

JANUARY-MARCH 2023

PCP QIP 1ST QUARTER MEASURE FOCUS:



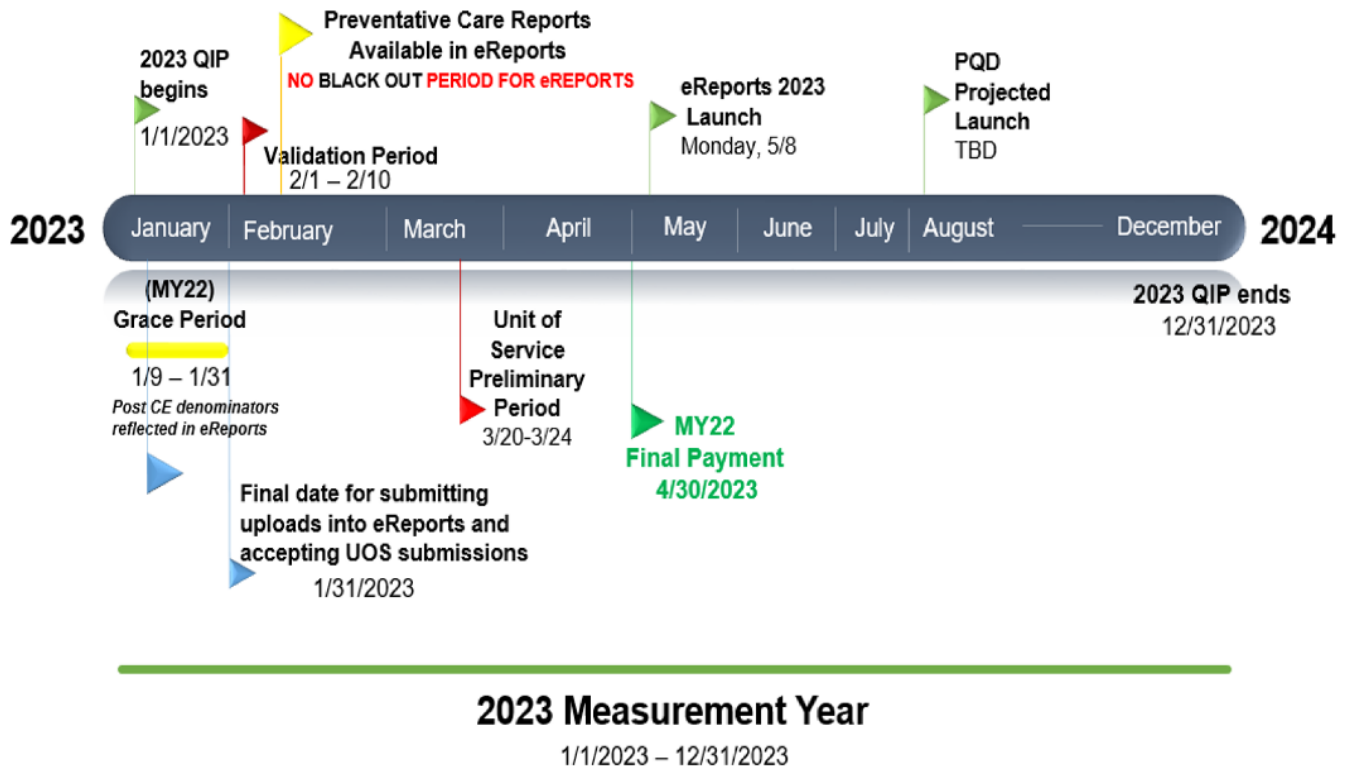
- Childhood Immunizations Status
- Well-Child First 15 Months of Life
- Asthma Medication Ratio
- Controlling High Blood Pressure
- Diabetes Management- A1c Good Control
- Diabetes Management- Retinal Eye Exams
- Child and Adolescent Well Care Visits

2023 PCP QIP Specifications are available on our website: [Click Here](#)

PLEASE NOTE: The website version of the PCP QIP specifications do not contain any proprietary language from HEDIS or NCQA. This language is included in our detailed specification document housed in eReports. Until 2023 eReports launches on May 8th, 2023, please email the QIP team (qip@partnershiphp.org) so we can send them to you in a secure email.

Important Program Reminders and Updates:

- Payment for MY (Measurement Year) 2022 will be distributed on April 30th, 2023
- eReports currently displays 2022 non-final data. eReports will launch on May 8th with 2023 data
- Partnership Quality Dashboard (PQD) relaunch is TBD



*Program year timeline can be found on the PHC QIP [webpage](#)

NEW! Preventive Care Reports:

The Preventive Care Dashboard is a replacement of the Immunization Dose Dashboard. This dashboard includes four (4) total reports for PCP QIP Measures: 1) Childhood Immunization Status (CIS_0-2YRS), 2) Immunizations for Adolescents (IMA_9-13YRS), 3) Well-Child Visits in first 15 months (6+visits by 15 months) and 4) Child and Adolescent Well Care Visits (Annual Well Care Visits).

These reports consist of patient contact information, in addition to existing immunization and well-care visit date of services. These reports can be used to identify members who are missing necessary vaccinations and/or well care visits and assist with member outreach efforts. PHC strongly recommends accessing these reports early in the measurement year, prior to eReports relaunch in May 2023, to help initiate early measure quality improvement efforts. The dashboard can be found in [eReports](#). The data is updated daily Monday- Friday after 7am.

The screenshot shows the eReports interface for Preventive Care Reports. The left sidebar contains a navigation menu with items like 'Home', 'My QIP Scores', 'QIP Measure Report', 'QIP Member Report', 'Member Search', 'Upload QIP Data', 'Weekly Count Report', 'My eAdmins', 'eAdmin', 'Diagnosis Crosswalk', 'QIP Specification Manual', 'Specs & Templates', 'PHC Internal User Menu', 'Partnership Quality Dashboard', and 'Preventive Care Reports' (highlighted in yellow). The main content area is titled 'Preventive Care Reports' and includes a 'Summary Information' bar with filters for 'CIS_0-2 Yrs', 'IMA_9-13 Yrs', '6+ Visits by 15 Months', and 'Annual Well Care Visits'. Below this is the 'Partnership Health Plan of California' logo and a detailed description of the reports, including sections for 'Immunization Dose Reports', 'Well Care Reports', 'Recommended Use', and 'Important Notes'. A 'Frequently Asked Questions' section is also present on the right side of the main content area.

PCP QIP Unit of Service Measure: Patient-Centered Medical Home (PCMH) Recognition

Discount opportunity for practices applying for initial NCQA recognition

Good news! We are excited to inform you that Partnership is now recognized as a member of NCQA's "Partners in Quality" program. With our inclusion in this program, NCQA provided a discount code we can share with practices applying for **initial** NCQA Patient-Centered Medical Home (PCMH) recognition.

The discount code is **CCAPHC**. Qualifying practices may use this code* for a **20% discount** for initial NCQA Recognition. Please use this discount **before submitting payment to NCQA**. NCQA does not reimburse practices/clinicians after submission of the application and final payment for processing.

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.).

To qualify for the yearly \$1000 incentive under this measure, a PCP site must be eligible for unit of service measure payments, have more than 50 enrolled PHC members, and must receive accreditation, maintain accreditation, or re-certify within the measurement year from NCQA, or equivalent from AAAHC or JCAHO.

Please let us know if you have any questions about this offer, and thank you for the work you are doing *to help our members, and the communities we serve, be healthy.*

*The discount code applies only to *initial Recognition program fees*; it does not apply to annual reporting, education sessions, survey tools or NCQA publications.

Accelerated Learning Education Program:

Early Cancer Detection (Cervical, Breast and Colorectal Cancer Screening): Tuesday, April 25th, 2023. Noon-1:30pm. [Register Here](#)

Objectives:

- Understand the clinical background, specifications, and performance threshold definitions of the 2023 PCP QIP Cervical, Breast and Colorectal Cancer Screening measures.
- Apply documentation requirements to maximize adherence and measure performance in the delivery of cervical, breast, and colorectal cancer screening services.
- Identify best and promising practices that can be used to address clinical work flows, improve interpersonal communication, member and staff education, eliminate barriers to access, improve outreach for patients from groups that have been historically, economically, or socially marginalized, and provide technical tips to facilitate early cancer detection screening services, especially for populations with higher incidence and mortality rates.

Advancing Health Equity: Linking Quality and Equity in Quality Improvement Projects:

Tuesday, April 18, 2023. Noon-1pm [Register Here](#)

Description: In order to reduce health and health care inequities in our patient populations, our actions must be part of a broader shift to build the culture of equity. Similar to building a culture of quality in our organizations, creating and sustaining a culture of equity takes time, teamwork, and continual attention. This webinar presents information from the [Roadmap to Advance Health Equity](#) developed by Advancing Health Equity: Leading Care, Payment and Systems Transformation (AHE). The webinar will discuss key topics including: discovering and prioritizing differences in care, outcomes, and/or experiences across patient groups; planning equity-focused projects; and measuring impact.

Who Should Attend? Quality improvement staff, team leaders, managers, and front-line staff

Presented By: The Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN)

CAIR:

The state recently launched a public portal into CAIR. An individual can now check personal immunization records [HERE](#)

QIP Contact: QIP@partnershiphp.org. Please allow 48 hours for a response.