role in making decisions about her own care.

Timely — Reduce waiting for both patients and those who give care. Prompt attention benefits both the patient and the caregiver.

Efficient — Reduce waste. The health care system should constantly seek to reduce the waste and the cost of supplies, equipment, space, capital, ideas, time and opportunities.

Equitable — Close racial and ethnic gaps in health status. Race, ethnicity, gender and income should not prevent anyone from receiving high-quality care.

Quality Assurance and Quality Improvement

• Quality Assurance – Purpose is to assess when we have achieved the intended quality of service or product

• Quality Improvement – Purpose is to move the system from current state of performance to a new state of performance
QA and QI are complementary

1. **Aims**: what are the “gaps” in performance and outcomes
2. **Measures**: tools to measure and feedback processes and outcomes
3. **Changes**: frontline methods and activities to close the “gap”

**IMPROVED OUTCOMES**
Roles and Responsibilities for QI Project

• Oversight team based in lead agency
  • Establishes the charge

• Implementation leader
  • Responsible for the overall QI project

• Implementation teams
  • Informs planning and execution of the QI project

• Topical experts
  • Identifies evidence-based changes and helps to determine feasibility

• Improvement teams
  • Deploys the improvement efforts in the field

• Analytic support
  • Collects and reports on data

• QI experts, as needed
<table>
<thead>
<tr>
<th>Prevention and Health Promotion</th>
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<tbody>
<tr>
<td>Timeliness of Prenatal Care</td>
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<td>Frequency of Ongoing Prenatal Care</td>
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<td>Behavioral Health Risk Assessment (for Pregnant Women) – <strong>NEW IN 2013</strong></td>
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<td>Percentage of Live Births Weighing less than 2,500 Grams</td>
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<td>Cesarean Rate for Nulliparous Singleton Vertex</td>
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<td>Childhood Immunization Status</td>
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<td>Adolescent Immunization Status</td>
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<td>Human Papillomavirus (HPV) Vaccine for Female Adolescents – <strong>NEW IN 2013</strong></td>
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<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment</td>
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<td>Developmental Screening in the First Three Years of Life</td>
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<td>Chlamydia Screening in Women</td>
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<td>Well-Child Visits in First 15 Months of Life</td>
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<td>Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life</td>
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<td>Adolescent Well-Care Visit</td>
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<td>Percentage of Eligibles Who Received Preventive Dental Services</td>
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<td>Availability</td>
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<td>Child and Adolescent Access to Primary Care Practitioners</td>
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<td>Management of Acute Conditions</td>
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<td>Appropriate Testing for Children with Pharyngitis</td>
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<td>Percentage of Eligibles who Received Dental Treatment Services</td>
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<td>Ambulatory Care: Emergency Department Visits</td>
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<td>Pediatric Central-line Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit</td>
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<td>Management of Chronic Conditions</td>
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<td>Annual Percentage of Asthma Patients with One or More Asthma-related Emergency Room Visits</td>
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<td>Medication Management for People with Asthma – <strong>NEW IN 2013</strong></td>
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<td>Annual Pediatric Hemoglobin A1C Testing</td>
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<td>Follow-up After Hospitalization for Mental Illness</td>
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<td>Family Experiences of Care</td>
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<tr>
<td>Consumer Assessment of Healthcare Providers and Systems 5.0H (child version including children with chronic conditions supplemental items)</td>
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# Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

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<td>Adult BMI Assessment</td>
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<td>Breast Cancer Screening</td>
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<td>Cervical Cancer Screening</td>
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<td>Screening for Clinical Depression and Follow-Up Plan</td>
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<td>Diabetes, Short-term Complications Admission Rate</td>
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<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) Admission Rate</td>
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<tr>
<td>Congestive Heart Failure Admission Rate</td>
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<td>Adult Asthma Admission Rate</td>
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<tr>
<td>Chlamydia Screening in Women age 21-24</td>
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<td>Prenatal and Postpartum Care: Postpartum Care Rate</td>
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<td>Management of Acute Conditions</td>
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<td>Follow-Up After Hospitalization for Mental Illness</td>
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<td>CAHPS Health Plan Survey – Adult Questionnaire <em>with</em> CAHPS Health Plan Survey v. 5.0H</td>
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