Performance Improvement Team presents:

Accelerated Learning Education Program

Controlling High Blood Pressure

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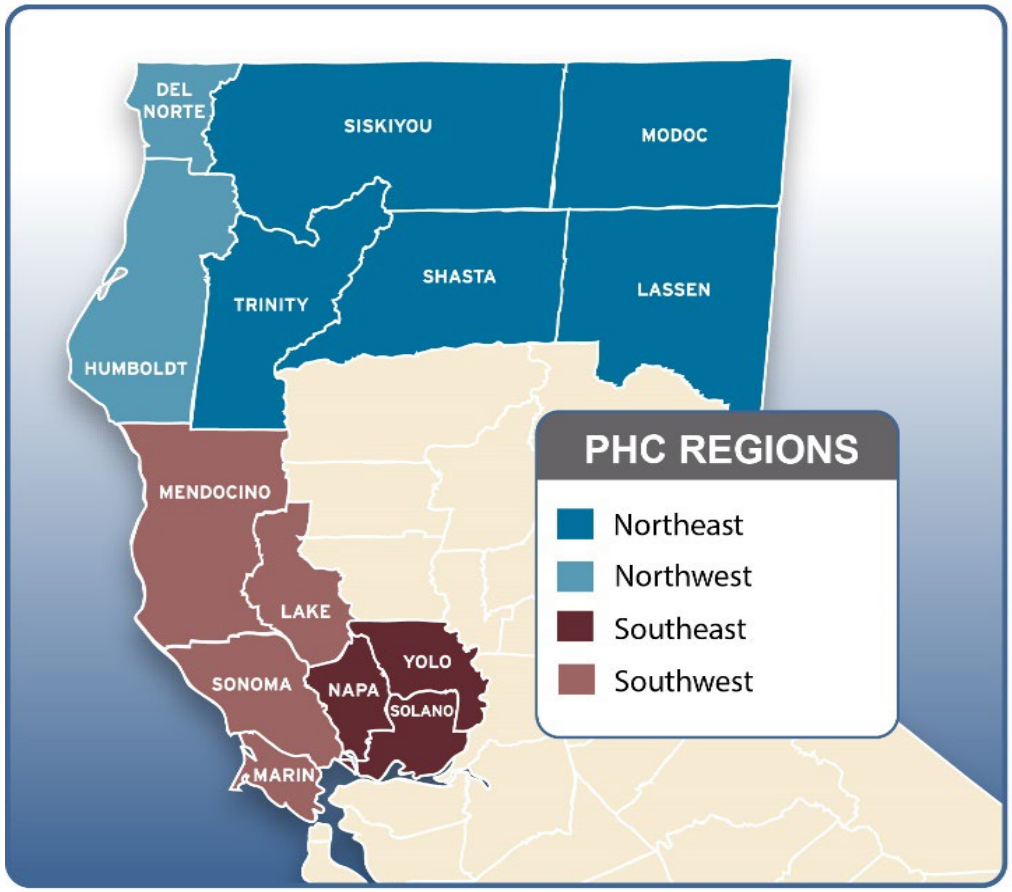
March 15, 2022

Partnership HealthPlan of California (PHC) Regions



Mission

To help our members, and the communities we serve, be healthy

Vision

To be the most highly regarded managed care plan in California

Objectives

1 Overview of Hypertension

- Understand clinical diagnosis of hypertension
- Understand the importance of controlling high blood pressure
- Review the treatment options for achieving blood pressure control
- Review PHC benefits to support blood pressure control

2 PHC's Quality Incentive Program

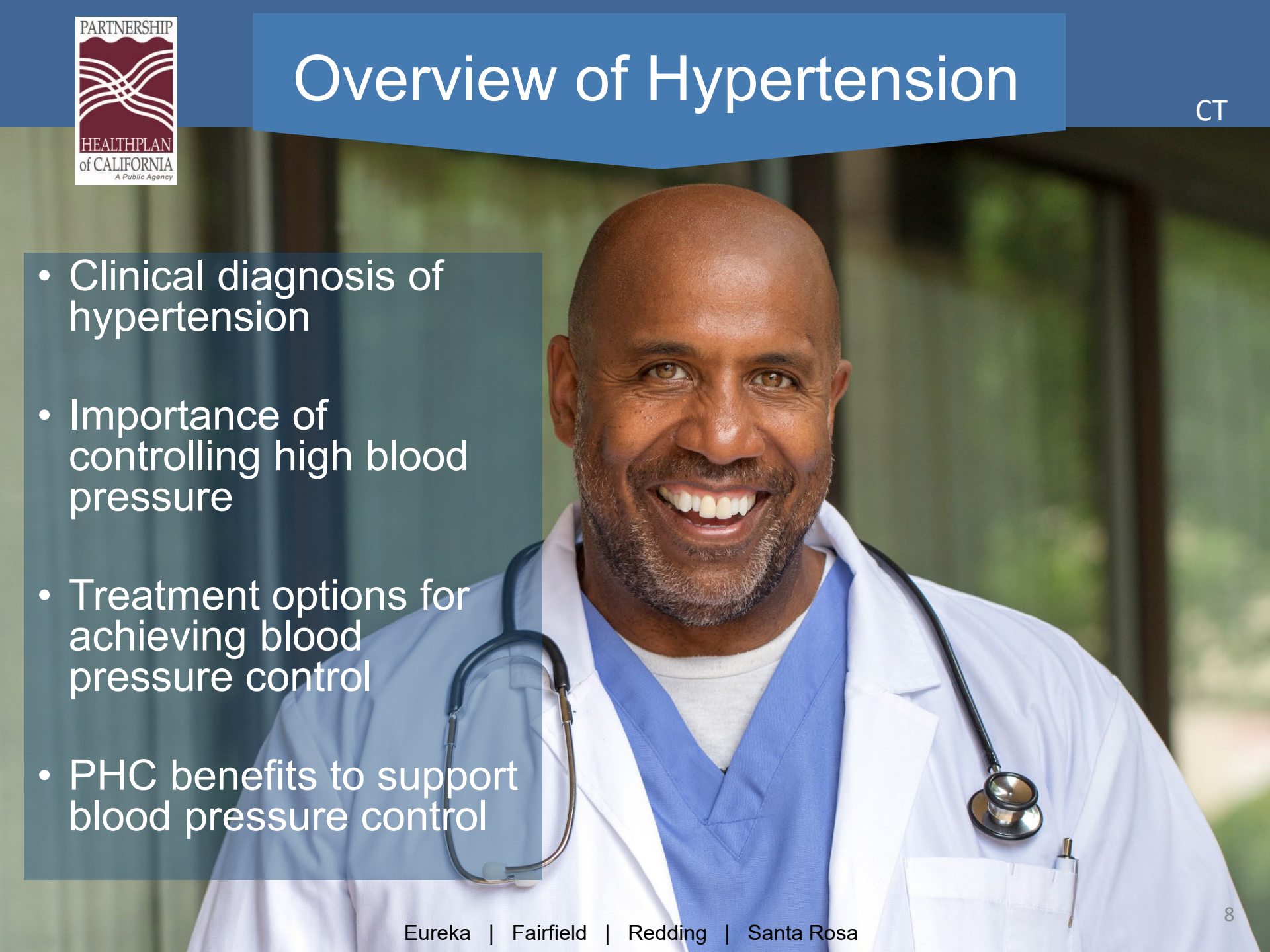
- Review 2021 threshold and targets
- Understand compliant vs. non-compliant documentation
- Review exclusions

3 Best and Promising Practices

- Review promising practices to increase high blood pressure rates
- Hear from high performing organization on how they scored high on controlling high blood pressure measure

Overview of Hypertension

CT



- Clinical diagnosis of hypertension
- Importance of controlling high blood pressure
- Treatment options for achieving blood pressure control
- PHC benefits to support blood pressure control

Hypertension Overview

Epidemiology

- Affects ~ 50 million people in the U.S.
- The most common reason for office visits in the U.S.
- About 50% of people with hypertension are not at adequate control of their blood pressure

Types

- Primary – the most common form of hypertension
  - Without a source or associated with any other disease
- Secondary
  - Associated with another disease such as kidney disease

Blood Pressure

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What is blood pressure?

- Force of the blood pushing against the walls of arteries
- Normal range blood pressure (120/80 mm Hg) efficiently delivers oxygenated blood to organs and tissues
- Normal BP increases in response to stress and exercise

What do blood pressure numbers mean?

- Top number - *systolic blood pressure* - measures the pressure in the arteries when the heart beats
- Bottom number - diastolic blood pressure - measures the pressure in the arteries when the heart rests between beats
- Normal blood pressure 120/80

  Example: 120 systolic and 80 diastolic, 120 over 80 or 120/80

Hypertension
Sustained High Blood Pressure

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- The force from high blood pressure causes the heart to work harder to pump blood to the body
- When the force of blood flow stays high, the tissue around the arteries stretch
- Stretching weakens the blood vessels making them prone to rupture
- High pressure damages blood vessels and allows fat and cholesterol to build up, causing plaques
- Plaques break off and cause heart attacks and strokes

Hypertension - A Silent Killer

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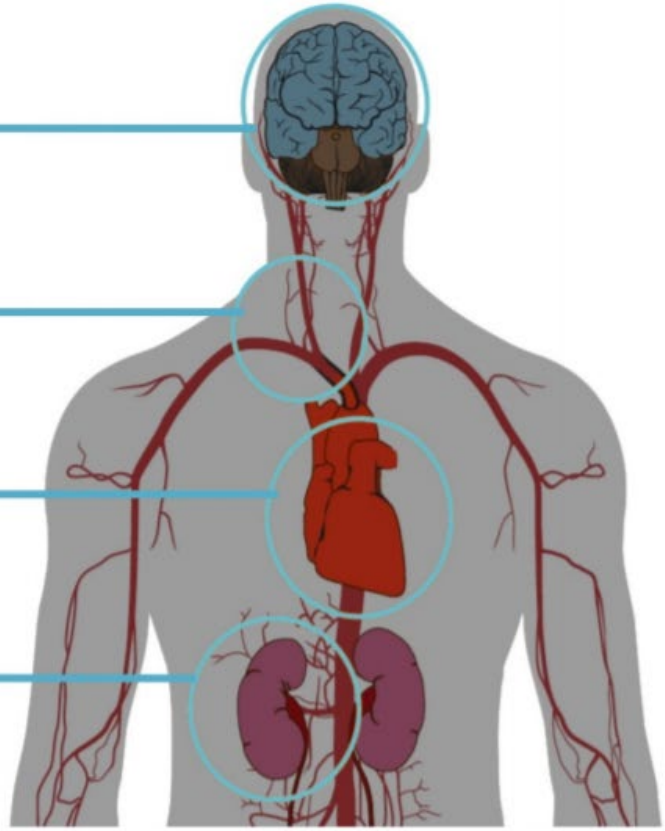
Hypertension can cause:

Brain
- Stroke
- Dementia

Arteries
- Artery damage and narrowing
- Aneurysm
- Leg amputation

Heart
- Coronary artery disease
- Heart attack
- Congestive heart failure

Kidneys
- Kidney failure
- Kidney artery aneurysm



cdc.gov/globalhealth/healthprotection

What is High Blood Pressure (Hypertension)

CT

Blood Pressure Levels

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003 Guideline)[2]		*The American College of Cardiology/American Heart Association Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults (2017 Guideline)*[1]	
Normal	Systolic less than 120 mm Hg diastolic: less than 80 mm Hg	Normal	Systolic less than 120 mm Hg diastolic: less than 80 mm Hg
At risk (prehypertension)	Systolic 120 - 139	Elevated	systolic: 120–129 mm Hg diastolic: less than 80 mm Hg
High Blood Pressure (hypertension)	systolic: 140 mm Hg or higher diastolic: 90 mm Hg or higher	High blood pressure (hypertension)	systolic: 130 mm Hg or higher diastolic: 80 mm Hg or higher

Center for Disease Control and Prevention

Factors That Contribute to Hypertension

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Age

- Hypertension is more common with advancing age

Race ~ Black Populations

- Hypertension is more common, more severe and occurs at younger age
- More impact overall and more end organ disease

Family History

- Individuals with one or two parents with hypertension carry twice the risk

Environmental or Behavioral Factors

- Obesity
- Alcohol
- Inactivity
- Medications
- Caffeine
- High sodium diet
- Tobacco Use

Less Common Factors

- Kidney anatomy
- Genetic conditions

Medications that Impact Blood Pressure Control

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Common medications that can increase blood pressure:

- Corticosteroids
- NSAIDs
- Combined oral contraceptive pills
- Select antidepressant medications (TCAs, SNRIs)
- Decongestants (pseudoephedrine)
- Stimulants (ADHD, weight loss medications)

Hypertension Treatment: More than Medications

CT

Lifestyle Changes for Prevention and Treatment

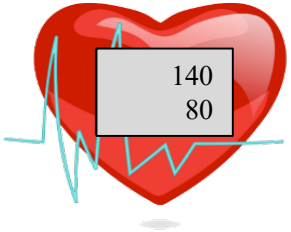
- Diet changes
- Regular physical activity and exercise
- Primary care provider (PCP) consults to address modifiable risk factors, early detection, and initiation of treatment

Home Self Monitoring

- Self-monitoring empowers patients for self-management

Medication Management

- See chart for recommendations



Nutrition Education and Counselling

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- Provided by Registered Dietician (RD) or Certified Diabetes Educators (CDE)
  - Offers dietary recommendations to control BP and limits impact of hypertension by controlling other potential risk factors

- Individual or Group Visits
  - PHC benefit no RAF required

- Covered PHC Benefit for Adult and Pediatric Patients with Diagnosis of
  - Hypertension, hyperlipidemia
  - Cardiovascular disease or CVD risk
  - Diabetes/prediabetes
  - Chronic renal disease
  - Eating disorders, undernutrition or risk of dietary deficiency
  - Overweight and obesity by BMI

PHC Policy MCUP 3052 Medical Nutrition Services

PHC Support Self Blood Pressure Monitoring

CT

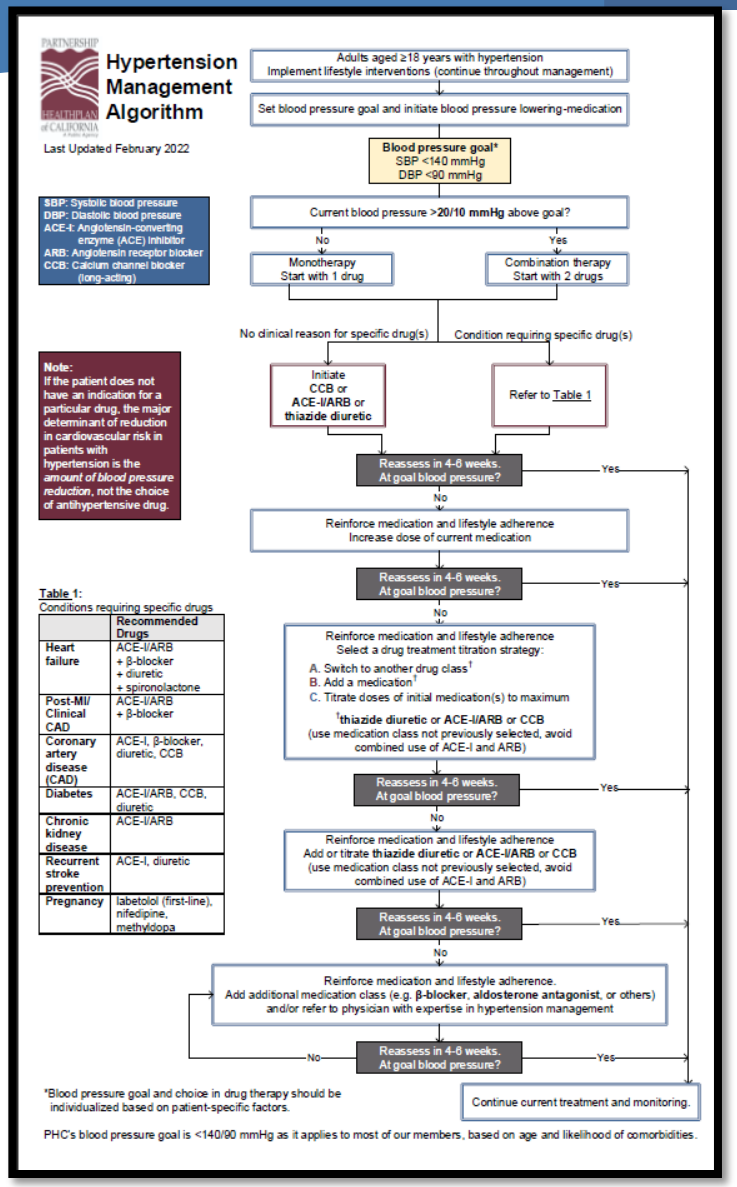
Home Blood Pressure Monitoring

- PHC Medical Equipment Distribution Services Program
  - PCPs order a blood pressure monitor to be sent to their PHC patient.
    - Includes BP digital monitor, cuffs, user instructions in the member's preferred language.
  - How to request:
    - Request form and guidelines are available through PHC's Provider Resources section at partnershiphp.org
    - Providers can send request form via
      - Secure email to request@partnershiphp.org or
      - Secure fax to (707) 420-7855

RX and Workflow Resources

JS

- Hypertension management algorithm
- Medi-Cal Rx Contract Drugs List: Oral medications for treatment of hypertension



PHC's Quality Incentive Program

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- 2022 threshold and targets
- Compliant vs. non-compliant documentation
- Exclusions

Measure Specifications

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Measure Description

The percentage of members 18 - 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.

- **Denominator:** Members 18 - 85 years of age by December 31, 2022, who had at least two visits on different dates of service on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Both visits must have a diagnosis of HTN.

- **Numerator:** The number of members whose most recent blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

PCP QIP 2022

KG

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine Internal Medicine	7 points 12.5 points	62.53%	75th
Partial Points	Family Medicine Internal Medicine	5 points 9 points	55.35%	50th

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.

QIP Compliant Documentation

A second diagnosis of hypertension must occur prior to counting the most recent BP reading.

- Eligible readings include:
  - Outpatient visit
  - Telephone visit
  - E-visit or virtual check-in
  - Remote monitoring taken by any **digital device**

- Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation.

- Multiple readings for a single date – use the lowest systolic and lowest diastolic BP.

  Example: BP reading on 5/30/20 were 140/**80**, 138/90 and **130**/87

  → Use **130/80**

Compliant Documentation (continued)

BP readings taken on the same day as a low-intensity or preventive procedure are eligible for use.

Examples: ***(list is not exhaustive)***

- Vaccinations
- Injections (i.e., allergy, insulin, steroid, etc.)
- TB test
- IUD insertion
- Eye exam with dilating agents
- Wart or mole removal

PHC will accept BP readings recorded at a dental office provided the EHR systems are integrated.

QIP Non-Compliant Documentation

The following BP readings **do not** meet the measure:

- Acute inpatient stay or ED visit
- Taken by the member using a non-digital device
- BP reading is ≥140/90
- No BP/incomplete reading during the measurement year
- Documented Pulmonary HTN
- Taken the same day as a diagnostic test or therapeutic procedure that requires a change in diet or medication regiment **on or one day before** the day of the test or procedure. (Example: colonoscopy)

Controlling High Blood Pressure Measure Exclusions

Exclude from the eligible population members with evidence of the following during the measurement year:

- Evidence of end-stage renal disease, dialysis, nephrectomy, or kidney transplant or dialysis
- Pregnancy
- Hospitalization or skilled nursing facility, rehabilitation center, or long term acute care facility
- Palliative care or hospice
- Diagnosis of frailty and advanced illness

Questions

Best and Promising Practices

- High-performing organization and how they scored high on controlling high blood pressure measure
- Promising practices to decrease high blood pressure rates

Voices from the Field

Adventist Health Northern California

Hypertension

March 15, 2022

AdventistHealth

Hypertension in the Clinics

- Educate Providers and Support Staff to Guidelines
- How to satisfy the Metric in EMR (Cerner)
- Best Practice for Second Blood Pressure Check and Repeat, and Care Redesigns
- Ongoing Reminders and Education to Metric
- Concept of 'Treat to Meet' regular sharing of data from e-Reports

2022 Quality Campaign Calendar

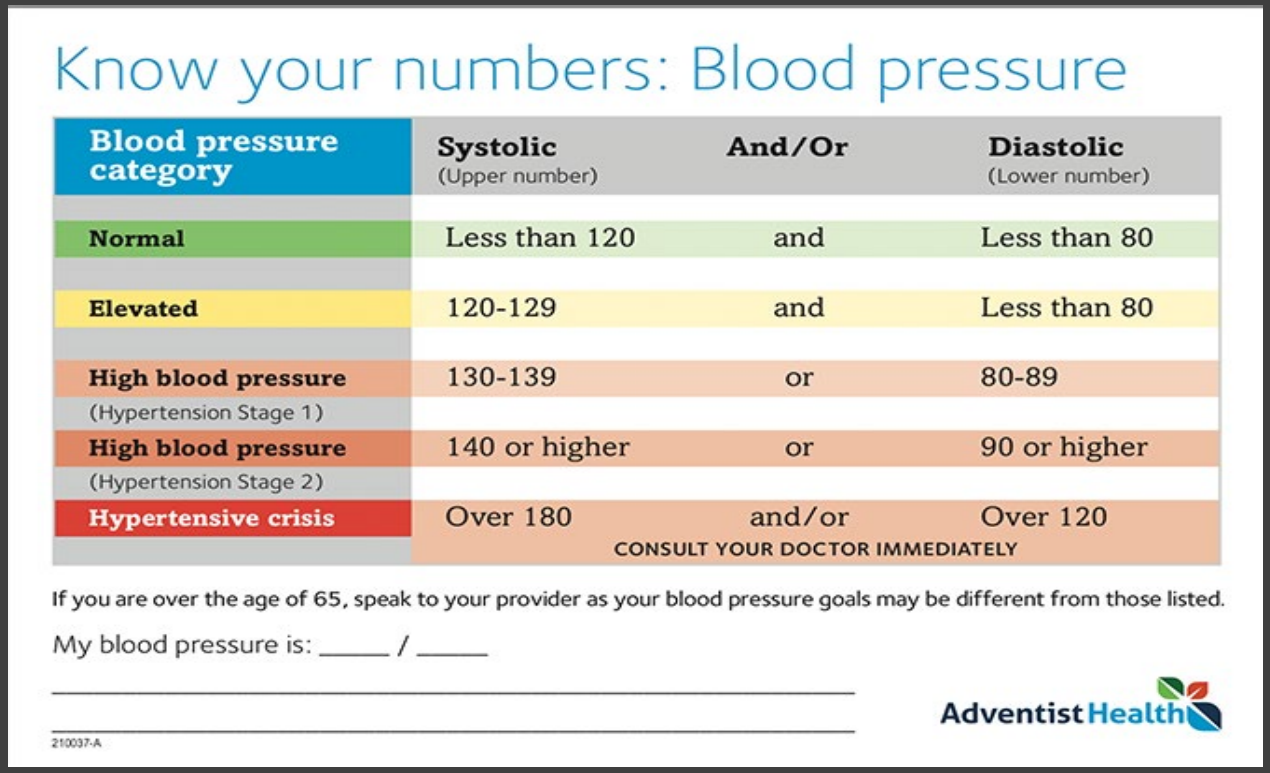
2022	Marketing	Service Line Discussion Topic	Care Gap Outreach Measure
Jan	Cervical Cancer	Women's Health	Cervical Cancer Screening
Feb	Cardiovascular Health	Cardiovascular/IVDCAD & HF	Diabetes: HbA1c & Hypertension: Blood Pressure
Mar	Colorectal Cancer	Gastroenterology	Colorectal Cancer Screening
April	Asthma	Pulm/Asthma/COPD	Optimal Asthma Control
May	Behavioral Health	Behavioral Health	Pending
June	Adult Wellness	Adult Wellness/Adv. Care Plan	Medicare Wellness Visit (ACO Members)
July	Pain Management	Pain Management/Opioids	Pending
Aug	Pediatric & Adolescent Wellness	Pediatric Wellness	Well Child Visits
Sept	Stroke Awareness/HTN	Cardiovascular/Stroke	Diabetes: HbA1c & Hypertension: Blood Pressure
Oct	Breast Cancer	Women's Health	Breast Cancer Screening
Nov	Diabetes/Movember	Endocrinology	Pneumococcal Vaccination - Older Adults
Dec	Influenza/Pneumonia	PCP/Influenza & Pneumonia	Adult & Peds: Influenza Vaccination

CAMPAIGN ELEMENTS

Know Your Numbers

patient education cards

Staff is educated to pass these cards to ALL patients that come in with a diagnosis of hypertension



Know your numbers: Blood pressure

Blood pressure category	Systolic (Upper number)	And/Or	Diastolic (Lower number)
Normal	Less than 120	and	Less than 80
Elevated	120-129	and	Less than 80
High blood pressure (Hypertension Stage 1)	130-139	or	80-89
High blood pressure (Hypertension Stage 2)	140 or higher	or	90 or higher
Hypertensive crisis	Over 180	and/or	Over 120
	CONSULT YOUR DOCTOR IMMEDIATELY		

If you are over the age of 65, speak to your provider as your blood pressure goals may be different from those listed.

My blood pressure is: _____ / _____

_____

_____

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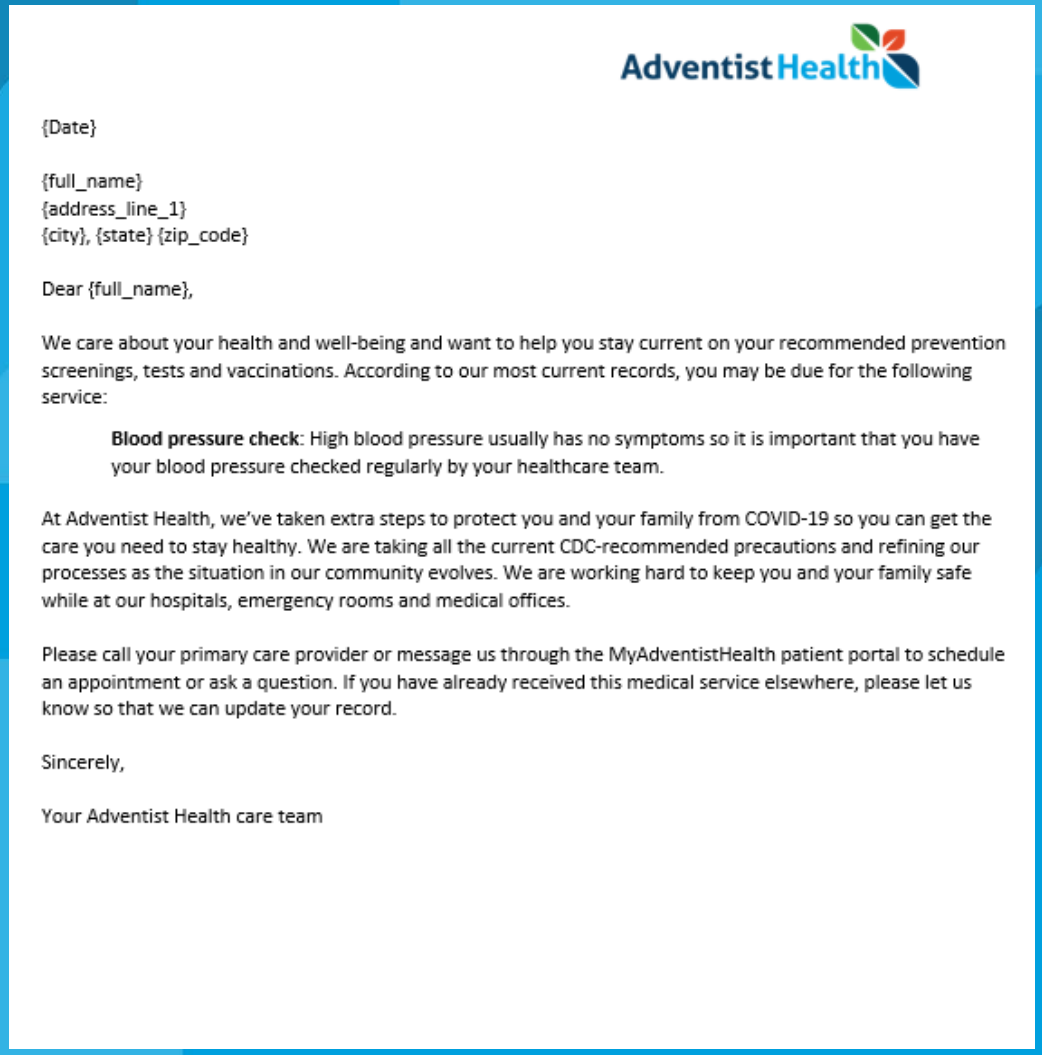
AdventistHealth

AdventistHealth

Patient Outreach Letters

Hypertension

- PEC360 is a team that is contracted to call Partnership patients
- Internal Outreach is assigned as well.



AdventistHealth

{Date}

{full_name}
{address_line_1}
{city}, {state} {zip_code}

Dear {full_name},

We care about your health and well-being and want to help you stay current on your recommended prevention screenings, tests and vaccinations. According to our most current records, you may be due for the following service:

Blood pressure check: High blood pressure usually has no symptoms so it is important that you have your blood pressure checked regularly by your healthcare team.

At Adventist Health, we've taken extra steps to protect you and your family from COVID-19 so you can get the care you need to stay healthy. We are taking all the current CDC-recommended precautions and refining our processes as the situation in our community evolves. We are working hard to keep you and your family safe while at our hospitals, emergency rooms and medical offices.

Please call your primary care provider or message us through the MyAdventistHealth patient portal to schedule an appointment or ask a question. If you have already received this medical service elsewhere, please let us know so that we can update your record.

Sincerely,

Your Adventist Health care team

The End of Year Sprint

- October-Actively Monitoring Denominators for Controlling High Blood Pressure
- Audit and upload routinely
- Invite patients in for Nurse Visits for Repeat Blood Pressure Checks
- Quality Team has scheduled Care Gap Fairs in Clinics to help support Metrics, Blood Pressure Checks included

Best and Promising Practices

KG

BP Measurement Workflows

- Complete regular trainings for clinical support teams on BP collection best practices (including repeat BP readings within an appointment)
- Measure BP at **each** visit and repeat if out of the normal range
- Perform a manual BP Measurement if elevated after second measurement
- Assign and train a designated medical assistant to perform manual BP checks
- Schedule BP short term follow-up appointment in real time to reassess after treatment changes

Best and Promising Practices

KG

Practice Workflows

- Reassess BP every three months after target is achieved
  - Follow-up on no shows
  - Run registry of patients with hypertension to ensure follow up
- Establish standardized processes in your practice site
  - Use of multidisciplinary team members (RN, RD, Pharmacist)
  - Standing orders
  - Treatment algorithms
- Refer/enroll with chronic case management

Best and Promising Practices

KG

Patient Education

- Provide education on the importance of BP control and the role of self monitoring
  - Review steps and goals of BP management
- Reinforce the importance of smoking cessation, increased physical activity, low sodium diets, and medication management

Outreach

- Member outreach for routine follow up (phone call, text, email, member portal, post card/letter)

Claims Submission

- Submit claims encounter data with 90 days of service

Evaluation

Please complete your evaluation.
Your feedback is important to us!

Contact Us

- **Regional Medical Director:**
  Dr. Colleen Townsend
  ctownsend@partnershiphp.org

- **QI/Performance Improvement Team:**
  ImprovementAcademy@partnershiphp.org

Resources

- Upcoming trainings and events
- RX and workflow resources
- Quick guide to starting QI projects
- Summary of 2022 QIP
- Contacts and links
- Evaluation

Upcoming Quality Improvement Trainings in 2022

Accelerated Learning Education Program

The Accelerated Learning webinars are designed to enhance learning on a subgroup of measures that are part of our Primary Care Provider Pay for Performance Program (PCP QIP). ***CME/CE credits are available for each session.***

- April 12 - Early Cancer Detection (Cervical, Breast, and Colorectal Screening)
- June 7 - Pediatric Health: A Cluster of Services for 0-2 Year *(Repeat session)*
- July 12 - Pediatric Health: Child and Adolescent Well Care Visits (3-17 years) *(Repeat session)*

***All sessions begin at noon and are 60 to 90 minutes in length.**

ABC's of Quality Improvement

This 5 session webinar series is designed to teach the basic principles of Quality Improvement. The course is designed for clinicians, practice managers, quality improvement team members, and staff who are responsible for leading quality improvement efforts within their organization.

- May 18, May 25, June 1, June 8, and June 22 (*Registration open April 1*)

***All sessions are from noon to 1pm.**

http://www.partnershiphp.org/Providers/Quality/Pages/PIAcademyLandingPage.aspx

PHC QI Resources

A Quick Guide to Starting Your Quality Improvement Projects

Summary of 2022 QIP

CLINICAL DOMAIN										
PRACTICE TYPE			MEASURE	MEASURE CATEGORY	AGE RANGE	TARGETS		FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FULL	PARTIAL	FAMILY	INTERNAL	PEDS
✓	✓	✓	Asthma Medication Ratio	CHRONIC DISEASE MGMT.	5 - 64 YRS	70.67%	64.78%	7 / 5	12.5 / 9	12 / 9
✓	✓		Comprehensive Diabetic Care - HbA1c Control		18 - 75 YRS	61.63%	56.81%	7 / 5	12.5 / 9	--
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	62.53%	55.35%	7 / 5	12.5 / 9	--
✓		✓	Immunization for Adolescents - Combination 2	PREVENTATIVE SCREENING	13 YRS	43.55%	36.74%	7 / 5	--	12 / 9
✓	✓		Breast Cancer Screening		50 - 74 YRS	58.70%	53.93%	7 / 5	12.5 / 9	--
✓	✓		Cervical Cancer Screening		21 - 64 YRS	63.66%	59.12%	7 / 5	12.5 / 9	--
✓		✓	Childhood Immunization Status - Combination 10		2 YRS	45.50%	38.20%	7 / 5	--	12 / 9
✓	✓		Colorectal Cancer Screening		51 - 75 YRS	TBD		6 / 5	12.5 / 9	--
		✓	Counseling for Nutrition for Children/Adolescents		3 - 17 YRS	76.64%	70.11%	--	--	12 / 9
		✓	Counseling for Physical Activity for Children /Adolescents		3 - 17 YRS	72.81%	66.18%	--	--	12 / 9
✓		✓	Child and Adolescent Well Care Visit	UTILIZATION	3 - 17 YRS	53.83%	45.31%	10 / 8	--	12.5 / 9
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	61.25%	54.92%	10 / 8	--	12.5 / 9

Summary of 2022 QIP

PRACTICE TYPE			NON-CLINICAL				FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS					FAMILY	INTERNAL	PEDS
ACCESS AND OPERATIONS									
✓	✓	✓	Ambulatory Care Sensitive Admissions		FULL POINT TARGET TBD (60th Percentile)	PARTIAL POINT TARGET TBD (70th Percentile)	5 / 4	5 / 4	--
			Risk Adjusted Readmission Rate		FULL POINT TARGET TBD	PARTIAL POINT TARGET TBD	5 / 4	5 / 4	--
APPROPRIATE USE OF RESOURCES									
✓	✓	✓	Avoidable ED Visits		FULL POINT TARGET TBD (60th Percentile)	PARTIAL POINT TARGET TBD (70th Percentile)	5 / 4	5 / 4	5 / 4
PATIENT EXPERIENCE									
✓	✓	✓	Patient Experience	**CAHPS**	**ACCESS**	**COMMUNICATIONS**	10 / 8	10 / 8	10 / 8
					FULL POINTS 50TH Percentile 47.62%	FULL POINTS 50TH Percentile 75.17%			
					PARTIAL POINTS 25TH Percentile 43.17%	PARTIAL POINTS 25TH Percentile 70.97%			
				SURVEY OPTION	**FULL POINTS**	**PARTIAL POINTS**	10 / 8	10 / 8	10 / 8
					PARTS 1 AND 2	PARTS 1 OR 2			

Summary of 2022 QIP

UNIT-OF-SERVICE				
PRACTICE TYPE			MEASURE	CRITERIA
FAMILY	INTERNAL	PEDS		
✓	✓		Advance Care Planning Attestations	Minimum 1/1000th (0.01%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000. • $100 per Advance Directive/POLST, maximum payment $10,000
		✓	Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
✓	✓	✓	PCMH Certification	$1,000 yearly for achieving or maintaining PCMH accreditation.
			Peer-led Self-Management Support Groups (both new and existing)	$1,000 per group (Maximum of 10 groups per parent organization).
✓	✓	✓	Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. The incentive is available once per parent organization.
			Initial Health Assessment	$2,000 per parent organization for submitting all required parts of improvement plan regardless of visit volume.
✓	✓	✓	Health Equity	$2000 per parent organization for submission of proposed plan to adopt internal best practices supporting a Health Equity initiative.
			Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11- 21 years of age after 3% threshold of assigned members screened.
✓		✓	Blood Lead Screening	Tier 1-3, $1000, $3000, $5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.
			Dental Varnish	$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office.

2022 eReports Upload Schedule

CLINICAL MEASUREMENT SET:

Cervical Cancer Screening Childhood Immunization Status - Combo 10 Counseling for Nutrition Counseling for Children/Adolescents Counseling for Physical Activity for Children/Adolescents Comprehensive Diabetes Care - Retinal Eye Exams Colorectal Cancer Screening Immunizations for Adolescents - Combination 2	MAR 01, 2022 - JAN 31, 2023
Comprehensive Diabetes Care - HbA1c Control (A1c) Controlling High Blood Pressure Well-Child Visits in the First 15 Months of Life	OCT 01, 2022 - JAN 31, 2023
Breast Cancer Screening Child and Adolescent Well Care Visits	JAN 10, 2023 - JAN 31, 2023
*Asthma Medication Ratio	N/A *

** Asthma Medication Ratio – Data is captured through claims and pharmacy data only. Uploads are not accepted for this measure.*

Claims Companion

CLINICAL DOMAIN						
PRACTICE TYPE			MEASURE	CODING	NUMERATOR CODING RULES	NUMERATOR COMPLIANCE
FAMILY	INTERNAL	PEDS				
✓	✓	✓	Asthma Medication Ratio	REFERENCE MEASURE(S) CODE-SET IN eREPORTS DIAGNOSIS CROSSWALK	REFERENCE DETAILED SPECIFICATIONS - IN eREPORTS	CLAIMS & PHARMACY DATA ONLY NO eREPORTS UPLOAD AVAILABLE
✓	✓		Comprehensive Diabetic Care - HbA1c Control			eREPORTS UPLOAD - ADHERE TO UPLOAD SCHEDULE
✓	✓		Controlling High Blood Pressure			
✓		✓	Immunization for Adolescents - Combination 2			
✓	✓		Breast Cancer Screening			
✓	✓		Cervical Cancer Screening			
✓		✓	Childhood Immunization Status - Combination 10			
✓	✓		Colorectal Cancer Screening			
		✓	Counseling for Nutrition for Children/Adolescents			
		✓	Counseling for Physical Activity for Children Adolescents			
✓		✓	Child and Adolescent Well Care Visit			
✓		✓	Well Child Visits in the First 15 Months of Life		ADHERE TO 14-DAY RULE (IN-BETWEEN DATES OF SERVICE)	

Medi-Cal Rx Contract Drugs List: Oral Medications for Treatment of Hypertension

Oral antihypertensive drugs covered by Medi-Cal

Drug Class	Generic Name		
ACE-I	benazepril captopril	enalapril lisinopril	ramipril
ARB	losartan	telmisartan	valsartan
CCB (dihydropyridine)	amlodipine isradipine	nicardipine nifedipine (long-acting)	nisoldipine
thiazide & related diuretics	chlorthalidone	hydrochlorothiazide	indapamide
β-blocker	acebutolol atenolol bisoprolol carvedilol	labetalol metoprolol succinate metoprolol tartrate	pindolol propranolol timolol
α2-adrenergic agonist	doxazosin	prazosin	terazosin
centrally-acting agent	clonidine	guanfacine	methyldopa
vasodilator	hydralazine		
loop diuretic	furosemide		
potassium-sparing diuretic	spironolactone		

Medi-Cal Rx Contract Drugs List: Oral Medications for Treatment of Hypertension

Oral antihypertensive combination products covered by Medi-Cal

Drug Class	Generic Name
ACE-I – thiazide diuretic	benazepril – hydrochlorothiazide
	lisinopril – hydrochlorothiazide
ARB – thiazide diuretic	losartan – hydrochlorothiazide
	telmisartan – hydrochlorothiazide
	valsartan – hydrochlorothiazide
CCB – ACE-I	amlodipine – benazepril
CCB – ARB	amlodipine – valsartan
CCB – ARB – thiazide diuretic	amlodipine – valsartan – hydrochlorothiazide
centrally-acting agent – thiazide diuretic	methyldopa – hydrochlorothiazide
diuretic combinations	spironolactone – hydrochlorothiazide
	triamterene – hydrochlorothiazide

Legend drugs not listed may be covered subject to authorization from a Medi-Cal consultant.

Last updated January 2022

ACE-I: Angiotensin-converting (ACE) inhibitor
ARB: Angiotensin receptor blocker
CCB: Calcium channel blocker

PHC Resources

QI/Performance Team: ImprovementAcademy@partnershiphp.org

Quality Improvement Program: QIP@partnershiphp.org

2022 PCP QIP Webpage:
http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2021.aspx

QI Monthly Newsletters:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

Measure Highlights:
http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx

eReports: https://qip.partnershiphp.org/

Resources

- *Northwest Regional Telehealth Resource Center, Quick Start Guide to Telehealth During the Current Public Health Emergency. March 2020.* https://nrtrc.org
- California Telehealth Resource Center, http://www.caltrc.org/knowledge-center/best-practices/sample-forms
- California Primary Care Association, www.CPCA.org
- Center for Care Innovations, https://www.careinnovations.org/wp-content/uploads/Sample-Remote-Visit-Workflow.pdf