

Prevention Framework Objectives and Measures

Objective One: By December 31st 2018, WA State will increase the proportion of the population who receive evidence based clinical and community **preventive screenings and services** that lead to a reduction in preventable health conditions.

As measured by:

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| Prenatal and Postpartum care: Timeliness of Prenatal Care | NQF 1517 |
| Well Child Visits in the first 15 months of life Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, six, or more well child visits with a PCP during their first 15 months of life. | NQF 1392 |
| Well Child Visits in the 3rd, 4th, 5th and 6th years of life Percentage of children ages 3-6 that had one or more well –child visits with a PCP during the measurement year. | NQF 1516 |
| Childhood immunization status Percentage of children that turned 2 years old during the measurement years and had specific vaccines by their second birthday. | NQF 0038 |
| Developmental Screening Developmental screening in the first 36 months of life | NQF 1448 |
| Adolescent well-care visits Percentage of adolescents age 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. | NCQA |
| Obesity Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | NQF 0024 |
| Tobacco Adult Four Level Smoking Status Measure Pair: A) Tobacco Use Assessment, B) Tobacco Cessation Intervention A) Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period, B) Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period. <i>Comment: Use additional data sources such as PQRS, and meaningful use – from CMS</i> | NQF 0028 |
| Obesity - Adult Weight Classification by BMI, Adult Weight Screening and Follow-Up Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented. <i>Waist circumference is a better measure for predicting obesity and metabolic syndrome</i> | NQF 0421 |
| Breast Cancer Screening Percentage of women 50-74 of age who had a mammogram to screen for breast cancer | HEDIS |
| Cervical Cancer Screening | NQF 0032 |
| Colorectal Cancer Screening Percentage of respondents aged 50-75 years who reported colorectal test use, by test type: <ul style="list-style-type: none"> • Up-to-date with CRC screening • FOBT within 1 year • Sigmoidoscopy within 5 years with FOBT within 3 years • Colonoscopy within 10 years | NQF 0034 |
| Alcohol or other substance misuse (SBIRT) | NQF 2152 |
| Clinical Depression Screening Screening for clinical depression and follow-up plan | NQF 0418 |
| Senior Falls Screening, Risk Assessment and Plan of Care to Prevention Future Falls Percentage of enrollees aged 65 y and older as of Dec 31 of the reporting period, screened for future fall risk at least once from January 1 to December 31 of the reporting period. | NCQA 0101 |

Objective Two: By December 31st 2018, WA State will increase the proportion of the population with better physical and behavioral health outcomes by engaging individuals, families, and communities in a responsive system that supports social and health needs.

As measured by:

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| Child and Adolescent Access to Primary Care Practitioners | NCQA |
| <p>Diabetes</p> <p>Percentage of Adults (aged 18 years or older) with Diabetes Having Two or More A1c Tests in the Last Year</p> <p>Optimal Diabetes Care The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.</p> <p><i>Comment: Some critics have noted that <8 are too tight of control. Another option is to measure poor control or <9. Just a thought to consider the respective measure would be NQF 0059. Comment: This measure aggregates a number of key clinical markers. We could also focus on LDL on its own as well just as we are proposing for HTN.</i></p> | BRFSS/ NQF 0729 |
| <p>Controlling High Blood Pressure</p> <p>Percentage of enrollees that has a diagnosis of hypertension and whose blood pressure and whose blood pressure was adequately controlled (<140/90) during the measurement year.</p> | NQF 0018 |
| <p>Plan All Cause Readmission</p> <p>For enrollees age 18 years and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmissions for any diagnosis within 30 days and the predicted probability of an acute readmissions.</p> | NQF 1768 |
| <p>Follow-up after hospitalization for mental illness</p> <p>Percentage of discharges for enrollees that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, and intensive outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge from an inpatient setting.</p> | NQF 0576 |
| <p>Care Transitions</p> <p>Percentage of Medicaid enrollees age 18 and older discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge</p> | NQF 648 |
| <p>Care Management</p> <p><i>Proportion of individuals with one or more chronic conditions whose health care is being well managed</i></p> | |
| <p>Housing</p> <p><i>Number of supported housing units available to assist the transition of persons with complex health conditions living homeless into long term housing (concept)</i></p> | |

Objective Three: By December 31st 2018, WA State will increase the number of communities with improved social and physical environments that encourage healthy behaviors, promote health and health equity.

Comment: In regards to wording - 'will increase the number of communities'. This is what needs measured. I think we need to have a core set of indicators that encapsulate "improved social and physical environments". I don't know of a dataset that captures this information. Different cities have data on complete streets, safe & active routes to school, food deserts, trails, etc... but nothing standardized and routinely collected. We would have to build/implement this...

As measured by:

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| Obesity Weight Classification by BMI | BRFSS |
| Diabetes Percent of adults with Diabetes | BRFSS |
| Healthy Eating Vegetable Consumption Median intake of fruits and vegetables (times per day) | BRFSS |
| Healthy Eating Food Desert/ Food Availability Percentage of the population living in census tracts designated as food deserts | USDA |
| Healthy Eating Number of Washington schools serving nutritious, Washington grown foods | OSPI |
| Breastfeeding Desired item: Breastfeeding initiation and duration. # of childcare, clinics hospitals and worksites adopted breastfeeding policies – Baby friendly Hospitals | MCH database and WIC. Hospital discharge records |
| Physical Activity Desired item: Total miles of paved sidewalks relative to the Total street miles. | |
| Physical Activity Desired item: Total miles of designated shared-use paths and bike lanes relative to the total number of streets. | |
| Physical Activity Desired item: Number of non-arterial streets that have reduced speed limits to ensure safe biking and walking. | |
| Trauma Informed Practices Desired item: Number of schools that assess/address adverse childhood experiences. | |
| Tobacco Percent of adult smokers | BRFSS |
| Tobacco Youth Percentage of 10th graders who report smoking cigarettes in the past 30 days | HYS |
| Tobacco/Marijuana Desired item: Number of stores that sell tobacco/marijuana/vapor products to youth. | |
| Tobacco Policy Number of Housing Authorities with tobacco free policies. | |

Objective Four: By December 31st 2018, WA State will increase the number of integrated efforts between public health, the health care delivery system and systems that influence social determinants of health to lower costs, improve health, improve the experience of care and contribute to the evidence base.

As measured by:

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| To Be Determined |
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