

QARR Report Series
Issue No. 5 of 5



Department
of Health

2016 Health Care Disparities in New York State



A Report on Health Care Disparities
for Government Sponsored
Insurance programs

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2016 Health Care Disparities Report in New York State

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Executive Summary

This report examines disparities in health care quality among New York State Medicaid members enrolled in the Medicaid Managed Care (MMC) program during 2015. The purpose is to identify priority health areas where disparities exist. This report can be used to inform quality improvement efforts in order to promote health equity for vulnerable populations in New York State.

Specifically, the report evaluates whether the disparities disproportionately affect the following vulnerable groups: racial/ethnic minorities, members with English as a second language (ESL), members with serious mental illness (SMI), members with a substance use disorder (SUD), members who received cash assistance, and members who received Supplemental Security Income (SSI). Definitions of these groups are described in detail on pages 6 and 7. Analyses in this report include 64 measures in the areas of adult health, women's preventive care, child health, and mental health.

Priority Health Areas

Among the health areas examined in this report, there are priority health areas where there is evidence of persistent disparities in quality of care within multiple vulnerable groups. These priority health areas include:

- *Managing Chronic Conditions*: managing cardiovascular disease, respiratory conditions, and diabetes
- *Preventive Care*: annual dental visits for children and adults
- *Mental Health*: adherence to antidepressants 3 and 6 months after diagnosis, follow-up visit after hospitalization for mental illness within 7 and 30 days post-discharge
- *Caring for Children and Adolescents with Illnesses*: appropriate testing for pharyngitis, controller medications are 50% or more of total asthma medications, percentage of children who remained on an asthma controller medication for at least 50% or 75% of their treatment period
- *Inappropriate Care*: percentage of adolescent females screened unnecessarily for cervical cancer, percentage of children with an upper respiratory infection who were prescribed an antibiotic, use of imaging within 28 days of diagnosis for back pain, use of multiple concurrent antipsychotics in children and adolescents

Priority Populations

The Office of Quality and Patient Safety has classified specific vulnerable groups as "priority populations," in order to facilitate quality improvement. Evidence from this report shows that the following priority populations: members with a substance use disorder, members who received cash assistance, and Black members in the MMC program experienced more negative health outcomes than the reference populations (i.e., members without a substance use disorder, members who did not receive cash assistance, and White members). Although other priority populations (SSI, Asian, Hispanic, ESL, SMI) had similar or better outcomes on the majority of measures in 2015, disparities continue to exist for these groups in particular areas.

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Greatest Evidence of Health Disparities

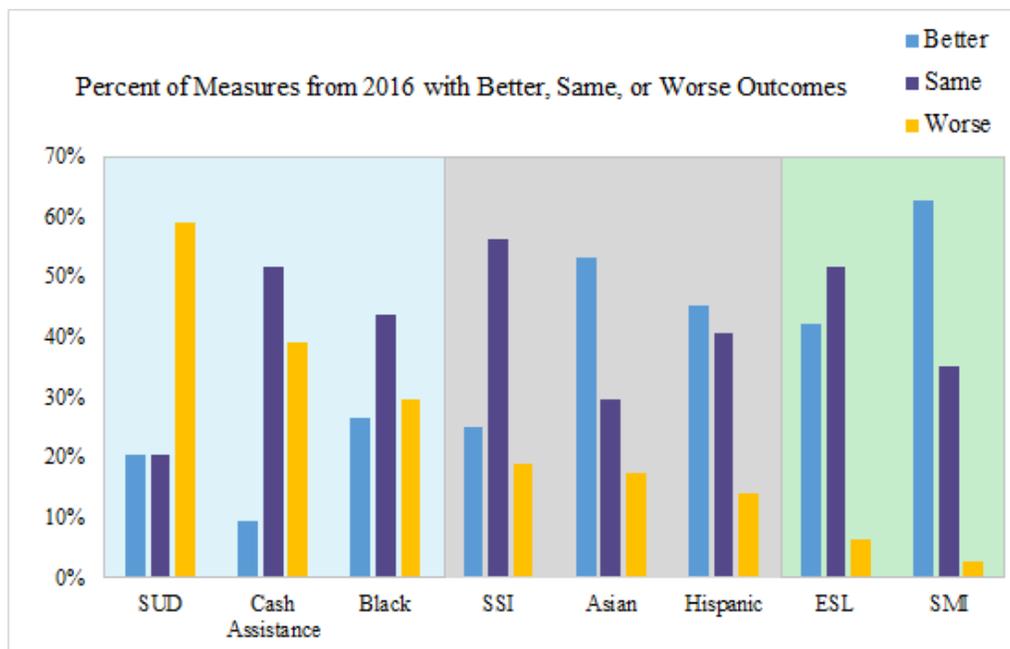
- Members with a substance use disorder had the greatest evidence of health disparities: 59% of their outcomes were worse than the outcomes of members without a substance use disorder. This population had worse outcomes on all measures regarding managing respiratory conditions (e.g., COPD and asthma).
- Members who received cash assistance had 39% more worse outcomes than members who did not receive cash assistance. Specifically, they had lower rates on women's preventive care measures (i.e., cancer screening, prenatal, and postpartum care) and children's preventive care measures (e.g., immunizations, well-child, and dental visits, and adolescent females were more likely to be screened unnecessarily for cervical cancer).
- Black members also had worse outcomes than White members on 30% of the measures. Most of these outcomes were found in managing cardiovascular conditions, mental health, and caring for children with illnesses.
- However, all minority groups had worse outcomes on the majority of measures related to caring for children with illnesses.

Moderate Evidence of Health Disparities

- Asian members, Hispanic members, and members who received SSI had moderate evidence of health disparities. Compared to their reference group, the percentage of measures with worse outcomes ranged from 14-19%.

Least Evidence of Health Disparities

- Members with SMI and members with ESL had the least evidence of health disparities. The two groups received worse outcomes on 3-6% of measures.



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Further investigation of the underlying drivers that promote inequity in these areas can help to develop a focused strategy to promote health equity for all the populations in New York State. In order to address the issues efficiently, efforts from national, state, and local organizations need to be integrated. Additionally, the New York State Department of Health will continue to work with health plans towards the goal of promoting health equity for vulnerable populations in New York State.

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Section 1: Overview

Background

According to the Centers for Disease Control and Prevention (CDC), health disparities are preventable differences in the burden of disease, injury, violence, and opportunities to achieve optimal health that are experienced by vulnerable populations.

Health disparities have been a public health concern for decades. Since 1980, the U.S. Department of Health and Human Services (DHHS) has developed *Healthy People* initiatives, a comprehensive set of national public health objectives – one of which includes decreasing health disparities. The Agency for Healthcare Research and Quality (AHRQ) has reported on disparities in health care quality based on racial, ethnic, and socioeconomic status since 2002 in the National Healthcare Quality and Disparities Report.

The Office of Quality and Patient Safety at the New York State Department of Health (NYSDOH) recognizes the importance of understanding the impact of health disparities and has been continuously monitoring the disparities in quality of care among members enrolled in the Medicaid Managed Care (MMC) program. These reports are published at: https://www.health.ny.gov/health_care/managed_care/reports/index.htm

Additional incentive to examine health disparities has been provided by the Center for Medicare and Medicaid Services which recently released “Improving the Quality of Care for Medicaid Beneficiaries,” Medicaid and CHIP Managed Care Final Rule (CMS-2390-F, 2016). This document explains that each state should design a plan to identify, evaluate, and reduce health disparities in order to support key quality goals.

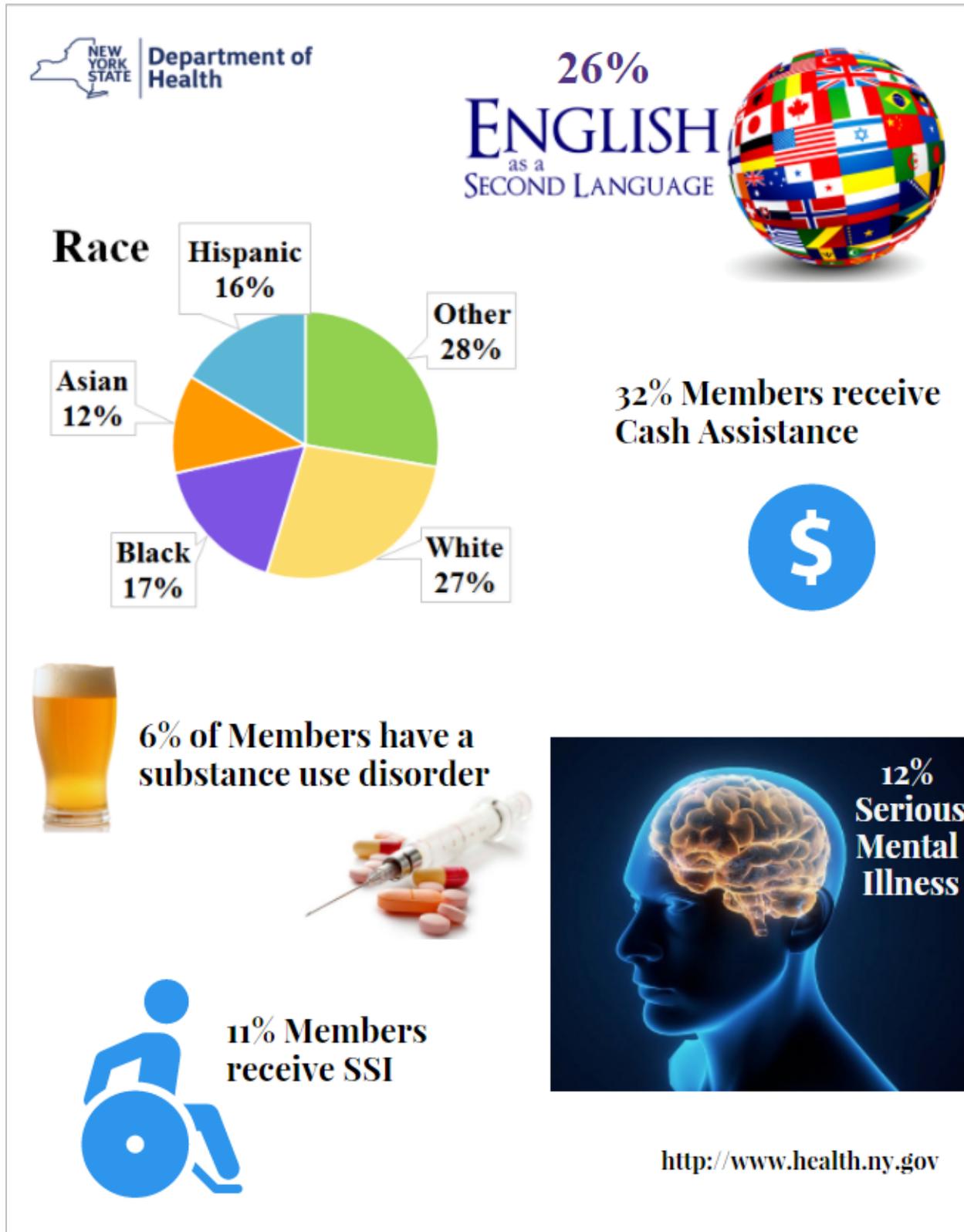
New York State Medicaid Managed Care program and Priority Populations

The New York State Medicaid Managed Care (NYS MMC) program provided health insurance coverage to close to five million people in 2015. For this report, Medicaid members enrolled in Managed Long Term Care (MLTC), Health and Recovery Plans (HARPs), and Fee for Service (FFS) were not included in these results. The program encompasses a racially and ethnically diverse population across the state. For calendar year 2015, White members represented 27%, Blacks represent 17%, Hispanics represented 16%, and Asians represented 12%. In this population, female members represented 54% and males represented 46%. Of all the members, 38% were children who were 17 years of age or younger, 37% were between 18 and 44 years of age, 21% were between 45 and 64 years of age, and 4% were 65 years of age or older.

Priority populations in this report were based on the groups specified by AHRQ in the 2013 National Healthcare Disparities Report. Specifically, they include racial/ethnic minorities, members with English as a second language (ESL), members with cash assistance (low-income members), members with serious mental illness (SMI), members with a substance use disorder (SUD), and members with SSI (elderly and disabled). See the graphic on page 5 to learn more about the prevalence of these priority populations in the NYS MMC population.

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Demographic Description of Priority Populations in NYS MMC



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Section 2: Data Source and Methods

Data Source

QARR Data: As a means to monitor managed care plan performance and improve the quality of care provided to New York State residents, the NYSDOH implemented a public reporting system in 1994 known as the Quality Assurance Reporting Requirements (QARR). QARR data is largely based on measures of quality developed and published by the National Committee for Quality Assurance (NCQA) in the Healthcare Effectiveness Data and Information Set (HEDIS®). The managed care plans are required to submit quality performance data each year to the Department. These data are published annually in a series of reports and consumer guides that are available on the NYSDOH web site: https://www.health.ny.gov/health_care/managed_care/reports/index.htm

Priority Populations Identified by Demographic Characteristics: Demographic characteristics were extracted from Medicaid member information collected during Medicaid enrollment and were linked to QARR member level data.

- **Race/Ethnicity** is defined as mutually exclusive categories of Asian/Pacific Islander, Black, Hispanic, White, or Other. It is possible for a member to denote that they belong to more than one race. Therefore, for purposes of this data, an algorithm was developed to ensure each member was assigned to just one race/ethnicity category. A member who self-identifies as Hispanic is defined as Hispanic, regardless of any other races noted. White race includes non-Hispanic whites without any other race noted. Similarly, Blacks and Asians include only non-Hispanic single race categorizations. Members of multiple races, Native Americans, and Unknown race/ethnicity are assigned to the category “Other Race/Ethnicity.”
- **Cash Assistance** is a program to help needy members and their families who are unable to work, cannot find a job, or have a job that does not pay enough to cover expenses. There are two major programs: family assistance or safety net. The cash assistance may be for housing (rent subsidies), utilities, emergency needs, temporary housing, or food assistance. Cash assistance is a marker of lower socioeconomic status as well as risk.
- **English as a second language (ESL)** is defined as members who self-reported that English is not their native language.
- **Serious mental illness (SMI)** is defined as an adult with serious and persistent mental illness and includes members who are 18 years of age and older and whose health profile (which includes diagnoses, procedures, and pharmacy utilization) over the past 12 months places them in a major diagnostic category of mental diseases and disorders. Additionally, these members had to have at least one service in the past 12 months with a diagnosis of at least one of the following conditions: schizophrenia and other psychotic disorders, major depression and bipolar disorders, cyclothymic disorder, schizotypal, chronic hypomanic, borderline personality disorders, post-traumatic stress disorder, attention deficit disorder, or obsessive-compulsive disorder.
- **Substance Use Disorder (SUD)** is defined as an adult, 18 years of age and older, having had a claim for chemical dependency services (i.e., inpatient, intensive

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outpatient, partial hospitalization, outpatient, and emergency department) in the past 12 months with a diagnosis of chemical dependency.

- **Supplemental Security Income (SSI)** is a federal program whose members are largely aged, blind, or disabled. Individuals eligible for SSI receive cash assistance.

Detailed measure rates stratified by these characteristics are published on the NYSDOH open data portal:

<https://health.data.ny.gov/Health/Quality-Assurance-Reporting-Requirements-QARR-Heal/6mvg-6ik8>

Data Visualization Tool

Trends: Graphs showing selected measure-specific performance over time are presented at the beginning of each section. Due to changes in measure specifications and the addition of new measures, not all measures can be compared over time. Only those measures with at least three years of available data were included. These results represent the number of measures where vulnerable populations had the same, better, or worse performance compared to the reference populations.

Charts: Bar charts examining the relationship between priority populations are presented. These results represent the number of measures where vulnerable populations had the same, better, or worse performance compared to the reference populations in 2015. For example, racial/ethnic minority groups' health outcomes are compared to the racial/ethnic majority reference group of Whites. The comparisons were adjusted by regression to assess whether the difference between the vulnerable populations versus the reference groups was statistically significant.

Health Areas Examined

The health areas are listed below and are described in greater detail in the appendices.

- *Adult Health:* managing preventive care and acute illness, managing cardiovascular conditions, managing respiratory conditions, managing diabetes, managing medications, and HIV/AIDS comprehensive care
- *Child and Adolescent Health:* child preventive care, caring for children and adolescents with illness, and preventive counseling for children and adolescents
- *Preventive Care for Women:* cancer and chlamydia screening, prenatal and postpartum care
- *Adult Mental Health:* remain on antidepressants after receiving diagnosis, follow-up visit after being discharged from the hospital for mental illness, and diabetes and cardiovascular monitoring for members with schizophrenia
- *Child Mental Health:* metabolic monitoring for children and adolescents on antipsychotics, follow-up care for children prescribed an ADHD medication, use of

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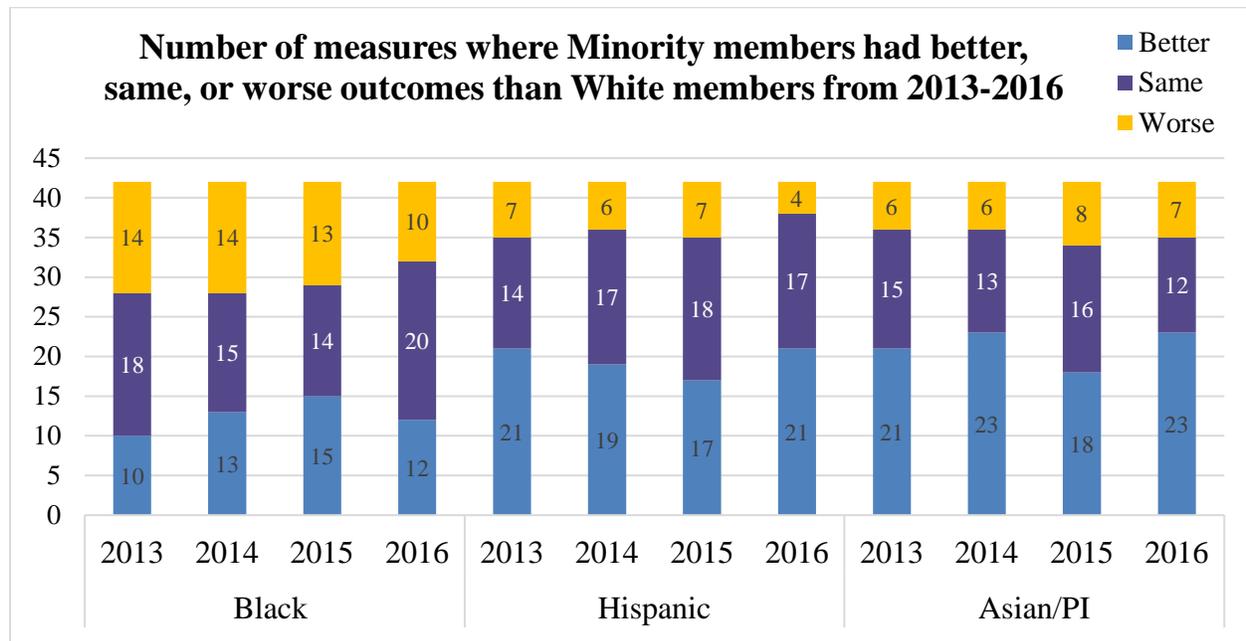
multiple concurrent antipsychotics in children and adolescents, metabolic monitoring for children and adolescents on antipsychotics

For each vulnerable group, we identify priority health areas where there are notable health disparities.

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Section 3: Racial/Ethnic Disparities and Health Areas

Trend over time (2013-2016) for Racial and Ethnic Minority Members



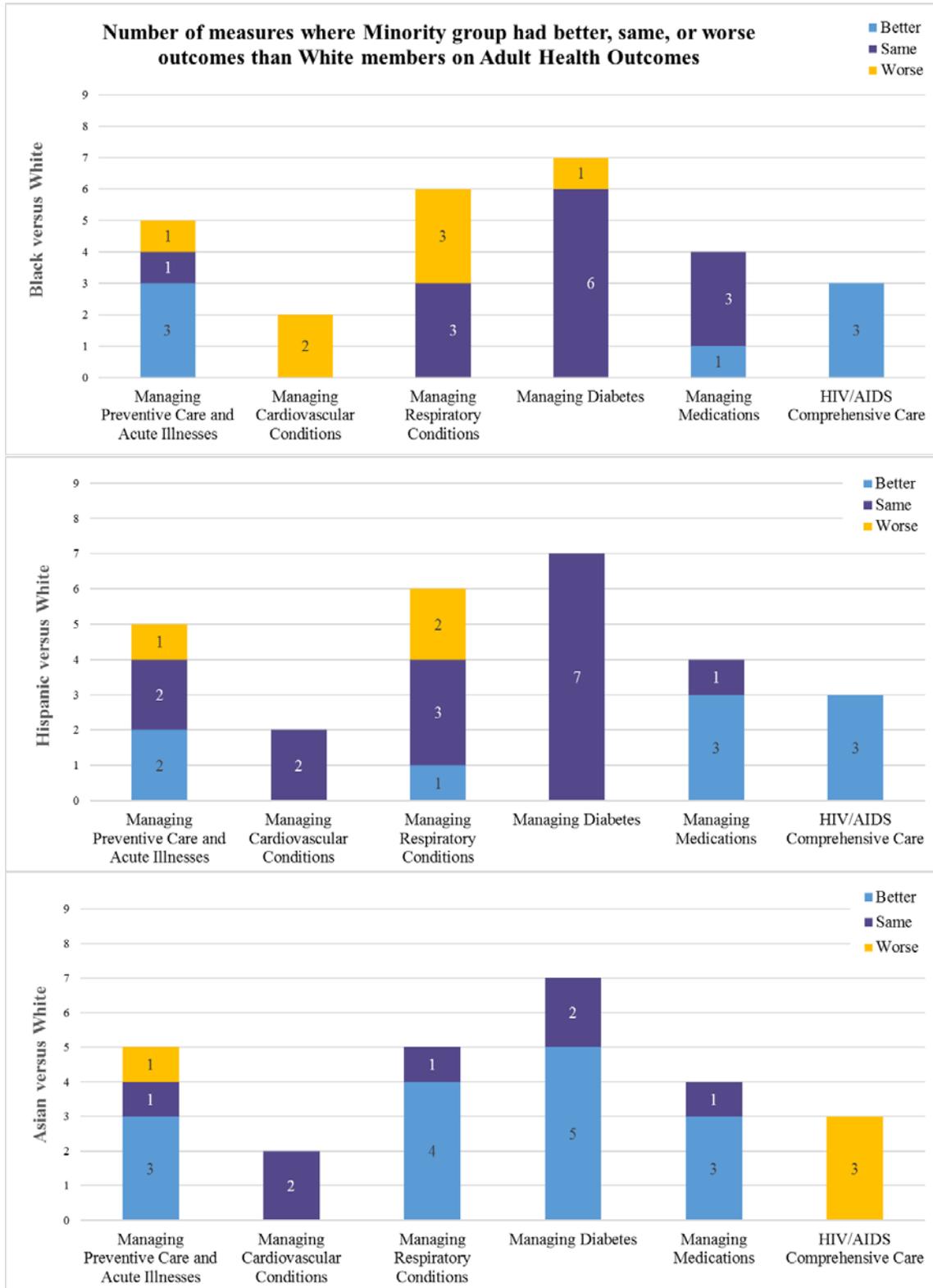
HIGHLIGHTS

Trend over time for Racial and Ethnic Minority Members

- Compared to Whites, all the three racial/ethnic minority groups have similar or better outcomes for the majority of the measures. However, Black members had a higher proportion of worse outcomes (30% on average) than Asian (16%) and Hispanic members (14%).
- Although the number of measures where Asian members had worse outcomes than White members has remained relatively stable from 2013-2016, there was a noticeable improvement observed for Black and Hispanic members over time, particularly in 2016.

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Disparities in Adult Health for Racial and Ethnic Minority Members



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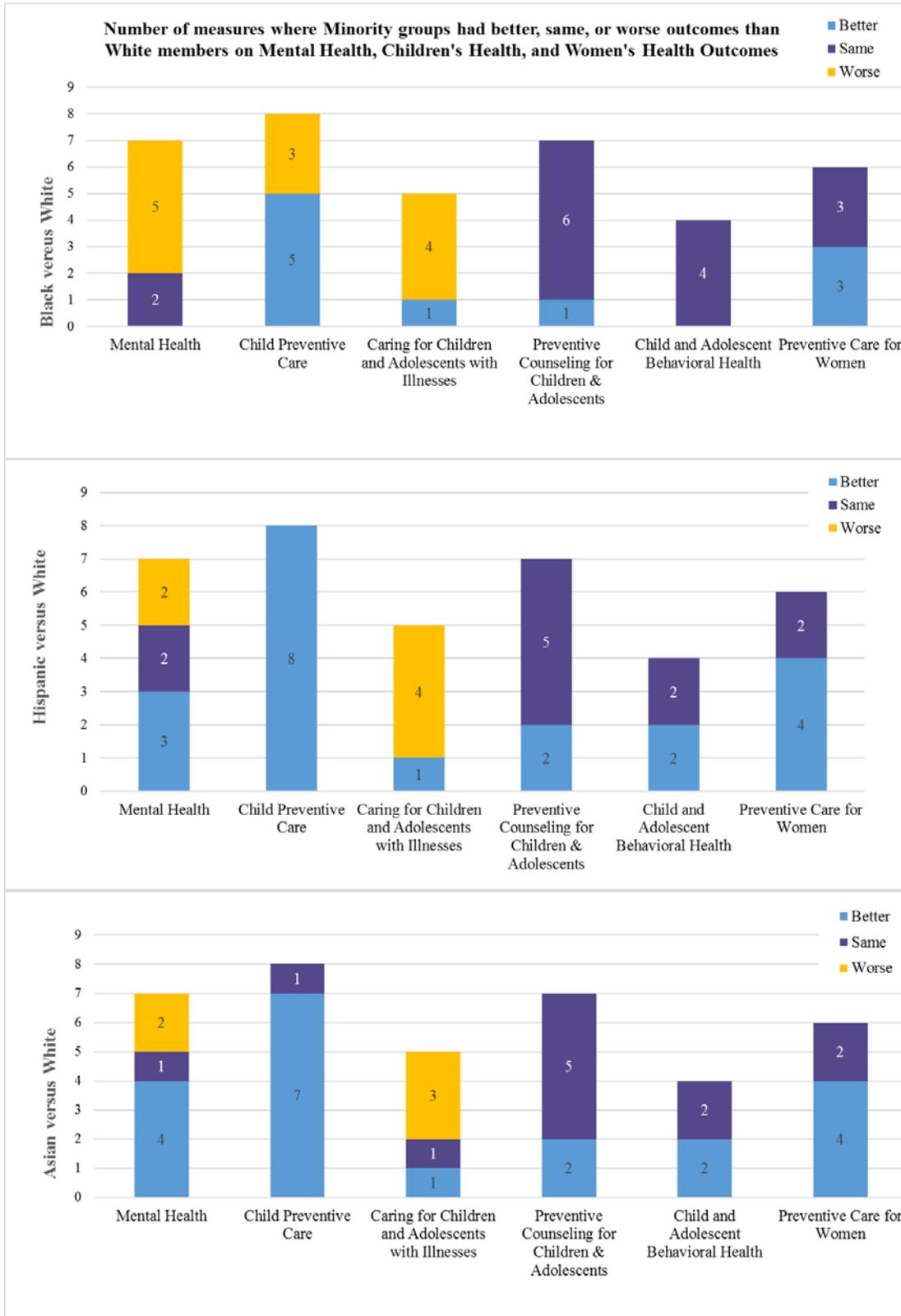
Priority Health Areas

Adult Health Outcomes for Racial and Ethnic Minority Members

- All of the racial minority groups were less likely to have an annual dental exam than were White members.
- Black members had lower performance than White members in managing cardiovascular conditions (i.e., controlling high blood pressure and using beta blocker after a heart attack), and controlling asthma by using asthma medications. Disparities on the cardiovascular measures were not seen among Asian and Hispanic members, but there was evidence of disparities on two of the asthma measures.
- While Black and Hispanic members with HIV received better care (i.e., viral load monitoring, syphilis screening, and being engaged in care) than White members, Asian members received lower rates of care on all three HIV measures.

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Disparities in Other Health Areas for Racial and Ethnic Minority Members



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Priority Health Areas

Mental Health Outcomes for Racial and Ethnic Minority Members

- All minority members were less likely to remain on antidepressants three months and six months after being diagnosed with depression than were White members.
- Black members were also less likely to receive a follow-up visit within 7 days and 30 days of being discharged from the hospital for mental illness than White members, and members with schizophrenia or bipolar disorder using antipsychotics were less likely to have diabetes screening than White members.
- Asian and Hispanic members with schizophrenia and bipolar disorder were more likely than White members to have a diabetes screening test, and Asian and Hispanic members with schizophrenia who also had diabetes or cardiovascular disease were as likely or more likely to have their conditions monitored.

Children's Health Outcomes for Racial and Ethnic Minority Members

- All the minority groups were found to have worse performance on caring for children and adolescents with illnesses (i.e., asthma and pharyngitis) than White children. The only exception was that Asian children were as likely as White children to have asthma controller medications comprise 50% or more of their total asthma medications.
- Although Black children and adolescents were equally or more likely to receive preventive counseling and to receive mental health services than White children, the data suggests that they have less access to providers for well-child visits and annual dental visits.

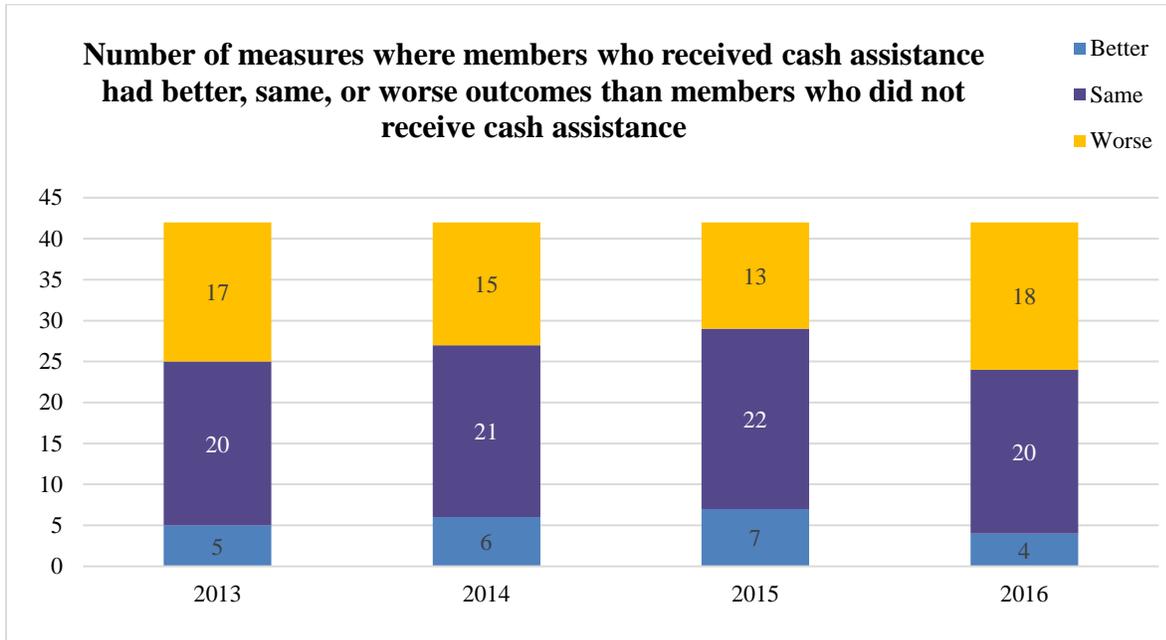
Women's Health Outcomes for Racial and Ethnic Minority Members

- Women from all minority groups were more likely to receive screening for chlamydia, cervical cancer, and breast cancer than were White women.
- Additionally, women from minority groups were as likely or more likely to have timely and frequent prenatal care, and to have postpartum care.

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Section 4: Disparities Among Other Populations

Trend over Time (2013-2016) for Members Who Received Cash Assistance



HIGHLIGHTS

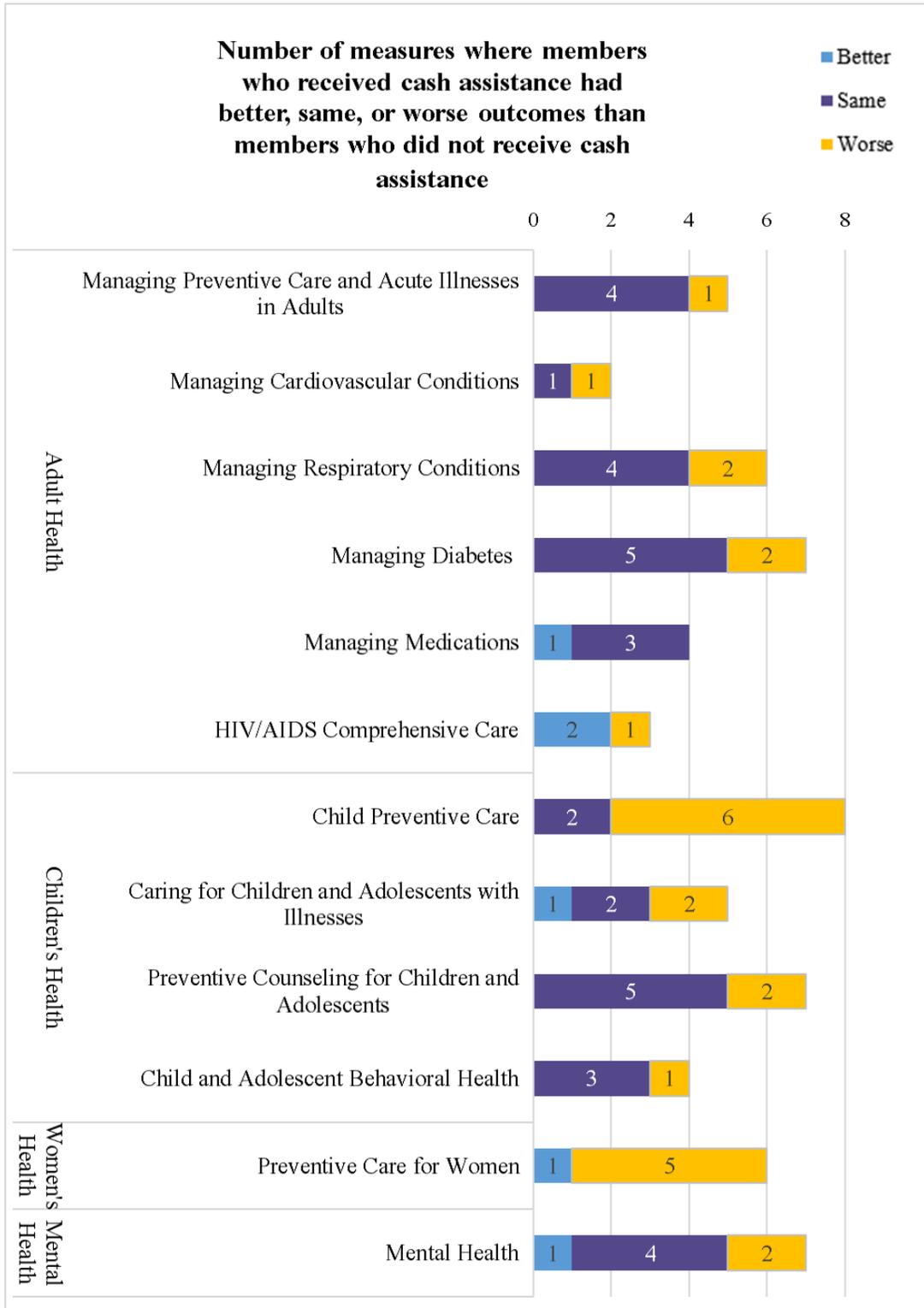
Trend over time for Members Who Received Cash Assistance

- Members who received cash assistance had the greatest evidence of health disparities from 2013-2016 across all of the priority populations in MMC with trend data¹. On average, they had worse outcomes on 38% of measures than members who did not receive cash assistance.
- While there was a gradual decrease in the number of measures where members with cash assistance had worse outcomes from 2013-2015, there was a 12 percent increase in 2016.

¹ Trend data is not available for the SUD population in this report.

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Disparities in Health Areas for Members Who Received Cash Assistance



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Priority Health Areas

Adult Health Outcomes for Members Who Received Cash Assistance

- Members who received cash assistance had worse outcomes than members who did not receive cash assistance on 33% of the measures related to managing chronic conditions (i.e., cardiovascular disease, respiratory conditions, and diabetes).

Women's Health Outcomes for Members Who Received Cash Assistance

- Women who received cash assistance were less likely than women who did not receive cash assistance to be screened for cervical and breast cancer and had lower rates of timely and frequent prenatal care as well as postpartum care.

Children's Health Outcomes for Members Who Received Cash Assistance

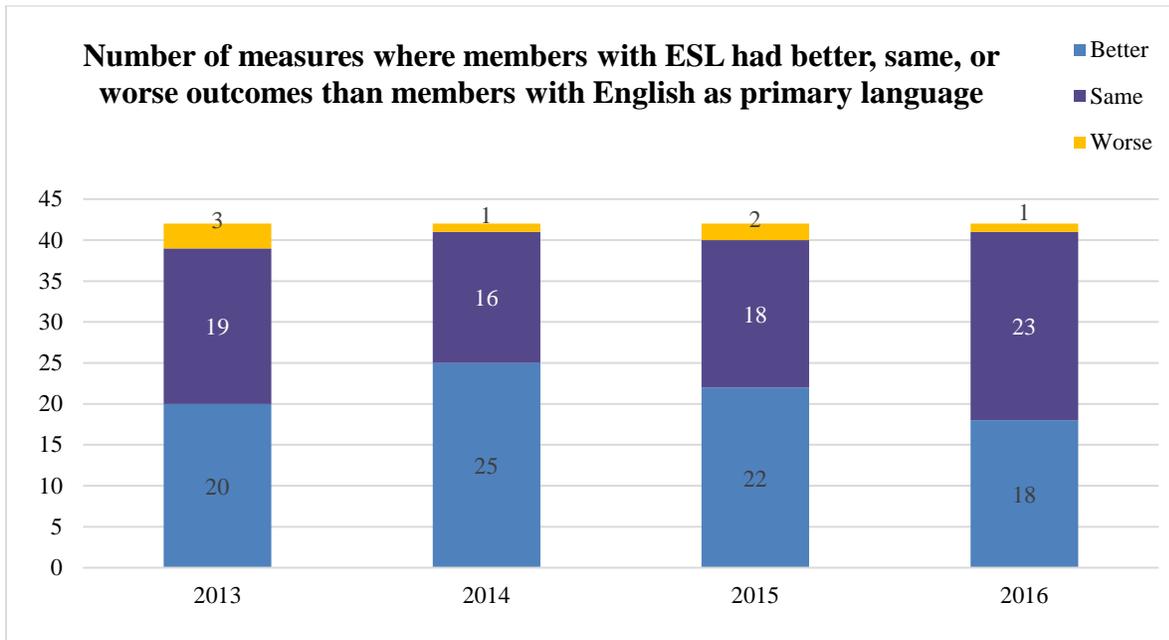
- Although children who received cash assistance were as likely to receive preventive counseling as children who did not receive cash assistance (except for counseling on physical activity and nutrition), they were less likely to receive preventive care (i.e., receive immunizations, all well-child visits, adolescent well-child visits, and annual dental visits).
- This population may receive less appropriate medical care. Children who received cash assistance were more likely to be screened unnecessarily for cervical cancer and less likely to be appropriately tested for pharyngitis than children who do not receive cash assistance. This was also the only population whose children and adolescents on antipsychotics were significantly less likely to be metabolically monitored than the reference group (i.e., members who did not receive cash assistance).

Mental Health Outcomes for Members Who Received Cash Assistance

- Members who received cash assistance were less likely to receive a follow-up visit within 7 days and 30 days of being discharged from the hospital for mental illness than members who did not receive cash assistance.

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Trend over Time (2013-2016) for Members with English as a Second Language (ESL)



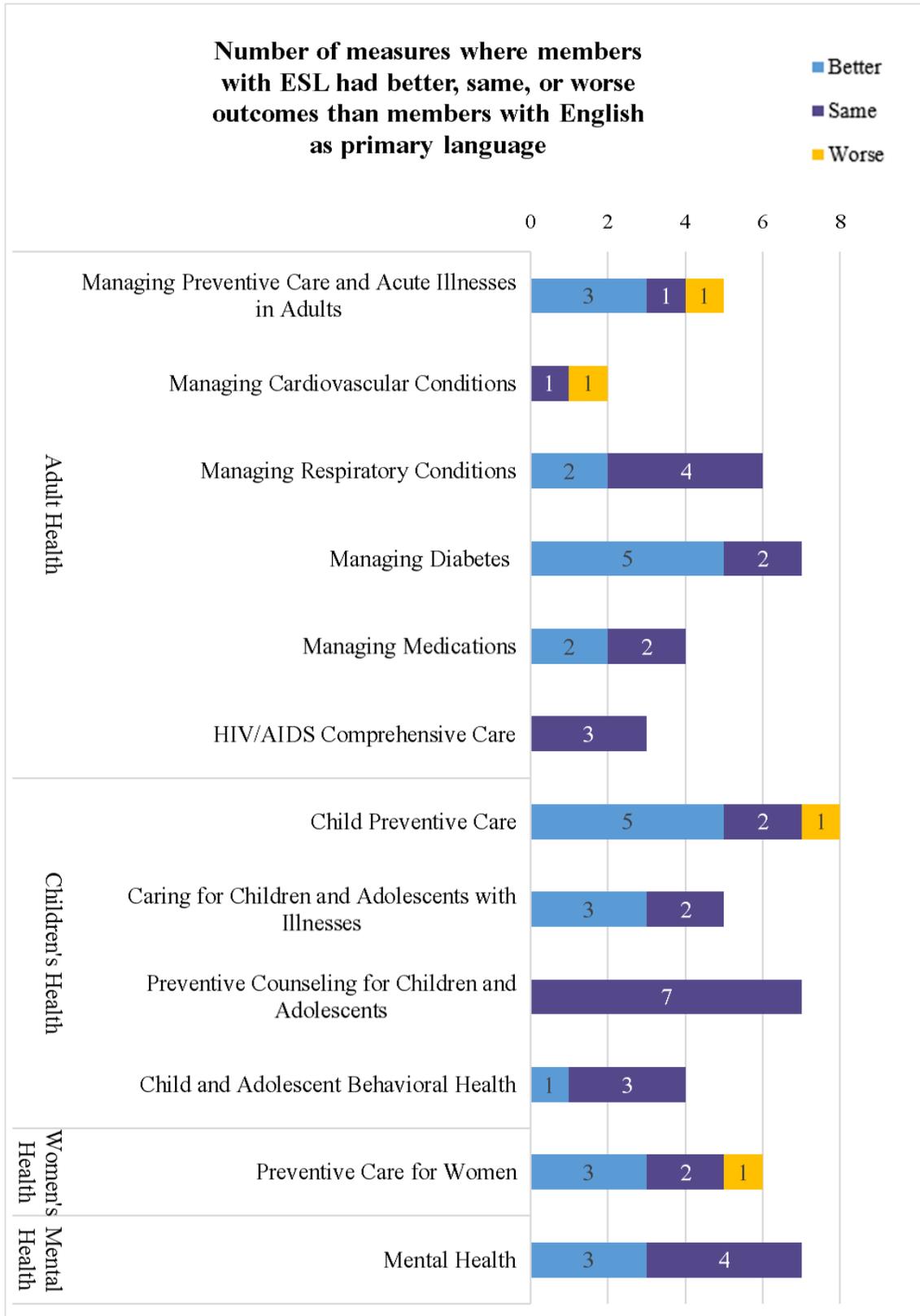
HIGHLIGHTS

Trend over time for Members with English as a Second Language

- Disparities were observed in less than 5% of the measures among members with ESL compared to members with English as a primary language in MMC.
- The small gap seen in this population has remained relatively stable over the four-year period.

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Disparities in Health Areas for Members with English as a Second Language



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Priority Health Areas

Adult Health Outcomes for Members with English as a Second Language

- Members with ESL who had a heart attack were less likely to remain on a beta-blocker for six months after discharge than members with English as their primary language.

Adult and Child Health Outcomes for Members with English as a Second Language

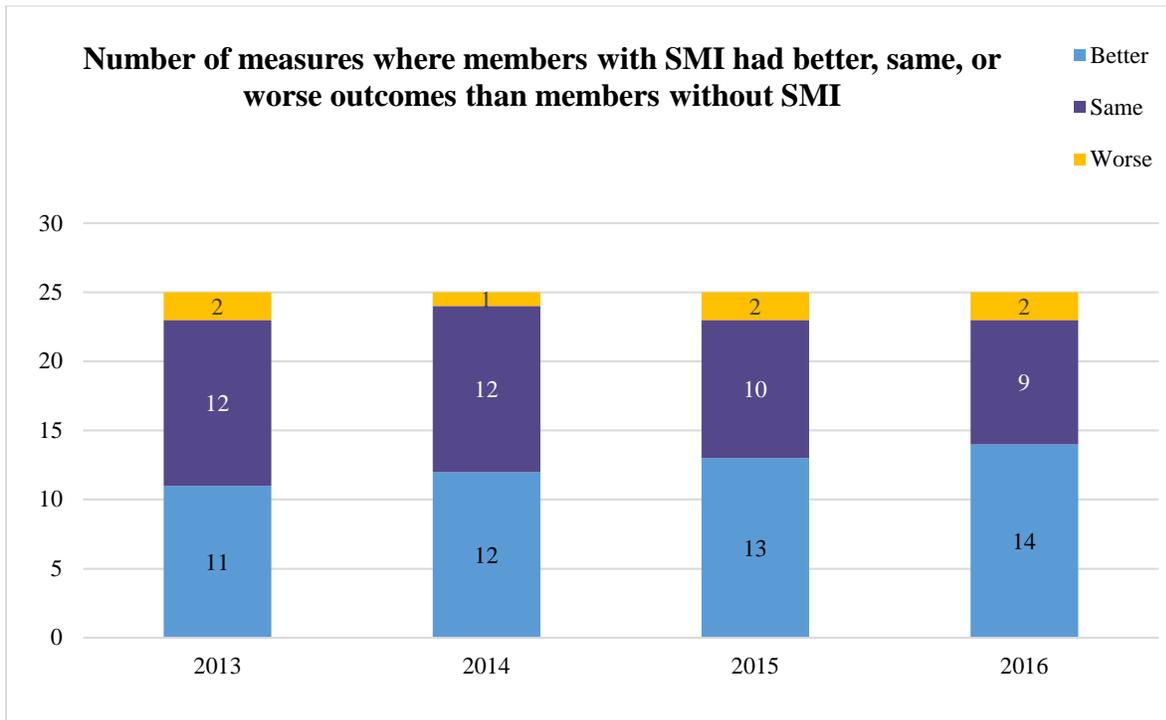
- Members with ESL received less appropriate care on two measures: adult ESL members with back pain were more likely to receive imaging within 28 days of diagnosis, and adolescent females with ESL were more likely to be screened unnecessarily for cervical cancer than members with English as their primary language.

Women's Health Outcomes for Members with English as a Second Language

- Although adolescent females with ESL have significantly higher rates of non-recommended cervical cancer screening than adolescents with English as a primary language, women with ESL were less likely to have recommended cervical cancer screening than women with English as a primary language.

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Trend over Time (2013-2016) for Members with Serious Mental Illness (SMI)



HIGHLIGHTS

Trend over time for Members with Serious Mental Illness

- Members with SMI had similar or better outcomes than members without SMI on 93% of the measures.
- Although the rates have been relatively stable over time, the number of measures where members with SMI had better outcomes than members without SMI has gradually increased from 2013-2016.

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Disparities in Health Areas for Members with Serious Mental Illness



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Priority Health Areas

Adult Health Outcomes for Members with Serious Mental Illness

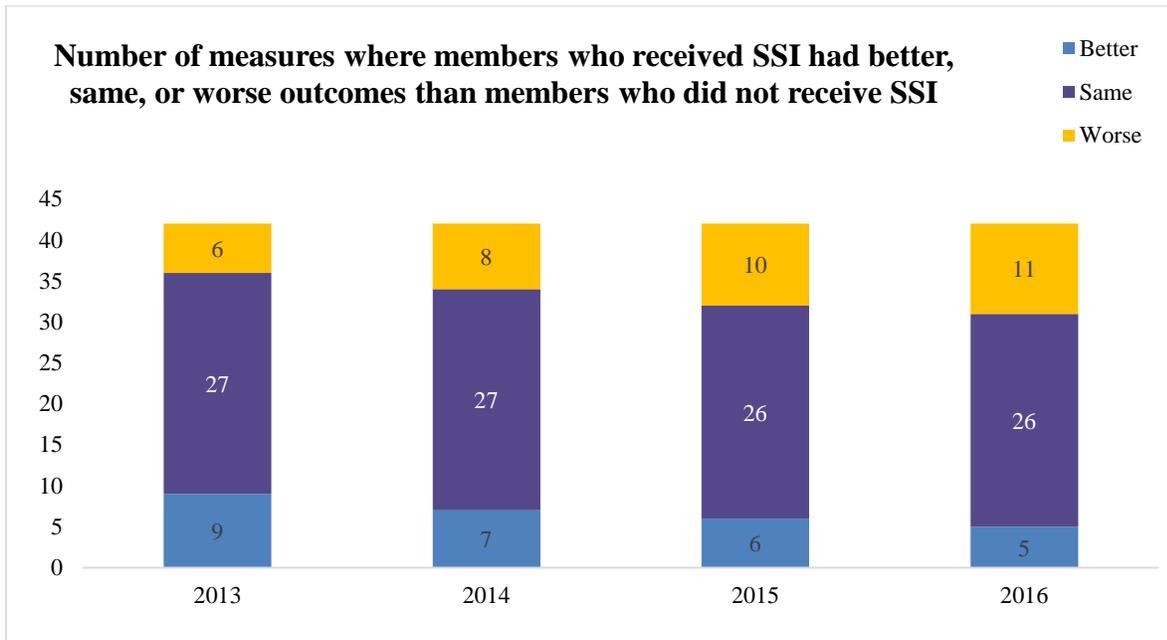
- Although members with SMI tend to have better outcomes in terms of managing medications than members without SMI, members with rheumatoid arthritis were less likely to be dispensed an anti-rheumatic drug than members without SMI.
- Members with SMI had better outcomes on all of the HIV measures than members without SMI (i.e., viral load monitoring, syphilis screening, and being engaged in care).

Women's Health Outcomes for Members with Serious Mental Illness

- Women with SMI were more likely to be screened for chlamydia, for cervical and breast cancer, and to have more frequent prenatal care than women without SMI.

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Trend over Time (2013-2016) for Members Who Received SSI (Elderly and Disabled Members)

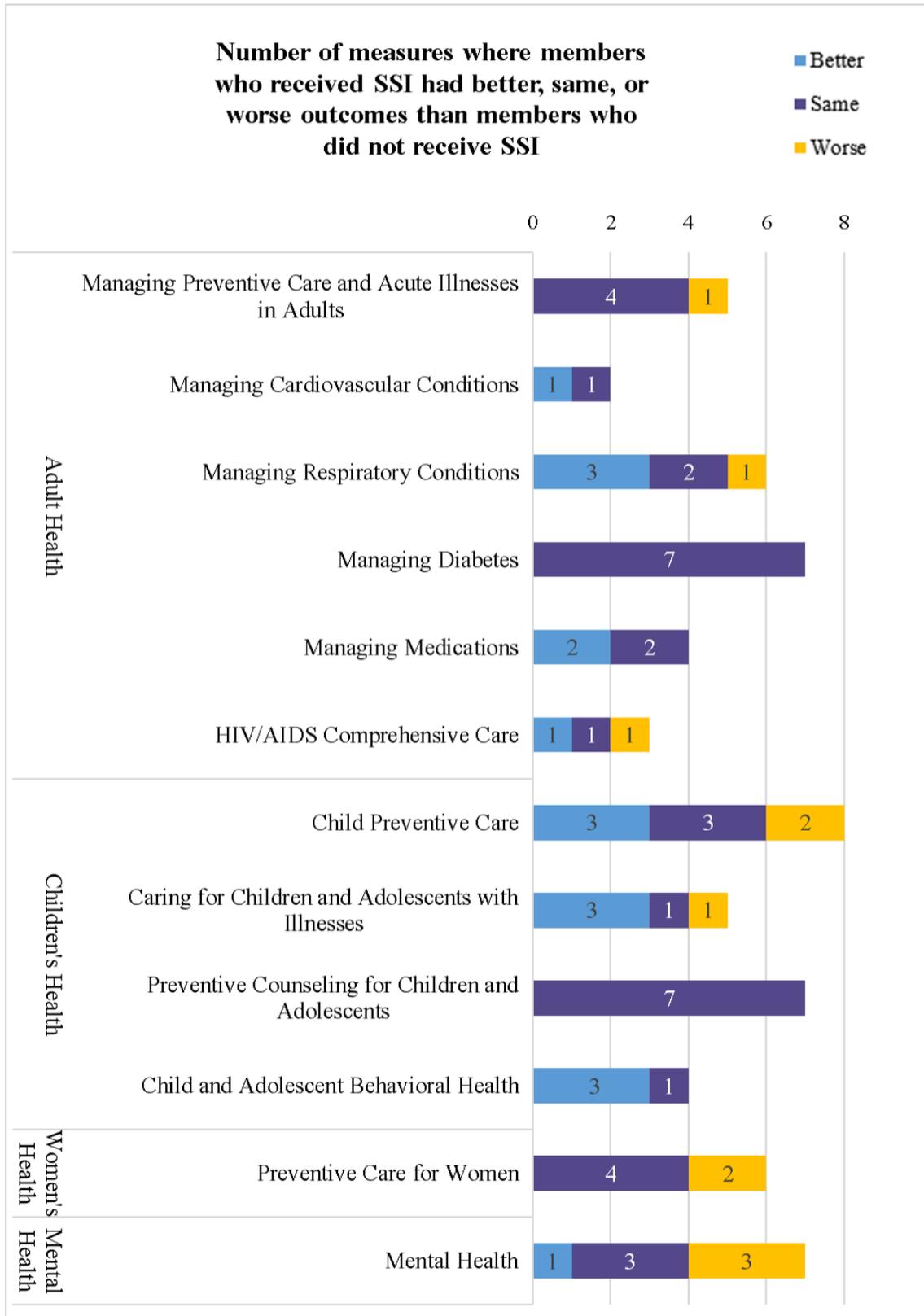


Highlights: Trend over time for Members Who Received SSI

- Members who received SSI had similar outcomes to members who did not receive SSI on 63% of measures.
- There has been a gradual increase over time in the number of measures where members who received SSI had worse outcomes than members who did not receive SSI.

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Disparities in Health Areas for Members Who Received Supplemental Security Income



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Priority Health Areas

Adult Health Outcomes for Members Who Received Supplemental Security Income

- Members with SSI had similar outcomes to members without SSI on the majority of measures related to managing chronic conditions (i.e., cardiovascular disease, respiratory conditions, and diabetes).
- Members with SSI were also less likely to have an annual dental visit than members who did not receive SSI.

Children's Health Outcomes for Members Who Received Supplemental Security Income

- Children who received SSI were less likely to have an annual dental exam and were less likely to receive five or more well-child visits during their first fifteen months of life.
- There is evidence that this population may receive less appropriate care. Children who received SSI were the only group that had higher rates of children prescribed antibiotics for an upper respiratory infection and had higher rates of children on multiple concurrent anti-psychotics.

Women's Health Outcomes for Members Who Received Supplemental Security Income

- This population had lower performance than members who did not receive SSI on chlamydia screening and breast and cervical cancer screening but had similar outcomes on prenatal and postpartum measures.

Mental Health Outcomes for Members Who Received Supplemental Security Income

- Members who received SSI were less likely to continue using antidepressants three months and six months after being diagnosed with depression and were less likely to have a follow-up after hospitalization for mental illness within 7 days after being discharged.

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Disparities in Health Areas for Members with a Substance Use Disorder ²



² Trend data for the SUD Population is not available in this report.

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Priority Health Areas

Adult Health Outcomes for Members with a Substance Use Disorder

- Members with a SUD had worse outcomes on all of the measures related to managing respiratory conditions (i.e., COPD and asthma) and 57% of measures related to managing diabetes, but had similar outcomes on managing cardiovascular conditions as members without a SUD.

Women's Health Outcomes for Members with a Substance Use Disorder

- Women with a SUD had lower cancer screening rates (i.e., cervical and breast), and fewer women had timely prenatal care and postpartum care than women without a SUD.

Mental Health Outcomes for Members with a Substance Use Disorder

- Members with a SUD had worse outcomes than members without a SUD on the majority of mental health measures (i.e., follow-up after hospitalization for mental illness, use of antidepressants after diagnosis, and diabetes monitoring among members with a SUD who have schizophrenia and diabetes).

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APPENDIX

Health Area	Domain	Measure
Adult Health	Managing Preventive Care and Acute Illnesses in Adults	Adult BMI Assessment
		Annual Dental Visit
		Use of Imaging Studies for Low Back Pain
		Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis
		Colorectal Cancer Screening
	Managing Cardiovascular	Controlling High Blood Pressure
		Persistence of Beta-Blocker Treatment after a Heart Attack
	Managing Respiratory Conditions	Asthma Medication Ratio (Ages 19-64)
		Use of Appropriate Medications for People with Asthma (Ages 19-64) - 50%
		Use of Appropriate Medications for People with Asthma (Ages 19-64) - 75%
		Use of Spirometry Testing in the Assessment and Diagnosis of COPD
		Pharmacotherapy Management of COPD Exacerbation- Bronchodilator Pharmacotherapy Management of COPD Exacerbation- Corticosteroid
	Managing Diabetes	HbA1c Testing
		Dilated Eye Exam
		Nephropathy Screening
		Poor HbA1c Control (<9.0%)
		HbA1c Control (<8.0%)
Good HbA1c Control (<7.0%) Blood Pressure Controlled (<140/90 mm/Hg)		
Managing Medications	Drug Therapy for Rheumatoid Arthritis	
	Annual Monitoring for Patients on Persistent Medications- ACE Inhibitors/ARBs	
	Annual Monitoring for Patients on Persistent Medications- Digoxin	
	Annual Monitoring for Patients on Persistent Medications- Diuretics	
HIV/AIDS Comprehensive Care	Engaged in Care	
	Syphilis Screening	
	Viral Load Monitoring	
Children's Health	Child Preventive Care	Childhood Immunization Status (Combo 3)
		Immunizations for Adolescents
		Lead Testing
		Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)
		Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life
		Adolescent Well-Care Visits
		Annual Dental Visit (Ages 2-18)
		Non-Recommended Cervical Cancer Screening in Adolescent Females
	Caring for Children and Adolescents with Illnesses	Appropriate Treatment for Upper Respiratory Infection (URI)
		Appropriate Testing for Pharyngitis
		Use of Appropriate Medications for People with Asthma (Ages 5-18) -50% Use of Appropriate Medications for People with Asthma (Ages 5-18) - 75% Asthma Medication Ratio (Ages 5-18)
	Preventive Counseling for Children and Adolescents	Weight Assessment- BMI Percentile
		Counseling for Nutrition
Counseling for Physical Activity		
Assessment, Counseling, or Education: Sexual Activity		
Assessment, Counseling, or Education: Depression Assessment, Counseling, or Education: Tobacco Use Assessment, Counseling, or Education: Alcohol and Other Drug Use		
Women's Health	Preventive Care for Women	Timeliness of Prenatal Care
		Postpartum Care
		Frequency of Ongoing Prenatal Care
		Breast Cancer Screening
		Cervical Cancer Screening
		Chlamydia Screening (Ages 16-24)
Mental Health	Adult Mental Health	Antidepressant Medication Management-Effective Acute Phase Treatment
		Antidepressant Medication Management-Effective Continuation Phase Treatment
		Follow-Up After Hospitalization for Mental Illness Within 7 Days
		Follow-Up After Hospitalization for Mental Illness Within 30 Days
		Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
		Diabetes Monitoring for People with Diabetes and Schizophrenia
		Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications
	Child and Adolescent Mental Health	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
		Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase
		Metabolic Monitoring for Children and Adolescents on Antipsychotics (Ages 1-17)
		Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Ages 1-17)