Performance Improvement Team presents:

Accelerated Learning Education Program

Pediatric Health: Child and Adolescent Well-Care Visits (3-17 years), Screenings, and Immunizations for Adolescents

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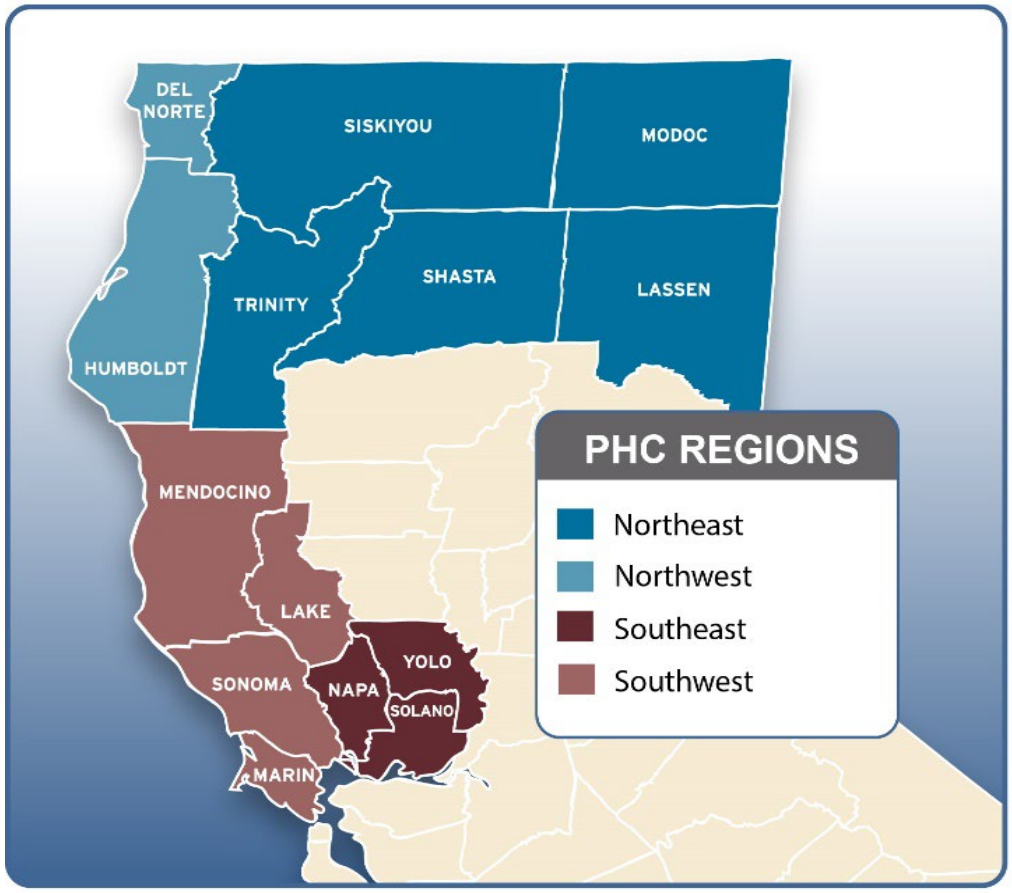
Objectives

At the end of this activity, you will be able to:

- Understand clinical background, specifications, and performance threshold definitions of the PCP QIP *Child and Adolescent Well-Care Visits, Screenings,* and *Immunizations for Adolescents* measures.
- Apply documentation requirements, including telehealth, to maximize measure performance adherence.
- Ensure that screenings such as Weight Assessment, Counseling for Nutrition and Physical Activity in the child and adolescent well-care visits assessment.
- Identify best and promising practices.

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

Background on Measures

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California State Auditor Report (March 2019): "Millions of Children on Medi-Cal Are Not Receiving Preventive Health Services"(1)

Vaccines For Children CDPH Program letter *"Routine Childhood Immunizations during COVID-19 Pandemic."*

Vaccines For Children CDPH Program letter *"Routine Childhood Immunizations during COVID-19 Pandemic."*

1. Full report: http://auditor.ca.gov/pdfs/reports/2018-111.pdf
   Customizable graphics: http://www.auditor.ca.gov/reports/2018-111/supplementalgraphics.html

Child and Adolescent Well-Care Visit

Measure Specifications

JR

Description: The percentage of members 3 -17 years of age who had at least one well-care visit with a PCP or an OB/GYN during the measurement year (MY).

Denominator: Number of continuously enrolled members 3 -17 years of age as of the measurement year (MY).

Numerator: Number of members in the denominator with at least one completed well-care visit with a PCP or OB/GYN during the measurement year (MY).

The practitioner does not have to be the practitioner assigned to the member

Five Segments to Include

JR

- Health history: Can include, but is not limited to, past illness (or lack of), surgery or hospitalization (or lack of these) and family health history.
- Physical development history – Includes age-appropriate milestones like motor development for infants and children; Tanner Stages, puberty, or smoking, illicit drug use, and alcohol use for adolescents.
- Mental development history – Milestones can include appropriate communication and mental milestones for age; reading for enjoyment; doing well in school; loving, caring and supportive relations with family; sexual identity.
- Physical exam – Includes records of at least two body systems not related to the reason for the visit if the visit is for an acute or chronic condition. Note of "physical exam WNL" is acceptable.
- Health education/anticipatory guidance – By health care provider in anticipation of emerging issues that a child or family may face. e.g., Notes of tobacco screening, use or exposure; physical abuse or neglect; preventive teaching in anticipation of child's development. Must be age-specific.

Chart Tips: Non- Adherence

JR

- Notes of allergies or medications or vaccine status alone. If all three are documented, it meets health history standard.

- Note of “appropriate age” without specific mention of development.
- Note of “well developed” alone.

- Note of “appropriate for age” without specific mention of development.
- Note of “neurological exam.”

- Vital signs alone.
- Visits to an OB/GYN if the visit is limited to OB/GYN topics alone (for adolescent well visits).

- Information regarding medication or vaccines or their side effects.
- Teaching, advising, or educating in response to a sick episode - services that are specific to an acute or chronic condition.

Child and Adolescent Well-Care Visits 2022

Description

The percentage of members 3 - 17 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31, 2022 (DOB between January 1, 2005 and December 31, 2019).

Numerator

The number of children in the eligible population with at least one well-child visit with a PCP or OB/GYN during the measurement year (January 1, 2022 and December 31, 2022).

Because well-care visit measure is administrative only, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2021, n.d).

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

Exclusions

This measure does not have any exclusions.

TARGETS:

53.83% - 75TH PERCENTILE (FULL POINTS)

45.31% - 50TH PERCENTILE (PARTIAL POINTS)

CODES USED

Denominator:

No codes applicable as eligibility is solely defined by age.

Numerator:

Codes to identify Well-Child Visits from claims/encounter data: Well-Care

EXCLUSIONS

This measure does not have any exclusions.

BMI Assessment, Nutrition/ Physical Activity Counseling and Screenings

JR

BMI Assessment, Nutrition/Physical Activity Counseling and Screenings

JR

Description: The percentage of assigned members 3 - 17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had *evidence of* the following during the measurement year.

- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Denominator: The number of assigned members 3 - 17 years of age as of the MY who had an outpatient visit with a PCP or an OB/GYN.

Numerator: The number of assigned members with evidence that BMI percentile documentation, counseling for nutrition and counseling for physical activity or referral for nutrition education and referral for physical activity was documented at least once during the MY.

BMI Assessment

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Documentation must include ALL of the following during the measurement year:
Height
Weight
Body Mass Index (BMI) percentile as a value to meet criteria (e.g., "85th percentile" or growth chart with BMI percentile plotted) **Note:** Ranges and threshold do not meet criteria - a distinct BMI percentile is required.
Member-reported body mass index, height, and weight are acceptable.

Nutrition Counseling

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Documentation should have date and at least one of the following:
Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
Checklist indicating nutrition was addressed
Counseling or referral for nutrition education
Member received educational materials on nutrition during a face-to-face visit
Anticipatory guidance for nutrition
Weight or obesity counseling

Physical Activity Counseling

JR

Documentation should have date and at least one of the following:
Discussion of current physical activity behaviors (e.g., exercise, participation in sports/activities)
Checklist indicating physical activity was addressed
Counseling or referral for physical activity
Member received educational materials on physical activity during a face-to-face visit
Anticipatory guidance for physical activity
Weight or obesity counseling

Additional Information on Documentation

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- Virtual visits are billed using a .95 modifier after the CPT code for the visit.
- Have clear notations of Physical Activity and Nutrition- include specific recommendations.

  Key phrases can include:
  - "counseled on the importance of nutrition and physical activity"
  - "advised on diet and exercise"
  - "increase fruits and vegetables and lean meats, eats a balanced diet; participates in school sports activities, runs or hikes"
- Counseling elements cannot be related to an acute or chronic condition.
- **Exclusions:** Members who have a diagnosis of pregnancy during the MY. Must include a note with a diagnosis of pregnancy.

Codes for BMI, Counseling

JR

Screening	ICD-10	HCPCS	CPT
BMI <5th %tile	Z68.51	—	—
BMI ≥5th and <85th %tile	Z68.52	—	—
BMI ≥85th and <95th %tile	Z68.53	—	—
BMI ≥95th %tile	Z68.54	—	—
Nutrition counseling	Z71.3	G0270,G0271,G0447 S9449, S9452, S9470	97802, 97803, 97804
Physical activity	Z71.82	G0447, S9451	—

Depression Screening and Follow-Up

JR

Description: 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 depression screen.

Examples of follow-up on positive screen:
An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
A depression case management encounter.
A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
A dispensed antidepressant medication.
Or
Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen).

Electronic Clinical Data Systems (ECDS) Measures: Participation to include data collection of defined clinical components for PHC members within your organization. Further detail of defined clinical components and specific data templates for each measure in the ECDS unit of service measure in ECDS Measure Requirements is in the 2022 PCP QIP Specification Manual and can be found in eReports .

Depression Screening

JR

Instruments for Adolescents (12 - 17 years)
Patient Health Questionnaire (PHQ-9)®
Patient Health Questionnaire Modified for Teens (PHQ-9M)®
Patient Health Questionnaire-2 (PHQ-2)
Beck Depression Inventory-Fast Screen (BDI-FS)®*
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)
PROMIS Depression

**There may be cost or licensing requirement associated with using these tools.*

Additional Screenings: Tobacco Use Screening

JR

Description: The percentage of members 11 - 21 years of age who had tobacco use screening or counseling one or more times during the measurement year (MY).
Denominator: Assigned members aged 11 - 21 years of age during the MY.
Numerator: Assigned members 11- 21 years of age who had tobacco use screening or counseling one or more times during the MY.

Tobacco use includes any type of tobacco and aligns with U.S. Preventive Services Task Force (USPSTF) recommendations.

PHC QIP Unit of Service Measure: $5 per tobacco use screening or counseling of members 11- 21 years of age after 3% threshold of assigned members screened. HCPCS: 4004F

Unhealthy Alcohol Use Screening and Follow-Up (ASP)

JR

Description: The percentage of members 11 - 21 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care.

Unhealthy Alcohol Use Screening: The percentage of members who had a systematic screening for unhealthy alcohol use.

Alcohol Counseling or Other Follow-up Care. The percentage of members receiving brief counseling or other follow-up care within two months of screening. The follow up must **include one** of the following. **Feedback** on alcohol use and harms. **Identification** of high-risk situations for drinking and coping strategies. **Increase** the motivation to reduce drinking. **Development** of a personal plan to reduce drinking. **Documentation** of receiving alcohol misuse treatment.

Electronic Clinical Data Systems (ECDS) Measures: Participation to include data collection of defined clinical components for PHC members within your organization. Further detail of defined clinical components and specific data templates for each measure in the ECDS unit of service measure in ECDS Measure Requirements is in the 2022 PCP QIP Specification Manual can be found in eReports .

Unhealthy Alcohol Use Screening and Follow-Up (ASP)

Eligible Screening Tools Standard assessment instruments with thresholds for positive findings include:

Instruments for Adolescents (12 - 17 years) AUDIT & AUDIT-C	Positive Finding ≥5 for AUDIT, and ≥3 for AUDIT-C (https://doi.org/10.1016/j.drugalcdep.2018.04.015)
CRAFFT (2.0 -> 2.1+N)	
GAIN (https://gaincc.org/instruments/)	

Unhealthy Alcohol Use Screening and Follow-Up (ASP)

W7000	Alcohol and/or substance (other than tobacco) use disorder screening; self administered
W7010	Alcohol and/or substance (other than tobacco) use disorder screening; provider administered structured screening (e.g., AUDIT, DAST)
W7020	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 3 minutes up to 10 minutes
W7021	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 10 minutes up to 20 minutes
W7022	Alcohol and/or substance (other than tobacco) use disorder intervention; greater than 20 minutes
4004F	Patient screened for tobacco use and received cessation intervention (counseling and/or pharmacotherapy), if identified as a tobacco user (PV, CAD)

CRAFFT+N Questionnaire

The CRAFFT+N Questionnaire

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	# of days
2.	Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	# of days
3.	Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.	# of days
4.	Use a **vaping device* containing nicotine and/or flavors**, or use any **tobacco products**†? Put "0" if none. **Such as e-cigs, mods, pod devices like JUUL, disposable vapes like Puff Bar, vape pens, or e-hookahs. †Cigarettes, cigars, cigarillos, hookahs, chewing tobacco, snuff, snus, dissolvables, or nicotine pouches.*	# of days

CRAFFT+N Questionnaire

5. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
6. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	**No**	**Yes**
7. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	**No**	**Yes**
8. Do you ever FORGET things you did while using alcohol or drugs?	**No**	**Yes**
9. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
10. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	**No**	**Yes**

CRAFFT+N Questionnaire

1. Have you ever tried to quit using, but couldn't?	**Yes**	**No**
2. Do you vape or use tobacco now because it is really hard to quit?	**Yes**	**No**
3. Have you ever felt like you were addicted to vaping or tobacco?	**Yes**	**No**
4. Do you ever have strong cravings to vape or use tobacco?	**Yes**	**No**
5. Have you ever felt like you really needed to vape or use tobacco?	**Yes**	**No**
6. Is it hard to keep from vaping or using tobacco in places where you are not supposed to, like school?	**Yes**	**No**
7. When you haven't vaped or used tobacco in a while (or when you tried to stop using)…		
a. did you find it hard to concentrate because you couldn't vape or use tobacco?	**Yes**	**No**
b. did you feel more irritable because you couldn't vape or use tobacco?	**Yes**	**No**
c. did you feel a strong need or urge to vape or use tobacco?	**Yes**	**No**
d. did you feel nervous, restless, or anxious because you couldn't vape or use tobacco?	**Yes**	**No**

Follow-up Care for Children Prescribed ADHD Medications

JR

Percentage of children ages 6 - 12 who are newly prescribed ADHD medication and had at least three follow-up visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

Initiation Phase: The percentage of members 6 - 12 years of age with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase*:* The percentage of members 6 - 12 years of age with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits within 270 days (9 months) after the Initiation Phase.

Electronic Clinical Data Systems (ECDS) Measures: Participation to include data collection of defined clinical components for PHC members within your organization. Further detail of defined clinical components and specific data templates for each measure in the ECDS unit of service measure in ECDS Measure Requirements is in the 2022 PCP QIP Specification Manual can be found in eReports .

Developmental and ACEs Screenings
Prop 56 Funded Priority

JR

Funds two important screenings for children and adults:

- Development Screening
- ACEs Screening

Enhanced funding for all providers including: FQHCs, RHCs, and Indian Health Services (outside of prospective payment)

- Developmental - $59.90 per screening (up to three screenings between 9 - 30 months of age)
- ACEs - $29 once per lifetime for adults or as appropriate for children

Standardized Screening/Testing Coding Fact Sheet for Primary Care Pediatricians: Developmental/Emotional/Behavioral – AAP
https://www.dhcs.ca.gov/provgovpart/Documents/Trauma-Screenings-Policy-10.3.pdf

Prop 56 (Tobacco Tax) Incentive Programs – Detailed Summary

*MUST bill with Type 1 – individual NPI in one of three available fields, rendering, ordering, prescribing, billing

Developmental Screening

- CPT - 96110, with modifier for autism screening
- Three screens per child
- Can be non-provider screening
- When performed with E/M code a 25 modifier should be used with the E/M code OR a 59 modifier to the 96110
- $59.90
- Screening tool - listed in notice

ACEs Screening

- CPT G9919 - positive (4+) and recommended f/u and G9920 - negative screen
- Children: PEARLS (age appropriate version)
  - Frequency as appropriate but not more than once per year per provider, per MCP
- Adults up to age 65 - ACEs Screening tool
  - Once in lifetime per provider
  - Excludes dually eligible
- Must complete online training
- $29 each

Immunizations for Adolescents Combination 2

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Call to Action in Closing the Gap

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Current Immunization activity is not enough to catch up on missed doses in the coming months.

As compared with 2019, in 2020 (CA Department of Public Health May 2021) :

- 19% fewer children ages 4 - 6 received a dose of MMR
- 20% fewer adolescents ages 11 - 13 years old received a dose of Tdap

COVID-19 Vaccination

JR

June 18, 2022, CDC and the ACIP recommendation- added that all children 6 months through 5 years should receive a COVID -19 vaccine.

CDC and AAP: co-administration is permissible with other routine vaccines.

AAP recommends that all children be vaccinated, included those who have been sick or tested positive for COVID-19.

Immunizations for Adolescents Combination 2

JR

Description:

The percentage of members who turn 13 years of age during the measurement year who had the following immunizations as stated in the next slide.

Denominator:

Number of continuously enrolled members who turn 13 years of age during the measurement year.

Numerator:

Number of eligible population (13 years of age during the measurement year) in the denominator who had all the immunizations by the 13th birthday.

Immunizations for Adolescents Combination 2

JR

Meningococcal: At least one meningococcal conjugate vaccine, with a date of service on or between the member's 11th and 13th birthdays.

Tdap: At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, with a date of service on or between the member's 10th and 13th birthdays.

HPV: At least two HPV vaccines, with different dates of service on or between the member's 9th and 13th birthdays.

Medical Record Documentation

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Evidence that the antigen was provided from either of the following:

- Medical record notation indicating the **name** of the specific antigen and the **date** of the immunization.
  A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations.
- Documentation from California Immunization Registry (CAIR-2).

Medical Record Documentation

JR

HPV: For the two-dose HPV vaccination series, there must be at least 146 days between the first and second doses of the HPV vaccine.

Meningococcal: Immunization documented under a generic header of “meningococcal” and was administered meets criteria. Immunizations under generic header of meningococcal polysaccharide vaccine or meningococcal conjugate vaccine meet criteria.

Tdap: Immunizations documented using a generic header of “Tdap/Td” can be counted. Ensure you differentiate between **Tdap** and **DTaP**.

Medical Record Documentation

JR

Non- Adherence:

- For meningococcal conjugate, do not count meningococcal recombinant (serogroup B) (MenB) vaccines.
- A note that the "patient is up-to-date" with all immunizations but does not list the dates of all immunizations and the names of the immunization **is not** sufficient evidence for QIP reporting.
- Retroactive entries are unacceptable – all services must be rendered and entered on or before the 13th birthday.
- Document parental refusal (Z28 code). Counted as non-compliant.

Exclusions to Immunizations for Adolescents Combo 2

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Adolescents who had a contraindication for a specific vaccine are excluded from the denominator.

Any of the following meet exclusion criteria:

- **Any particular vaccine:** Anaphylactic reaction to the vaccine must be a note with the day of the event any time on or before the member's 13th birthday.
- Anaphylactic reaction (due to serum) to the vaccine or its components with a date of service prior to October 1, 2012.
- **Tdap**: Encephalopathy with a vaccine adverse-effect code anytime on or before the member's 13th birthday.
- Members in hospice.

Immunizations for Adolescents FAQ - PCP QIP

JR

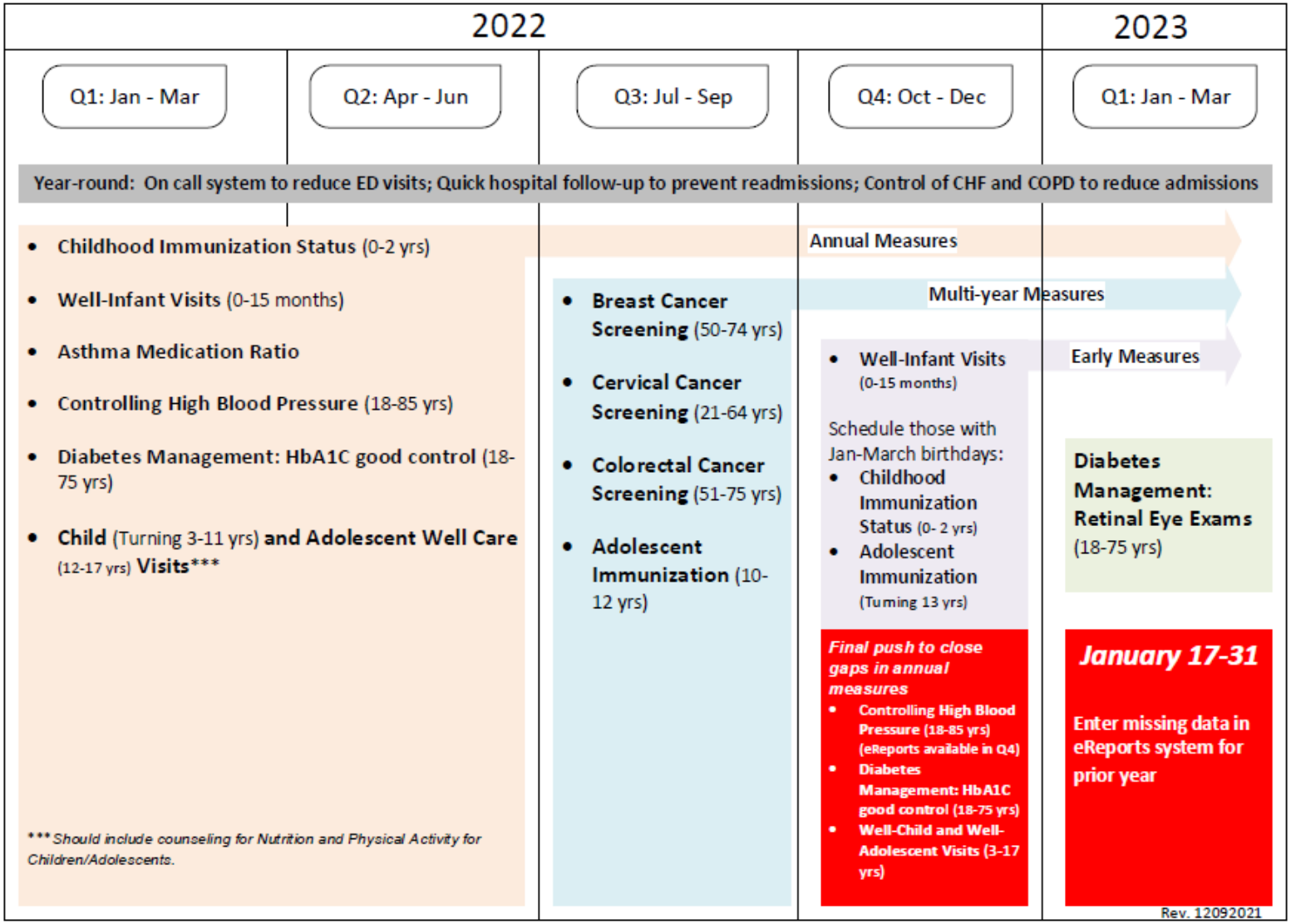
Question: What billing codes are captured to meet the Adolescent Immunization measure?

Answer:
Denominator eligibility is solely based on age. CAIR-2 data and eReports uploads are used to meet numerator compliance.

Question: Can we exclude members who have missed early required vaccinations?

Answer:
No, these members cannot be excluded.

Timeline for addressing 2022 and 2023 PCP QIP Measures



Child and Adolescent Well-Care Visit

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points Partial Points	Family Medicine	10 Points 8 Points	53.83% 45.31%	75th 50th
Full Points Partial Points	Pediatric	12.5 Points 9 Points	53.83% 45.31%	75th 50th

Immunization for Adolescents Combination 2

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	**Family Medicine**	**7 points**	**43.55%**	**75th**
	Pediatric	**12 points**	**43.55%**	**75th**
Partial Points	**Family Medicine**	**5 points**	**36.74%**	**50th**
	Pediatrics	**9 points**	**36.74%**	**50th**

Counseling for Nutrition for Children/Adolescents and Counseling for Physical Activity for Children/Adolescents

PCP QIP 2022	Measure	Practice Type	Total Points	Threshold	Percentile
Full Points Partial Points	Nutrition	Pediatric	12 Points 9 Points	76.64% 70.11%	75th 50th
Full Points	Physical Activity	Pediatric	12 Points 9 Points	72.81% 66.18%	75th 50th

Questions

Voices from the Field

FM

Voices from the Field

FM

Presenter:

Constance Mitchell DNP, RN, CPNP-PC, PHN

Pediatric Nurse Practitioner

Open Door Community Health Centers

References

AAP Bright Futures Guidelines:

https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/

5120 Every Day:

https://shop.aap.org/5210-pediatric-obesity-decision-support-chart-3rd-ed-paperback/

ACEs AWARE:

Acesaware.org

Community Pediatrics

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Community Pediatrics: Navigating the Intersection of Medicine, Public Health, and Social Determinants of Children's Health

COUNCIL ON COMMUNITY PEDIATRICS

KEY WORDS
community pediatrics, child advocacy, public health, social determinants of health

abstract

FREE

This policy statement provides a framework for the pediatrician's role in promoting the health and well-being of all children in the context of their families and communities. It offers pediatricians a definition of community pediatrics, emphasizes the importance of recognizing social determinants of health, and delineates the need to partner with public health to address population-based child health issues. It also recognizes the importance of pediatric involvement in child advocacy at local, state, and federal levels to ensure all children have access to a high-quality medical home and to eliminate child health disparities. This statement provides a set of specific recommendations that underscore the critical nature of this dimension of pediatric practice, teaching, and research. *Pediatrics* 2013;131:623–628

Reinventing Primary Care: Embracing Change, Preserving Relationships

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FROM THE EDITORS' DESK

Reinventing Primary Care: Embracing Change, Preserving Relationships

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Patients and doctors have reason to be dissatisfied with the US health care system. It is expensive. It is unreliable. It is unfair. And it can be alienating, both to those who receive care and those who provide it. If you are an average American, your chance of receiving recommended immunizations and cancer screenings is less than 75% (that's a "C" in most high schools).[1] If you have an acute upper respiratory tract infection, there's a good chance you'll be over-treated with antibiotics.[2] If you develop a serious symptom like syncope or hematuria and you are uninsured, you are unlikely to see a physician, at least not until things get worse.[3] If you are burdened with multiple chronic conditions (and assuming you have health insurance), you will probably see multiple specialists, each providing excellent evidence-based care for their disease of interest, but often oblivious to the effects of their ministrations on your overall health and life.

There is a prescription for what ails us, but it doesn't come in a bottle. It's called primary care. As defined by the pioneering work of Barbara Starfield, primary care is "first-contact, continuous, comprehensive, and coordinated care provided to populations undifferentiated by gender, disease, there is still much that can be done. We need to look to new models that deliver a better care experience, achieve better population health outcomes, and control costs. In short, we need to reinvent primary care.

In this issue of *JGIM*, we are pleased to feature six articles, supported by a special grant from the California Health Care Foundation, that review the current landscape of primary care innovation; stimulate thinking on new directions for primary care; and begin to construct an agenda for energetic reform. In the first article, Ellner and Phillips[6] provide a roadmap for primary care reinvention. They emphasize four principles: reforming payment, supporting relationships, building teams, and enlarging the scope of primary care practice. The principles are inextricably linked in ways both obvious and subtle. For example, primary care physicians (PCP) cannot possibly aspire to more comprehensive practice without the support of teams and a payment model that supports investment in personnel and infrastructure to support quality.

In the next piece, Shrank discusses how new primary care delivery models, harnessed to changing consumer expectations, can lead to more patient-centered care.[7] However, he cautions that such models will require both information technology interoperability (so PCPs can remain informed about treatment their patients have received in retail and employer-based clinics) and payment reform (so PCPs are fairly compensated for the time it takes to coordinate care across settings).

Questions

Best and Promising Practices

Seize Every Opportunity: Establish a practice commitment to update and complete well-care visits and immunizations

- ✓ Utilize “flag” alerts in the EMR/EHR.
- ✓ Review care gaps daily.
- ✓ Conduct chart scrubbing **prior** to the visit. Leverage CAIR2 data to update charts.
- ✓ Use standardized templates.
- ✓ Use your daily huddle time to brief/communicate.

Best and Promising Practices

Increase Access:

- ✓ Reduce waiting times/need to make an appointment, create immunization only services, drive-up and/or walk-in clinics.
- ✓ Increase or make more convenient the hours when services are provided.
- ✓ Initiate back-to-school “ break” clinics.

Best and Promising Practices

Increase Access:

- ✓ Identify and address barriers to care (transportation, language, cultural beliefs).
- ✓ Partner with established community agencies, faith-based organizations.
- ✓ Strengthen partnership with schools and after school programs-clinic days at their site.
- ✓ Consider using an equity approach to increase screening rates for targeted communities. Identify barriers that affect specific communities, and plan interventions to address these barriers.

Best and Promising Practices

Communication/Education:

- ✓ Staff - use approved tailored scripts and talking points.
- ✓ In-house training.
- ✓ Communication - portals, texts, and/or calls.
- ✓ Outreach to those “no-show” and repeat cancellations.
- ✓ Have handouts attached to well child templates.

Best and Promising Practices

Communication/Education:

- ✓ Use all visits as teachable moments to increase well visits and health literacy.
- ✓ Use approaches that align with your demographics.
- ✓ Patient information: ensure information is consistent, in plain, and person-centered appropriate language.
- ✓ Maximize on-line patient portal.

Best and Promising Practices

Immunization for Adolescents:

Co-administer the human papillomavirus vaccine (HPV) with other vaccines.

REINFORCE messaging:

It is part of the routine immunization schedule.

REFRAMING: Now or Never approach

"HPV is the only anti-cancer vaccine available."

Provider recommendation and explanation are essential! Establish rapport – deliver unambiguous recommendations especially with HPV.

Focus ahead on patients turning 13 in future years.

Best and Promising Practices

Strengthen Internal Operating Practices:

- ✓ Use California Immunization Registry (CAIR2), - bi-directional interface.
- ✓ Submit timely claims and encounter data within 90 days.
- ✓ Use complete and accurate codes.
- ✓ Review operational/clinical work flows.
- ✓ Report back to staff on your progress.

Celebrate success.

- ✓ Schedule a standing meeting with your QI staff to review the resources offered by PHC.

Best Practices - Screening

- Utilize EHR portal to complete screening/surveys prior to visit.

- Alternatively have members arrive 15 minutes prior to appointment to complete screenings.
- Schedule future appts in the exam room.

Questions

Evaluation

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

Contact Us

Regional Medical Director, Northwest Region

Jeff Ribordy, MD (jribordy@partnershiphp.org)

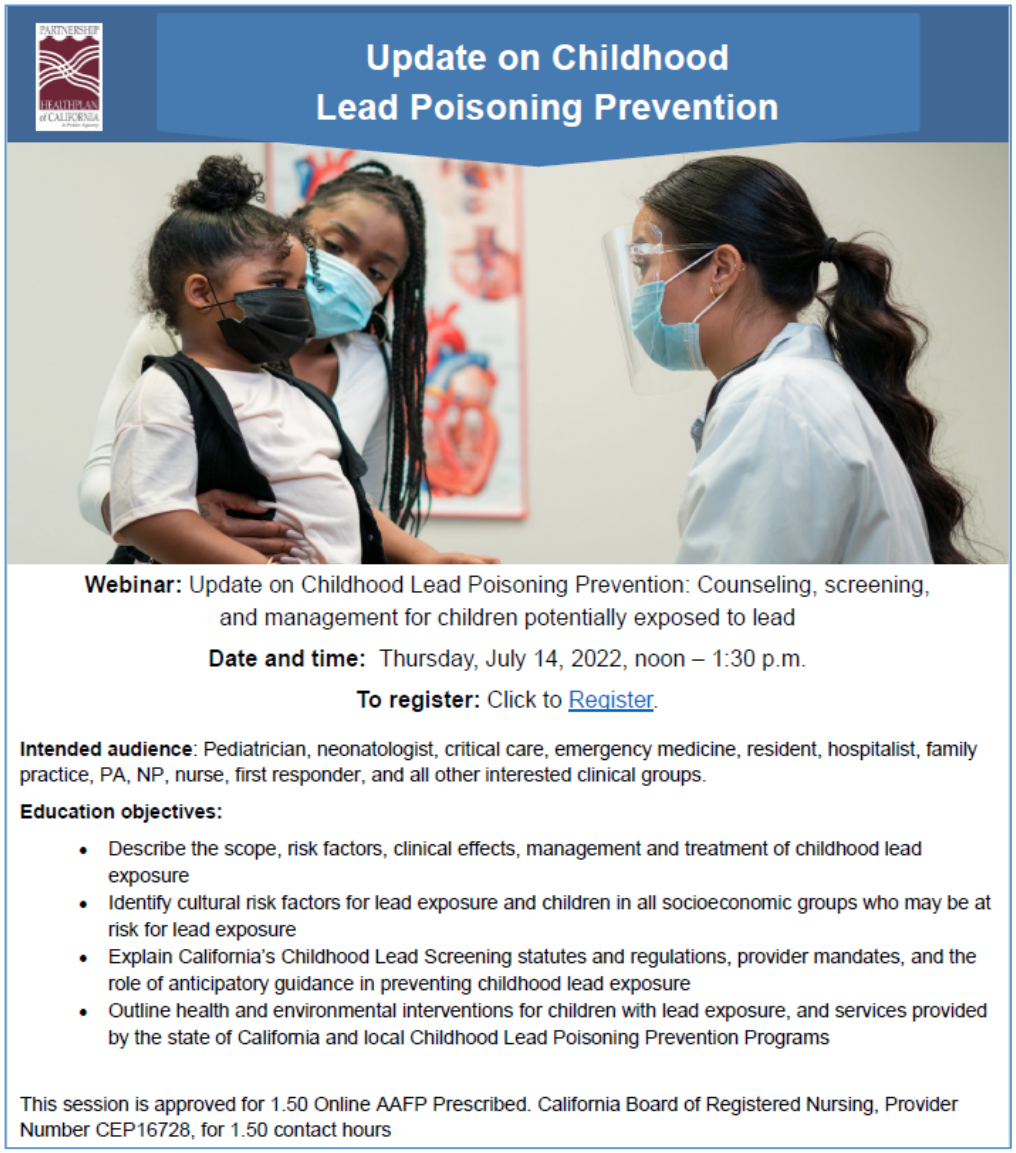
Quality Improvement Advisor:

Flora Maiki, MHA (fmaiki@partnershiphp.org)

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Childhood Lead Poisoning Prevention Upcoming Webinar - July 14



Recorded Webinar

Electronic Clinical Data Systems Webinar Recording:

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

Quality Improvement Trainings

On-Demand Courses

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

- Accelerated Learning
- PCP QIP High Performers - How'd They Do That?
- Project Management 101
- Tools for Prioritizing Quality Measures
- Understanding the Benefits Delivery System

PHC QI Resources

A Quick Guide to Starting Your Quality Improvement Projects

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

PHC QI Resources

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

DHCS Formulary Search Tool

https://www.dhcs.ca.gov/services/Pages/FormularyFile.aspx

Quality Improvement Program Email: QIP@partnershiphp.org

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

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

QI Monthly Newsletters:

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

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

Resources

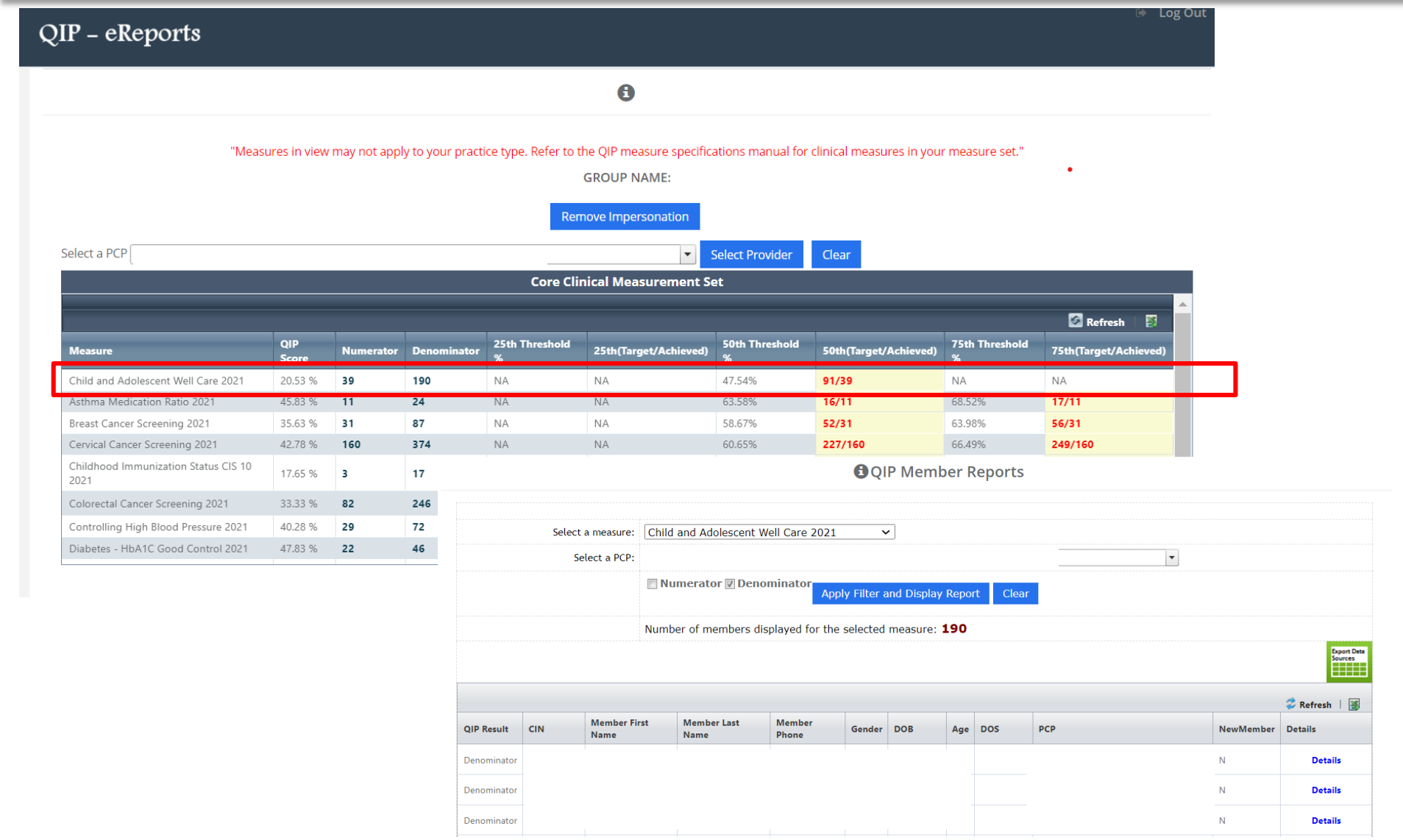
- https://eziz.org/assets/docs/VFC_Letters/VFCletter_PediatricIZGuidelinesduringCOVID19Pandemic_03_27_20.pdf
- https://www.aap.org/en-us/professional-resources/practice-transformation/telehealth/Pages/Sample-Documents.aspx
- California Telehealth Resource Center, http://www.caltrc.org/knowledge-center/best-practices/sample-forms
- California Primary Care Association, www.CPCA.org
- Center for Care Innovations, https://www.careinnovations.org/wp-content/uploads/Sample-Remote-Visit-Workflow.pdf
- California Immunization Registry (CAIR) http://cairweb.org/how-cair-helps-your-practice/

Resources

- https://www.niaaa.nih.gov/alcohols-effects-health/professional-education-materials/alcohol-screening-and-brief-intervention-youth-practitioners-guide/resources
- http://crafft.org/

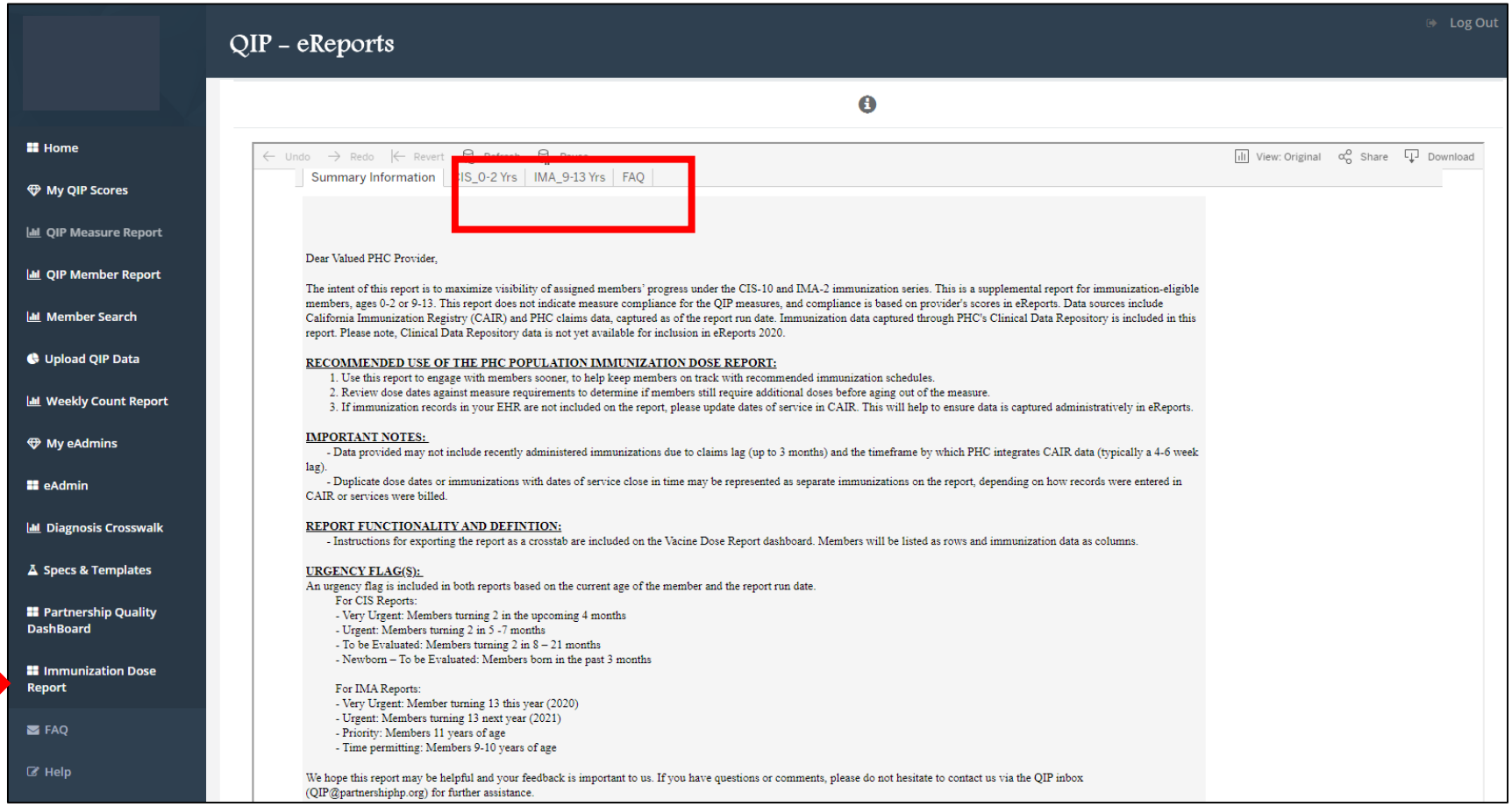
Primary Care Provider Quality Improvement Program (PCP QIP)

Strategy for eReports



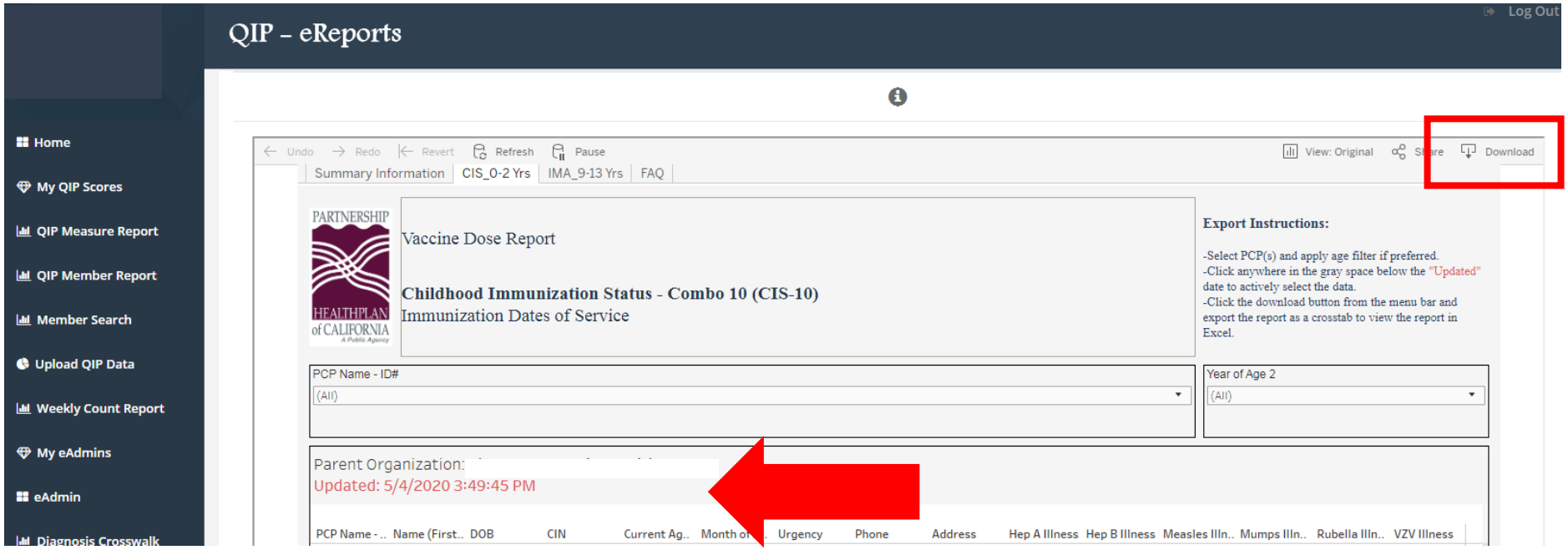
Immunization Dose Reports - On Demand

FM



How to Download the Immunization Dose Reports?

1. Click the data table to select data.
2. Click download and select Data or Crosstab.
3. Report will download into Excel.



2022 Core Measurement Set

Core Measurement Set – Family Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (70.67%)	50th Percentile (64.78%)	7	5
Breast Cancer Screening	75th Percentile (58.70%)	50th Percentile (53.93%)	7	5
Cervical Cancer Screening	75th Percentile (63.66%)	50th Percentile (59.12%)	7	5
Child and Adolescent Well Care Visits	75th Percentile (53.83%)	50th Percentile (45.31%)	10	8
Childhood Immunization Status: Combo 10	75th Percentile (45.50%)	50th Percentile (38.20%)	7	5
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.8%)	6	5
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (61.63%)	50th Percentile (56.81%)	7	5
Controlling High Blood Pressure	75th Percentile (62.53%)	50th Percentile (55.35%)	7	5
Immunizations for Adolescents – Combo 2	75th Percentile (43.55%)	50th Percentile (36.74%)	7	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.25%)	50th Percentile (54.92%)	10	8
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [2]				
Ambulatory Care Sensitive Admissions	60th Percentile (6.88)	70th Percentile (8.56)	5	4
Risk Adjusted Readmission Rate	Score <1.0	Score ≥ 1.0 -1.2	5	4
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 47.62%) 50th Percentile (Communication 75.17%)	25th Percentile (Access 43.17%) 25th Percentile (Communication 70.97%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8
MONITORING MEASURES				
Comprehensive Diabetes Care - Retinal Eye Exams	Monitoring Measure (50th – 51.36%)	Monitoring Measure (50th – 51.36%)	0	0
PCP Office Visits	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	(Greater than 2.1 visits per member per year on average.)	0	0
		TOTAL POINTS	**100**	**76**

[2] Non-clinical measure targets are the same as 2021 PCP QIP year.

2022 Summary of Core Measurement Set

Core Measurement Set – Pediatrics

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (70.67%)	50th Percentile (64.78%)	12	9
Child and Adolescent Well Care Visits	75th Percentile (53.83%)	50th Percentile (45.31%)	12.5	9
Childhood Immunization Status: Combo 10	75th Percentile (45.50%)	50th Percentile (38.20%)	12	9
Immunizations for Adolescents – Combo 2	75th Percentile (43.55%)	50th Percentile (36.74%)	7	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.25%)	50th Percentile (54.92%)	10	8
Counseling for Nutrition for Children/Adolescents	75th Percentile (76.64%)	50th Percentile (70.11%)	12	9
Counseling for Physical Activity for Children/Adolescents	75th Percentile (72.81%)	50th Percentile (66.18%)	12	9
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 47.62%) 50th Percentile (Communication 75.17%)	25th Percentile (Access 43.17%) 25th Percentile (Communication 70.97%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8
MONITORING MEASURES				
PCP Office Visits	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	0	0
		TOTAL POINTS	**100**	**75**

[4] Non-clinical measure targets are the same as 2021 PCP QIP year.

2022 Summary of Core Measurement Set

Core Measurement Set – Internal Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (70.67%)	50th Percentile (64.78%)	12.5	9
Breast Cancer Screening	75th Percentile (58.70%)	50th Percentile (53.93%)	12.5	9
Cervical Cancer Screening	75th Percentile (63.66%)	50th Percentile (59.12%)	12.5	9
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.8%)	12.5	9
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (61.63%)	50th Percentile (56.81%)	12.5	9
Controlling High Blood Pressure	75th Percentile (62.53%)	50th Percentile (55.35%)	12.5	9
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [3]				
Ambulatory Care Sensitive Admissions	60th Percentile (6.88)	70th Percentile (8.56)	5	4
Risk Adjusted Readmission Rate	Score <1.0	Score ≥ 1.0 -1.2	5	4
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 47.62%) 50th Percentile (Communication 75.17%)	25th Percentile (Access 43.17%) 25th Percentile (Communication 70.97%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2	10	8
MONITORING MEASURES				
Comprehensive Diabetes Care - Retinal Eye Exams	Monitoring Measure (50th – 51.36%)	Monitoring Measure (50th – 51.36%)	0	0
PCP Office Visits	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	Monitoring Measure (Greater than 2.1 visits per member per year on average.)	0	0
		TOTAL POINTS	**100**	**74**

[3] Non-clinical measure targets are the same as 2021 PCP QIP year.

2022 Summary of Unit of Service Measures

Measure	Incentive
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership18 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	$1000 yearly for achieving or maintaining PCMH accreditation.
Peer-led Self-Management Support Groups (both new and existing)	$1000 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 $3000 incentive is available once per parent organization.
Initial Health Assessment	$2000 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.
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.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.
ECDS	$5,000 per parent organization for participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year.

References

References:

National Committee on Quality Assurance (NCQA) HEDIS® Measurement Year 2021 and Measurement Year 2022 Vol 2 Technical Specifications for Health Plans. HEDIS® is a registered trademark of NCQA.

American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health of Infants, Children and Adolescents (published by the National Center for Education in Maternal and child Health) at www.Brightfutures.org

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020.

WWW.Crafft.org

CDC and AAP:(https://www.aappublications.org/news/2021/05/12/cdc-aap-pfizer-covid-vaccine-teens-051221

1. Full report: http://auditor.ca.gov/pdfs/reports/2018-111.pdf
   Customizable graphics: http://www.auditor.ca.gov/reports/2018-111/supplementalgraphics.html

2. Staying Healthy Assessment- California Department of Health Care Services: https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

3. The Needs to Optimize Adolescent Immunization, American Academy of Pediatrics: https:pediatrics-aappublications.orgcontent/139/3/e20164186