# Performance Improvement Projects Related to CDC's 6|18 Initiative: A Scan of External Quality Review Organization Reports

States implementing interventions under CDC's 6|18 Initiative may benefit from reviewing External Quality Review Organization (EQRO) reports on Medicaid managed care organizations' (MCOs) performance improvement projects (PIPs). Per federal regulations, states contract with EQROs to conduct a range of activities related to monitoring the performance of health plans, including the validation and assessment of PIPs. EQRO technical reports about PIPs can help states engaged in CDC's 6|18 Initiative to: (1) more strategically partner with Medicaid MCOs on 6|18-related activities; (2) promote alignment between CDC's 6|18 interventions and existing projects; and (3) learn from past state prevention efforts. Reports generally include information related to:

- The types of prevention interventions Medicaid health plans are implementing;
- Challenges associated with implementing these interventions;
- Measures being using to track progress; and
- The impact and outcomes associated with adopting these prevention interventions.

This resource provides a scan of recent, publicly available EQRO technical reports that included PIP(s) related to four health condition priority areas included in CDC's 6|18 Initiative: controlling asthma, preventing diabetes, controlling high blood pressure, and reducing tobacco use. For each of the four health condition priority areas, information about relevant PIP outcomes and recommendations is pulled out first (to the extent available), then details about individual PIPs is included in a subsequent table. These tables include the following details about relevant PIPs: barriers to overcome; interventions implemented; measures tracked or proposed; and whether outcomes were positive, negative, or mixed. For example, the PIP may have resulted in improved results on one measure, but had no impact or a negative effect on another; in that case, we categorize the outcomes as "mixed." Unless otherwise noted, outcomes were tested for statistical significance. Table 1 below summarizes the relevant PIPs included in the EQRO reports by state; the appendix of this document provides specific page number references for EQRO technical reports.

**Table 1: 6|18 Relevant PIPs in State EQRO Technical Reports**

| | | States | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | CA | CO | DC | FL | IN | KY | MD | MI | MN | MO | NH | NM | NV | WA | WV |
| 6\|18 Conditions | Control Asthma | X | | X | X | | X | | | | X | | | | | |
| | Prevent Type 2 Diabetes | | X | | | | | | X | | | X | X | X | | X |
| | Control High Blood Pressure | X | | | | | | X | X | X | | | | | | |
| | Reduce Tobacco Use | | | | | X | X | | | | | | | | X | |

*Source: SHADAC review of External Quality Review Organization (EQRO) technical reports.*

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*The views expressed here do not necessarily reflect the views of the Foundation.*

# Asthma Control Performance Improvement Projects

This section summarizes information that may be helpful to states implementing CDC's 6|18 Initiative interventions related to controlling asthma. Table 2 (see next page) summarizes information about each of the PIPs related to controlling asthma.

## Outcomes and Recommendations

The reports varied in the degree of detail provided or available about outcomes and recommendations for future improvement. California and Montana PIPs contain relevant outcomes and EQRO recommendations relevant to state Medicaid and public health teams implementing CDC's 6|18 interventions:

### *California: Asthma medication management*

- **Outcomes** The rates for both *Medication Management for People with Asthma* measures improved significantly over the observation period, but the rate for the *Medication Compliance 50* measure remained below the target.
- **Recommendations** EQRO recommended continuing the PIP activities to meet target for *Medication Compliance 50 percent*.

### *Montana: Reducing readmissions for asthma patients*

- **Outcomes** The number of members who experienced readmissions at 30 days was reduced for Healthcare Effectiveness Data and Information Set (HEDIS) year 2015 by two percent. Members who utilized all the interventions had no readmissions at 60 days. The number of members who cooperated with all interventions increased by an additional seven percent at 30 days. The number of members who received no interventions was reduced from 60 percent in CY 2013 to 54 percent in CY 2014.
- **Recommendations** The plan did not achieve the goal of increasing the number of members who participated in the program by 10 percent. The EQRO suggested targeting case management contact with the member while they are in the hospital.

## Table 2: Asthma Control PIPs

| State | PIP | Barriers | Interventions | Measures | Outcomes |
|---|---|---|---|---|---|
| **CA** | Improving Asthma Health Outcomes | None listed | ■ Implement provider education on asthma action plan.<br>■ Add flag for asthma plan completion in data shared with providers.<br>■ Create electronic version of asthma plan for providers to fill out (improve legibility). | ■ Medication Management for People with Asthma- Medication Compliance 50 percent<br>■ Emergency department (ED) visits for asthma<br>■ Hospitalizations for asthma | N/A |
| **CA** | Asthma Medication Management | ■ Quarterly provider/patient monitoring not completed.<br>■ Providers not sending educational messages to patients.<br>■ Lack of provider/patient incentives. | ■ Reach out to non-compliant patients to clarify prescription schedules and inform about availability of mail prescriptions. | ■ Medication Management for People with Asthma-Medication Compliance 75 percent<br>■ Medication Management for People with Asthma- Medication Compliance 50 percent | Mixed |
| **DC** | Pediatric Asthma | ■ Lack of member knowledge about triggers and self-management.<br>■ Limited access to services during non-business hours.<br>■ Limited provider resources to follow-up with members who have missed appointments.<br>■ Providers do not consistently document asthma plans.[1] | ■ Contract with asthma education plan, IMPACT (Improving Pediatric Asthma Care) DC.<br>■ Mandatory training for all care management staff on asthma treatment.<br>■ Work with DC Healthy Homes to eliminate asthma triggers.<br>■ Quarterly provider outreach and education about asthma plans.[1] | ■ Medication Management for People with Asthma- Medication Compliance 50 percent<br>■ ED visits for asthma ages 2-20<br>■ Hospitalizations for asthma ages 2-20<br><br>Measures reviewed for subset (30) of members (case management review):<br>■ Evidence of a care plan<br>■ Evidence of monitoring medication compliance<br>■ Referrals/participation in IMPACT DC<br>■ Member engagement with PCP | N/A |
| **FL** | Improving the Rate of Asthmatic Children Using Controller Meds | None listed | None listed | ■ Percent of asthmatics ages 2 -15 dispensed at least one controller prescription during measurement year | N/A |
| **FL** | Improving Use of Appropriate Meds for People with Asthma | None listed | None listed | ■ Percent of members ages 5-64 with persistent asthma appropriately prescribed medication | N/A |
| **KY** | Asthma Control | None listed | ■ Implement provider education and outreach about asthma education and management.<br>■ Work with providers to locate at-risk members that plan cannot contact.<br>■ Embed case manager in location with high prevalence of asthma patients.<br>■ Outreach to providers and patients to develop asthma action plan.<br>■ Identify and reach out to members 30 days behind on controller medication.<br>■ Telephone follow-up with patients based on ED use and readmissions.[2] | ■ Medication Management for People with Asthma-- Medication Compliance 75 percent<br>■ Asthma Medication Ratio<br>■ Medication Therapy for persons with Asthma- suboptimal control<br>■ Medication Therapy for persons with Asthma-Absence of Controller Therapy | N/A |
| **MO** | Reducing Readmissions for Asthma Patients: Targeted at Patients with Inpatient Admission for Asthma | None listed | ■ Provide individualized education on disease process, asthma triggers, and medication use.<br>■ Assist with follow-up appointments, including specialist referrals.<br>■ Provide referrals to available community resources.<br>■ Assist with identifying barriers to care. | ■ Readmissions<br>■ Member participation in the program | Positive |

*Source: SHADAC review of External Quality Review Organization (EQRO) technical reports.*

[1] Subset of interventions, for full list see pages 24-25 of DC EQRO report; [2]Subset of interventions, for full list see pages 92-93 of KY EQRO report.

# Type 2 Diabetes Prevention Performance Improvement Projects

This section summarizes information that may be helpful to states implementing CDC's 6|18 Initiative intervention to prevent type 2 diabetes, with a focus on PIPs related to obesity, nutrition, physical activity, diabetes screening, and/or a formal diabetes prevention program. Because CDC's 6|18 Initiative is targeted at preventing diseases, the document does not include PIPs related to the management of diabetes. Table 3 (see next page) summarizes information about each of the PIPs related to type 2 diabetes prevention.

## Outcomes and Recommendations

The reports varied in the degree of detail provided or available about outcomes and recommendations for future improvement. Colorado, Michigan, New Mexico and West Virginia PIPs contain relevant outcomes and EQRO recommendations:

### *Colorado: Improving rate of body mass index (BMI) documentation in medical records*

- **Outcomes** The PIP resulted in sustained, statistically significant improvement in the percentage of the eligible population with BMI documented, from 69.6 percent to 80.3 percent.

### *Colorado: Improving follow-up communication between referring providers and pediatric obesity specialty clinics*

- **Recommendations** The plan's baseline rates were 100 percent and 91 percent respectively, which demonstrates that little to no opportunity for improvement exists. The plan will be proposing a new PIP topic for the next validation year.

### *Michigan: Increasing the calculated adult BMI administrative rates for Medicaid members with a comorbidity of hypertension*

- **Outcomes** The PIP resulted in sustained, statistically significant improvement in the percentage of the eligible population with BMI calculated, from 35.4 percent to 66.7 percent.

### *New Mexico: Diabetes prevention program*

- **Recommendations** The health plan did not meet the requirements for providing evidence for the diabetes prevention program; specifically, there was insufficient evidence regarding the choice of the study question, indicators, sampling technique, and improvement strategies. The EQRO recommended that the plan correct these problems and continue its efforts to reduce the incidence of diabetes. In other words, the challenges were not with the outcomes of the program, but with the evidence provided for selecting it and the associated measures. The report did not provide detail on the specific recommendations regarding recommended improvements.

### *West Virginia: Childhood Obesity*

- **Outcomes** Preliminary results show improvements in the point estimates for all three indicators, but the report did not include statistical testing.
- **Recommendations** The health plan should consider financial incentives for coding BMI and counseling for nutrition and activity.

### Table 3: Type 2 Diabetes Prevention PIPs

| State | PIP | Barriers | Interventions | Measures | Outcomes |
|---|---|---|---|---|---|
| **CO** | Improving Rate of BMI Documentation in Medical Records. | None listed | ■ Improve practice workflow to support BMI assessment and documentation | ■ Percent of the eligible population with BMI percentile documentation during the measurement year or year prior to the measurement year. | Positive |
| **CO** | Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics. | ■ Members do not show up for appointments.<br>■ Lack of effective follow-up activities by the provider.<br>■ Providers are not following appointment request list protocols when entering the reason for the referral.<br>■ Lack of synchronization between EPIC and Denver Health referral information systems. | None listed | ■ Percent of patients with referrals and completed visits to specialty clinic whose referring PCP receives a report from specialty clinic within seven days of visit.<br>■ Percent of patients with referrals and completed visits to specialty clinic whose referring doctor and PCP (if PCP is not referring provider) receives a report from specialty clinic within 30 days of visit. | N/A |
| **MI** | Increasing the Calculated Adult BMI Administrative Rates for Medicaid Members with a Comorbidity of Hypertension. | ■ Lack of real-time access to data reports.<br>■ Providers' lack of coding.<br>■ Providers' difficulty adapting clinic systems. | ■ Conduct one-on-one provider outreach education on proper coding of BMI.<br>■ Conduct provider phone and on-site outreach to propose a LEAN presentation to effect a process change for BMI submission and distribution of BMI codes tool. | ■ Percent of enrollees 18 to 74 years of age with a diagnosis of hypertension who had at least one outpatient visit during the first six months of the measurement year and who had evidence of BMI documentation the year prior to or during the measurement year. | Positive |
| **NH** | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents. | None listed | None listed | ■ Percent of eligible members ages 3 to 17 years with evidence of BMI documentation.<br>■ Percent of eligible members ages 3 to 17 years with evidence of counseling for nutrition.<br>■ Percent of eligible members ages 3 to 17 years with evidence of counseling for physical activity. | N/A |
| **NM** | Diabetes Prevention Program for Youth. | None listed | ■ Deliver National Diabetes Prevention Program curriculum through a summer program at New Mexico boys and girls club that serves large number of Medicaid members. | ■ Percent of participants attending at least 5 sessions<br>■ Percent of participants reporting they had fun or would come to the class again (engagement measure).<br>■ Percent of participants who learned at least one thing from participating in class. | N/A |
| **NV** | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC). | ■ Incomplete coding by physician of the well-child visit.<br>■ Not all well-child visits are captured.<br>■ Member education and outreach to schedule well-child visits are not consistent.<br>■ Provider is completing BMI percentile, counseling for nutrition, and counseling for physical activity, but not documenting in medical record.<br>■ Provider is completing BMI percentile, counseling for nutrition, and counseling for physical activity, but not billing for each sub-measure. | ■ Scheduler reviews alert screen for WCC visit in current measurement year.<br>■ Physician reviews alert screen for WCC visit in current measurement year.<br>■ Physician documents visit in electronic medical record.<br>■ Medical assistant inputs vitals in electronic medical record.<br>■ Member outreach and education. | ■ Percent of eligible members ages 3 to 17 years with evidence of BMI documentation.<br>■ Percent of eligible members aged 3 to 17 years with evidence of counseling for nutrition.<br>■ Percent of eligible members aged 3 to 17 years with evidence of counseling for physical activity. | N/A |

*Source: SHADAC review of External Quality Review Organization (EQRO) technical reports.*

# Controlling High Blood Pressure Performance Improvement Projects

This section summarizes information that may be helpful to states implementing CDC's 6|18 Initiative interventions related to controlling high blood pressure. Table 4 (see next page) summarizes information about each of the PIPs related to controlling high blood pressure.

## Outcomes and Recommendations

The reports varied in the degree of detail provided or available about outcomes and recommendations for future improvement. California, Maryland, Michigan, and Minnesota PIPs contain relevant outcomes and EQRO recommendations:

### *California: Improving anti-hypertensive medication fills among members with hypertension*

- **Outcomes** Results showed statistically significant and sustained improvement for the share of members diagnosed with hypertension in the first six months of the measurement year taking at least 1,2, or 3 anti-hypertensive medications with a fill rate of at least 40 percent (from 65.6 to 68.6 percent). There was no improvement in the share of members who filled at least one anti-hypertensive medication.

### *California: Improving hypertension control*

- **Outcomes** The results were mixed across counties. In Sacramento County, the Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) and Controlling High Blood Pressure measures improved, however the rate for the Controlling High Blood Pressure measure in Riverside/San Bernardino counties declined significantly and remained below the state median.
- **Recommendations** The plan was required to continue the improvement plan in Riverside/San Bernadino counties.

### *Maryland: Controlling high blood pressure*

- **Outcomes** All plans participating in the PIP made improvements from baseline percentage of members 18–64 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. The improvements ranged from five to 20 percentage points.

### *Michigan: Management of blood pressure in adults with a diagnosis of diabetes and critical comorbid condition of hypertension*

- **Outcomes** There was a significant decline in the percentage of enrollees 18 to 75 years of age with a diagnosis of diabetes and hypertension whose most recent systolic blood pressure reading was less than 140 / 90 mmHg as of December 31 of the measurement year. This rate fell from 63 percent to 44.7 percent.
- **Recommendations** The health plan stated that poor outcomes were due, in part, to loss of membership and underlying disparities in socioeconomic status in the target population. In addition to the existing interventions, they planned to research interventions related to community outreach via community health workers, health fairs, and outreach campaigns for men's health, with a focus on diabetes and hypertension education.

### *Minnesota: Blood pressure control for members with diabetes*

- **Outcomes** There was a significant improvement in the share of members with diabetes whose blood pressure was under control (i.e., less than 130/80 mm Hg), moving from 80.3 percent at baseline to 87.16 percent at the end of the PIP period.

## Table 4: High Blood Pressure Control PIPs

| State | PIP | Barriers | Interventions | Measures | Outcomes |
|---|---|---|---|---|---|
| **CA** | Improving Anti-Hypertensive Medication Fills among Members with Hypertension | ■ The managed care plan failing to implement quarterly member/provider monitoring and provider education.<br>■ Poor communication between patients and providers associated with inadequate educational messages to patients and/ or language barriers.<br>■ Provider and member incentives not available. | ■ Conduct provider outreach, including sending tip sheets with information about the HEDIS 2015 *Controlling High Blood Pressure* measure changes, encouraging providers to follow best practices, sending examples of improvement strategies, and conducting quarterly site visits to provide a coordinated effort in sharing current HEDIS practicemeasures.<br>■ Identify members with uncontrolled hypertension and who were either noncompliant or had never been prescribed anti-hypertensive medications.<br>■ Conduct member outreach with interactive voice response (IVR) reminder calls to members who did not retrieve their medications and offered them a 90- day supply of maintenance medications (implemented as part of Alameda Alliance for Health's *Improving Anti-Hypertensive Diagnosis and Medication Fills Among Members with Hypertension* QIP). | ■ Percent of members 18-85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in *the first six months of the measurement year who filled at least one anti- hypertensive medication.*<br>■ Percent of members 18–85 years of age continuously enrolled as of December 31 of each measurement year, with a diagnosis of hypertension in the first six months of the measurement year and taking at least 1, 2, or 3 anti-hypertensive medications who had a fill rate of at least 40 percent during the measurement year. | Positive |
| **CA** | Controlling High Blood Pressure | ■ Members ages 56–65 having a higher rate of hypertension diagnoses and higher rate of noncompliance with the treatment regimen compared to members ages 18–55.<br>■ Members lack knowledge regarding having uncontrolled blood pressure.<br>■ Providers' lack of knowledge of the current clinical practice guidelines for hypertension and implementing different treatment protocols.<br>■ Primary care providers (PCPs) lack awareness of their assigned members' hypertension diagnoses and need for annual visits and appropriate treatment.<br>■ Members lack understanding of the importance of controlling hypertension and taking prescribed medications. | ■ Produce and send a report to PCPs with a list of members in need of an annual visit for hypertension.<br>■ Distribute to PCPs the clinical practice guidelines on treatment of hypertension.<br>■ Conduct member outreach calls to increase medication compliance.<br>■ Conduct member education and outreach through distribution of postcards. | ■ NQF Measure 0061: Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg).<br>■ NQF Measure 0018: Controlling High Blood Pressure. | Mixed |
| **MD** | Controlling High Blood Pressure | ■ Member: Noncompliance with diet, exercise, and medication regime.<br>■ Member: Noncompliance with follow-up care.<br>■ Member: Lack of transportation for PCP appointments.<br>■ Member: African-Americans face more health disparities than whites for high blood pressure.<br>■ Provider: Lack of continuity and coordination of care between ED, specialist and PCP.<br>■ Providers: Knowledge deficit of missed appointments by their patient population.<br>■ Provider: Lack of awareness of current treatment guidelines.<br>■ Provider: Lack of awareness of the MCO resources available to assist in member compliance (i.e., member outreach initiatives, available benefits, health education opportunities).<br>■ Provider: Variation in staffing and skill set at practices for taking blood pressure readings.<br>■ MCO: Insufficient or inaccurate member contact and demographic data.<br>■ MCO: Limited line of sight into actual blood pressure readings.<br>■ MCO: Controlling blood pressure measure has a unique structure that makes it difficult to follow members' progress/needs year round. | ■ Disease management programs addressing management of hypertension.<br>■ Onsite appointment scheduling.<br>■ Medication adherence and gaps in therapy reports/letters to PCPs and members.<br>■ Access to blood pressure readings at high-volume provider sites.<br>■ Quarterly newsletters to African Americans with high blood pressure.<br>■ Follow up on ED encounters to ensure appointments with PCP.<br>■ Member and provider education.<br>■ Transportation for member PCP appointments.<br>■ Medical record reviews to ensure documentation of blood pressure readings.<br>■ Member outreach and incentives.<br>■ Shared medical appointments for members with hypertension and/or diabetes funded by a Maryland Department of Health and Mental Hygiene grant. | ■ Percent of members 18–64 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year. | Positive |

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| State | PIP | Barriers | Interventions | Measures | Outcomes |
|---|---|---|---|---|---|
| **MI** | Management of Blood Pressure in Adults with a Diagnosis of Diabetes and Critical Comorbid Condition of Hypertension | ■ Lack of provider adherence to established clinical guidelines for management of diabetic patients with hypertension, enrollees'<br>■ Lack of understanding the importance of good blood pressure control, the health plan staff members'<br>■ Lack of knowledge of continuing targeted interventions due to the health plan's reorganization, and lack of resources to complete medical record reviews | ■ Disseminate clinical practice guidelines to providers, and placed guidelines on the health plan's website.<br>■ Generate one-on-one provider reports and conducted meetings to review chart audit results.<br>■ Educate providers on enrollee incentives.<br>■ Place disease management reminder/outreach calls to enrollees with diabetes and hypertension.<br>■ Initiate reminder postcard mailings for preventive care.<br>■ Send a seven-day follow-up letter post hospital discharge.<br>■ Survey disease management program enrollees to assess satisfaction and identify opportunities for improvement. | ■ Percent of enrollees 18 to 75 years of age with a diagnosis of diabetes and hypertension whose most recent systolic blood pressure reading is < 140 mmHg and whose diastolic blood pressure reading is < 90 mmHg as of December 31 of the measurement year. | Negative |
| **MN** | Blood Pressure Control for Members with Diabetes | None listed | None listed | ■ Percent of enrollees 18 to 75 years of age with a diagnosis of diabetes and hypertension whose most recent systolic blood pressure reading is < 140 mmHg and whose diastolic blood pressure reading is < 90 mmHg as of December 31 of the measurement year. | Positive |

*Source: SHADAC review of External Quality Review Organization (EQRO) technical reports*

# Reducing Tobacco Use Performance Improvement Projects

This section summarizes information that may be helpful to states implementing CDC's 6|18 Initiative interventions related to reducing tobacco use.

### *Table 5: Tobacco Use Reduction Performance Improvement Projects*

| State | PIP | Barriers | Interventions | Measures | Outcomes |
|---|---|---|---|---|---|
| **IN** | Smoking Cessation | None listed | ■ Provide smoking cessation kits and follow-up with members who request them.<br>■ Measure prescribing patterns of nicotine replacement therapies.<br>■ Follow-up to determine if therapies were helpful and effective. | ■ Percent of members advised by doctor to quit smoking in past six months.<br>■ Percent of members whose physician recommended medication to assist with quitting.<br>■ Percent of members whose provider recommend other strategies to assist with smoking cessation. | N/A |
| **IN** | Smoking Cessation for Pregnant Women | ■ Late notification of pregnancy<br>■ Lack of interest in Puff-Free Program | ■ Provide smoking cessation education/quitline info to pregnant members.<br>■ Conduct disease management through Puff-Free Pregnancy Programs. | ■ Smoking cessation rate among Puff Free Program participants. | N/A |
| **KY** | Prenatal Smoking | None listed | ■ Conduct provider education on ACOG and to provide prescriptions for cessation medications at time of screening.<br>■ Provide member incentives for quitline engagement.<br>■ Develop and promote use of form for providers to notify plan of prenatal smokers.<br>■ Develop a smoker registry.<br>■ Tailor care coordination and care management for<br>■ susceptible populations.1 | None listed | N/A |
| **WA** | Tobacco Use Cessation: Ask and Record | None listed | ■ Improve assessment of tobacco use and documenting in electronic medical record.<br>■ Use clinical practice guideline "Treating Tobacco Use and<br>■ Dependence." | ■ Tobacco use pre- and post-intervention | N/A |

*Source: SHADAC review of External Quality Review Organization (EQRO) technical reports.*

[1] Subset of interventions, for full list see pages 92-93 of KY EQRO report.

## ADVANCING IMPLEMENTATION OF THE CDC'S 6|18 INITIATIVE

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, in collaboration with a number of partners, is coordinating technical assistance to facilitate state Medicaid and public health implementation of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative. The CDC's 6|18 Initiative promotes the adoption of evidence-based interventions that can improve health and control costs related to six high-burden, high-cost health conditions — tobacco use, high blood pressure, inappropriate antibiotic use, asthma, unintended pregnancies, and type 2 diabetes. For more information and additional resources, visit www.618resources.chcs.org.

# Appendix: Page References for EQRO Technical Reports Reviewed

| Condition | State | Report Date | Performance Improvement Project | Page Numbers | EQRO vendor |
|---|---|---|---|---|---|
| Asthma | **CA** | Apr. 2016 | Improving Asthma Health Outcomes | I-23-I-24 | HSAG |
| Asthma | **CA** | Apr. 2016 | Medication Management for People with Asthma | B-13 -B-14 | HSAG |
| Asthma | **DC** | Mar. 2016 | Pediatric Asthma | 7, 15-16, 21-25 | Delmarva Foundation |
| Asthma | **MO** | Dec. 2015 | Reducing the Readmission Rate for Asthma Patients | 31-32 | Behavioral Health Concepts |
| Asthma | **FL** | Apr. 2017 | Improving Use of Appropriate Medications for People with Asthma | 163 | HSAG |
| Asthma | **FL** | Apr. 2017 | Improving Rate of Asthmatic Children Using Controller Medications | 165 | HSAG |
| Asthma | **KY** | Apr. 2017 | Asthma Control | 92-93 | IPRO |
| Type 2 Diabetes | **CO** | Oct. 2014 | Improving Rate of BMI Documentation in Medical Records | 3-40 - 3-42 | HSAG |
| Type 2 Diabetes | **CO** | Oct. 2016 | Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics | 3-41 - 3-43 | HSAG |
| Type 2 Diabetes | **NH** | Apr. 2017 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | p 4-9 | HSAG |
| Type 2 Diabetes | **NM** | May 2017 | Diabetes Prevention Program for Youth | 30-31 | Health Insight |
| Type 2 Diabetes | **NV** | Oct. 2016 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | 6-2; 6-4; 6-6; 6-10 | HSAG |
| Type 2 Diabetes | **WV** | Apr. 2014 | Childhood Obesity | 15-17 | |
| Type 2 Diabetes | **MI** | Apr. 2017 | Increasing the Calculated Adult BMI Administrative Rates for Medicaid Members with a Comorbidity of Hypertension | K10-K11 | HSAG |
| High BP | **CA** | Apr. 2016 | Improving Anti-Hypertensive Medication Fills among Members with Hypertension | B-12-B-13; B20 | HSAG |
| High BP | **CA** | Apr. 2016 | Improving Hypertension Control | V-31-V-32 | HSAG |
| High BP | **MD** | Apr. 2017 | Controlling High Blood Pressure | iii-9 - iii-11 | Delmarva Foundation |
| High BP | **MI** | Apr. 2017 | Management of Blood Pressure in Adults with a Diagnosis of Diabetes and Critical Comorbid Condition of Hypertension | f-10 - f-13 | HSAG |
| High BP | **MN** | Apr. 2016 | Blood Pressure Control for Members with Diabetes | 86 | IPRO |
| Tobacco Use | **IN** | Mar. 2016 | Smoking Cessation | IV-11-IV-12 | Burns & Associates |
| Tobacco Use | **IN** | Mar. 2016 | Smoking Cessation for Pregnant Women | IV-11-IV-12 | Burns & Associates |
| Tobacco Use | **WA** | Feb. 2016 | Tobacco Use Cessation: Ask and Record | 67 | Qualis Health |
| Tobacco Use | **KY** | Apr. 2017 | Prenatal Smoking | 77; 82;90;99; 108 | IPRO |

*Source: SHADAC review of External Quality Review Organization (EQRO) technical reports.*