2019 Primary Care Provider Quality Improvement Program (PCP QIP)
Measurement Specifications

PEDIATRIC MEDICINE PRACTICES

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I. Quality Improvement Program Contact Information

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II. Program Overview

The PCP Quality Improvement Program (QIP), designed in collaboration with PHC providers, offers sizable financial incentives and technical assistance to primary care providers so that they can make significant improvements in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience
- Advance Care Planning

Although the PCP Quality Improvement Program evaluates performance on PHC's Medi-Cal line of business, PHC encourages quality, cost-efficient care for all your patients. Incentives are based on meeting specific performance thresholds in measures that address the above areas (see p.6-10 for a Summary of Measures).

Guiding Principles

The QIP uses nine guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within the program.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable measures
4. Feasible data collection
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measurement set
8. Align measures that are meaningful
9. Stable measures

The guiding principles outlined above are used to select measures for improvement. These measures are selected in areas that are not addressed under PCP contracts, such as population-level screening targets and other population-level preventive care services. The QIP serves to increase health plan operational efficiencies by prioritizing areas that drive high quality care and have potential to reduce overall healthcare costs.

Program Timeline: 2018

The 2019 measurement year begins on January 1, 2019 and ends on December 31, 2019. Please see Appendix VII for details on deadlines specific to any measures. Payment is sent out 120 days after the program period ends, on April 30, 2019.

Definitions

Parent Organization: A health center that may or may not operate multiple sites.

Primary Care Provider Site: Clinic location that has been designated with a unique PCPID with members actively assigned by Partnership HealthPlan of California.

The Department of Health Care Services (DHCS) requires each physical location that is open for at least 20 hours per week to have its own assigned ID in order to have members assigned to it. PHC requires all facilities meeting the 20 hour per week criteria to be included in the Provider Directory.

Provider: Please refer to Primary Care Provider Site definition above. This term is not interchangeable with an individual physician or other licensed health care professionals and teams.

Provider Eligibility Criteria

All current primary care providers, including pediatric, family, and internal medicine sites, that have capitated Medi-Cal only members assigned and are contracted with PHC for the entire measurement year are automatically enrolled in the QIP. A provider must be enrolled in the program as of December 1st of the measurement year in order to be eligible for incentive payments Eligibility criteria for specific measure domains vary.

If a contract is terminated during the measurement year, eligibility will be reviewed on a case-by-case basis. In order to offer comprehensive QIP data, sites are required to report to the QIP at the PCPID level.

Clinical Measures

PCP sites that join PHC's network mid-year are eligible for Clinical Measures of the QIP under the following circumstances:

- Provider sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice):
    - Must be contracted with members assigned for at least nine months.

- Provider sites joining Partnership as part of a parent organization where members from an existing QIP participant are potentially being reassigned to the new site (example – new site opens within multi-site FQHC model)
    - Must be contracted with members assigned by October 1.
    - New sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the parent organization will be used to support continuous enrollment requirements for Clinical Measures.

Non-Clinical Measures

PCP sites that join PHC's network mid-year are eligible for measures in the Non-Clinical domains under the following circumstances:

- All providers, regardless of any affiliation:
    - Must be contracted with members assigned for at least nine months of the measurement year.

Eligible Member Population

The eligible population used to calculate the final scores for all measures is defined as capitated Medi-Cal members. In addition, beginning in 2019, members that qualify for California Children Services and certain Native Americans will be assigned to PCP sites without capitation. These members are eligible to be included in sites' denominator lists assuming denominator criteria are met. Member month assignments will also count towards the member month totals used for payment calculations.

For measures in the Clinical domain, the member also has to be continuously enrolled within a PCP organization, with continuous enrollment defined as being assigned for nine out of the 12 months between 1/1/2019 and 12/31/2019. For multi-site organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a site's final denominator is December 1st; this means members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Medi-Medi or dually eligible members are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate should be presented to the QIP Team.

For measures in the Non-Clinical domain, continuous enrollment criteria are detailed within each measure's specifications.

Measure Development and Selection

The measurement set for the QIP is reviewed and developed annually. In order to maintain a stable measurement set, major changes are only made every other year. With input from the network, the Provider Advisory Group, and internal departments, the measurement set requires approval from the Physician Advisory Committee. Once approved, the finalized set for the next year is shared with the network and specifications are developed. It is possible for the measurement set to change slightly during the measurement year due to new information becoming available (i.e. a measure's retirement from the Department of Health Care Services External Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be announced through e-mail to all providers as well as through the program's monthly newsletter.

Measures may evaluate a provider's utilization of a certain service or provision of treatment. PHC recognizes the potential for underutilization of care and services and takes appropriate steps to monitor for this. The processes utilized for decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not offer incentives or compensation to providers, consultants. or health plan staff to deny medically appropriate services requested by members, or to issue denials of coverage.

Payment

The PCP QIP is comprised of two measurement sets each with its own payment methodology.

The PCP QIP Core Measurement Set includes measures in the Clinical, Appropriate Use of Resources, Operations and Access, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. There is a fixed per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

Example: ***For illustrative purposes only***, assume the PMPM for the 2019 year is $10.00.

- A site that earns 100% of their QIP Core Measurement Set points would earn 100% of the site's potential amount. If the site had a monthly average of 1,000 members, that would result in a total of 12,000 member months. The $10 is then multiplied by 12,000, equaling a payment of $120,000. This breaks down to a realized $10.00 PMPM.

- A site that earns 55% of their QIP Core Measurement Set points would earn 55% of the site's total potential amount. If the site had an average of 1,000 members and 12,000 member months, this would equal a final payment amount of $66,000. This breaks down to a realized $5.50 PMPM.

The PMPM amount may change annually based on the plan's financial performance. It is announced annually at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.

For the Unit of Service domain, the payment is independent of, and distinct, from the financial incentives a site receives from the Core Measurement Set. A site receives payment according to the measure specifications if the requirements for at least one Unit of Service measures are met.

Billing

The QIP often uses administrative data to evaluate performance on clinical and non-clinical measures. The codes that will trigger automatic inclusion for evaluation are listed in our Code List and specified within each measure. These claims may not be wholly representative of reimbursable codes of PHC. Please review the code list for any potential billing discrepancies.

eReports

eReports, an online system built for the QIP Clinical measures, is the mechanism by which providers can monitor their performance and submit supplemental data to PHC. The eReports portal may be accessed at https://qip.partnershiphp.org/. The launch date of eReports falls within the first quarter of the measurement year to ensure availability of data throughout the measurement year; the exact date may vary from year to year and

is announced via the QI Newsletter. Providers have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e. January 31 following the measurement year, and is intended to allow for final data collection and uploads.

All providers, regardless of denominator size, will be held against the established thresholds. We are aware that small denominators may negatively impact the overall performance on that measure. Therefore, if a provider 1) has fewer than 10 members in the denominator for any clinical measure after continuous enrollment is applied and 2) does not meet the threshold, there will be an additional opportunity to submit evidence of outreach efforts to non-compliant members conducted during the measurement year. Providers with denominators of less than 10 members must provide evidence of three targeted outreach attempts when requesting a member be excluded from the denominator. Outreach information must be submitted to the QIP team by 5 p.m. on January 31, 2020.

Partnership Quality Dashboard

In addition to the eReports system, the QIP Team utilizes a new portal called the Partnership Quality Dashboard (PQD) specifically for tracking measures in the Non-Clinical domains. The PQD is accessible through the eReports system and provides available claims and encounter data based information. Non-Clinical reports will no longer be produced and shared with individual sites. The PQD has other capabilities as well, such as trending performance from previous years across all domains and projecting point earnings based on current performance. Please review the PQD Overview Webinar for more details on the functionality, and contact the QIP Team with questions.

Payment Dispute Policy

Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and, during the validation period after the end of the measurement year, review data on which your final point earnings will be based. If during the Preliminary Report review period or eReports validation period a provider does not inform PHC of a calculation or point attribution error that would result in potential under or over payment, the error may be corrected by PHC post-payment. This means PHC may recoup overpaid funds any time after payment is distributed. Dispute of final data described below will not be considered:

1. QIP scores on eReports
   eReports refreshes data on a weekly basis and providers have access to eReports through the well-published grace period (30 days after the end of the measurement year, through January 31) to check for data disparities. Additionally, providers have access to eReports for during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, PHC may assist a provider with uploading data before the close of the grace period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.

2. Exclusions on eReports
   Some exclusions from denominators, when approved, involve a manual process by PHC staff. Since the QIP receives a large volume of exclusion requests, providers are responsible for checking that members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. The deadline for exclusion requests for most measures is the 5 p.m. on the last day of the grace period (January 31). The deadline for exclusion requests for Cervical Cancer Screenings and the three Diabetes Management measures is January 15, 2020.

3. Data reported on the Year-End Preliminary Report

At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the earnings for manually tracked measures (i.e. PCMH Certifications, Initial Health Assessments, etc.). Providers will be given one week, hereafter referred to as Preliminary Report Review Period, to review this report for performance discrepancies and calculation or point attribution errors.

4. Practice type designations
   Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice according to the accepted age groupings listed in the Provider Directory and a historical review of member months. Each practice type is responsible for different QIP measures. The QIP team is available throughout the measurement year to answer questions about these designations as defined in the QIP. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.

5. Thresholds
   Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year. The QIP may consider adjusting thresholds mid-year based on provider feedback. However, post-payment disputes related to thresholds cannot be accommodated.

   Should a provider have a concern that does <u>not</u> fall in any of the categories above (i.e. the score on your final report does not reflect what was in eReports), a Payment Dispute Form must be filled out within 30 days of receiving the final statement. All conversations regarding the dispute will be documented and reviewed by PHC. All payment adjustments will require approval from PHC's Executive Team.

<u>Governance Structure</u>
The QIP and its measurement set are developed collaboratively with internal and external stakeholders and receive feedback and approval from the following parties:

Provider Network: Providers provide feedback on program structure and measures throughout the measurement year. During the measure development cycle, proposed changes are released to the network for public comment.

QIP Technical Workgroup: The QIP internal workgroup consisted of representatives from Finance, Provider Relations, and IT Departments reviews program policies and proposes measure ideas.

QIP Advisory Group: The QIP external advisory group comprised of physicians and administrators from all practice types and counties provides recommendations on measures and advises on QIP operations

PHC Physician Advisory Committee: The Brown Act committee with board certified physicians is responsible for approving measures.

Board of Commissioners: The PHC Board approves the financial components of the QIP.

III. Summary of Measures

For the tables below, please refer to these notes:

1: For most existing clinical measures, the full-point target is set at the 90th percentile performance of all Medicaid health plans. Sites have the opportunity to receive half points on measures if the 75th percentile performance is met. For all new clinical measures, the full-point target is set at the 50th percentile performance, and no partial points are available. The 2019 thresholds for the Immunizations for Adolescents Combo 2 and Childhood Immunizations Combo 3 measures have been set to the 50th percentile performance for partial points and the 75th percentile performance for full points. No points through relative improvement are available for these measures.

2: For existing clinical measures, sites can also earn partial points based on relative improvement (RI). Please note that if a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through relative improvement in the current measurement year. Relative improvement measures the percentage of the distance the provider has moved from the previous year's rate toward a goal of 100 percent. The method of calculating relative improvement is based on a *Journal of the American Medical Association* article authored by Jencks et al in 2003, and is as follows:

$$\frac{\text{(Current year performance) – (previous year performance)}}{\text{(100 – Previous year performance)}}$$

The formula is widely used by the Integrated Healthcare Association's commercial pay for performance program as well as by the Center for Medicare and Medicaid Services.

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure.
- A minimum of 10% RI will be needed to earn partial points.

3: Site specific and practice type risk adjusted targets will be sent to each participating site in Spring 2019.

4: All clinical measures except Colorectal Cancer Screening use as targets the performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2018. The Colorectal Cancer Screening targets are based on the 75th and 90th percentile plan-wide performance from the 2018 QIP, as NCQA data for Medicaid is not available.

Measures	Targets	Points	Risk Adjusted?
CLINICAL DOMAIN (90 Points Total)			
1. Nutrition Counseling (3-17 yrs)	-Full Points: 83.45%[1] -Partial Points: 77.91%[1] or, if performance meets 50th (69.57%), 10% Relative Improvement[2]	15	No
2. Physical Activity Counseling (3-17 yrs)	-Full Points: 78.35%[1] -Partial Points: 71.29%[1] or, if performance meets 50th (63.50%), 10% Relative Improvement[2]	15	
3. Well Child Visits (3-6 yrs)	-Full Points: 83.70%[1] -Partial Points: 79.33%[1] or, if performance meets 50th (73.89%), 10% Relative Improvement[2]	15	
4. Adolescent Immunization	-Full Points: 37.71%[1] -Partial Points: 31.87%[1]	15	
5. Childhood Immunization Combo-3	-Full Points: 74.70%[1] -Partial Points: 70.80%[1]	15	
6. Asthma Medication Ratio	-Full Points: 62.28%[1]	15	
ACCESS & OPERATIONS (5 Points Total)			
7. Primary Care Utilization: ED Visits and PCP Office Visits	-Full Points: At or below target for ED visits AND at or above target for PCP office visits[3] -Partial Points: At or below target for ED visits[3]	5	Yes: By plan and PCP/site[3]

PATIENT EXPERIENCE (5 Points Total)			
8. CAHPS Survey for qualified sites, or Survey Option for all other sites	CAHPS surveys will be paid based on site's Access and Communication composites according to the following targets: -Full Points: Re-survey result ≥PHC 50th percentile score -Partial Points: Re-survey result between PHC 25th and 50th percentile scores Access 50th Percentile: 48.22% Access 25th Percentile: 43.07% Communication 50th Percentile: 71.78% Communication 25th Percentile: 69.01%	5	No

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning attestations	$5,000 for 50-99 attestations; $10,000 for 100+ attestations; in addition, $5,000 for 50-99 advance directives/POLST; $10,000 for 100+ advance directives/POLST for Medi-Cal members 18 years and older.
Access/Extended Office Hours	10% of Capitation for sites that 1) earned at least 35 points in previous QIP year and 2) are open for extended office hours as defined as eight hours beyond normal business hours per week.
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 ten groups per parent organization)
Alcohol Misuse Screening and Counseling	$5 per screening for screening a minimum of 10% of eligible adult members
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1000 incentive for showing continued participation with a local or regional health information exchange. The incentive is available once per parent organization.
Initial Health Assessment	$2000 for submitting all required parts of improvement plan
Palliative Care Identification & Referral	$2000 for sharing plan for identifying and communicating with potential palliative care patient and reporting the number of referrals made. The incentive is available once per parent organization.

Measure 1. *Well Child Visits*

Description

The percentage of continuously enrolled Medi-Cal members 3-6 years of age who received one or more well child visits with a PCP during the measurement year.

Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents.[2] Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood.[3] Well-care visits provide an opportunity for providers to influence health and development and they are a critical opportunity for screening.

Meeting and exceeding targets for annual well child visits is a challenge. Routine PCP contracts do not account for this. The QIP leverages this burden due in order to establish habitual preventive care for children.

Thresholds

- Full points: 90th percentile (83.70%)
- Half Points: 75th percentile (79.33%) or, if performance meets 50th percentile, 10% Relative Improvement

  Beginning in 2019, a site's performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (73.89%)

Denominator

The number of continuously enrolled Medi-Cal members 3-6 years of age as of December 31, 2019 (i.e. DOB between January 1, 2013 and December 31, 2016).

Numerator

The number of children in the eligible population with at least one well child visit with a PCP during the measurement year, between January 1, 2019 and December 31, 2019.

NOTE: To be eligible for eReports data entry, documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners considered PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

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

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 Value Set.

Exclusions (only if not numerator hit)

N/A

Measure 2. *Childhood Immunization Combo 3*

Description

The percentage of continuously enrolled Medi-Cal children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV).

Nowadays, the drop in disease rates in relies heavily on vaccination. The primary benefit of vaccination is that it prevents disease and saves lives. Immunization is considered one of the greatest public health achievements of the 20th century. Studies have showed that vaccines prevent 33,000 deaths in the U.S annually, and between two and three million deaths worldwide.[26] Coordinating and administering the large number of childhood immunizations is a challenge for providers and falls outside of general PCP contracts. The QIP incentivizes this measure to reduce costly treatment for sickness that can be prevented by utilizing the above vaccines.

Thresholds

- Full points: 75th percentile (74.70%)
- Half Points: 50th percentile (70.80%)

Denominator

The number of continuously enrolled Medi-Cal members who turn two years of age between January 1, 2019 and December 31, 2019 (DOB between January 1, 2017 and December 31, 2017).

Numerator

The number of eligible population in the denominator with the following:

For MMR, hepatitis B, and VZV, count any of the following:
- Evidence of the antigen or combination vaccine, ***or***
- Documented history of the illness, ***or***
- A seropositive test result for each antigen.

For DTap, IPV, HiB, and PCV count only:
- Evidence of the antigen or combination vaccine.

For combination vaccines that require more than one antigen (i.e., DTap and MMR), evidence of all the antigens must be found.

DTap: At least four DTaP vaccinations, with different dates of service, on or before the child's 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

IPV: At least three IPV vaccinations, with different dates of service, on or before the child's 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

MMR: Any of the following on or before the child's 2nd birthday meet criteria:
- At least one MMR vaccination
- At least one measles and rubella vaccination ***and*** at least one mumps vaccination or history of the illness on the same date of service or on different dates of service.

- At least one measles vaccination or history of the illness ***and*** at least one mumps vaccination or history of the illness ***and*** at least one rubella vaccination or history of the illness on the same date of service or on different dates of service.

Note: General Guideline 39 (i.e. the 14-day rule) does not apply to MMR.

HiB: At least three HiB vaccinations, with different dates of service, on or before the child's 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

Hepatitis B: Any of the following on or before the child's 2nd birthday meet criteria:

- At least three HepB vaccinations with different dates of service
  -One of the three vaccinations can be a newborn HepB vaccination during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the member's date of birth is December 1, the newborn HepB vaccination must be on or between December 1 and December 8.
- History of hepatitis illness

VZV: Either of the following on or before the child's 2nd birthday meet criteria:

- At least one VZV vaccination, with a date of service on or before the child's second birthday.
- History of varicella zoster (e.g. chicken pox) illness.

PCV: At least four PCV vaccinations, with different dates of service, on or before the child's 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:

- A note 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 administered.

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's 2nd birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for QIP reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be countered as evidence of DTaP. The burden on PCPs to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

Codes Used

Denominator: No codes applicable as eligibility is solely defined by age.

Numerator: Codes to identify DTaP vaccination: DTaP Vaccine Administered Value Set.
Codes to identify IPV vaccination: Inactivated Polio Vaccine (IPV) Administered Value Set.
Codes to identify MMR vaccination: Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set.
Codes to identify measles and rubella vaccination: Measles/Rubella Vaccine Administered Value Set.

Codes to identify mumps vaccination or history of the illness: Mumps Vaccine Administered Value Set; Mumps Value Set.
Codes to identify measles vaccination or history of the illness: Measles Vaccine Administered Value Set; Measles Value Set.
Codes to identify rubella vaccination or history of the illness: Rubella Vaccine Administered Value Set; Rubella Value Set.
Codes to identify HiB vaccination: Haemophilus Influenzae Type B (HiB) Administered Value Set.
Codes to identify HepB vaccination: Hepatitis B Vaccine Administered Value Set.
Codes to identify newborn hepatitis B vaccination: Newborn Hepatitis B Vaccine Administered Value Set.
Codes to identify history of hepatitis illness: Hepatitis B Value Set.
Codes to identify VZV vaccination: Varicella Zoster (VZV) Vaccine Administered Value Set.
Codes to identify history of VZV illness: Varicella Zoster Value Set.
Codes to identify PCV vaccination: Pneumococcal Conjugate Vaccine Administered Value Set.

Exclusions (only if not numerator hit)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the member's 2nd birthday meet optional exclusion criteria:

Any particular vaccine: Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set).

DTap: Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set).

MMR, VZV: Immunodeficiency (Disorders of the Immune System Value Set); HIV (HIV Value Set; HIV Type 2 Value Set); Lymphoreticular cancer, multiple myeloma or leukemia; Anaphylactic reaction to neomycin (Malignant Neoplasm of Lymphatic Tissue Value Set).

IPV: Anaphylactic reaction to streptomycin, polymyxin B or neomycin.

Hepatitis B: Anaphylactic reaction to common baker's yeast.

Measure 3. *Immunizations for Adolescents*

Description

The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and two doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Receiving recommended vaccinations is the best defense against vaccine-preventable diseases, including meningococcal meningitis, tetanus, diphtheria, pertussis (whooping cough) and human papillomavirus.[19,20] These are serious diseases that can cause breathing difficulties, heart problems, nerve damage, pneumonia, seizures, cervical cancer and even death.[21]

Meeting and exceeding targets for immunizations is great challenge for providers. Routine PCP contracts do not account for this. The QIP leverages the additional burden as a matter of public health and avoidance of costs associated with preventable illnesses.

Thresholds

- Full points: 75th percentile (37.71%)
- Half Points: 50th percentile (31.87%)

Denominator

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1, 2019 and December 31, 2019 (DOB between January 1, 2006 and December 31, 2006).

Numerator

The number of eligible population in the denominator who are numerator compliant for all three indicators (meningococcal, Tdap, HPV):

For meningococcal conjugate, Tdap and HPV, count only evidence of the antigen or combination vaccine.

Meningococcal: At least one meningococcal conjugate vaccine, with a date of service on or between the member's11th 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's10th and 13th birthdays.

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

- There must be at least 146 days between the first and the second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:

- A note 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 administered.

For meningococcal conjugate, do not count meningococcal polysaccharide or meningococcal recombinant (serogroup B) (MenB) vaccines. Generic documentation that the "meningococcal vaccine" was administered meets criteria.

Immunization documented using a generic header or "Tdap/Td" can be countered as evidence of Tdap. The burden on PCPs to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

Codes Used

Denominator: No codes applicable as eligibility is solely defined by age.

Numerator: Codes to identify meningococcal conjugate: Meningococcal Vaccine Administrated Value Set.
Codes to identify Tdap: Tdap Vaccine Administrated Value Set.
Codes to identify HPV: HPV Vaccine Administrated Value Set.

Exclusions (only if not numerator hit)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Contraindicated adolescents may be excludes only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011.

Measure 4. *Nutritional Counseling*

Description

The percentage of continuously enrolled Medi-Cal members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN during the measurement year and who had evidence of counseling for nutrition or referral for nutrition education during the measurement year.

Over the last three decades, childhood obesity has more than doubled in children and tripled in adolescents.[17] It is the primary health concern among parents in the United States, topping drug abuse and smoking.[18] Childhood obesity has both immediate and long-term effects on health and well-being.

Counseling on pediatric nutrition is not a requirement of normal PCP contracts. The QIP leverages this extra task because establishing proper nutrition habits at a younger age can prevent future health care costs associated with improper nutrition or obesity.

Thresholds

- Full points: 90th percentile (83.45%)
- Half Points: 75th percentile (77.91%) or, if performance meets 50th percentile, 10% Relative Improvement

  Beginning in 2019, a site's performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (69.57%)

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31, 2019 (DOB between January 1, 2002 and December 31, 2016) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

Numerator

The number of children in the eligible population with evidence that counseling for nutrition or referral for nutrition education was documented at least once during the measurement year.

To be eligible for eReports data entry, documentation must include the 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.

Codes Used

Denominator: Codes to identify Outpatient Visits from Claims/Encounter Data: Outpatient Value Set.

Numerator: Codes to identify counseling for nutrition from claim/encounter data: (Nutrition Counseling Value Set).

Exclusions (only if not numerator hit)

Members who have a diagnosis of pregnancy during the measurement year.

Codes to identify exclusions: Pregnancy Value Set.

Measure 5. *Physical Activity Counseling*

Description

The percentage of continuously enrolled Medi-Cal members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN during the measurement year and who had evidence of counseling for physical activity or referral for physical activity during the measurement year.

Over the last three decades, childhood obesity has more than doubled in children and tripled in adolescents.[17] It is the primary health concern among parents in the United States, topping drug abuse and smoking.[18] Childhood obesity has both immediate and long-term effects on health and well-being.

Counseling on pediatric physical activity is not a requirement of normal PCP contracts. The QIP leverages this extra task because establishing proper exercise habits at a younger age can prevent future health care costs associated with a sedentary lifestyle or obesity.

Thresholds

- Full points: 90th percentile (78.35%)
- Half Points: 75th percentile (71.29%) or, if performance meets 50th percentile, 10% Relative Improvement

  Beginning in 2019, a site's performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (63.50%)

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31, 2019, (DOB between January 1, 2002 and December 31, 2016) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

Numerator

The number of children in the eligible population with evidence that counseling for physical activity or referral for physical activity was documented at least once during the measurement year.

To be eligible for eReports data entry, documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- 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 specific to the child's physical activity.
- Weight or obesity counseling.

Codes Used

Denominator: Codes to identify Outpatient Visits from Claims/Encounter Data: Outpatient Value Set.

Numerator: Codes to identify counseling for physical activity from claim/encounter data: Physical Activity Counseling Value Set.

Exclusions (only if not numerator hit)

Members who have a diagnosis of pregnancy during the measurement year.

Codes to identify exclusions: Pregnancy Value Set.

Measure 6. *Asthma Medication Ratio*

Description

The percentage of continuously enrolled Medi-Cal members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater between January 1, 2019 and December 31, 2019.

The Asthma Medication Ratio is a measure to help providers assess the quality of asthma care received by their patients with persistent/chronic asthma. Studies have shown that the AMR to be a better predictor of acute asthma exacerbations than any prior measure of controller medication use.[28] Routine PCP contracts do not account for this. The QIP incentivizes this measure to increase the quality of asthma care and reduce the cost of asthma exacerbations.

Thresholds

- Full points: 50th percentile (62.28%)
- No partial point is available for this measure

Definition

Oral Medication Dispensing Event:

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30) = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days' supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

Refer to the definition of oral medication dispensing event in MMA for examples.

Inhaler Dispensing Event:

When identifying the eligible population, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the Drug ID field in the NDC list to determine if the prescriptions are the same or different.

Injection Dispensing Event:

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different

medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Allocate dispensing events to the appropriate year based on the date on which the prescription is filled.

Units of Medications:
When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication. For example, two inhalers canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event

Use the package size and units columns in the NDC list to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10g and pharmacy data indicates the dispensed amount is 30g, this indicates three inhalers canisters were dispensed.

Denominator

The number of continuously enrolled Medi-Cal members 5-64 years of age as of December 31, 2019 (DOB between January 1, 1955 and December 31, 2014).

Follow the steps below to identify the eligible population:

Step 1: Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least one ED visit, with a principal diagnosis of asthma.
- At least one acute inpatient encounter, with a principal diagnosis of asthma.
- At least four outpatient visits or observation visits, on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events (Table MMA-A).

Step 2: A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any settings, in the same years as one leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

Step 3: Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year.
  -Emphysema Value set.
  -Other Emphysema Value Set.
  -COPD Value Set.
  -Obstructive Chronic Bronchitis Value Set.
  -Chronic Respiratory Conditions Due To Fumes/Vapors Value Set.
  -Cystic Fibrosis Value Set.
  -Acute Respiratory Failure Value Set.
- Members who had no asthma medications (controller or reliever) dispensed (Table AMR-A) during the measurement year.

Numerator

The number of eligible population in the denominator who have a medication ratio of 0.50 or greater between January 1, 2019 and December 31, 2019. Following the steps to calculate the ratio.

Step one: For each member, count the units of controller medications (Table AMR-A) dispensed between January 1, 2019 and December 31, 2019. Refer to the definition of *Units of medications.*

Step two: For each member, count the units of reliever medications (Table AMR-A) dispensed between January 1, 2019 and December 31, 2019. Refer to the definition of *Units of medications.*

Step three: For each member, sum the units calculated in step one and step two to determine units of total asthma medications.

Step four: For each member, calculate the ratio of controller medications to total asthma medications using the following formula.

$$\frac{\text{Units of Controller Medications (step1)}}{\text{Units of Total Asthma Medications (step3)}}$$

Step five: Sum the total number of members who have a ratio of 0.50 or greater in step four.

Table AMR-A: Asthma Controller and Reliever Medications

ASTHMA CONTROLLER MEDICATIONS	
Description	**Prescriptions**
Antiasthmatic Combinations	Dyphylline-guaifenesin, Guaifenesin-theophylline
Antibody inhibitors	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone, Flunisolide, Budesonide , Fluticasone, CFC free Ciclesonide, Mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Max cell stabilizers	Cromolyn
Methylxanthines	Aminophylline, Dyphylline, Theophylline
ASTHMA RELIEVER MEDICATIONS	
Description	**Prescriptions**
Short-acting, inhaled beta-2 agonists	Albuterol, Levabuterol, Pirbuterol

Table MMA-A: Asthma Medications

Description	Prescriptions
Antiasthmatic Combinations	Dyphylline-guaifenesin, Guaifenesin-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone, Flunisolide, Budesonide, Fluticasone, CFC free Ciclesonide, Mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Max cell stabilizers	Cromolyn
Methylxanthines	Aminophylline, Dyphylline, Theophylline

Short-acting, inhaled beta-2 agonists	Albuterol, Levabuterol, Pirbuterol

Codes Used

Denominator:

Codes to identify ED visit: ED Value Set.
Codes to identify a principal diagnosis of asthma: Asthma Value Set.
Codes to identify acute inpatient encounter: Acute Inpatient Value Set.
Codes to identify outpatient visit: Outpatient Value Set.
Codes to identify observation visit: Observation Value Set.

Numerator: No codes applicable as eligibility is solely based on medication ratio.

Exclusions (only if not numerator hit)

N/A

Measure 7. *Primary Care Utilization*

Description

Two part measure rewarding low ED usage as well as high primary care access as measured by the number of PCP office visits.

Providers are often empaneled with a large number of patients for whom they are expected to establish care. Controlling the number of avoidable ED visits requires addressing patient access to care and influencing an individual's health behaviors, both of which are external to routine PCP contracts. Additionally, routine PCP contracts do not demand a certain number of visits each year. This measure exists to encourage providers to focus on this access issue, and to help curb the high costs associated with preventable ED visits. Providers are incentivized to integrate ED visit prevention into a strategy to make sure patients are establishing care with their assigned PCP.

Thresholds

- Full points: At or below target for ED visits AND at or above target for PCP office visits
- Partial points: At or below target for ED visits

Targets are set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets will be sent in Spring 2019.

Data Criteria

A three month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

PHC will calculate the total eligible non-dual capitated member months after the month-end eligibility reconciliation load from the State. Member months are calculated by counting the total number of members who are eligible at the end of each month.

ED Visits: PHC will extract facility or professional claims with a location code indicating an Emergency Department, using allowable PHC claim and encounter data, for services provided to the PCP site's assigned members. Only claims with at least one of the diagnoses codes included in the Avoidable ED tab in the Code List will be included. The presence of at least one diagnosis code not considered avoidable will deem the visit as not avoidable.

Step 1: Identify total members assigned to PCP during each month.

Step 2: For those members, obtain all ED facility claims and professional claims.

Step 3: An ED visit is avoidable if every diagnosis code associated with an ED episode (both professional and facility claims) is included in the list of avoidable diagnoses codes.

Calculation

*Avoidable ED Visits per 1000 = (Avoidable ED visits / Non-Dual Capitated Member Months)*12,000*

PCP Office Visits: PHC will extract the total number of PHC office visits using allowable PHC claim and encounter data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site. An estimate for incurred but not yet paid/processed claims data will be included.

Step 1: Identify total members assigned to PCP during each month.

Step 2: For those members, identify all their PCP office visits by procedure codes during that month, regardless of who the provider of the visit is, that occur in the following locations: office, home or private residence of patient, FQHC, State or local health clinic, or Rural Health Clinic.

Step 3: To calculate monthly performance for a specific provider site, divide the total number of PCP office visits by assigned members that month by the total number of non-dual capitated member months that month.

Step 4: To calculate YTD performance for a specific provider site, add up all the monthly numerators (visits by assigned members) and monthly denominators (non-dual capitated member months).

Note: it is possible that the numerator may contain visits for members who are not in the denominator, because of retroactive enrollment changes.

Calculation:

*PCP Office Visits PMPY= (# Office Visits/ Non-Dual Capitated Member Months)*12*

Codes Used

Codes to identify service location as ED: Avoidable ED Inclusion – Location Code on Code List
Codes to identify ED claims type (facility or professional): Avoidable ED Inclusion – ED Claims Type on Code List
Codes to identify ED Avoidable Diagnosis Codes: Avoidable ED Inclusion – Primary Diagnosis ICD9/10 on Code List
Codes to identify office visits location: OV Inclusion – Location Code on Code List
Codes to identify office visits: OV Inclusion – Procedure Code on Code List
Codes to identify void or denied claims in exclusions: OV Exclusion – Explain Code on Code List

Exclusions

Members age <1 for Avoidable ED Visits

Void claims and denied claims with certain explanation codes (See Code List – OV Exclusion) for PCP office visits

VI. PATIENT EXPERIENCE — MAXIMUM NUMBER OF POINTS: 5

Measure 8. *Patient Experience*

Description

This measure aims to improve the patient experience. There are two ways in which to earn points:

- PHC contracts with a vendor to conduct the Consumer Assessment of Healthcare Providers and System (CAHPS) survey once during the measurement year;

OR

- PCP conducts a survey to understand the patient experience and reports results and findings using the submission template

CAHPS: Providers that have sufficient PHC patient volume can earn up to a maximum of 10 points on their performance on the Access and Communication composites in the Clinician-Group CAHPS survey.

Survey Option: This option allows providers to fulfill the requirements by soliciting feedback from patients and implementing changes to improve the patient experience.

Refer to the Thresholds section below for detailed specifications.

Patient feedback can help providers capture the patient's voice, gain more understanding of the patient population, and target specific improvement areas to improve the overall quality of health service delivery. PCP contracts do not account for this. This measure can incentivize providers to understand more about patients' need and save future costs by identifying the right patient concerns and utilizing resources efficiently.

Thresholds

1) **CAHPS**

Providers that have sufficient PHC patient volume can earn up to a maximum of 5 points for meeting performance thresholds in key measures in the Clinician & Group CAHPS 3.0 survey. The validated tool can be found here: http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html. Sites will be notified by May 1, 2019 whether or not they meet sufficient volume for inclusion in the CAHPS survey. A third-party vendor hired by PHC will conduct the survey independently.

Sufficient patient volume is defined as having at least one visit by 1200 unique PHC members between April 1, 2018 and March 31, 2019 at the parent organization level. If a site does not belong to any parent organization, it is considered a parent organization for this measure. The survey results will be analyzed at the parent organization level. Eligible population includes assigned members with at least one unique visit or special members with at least two visits during this period. Members 13-17 years of age are excluded. Adults and children will be surveyed separately.

Payment methodology: Providers will earn points by meeting the performance targets set based on the baseline survey conducted in 2018. If both the adult and child CG-CAHPS surveys are conducted at your site, you will be paid based on the higher of the two results. We will pay for the Access and Communication composites according to the following targets:

- Full points (2.5 points for each composite): Re-survey result ≥ PHC 50th percentile score
- Half points (1.25 points for each composite): Re-survey result between PHC 25th and 50th percentile scores

The 2019 targets will be based on 2018 survey results:

	Access	Communication
Median (≥ 50th Percentile)	48.22%	71.78%
≥ 25th - < 50th Percentile	43.07%	69.01%

OR

2) Survey Option

Sites that do not meet the patient volume threshold can conduct an internal survey and report results using the template found in Appendix I. There are two parts to this option. Please follow the steps below accordingly. Sites can describe existing survey efforts, such as the NCQA PCMH survey.

Part I (2.5 points):

1) Implement a survey which must include at least two questions regarding access to care (questions do not need to come from the CAHPS survey, although we encourage using CAHPS or another well vetted survey). Collect at least 100 responses per site.
2) Analyze baseline data, select measures from survey to target for improvement, identify change(s) to implement, and report on successes and challenges in the Survey Option Part I submission template.

Part II (2.5 points):

3) Implement change(s) for improvement.
4) Re-measure patient experience using the same survey at least once after implementing changes.

Submission Process

Only sites that use the Survey Option (i.e. sites that do not meet the patient volume threshold) are required to submit data. For the Surveys, submit the Patient Experience Submission Template (Appendix I) via fax or e-mail to QIP@PartnershipHP.org. Part I is due on July 31, 2019 and Part II January 31, 2020.

Exclusions

N/A

Measure 9. *Advanced Care Planning*

Description

This measure pays for both the process and the outcome of advance care planning discussions. Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members over the age of 18. Providers will receive $5,000 for submitting records of 50-99 approved discussions, and $10,000 for submitting 100 or more approved discussions. In addition, providers will receive $5,000 for submitting 50-99 records of approved advanced directives or POLST forms, and $10,000 for submitting 100 or more records of approved advanced directives or POLST forms. The count of discussions is separate from the combined count of advanced directives and POLST forms.

The purpose of this measure is to encourage providers to integrate these important planning discussions with patients into their standard practices. Advanced care planning is valuable across the spectrum of needs. Planning for end of life care has been shown to reduce offered yet sometimes unwanted treatments. Ultimately, ACP helps ensure that unnecessary treatments are not conducted, and can result in a large cost savings. A study published in JAMA on October 5, 2011, showed that a patient dying with an advanced directive had $5585 less in hospital cost than a patient who dies without an advanced directive.

Measure Requirements

Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members over the age of 18 after a threshold is met. Providers will receive $5,000 for submitting records of 50-99 approved ACP conversations. Providers will receive $10,000 for submitting records of 100 or more approved ACP conversations.

In addition, providers will receive $5,000 for submitting 50-99 approved records of advanced directives or Physician Orders for Life-Sustaining Treatment (POLST) forms. Providers will receive $10,000 for submitting records of100 or more approved advanced directives or POLST forms. The counts of POLST and advanced directive completion will be combined, while the ACP conversations are separate.

ACP discussions must take place between January 1, 2019, and December 31, 2019 in order to be eligible for this measure.

Note that ACP is a covered benefit and can be reimbursed. If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC's Claims Department to identify conversations that have been reimbursed. Also note that this measure is not exclusive to patients with a life-limiting disease or condition.

<u>Provider sites that have 50-100 assigned members are eligible for this measure with the following conditions:</u>

- Attestation: 50% of assigned membership over the age of 18 must have an attestation for an ACP discussion, which will be reimbursed for $100 each.
- Advanced Directive and/or POLST: 30% of the assigned membership over the age of 18 must have a submitted AD or POLST which will be reimbursed for $100 each.
- The total payment for each count must be under $5,000.

<u>Advance Directive and/or POLST:</u>
Only one record of each form per patient per measurement year. If a patient has a previously completed form and does not wish to make any changes, documentation of a conversation during the measurement

period confirming that no change will qualify.

Attestation:
Only one conversation per patient per measurement year. In addition to patient identification information including name, CIN, and date of birth, the following components are required to be documented in the chart for a provider to attest to the completion of an ACP discussion:

- Conversation about patient goals, general preferences around end of life, and prognosis (if appropriate)
- Documentation of conversation with family or recommendation for patient to talk with family
- Status of the Advance Directive:
    - Discussed
    - Given to patient
    - Completed
    - Copy in chart
    - Patient refused
- Summary of patient wishes, whether from conversation or from an Advanced Directive. Some options include:
    - Full treatment
    - Comfort care
    - Hospice
    - DNR
    - DNI
    - Other (tube feeds and blood transfusion and transfer to hospital are common items)
- If a POLST is appropriate, some status options include:
    - Discussed
    - Given to patient
    - Completed
    - Copy in chart
    - Patient refused
- Plan for next conversation.

Submission Process

Beginning in 2019, this Unit of Service measure will utilize the eReports system for submitting records of ACP discussions and forms. Once available in Spring 2019, providers must utilize the templates found within eReports to submit documentation for individual patients. Faxed or e-mailed attestation forms will not be accepted. Submissions are due to Partnership no later than January 31, 2020. Payments will be made on an annual basis.

eReports Upload Specifications:
- Attestation/Advance Directive/ POLST date of service in the measurement year.
- Member must be eligible on the Attestation/Advance Directive/ POLST date of service.
- Member Age: 18 years of older as of the date of service.
- Member must have PHC as the primary insurance carrier and not have any record of other insurance during the measurement year.

- Member will only be counted once in the measurement year.

Exclusions

If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC's Claims Department to identify conversations that have been reimbursed. If a member's eligibility status changes during the measurement year, the site's count of accepted attestations may change.

Measure 10. *Extended Office Hours*

Description

For PCP sites that earned a minimum of 35 points in the prior QIP measurement period, providers receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

PCP sites that are part of a large organization and within a five mile radius of each other are eligible for the increased cap.

Example 1: A parent organization has two sites within five miles of each other (Site A and Site B). Site A meets the criterion for holding extended office hours. Site B does not hold extended office hours. Since Site B is within a five mile radius, patients who are seen at Site B can easily access Site A during the extended hours of service. Both Site A and Site B are eligible for the payment.

Example 2: Site A and Site B are located 15 miles apart. Only Site A holds extended office hours and meets the criterion. In this scenario, Site A is eligible for the payment but Site B is not eligible for the payment.

Continuity of care is a central goal of primary care improvement efforts nationwide, because physician's offices with office hours during the weekends and evenings allow patients more opportunities to be seen, yielding opportunities for improved health outcomes, more patient satisfaction, and lower healthcare costs. Efforts in this area are not addressed in routine PCP contracts.

Measure Requirements

PCP sites must have earned a minimum of 35 points in the 2018 QIP measurement period in order to be eligible for this measure. PCP site must be open an additional eight hours per week or more, beyond the normal business hours, defined as Monday-Friday, 8:00 a.m. to 5:00 p.m., for the entire quarter.

No award if, during a quarter, the practice site no longer offers extended office hours or reduces the hours and no longer meets the eight hour minimum.

Submission Process

Partnership's Provider Relations department keeps track of extended office hours. No submission is required for this measure. Payment is in accordance with information listed on the Provider Directory.

Exclusions

An exception to this measure is made for any PHC site with less than 2000 members and more than 30 minute drive to the nearest ED. They would need to demonstrate the following:

- Have on-call arrangements available where by the on-call physicians come to the office to see urgent problems (arrangement to be submitted in writing annually to the PR representative of your county, including what types of urgent issues will be seen in the office) after hours. Deadline to submit arrangement is March 30, 2020.

- Demonstrate the use of arrangement with at least three PHC members seen in the office after hours per quarter, to be submitted quarterly by the site to their Provider Relations representative of your county. Deadlines are as follows:

- Q1: March 31, 2019
- Q2: June 30, 2019
- Q3: September 30, 2019
- Q4: December 31, 2019

Please note this measure is subject to an audit by the Provider Relations department.

VII. UNIT OF SERVICE $1,000 PER SITE

Measure 11. *Patient-Centered Medical Home Recognition*

Description

$1000 yearly incentive for achieving or maintaining PCMH accreditation from NCQA, or equivalent from AAAHC or JCAHO.

Accomplishing excellent levels of service, care integration, and panel management are goals external to routine PCP contracts. This measure incentivizes providers to improve standards of care across their panels of patients, achieve recognition from established quality organizations, and maintain accreditation.

Refer to Appendix II for submission template for this measure.

Measure Requirements

Primary care provider sites with a minimum of 50 assigned Partnership members. Sites must receive accreditation, maintain accreditation, or re-certify within the measurement year. Documentation of PCMH recognition, accreditation maintenance, or re-certification from NCQA, AAAHC, or JCAHO must be faxed or emailed to QIP@partnershiphp.org by January 31, 2020.

Submission Process

You may refer to (Appendix II) for the documentation template, which can be faxed or emailed to QIP@partnershiphp.org by January 31, 2020.

Exclusions

Primary care provider sites with fewer than 50 assigned Partnership members.

Measure 12. *Peer-Led Self-Management Support Groups*

Description

Payment for starting or continuing a peer-run self-management support group at a contracted primary care provider site ($1,000 per group).

Hosting and leading support groups for various health needs is not part of routine PCP contracts. They are not considered a routine part of primary care. Incentivizing this measure allows for patients to receive additional support for needs that affect their overall health and overall health expenditures.

Refer to Appendix III for submission template for this measure.

Measure Requirements

Primary care provider sites with a minimum of 50 assigned Partnership members.

Qualifying peer groups must meet at least four times in the 2019 calendar year and have a peer-facilitation component and a self-management component. Group can serve both PHC and non-PHC members, but must include at least 16 PHC total member visits per year (For example, if there are four PHC members in the group and the group meets for four sessions, the group will meet this criterion). The groups may be general, for patients with a variety of conditions, or focused on specific diseases or conditions, such as: Diabetes, Rheumatoid Arthritis, Chronic Pain, Hepatitis C, Cancer, Congestive Heart Failure, COPD, Asthma, Depression, Anxiety/Stress, Substance use, Pregnancy.

The following components have to be submitted in order to qualify for this incentive:

1. Name of group
2. Name and background information/training of group facilitator
3. Site where group visits took place
4. Narrative on the group process that includes: location and frequency of the group meetings
5. List of major topics/themes discussed at each meeting
6. A description of the way that self-management support is built into the groups
7. An assessment of successes and opportunities for improvement of the group
8. Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and dates of meetings

Maximum number of groups eligible for payment:

- Up to a maximum of 10 per parent organization

Documentation will be reviewed and approved by the CMO or physician designee. Proposed groups may submit elements 1-7 above prospectively for review and feedback at any time in the year, before groups start, to ensure program will be eligible for bonus.

Examples of the curriculum and evidence base for this approach can be found at: http://patienteducation.stanford.edu/programs/

Submission Process

All documentation must be submitted on the Peer-led Self-Management Support Group template (Appendix III) by January 31, 2020, and can be faxed or emailed to QIP@partnershiphp.org.

Exclusions

Primary care provider sites with fewer than 50 assigned Partnership members.

Measure 13. Alcohol Misuse Screening and Counseling

Description

This measure incentivizes providers to screen and counsel patients for alcohol misuse using standardized tools. Providers receive the incentive provided that they screen a minimum of 10% of eligible members.

Substance abuse is associated with additional adverse health outcomes and costs. Screening for abuse is not a part of routine PCP contracts. However, the QIP leverages this incentive in order to ensure providers are identifying a potential need that could be tied to other risky behaviors.

Measure Requirements

Primary care provider sites with a minimum of 50 assigned Partnership members.

The following code will be used to pull the total number of screenings:

- G0442 (Alcohol screening)
- G0443 (Alcohol counseling)

PHC's claim system will validate and pay for up to two screenings for an individual every six months. Sites that hit the 10% target will earn a site-specific incentive.

We use the following formula to determine each site's screening rate:

$$\frac{Number\ of\ screenings\ billed\ with\ HCPCS\ codes\ G0442\ and\ G0443}{Number\ of\ assigned\ adult\ members}$$

We use the following formula to determine the financial incentive the site is eligible for:

Number of Screenings*$5

Submission Process

PHC will extract this data three months after the end of the reporting year (i.e. March 31, 2020) by identifying claims for G0442 and G0443 submitted through the claims department.

Exclusions

Primary care provider sites with fewer than 50 assigned Partnership members.

Claims submitted in excess of two screenings per individual patient within a six month time frame.

Measure 14. *Health Information Exchange Participation*

Description

Sites will be reimbursed for participating in a local or regional health information exchange (HIE). Sites that first establish linkage during the 2019 measurement year are eligible to earn $3,000. Sites that can show continued linkage and utilization of an HIE prior to the 2019 measurement year are eligible to earn $1,500.

Electronic HIE allows doctors, nurses, pharmacists, and other health care providers to appropriately access and securely share a patient's vital medical information electronically. Providing physicians with information regarding their patients' significant hospital events allows for more streamlined follow-up care, considering access to this information via claims data can potentially take anywhere from 60-90 days after an episode of care is delivered. HIE interface has been associated with not only an improvement in hospital admissions and overall quality of care, but also with other improved resource use: studies found statistically significant decreases in imaging and laboratory test ordering in EDs directly accessing HIE data. In one study population, HIE access was associated with an annual cost savings of $1.9 million for a hospital.[24]

Establishing and maintaining a connection with a local health information exchange can be costly and is outside the parameters of routine PCP contracts. The measure seeks to make important health information available to local health care systems in order to reduce duplicative care and potentially risky care decisions.

Measure Requirements

Provider sites must specify on the Submission Template when linkage was established. In order to qualify for the incentive, linkage with the HIE has to be established by:

- Sending an HL7 Patient Visit Information to the HIE
    - The HL7 PV1 segment contains basic inpatient or outpatient encounter information and consists of various fields with values ranging from assigned patient location, to admitting doctor, to visit number, to servicing facility.

OR

- Sending CCD document to the HIE
    - The Continuity of Care Document summarizes a patient's medical status for the purpose of information exchange. The content may include administrative (e.g., registration, demographics, insurance, etc.) and clinical (problem list, medication list, allergies, test results, etc.) information. This component defines content in order to promote interoperability between participating systems such as Personal Health Record Systems (PHRs), Electronic Health Record Systems (EHRs), Practice Management Applications and others.

OR

- Retrieving clinical information (such as labs, images, etc.) from the HIE.

Recognized Community Health Information Exchange organizations include the following:

- Sac Valley Med Share
- North Coast Clinical Information Network

- Redwood Med Net
- Connect Healthcare
- Jefferson HIE

Linkage to other HIEs may also qualify for the incentive; submission of justification will be reviewed on a case-by-case basis.

Submission Process

Submit the HIE Attestation form (Appendix IV) by January 31, 2020. PHC will validate the data exchange by working directly with the specified HIE.

Exclusions

N/A

Measure 15. *Initial Health Assessment Improvement Plan*

Description

Providers are mandated by the state of California to schedule patients within 120 days of becoming a PHC member for an IHA (Initially Health Assessment) including the following criteria:

- Physical and mental history
- Identification of high-risk behaviors
- Assessment of need for preventative screenings or services, and health education
- Diagnosis and plan for treatment of any diseases
- A completed SHA (Staying Healthy Assessment)
- Providers that have sufficient PHC patient volume can earn an annual Unit of Service measure payout of $2000 based on submission of template form outlining data collection plan and documentation of process to improve site compliance for the IHA. The intent in this introductory year is to encourage IHA improvement plan development. Expect this measure to evolve in future iterations to include a reporting element, demonstrating impact of implementing an approved plan.

Completion of the IHA will help providers to determine current, acute, chronic and preventative needs in a comprehensive and timely manner, potentially addressing problems sooner and lowering overall healthcare costs.

Refer to Appendix V for submission template for this measure.

Measure Requirements

Providers that have sufficient PHC patient volume can earn a one-time annual payment based on points earned for completing and turning in an IHA Improvement Plan.

Sufficient patient volume to participate is defined as having at least one visit by 1200 unique PHC members between April 1, 2018 and March 31, 2019 at the entity level. If a site does not belong to any entity, it is individually considered an entity for this measure. This criterion mirrors the eligibility requirement for the Patient Experience – CAHPS survey, which means that a site is eligible to participate if it received CAHPS results from PHC in 2018.

Submission Process

Submit completed template via fax or email to QIP@partnershiphp.org. Submissions are due to Partnership no later than 1/31/2020. Payments will be made on an annual basis. Refer to Appendix V for IHA template.

Exclusions

Sites with a patient volume less than 1200 unique members with visits between April 1 2018 and March 31, 2019.

Measure 16. *Palliative Care Identification and Referral*

Description

Sites will be rewarded for submitting a plan for identifying and communicating with adult patients who would qualify for intensive outpatient palliative care.

Palliative care is defined as: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice." (Centers for Medicare and Medicaid Services) Major topics covered in a typical palliative care conversation include defining the patient's goals of care, and planning for future intensity of care provided (Advance Care Planning) which may include defining specific patient plans for future and documenting them in the form of an Advance Directive or Physician Order for Life Sustaining Treatment (POLST).

Increasing the utilization of intensive outpatient palliative care is a key strategic initiative of Partnership HealthPlan that falls outside of the usual scope of primary care contracts. Leveraging the primary care network to identify patients that would benefit from intensive outpatient palliative care will further PHC's initiative and offer an appropriate level of care for vulnerable patients. A provider site that meets this measure indicates full understanding of palliative care needs and goals.

PHC has contracted providers of Intensive Outpatient Palliative Care services in all the counties served, beginning in 2018. A list of providers with contact information can be found in PHC's Provider Directory. For reference, a description of the Intensive Outpatient Palliative Care Program can be found in policy MCUP 3137 on the PHC website. Patients with Medicare are not eligible for PHC's Intensive Outpatient Palliative care program, but your local palliative care organization may have some capacity to accept some of these; check with them to be sure.

Only sites classified as adult medicine or family medicine will qualify. Sites must have at least 1000 assigned adults to qualify.

Measure Requirements

This measure requires providers to submit a form detailing the process and criteria used for identifying which, if any, primary care patients are suitable candidates for outpatient palliative care as defined below. Providers should complete the submission template found as Appendix VI. A minimum of one referral accepted into outpatient palliative care services must be documented in order for the submission to qualify.

Some general criteria for identifying palliative care patients among those with qualifying diagnostic criteria include (1) poor functional status (a palliative performance score of 70 or less) and (2) the potential for death within the next 12 months would not be unexpected.

The submission form should indicate the process used to identify

1. each of the disease specific criteria (below)
2. criteria to determine which patients with applicable diagnoses are suitable for referral to an intensive outpatient palliative care program
3. criteria to determine which patients with applicable diagnoses are NOT suitable for referral to an intensive outpatient palliative care program
4. A detailed process being planned for outreaching to patients suitable for intensive outpatient palliative care, including the proposed timeline, person responsible and measures of progress/success that will be

followed.

5. A detailed process for referring patients to the appropriate palliative care organization, once member has agreed to participate

Disease Specific Criteria

1. Congestive Heart Failure (CHF); Member must meet (a) and (b)
    a) The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, AND
    b) The member has an ejection fraction of < 30% for systolic failure OR significant comorbidities.
2. Chronic Obstructive Pulmonary Disorder (COPD): Member must meet (a) or (b)
    a) The member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
    b) The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
3. Advanced Cancer: Member must meet (a) and (b)
    a) The member has a diagnosis of stage III or IV solid organ cancer, lymphoma, or leukemia, AND
    b) The member has Performance Scale (KPS) score less than or equal to 70, or has failure of two lines of standard chemotherapy.
4. Liver Disease: Member must meet (a) and (b) combined, or (c) alone
    a) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND
    b) The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
    c) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
5. End Stage Degenerative Neurologic Condition, dependent on a ventilator for respiratory support
    a) ALS, Multiple Sclerosis, Muscular Dystrophy, End Stage Myasthenia, Other end stage neuro-degenerative condition dependent on a ventilator for respiratory support
    b) Dementia and Frailty are not covered under this extended benefit

Submission Process

Submit completed template via fax or email to QIP@partnershiphp.org. Submissions are due to Partnership no later than **July 1, 2019**. Payments will be made on an annual basis. Refer to Appendix VI for Palliative Care Referral submission template.

Exclusions

N/A

Appendix I: Patient Experience Survey Submission Template

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program – Patient Experience

Survey Submission Template and Example

Due date for Part I submission: July 31, 2019
Due date for Part II submission: January 31, 2020

Below you will find the submission template and example for the Survey Option. This is a guide for your submission, and if you decide to not use it, points will still be rewarded as long as all areas are addressed in your submission. For detailed instructions, please refer to the Measure Specifications.

Survey: Part I Submission Template

(Due July 31, 2019)

1. Attach a copy of the survey instrument administered (Survey must include at least two questions on access to care. For examples of access questions, please refer to the CAHPS questions listed on the last page of this document)

2. Provide descriptions for the following:

   a. Population surveyed

   b. How the survey was administered (via phone, point of care, web, mail, etc.)

   c. The time period for when the surveys were administered

   d. Total number of surveys distributed

   e. Total number of survey responses collected/received

   f. Response Rate

3. Based on the results from your survey, what specific measure(s) have you selected to improve?

4. For each measure or composite of questions selected for improvement, what is your specific objective?

5. For the measures selected for improvement, describe the specific changes/interventions/actions you believe will improve your performance.

Submitted by _____ (Name & Title) **on** _____ (Date)

Survey: Part II Submission Template

(Due January 31, 2020)

1. Describe specific changes/actions/interventions you implemented to improve your performance in the measures you selected in Part I. Include specific timelines, who implemented the changes, and how changes were implemented.

2. Provide descriptions for the following for your re-measurement period:

   a. Population surveyed

   b. How the survey was administered (via phone, point of care, web, mail, etc.)

   c. The time period for when the surveys were administered

   d. Total number of surveys distributed

   e. Total number of survey responses collected/received

   f. Response Rate

3. Comparing your re-measurement period (s) to baseline and other sources of data, did you observe improvements in the measures targeted? Did you meet your stated objectives in your improvement plan? Please describe changes in performance and which changes you believe contributed to improvements observed.

4. What challenges did you experience and how did you overcome these?

Submitted by _____ (Name & Title) **on** _____ (Date)

EXAMPLE
Note: Sample text is provided in blue **font**
Survey: Part I Submission

1. Attach a copy of the survey instrument administered: See below

Dear Patient,

We want every patient to have a positive experience every time they come to our clinic. We would like to know how you think we are doing. Please take a few minutes to fill out this survey and drop it off at the comment box on your way out. Thank you so much.

Please rank the following statements based on your visit today:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be.				
2. The non-clinical staff at this office were friendly to me.				
3. The non-clinical staff at this office addressed my concerns adequately.				
4. I was given more than one option in terms of how and when to schedule the next appointment.				
5. I felt comfortable asking the non-clinical staff questions.				
6. When I called for an appointment, the wait time was reasonable.				
7. I was given an appointment when I wanted it.				
8. I feel confident that my personal information is kept private.				
9. Charges were explained to me clearly.				

2. Provide descriptions for the following

   a. Population surveyed

   b. How the survey was administered (via phone, point of care, web, mail, etc.)

   c. The time period for when the surveys were administered

   d. Total number of surveys distributed

   e. Total number of survey responses collected/received

   f. Response Rate

   Between March 1, 2019 and May 1, 2019, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 20198. The first mailing was sent on March 1, followed by a second mailing on April 15. 500 surveys were mailed and 250 surveys were returned; yielding a 50% response rate.

3. Based on the results from your survey, what specific measures in the survey have you selected to improve?

   "I was given an appointment when I wanted it."

4. For each selected measure or composite of measures selected for improvement, what is your specific objective?

   80% of patients surveyed will select "strongly agree."

5. For the measures selected for improvement, describe the specific changes/interventions/actions you believe will improve your performance.

   To improve the appointment wait times, our clinic will test adding same day appointments and extending visit intervals for well controlled patients with chronic conditions to improve the time it takes to get a routine appointment.

Submitted by Elizabeth Jones (QI Director) (Name & Title) **on** July 10, 2019 (Date)

EXAMPLE
Note: Sample text is provided in blue **font**
Survey: Part II Submission

1. Describe specific changes/actions/interventions you implemented to improve your performance in the measure(s) you selected in Part I. Include specific timelines and who implemented the changes and how changes were implemented.

   We had a consultant train our site over a two-month period (June- July 2018) on how to add same day appointments. The trainings included improvements to our scheduling system such as reducing the number of appointment types from 50 to 4. We developed and implemented scripts for the front desk staff so that they can educate our patients on the change in scheduling. We also collected data daily on our patient demand, supply and activity. This helped us determine where we can shift appointment slots based on our demand and corresponding supply. We also tried extending visit intervals for our well controlled patients with diabetes. Rather than bringing them in every 3 months, we now bring them in every 6 months.

2. Provide descriptions for the following for your re-measurement period:

   a. Population surveyed:

   b. How the survey was administered (via phone, point of care, web, mail, etc.):

   c. The time period for when the surveys were administered:

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

   Between October 15, 2019 and November 1, 2019, our site mailed a survey to all our adult patients who came in for an office visit between September 1 and October 1. We were only able to do one re-measurement cycle. The mailing was sent on October 15. Two hundred surveys were mailed and 110 surveys were returned; yielding a 55% response rate.

3. Comparing your re-measurement period (s) to baseline and other sources of data, did you observe improvements in the measures targeted? Did you meet your stated objectives in your improvement plan? Please describe changes in performance and which changes you believe contributed to improvements observed.

   In the question, “I was given an appointment when I wanted it,” we exceeded our goal in that 83% of our patients reported “Strongly agree,” compared to our goal of 80% and our baseline score of 72%.

4. What challenges did you experience and how did you overcome these?

   We learned a lot while facing many challenges. The most important lesson was that patients were very skeptical about getting appointments “same day”. It took a lot of educating our patients on this change. There was also a lot of resistance from some of the providers as they were concerned that the no-show rate would increase. We started collecting no show rate data to monitor this in combination with appointment availability (3NA). We encountered challenges with reducing the number of appointment types. We had to re-train our scheduling staff and in the end, they preferred this as it was simple and they were more efficient with scheduling.

Submitted by Elizabeth Jones (QI Director) (Name & Title) **on** January 10, 2020 (Date)

Appendix II. Patient-Centered Medical Home Documentation Template

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Patient Centered Medical Home Recognition Template

Please complete all of the following fields on this form by **January 31, 2020** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

1. **Name of Recognition entity (NCQA, JCAHO or AAAHC):**
2. **Recognition status (First time, Maintenance or Re-certification):**
3. **Date of recognition received:**
4. **Level accomplished (if applicable):**
5. **How often is recognition obtained?**
6. **Attach a copy of PCMH recognition documentation provided by the recognizing entity (must contain a date of recognition within the measurement year).**

Additional Notes/Comments:

Appendix III: Submission Template for Peer-led Self-Management Support Group

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Peer-led Self-Management Support Group Template

Please complete all of the following fields on this form by **January 31, 2020** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure program will be eligible for the bonus.

1. **Name of group**
2. **Name and background information/training of group facilitator**
3. **Site where group visits took place**
4. **Narrative on the group process that includes: location and frequency of the group meetings**
5. **List of major topics/themes discussed at each meeting**
6. **A description of the way that self-management support is built into the groups**
7. **An assessment of successes and opportunities for improvement of the group**
8. **Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and date of group**

Appendix IV: Submission Template for HIE

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Health Information Exchange (HIE) Reporting Template

If your site is linked to an HIE during or prior to the 2019 Measurement year, you may qualify for an incentive for the 2019 PCP QIP. Please complete all of the following fields on this form and submit by **January 31, 2020** to:

Email: QIP@partnershiphp.org
Fax: 707-863-4316
Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

PHC will verify the following information with the HIE specified. Sites will qualify for an incentive based on **either** HIE linkage (as a first time user) or HIE maintenance (as a continuing user). Please refer to the Measure Specifications for details.

1. Name of practice linked to the HIE:_____

2. Type of linkage established (check at least one that applies):

   ☐ Sending HL7/ Patient Visit Information history to the HIE
   ☐ Sending CCD document to the HIE
   ☐ Retrieving clinical information such as labs from the HIE

3. Type of incentive
   - ☐ Linkage: First joined HIE *during* 2019 (list date) _____
   - ☐ Maintenance: First joined HIE *prior to* 2019 (list date) _____

4. Name of the HIE linked to (check the option that applies):

   ☐Sac Valley Med Share
   ☐North Coast Clinical Information Network
   ☐Redwood Med Net
   ☐Connect Healthcare
   ☐Jefferson HIE

   Submitted by: _____ Date:_____

   Title:_____ Phone:_____

   Email:_____

Appendix V: Initial Health Assessment (IHA) Improvement Plan Template

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Initial Health Assessment Improvement Plan Template

Please complete the form and follow instructions below. Submit material by **January 31, 2020** to:

Email: QIP@partnershiphp.org
Fax: 707-863-4316
Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

Practice Name: _____

Practice Address:_____

Contact Name:_____ Contact E-mail:_____

Improvement Plans should be a minimum of 400 words.

1. Attach a plan or report on how you are determining eligible patients. (How is your site running reports, or retrieving information to determine the eligible population?)

2. Provide documentation of the process in which the site is reaching out to the newly assigned members (i.e. mailers/phone calls etc.).

3. Provide a data collection plan to demonstrate how many members keep IHA appointments within the plan's timeframe AND the capture of the minimum necessary documentation. This includes:

    - A physical and mental history
    - Identification of high risk behavior
    - Assessment of need for preventative screenings or services, and health education
    - Diagnosis and plan for treatment of any disease
    - A completed Staying Health Assessment (SHA) form

4. Provide data collection plan for measuring any declinations to come in for an IHA appointment as well as completion of the SHA.

5. Has this been on a recent MRR CAP? If so, provide documentation/plan implementation of what you have done since the accepted CAP date to increase compliance with the IHA.

Appendix VI. Palliative Care Referral Submission Template

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Palliative Care Referral Submission Template

Please complete all of the following fields on this form by **July 1, 2019** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

1. **Provider Site Name: _____**
2. **PCPID Number:_____**
3. **Number of referrals made to outpatient palliative care services between January 1, 2019 and December 31, 2019: _____**

Please describe in detail the process used to identify palliative care patients as described in the measure specifications.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Appendix VII: 2019 PCP QIP Submission and Exclusion Timeline

2019 QIP Submissions		
DUE DATE	**QIP MEASURE**	**REPORTING TEMPLATE**
July 1, 2019	Palliative Care Referral	Appendix VI
January 31, 2020	All Clinical Domain Measures and Advanced Care Planning	Find on eReports
January 31, 2020	Patient Experience – Survey Option	Appendix I
January 31, 2020	PCMH Recognition	Appendix II
January 31, 2020	Peer-led Self-Management Support Group	Appendix III
January 31, 2020	Health Information Exchange	Appendix IV
January 31, 2020	Initial Health Assessment Improvement Plan	Appendix V

2019 QIP Exclusions	
LAST DAY TO SUBMIT (ACCEPTED ALL YEAR)	**APPLICABLE MEASURES**
January 15, 2020	Cervical Cancer Screening Retinal Eye Exams A1C Good Control Nephropathy Screening
January 31, 2020	All other measures from the Clinical Domain

Appendix VIII: Data Source Table

*For any measure, if "Provider" is listed as the **only** data source, that means a site will not get credit unless data is submitted. These are measures where data from health plan sources (e.g. Claims, Pharmacy, Provider Directory) is not available.

PCP QIP Core Measures	Data Source*	System Used for Data Monitoring	System Used for Data Submission
Clinical Care: Pediatric Medicine			
1. Nutrition Counseling (ages 3-17)	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Physical Activity Counseling (ages 3-17)			
3. Well Child Visits (ages 3-6)			
4. Immunizations for Adolescents			
5. Childhood Immunization Combo-3			
6. Asthma Medication Ratio			
Clinical Care: Family Medicine			
1. Well Child Visits (ages 3-6)	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Controlling High Blood Pressure			
3. Cervical Cancer Screening			
4. Colorectal Cancer Screening			
5. HBA1C Good Control			
6. Retinal Eye Exam			
7. Screening for Nephropathy			
8. Breast Cancer Screening			
9. Childhood Immunization Combo-3			
10. Immunization for Adolescents			
11. Asthma Medication Ratio			
Clinical Care: Internal Medicine			
1. Controlling High Blood Pressure	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Cervical Cancer Screening (			
3. Colorectal Cancer Screening			
4. HbA1C Good Control			
5. Retinal Eye Exam			
6. Nephropathy Screening			
7. Breast Cancer Screening			
8. Asthma Medication Ratio			

Appropriate Use of Resources: Family and Internal Medicine			
1. Ambulatory Care Sensitive Admissions 2. Readmission Rate	PHC	Partnership Quality Dashboard	N/A
Access/Operations Measures: All Practice Types			
1. Primary Care Utilization	PHC	Partnership Quality Dashboard	N/A
Patient Experience: All Practice Types			
Survey Option (sites not qualified for CAHPS)	Provider	Partnership Quality Dashboard	Submission Template
CAHPS Survey (for qualified sites)	PHC Vendor	Partnership Quality Dashboard	N/A

Unit of Service Measures	Data Source*	System Used for Data Monitoring	System Used for Data Submission
Advance Care Planning	Provider	Year-End Report	eReports
Access/Extended Office Hours	PHC	Year-End Report	Provider Relations Department
PCMH Certification	PHC and Provider	Year-End Report	Submission Template
Peer-led self-management support groups	Provider	Year-End Report	Submission Template
Alcohol Misuse Screening and Counseling	PHC	n/a	N/A
Health Information Exchange	Provider	Year-End Report	Submission Template
Initial Health Assessment	Provider	Year-End Report	Submission Template
Timely Data Submission via eReports	Provider	eReports	eReports
Palliative Care Identification and Referral	Provider	Year-End Report	Submission Template

Appendix IX: Works Cited for All Practice Types

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