Quality Measure Reference Guide

HEDIS MEASUREMENT YEAR (MY) 2025

NORTH Dakota | Health & Human Services
Be Legendary.

Achieve better outcomes for your patients and your practice

Like you, we want your patients, who are ND Medicaid members, to be as healthy as possible. And a big part of that is making sure they get the preventive care and chronic condition management they need.

The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and Centers for Medicare and Medicaid Services (CMS) measures are not only important for you as a healthcare provider, but they also help guide your patients to quality care.

Take advantage of this *Quality Measure Reference Guide* to help your practice understand the HEDIS measures with measure descriptions and details, coding recommendations and actionable takeaways. These materials are updated annually or as changes are implemented.

The goal is for healthcare providers to submit claims/encounters with the complete and accurate coding that administratively captures all required HEDIS data through claims. When you add them for certain preventive care services and test results, we can get a more complete picture of our members' health and it helps you to identify and address open care opportunities.

CPT II codes are to be billed at $0.00 or a nominal amount (such as $0.01), and the MMIS will adjudicate the claim at zero payment.

Table of Contents

Measure Specifications

This document is an overview of measures. For the complete specifications, please refer to the resources listed below.
HEDIS Measures and Technical Resources - NCQA

		CMS Child Core Set	CMS Adult Core Set
Technical Specification		CMS 2025 Child Resource Manual and Technical Specifications	CMS 2025 Adult Resource Manual and Technical Specifications
Value Set References	HEDIS	https://store.ncqa.org/hedis-2025-child-core-set-hedis-value-set-directory-my-2024.html	https://store.ncqa.org/hedis-2025-adult-core-set-value-set-directory-my-2024.html.
	Non-HEDIS	CCP-CH, CCW-CH, CDF-CH, and OEVP-CH https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-child-non-hedis-value-set-directory.zip	CCP-AD, CCW-AD, CDF-AD, EDV-AD, HVL-AD, OEVP-AD, OUD-AD, PQI01-AD, PQI05-AD, PQI08-AD, and PQI15-AD https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.
			COB-AD and OHD-AD measures, as well as the National Drug Codes (NDCs) for opioid medications https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
	Electronic Specifications	Available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at https://vsac.nlm.nih.gov. To download value sets the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a free UMLS license at https://www.nlm.nih.gov/databases/umls.html. When searching for value sets for a measure, states should use the measure's associated electronic specification number. To report on the 2025 measures, use the version of the value sets associated with the May 2023 release.	
		This applies to: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH.	This applies to: AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, COL-AD, HVL-AD, and IET-AD.
Medication lists		Several HEDIS measures reference medication lists, which are a list of codes and medications used to identify dispensed medications. The Medication List Directory is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html/). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).	
		This applies to: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, and FUA-CH.	This applies to: AAB-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CHL-AD, COL-AD, FUA-AD, GSD-AD, HPCMI-AD, IET-AD, SAA-AD, and SSD-AD.

Primary Care Access & Preventative Care

Measure and Definition	Measure Steward	Line of Business	Best Practices

Immunizations

Adult Immunization Status

HEDIS | Commercial | Medicaid | Medicare

The percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

Childhood Immunization Status

HEDIS | Commercial | Medicaid

The percentage of children 2 years of age who had the following vaccinations:

Vaccine		Doses	HEDIS Timeline
DTaP	{diphtheria, tetanus, and acellular pertussis}	4	Not before 42 days old, and by 2nd birthday
IPV	{polio}	3	Not before 42 days old, and by 2nd birthday
MMR	{measles, mumps, and rubella}	1	On or between 1st and 2nd birthday
HiB	{haemophilus influenza type B}	3	Not before 42 days old, and by 2nd birthday
HepB	{Hepatitis B}	3	By 2nd birthday
VZV	{chicken pox}	1	On or between 1st and 2nd birthday
PCV	{Pneumococcal conjugate}	4	Not before 42 days old, and by 2nd birthday
HepA	{Hepatitis A}	1	On or between 1st and 2nd birthday
RV	{Rotavirus}	*2 or 3	Full series completed by 8 months (per CDC)
FLU	{Influenza}	*2	By 2nd birthday

Immunizations for Adolescents

HEDIS | Commercial | Medicaid

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

**Teen combination 1 = 1 Tdap +1 MCV4; Teen combination 2 = 1 Tdap + 1 MCV4 + HPV up to date.*

- Utilize Gap in Care Registries
- Plan ahead of visits to set reminders if patient is due for immunizations
- Send out reminder post cards or letters
- Update the ND Immunization Information System registry.
- Be sure to code/bill all immunizations given.
- Schedule appointments to coincide with required timeframes for immunization administration.
- Schedule the 2-year well-child visit on or before the 2nd birthday – vaccines given after the second birthday will NOT be compliant for HEDIS®.
- Use each visit to review vaccine schedule and catch-up on missing immunizations.
- Use your electronic medical record (EMR) system to set reminder flags.
- During visits, talk to parents about the importance of having their children immunized.
- Document any parental refusal for immunizations. This does not exclude member from measure.
- Ensure the member's medical record includes immunization history from all sources (NOTE: "Child is up to date with all immunizations" does not meet compliance).
- Reference the CDC Immunization Vaccine Schedule.

Screenings				
Breast Cancer Screening	HEDIS	Commercial	Medicaid	Medicare
Percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years.				
Cervical Cancer Screening	HEDIS	Commercial	Medicaid	
The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: ➢ Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. ➢ Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. ➢ Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.				
Chlamydia Screening in Women	HEDIS	Commercial	Medicaid	
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.				
Colorectal Cancer Screening	HEDIS	Commercial	Medicaid	Medicare
The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. Any of the following meet criteria: ➢ Fecal occult blood test during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. ➢ Stool DNA (sDNA) with FIT test during the measurement period or the 2 years prior to the measurement period. ➢ Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period. ➢ CT colonography during the measurement period or the 4 years prior to the measurement period. ➢ Colonoscopy during the measurement period or the 9 years prior to the measurement period.				

- Educate patients on appropriate screening guidelines, available screening options, and importance of early detection.
- Establish standing orders when logical
- Prepare charts prior to appointments each day, verifying last screening.
- Utilize the Gaps in Care Report and set care gap "alerts" in your electronic medical record.
- Use phone, mail, email, or other electronic messaging to have patients come in for annual visit.
- Ensure claims documentation of past unilateral/bilateral mastectomy.
- Request to have screening results sent to you if done at another office or clinic.
- Document the month, year and results of most recent screening in the medical record.
- Events where patients can come and have their screening done and participate in shopping from local vendors or a craft fair or another type of activity.
- Assess existing barriers with screening
- Engage patients to discuss their fears.
- Reference The American Cancer Society Guidelines for Prevention and Early Detection
- Screening should occur with or without symptoms.
- Distribute FOBT or FIT test kits to members who need to be screened for colorectal cancer.
- Act quickly for members who have a positive stool test result.
- New National Cancer Institute Colorectal Cancer Risk Assessment Tool

Developmental Screening in the First Three Years of Life	HEDIS	Commercial	Medicaid	
Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.				

- American Academy of Pediatrics (AAP) recommends developmental and behavioral screenings for all children during regular well-child visits at 9 months, 18 months, and 30 months.
- AAP recommends that all children be screened specifically for the autism spectrum disorder (ASD) during regular well-child visits at 18 months and 24 months.
- Educate staff to schedule member office visits within guideline time frames.
- Use Standardized developmental screening tools such as:
  - Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
  - Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
  - Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
  - Survey of Well-Being in Young Children (SWYC)
  - Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
  - Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
  - Brigance Screens-II - Birth to 90 months
  - Child Development Inventory (CDI) - 18 months to age 6
  - Infant Development Inventory - Birth to 18 months

It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not acceptable screeners related to global developmental screening that identify risk for developmental, behavioral, and social delays.
Bright Futures Recommendations for Preventive Care

Lead Screening in Children	HEDIS		Medicaid		• Discuss the risks of not being tested, including the possibility of behavioral and cognitive issues. • Offer Saturday and walk-in appointments for lead testing. • Discuss the importance of early lead screening during both well and sick visits. • Order the test at the appropriate age and ensure it is completed. • Follow up on open lab orders for lead screening before the second birthday. • Provide in-office testing. • Be sure the chart documentation includes the date the test was performed AND the result or finding. • Educate parents that while the child may not be exposed at home, other environments may present a new risk.
Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.					
Well Child					
Child and Adolescent Well-Care Visits	HEDIS	Commercial	Medicaid		• Scheduling the next visit at the end of each appointment. • Combining a sick visit with a wellness visit if it makes sense to do both at the same time. • Combine Sports Physicals and wellness exams if it makes sense. • Utilize the Gaps in Care Report • Sending Birthday cards with well child check reminders • Back to school well child check events.
Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.					

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS	Commercial	Medicaid		• Take advantage of every visit, including sick visits, to capture BMI percentile and nutrition and physical activity assessments/anticipatory guidance. • Document weight and obesity counseling, if applicable, to comply for both Nutrition and Physical Activity sub-measures • Encourage patients to maintain the relationship with a PCP to promote consistent and coordinated health care. • Educate patients on the importance of having at least one ambulatory or preventive care visit during each measurement year. • Make outreach calls and/or send letters to advise members of the need for a visit.
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: 1. **BMI percentile documentation** 2. **Counseling for nutrition** 3. **Counseling for physical activity**					
Well Child Visits First 30 Months of Life	HEDIS	Commercial	Medicaid		• Scheduling upcoming visits in advance • Scheduling all 6 well child visits when scheduling the first one. • Combining a sick visit with a well visit if it makes sense to do both at the same time. • Building and utilizing Gaps in Care Reports • Sending Birthday cards with well child check reminders • Providing refrigerator magnets with schedule of visits • Hosting community events for kids that bring together well child education, scheduling of well child checks, car seat checks, ambulance tours, etc.
1. **Well-Child Visits in the First 15 Months** Percentage of children who turned age 15 months during the measurement year and had six or more well-child visits. 2. **Well-Child Visits for Age 15 Months–30 Months** Percentage of children who turned age 30 months during the measurement year and had two or more well-child visits NOTE: The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child					

Care of Acute & Chronic Conditions

Measure and Definition	Measure Steward	Line of Business			Best Practices
Antibiotics					
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. **Inverted measure - a higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).*	HEDIS	Commercial	Medicaid	Medicare	• Reference the Centers for Disease and Control Prevention "Be Antibiotics Aware: Smart Use, Best Care."
Asthma/COPD					
Asthma in Younger Adults Admission Rate Hospitalizations with a principal diagnosis of asthma per 100,000 beneficiary months for beneficiaries ages 18 to 39. *Note: A lower rate indicates better performance.*	AHRQ	Commercial	Medicaid		• Develop an Asthma and/or COPD Action Plan • Educate members on the importance of adhering to medications and reducing asthma and COPD triggers. • Advise members to incorporate inhalers into their daily routine. • Schedule periodic follow-up visits: annually, every 6 months, every 3 months or more frequently depending on member need. • Encourage annual wellness visits, screenings and keeping up to date with immunizations such as Influenza and Pneumococcal vaccines. • Educate patients on the difference between controller and rescue medications/inhalers • Regularly evaluate patient's inhaler technique • Reference the Centers for Disease and Control Prevention "Be Antibiotics Aware: Smart Use, Best Care."
Asthma Medication Ratio The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	HEDIS	Commercial	Medicaid		
COPD or Asthma in Older Adults Admission Rate Hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older. *Note: A lower rate indicates better performance.*	HEDIS	Commercial	Medicaid	Medicare	

Diabetes				
Diabetes Short-Term Complications Admission Rate	HEDIS	Commercial	Medicaid	Medicare
Hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older. *Note: A lower rate indicates better performance.*				
Glycemic Status Assessment for Patients with Diabetes	HEDIS	Commercial	Medicaid	Medicare
Percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: ❖ HbA1c Control (<8.0%) ❖ HbA1c Poor Control (>9.0%)				

- Educate members on the importance of adhering to medications and treatment plan.
- Schedule periodic follow-up visits: annually, every 6 months, every 3 months or more frequently depending on member need.
- Encourage annual wellness visits and screenings.
- Ensure HbA1c and other labs are ordered prior to patient appointments.
- Consider referral to diabetic educator or nutritionist.
- Educate patients on the importance of their annual diabetic eye exam, completing lab work and screenings.
- Outreach to patients with sub-optimal HbA1c.
- Outreach patients who cancel appointments and reschedule them as soon as possible.
- Remind patients to bring logbooks or glucose monitors to their appointment.
- Care coordination with other providers caring for the patient.
- Ensure patient understands education materials with new onset diabetes.
- Set up a tracking mechanism within your healthcare system to identify gaps in care.
- Utilize EHR flags and reporting to assist in tracking patients in need of follow-up visits.

Heart Failure					
Heart Failure Admission Rate	AHRQ		Medicaid	Medicare	• Every CHF patient should have an action plan that includes daily monitoring and steps for getting emergency care quickly in the event of severe symptoms. • Utilize AHA Guidelines and Toolkit to assist with patient management. • Educate members on the importance of adhering to medications and treatment plan. • Schedule periodic follow-up visits: annually, every 6 months, every 3 months or more frequently, depending on member need.
Hospitalizations with a principal diagnosis of heart failure per 100,000 beneficiary months for beneficiaries age 18 and older. *Note: A lower rate indicates better performance.*					

HIV					
HIV Viral Load Suppression	Health Resources and Services Admin	Commercial	Medicaid	Medicare	• Plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment, because viral load is the most important indicator of response to antiretroviral therapy (ART).
Percentage of beneficiaries age 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.					

Hypertension					
Controlling High Blood Pressure	HEDIS	Commercial	Medicaid	Medicare	• Document BP readings at every visit. • BP readings that are 140/90 or greater should be re-taken. • Schedule follow-up visits for blood pressure control after diagnosis or med adjustment • Consider referral to cardiologist for those whose BP goal cannot be attained, or for complicated patients. • Make sure the proper cuff size is used. • Ensure patients don't cross their legs and have their feet flat on the floor during the reading. Crossing legs can raise the systolic pressure by 2-8 mmHg. • Make sure the elbow is at the same level as the heart. If the patient's arm is hanging below heart level and unsupported, this position can elevate the measured blood pressure by 10-12 mmHg. • If the patient has a high blood pressure reading at the beginning of the visit, retake and record it at the end of the visit. Consider switching arms for subsequent readings. • Educate patients about the risks of uncontrolled blood pressure. • Reinforce the importance of medication adherence and encourage patients to report side effects. • Do not include BPs taken in an acute inpatient setting or during an ED visit
The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.					

Opioids					
Concurrent Use of Opioids and Benzodiazepines	Pharmacy Quality Alliance	Commercial	Medicaid	Medicare	• Review and reconcile all medications at each visit. • Query Prescription Drug Monitoring Program prior to prescribing any new medications. • This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Centers for Disease Control and Prevention (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain
Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. *Note: A lower rate indicates better performance.* **Numerator Compliance** The number of beneficiaries from the denominator with: o Two or more prescription claims for any benzodiazepine with different dates of service, AND Concurrent use of opioids and benzodiazepines for 30 or more cumulative days.					
Use of Opioids at High Dosage in Persons Without Cancer	Pharmacy Quality Alliance	Commercial	Medicaid	Medicare	• Use the lowest dosage of opioids for the shortest length of time possible. • Track the daily dosage in MMEs and the total number of days in the calendar year that the member is prescribed opioids. The average daily MMEs for all the days the prescription opioids covered should not be ≥90. • Employ urine screens and/or breathalyzer to assess for use of other substances or illicit substance use. • Engage parents/guardian/family/support system or significant others in the treatment plan when possible. Advise them about the importance of treatment and attending appointments. • Establish and measure goals for pain and function.
The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. *Note: A lower rate indicates better performance.*					

	• Discuss benefits and risks and availability of non-opioid therapies with patient. • Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. • Review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put them at high risk for overdose. • Emphasize the importance of consistency and adherence to the medication regimen.

Behavioral Health

Measure and Definition	Measure Steward	Line of Business			Best Practices
ADHD					
Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication The percentage of children newly prescribed attention- deficit/hyperactivity disorder (ADHD) medication as of the Index Prescription Start Date (IPSD) who had at least three follow-up care visits within a 10- month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported: 1. **Initiation Phase:** The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow- up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. 2. **Continuation and Maintenance (CandM) Phase:** The percentage of members 6– 12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended	HEDIS	Commercial	Medicaid		• Discuss with patients the importance of taking medication as prescribed and remaining on the medication. • Educate patients and caregivers on possible side effects and the length of time it will take for the medication to have the desired effect. • Schedule at least three follow-up appointments within a 10- month period (e.g., 2-week, 6-week, 3- or 6-month appointments) before the patient leaves the office. First visit must be completed within 30 days of IPSD. • Send appointment reminders to ensure the patient returns. • Develop tracking method for patients who were prescribed or restarted ADHD medication. • Require staff to follow up with patients who miss or cancel their appointment. • Consider telemedicine appointments if in-person visits are not available. • Consider the parent's work schedule as a barrier to the visit and offer extended evening or weekend hours.

Depression Screening					
Screening for Depression and Follow-Up Plan	HEDIS	Commercial	Medicaid	Medicare	• Screen patients for depression annually at a minimum, could be at a wellness visit or any other visit. • An outpatient, telephone, e-visit or virtual check-in follow-up are also acceptable to meet the measure requirements. • The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. • Ensure claims include G codes as defined below, when depression screening is done. • To satisfy the follow-up requirement for the member screening positively, the provider would need to provide one of the specified follow-up actions on the same date as the screening occurred, which includes one or more of the following: - Referral to a provider for additional evaluation - Pharmacological interventions - Other interventions for the treatment of depression
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.					

Diabetes					
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	HEDIS		Medicaid		• Order a diabetes screening test every year and build care gap "alerts" in your electronic medical record. • Follow up with patients to discuss and educate on lab results. • Coordinate care with patients' other providers. • Outreach patients who cancel appointments and reschedule them as soon as possible. • Encourage shared decision-making by educating patients and caregivers about increased risk of diabetes with antipsychotic medications. • Discuss with member the importance of screening for diabetes. • Educate the member on symptoms of new onset diabetes. • Order labs prior to members' appointments. • Ensure documentation in the medical record includes the date when the HbA1c was performed, and the result. • Follow up with patients to discuss and educate on effects of diabetes.
Percentage of beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.					
Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)	CMS		Medicaid		
Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (>9.0%). *Note: A lower rate indicates better performance (e.g., low rates of poor control indicate better care).*					

ER/Hospital Follow-up

Follow-Up After Emergency Department Visit for Mental Illness	HEDIS	Commercial	Medicaid	Medicare

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Follow-Up After Emergency Department Visit for Substance Use	HEDIS	Commercial	Medicaid	Medicare

The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up.

Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Emergency Care

- Assisting members with scheduling an in-person or telehealth visit within 7 days.
- Train patients and staff on the "Teach Back Method" to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow–up.
- Educate the patient about the importance of follow-up and adherence to treatment recommendations.
- Focusing on member preferences for treatment, allowing the member to take ownership of the treatment process.
- Sending discharge paperwork to the appropriate outpatient provider within 24 hours of discharge.

Primary Care

- Schedule follow-up appointments as soon as possible, particularly those patients recently discharged from the ED.
- Encouraging members to bring their discharge paperwork to their first appointment.
- Coordinate care with behavioral health practitioners by sharing progress notes and updates.
- Outreach patients who cancel appointments and assist them with rescheduling as soon as possible.
- Set flags if available in EHR or develop tracking method for patients due or past due for follow-up after discharge visits.
- Use the same diagnosis for substance use disorder each follow-up (a non-substance use diagnosis code will not fulfill this measure)

Follow-Up After Hospitalization for Mental Illness	HEDIS	Commercial	Medicaid	Medicare	• Educate patients and caregivers on the importance of follow-up to reduce the risk of inpatient admission. • Train staff on the "Teach Back Method" to ensure patients and caregivers review and understand discharge instructions and the next steps in their care for follow–up. • Develop outreach systems or assign case managers to encourage recently released patients to keep follow-up appointments or reschedule missed appointments. • Set flags if available in EHR or develop tracking method for patients due or past due for follow-up after discharge visits. • Coordinate care with behavioral health practitioners by sharing progress notes and updates.
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: 1. The percentage of discharges for which the member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.					
Medication Management					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	HEDIS	Commercial	Medicaid	Medicare	• Educate patients and their caregivers on the importance of medication compliance. • Discuss with patients potential medication side-effects and when to call their provider. • Ensure appointment availability for patients. • Schedule follow-up appointments before the patient leaves appointment • Reach out to patients that do not keep follow-up appointments and set flags if available in EHR or develop tracking method for patients due or past due for follow-up visits and require staff to follow up with patients that miss or cancel their appointment.
The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. **Numerator Compliance** • Members who achieved a PDC of at least 80% for their antipsychotic medications during the measurement year. IPSD - Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication during the measurement year. Treatment period - The period of time beginning on the IPSD through the last day of the measurement year.					

<table>
<tr><td colspan="5">PDC - Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.</td><td>• Coordinate care with patients' behavioral health specialists.</td></tr>
<tr><td>Antidepressant Medication Management</td><td>HEDIS</td><td>Commercial</td><td>Medicaid</td><td>Medicare</td><td rowspan="2">• Discuss with patients the importance of taking medication as prescribed and remaining on medication for a minimum of six months even when the patient starts to feel better.
• Discuss with patients the risks of stopping medication before six months or abruptly and recommend follow-up first for a consultation.
• Educate patients on possible side effects and length of time for the medication to have the desired effect.
• Schedule follow up appointment before the patients leave the office and send appointment reminders.
• Develop tracking method for patients prescribed antidepressants and require staff to follow up with patients that miss or cancel their appointment.
• When available, use gap lists to help manage your total population.
• Offer extended evening, weekend hours or telemedicine.</td></tr>
<tr><td colspan="5">The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.

Two rates:
1. Effective Acute Phase Treatment - The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. Effective Continuation Phase Treatment - The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).</td></tr>
</table>

Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS	Commercial	Medicaid	

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Three rates are reported:

1. **Blood Glucose:** The percentage of children and adolescents on antipsychotics who received blood glucose testing.
2. **Cholesterol:** The percentage of children and adolescents on antipsychotics who received cholesterol testing.
3. **Blood Glucose and Cholesterol**: The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

- Monitor glucose and cholesterol levels for children and adolescents prescribed antipsychotic medications as recommended by The American Academy of Child and Adolescent Psychiatry (AACCAP)
- Monitor children on antipsychotic medications to avoid metabolic health complications such as weight gain and diabetes.
- Inform parents/guardians of metabolic problems in childhood and adolescence that are associated with poor cardio-metabolic outcomes in adulthood.
- Inform parents/guardians of the long-term consequences of pediatric obesity and other metabolic disturbances including higher risk of heart disease in adulthood.
- Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side-effects of antipsychotic medication therapy.
- Arrange for lab tests to be done in the office during a patient's visit or schedule lab testing before the patient and parent/guardian leaves the office.
- Determine whether the electronic medical record can flag for lab tests based on diagnosis or when antipsychotic medications are prescribed.
- Educate the parent/guardian about appropriate health screenings for certain medication therapies.

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	AHRQ, HEDIS, CMS	Commercial	Medicaid		• Periodically review the ongoing need for continued therapy with antipsychotic medications • Establish a baseline and continuously monitor metabolic indices to ensure appropriate management of side-effects of antipsychotic medication therapy. • For new child/adolescent patients taking antipsychotics medications, complete a thorough evaluation and coordination with the mental health professional to ensure that all medications are addressing current symptoms for the patient's on-going stability and recovery. • Monitor children and adolescents prescribed antipsychotics closely as they are more at risk for serious health concerns, including weight gain, extrapyramidal side effects, hyperprolactinemia and some metabolic effects including glucose and cholesterol levels, as recommended by The American Academy of Child and Adolescent Psychiatry • Monitor female children/adolescents treated with certain antipsychotics closely as they may also be at increased risk for gynecological problems. • Educate and inform parents/guardians of the increased side effect burden of multiple concurrent antipsychotics on children's health, which has implications for future. physical health concerns including obesity and diabetes.
The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.					

Substance Use					
Initiation and Engagement of Substance Use Disorder Treatment	HEDIS	Commercial	Medicaid	Medicare	• Schedule an initial follow-up appointment within 14 days during the first service. • Discuss with the patient the importance of timely follow-ups and what type of follow-up visits are recommended. • Coordinate care between behavioral health and primary care. • Reach out to patients who cancel or no-show appointments and assist them with rescheduling. • Telemedicine is approved for this measure. Ensure diagnosis code used for the visit is a substance use diagnoses code. • Notify patients of Recovery Talk 24/7 Recovery Support. • Utilize SAMHSA resources on substance abuse prevention. • Discuss the importance of timely, recommended follow-up visits. Use the same diagnosis for substance use at each follow-up.
Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: 1. **Initiation of SUD Treatment:** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. 2. **Engagement of SUD Treatment:** The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation					
Medical Assistance with Smoking and Tobacco Use Cessation	HEDIS	Commercial	Medicaid		• Promote annual visits through regular outreach such as sending letters or electronic messages • Discuss tobacco use at annual visits • Support Tobacco Control Programs • Education on cessation interventions
The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: 1. **Advising Smokers and Tobacco Users to Quit.** A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who received advice to quit during the measurement year. 2. **Discussing Cessation Medications.** A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.					

3. **Discussing Cessation Strategies.** A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.					
Use of Pharmacotherapy for Opioid Use Disorder	CMS	Commercial	Medicaid	Medicare	• Medication Assisted Treatment (MAT) for opioid abuse or dependence is proven to show a decrease in, Opioid use, Relapse, Overdose-related emergency department or inpatient admissions, Risk of death. • Patients with OUD should be informed of the risks and benefits of pharmacotherapy, treatment without medication, and no treatment. • Provide empathic listening and nonjudgmental discussion of triggers that precede use or increased craving and how to manage them. • Provide ongoing assessment to mark progress. Revise treatment goals via shared decision making to incorporate new insights. • Engage and educate patient's support persons who are reluctant to accept medication's role in treatment.
Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported: **1.** A **total (overall)** rate capturing any medications used in medication assisted treatment of opioid dependence and addiction ➢ Four separate rates representing the following types of FDA-approved drug products: **2. Buprenorphine** **3. Oral naltrexone** **4. Long-acting, injectable naltrexone** **5. Methadone**					

Dental & Oral Health Services

Measure and Definition	Measure Steward	Line of Business			Best Practices
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	*		Medicaid		• Encourage at least an annual checkup with a dentist. • Promote regular dental cleanings to help reduce gum disease and cavities. • Promote good oral hygiene habits: brushing teeth twice a day and flossing. • Oral Health in North Dakota Booklet • Combine topical fluoride with Wellness Visits • During visits, talk to parents about the importance of having children receive fluoride varnish applications. • Use your electronic medical record (EMR) system to set reminder flags. • Send reminder postcards. • Utilize the Gaps in Care Report
Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 beneficiary months for adults age 18 and older. *Note: A lower rate indicates better performance*					
Oral Evaluation, Dental Services	*		Medicaid		
Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.					
Oral Evaluation During Pregnancy	*		Medicaid		
Percentage of enrolled persons ages 15 to 44 with live-birth deliveries in the measurement year who received a comprehensive or periodic oral evaluation during pregnancy.					
Sealant Receipt on Permanent First Molars	*		Medicaid		
Percentage of enrolled children who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate.					
Topical Fluoride for Children	*		Medicaid		
Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.					

**Measure Steward for all Dental and Oral Health Services is the American Dental Association on behalf of the Dental Quality Alliance*

Maternal & Perinatal Health

Measure and Definition	Measure Steward	Line of Business			Best Practices
Contraceptive Care-All Women – All Women Ages 21 to 44 Among women ages 21 to 44 at risk of unintended pregnancy, the percentage that: 1. Were provided a most effective (sterilization, IUD/IUS, or implant) or moderately effective (injectables, oral pills, patch, or ring) method of contraception. 2. Were provided a long-acting reversible method of contraception (LARC).	HHS Office of Public Affairs	Commercial	Medicaid		• Offer educational materials on LARC to patients. - Offer English, Spanish, and other language versions - Offer interpretation services • If your practice is not trained on LARC insertion refer interested patients to an Ob/Gyn for an annual well woman exam and contraceptive counseling • Advise women that LARC is safe for all ages and fertility is rapid after removal.
Contraceptive Care-Postpartum Women Among women ages 21 to 44 who had a live birth, the percentage that: 1. Were provided a most effective (sterilization, IUD/IUS, or implant) or moderately effective (injectables, oral pills, patch, or ring) method of contraception within 3 days of delivery and within 90 days of delivery. 2. Were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery and within 90 days of delivery.	HEDIS	Commercial	Medicaid		
Postpartum Depression Screening and Follow-up The percentage of deliveries in which beneficiaries were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. 1. **Depression Screening**. The percentage of deliveries in which beneficiaries were screened for clinical depression using a standardized instrument during the postpartum period. 2. **Follow-Up on Positive Screen**. The percentage of deliveries in which beneficiaries received follow-up care within 30 days of a positive depression screen finding.	HEDIS	Commercial	Medicaid		• Educate patients on the importance of the prenatal/initial visit. • Review the visit schedule with the patient. • Connect patients to resources for family assistance programs.

Low-Risk Cesarean Delivery	Centers for Disease Control and Prevention/National Center for Health Statistics		Medicaid	
Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births to mothers under age 20 delivered by cesarean during the measurement year. *Note: A lower rate indicates better performance.*				
Live Birth Weighing Less Than 2,500 Grams	Centers for Disease Control and Prevention/National Center for Health Statistics		Medicaid	
Percentage of live births that weighed less than 2,500 grams at birth during the measurement year. *Note: A lower rate indicates better performance.*				
Prenatal and Postpartum Care	HEDIS	Commercial	Medicaid	
The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. 1. **Timeliness of Prenatal Care:** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. 2. **Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery				
Prenatal Immunization Status	HEDIS	Commercial	Medicaid	
The percentage of deliveries in the measurement period in which beneficiaries had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.				

- Educate patients on the importance of the prenatal/initial visit.
- Review the visit schedule with the patient.
- Connect patients to resources for family assistance programs.
- Encourage patients to maintain the relationship with an OB/GYN to promote consistent and coordinated health care.
- Educate patients on the importance of keeping each prenatal visit and post-partum visit.
- Consider offering extended practice hours to increase care access.
- Remind patients of their appointment by making calls or sending texts
- Make outreach calls and/or send letters to advise members of the need for a visit.
- Ensure vaccinations are up to date at every visit

Disclaimer

The material in this Reference Guide is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit, and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

For questions regarding this Reference Guide, please contact dhsmedicaidquality@nd.gov.

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