



Primary Care Provider

Quality Improvement Program (PCP QIP)

Website Specifications

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MEASUREMENT YEAR

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I. Quality Improvement Program Contact Information

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II. Program Overview

The Primary Care Provider Quality Improvement Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California (PHC) providers, offers sizable financial incentives and technical assistance to primary care providers so 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 high quality, cost-efficient care for all your patients. Incentives are based on meeting specific performance thresholds in measures that address the above areas.

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: Calendar Year

The measurement year begins on January 1 and ends on December 31 of the current year. Please see [Appendix V](#) for details on deadlines specific to any measures. Payment is sent out 120 days after the program period ends, on April 30 of the next year.

Definitions

Parent Organization (PO): A health providing organization (e.g. a health center, an integrated health system, or a health care administrative entity that owns and oversees the operations of one or more sites in a defined administrative region) that may or may not operate multiple sites.

Primary Care Provider Site (PCP Site): A clinic location that has been designated with a unique PCP ID with members actively assigned by Partnership HealthPlan of California. Eligibility and requirements for Primary Care Provider sites are listed in the PHC Policy MPQP1023, (Access Standards and Monitoring), subject to California Health and Safety Code 1206(h) and HRSA regulations on intermittent sites. All Primary Care Provider Sites are listed in the [Provider Directory](#).

Provider: A term that may refer to a PCP PO, a PCP Site, a PCP Clinician, or any other entity or professional that is contracted to provide health care services to PHC members.

Eligibility for PHC Program

Eligible providers must have a PHC contract within the first three months of the [PHC QIP, grant or other disbursement program]. The provider must remain contracted through the end of the [measurement year (for QIPs)] or [contract period] to be eligible for payment.

Eligible providers must be in Good Standing continuously from the beginning of the [measurement year (for QIPs)] or [grant application (for grants)] to the month the payment is to be disbursed.

Definition of Good Standing:

PHC has the sole authority to determine if a provider is in Good Standing based on the criteria set forth below.

1. Provider is open for services for PHC members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, PHC will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against PHC.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with PHC on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following PHC policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement or overbilling.
9. Provider is not conducting other activities adverse to the business interests of PHC.

Clinical Measures

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

- PCP sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice or new PCP PO):
 - Must be contracted with members assigned for at least nine (9) months.
- PCP sites joining Partnership as part of a PCP PO where members from an existing QIP participant (an existing primary care site) 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 PCP sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the PCP 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 PCP sites, regardless of any affiliation with a PCP PO:
 - Must be contracted with members assigned for at least nine (9) months of the measurement year.

Eligible Member Population

The eligible population used to calculate the final scores for all measures is defined as capitated or assigned medical home Medi-Cal members. These members are eligible to be included in PCP sites' denominator lists assuming other 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 must be continuously enrolled within a PCP parent organization, with continuous enrollment defined as member assignment for nine (9) out of the 12 months between January 1 and December 31 of the current measurement year (assignment to a site occurs on the first of the month). For multi-site PCP parent organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a PCP site's final denominator is December 1st. This means that members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Members who are dually enrolled in Medicare and Medi-Cal (Medi-Medi members) are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate (compared to the rate calculated in eReports prior to continuous enrollment being applied) should be presented to the QIP Team. Each case will be screened by QIP internal governance for consideration. Sites will be notified of all results prior to final payment.

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 clinically relevant alignment with key external healthcare measurement entities, and a stable measurement set, major changes occur only when significant changes are made across a majority of the key external healthcare measurement entities measurement sets.¹ 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 Managed Care Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be communicated through e-mail to all providers as well as through the program's monthly newsletter.

Measures may evaluate a PCP site'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 measurement 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.

¹ Key External Healthcare Measurement Entities: Healthcare Effectiveness Data and Information Set (HEDIS); National Committee for Quality Assurance - Health Plan Accreditation (NCQA); National Quality Forum (NQF); Patient-centered medical home (PCMH) and Uniform Data System (UDS).

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

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. The specific codes are listed in the Code Set and specified within each measure. These codes are not wholly representative of reimbursable codes of PHC but codes outside of the Code List are not used for measure evaluation.

eReports

eReports is an online application by which PCP sites can monitor their own performance within the QIP Clinical measures 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 year. Typically eReports is available in early March and is announced via the QI Newsletter. PCP sites 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 membership size, will have measures compared against the specified measure thresholds. We are aware that small denominators may negatively impact the overall performance on a particular measure. Therefore, if a provider 1) has fewer than 15 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 15 members must provide evidence of three targeted outreach attempts when requesting a member be excluded from the denominator. The three Outreach attempts must include one written, one verbal, and a third of the sites choice with the date and type of outreach is documented. Evidence of documentation may be formatted in the manner of the site's discretion but must be clear. Outreach information must be submitted to the QIP team via email or fax on January 15 following the measurement year.

Partnership Quality Dashboard

The Partnership Quality Dashboard (PQD) is a Tableau dashboard that is integrated into eReports and designed to visualize Primary Care Provider Quality Incentive Program (PCP QIP) data. PQD dashboards are designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. Performance data in PQD can be rolled up, in executive summary views and drilled-down to the patient demographic level. We hope you find the PQD actionable, informative, and supportive in pursuit of your QI goals. If you have any questions or feedback, please contact the PCP QIP Team.

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 bi-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 approved exclusions from involve a manual process by PHC staff. Providers are responsible for checking that members are correctly excluded. Post-payment disputes related to exclusions. The deadline for exclusion requests that need to be executed by the QIP Team is January 15 following the measurement year.
- 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 Unit of Service measures. Providers will be given one week, hereafter referred to as Preliminary Report Review Period, to review this report for calculation discrepancies.
- 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 quantified circumstances as reviewed by QIP governance and approved by PHC's Executive Team. Post-payment disputes related to thresholds, however, cannot be accommodated.

Should a provider have a concern that does not fall in any of the categories above (i.e. the score on your final report does not reflect your eReports data at the conclusion of the validation period), a Payment Dispute Form must be completed 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.

Governance Structure

The QIP and its measurement set are developed collaboratively with internal and external stakeholders and receive feedback and approval from the following parties:

- ***PCP Provider Network***: PCP 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 comprised 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.
- ***PHC Board of Commissioners***: The PHC Board approves the financial components of the QIP and reviews and approved the actions of the Physician Advisory Committee, including the QIP measures.

III. Summary of Measures

2022 Primary Care Provider Quality Improvement Program 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 75th percentile performance of all Medicaid health plans reporting to the National Committee for Quality Assurance (NCQA); sites can receive partial points on these measures if the 50th percentile performance is met. For most new clinical measures, the full-point target is set at the 50th percentile performance, with no partial points available. No points through relative improvement are available for new measures.

2: For most existing clinical measures, sites can also earn 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:

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

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
- **AND** -
- Have an RI score of 10% or higher, as compared to the previous year's performance, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
- Exclusion: New clinical measures that use the 50th performance level as the single full point targets.

3: Site specific and practice type risk adjusted targets will be sent to each participating site in spring 2022.

4: Most of the clinical measures use performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2021 as targets.

2022 Primary Care Provider Quality Improvement Program Summary of Measures

Core Measurement Set – Family Medicine

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

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

2022 Core Measurement Set – Internal Medicine

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

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

2022 Core Measurement Set – Pediatrics

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

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

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning	Minimum 1/1000 th (0.001%) of the sites assigned monthly membership 18 years and older for: <ul style="list-style-type: none"> • \$100 per Attestation, maximum payment \$10,000. • \$100 per Advance Directive/POLST, maximum payment \$10,000
Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
PCMH Certification	\$1000 yearly for achieving or maintaining PCMH accreditation.
Peer-led Self-Management Support Groups	\$1000 per group, either new or existing. (Maximum of 10 groups per parent organization).
Health Information Exchange	One time \$3000 incentive for signing on with a local or regional health information exchange; Annual \$1500 incentive for showing continued participation with a local or regional health information exchange. The \$3000 incentive is available once per parent organization.
Initial Health Assessment	\$2000 per parent organization for submitting all required parts of improvement plan regardless of visit volume.
Health Equity	\$2000 per parent organization for submission of proposed plan to adopt internal best practices supporting a Health Equity initiative.
Blood Lead Screening	Tier 1-3, \$1000, \$3000, \$5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.
Dental Varnish	\$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office.
Tobacco Screening	\$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.
Electronic Clinical Data System (ECDS)	\$5,000 per parent organization for participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year.

IV. Clinical Domain

Measure 1. Asthma Medication Ratio⁵

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, 2022 and December 31, 2022.

For PHC's Clinical Practice Guidelines for the diagnosis and management of Asthma:
<http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 5-64 years of age as of December 31 of the measurement year (DOB between January 1, 1958 and December 31, 2017) identified 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.

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

Numerator

The number of assigned members who have a medication ratio of 0.50 or greater between January 1, 2022 and December 31, 2022.

Important Note: The Asthma Controller and Relievers Medications tables will be reviewed and updated by PHC's Pharmacy Department during the year as new medications are approved.

Exclusions

- 1) Members who had any of the following diagnoses any time during the patient's history through the end of the measurement year (i.e., December 31):
 - COPD
 - Emphysema
 - Obstructive Chronic Bronchitis
 - Chronic Respiratory Conditions Due To Fumes/Vapors
 - Cystic Fibrosis
 - Acute Respiratory Failure

⁵ National Quality Forum (NQF) Asthma Medication Ratio (#1800). <http://www.qualityforum.org>

- 2) Exclude any members who had no asthma medications (controller or reliever) dispensed during the measurement year.
- 3) Exclude members in hospice.

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), the quality of asthma care can vary widely across communities and population groups (Improving Asthma Care Quality, n.d.). Gaps in care can lead to complications or death and can increase costs. Information from government agencies illustrates why asthma has been a target for quality improvement efforts:

- The prevalence has been increasing;
- Asthma can be effectively treated and controlled;
- Uncontrolled asthma is costly (Improving Asthma Care Quality, n.d.).

DHCS requires PHC to report this as part of the annual Managed Care Accountability Set (MCAS) report in Measurement Year (MY) 2022.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Respiratory Conditions, MCAS, and NQF Asthma Medication Ratio (#1800).

IV. Clinical Domain

Measure 2. Breast Cancer Screening⁶

Description

The percentage of continuously enrolled Medi-Cal women 50-74 years of age who had a mammogram to screen for breast cancer.

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 52 – 74 years of age as of December 31 of the measurement year (DOB between January 1, 1948 and December 31, 1970).

Numerator

The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2020 and December 31, 2022.

Exclusions

- Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
- Bilateral (or unilateral left and right) mastectomy any time during the member's history through December 31, 2022.

Measure Rationale and Source

According to JAMA Network's Jill Jin, MD, MPH (2014), screening for breast cancer means looking for signs of breast cancer in all women, even if they have no symptoms (Jin, 2014). The goal of screening is to catch cancers early (Jin, 2014). Early-stage cancers are easier to treat than later-stage cancers, and the chance of survival is higher (Jin, 2014). Routine screening for breast cancer lowers one's risk of dying of breast cancer (Jin, 2014).

DHCS requires PHC to report this as part of the annual MCAS measures reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Breast Cancer Screening (#2372), and UDS Breast Cancer Screening (CMS125v8).

⁶ National Quality Forum (NQF) Breast Cancer Screening (#2372). <http://www.qualityforum.org>

IV. Clinical Domain

Measure 3. Cervical Cancer Screening⁷

Description

Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned women 24 - 64 years of age as of December 31 of the measurement year (DOB between January 1, 1958 and December 31, 2001).

Numerator

The number of assigned women in the eligible population who were appropriately screened according to evidence-based guidelines any time during the measurement year.

Exclusions

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.
- Documentation of "complete," "total" or "radical" abdominal or "vaginal hysterectomy" date meets the criteria for hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year.
- Documentation of a "vaginal Pap smear" in conjunction with documentation of "hysterectomy" date any time during the member's history through December 31 of the measurement year.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening date any time during the member's history through December 31 of the measurement year.
- Members receiving palliative care during the measurement year.
- Cervical Cancer Screening in Transgender Individuals: Transgender females (born males but currently with gender identity of female), may use diagnosis of congenital absence of cervix ICD10 = Q51.5) to exclude from denominator. Transgender males or gender non-conforming who were born females but currently with gender identity of male should be screened for cervical cancer if their cervix is still intact, but they will not be part of the official denominator for this measure due to system constraints.

Measure Rationale and Source

According to American College of Obstetricians and Gynecology (ACOG), it usually takes 3–7 years for high-grade changes in cervical cells to become cancer (Cervical Cancer Screening, n.d.). Cervical cancer screening may detect these changes before they become cancer (Cervical Cancer

⁷ National Quality Forum (NQF) Cervical Cancer Screening (#0032). <http://www.qualityforum.org>

Screening, n.d.). Women with low-grade changes can be tested more frequently to see if their cells go back to normal (Cervical Cancer Screening, n.d.). Women with high-grade changes can get treatment to have the cells removed (Cervical Cancer Screening, n.d.).

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Cervical Cancer Screening (#0032), and UDS Cervical Cancer Screening (CMS124v7).

IV. Clinical Domain

Measure 4. Child and Adolescent Well-Care Visits⁸

Description

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

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at:
<http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx>
- Training materials for the clinician: <http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx>
- For the billing team, Important Provider Notice regarding the change in frequency limits for the CPTs codes based on the age of the patient:
<http://www.partnershiphp.org/Providers/Claims/ProviderNotices/MCPN0405.pdf>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

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

Numerator

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

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

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

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to the American Academy of Pediatrics (AAP), parents know who they should go to when their child is sick. But pediatrician visits are just as important for healthy children (Sturgeon, 2015).

Here are some of the benefits of well-child visits:

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;

⁸ 2021 HEDIS measure criteria for Child and Adolescent Well Care with the allowable adjustments.

- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;
- Raising concerns. Make a list of topics you want to talk about with your child's pediatrician such development, behavior, sleep, eating or relations with other family members. Present your top three to five questions or concerns to the pediatrician at the start of the visit;
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires PHC to report this as part of the annual report of MCAS measures. Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, and MCAS.

IV. Clinical Domain

Measure 5. Childhood Immunization Status⁹

Description

The percentage of children 2 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); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: <http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx>
- Training materials for the clinician: <http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx>
- For the billing team, Important Provider Notice regarding the change in frequency limits for the CPTs codes based on the age of the patient: <http://www.partnershiphp.org/Providers/Claims/ProviderNotices/MCPN0405.pdf>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn two years of age between January 1 and December 31 of the measurement year. (DOB between January 1, 2020 and December 31, 2020).

Numerator

The number of assigned children who received the recommended vaccines by their second birthday.

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

Exclusions

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC), diseases that used to be common in this country and around the world, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, rotavirus and Haemophilus influenza type b (Hib) can now be prevented by vaccination (Why are Childhood Vaccines So Important? n.d.).

⁹ National Quality Forum (NQF) Childhood Immunization Status (#0038). <http://www.qualityforum.org>

Thanks to a vaccine, one of the most terrible diseases in history – smallpox – no longer exists outside the laboratory (Why are Childhood Vaccines So Important? n.d.). Over the years vaccines have prevented countless cases of disease and saved millions of lives (Why are Childhood Vaccines So Important? n.d.).

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, MCAS, NQF Childhood Immunization Status (#0038), and UDS Childhood Immunizations (CMS117v7).

IV. Clinical Domain

Measure 6. Colorectal Cancer Screening¹⁰

Description

The percentage of assigned members 50–75 years of age who had appropriate screening for colorectal cancer.

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 51-75 years of age by December 31 of the measurement year (DOB between January 1, 1947 and December 31, 1971).

Numerator

The number of assigned members who had one or more screenings for colorectal cancer according to clinical guidelines.

Exclusions

This measure excludes members with a history of colorectal cancer or total colectomy. The measure also excludes members receiving palliative care or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC), colorectal cancer screening saves lives (Colorectal Cancer Awareness, n.d.). Regular screening, beginning at age 50, is the key to preventing colorectal cancer (Colorectal Cancer Awareness, n.d.). If the member is older than 75, screening is to be determined by the physician (Colorectal Cancer Screening, n.d.).

IMPORTANT NOTE: Screening individuals between ages of 45-50 is now a USPSTF class B recommendation. We anticipate extending the age range for this measure, targeting 2023 PCP QIP Measurement Year.

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, NQF Colorectal Cancer Screening (#0034), and UDS Colorectal Cancer Screening (CMS130v7).

¹⁰ National Quality Forum (NQF) Colorectal Cancer Screening (#0034). <http://www.qualityforum.org>

IV. CLINICAL DOMAIN

Measure 7. Comprehensive Diabetes Management – HbA1c Good Control¹¹

Description

The percentage of assigned members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold.

For PHC's Clinical Practice Guidelines for diabetes mellitus:

<http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 18-75 years of age (DOB between January 1, 1947 and December 31, 2004) with diabetes identified as of December 31 of the measurement year.

Numerator

The number of diabetics in the eligible population with evidence of the most recent measurement at or below the threshold for HbA1c $\leq 9.0\%$ during the measurement year.

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2021 – December 31, 2022), and who meet either of the following criteria:

- Members receiving palliative care during the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year with a current lab value (less than 12 months old) indicating no diabetes and more recent than the last diabetic triggering event visible in eReports. See [Appendix VII](#) for the diabetes management table that includes lab value ranges eligible as proof for exclusions and the Diabetes Exclusions Flow Chart.

Measure Rationale and Source

Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin (National Diabetic Statistics Report, 2020). Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death (National Diabetic Statistics Report, 2020). Many interventions intended to prevent/control diabetes are cost saving or very cost-effective and supported by strong evidence (Li et al., 2010).

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure CDC: Comprehensive Diabetes Care, MCAS, and NQF Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control ($>9.0\%$) (#0059), and Diabetes Poor Control (CMS122v7).

¹¹ National Quality Forum (NQF) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control ($>9.0\%$) (#0059). <http://www.qualityforum.org>

IV. CLINICAL DOMAIN

Measure 8. Controlling High Blood Pressure¹²

Description

The percentage of assigned members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 18-85 years of age as of December 31, 2022 (DOB between January 1, 1937 and December 31, 2004) who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year (01/01/2021 – 06/30/2022).

Numerator

The number of assigned members population whose most recent BP reading taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event was <140/90 mm Hg during the measurement year.

The BP reading must occur on or after the most recent diagnosis of hypertension that is greater than or equal to the second diagnosis of hypertension.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Exclusions

- Exclude from the eligible population all members with evidence of end-stage renal disease [ESRD Diagnosis](#), dialysis [Dialysis Procedure](#), [Nephrectomy](#) or kidney transplant [Kidney Transplant](#); [History of Kidney Transplant](#) on or prior to December 31 of the measurement year.
- Exclude from the eligible members with a diagnosis of pregnancy during the measurement year.
- Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC) 2012 Vital Signs report:

- Nearly 1 in 3 adults (about 67 million) have high blood pressure;
- About 36 million adults with high blood pressure don't have it under control;
- High blood pressure contributes to nearly 1,000 deaths a day (Getting Blood Pressure Under Control, 2012).

¹² National Quality Forum (NQF) Controlling High Blood Pressure (#0018). <http://www.qualityforum.org>

IV. CLINICAL DOMAIN

Measure 9. Counseling for Nutrition Counseling for Children/Adolescents¹³

Description

The percentage of assigned 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.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at:
<http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx>
- Training materials for the clinician: <http://www.partnershiphp.org/Providers/Medical/Pages/Well-Child-Visits-Training-Materials.aspx>
- For the billing team, Important Provider Notice regarding the change in frequency limits for the CPTs codes based on the age of the patient:
<http://www.partnershiphp.org/Providers/Claims/ProviderNotices/MCPN0405.pdf>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 3-17 years of age as of December 31 of the measurement year (DOB between January 1, 2005 and December 31, 2019) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

Numerator

The number of assigned members with evidence that counseling for nutrition or referral for nutrition education was documented at least once during the measurement year.

Please Note: We know that this counseling can be included in any office visit, acute or preventative, performed in-person, virtually by phone or video depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit.

Exclusions

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

Measure Rationale and Source

According to the American Academy of Pediatrics Bright Futures, infancy, childhood, and adolescence are marked by rapid physical growth and development, and every child's and adolescent's health and development depends on good nutrition (Promoting Healthy Nutrition, n.d.). Any disruption in appropriate nutrient intake may have lasting effects on growth potential and developmental achievement (Promoting Healthy Nutrition, n.d.). Physical growth, developmental

¹³ National Quality Forum (NQF) Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024) <http://www.qualityforum.org>

requirements, nutrition needs, and feeding patterns vary significantly during each stage of growth and development (Promoting Healthy Nutrition, n.d.).

The following essential components of nutrition are useful constructs for discussing nutrition from birth through young adulthood:

- Nutrition for appropriate growth. Provide adequate energy and essential nutrients to ensure appropriate growth and prevent overweight or obesity;
- Nutrition and development of feeding and eating skills. Choose foods that provide essential nutrients and support the development of age-appropriate feeding and eating skills;
- Healthy feeding and eating habits. Establish a positive, nurturing environment and healthy patterns of feeding and eating to promote eating habits that are built on variety, balance, and moderation;
- Healthy eating relationships. Promote healthy adult-child feeding relationships and social and emotional development;
- Nutrition for children and youth with special health care needs. Recognize specific nutrient demands or supplemental needs for vitamins or minerals related to a child's special health condition and provide these nutritional components (Promoting Healthy Nutrition, n.d.).

DHCS is phasing out this measure as part of the MCAS, so this measure is likely to be discontinued after this year.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024), and UDS Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155v9).

IV. CLINICAL DOMAIN

Measure 10. Counseling for Physical Activity for Children/Adolescents¹⁴

Description

The percentage of assigned 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.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: <http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx>
- Training materials for the clinician: <http://www.partnershiphp.org/Providers/Medical/Pages/Well-Child-Visits-Training-Materials.aspx>
- For the billing team, Important Provider Notice regarding the change in frequency limits for the CPTs codes based on the age of the patient: <http://www.partnershiphp.org/Providers/Claims/ProviderNotices/MCPN0405.pdf>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 3-17 years of age as of December 31 of the measurement year (DOB between January 1, 2005 and December 31, 2019) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

Numerator

The number of assigned members with evidence that counseling for physical activity or referral for physical activity was documented at least once during the measurement year.

Please Note: We know that this counseling can be included in any office visit, acute or preventative, performed in-person, virtually by phone or video depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit.

Exclusions

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

Measure Rationale and Source

According to the American Academy of Pediatrics Bright Futures, participating in physical activity is an essential component of a healthy lifestyle and ideally begins in infancy and extends throughout adulthood (Promoting Physical Activity, n.d.). Regular physical activity increases lean body mass, muscle, and bone strength and promotes physical health (Promoting Physical Activity, n.d.). It fosters psychological well-being, can increase self-esteem and capacity for learning, and can help

¹⁴ National Quality Forum (NQF) Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024) <http://www.qualityforum.org>

children and adolescents handle stress. Parents should emphasize physical activity, beginning early in a child's life (Promoting Physical Activity, n.d.).

Please note: DHCS is phasing out this measure as part of the MCAS, so this measure is likely to be discontinued after this measurement year.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024), and UDS Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155v9).

IV. CLINICAL DOMAIN

Measure 11. Immunizations for Adolescents¹⁵

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.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: <http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx>
- Training materials for the clinician: <http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx>
- For the billing team, Important Provider Notice regarding the change in frequency limits for the CPTs codes based on the age of the patient: <http://www.partnershiphp.org/Providers/Claims/ProviderNotices/MCPN0405.pdf>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2009 and December 31, 2009).

Numerator

The number of assigned adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

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

Exclusions

This measure excludes members who have had a contraindication for the vaccine and patients utilizing hospice services during the measurement year.

Measure Rationale and Source

Thirty-five million American adolescents fail to receive at least one recommended vaccine (Schaffer et al., 2005). This gap exists despite specific adolescent immunization recommendations from the U.S. Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) (Schaffer et al., 2005). Low immunization rates in adolescents have a wide array of implications—outbreaks of vaccine-preventable diseases, negative effects on quality of life and increased disease associated costs (Schaffer et al., 2005). Importantly, low immunization rates

¹⁵ National Quality Forum (NQF) Immunizations for Adolescents (#1407) <http://www.qualityforum.org>

establish reservoirs of disease in adolescents that can affect others, including high-risk infants, elderly persons and persons with underlying medical conditions (Schaffer et al., 2005).

DHCS requires PHC to report this as part of the annual MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, and NQF Immunizations for Adolescents (#1407).

IV. CLINICAL DOMAIN

Measure 12. Well-Child Visits in the First 15 Months of Life¹⁶

Description

The percentage of assigned children 15 months old who had well-child visits with a PCP during the measurement year.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at:
<http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx>
- Training materials for the clinician: <http://www.partnershiphp.org/Providers/Medical/Pages/Well-Child-Visits-Training-Materials.aspx>
- For the billing team, Important Provider Notice regarding the change in frequency limits for the CPTs codes based on the age of the patient:
<http://www.partnershiphp.org/Providers/Claims/ProviderNotices/MCPN0405.pdf>

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned children who turn 15 months old during the measurement year.

Numerator

The number of assigned children who received six or more well-child visits with a PCP by the date of age 15 months.

14 Days Rule:

*There must be at least 14 days between each date of service. For example, if the first date of service was completed on 12/1, the next date of service, would have to be 12/15 or later. A date of service on 12/14, wouldn't count towards the numerator.

Because Well-Child Visits in the First 15 Months of Life is an administrative measure, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2021, n.d.).

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

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

¹⁶ National Quality Forum (NQF) Well-Child Visits in the First 15 Months of Life (#1392)
<http://www.qualityforum.org>

According to the American Academy of Pediatrics (AAP), parents know who they should go to when their child is sick. But pediatrician visits are just as important for healthy children (Sturgeon, 2015).

Here are some of the benefits of well-child visits:

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;
- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;
- Raising concerns. Make a list of topics you want to talk about with your child's pediatrician such development, behavior, sleep, eating or relations with other family members. Present your top three to five questions or concerns to the pediatrician at the start of the visit;
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires PHC to report this as part of the annual MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, and NQF Well-Child Visits in the First 15 Months of Life (#1392).

V. Appropriate Use of Resources

Measure 13. Ambulatory Care Sensitive Admissions¹⁷

Description

Admission rate of assigned members with any of the principle diagnoses from Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI), listed in the numerator, during the measurement year.

Sites must have a minimum of 100 eligible members by December of the measurement year.

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

Total hospital days for all admissions for eligible population during the measurement period.

Numerator

Total hospital days for inpatient admissions with a qualifying diagnosis from the provided list of PDIs and PQIs. The PQI and PDI principle diagnoses for each are located on [AHRQ resource page](#).

Preventive Quality Indicators (PQI)	Pediatric Quality Indicators (PDI):
<ul style="list-style-type: none"> • PQI 01 – Diabetes Short-term Complications • PQI 03 – Diabetes Long-term Complications • PQI 05 – COPD or Asthma in Older Adults Admission Rate • PQI 07 – Hypertension • PQI 08 – Heart Failure • PQI 11 – Community Acquired Pneumonia Admission Rate • PQI 12 – Urinary Tract Infection • PQI 14 – Uncontrolled Diabetics • PQI 15 – Asthma in Younger Adults • PQI 16 – Lower-Extremity Amputation among Patients with Diabetes 	<ul style="list-style-type: none"> • PDI 14 – Asthma Admissions Rate • PDI 15 – Diabetes Short-term Complications • PDI 16 – Gastroenteritis • PDI 18 – Urinary Tract Infection

Calculation:

$$\text{Ambulatory Care Sensitive Admissions (ACSA)} = \frac{\text{Total \# of ACSA days}}{\text{Total \# of All Inpatient Admission days}}$$

¹⁷ Agency for Healthcare Research and Quality (AHRQ). PQI and PDI Measures. Retrieved from: https://www.qualityindicators.ahrq.gov/Modules/all_resources.aspx

Exclusions

This measure excludes members who:

- See the PQI and PDI numerator details section for exclusions from the individual composite indicators
- Hospitalizations for obstetrics
- Hospice
- Acute hospital transfers

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), the PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease (Guide to Prevention Quality Indicators, 2001). The Pediatric Quality Indicators (PDIs) focus on potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals and on preventable hospitalizations among pediatric patients, taking into account the special characteristics of the pediatric population (Pediatric Quality Indicators Overview, n.d.).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including Agency for Healthcare Research and Quality (AHRQ) PQI and PDI Measures.

VI. APPROPRIATE USE OF RESOURCES

Measure 14. Risk Adjusted Readmissions¹⁸

Description

For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays* (denominator)
2. Observed Readmissions: Count of 30-Day readmissions (numerator)
3. Expected Readmissions: Sum of adjusted readmission risk (numerator)
4. Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between January 1 and December 1 of the measurement by members age 18 to 64 years of age continuously enrolled for at least 90 days prior admission date and for at least 30 days after admission date.

Numerator

Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between January 3rd and December 31 of the measurement year by members included in the denominator

$$\text{Calculation: Observed 30 Day Readmissions Rate} = \frac{\text{Observed 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$$

Note: Inpatient stays where the discharge date from the first setting and admission date to the second setting must be two or more days apart and considered distinct inpatient stays.

Expected 30-Day Readmission: An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

$$\text{Calculation: Expected 30 Day Readmissions Rate} = \frac{\text{Expected 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$$

¹⁸ National Quality Forum (NQF) Plan All-Cause Readmissions (#1768) <http://www.qualityforum.org>

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

Exclusions

Exclusions for Numerator and Denominator:

- Discharges for death
- Pregnancy condition
- Perinatal condition
- Stays by members with 4 or more index admissions in the measurement year

Exclusions for Numerator

- Planned admission using any of the following:
 - Chemotherapy
 - Rehabilitation
 - Organ Transplant
 - Planned procedure without a principal acute diagnosis

Measure Rationale and Source

According to National Committee for Quality Assurance (NCQA), a “readmission” occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time (Plan All-Cause Readmission, n.d.). A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination (Plan All-Cause Readmission, n.d). Unplanned readmissions are associated with increased mortality and higher health care costs (Plan All-Cause Readmission, n.d). They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768).

VI. ACCESS AND OPERATIONS

Measure 15. Avoidable Emergency Department (ED) Visits/1000 Members per Year¹⁹

Description

The rate of assigned members with an “avoidable ED visits” with a primary diagnosis that matches the diagnosis codes selected by PHC.

Points and Thresholds by Practice Type

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 1 year of age or older with an emergency department visit anytime during the measurement year.

Numerator

The number of assigned members 1 year of age or older with “avoidable ER visits” with a primary diagnosis that matches the diagnosis codes selected by PHC.

Calculation:

$$\text{Avoidable ED Visits per Member per Year} \times 1000 = \frac{\text{Avoidable ED Visits}}{(\text{Sum of Member Months}) * 12,000}$$

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.

Exclusions

This measure excludes member who are less than 1 year of age (DOB on or after January 1, 2021).

ED claims with at least one diagnosis code not considered avoidable will deem the visit as not avoidable.

Measure Rationale and Source

ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients (Measures of Care Coordination, 2015). Some ED events may be attributed to preventable or treatable conditions (Measures of Care Coordination, 2015). A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented (Dowd, et al., 2014).

Inclusion of this measure and benchmark determination is supported by alignment with external health care measurement entities.

¹⁹ (June 2012) Statewide Collaborative Quality Improvement Project. Reducing Avoidable Emergency Room Visits. Final Remeasurement Report: January 1, 2010 – December 31, 2010. Retrieved from: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Coll_ER_Remeasure_Report.pdf

VII. Patient Experience

Measure 16. Patient Experience²⁰

Description

This measure the organization's consumers to report on and evaluate their experiences with health care. 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

Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria. There are two ways in which to earn points:

1) **CAHPS**

Providers that have sufficient PHC patient volume, or for PCPs who operate in counties with no provider meeting this threshold and see the largest number of PHC members in that county, can earn up to a maximum of 10 points for meeting performance thresholds in key measures in the Clinician & Group CAHPS 3.0 survey.

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 X](#) 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.

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right (Why Improve Patient Experience, n.d.). But good patient experience also is associated with important clinical processes and outcomes (Why Improve Patient Experience, n.d.). Measures of patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety, and efficiency (Why Improve Patient Experience, n.d.).

Patient experience is correlated with key financial indicators, making it good for business as well as for patients (Why Improve Patient Experience, n.d.). For example:

- Good patient experience is associated with lower medical malpractice risk. A 2009 study found that for each drop in patient-reported scores along a five-step scale of "very good" to "very poor," the likelihood of a provider being named in a malpractice suit increased by 21.7 percent.¹⁴;
- Efforts to improve patient experience also result in greater employee satisfaction, reducing turnover. Improving the experience of patients and families requires improving work

²⁰ National Quality Forum (NQF) CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (#0005) <http://www.qualityforum.org>

processes and systems that enable clinicians and staff to provide more effective care. A focused endeavor to improve patient experience at one hospital resulted in a 4.7 percent reduction in employee turnover;

- Patients keep or change providers based upon experience. Relationship quality is a major predictor of patient loyalty; one study found patients reporting the poorest-quality relationships with their physicians were three times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships (Why Improve Patient Experience, n.d.).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NQF CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (#0005).

Measure 1. Advanced Care Planning**Description**

This measure encourages the PCP to provide annual awareness to PHC members 18 years or older understand the how the advance care plan (ACP) can help alleviate unnecessary suffering, improve quality of life and provide better understanding of the decision-making challenges facing the individual and his or her caregivers (Advance Care Planning, n.d.). An advance care plan can be used at any stage of life and should be updated as circumstances change (Advance Care Planning, n.d.).

Thresholds

Minimum 1/1000th(0.001%) of the sites assigned monthly membership 18 years and older for:

- \$100 per Attestation, maximum payment \$10,000.
- \$100 per Advance Directive/POLST, maximum payment \$10,000

Measure Requirements

ACP discussions must take place between January 1 and December 31 of the measurement year in order to be eligible for this measure.

Advance Directive and/or POLST:

If a patient has a previously completed Advance Directive or POLST and does not wish to make any changes, documentation of a conversation during the measurement period confirming that no changes are needed will qualify.

Attestation:

Only one conversation per patient per measurement year. The following components are required to be documented in the chart for a provider to attest to the completion of an ACP discussion:

- Documented discussed of social supports, patient preferences and likely course of action for acute illness, a long term chronic illness or a terminal illness, and “what ifs” for serious accidents (Advance Care Planning, n.d.).
- Documented discussed review of Advance Directive or POLST already on file and updates as needed in the member’s life as health status and living circumstances change (Advance Care Planning, n.d.).

Submission Process

Providers must utilize the templates found within eReports to submit documentation for individual patients.

Exclusions

ACP is a covered benefit and can be reimbursed using CPT codes, 99497 or 99498. Any billed using the allowable CPT codes will be excluded.

Submission(s) received after the close of the “grace period” that ends on January 31 following the close of the measurement year.

Measure Rationale and Source

According to Centers for Disease Control and Prevention (CDC):

- Most people say they would prefer to die at home, yet only about one-third of adults have an advance directive expressing their wishes for end-of-life care (Pew 2006, AARP 2008). Among those 60 and older, that number rises to about half of older adults completing a directive (Advance Care Planning, n.d.).
- Only 28 percent of home health care patients, 65 percent of nursing home residents and 88 percent of hospice care patients have an advance directive on record (Jones 2011).
- Even among severely or terminally ill patients, fewer than 50 percent had an advance directive in their medical record (Kass-Bartelmes 2003).
- Between 65 and 76 percent of physicians whose patients had an advance directive were not aware that it existed (Kass-Bartelmes 2003).

Measure 2. Extended Office Hours**Description**

Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

Definition of regular business hours:

Total open office hours equals at least eight hours between the hours of 8 a.m. and 5 p.m. OR 9 a.m. and 6 p.m., Monday through Friday. Being open and seeing patients during lunch does not count toward the extended hours. The site must be open to scheduled visits during the extended office time to receive credit.

Thresholds

Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

Measure Requirements

Option 1: PCP sites that have at least eight extended office hours for a full quarter listed in the [PHC Provider Directory](#) for Provider Relations to confirm.

Option 2: PCP sites that are part of a large organization AND within a five mile or less radius of an eligible site for the incentive payment equal to 10% of capitation.

- Example 1:

If site A (qualifying site) has the extended office hours offering at least eight extended office hours, **AND** is willing to see members from sites B, C, D, etc. **WHO ARE** within the five mile or less radius of site A (qualifying site), **THEN** sites B, C, D, etc. are eligible for extended office hours due to meeting the minimum distance requirement from site A (qualifying site). Lastly, site A (qualifying site) needs to have the at least eight extended office hours listed for a full quarter in the [PHC Provider Directory](#) for Provider Relations to confirm, not a combination/summation of hours amongst sites is acceptable.

- 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.

Option 3: PHC site with less than 2,000 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 of the measurement year.

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

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.

Measure Rationale and Source

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.

VI. UNIT OF SERVICE

\$1,000 per site

Measure 3. Patient-Centered Medical Home Recognition (PCMH)

Description

This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand (What is Patient-Centered Medical Home, n.d.).

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

Thresholds

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

Measure Requirements

PCP sites must receive accreditation, maintain accreditation, or re-certify within the measurement year from NCQA, or equivalent from AAAHC or JCAHO.

Submission Process

All documentation must be submitted on the Patient-Centered Medical Home Recognition template ([Appendix I](#)) by January 31, 2023 via email to gip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Submission(s) received after the close of the “grace period” that ends on January 31 following the close of the measurement year.

Measure Rationale and Source

According to the American College of Physicians (ACP), the objective of PCMH is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family (What is Patient-Centered Medical Home, n.d.). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner (What is Patient-Centered Medical Home, n.d.).

Measure 4. Peer-Led Self-Management Support Groups**Description**

This measure encourages the PCP organization to host peer-led self-management groups for PHC member and non-PHC members focused 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, and Substance use.

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

Thresholds

The parent organization is eligible to earn \$1,000 per group, maximum 10 groups, to the parent organization.

- The peer-led self-management group must meet at least four times and have at least 16 PHC total member visits per group, confirmed via sign-in sheets.
- Documentation will be reviewed and approved by PHC's CMO or physician designee.

Measure Requirements

Qualifying peer groups must have a peer-facilitation component and a self-management component via face-to-face, telephonic, or video meetings.

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

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.

Submission Process

All documentation must be submitted on the Peer-led Self-Management Support Group template ([Appendix II](#)) by January 31, 2023 via email to gip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

PHC's CMO or physician designee unapproved peer-led groups that do not meet the measure requirements.

Submission(s) received after the close of the "grace period" that ends on January 31 following the close of the measurement year.

Measure Rationale and Source

Studies suggest peer-led self-management training improves chronic illness outcomes by enhancing illness management self-efficacy (Jerant, Moore-Hill, and Franks, 2009). Interventions to help patients manage health conditions have potential as cost-effective ways to improve chronic illness outcomes (Jerant, Moore-Hill, and Franks, 2009). The peer-led groups aims to enhance self-efficacy or confidence to execute illness management behaviors, regardless of specific diagnosis (Jerant, Moore-Hill, and Franks, 2009). Hosting and leading support groups for various health needs is not part of routine PCP contracts.

Measure 5. Health Information Exchange Participation**Description**

This measure encourages the PCP parent organizations to establish and maintain a continued linkage to a recognized community health information exchange (HIE) organizations.

Thresholds

The PCP parent organizations will be reimbursed for participating:

- Establishing first time linkage: During the measurement year, first year HIE connection is established are eligible to earn \$3000.
- Continued utilization of the HIE: Year 2 and beyond of utilization of the HIE are eligible to earn \$1500.

Measure Requirements

In order to qualify for the incentive PHC will validate the data exchange by working directly with the specified HIE to confirm the linkage with the HIE has to be established by confirming:

- Sending an HL7 Patient Visit Information to the HIE

OR

- Sending CCD document to the HIE

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 Improvement and Information Network (NCHIIN)
- 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

All documentation must be submitted on the HIE Attestation template ([Appendix III](#)) by January 31, 2023 via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Unapproved HIE connections that do not meet the measure requirements.

Measure Rationale and Source

According to the Office of the National Coordinator for Health Information Technology (ONC), electronic exchange of clinical information is vital to improving health care quality, safety, and patient outcomes (Why is health information exchange important, n.d.). Health information exchange (HIE) can help your organization:

- **Improve Health Care Quality:** Improve health care quality and patient outcomes by reducing medication and medical error;
- **Make Care More Efficient:** Reduce unnecessary tests and services and improve the efficiency of care by ensuring everyone involved in a patient's care has access to the same information;
- **Streamline Administrative Tasks:** Reduce administrative costs by making many administrative tasks simpler and more efficient;
- **Engage Patients:** Increase patient involvement in their own health care and reduce the amount of time patients spend filling out paperwork and briefing providers on their medical histories; and
- **Support Community Health:** Coordinate with and support public health officials to improve the health of your community (Why is health information exchange important, n.d.).

Electronic exchange of clinical information allows doctors, nurses, pharmacists, other health care providers, and patients to access and securely share a patient's vital medical information electronically—improving the speed, quality, safety, coordination, and cost of patient care (Why is health information exchange important, n.d.).

Measure 6. Initial Health Assessment Improvement Plan**Description**

This measure encourages our PCP organizations to develop and submit an initial health assessment (IHA) improvement plan for ensuring newly assigned members are scheduled and seen within PHC's timeframe of within 90 days following the first month of PHC eligibility.

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.

Thresholds

The PCP parent organization is eligible to earn an annual amount of \$2,000 for submitting IHA improvement plan.

- Documentation will be reviewed and approved by PHC's Manager of Clinical Quality and Patient Safety or other registered nurse (RN) designee.

Measure Requirements

In order to qualify PCP parent organizations need to submit IHA plans that address of all elements of the IHA template. Refer to [Appendix IV](#) for IHA template.

Our interpretation of the telehealth flexibilities is that an initial health assessment may be done through a video visit, if it includes all the elements of a comprehensive initial visit.

The [IHA \(Initial Health Assessment\)](#) includes the following criteria:

- Medical and Behavioral Health histories
- 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)

Submission Process

All documentation must be submitted on the IHA template ([Appendix IV](#)) by January 31, 2023 via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Unapproved IHA plans that do not meet the measure requirements.

Measure Rationale and Source

Timely 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.

DHCS requires the health plans to ensure that all new Medi-Cal beneficiaries have an initial health assessment (a first visit, including a health screening with the DHCS's Staying Healthy Assessment questionnaire. Normally this assessment includes an examination and must occur within 120 days of

enrollment into Medi-Cal Managed care. Since a new Medi-Cal member has 1 month to select a PCP, the assigned PCP has about 90 days to complete this assessment. [Most recent update](#), DHCS permitted to defer the completion of the IHA for these members until the COVID-19 emergency declaration is rescinded; however, DHCS will require the completion of the IHA for these members once the public health emergency is over (DHCS, 2020, page 9, para 4).

Measure 7. Health Equity (HE) Implementation Plan**Description**

PHC is actively engaged in HE initiatives that bring about equitable awareness and result driven change within the 14 counties we serve and we highly encourage provider organizations to join our efforts. At PHC, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to healthcare.

Thresholds

The PCP parent organization is eligible to earn an annual amount of \$2,000 for the submission of proposed plan and adoption of internal best practices that support a Health Equity (HE) initiative.

Measure Requirements

Submission shall demonstrate HE characteristics PCPs can successfully integrate as a core strategy. Should include how best practices apply to internal domains such as: Access, Referral Processes, Avoidable ED Visits, Community Partnerships, and Staff Education.

1. Make HE a leader-driven priority.
2. Identify specific health disparities, then act to close the gaps.
3. Confront institutional racism.
4. Develop processes that support equity (health systems/dedicated, resources, governance structure to oversee).
5. Partner with community organizations.

Submission Process

All plans must be submitted by January 31, 2023 via email to gjp@partnershiphp.org or fax to (707) 863-4316.

Measure Rationale and Source

PHC is actively engaged in HE initiatives that bring about equitable awareness and result driven change within the 14 counties we serve and we highly encourage provider organizations to join our efforts. At PHC, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to healthcare.

Measure 8. Blood Lead Screening**Description**

Blood lead screening of young children enrolled in Medi-Cal is a federal and state law requirement.

IMPORTANT NOTE: The blood lead screening will be a new HEDIS measure required by DHCS. DHCS has a more expansive measures reporting requirement, compared to the HEDIS measure.

Denominator

The number of assigned members 24 to 72 months during the measurement year. (DOB between January 1, 2017 and December 31, 2020).

Numerator

The number of members aged 24 to 72 months old who had one or more capillary or venous lead blood test for lead poisoning in the lifetime of the member.

Thresholds

Incentive paid at Parent Organization (PO). Minimum of 50 lead screens performed (denominator population) anytime in the past 60 months on the following incentive tiers:

Tier 1: Minimum lead screening - \$1,000

Tier 2: Lead screening rate >75% - \$5,000

Tier 3: Lead screening rate of 50%, and at least 15% Relative Improvement (RI) of 2021 lead screenings - \$3,000

Relative Improvement (RI) methodology: Please see the [Summary of Measures Table](#) for points, thresholds, and relative improvement criteria.

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with Blood Lead Screenings (BLS):

- CPT: 83655
- LOINC codes: 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7.

Exclusions

Claims denied.

Measure 9. Dental Fluoride Varnish Use**Description**

The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Denominator

Assigned members aged 6 months to 5 years during the measurement year.

Numerator

The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Thresholds

Incentive to improve dental fluoride application at site level or submission of protocol and implementation plan.

Part 1: \$1,000 per Parent Organization

Parent Organization (PO) submission of proposed plan to implement fluoride varnish application in the medical office. The protocol should accomplishing the following objectives:

- A plan to identify children at risk for, dental decay and who would benefit from fluoride varnish.
- Provide education plan that will afford consultation and written member (parent or guardian) information on the importance of dental hygiene and fluoride varnish use.
- Provide clinical staff training on varnish application.
- Implementation target date.

Part 2: At least 2% of the sites assigned members in the age range above must receive fluoride varnish administered by a non-dental practitioner at least once in the measurement year. The incentive payment amount for reaching this threshold is \$5.00 per application.

- Numerator: The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with dental varnish application: CPT code: 99188 (Non-dental practitioner).

Measure Rationale and Source

Studies have shown that low-income young children are often at higher risk for dental decay. According to the American Dental Association (ADA), drinking local public water that provides fluoridation and applying dental fluoride varnish combined is the best methods to reduce early tooth decay. Primary care exams occur earlier and more frequent with young children compared to dentistry and early detection and varnish application during annual check-up is more likely to occur.

Measure 10. Tobacco Use Screening

Description

This measure supports National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 years of age and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco and aligns with U.S. Preventive Services Task Force (USPSTF) recommendations with regards to screening/counseling for tobacco.

Denominator

Assigned members aged 11– 21 years of age during the measurement year.

Numerator

Assigned members 11– 21 years of age who had tobacco use screening or counseling one or more times during the measurement year.

Thresholds

Incentive to improve early detection of and intervention toward tobacco use.

Incentive payment: \$5.00 per screening. Minimum 3% of the sites assigned monthly assigned members achieves one or more tobacco screenings in the measurement year.

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with Tobacco Use Screening: HCPCS: 4004F

Measure 11. Electronic Clinical Data Systems (ECDS)**Description**

This measure supports the allowance of data exchange from Provider Electronic Health Records to PHC in order to capture clinical screenings, follow-up care and outcomes. ECDS implementation is a vital component of furthering the quality of care for covered PHC members.

Thresholds

Incentive can be achieved by participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year.

\$5,000 per Parent Organization

Measure Requirements

Participation to include data collection of the following clinical components for all PHC members within your organization.

1. Attention-deficit/hyperactivity disorder (ADHD)
2. Breast Cancer Screening (BCS)
3. Alcohol Screening and Counseling (11 years and older)
4. Depression Screening

A sample SQL program with the logic for generating a monthly report of these measures will be provided to sites intending to participate in this measure by June 2022. The ECDS Medical Record Data Exchange Data Standards and Specifications are posted within the PCP QIP Specifications manual on [eReports](#) and the submission data reporting templates are available on [eReports'](#) user help page. Please note, each will need to be adapted/mapped to your individual electronic medical record system.

Payment will require:

1. Acceptance by PHC IT department of a test file of these 4 measures, by October 1, 2022. We recommend a first test file be submitted by September 1, in case there are errors in the first test file that need to be corrected, with subsequent resubmission.
2. PHC's HEDIS team will be randomly auditing a few records from each providers to validate the mapping process in the fall of 2022 and winter of 2023. Sites must cooperate with associated audit requests
3. A final report based on all patients seen who are covered by PHC (whether assigned or direct members) in 2022, with updated data for all of 2022, must be submitted between January 8, 2023 and January 28, 2023. The reporting programming and format must be the same as the final approved version of the test file in number 1, above.

VII. APPENDICES

Appendix I. Patient-Centered Medical Home Documentation Template



4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** 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 II: Submission Template for Peer-led Self-Management Support Group



4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** 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 paid to the parent organization, not the individual sites.

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 III: Submission Template for HIE

If your organization is linked to an HIE during or prior to the 2021 Measurement year, you may qualify for an incentive for the 2021 PCP QIP. Please complete all of the following fields on this form and submit by **January 31 following the measurement year** and send 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. The parent organization, not the individual 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* 2022 (list date) _____
 - Maintenance: First joined HIE *prior to* 2022 (list date) _____
4. Name of the HIE linked to (check the option that applies):
 - Sac Valley Med Share
 - North Coast Improvement and Information Network (NCHIIN)
 - Jefferson HIE
 - Other: _____

Submitted by: _____ Date: _____
Title: _____ Phone: _____
Email: _____

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



The parent organization will qualify for an incentive based on approved Initial Health Assessment Plan. Please refer to the Measure Specifications for details.

Please complete the form and follow instructions below. Submit material by **January 31 following the measurement year** to:

Email: QIP@partnershiphp.org

Fax: 707-863-4316

Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

Organization Name: _____

Practice Address: _____

Contact Name: _____ Contact Email: _____

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 V: 2022 PCP QIP Submission and Exclusion Timeline

2022 QIP Submissions

DUE DATE	QIP MEASURE	REPORTING TEMPLATE
January 31, 2023	All Clinical Domain Measures and Advanced Care Planning	Find on eReports
January 31, 2023	PCMH Recognition	Appendix I
January 31, 2023	Peer-led Self-Management Support Group	Appendix II
January 31, 2023	Health Information Exchange	Appendix III
January 31, 2023	Initial Health Assessment Improvement Plan	Appendix IV
NO LATER OR EARLIER THAN THE LAST DAY OF EACH QUARTER END.	Extended Office Hours	Appendix IX

2022 QIP Exclusions

LAST DAY TO SUBMIT (ACCEPTED ALL YEAR)	APPLICABLE MEASURES
January 15, 2023	A1C Good Control
January 31, 2023	All other measures from the Clinical Domain

Appendix VI: Data Source Table

PCP QIP Core Measures	Practice Type	Data Source ²¹	System Used for Data Monitoring	System Used for Data Submission
Clinical Domain				
1. Asthma Medication Ratio	Family, Internal, Pediatrics	PHC	eReports and Partnership Quality Dashboard (PQD)	Claims
2. Breast Cancer Screening	Family and Internal	PHC and Providers		eReports
3. Cervical Cancer Screening	Family and Internal			
4. Child and Adolescent Well Care Visits	Family and Pediatrics			
5. Childhood Immunization Status, Combination 10	Family and Pediatrics			
6. Colorectal Cancer Screening	Family and Internal			
7. Comprehensive Diabetic Care – HbA1c Control	Family and Internal			
8. Controlling High Blood	Family and Internal			
9. Immunization for Adolescents – Combination 2	Family and Pediatrics			
10. Well-Child Visits in the First 15 Months of Life	Family and Pediatrics			
11. Counseling for Nutrition for Children/Adolescents	Pediatrics			
12. Counseling for Physical Activity for Children/Adolescents	Pediatrics			
Appropriate Use of Resources Domain				
1. Ambulatory Care Sensitive Admissions	Family and Internal	PHC	PQD	Claims
2. Risk Adjusted Readmissions	Family and Internal			
Access/Operations Measures Domain				
1. Avoidable ED Visits	Family, Internal, Pediatrics	PHC	PQD	Claims
Patient Experience Domain				
Survey Option (sites not qualified for CAHPS)	Family, Internal, Pediatrics	PHC and Provider	PQD	Submission Template
CAHPS Survey (for qualified sites)	Family, Internal, Pediatrics	PHC Vendor		PHC Vendor
Monitoring Measures				
1. Comprehensive Diabetic Care – Eye Exams (EYE)	N/A	PHC and Providers	eReports and PQD	eReports
2. PCP Office Visits	N/A	PHC		Claims

²¹ For any measure, if “PHC” is the only data source, Providers may not submit uploads for the measure through eReports. PHC uses administrative data (Claims/Encounter/RxClaims) for these measures only.

Appendix VII: Diabetes Management Table

The table below indicates lab values that the QIP accepts as proof that the member is not diabetic and thus should be excluded from the diabetes management measures. In addition to the values, please refer to the flow chart on the next page to understand the exclusion protocol. For this measure, members may only be excluded by presenting lab values indicating no Diabetes, and only labs that take place *after* the date of diagnosis will be considered.

Lab	Description	Value accepted for diabetes exclusions
HbA1c value (%)	-	< 6.5%
Random blood sugar test (mg/dL or mmol/L)	Blood sample taken at a random time regardless of when the patient last ate.	<126 mg/dL
Fasting blood sugar test (mg/dL or mmol/L)	Blood sample taken after an overnight fast.	< 126 mg/dL or 7 mmol/L
Oral glucose tolerance test	Overnight fast, and the fasting blood sugar is measured, then the patient drinks a sugary liquid, blood sugar levels tested periodically for the next two hours.	< 200 mg/dL or 11.1 mmol/L after two hours

Appendix VIII: QIP Diabetes Exclusion Flow Chart





Appendix IX: Patient Experience Survey Submission Template

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Fairfield, CA 95434

Quality Improvement Program – Patient Experience Survey Submission Template and Example

Due Date for Part I Submission: July 31 of the measurement year.
Due Date for Part II Submission: January 31 following the measurement year

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 of the measurement year)

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 following the measurement year)

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, 2022 and May 1, 2022, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2022. 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, 2022 (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 2022) 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, 2022 and November 1, 2022, 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, 2023 (Date)

VII. Monitoring Measurement Set for the MY2022

PHC wants to emphasize that the measures not included in the payment group remain clinically important. Therefore, we are including this Monitoring Measurement Set.

The Monitoring Measurement Set is a separate and distinct measurement set that **does not have any points assigned to each measure**. The intent of this set is to provide visibility to your performance and access to the member gap-in-care list throughout the measurement year.

Monitoring Measure 1. Comprehensive Diabetes Management – Retinal Eye Exam²²

Description

The percentage of members 18-75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy.

For PHC's Clinical Practice Guidelines for diabetes mellitus:

<http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx>

Thresholds

- Points Not Applicable

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1947 and December 31, 2004) with diabetes identified as of December 31, 2022.

Members with diabetes are identified through pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC will count services that occur during the measurement year or the year prior (i.e. January 1, 2021 –December 31, 2022).

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2021 – December 31, 2022).

- At least two outpatient visits, observation visits, ED visits, non-acute inpatient encounters, telephone visit or online assessment, on different dates of service, with a diagnosis of diabetes. The visit types do need not be the same for the two visits.

OR

- At least one acute inpatient encounter with a diagnosis of diabetes.

OR

- Members who were dispensed insulin or hypoglycemics/antihyperglycemics, per pharmacy data, on an ambulatory basis during the measurement year or the year prior to the measurement year.

Numerator

An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had any one of the following:

- A retinal or dilated eye exam (Diabetic Retinal Screening Value Set) by an eye care professional (optometrist or ophthalmologist or teleoptometry service such as EyePACs) in the measurement year.

²² National Quality Forum (NQF) Comprehensive Diabetes Care: Eye Exam (#0055).

<http://www.qualityforum.org>

- A negative retinal or dilated eye exam (negative for retinopathy) ([Diabetic Retinal Screening Negative Value Set](#)) by an eye care professional during the measurement year or the year prior. For exams performed with a negative result in the year prior to the measurement year, a result must be available.
- Unilateral eye enucleation with a bilateral modifier.).
- Left unilateral eye enucleation ([Unilateral Eye Enucleation Left Value Set](#)) and right unilateral eye enucleation ([Unilateral Eye Enucleation Right Value Set](#)) on the same or different dates of service.

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2021 – December 31, 2022), and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes ([Diabetes Exclusions](#)) in any setting, during the measurement year or the year prior to the measurement year.
- Have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports). See [Appendix VIII](#) for the diabetes management table that includes lab value ranges eligible as proof for exclusions and [Appendix IX](#) for the Diabetes Exclusions Flow Chart.

Measure Rationale and Source

DHCS requires PHC to report this as part of the annual MCAS measures reporting MCAS measures reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Respiratory Conditions, MCAS, and NQF Comprehensive Diabetes Care: Eye Exam (#0055).

VII. Monitoring Measurement Set

Monitoring Measure 2. PCP Office Visits

Description

The number of Primary Care Provider visits per member per year by PHC eligible members with participating QIP providers.

PHC will extract the total number of PHC office visits, telephone visits, and video visits from claims and encounter claims data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site.

Thresholds

- Points Not Applicable

Denominator

The average number of months per year a member is assigned to a participating QIP PCP.

Numerator

The total number of visits during the measurement year with any PCP in PHC's network. PCP Visits include face-to-face, video or telephonic services in provider's office, or patient's home or private residence settings.

Calculation:

$$PCP\ Office\ Visits\ PMPY = (\#PCP\ Visits \div \text{Sum of eligible Member Months}) \times 12$$

Codes Used

- 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

This measure excludes the following:

- Medicare-Medi-Cal dual capitated members

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