NEW YORK STATE | Department of Health | Medicaid Redesign Team

Chronic Pulmonary, Chronic Heart, Diabetes, and Primary Care Clinical Advisory Group (CAG) Meeting

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Agenda

1. Introductions and Background	**10 min**
2. Integrated Primary Care Arrangement and Quality Measurement	**15 min**
Review of the TCGP/IPC Arrangement and the VBP Pilot Program	5 min
VBP Measure Development and Implementation Timeline	10min
3. Clinical and Care Delivery Goals / Gap Identification	**55 min**
Priority Clinical and Care Delivery Goals	20 min
Identification of Gap Areas	35 min
4. Final Thoughts and Next Steps	**10 min**

Part 1: Introduction and Background

- VBP Program Goals and Timeline
- Initial Program Development and Governance Structure
- Creating the Initial TCGP/IPC Quality Measure Set
- Looking ahead: The role of the CAG Then and Now

Value Based Payments: Why is this important?

By DSRIP Year 5 (2020), all Medicaid MCOs must employ Value Based Payment (VBP) systems that reward value over volume for at least 80 – 90% of their provider payments.

Value Based Payments

- An approach to Medicaid reimbursement that rewards value over volume
- An approach to incentivize VBP Contractors through shared savings and financial risk
- A method to directly tie payment to VBP Contractors with quality of care and health outcomes
- A component of DSRIP that is key to the sustainability of the program

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.

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VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

April 2017

Performing Provider Systems (PPS) requested to submit growth plan outlining path to 80-90% VBP

April 2018

≥ 10% of total Managed Care Organization (MCO) expenditure in Level 1 VBP or above

April 2019

≥ 50% of total MCO expenditure in Level 1 VBP or above.
≥ 15% of total payments contracted in Level 2 or higher *

April 2020

80-90% of total MCO expenditure in Level 1 VBP or above
≥ 35% of total payments contracted in Level 2 or higher *

* For goals relating to VBP level 2 and higher, calculation excludes partial capitation plans such as MLTC from this minimum target.

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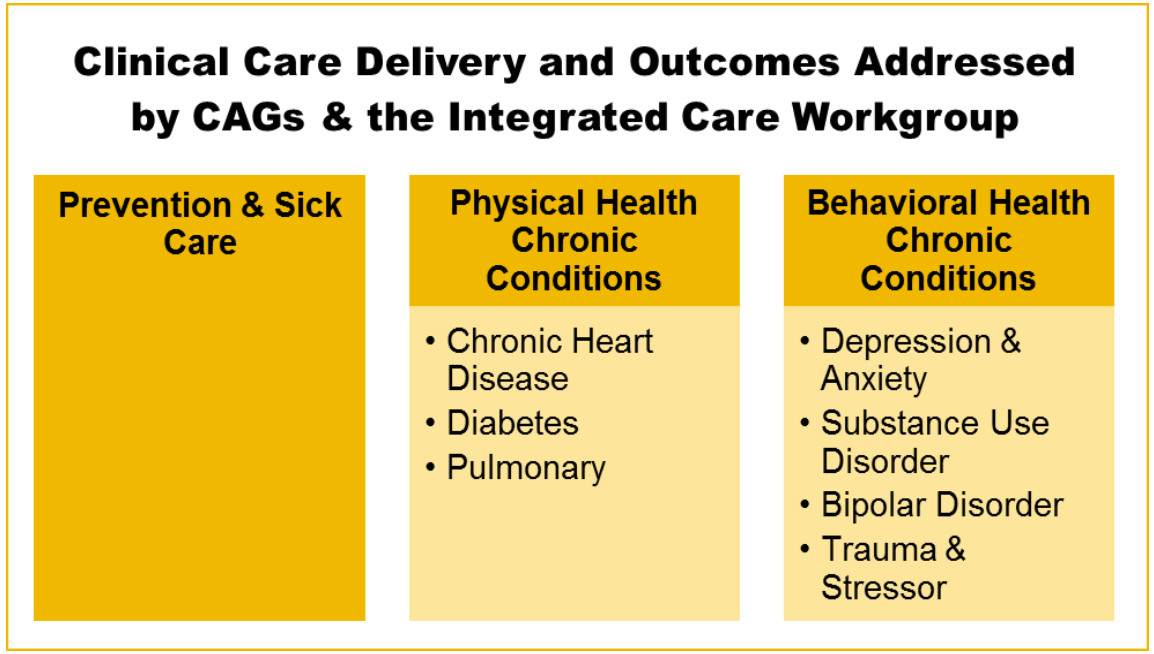
Developing the Initial Quality Measure Set

Alignment of patient Care goals and performance measurement across the enterprise to support VBP adoption.

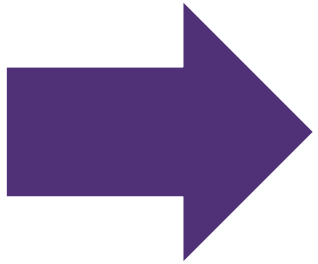
- In 2015 and 2016:
  - Three physical health and one behavioral health CAGs met to review seven episodes of care and recommend measures for the Total Cost General Population (TCGP) and Integrated Primary Care (IPC) Arrangement Measure Sets.
  - The Integrated Care Workgroup discussed the Advanced Primary Care model, including quality measures for the model.
- That work was combined to form a measure set for use in the TCGP and IPC VBP arrangements for 2017.
- The State conducted further feasibility review and analysis to define a final list of measures.



The Role of the CAGs: Then and Now

Recommendations for the Initial Measure Sets

The **VBP CAGs** and subcommittees were created to address the larger VBP design questions. Their charge was to produce recommendations to the VBP Workgroup and to the State with their best design solutions. As a result, a number of VBP standards and guidelines were developed (included in the current version of the Roadmap) by the Subcommittees. The CAGs' scope of work included selecting Quality Measures for specific arrangements.



Identification of VBP Measurement Targets and Gaps

The CAG will focus its activities on refining the priority clinical and care delivery goals for the VBP arrangements and provide recommendations, on an annual basis, to revise, strengthen, and improve the priority goals that will serve as the guide for long-term VBP Measure Set strategy, development and implementation.

The CAG will identify and fill critical gaps in the clinical and care delivery goals specific to the Medicaid population. The focus will be on **significant changes in the evidence base and clinical guidelines, along with opportunities for improvement** identified through experience in clinical practice and feedback from MCOs and VBP contractors.

Part 2: Review of the TCGP/IPC Arrangement and the VBP Pilot Program

- Review of the TCGP/IPC Arrangement and the VBP Pilot Program
- VBP Measure Development and Implementation Timeline

Integrated Primary Care (IPC) Arrangement

IPC Arrangement =

Preventive Care Component

Includes care activities such as wellness visits, checkups, immunizations, screening laboratory tests, etc.

- Preventive Care Episode

+

Chronic Condition Component

Includes disease management and secondary prevention activities related to 14 chronic conditions identified as priority by the State

- Arrhythmia/ Heart Block/ Conduction Disorders Episode
- Asthma Episode
- Bipolar Disorder Episode
- COPD Episode
- Coronary Artery Disease Episode
- Depression & Anxiety Episode
- Diabetes Episode
- GERD Episode
- Heart Failure Episode
- Hypertension Episode
- Low Back Pain Episode
- Osteoarthritis Episode
- Substance Use Disorder Episode
- Trauma & Stressors Disorders Episode

+

Sick Care Component

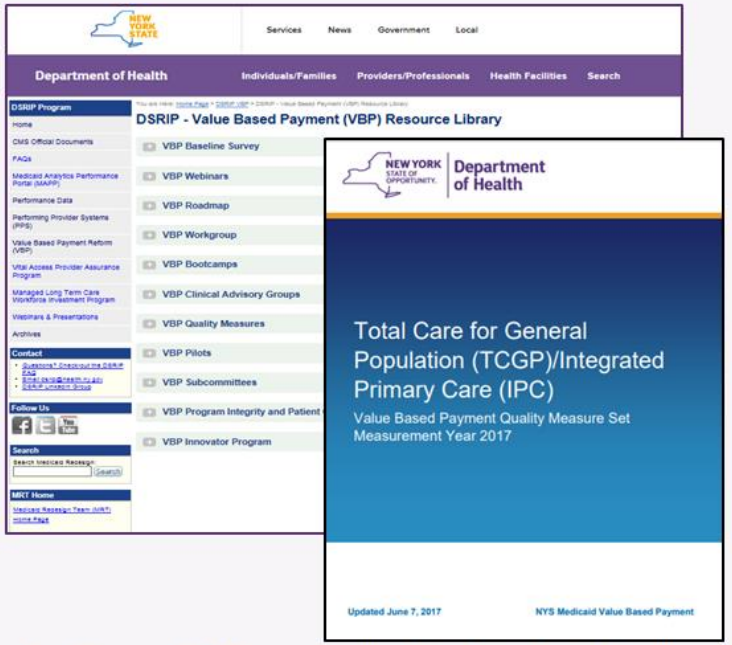
Includes care for symptoms such as headache or abdominal pain and minor acute conditions and procedures

- Chronic Sinusitis/Rhinitis Episode
- Tonsillectomy Episode
- URI Episode
- Routine Sick Care Episode

2017 TCGP/IPC Arrangement Quality Measure Set

- The TCGP/IPC VBP Arrangement incentivizes primary care providers to provide more integrated care, including for behavioral health conditions.
- Measures have been classified in two ways.
  - Category 1 quality measures are to be reported to the State by VBP Contractors. Some, designated as pay-for-performance (P4P), are recommended for use to determine shared savings for which VBP Contractors are eligible[1].
  - Category 2 measures have been accepted by the State based on agreement of measure importance, validity, and reliability, but flagged as presenting concerns regarding implementation feasibility. These measures will be further investigated in the VBP pilots.

Access the complete TCGP / *IPC Value Based Payment Quality Measure Set* on the VBP Resource Library!



https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm

[1] New York State Department of Health, Medicaid Redesign Team, *A Path toward Value Based Payment: Annual Update, June 2016: Year 2, New York State Roadmap for Medicaid Payment Reform, June 2016*. (Link)

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An Overview of the VBP Pilot Program

Effective January 1, 2017 through December 31, 2018, the two year VBP Pilot Program is intended to support the transition to VBP, establishing best practices and sharing lessons learned.

Arrangement	Provider	Managed Care Organization	VBP Level (Year 1)
Health and Recovery Plans (HARP)	Maimonides Medical Center	Healthfirst PHSP, Inc.	1
	Mount Sinai Health Partners	Healthfirst PHSP, Inc.	1
Integrated Primary Care (IPC)	Community Health IPA	Affinity Health Plan, Inc.	1
	Hudson Headwaters Health Network	New York State Catholic Health Plan, Inc.	1
Total Care for the General Population (TCGP)	Greater Buffalo United ACO	Yourcare Health Plan, Inc.	1
	Somos Your Health IPA	Affinity Health Plan, Inc.	2
	Somos Your Health IPA	HealthPlus HP, LLC	2
	Somos Your Health IPA	New York State Catholic Health Plan, Inc.	2
	Somos Your Health IPA	Healthfirst PHSP, Inc.	2
	Somos Your Health IPA	United Healthcare of New York, Inc.	2
	Somos Your Health IPA	Wellcare of New York, Inc.	2
	St. Joseph's Hospital Health Center	New York State Catholic Health Plan, Inc.	1
	St. Joseph's Hospital Health Center	Molina Healthcare of New York, Inc.	1

VBP Measure Development and Implementation Timeline

VBP Measure Set Development: *Crawl, Walk, Run!*

Status in VBP	• Several measures require final specifications and/or clinical or other data elements	• Work with measure stewards to develop and finalize specifications	• Fully developed VBP measures included in Measurement Years 2018 and 2019
Data Availability and Sources	• Assess data availability • Identify and investigate potential data sources • Survey technological capabilities	• Implement new data and reporting flows • Develop additional data sources	• Coordination established with Qualified Entities (QEs) for clinical data integration
Data Collection and Infrastructure	• Gather requirements for data collection • Begin developing infrastructure to support new data sources	• Initiate testing and evaluation of data collection methodologies • Work closely with technology vendors	• Data and reporting flows have been established • New data source infrastructure established

Note: Timelines will vary. The intent is to make substantive contributions within each phase to help realize NYS VBP Roadmap goals.

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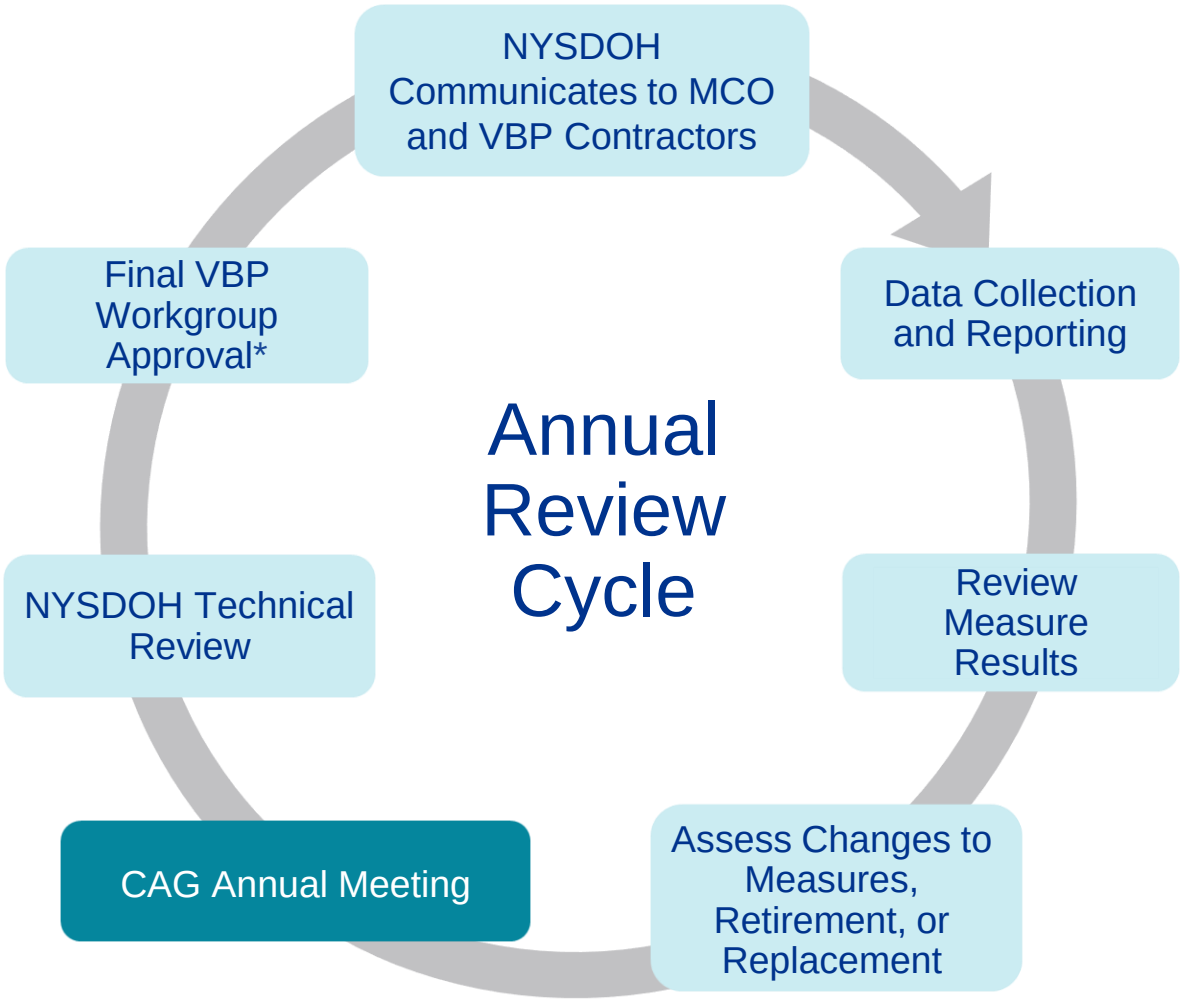
VBP Quality Measure Set Annual Review



Annual Review

Clinical Advisory Groups will convene to evaluate the following:

- Feedback from VBP Contractors, MCOs, and stakeholders
- Any significant changes in evidence base of underlying measures and/or conceptual gaps in the measurement program

State Review Panel

- Review data, technical specification changes or other factors that influence measure inclusion/exclusion*
- Review measures under development to test reliability and validity
- Review measure categorizations from CAG and make recommendations where appropriate (Cat. 1 vs. Cat. 2; P4P vs. P4R)

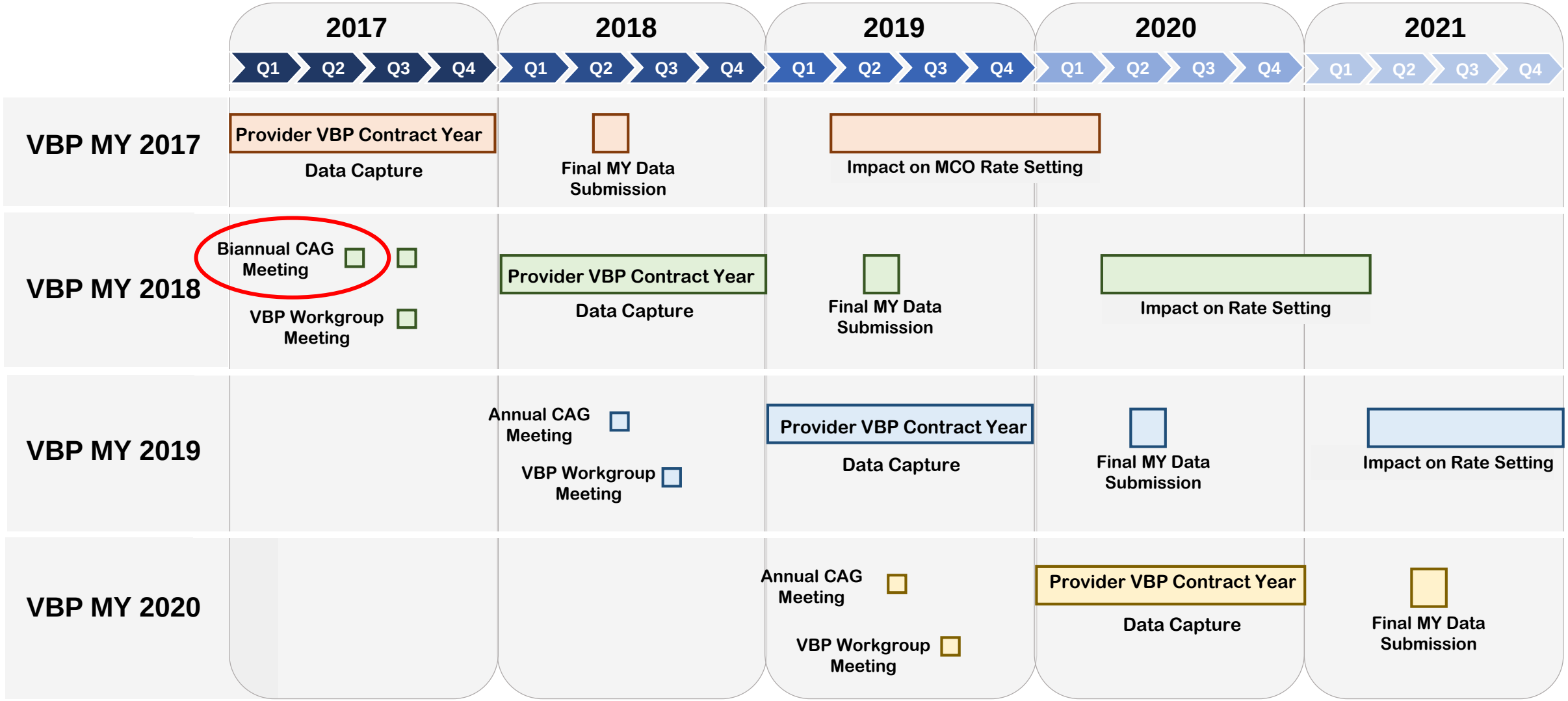
** Final Workgroup approval will occur annually in September*

Annual Measure Maintenance

Measures are assessed for various changes to their status

- Measure steward or National Endorsement changes
- Measure retirement
- National measures not in alignment with NYS medical guidelines
- NYS medical guidelines change and a measure loses relevance or feasibility (e.g. sample size)

VBP Contracting, Measure Implementation and Reporting Timeline



Part 3: Clinical and Care Delivery Goals / Gap Identification

- Priority Clinical and Care Delivery Goals
- Identification of Gap Areas

Confirm and Expand Priority Clinical and Care Delivery Goals

- The initial set of Priority Clinical and Care Delivery Goals for the TCGP and IPC Arrangements are based on review of the CAG and Integrated Care Workgroup (ICWG) Measure Set recommendations.
  - Measures were associated with a clinical or care delivery goal and targeted phase of care based on the measure detail and the purpose or intent for use.
- Goal setting will establish clear clinical and care delivery targets and will provide strategic direction for the State to consider in the development of a multi-year strategy for implementation of a high-value, responsive measure set for the TCGP and IPC Arrangements.
- The following slides present an initial set of Priority Clinical and Care Delivery Goals.
  - Clinical and Care Delivery Goals are broad-based aims that promote optimal patient outcomes through the delivery of safe, effective, and efficient evidence-based care for:
    - General Primary and Secondary Prevention
    - Diabetes
    - Cardiovascular
    - Pulmonary

Priority Clinical and Care Delivery Goals

General Primary and Secondary Prevention*

Phases of Care	Priority Clinical and Care Delivery Goals	
1) Optimal Health Behaviors	• Mental Health • Smoking Cessation	• Healthy weight • Dental Health
2) Immunizations	• Childhood Immunizations	• Prevention and Control of Seasonal Influenza with Vaccines
3) Cancer Screening	• Screening and Early Detection	• Breast and Cervical Cancer
4) Women's Health: Disease Prevention and Detection	• Breast and Cervical Cancer	• Sexually Transmitted Disease

*General Primary and Secondary Prevention Goals represent ICWG and CAG recommendations

Priority Clinical and Care Delivery Goals

Diabetes

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management	• Access to Care • Care Coordination • Glycemic Control • Cardiovascular Disease • Eye Care	• Foot Care • Kidney Disease • Medication Management • Smoking Cessation • Weight Management and Nutrition
2) Exacerbation and Complex Treatment	• Access to Care • Care Coordination	• Outcomes

Priority Clinical and Care Delivery Goals Cardiovascular

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	• Access to Care • Care Coordination • Blood Pressure Control • Lipid Control • Smoking Cessation • Medication Management	• Functional Status Assessment • Cardiovascular Function (Ejection Fraction) • Stroke Risk Assessment • Weight Management and Nutrition
2) Acute / Hospitalization	• Care Coordination • Mortality	• Outcomes
3) Post Acute / Rehab	• Access to Care	• Care Coordination
4) Cardiac Procedures	• Cardiac Catheterization	
5) Cardiac Imaging	• Appropriate Use of Healthcare Resources	

Priority Clinical and Care Delivery Goals Pulmonary

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management	• Access to Care • Asthma Severity Assessment and Monitoring • Asthma Self Management	• Care Coordination • Medication Management • Pulmonary Function
2) Acute / Hospitalization	• Asthma Self Management • Mortality	• Outcomes
3) Post Acute / Rehab	• Functional Status Assessment	• Health Related Quality of Life

Identification of Gap Areas: Addition and Modification of Goals

- Focus activity on refining the priority clinical and care delivery goals for the TCGP and IPC Arrangements and provide recommendations to revise, strengthen, and improve priority goals.
- Identify Subgoals or important underlying objectives where necessary. Subgoals will highlight critical steps and improvement opportunities to achieve priority goals.
- The following slides present identified priority goals along with the TCGP and IPC Arrangement measures that support improvements related to each goal.

1) General Primary and Secondary Prevention

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
1) Optimal Health Behaviors	Mental Health	• ***Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan***	
	Tobacco Avoidance and Cessation	• ***Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention***	
	Healthy weight	• ***Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*** • ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents***	• *Patient education and engagement in lifestyle management and goal setting including nutrition and daily activity levels* • **Stratification / targeted risk assessment based on race/ethnicity*
	Dental Health	• *Topical Fluoride for Children at Elevated Caries Risk, Dental Services*	
2) Immunizations	Childhood Immunizations	• ***Childhood Immunization Status***	
	Prevention and Control of Seasonal Influenza with Vaccines	• ***Preventive Care and Screening: Influenza Immunization***	

*Cardiometabolic Abnormalities Among Normal-Weight Persons From Five Racial/Ethnic Groups in the United States: A Cross-sectional Analysis of Two Cohort Studies. *Ann Intern Med.* 2017;166(9):628-636. [Link]

NOTE: Category 1 measures are **bolded**.

1) General Primary and Secondary Prevention

Clinical Focus Area	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
3) Cancer Screening	Screening and Early Detection	• ***Breast Cancer Screening*** • ***Cervical Cancer Screening*** • ***Colorectal Cancer Screening***	• **Guideline updates addressing low dose aspirin to prevent CRC*
4) Women's Health: Disease Prevention and Detection	Breast and Cervical Cancer	• ***Breast Cancer Screening*** • ***Cervical Cancer Screening***	
	Sexually Transmitted Disease	• ***Chlamydia Screening for Women***	

* *AAFP Summary of Recommendations for Clinical Preventive Services* (Link)
NOTE: Category 1 measures are **bolded**.

2) Diabetes

Phase	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
1) Evaluation and Ongoing Management	Glycemic Control	• ***Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]*** • ***Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*** • ***Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)***	• **Guideline updates and focus on lifestyle management?* • *Patient engagement in care planning and personalized goal setting?*
	Cardiovascular Disease	• ***Controlling High Blood Pressure***	
	Eye Care	• ***Comprehensive Diabetes Care: Eye Exam (retinal) performed***	
	Foot Care	• ***Comprehensive Diabetes Care: Foot Exam***	
	Kidney Disease	• ***Comprehensive Diabetes Care: Medical Attention for Nephropathy***	
	Medication Management	• ***Statin Therapy for Patients with Diabetes*****	• **Guideline updates and focus on lifestyle management including patient access and adherence to therapy regimen?*
	Smoking Cessation	• ***Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention***	

**Consensus Statement By the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm* (Link)
**Measure is part of the 2017 QARR measure set and replaces 'Adherence to Statins for Individuals with Diabetes Mellitus.'
NOTE: Category 1 measures are **bolded**.

2) Diabetes (cont.)

Phase	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
[continued] 1) Evaluation and Ongoing Management	Weight Management and Nutrition	• ***Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*** • ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents***	
	Access to Care		
	Care Coordination		
2) Exacerbation and Complex Treatment	Clinical Outcomes		
	Access to Care		
	Care Coordination		

NOTE: Category 1 measures are **bolded**.

3) Cardiovascular

Phase	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
1) Evaluation and Ongoing Management / Secondary Prevention	Blood Pressure Control	• ***Controlling High Blood Pressure***	
	Lipid Control		
	Smoking Cessation	• ***Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention***	
	Weight Management and Nutrition	• ***Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*** • ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents***	
	Medication Management	• ***Statin Therapy for Patients with Cardiovascular Disease***	
	Functional Status		**New guidelines and practice recommendations to consider?*
	Cardiovascular Function *(Ejection Fraction)*		
	Stroke Risk Assessment		
	Access to Care		
	Care Coordination		

* 2017 ACC/AHA/HRS Guideline for the Evaluation and Management of Patients With Syncope: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines, and the Heart Rhythm Society (Link)

NOTE: Category 1 measures are **bolded**.

3) Cardiovascular (cont.)

Phase	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
2) Acute / Hospitalization	Outcomes *(readmissions, avoidable hospitalizations, healthcare acquired infections, etc.)*		
	Mortality		
3) Post Acute / Rehab	Care Coordination		
	Access to Care		
4) Cardiac Procedures	Cardiac Catheterization		
5) Cardiac Imaging	Appropriate Use of Healthcare Resources		

NOTE: Category 1 measures are **bolded**.

4) Pulmonary

Phase	Clinical Priorities and Opportunities for Improvement	IPC Arrangement Measure Set	*Additional Subgoals*
1) Evaluation and Ongoing Management	Asthma Severity Assessment and Monitoring	• *Asthma: Assessment of Asthma Control – Ambulatory Care Setting*	
	Pulmonary Function	• *Lung Function/Spirometry Evaluation (asthma)* • ***Use of spirometry testing in the assessment and diagnosis of COPD***	** Appropriate testing and practice recommendation updates?*
	Asthma Self Management	• *Patient Self-Management and Action Plan* (asthma)*	
	Medication Management	• ***Medication Management for People With Asthma (ages 5 - 64) – 50 % and 75% of Treatment Days Covered***	
	Access to Care		
	Care Coordination		
2) Acute / Hospitalization	Outcomes		
	Asthma Self Management	• *Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver**	
3) Post Acute / Rehab	Functional Status Assessment		
	Health Related Quality of Life		

**GOLD 2017 Global Strategy for the Diagnosis, Management and Prevention of COPD* (Link)
NOTE: Category 1 measures are **bolded**.

Worksheet Example:

Recommendation of Additional Priority Goals

General Primary and Secondary Prevention			
Clinical Focus Area	**Clinical and Care Delivery Goals**	**Description**	**Additional Subgoals**
1) Optimal Health Behaviors	*Suggested Priority Goal 1*	*Description*	*(No Subgoals)*
	Suggested Priority Goal 2	*Description*	• *Subgoal 1* • *Subgoal 2*
2) Immunizations			
3) Cancer Screenings			
4) Women's Health: Disease Prevention and Early Detection			

Instructions on how to submit additional recommendations will be sent to the CAG members following this meeting.

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4. Final Thoughts and Next Steps

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov

Appendix

TCGP/IPC Arrangement Category 1 Measures (1/3)

Measures	Measure Steward	Measure Identifier	Classification
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Centers for Medicare & Medicaid Services (CMS)	NQF 1880	P4P
Antidepressant Medication Management - Effective Acute Phase Treatment & Effective Continuation Phase Treatment	National Committee for Quality Assurance (NCQA)	NQF 0105	P4P
Breast Cancer Screening	NCQA	NQF 2372	P4P
Cervical Cancer Screening	NCQA	NQF 0032	P4P
Childhood Immunization Status	NCQA	NQF 0038	P4P
Chlamydia Screening for Women	NCQA	NQF 0033	P4P
Colorectal Cancer Screening	NCQA	NQF 0034	P4P
Comprehensive Diabetes Care: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	NCQA	NQF #s 0055, 0062, 0057	P4P
Comprehensive Diabetes Care: Eye Exam (retinal) Performed	NCQA	NQF 0055	P4P
Comprehensive Diabetes Care: Foot Exam	NCQA	NQF 0056	P4R

TCGP/IPC Arrangement Category 1 Measures (2/3)

Measures	Measure Steward	Measure Identifier	Classification
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA	NQF 0575	P4R
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	NQF 0059	P4P
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing *[performed]*	NCQA	NQF 0057	P4P
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA	NQF 0062	P4P
Controlling High Blood Pressure	NCQA	NQF 0018	P4P
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	NQF 1932	P4P
Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)	NCQA	NQF 0004	P4P
Initiation of Pharmacotherapy for Alcohol Dependence	NYS Office of Alcoholism and Substance Abuse Services (OASAS)	-	P4R
Initiation of Pharmacotherapy for Opioid Use Disorder	NYS OASAS	-	P4P
Medication Management for People With Asthma (ages 5 - 64) – 50 % and 75% of Treatment Days Covered	NCQA	NQF 1799	P4P

TCGP/IPC Arrangement Category 1 Measures (3/3)

Measures	Measure Steward	Measure Identifier	Classification
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow- Up Plan	CMS	NQF 0421	P4R
Preventive Care and Screening: Influenza Immunization	American Medical Association Physician Consortium for Performance Improvement (AMA PCPI)	NQF 0041	P4R
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS		P4R
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	AMA PCPI		P4R
Statin Therapy for Patients with Cardiovascular Disease	NCQA		P4R
Statin Therapy for Patients with Diabetes	NCQA		P4R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA		P4R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA		P4P

TCGP/IPC Arrangement Category 2 Measures

Measures	Measure Steward	Measure Identifier
Asthma: Assessment of Asthma Control – Ambulatory Care Setting	The American Academy of Allergy, Asthma & Immunology (AAAAI)	-
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA	NQF 0058
Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	NYS OASAS	-
Continuity of Care (CoC) Within 14 Days of Discharge From Any Level of SUD Inpatient Care	NYS OASAS	-
Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver	The Joint Commission	NQF 0338
Lung Function/Spirometry Evaluation *(Asthma)*	AAAAI	-
Patient Self-Management and Action Plan *(Asthma)*	AAAAI	-
Topical Fluoride for Children at Elevated Caries Risk, Dental Services	American Dental Association (ADA)	NQF 2528
Use of Imaging Studies for Low Back Pain	NCQA	NQF 0052
Utilization of Pharmacotherapy for Alcohol Dependence	NYS OASAS	-
Utilization of Pharmacotherapy for Opioid Use Disorder	NYS OASAS	-