Clinical Guideline: Asthma (Adult)

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
Removed clinical indicator: Asthma Medication Ratio (AMR) retired. **Added clinical indicator:** Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E). This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. **Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E)** (Source: HEDIS® MY 2026 Vol. 2, Technical Specifications)	The percentage of persons 5-64 years of age with an urgent care visit, acute inpatient discharge, observation stay discharge or ED visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days.
Reference	**Reference Link**
Asthma Management Guidelines	**2025 GINA Summary Guide - Global Initiative for Asthma - GINA** **Asthma: Learn More Breathe Better**

Clinical Guideline: Bipolar (Adult)

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1**. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)** (Source: HEDIS® MY 2026 Vol. 2, Technical Specifications)	The percentage of persons 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement period.
2. Follow-Up After Hospitalization for Mental Illness (FUH) (Source: HEDIS® MY 2026 Vol. 2, Technical Specifications)	The percentage of discharges for persons 6 years of age and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported: 1. The percentage of discharges for which the person received follow-up within 30 days after discharge. 2. The percentage of discharges for which the person received follow-up within 7 days after discharge.
Reference	**Reference Link**
Clinical Practice Guidelines for Treatment of Patients with Bipolar Disorder	Clinical practice guidelines GUIDELINE WATCH: PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH BIPOLAR DISORDER, 2ND EDITION Bipolar Disorders: Evaluation and Treatment
Clinical Practice Guidelines for the Treatment of Patients with Schizophrenia	Treatment of Patients with Schizophrenia (2020) The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia

Clinical Guideline: Cardiovascular Disease

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026
Removed Clinical Indicator: Statin Therapy for Patients with Cardiovascular Disease (SPC) was retired. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.

Clinical Indicators	**Description of the indicator**
1. **Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)** (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of people 18 years of age and older during the measurement period who were hospitalized and discharged from July 1 of the year prior to the measurement period to June 30 of the measurement period with a diagnosis of AMI and who received persistent beta-blocker treatment for 180 days (6 months) after discharge.
Reference	**Reference Link**
One-Year Landmark Analysis of the Effect of Beta-Blocker Dose on Survival After Acute Myocardial Infarction	One-Year Landmark Analysis of the Effect of Beta-Blocker Dose on Survival After Acute Myocardial Infarction
Treatment of Blood Cholesterol	Statin Use in Adults Cholesterol Management: ACC/AHA Updates Guideline
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions	Supplemental Resource: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
Guideline for the Management of Heart Failure	Supplemental Resource: 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure

Clinical Guideline: Chronic Obstructive Pulmonary Disease

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
2. **Pharmacotherapy Management of COPD Exacerbation (PCE)** (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of COPD exacerbations for persons 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement period and were dispensed appropriate medications. Two rates are reported: • Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. • Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.
Reference	**Reference Link**
Chronic Obstructive Pulmonary Disease: Screening	Chronic Obstructive Pulmonary Disease: Screening Screening for Chronic Obstructive Pulmonary Disease
Global Strategy for Prevention, Diagnosis and Management Of COPD: 2025 Report	POCKET GUIDE TO COPD DIAGNOSIS, MANAGEMENT AND PREVENTION: 2025 Report GOLD REPORT 2025 KEY CHANGES SUMMARY

Clinical Guideline: The Management of Major Depression in Adults in Primary Care

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
Updated: Clinical Indicator: Added the PROMIS Emotional Distress—Depression—Short Form instrument to the list of depression screening instruments for adults 18+ years of age. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) (Source: HEDIS Measurement Year (MY) 2026 Vol 2., Technical Specifications)	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. • Depression Screening. The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-Up on Positive Screen. The percentage of members who received follow-up care within 30 days of a positive depressions screen finding.
References	**Reference Link**
Mayo Clinic: Depression (Major Depressive Disorder) (2023)	Mayo Clinic: Depression (Major Depressive Disorder)
Multiple Chronic Conditions, Depression Guidelines (2025)	Multiple Chronic Conditions, Depression Guidelines
American Psychological Association Psychotherapy and Pharmacotherapy for Treating Depression (2019)	American Psychological Association Psychotherapy and Pharmacotherapy for Treating Depression

Clinical Guideline: Diabetes

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. Glycemic Status Assessment for Patients with Diabetes (GSD) (Source: HEDIS® MY 2025, Vol. 2, Technical Specifications)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: • HbA1c Control (<8.0%). • HbA1c Poor Control (>9.0%).
2. Blood Pressure Control for Patients with Diabetes (BPD) (Source: HEDIS® MY 2025, Vol. 2, Technical Specifications**)**	The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
3. Eye Exam for Patients with Diabetes (EED) (Source: HEDIS® MY 2025, Vol. 2, Technical Specifications)	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Reference	**Reference Link**
American Diabetes Association Standards of Medical Care in Diabetes - 2025	Improving Care and Promoting Health in Populations: Standards of Care in Diabetes
Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening	Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening

Clinical Guideline: Healthy Weight Management

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026
Updated: References: American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity – updated for 2025. **Updated: References:** USDA Dietary Guidelines updated for 2025-2030. **Added: Clinical Indicators:** Obesity Rates for Adults for Delaware. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.

Clinical Indicators	**Description of the indicator**
1. Obesity rates for adults in Delaware by ethnicity*: • White 35.6% • Black 46.2% • Hispanic 31.7% • American Indian or Alaskan, non-Hispanic 25.1% • Asian, non-Hispanic 16% * 2024 CDC BRFSS BMI data	**Statistical Data:** Age group: 18 years and older • Racial/ethnic groups are mutually exclusive. Percentages are weighted to reflect population characteristics. • An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. • Data based on the Behavioral Risk Factor Surveillance System, an ongoing, state- based, random-digit-dialed telephone survey of non-institutionalized civilian adults aged 18 years and older. Information about the BRFSS is available at http://www.cdc.gov/brfss/index.html. • Release date represents the date figures were accessed.
2. Reduce the proportion of adults with obesity	**Healthy People 2030 Objective:** Target: 36.0 percent **Numerator** Number of adults aged 20 years and over with a body mass index (BMI) equal to or greater than 30.0 **Denominator** Number of adults aged 20 years and over

References	**Reference Link**
Centers for Disease Control and Prevention (CDC) – Overweight and Obesity (2024)	Centers for Disease Control and Prevention (CDC) – Overweight and Obesity

Healthy People 2030 Reduce the portion of Adults with Obesity (2020)	Healthy People 2030 Reduce the portion of Adults with Obesity
American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity 2025 UPDATE (2025)	American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) Clinical Practice Guidelines for Comprehensive Medical Care of Patients with Obesity
Evidence Analysis Library Adult Weight Management Guideline 2021-2022 (2022)	Evidence Analysis Library Adult Weight Management Guideline 2021-2022
2025-2030 USDA Dietary Guidelines for Americans (2025)	2025-2030 USDA Dietary Guidelines for Americans
NIH Overweight and Obesity Treatment (2022)	NIH Overweight and Obesity Treatment

Clinical Guideline: Human Immunodeficiency Virus HIV

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. HIV Medical Visit Frequency	Percentage of patients, regardless of age with a diagnosis of HIV who had at least one medical visit in each 6-month period of the 24-month measurement period, with a minimum of 60 days between medical visits. (HRSA)
2. HIV Viral Load Suppression	The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. (HRSA)
Reference	**Reference Link**
Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis	Recommendation: Prevention of Acquisition of HIV: Preexposure Prophylaxis | United States Preventive Services Taskforce
Human Immunodeficiency Virus (HIV) Infection: Screening	Human Immunodeficiency Virus (HIV) Infection: Screening
Infectious Disease Society of America Guidance for Persons with HIV	Primary care for people with HIV Clinical Infectious Diseases

Clinical Guideline: Prevention, Detection, Evaluation, and Treatment of High Blood Pressure

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
References: Journal of the American College of Cardiology, Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adult: Updated for 2025. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Controlling High Blood Pressure (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications) *CBP*	Percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (BP was <140/90 mm Hg) during the measurement year.
2. Blood Pressure Control for Patients with Hypertension (Source: HEDIS Measurement Year (MY) 2026, Vol. 2., Technical Specifications *(BPC-E)*	The percentage of members 18-85 years of age who had a diagnosis of hypertension and whose most recent BP was <140/90 mm Hg during the measurement period.
References	**Reference Link**
Journal of the American College of Cardiology, Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2025)	Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults
American College of Cardiology/American Heart Association, Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary (2019)	ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
Guideline-Driven Management of Hypertension: An Evidence-Based Update (2021)	Guideline-Driven Management of Hypertension: An Evidence-Based Update

Clinical Guideline: Prescribing Opioids for Chronic Pain

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1. Use of Opioid at High Dosage (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *HDO*)	The percentage of members 18 years and older who received prescribed opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year. ***Note:*** *A lower rate indicates a better performance*.
2. Use of Opioids from Multiple Providers (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *UOP*)* **Adapted with financial support from CMS and with permission from the measure developer, Pharmacy Quality Alliance (PQA).*	The percentage of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year, who received opioids from multiple providers. Three rates are reported. 1. **Multiple prescribers** defined as the percentage of members receiving prescriptions for opioids from four or more different prescribers during the measurement year 2. **Multiple pharmacies** defined as the percentage of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year. 3. **Multiple prescribers and multiple pharmacies** defined as percentage of members receiving prescriptions for opioids from 4 or more different prescribers **and** 4 or more different pharmacies during the measurement year. (i.e., the proportion of member who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates). ***Note:*** *A lower rate indicates a better performance for all three rates*.

3 Continued Opioid Use (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - COU)* ***Adapted with financial support from the Centers for Medicare & Medicaid Services (CMS) and with permission from the measure developer, Minnesota Department of Human Services.*	The percentage of members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported: 1. The percentage of members with at least 15 days of prescription opioids in a 30-day period. 2. The percentage of members with at least 31 days of prescription opioids in a 62-day period. ***Note:*** *A lower rate indicates better performance.*

References	**Reference Link**
CDC Guideline for Prescribing Opioid for Chronic Pain (2022)	CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR
CDC's Efforts to Prevent Overdoses and Substance Use-Related Harms (2024)	CDC's Efforts to Prevent Overdoses and Substance Use-Related Harms
FDA Identifies Harm Reported from Sudden Discontinuation of Opioid Pain Medicines (2019)	FDA Identifies Harm Reported from Sudden Discontinuation of Opioid Pain Medicines
NEJM: No Shortcuts to Safer Opioid Prescribing (2019)	NEJM: No Shortcuts to Safer Opioid Prescribing

Clinical Guideline: Palliative Care

Care Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1.Care for Older Adults-Medication review (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *COA)*	Either of the following meets criteria: • Both of the following during the same visit during the measurement year where the provider type is a prescribing practitioner or clinical pharmacist. Do not include codes with a modifier. • At least one medication review • The presence of a medication list in the medical record • Transitional care management services during the measurement year. *Do not include services provided in an acute inpatient setting*
2.Care for Older Adults-Functional Status Assessment (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *COA*)	At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.
References	**Reference Link**
National Coalition for Hospice and Palliative Care (NCHP), National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care (2018)	National Coalition for Hospice and Palliative Care Clinical Practice Guidelines for Quality Palliative Care

Clinical Guideline: Prenatal Care (Routine and High Risk)

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption:

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. Prenatal and Postpartum Care (PPC) (Source: HEDIS® MY 2026, Technical Specifications)	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. *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before enrollment start date or within 42 days of enrollment in the organization. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery
Reference	**Reference Link**
ACOG Clinical Guidance Current Practice Bulletin	Tailored Prenatal Care Delivery
Preeclampsia: Screening	Preeclampsia: Screening
2021 United States Preventive Services Task Force Perinatal Depression Preventive Interventions	2021 United States Preventive Services Task Force Perinatal Depression Preventive Interventions
Marijuana Use During Pregnancy and Lactation	Clinical Recommendations
Tobacco Smoking Cessation in Adults: Interventions	https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions

Clinical Guideline: Adult Preventative Guidelines (21 & Over)

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
Added: Clinical Indicators: Adult Immunization Status - Added the COVID-19 indicator for adults 65 and older. This indicator is in first-year status for measurement year 2026. **Updated: Reference:** American Association of Family Physicians, Adult Immunization Schedule for Ages 19 years and Older (2026) Regarding This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1. Breast Cancer Screening (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *BCS-E*)	The percentage of members 50–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
2. Cervical Cancer Screening (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *CCS-E*)	The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who 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) cotesting within the last 5 years.
3. Chlamydia Screening (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications - *CHL*)	The percentage of members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.

4. Adult Immunization Status (Source: HEDIS Measurement Year 2026, Vol. 2, Technical Specifications-AIS-E)	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, pneumococcal and hepatitis B.
5. Documented Assessment After Mammogram (Source: HEDIS Measurement Year 2026, Vol. 2., Technical Specifications DBM-E)	The percentage of episodes of mammograms documented in the form of a BI-RADS assessment within 14 days of the mammogram for members 40-74 years of age
6. Adults' Access to Preventive/Ambulatory Health Services (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications – *AAP*)	The percentage of members 20 years and older as of December 31 who had an ambulatory or preventive care visit. • Medicaid members who had an ambulatory or preventive care visit during the measurement year.
Reference	**Reference Link**
American Association of Family Physicians, Adult Immunization Schedule for Ages 19 years and Older (2026)	https://www.aafp.org/clinical-insights/immunizations-and-vaccines/immunizations-schedules-resources/adult-immunization-schedules
U.S. Preventive Task Force Recommendations Adult Preventive Health Care Schedule (2022)	U.S. Preventive Task Force Recommendations Adult Preventive Health Care Schedule
U.S. Preventive Services Task Force Final Recommendations Statement Breast Cancer: Screening (2024)	U.S. Preventive Services Task Force Final Recommendations Statement Breast Cancer: Screening
U.S. Preventive Services Task Force Final Recommendations Statement Cervical Cancer Screening (2018)	U.S. Preventive Services Task Force Final Recommendations Statement Cervical Cancer Screening
U.S. Preventive Services Task Force Final Recommendations Statement Chlamydia and Gonorrhea: Screening (2018)	U.S. Preventive Services Task Force Final Recommendations Statement Chlamydia and Gonorrhea: Screening

Clinical Indicator	Ages 21-39	Ages 40-49	Ages 50-64	Ages 65+
Assessing Tobacco Use	Every Visit	Every Visit	Every Visit	Every Visit
Advising Smokers to Quit	At least annually	At least annually	At least Annually	At least Annually
Assess Drug/Alcohol Use	Annually	Annually	Annually	Annually
Depression Screening	Annually	Annually	Annually	Annually
Assess STD Risk	Annually	Annually	Annually	Annually
Assessment of Functional Status				Annually
Assessment of Fall Risk			Annually if high risk	Annually
Pain Assessment				Annually
Medication Review	Every Visit	Every Visit	Every Visit	Every Visit
Advance Care Planning	Annually	Annually	Annually	Annually
Discussion of Aspirin Prophylaxis	High Risk	If high risk: Men-annually Women-post menopausal	Annually if high risk	Annually if high risk
Preventive Screening Evaluation	Every Visit	Every Visit	Every Visit	Every Visit
Blood Pressure	Every Visit	Every Visit	Every Visit	Every Visit
Cervical Cancer Screening (PAP)	At a minimum every three years, more frequently if in a high-risk group. When combined with HPV contesting, once every 5 years for women ≥ 30 years.	At a minimum every three years, more frequently if in a high-risk group. When combined with HPV contesting, once every 5 years for women ≥ 30 years.	At a minimum every three years, more if in a high-risk group. When combined with HPV contesting, once every 5 years for women ≥ 30 years.	Women: High-risk
HPV	Women: ≥ age 30 every 5 years, more frequently if in a high-risk group	Women: ≥ age 30 every 5 years, more frequently if in a high-risk group	Women: ≥ age 30 every 5 years, more frequently if in a high-risk group	Women high-risk
Mammogram		Women, if high risk: May benefit from screening in their 40's	Women: every 2 years	Women every 2 years until the age of 75
Abdominal Aortic Aneurysm Screening				Men aged 65 to 75 who have ever smokes (One-time screening)
Chlamydia Screening	Women: annually to age 24 & with Pregnancy	If high-risk	If high-risk	
Discuss Prostate Cancer Screening		Annually	Annually	Annually

Colorectal Cancer screening by any of the following methods: Fecal occult blood (high sensitivity) or			Annually	Annually until age 75
Fecal Immunochemical Test-DNA or			Every 3 years	Every 3 years until age 75
Sigmoidoscopy or			Every 5 years	Every 5 years until age 75
Colonoscopy			Every 10 years	Every 10 years until age 75
Vision, Hearing	Every 5 years, Diabetics Annually	Every 5 years, Diabetics Annually	Every 5 years, Diabetics Annually	Every 5 years, Diabetics Annually
Lipid Profile	Men ≥ 20: every 5 years unless high-risk	Men: every 5 years unless high-risk Women ≥ age 45: every 5 years unless high risk	Every 5 years unless high risk	If not checked previously
Obesity Screening (BMI)	Every visit	Every visit	Every visit	Every visit
Domestic Violence	Annually	Annually	Annually	Annually
Osteoporosis Screening	BMD testing if postmenopausal woman who is at increased risk of osteoporosis	BMD testing if postmenopausal woman who is at increased risk of osteoporosis	BMD testing if postmenopausal woman who is at increased risk of osteoporosis	At age 65, provide BMD testing if not previously tested. Evidence is lacking about optimal intervals for repeated screening
Hepatitis C Screening	At least once if high risk	At least once if high risk	One time screening for those aged 50-64	One time screening for those aged 65-70
HIV screening	At least once or annually if high-risk	At least once or annually if high-risk	At least once or annually if high-risk	At least once or annually if high-risk
Bladder Control/Incontinence				Annually
Diabetes screening w/out prior diagnosis – HbA1C		At least once or annually if at risk	At least once or annually if at risk	At least once or annually if

				at risk until age 70
Diabetes screening w/prior diagnosis – HbA1C, dilated retinal examination, and microalbumin/nephropathy testing	At least once annually	At least once annually	At least once annually	At least once annually
Wellness Visit or Physical	Annually	Annually	Annually	Annually

1 Use CAGE screening. C: "Have you ever felt you ought to Cut down on drinking?" A: "Have people Annoyed you by criticizing your drinking?" G: "Have you ever felt bad or Guilty about your drinking?" E: "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye opener)?

2 Screening questions are: "Over the past month have you felt down, depressed or hopeless" and "Over the past month have you felt little interest or pleasure in doing things." 3 Aspirin prophylaxis high risk-diabetes, elevated cholesterol levels, low levels of HDL cholesterol, elevated blood pressure, family history and smoking.

4 Discontinuation of cervical cancer screening in older women is appropriate, provided women have had adequate recent screening with normal Pap results. Screening is recommended in older women who have not been previously screened, when information about previous screening is unavailable or when screening is unlikely to have been done in the past. Recommendations from various organizations differ in how often the Pap screen should be done. The general recommendation is to screen every 2-3 years after 3 years of being sexually active but not later than age 21. Women ages 30-64 may only need to be screened every 5 years if the Pap test is done in combination with HPV testing.

5 Although the United States Preventive Services Task Force found insufficient evidence to recommend for or against screening, other organizations endorsed routine screening along with Pap tests for women age 30 and older.

6 There is controversy over how often and at what age the mammograms should be done. Various agencies recommend starting annual screening at age 40 for all women, other agencies say to start at age 50. The included recommendation is based off of current United States Preventive Services Task Force guidelines. The United States Preventive Services Task Force also suggests that screening starting at age 40 may benefit high risk women.

7 United States Preventive Services Task Force

8 Chlamydia screening high risk – Prevalence is higher in the following populations: unmarried women, African American race, prior history of STD, having new or multiple sex partners, having cervical ectopy using barrier contraceptives inconsistently, and partners having multiple partners who engage in high-risk behavior.

9 The American Urological Association recommends shared decision making with men on the use of PSA for screening. Men ages 40-54 at high risk and men at average risk ages 55-69 with a life expectancy > 10 years who decide to include PSA should have routine screening every two years. PSA screening is not recommended for men ages 70+.

10 United States Preventive Services Task Force recommends against routine screening for colorectal cancer in adults 76-85. There may be considerations that support colorectal cancer screening in an individual patient.

11Lipid disorder high risk – diabetes, history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives, history suggestive of familial hyperlipidemia, multiple coronary heart disease risk factors and people who have lipid levels close to those warranting treatment.

12Assess BMI and waist circumference at every visit during which weight is measured. Use 5As: Ask if patient is ready to make a change. Advise in a clear, specific and tailored manner. Assess level of obesity and co morbidities. Assist by providing necessary tools and support. Arrange contact with other providers who can provide a team approach.

13 At each visit ask: "Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?" "Are you in a relationship with a person who physically hurts you?" "Has anyone forced you to have sexual activities that make you feel uncomfortable?"

14Men and women ages 40-70 years who have at least one risk factor should be screened at least once annually. Risk factors include a BMI > 25, history of smoking, or a prior abnormal A1C. Abnormal A1C tests should receive follow-up within 3-6 months. 15Microalbumin/ nephropathy testing should occur annually if results are negative. Positive results should receive follow-up testing within 3-6 months

Clinical Guideline: Schizophrenia (Adults)

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care.	
Clinical Indicators	**Description of the indicator**
1.**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)** (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
2.**Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)** (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of persons 18–64 years of age with schizophrenia or schizoaffective disorder and cardiovascular disease, who had an LDL-C test during the measurement period.
3.**Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)** (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
4. **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** (Source: HEDIS® MY 2026, Vol. 2, Technical Specifications)	The percentage of people 18 years of age and older during the measurement period, with schizophrenia or schizoaffective disorder, who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
Reference	**Reference Link**
Clinical Practice Guidelines for Patients with Schizophrenia	Clinical Practice Guidelines for Patients with Schizophrenia

Clinical Guideline: The Treatment of Patients with Substance Use Disorders

Line of Business: Delaware Medicare D-SNP

Date of QI/UM Committee Review and Adoption: 5/26/2026

Changes for 2026	
No changes. This guideline does not replace the judgment or the role of the clinician in the decision-making process for individual patients, and it is only intended to serve as an educational resource for the delivery of care	
Clinical Indicators	**Description of the indicator**
1.Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence (AOD) Treatment (Source: HEDIS® Measurement Year (MY) 2026 Vol. 2, Technical Specifications*, IET*)	The 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.
2.Follow-Up After Emergency Department Visit for Substance Use (Source: HEDIS® Measurement Year (MY) 2026, Vol. 2, Technical Specifications, *FUA*) **Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).*	The percentage of emergency department (ED) visits for members 13 years of age 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).
References	**Reference Link**

VA/DoD Clinical Practice Guidelines, Management of Substance Use Disorder, (2021)	Management of Patients with Substance Use Disorders
APA Practice Guideline for The Pharmacological Treatment of Patients with Alcohol Use Disorder (2018)	APA Practice Guideline for The Pharmacological Treatment of Patients with Alcohol Use Disorder
National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment (2023).	National Institute on Drug Abuse (NIDA) Principles of Drug Addiction Treatment
Dartmouth-Hitchcock Knowledge Map, Unhealthy Alcohol and Drug Use – Adult Primary Care (2017)	Dartmouth-Hitchcock Knowledge Map, Unhealthy Alcohol and Drug Use – Adult Primary Care
Dartmouth-Hitchcock Unhealthy Alcohol and Drug Use (2021)	Dartmouth-Hitchcock Unhealthy Alcohol and Drug Use
ASAM National Practice Guideline for treatment of Stimulant Use Disorder (2026)	National Practice Guideline for Stimulant Use Disorder
American Society of Addiction Medical (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2024)	American Society of Addiction Medical (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder
American Society of Addiction Medical (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management (2026)	American Society of Addiction Medical (ASAM) Clinical Practice Guideline on Alcohol Withdrawal Management