2017 Primary Care Provider Quality Improvement Program (QIP) Transition Period Measurement Specifications

FAMILY MEDICINE PRACTICES

Developed by: The QIP Team

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I. Quality Improvement Program Contact Information

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Website: Primary Care Provider Quality Improvement Program

II. Program Overview

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

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

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

Guiding Principles

The QIP uses ten 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. Distribute 100% of fixed pool per member per month funds
4. Actionable measures
5. Feasible data collection
6. Collaboration with providers
7. Simplicity in the number of measures
8. Comprehensive measurement set
9. Align measures that are meaningful
10. 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: 2017 Transition Period

Historically, the PCP QIP has run on an annual program period beginning July 1 and ending June 30. The PCP QIP is now transitioning to an annual program period aligned with the calendar year, beginning January 1 and ending December 31. To make this transition possible, we are introducing a 6-month “transition period” at the conclusion of the 2016-2017 year, from July 1, 2017 to December 31, 2017. After the transition period, the calendar cycle will begin January 1, 2018. That measurement period will last 12 months through December 31, 2018, and the PCP QIP will continue on an annual, calendar-year basis thereafter.

Please note that this 6-month transition period will look back at performance between January 1, 2017 and December 31, 2017, and the incentive amount will be pro-rated based on member months between July 1, 2017 and December 31, 2017. Payment is sent out 120 days after the program period ends, on April 30,
2018. In order to maintain a stable measurement set, measure development occurs on a two-year cycle; major changes are only made every other year. The transition period measures are based on those used in the 2016-2017 measurement year.

**Eligibility Criteria**

All primary care providers, including pediatric, family, and internal medicine sites, that have capitated Medi-Cal only members and are contracted with PHC for at least six months during the measurement year are enrolled in the QIP.

If a provider site is contracted for at least 11 out of 12 months between 1/1/17 and 12/31/17, it reports on all applicable measures. If a provider site is contracted for more than six but less than 11 months during the measurement year, it only reports on measures that rely on administrative data; the Clinical and Patient Experience measures in the Fixed Pool Measurement Set do not apply. If a contract is terminated during the measurement year, the provider is ineligible.

**Eligible Population**

The eligible population used to calculate the final scores for all measures is defined as capitated Medi-Cal members. For Clinical measures, the member also has to be continuously enrolled with their PHC assigned provider, with continuous enrollment defined as being assigned for 11 out of the 12 months between 1/1/17 and 12/31/17. Assigned provider is defined as the reporting entity designated for the QIP. Medi-Medi members (dually eligible members) are excluded from all measures.

**Payment**

There are two measurement sets, each with a different payment methodology.

For the Fixed Pool measures, the total sum of financial incentives distributed for any given measurement year – known as the “payment pool” – is based on all capitated member months accrued throughout the measurement year. Member months is defined as the total number of capitated Medi-Cal patients assigned to a site each month (i.e. if a provider has 100 Medi-Cal Partnership patients assigned each month for all 12 months of the measurement year, the provider’s total member months will be 1200). Each year, PHC budgets a base per member per month (PMPM) amount, which determines the QIP payment pool (i.e. if the base PMPM amount is $4 and there is a total of 500,000 member months in the measurement year, the QIP payment pool will be $2 million). All of the payment pool is distributed among all participating QIP sites at the end of the measurement year. Because the payment pool is fixed, the incentive payment a site is able to earn is based on the site’s performance in the measures, its number of member months, and the relative performance of other sites. The base PMPM amount is announced 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 measures, the payment is independent of and distinct from the financial incentives a site receives from the QIP fixed payment pool. A site receives payment according to the measure specifications if the requirements for one or more Unit of Service measures are met.

**Billing**

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

**eReports**

eReports, an online system built for the QIP Clinical measures, is the mechanism by which providers can monitor their performance and submit supplemental data to PHC. The eReports portal may be accessed at https://qip.partnershiphp.org/.
All providers, regardless of denominator size, will be held against the established thresholds. We are aware that small denominators may negatively impact the overall performance on that measure. Therefore, if a provider 1) has fewer than 10 members in the denominator for any clinical measure after continuous enrollment is applied and 2) does not meet the threshold, there will be an additional opportunity to submit evidence of outreach efforts to non-compliant members conducted during the measurement year. Please reach out to the QIP team in January 2018 if you would like to submit outreach information.

Non-Clinical Reports

In addition to the eReports system, the QIP Team produces site-specific Non-Clinical Reports on a bimonthly basis, containing performance data on the Non-Clinical measures (i.e. measures in the Appropriate Use of Resources, Access & Operations, and Patient Experience domains). These reports provide a retrospective look at a site’s performance based on available data. They will be distributed via e-mail to the preferred contacts at each QIP participating site.

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:

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

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

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

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

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

For the tables below, please refer to these notes:

1: For all clinical measures, the target is set at the 90th percentile performance of all Medicaid health plans. Sites have the opportunity to receive half points on measures if the 75th percentile performance is met.

2: For existing measures, sites can also earn partial points based on relative improvement. 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* 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 commercial pay for performance program as well as by the Center for Medicare and Medicaid Services. Points are awarded according to the following scale:

- ≥ 15% Relative Improvement = Full Points
- 10.0-14.9% Relative Improvement = 75% Points
- 5.0-9.9% Relative Improvement = 50% Points
- 0.1-4.9% Relative Improvement = 25% Points

3: Site specific and practice type risk adjusted targets were sent with January 2017 Non-Clinical Reports.

4: All measures except Colorectal Cancer Screening use as targets the performance percentiles obtained from the NCQA national averages for Medicaid health plans reported in 2015. The Colorectal Cancer Screening targets are based on the 75th and 90th percentile plan-wide performance, as data for Medicaid is not available.
<table>
<thead>
<tr>
<th>CRITERIA &amp; WEIGHT</th>
<th>RISK ADJUSTED?</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL DOMAIN (60 Points Total)</strong></td>
<td></td>
<td>1,2 Full Point Targets for Existing Measures:</td>
</tr>
<tr>
<td>1. Annual Monitoring Patients on Persistent Medications (&gt;18 years) (10 pts)</td>
<td>No</td>
<td>• Annual Monitoring Patients on Persistent Medications: 92.1%</td>
</tr>
<tr>
<td>2. Well Child Visits (3-6 years) (10 pts)</td>
<td></td>
<td>• Well Child Visits: 83.0%</td>
</tr>
<tr>
<td>3. Childhood Immunization (2 years): DTaP (5 pts)</td>
<td></td>
<td>• Childhood Immunization – DTaP: 85.2%</td>
</tr>
<tr>
<td>4. Controlling High Blood Pressure (18-85 years) (5 pts)</td>
<td></td>
<td>• Controlling High Blood Pressure: 70.6%</td>
</tr>
<tr>
<td>5. Cervical Cancer Screening (21-64 years) (10 pts)</td>
<td></td>
<td>• Cervical Cancer Screening: 69.9%</td>
</tr>
<tr>
<td>6. Colorectal Cancer Screening (51-75 years) (5 pts)</td>
<td></td>
<td>• Colorectal Cancer Screening: 51.2%</td>
</tr>
<tr>
<td>7. Diabetes Management: HbA1C Control (18 – 75 yrs) (5 pts)</td>
<td></td>
<td>• Retinal Eye Exam: 68.1%</td>
</tr>
<tr>
<td>8. Diabetes Management: Retinal Eye Exam (18 – 75 yrs) (5 pts)</td>
<td></td>
<td>• HbA1c Control (≤9%): 70.7%</td>
</tr>
<tr>
<td>9. Diabetes Management: Nephropathy (18 – 75 yrs) (5 pts)</td>
<td></td>
<td>• Nephropathy: 93.5%</td>
</tr>
<tr>
<td><strong>APPROPRIATE USE OF RESOURCES (25 Points Total)</strong></td>
<td></td>
<td>OR Half Points Targets for Existing Measures:</td>
</tr>
<tr>
<td>10. Admissions/1000 OR Follow-up post discharge* (7.5 pts)</td>
<td>Yes: By PCP/Site³</td>
<td>• Annual Monitoring Patients on Persistent Medications: 89.9%</td>
</tr>
<tr>
<td>*Follow-up post discharge can be the back-up measure for either admissions/1000 or readmission rate, but not both.</td>
<td></td>
<td>• Well Child Visits: 77.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Childhood Immunization – DTaP: 82.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Controlling High Blood Pressure: 63.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cervical Cancer Screening: 63.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Colorectal Cancer Screening: 39.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Retinal Eye Exam: 61.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HbA1c Control (≤9%): 63.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nephropathy: 92.0%</td>
</tr>
</tbody>
</table>
11. Readmission Rate OR Follow-up post discharge* (7.5 pts)
*Follow-up post discharge can be the back-up measure for either admissions/1000 or readmission rate, but not both.

<table>
<thead>
<tr>
<th>Yes: By Practice Type³</th>
<th>Full points = ≤110% of target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Half points = 111-119% of target</td>
</tr>
</tbody>
</table>

12. Pharmacy Utilization (10 pts)

<table>
<thead>
<tr>
<th>No</th>
<th>Full points = At least 85.0% generic rate or 98.0% formulary compliance rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Half points = 83.0-84.9% generic rate or 96.0-97.9% formulary compliance rate</td>
</tr>
</tbody>
</table>

*Back-Up Measure: Follow-Up Post Discharge

<table>
<thead>
<tr>
<th>Full points: 50% of discharged members contacted within 4 calendar days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half points: 25-49% of discharged members contacted within 4 calendar days</td>
</tr>
</tbody>
</table>

**ACCESS & OPERATIONS (15 Points Total)**

13. Avoidable ED Visits (5 points)

<table>
<thead>
<tr>
<th>Yes: By PCP/Site³</th>
<th>Full Points: At or below site-specific threshold</th>
</tr>
</thead>
</table>

14. Practice open to PHC members (5 points)

<table>
<thead>
<tr>
<th>No</th>
<th>1 point per quarter + 1 extra point for all quarters:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Open 1 full quarter = 1 point</td>
</tr>
<tr>
<td></td>
<td>Open 2 full quarters = 2 points</td>
</tr>
<tr>
<td></td>
<td>Open 3 full quarters = 3 points</td>
</tr>
<tr>
<td></td>
<td>Open 4 full quarters = 5 points</td>
</tr>
<tr>
<td></td>
<td>Partial Points: Any age restrictions = ½ points per quarter</td>
</tr>
</tbody>
</table>

15. PCP Office Visits (5 points)

<table>
<thead>
<tr>
<th>Yes: By PCP/site³</th>
<th>Full Points: At or above site-specific threshold. PHC plan-wide mean used to calculate site-specific threshold: 2.2 visits/year.</th>
</tr>
</thead>
</table>
## Unit of Service Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning attestations</td>
<td>$100 per attestation for ACP discussions and $100 per submitted Advanced Directive or POLST for Medi-Cal members 18 years and older</td>
</tr>
<tr>
<td>Access/Extended Office Hours</td>
<td>10% of Capitation</td>
</tr>
<tr>
<td>PCMH Certification</td>
<td>Level 1: $2000  Level 2: $3000  Level 3: $3500</td>
</tr>
<tr>
<td>Peer-led self-management support groups (both new and existing)</td>
<td>$1000 per group (Maximum of 5 groups per site)</td>
</tr>
<tr>
<td>Buprenorphine Qualified Providers</td>
<td>$500 per credential prescriber (Maximum of 5 per site)</td>
</tr>
<tr>
<td>SBIRT</td>
<td>$5 per screening</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>One time $2500 incentive for signing on with a local or regional health information exchange</td>
</tr>
</tbody>
</table>
Measure 1. Annual Monitoring for Patients on Persistent Medications

**Description**

The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report as a total rate:

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).

- Annual monitoring for members on diuretics.

Studies show that adverse drug events cause more than 700,000 visits to the ER each year, and the more medications people take, the higher their risk of having an adverse drug event. These adverse drug events can contribute to patient injury and increased health care costs. For patients on persistent medications, appropriate monitoring can reduce the occurrence of preventable adverse drug events.

Meeting and exceeding targets for kidney function screenings for all patients on persistent medications is a challenge. Routine PCP contracts do not account for this. However, the QIP sees these screenings as vitally important for preventing adverse drug events which can add to future costs.

**Thresholds**

- Full points: 90th percentile (92.1%)

- Half Points: 75th percentile (89.9%)

- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

**Denominator**

The number of continuously enrolled Medi-Cal members 18 years of age or older as of December 31, 2017 (DOB on or before December 31, 1999) who, during the measurement year, received at least 180 treatment days of ACE inhibitors or ARBs or at least 180 treatment days of Diuretics.

Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days’ supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition). Separately, members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days’ supply for those medications count toward the total 180 treatment days. The 180 treatment days must come from therapies within one table. Having 180 treatment days from treatments across two tables will not count towards the denominator.
Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e. a prescription of 90 days' supply dispensed on December 1, 2017 counts as 30 treatment days). Sum the days' supply for all medications and subtract any day's supply that extends beyond December 31, 2017 of the measurement year.

Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

<table>
<thead>
<tr>
<th><strong>Numerator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one serum potassium and a serum creatinine therapeutic monitoring test during the measurement year, between January 1, 2017 and December 31, 2017. Any of the following during the measurement year meet criteria:</td>
</tr>
<tr>
<td>• A lab panel test.</td>
</tr>
<tr>
<td>• A serum potassium test and a serum creatinine test.</td>
</tr>
<tr>
<td>The tests do not need to occur on the same service date, only within the measurement year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Codes Used</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
</tr>
<tr>
<td>Codes to identify ACE inhibitors or ARBs: Table CDC-L on Code List</td>
</tr>
<tr>
<td>Codes to identify Diuretics: Table MPM-C on Code List</td>
</tr>
<tr>
<td>Numerator:</td>
</tr>
<tr>
<td>Codes to identify lab panel test: Table 9B on Code List</td>
</tr>
<tr>
<td>Codes to identify serum creatinine test: Table 9C on Code List</td>
</tr>
<tr>
<td>Codes to identify serum potassium: Table 9D on Code List</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Exclusions</strong> (only if not numerator hit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclude members from each eligible population rate who had an acute inpatient encounter (Table 5A on Code List) or non-acute inpatient encounter (Table 8G on Code List) during the measurement year.</td>
</tr>
<tr>
<td>Each member can only be counted in a provider’s denominator once. If a member has 180 treatment days on ACE inhibitors or ARBs, as well as 180 treatment days on Diuretics, he or she will only appear once in the denominator list.</td>
</tr>
</tbody>
</table>
Measure 2. **Well Child Visits**

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

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

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

**Thresholds**

- **Full points:** 90th percentile (83.0%)
- **Half points:** 75th percentile (77.6%)
- **Relative Improvement Targets per Measure:**
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25%)

**Denominator**
The number of continuously enrolled Medi-Cal members 3-6 years of age as of January 1, 2017 (i.e. DOB between January 1, 2011 and December 31, 2014).

**Numerator**
The number of children in the eligible population with at least one well child visit with a PCP during the measurement year, between January 1, 2017 and December 31, 2017.

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

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.
Do not include services rendered during an inpatient or ED visit.

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

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

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

### Codes Used

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

**Numerator:** Codes to identify Well Child Visits from claims/encounter data: Table 2A on Code List.

### Exclusions (only if not numerator hit)

N/A
Measure 3. Childhood Immunization – DTaP

Description

The percentage of children 2 years of age who had 4 diphtheria, tetanus, and acellular pertussis (DTaP) vaccines by their second birthday.

Childhood vaccines protect children from a number of serious and potentially life-threatening diseases such as diphtheria, measles, meningitis, polio, tetanus and whooping cough, at a time in their lives when they are most vulnerable to disease. Approximately 300 children in the United States die each year from vaccine-preventable diseases. Immunizations are essential for disease prevention and are a critical aspect of preventive care for children. Vaccination coverage must be maintained in order to prevent a resurgence of vaccine-preventable diseases.

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

Thresholds

Full points: 90th percentile (85.2%)

- Half points: 75th percentile (82.2%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

Denominator

The number of continuously enrolled Medi-Cal members who turn 2 years of age during the measurement year, between January 1, 2017 and December 31, 2017 (DOB between January 1, 2015 and December 31, 2015).

Numerator

The number of children in the eligible population with at least 4 DTaP vaccinations, with different dates of service, on or before the child’s 2nd birthday. Do not count vaccinations administered prior to 42 days after birth.

Codes Used

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

Numerator: Codes to identify DTaP Immunization: Table 3C on Code List.

Exclusions (only if not numerator hit)

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

- Anaphylactic reaction to the vaccine or its components: Table 3A on Code List.
- Encephalopathy (Table 3K on Code List) with a vaccine adverse-effect code (Table 3J on Code List).
### Measure 4. Controlling High Blood Pressure

#### Description

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

Known as the “silent killer,” high blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States. Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions. Some studies also indicate that failure to achieve blood pressure targets contribute to avoidable costs and the number of cardiovascular events. Health care providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.

Due to the size of the hypertension population, meeting and exceeding targets for controlling high blood pressure readings can be a challenge for providers. Routine PCP contracts do not account for this. The QIP incentivizes this measure in order to combat a chronic health condition as well as reduce costs that accompany it.

#### Thresholds

- **Full points**: 90th percentile (70.6%)
- **Half points**: 75th percentile (63.9%)
- **Relative Improvement Targets per Measure**:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

#### Denominator

The number of continuously enrolled Medi-Cal members 18-85 years of age as of December 31, 2017 (i.e. DOB between January 1, 1932 and December 31, 1999) with at least one outpatient visit, with a diagnosis of hypertension, during the 6 months prior to the measurement year (i.e. July 1, 2016 – December 31, 2016).

#### Numerator

The number of eligible population in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Members 18–59 years of age as of December 31, 2017 whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31, 2017 and flagged with a diagnosis of diabetes (see note below) whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31, 2017 and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.
To determine if the member’s BP is adequately controlled, the representative BP must be identified. Representative BP is defined as the most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g. sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g. stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the patient.

Members who met any of the following criteria during the measurement year or the year prior to the measurement year (January 1, 2016 – December 31, 2017) are identified as diabetic:

- At least 2 outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. The visit types do not need to be the same for the 2 visits.
- At least one acute inpatient encounter with a diagnosis of diabetes.
- Dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis.

Members who met any of the following criteria are identified as not diabetic:

- Do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year (January 1, 2016 – December 31, 2017).
- A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year (January 1, 2016 – December 31, 2017).

Note: Members classified as diabetic in Step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as not diabetic in this step.

### Codes Used

| Denominator: |
| Codes to identify outpatient visits: Outpatient without UBREV Table on Code List. |
| Codes to identify Hypertension: Table 8E on Code List. |

| Numerator: | See codes below to identify diabetic and non-diabetic members. |

### Diabetic Members:

| Codes to identify outpatient visits: Table 1D on Code List. |
| Codes to identify observation visits: Table 5I on Code List |
| Codes to identify ED visits: Refer to Table 5G on Code List |
| Codes to identify nonacute inpatient encounters: Table 8G on Code List |
| Codes to identify acute inpatient encounters: Table 5A on Code List |
| Codes to identify diabetes diagnosis: Table 8A on Code List |
Codes to identify insulin or hypoglycemics/antihyperglycemics: Table CDC-A on Code List

*Non-diabetic Members:*
  Codes to identify gestational or steroid-induced diabetes diagnosis: Table 8B on Code List

Please use eReports to upload data for most recent BP readings.

<table>
<thead>
<tr>
<th>Exclusions (only if not numerator hit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exclude from the eligible population all members with a diagnosis of pregnancy (Table 1F on Code List) during the measurement year.</td>
</tr>
<tr>
<td>• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (Table 8D on Code List) or kidney transplant (Table 8F on Code List) on or prior to December 31, 2017. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.</td>
</tr>
<tr>
<td>• Exclude from the eligible population all members who had a non-acute inpatient admissions during the measurement year. To identify non-acute inpatient admissions:</td>
</tr>
<tr>
<td>o Identify all acute and non-acute inpatient states (Inpatient Stay Value Set Table on Code List).</td>
</tr>
<tr>
<td>o Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim.</td>
</tr>
<tr>
<td>o Identify the discharge date for the stay.</td>
</tr>
</tbody>
</table>
Measure 5. Cervical Cancer Screening

Description
The percentage of continuously enrolled Medi-Cal women 21-64 years of age who were screened for cervical cancer according to the evidence-based guidelines:

- Women age 21-64 who had cervical cytology performed every 3 years.
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Cervical cancer is a disease in which cells in the cervix (the lower, narrow end of the uterus) grow out of control. Cervical cancer used to be one of the most common causes of cancer death for American women; effective screening has reduced the mortality rate by more than 50 percent over the last 30 years. Cervical cancer is preventable in most cases because effective screening tests exist. If detected early, cervical cancer is highly treatable.11

Meeting and exceeding targets for population-level screenings for cervical cancer is a challenge for providers. Routine PCP contracts do not account for this. The QIP leverages this burden because improvements in screening rates have been associated with decreased morbidity and mortality from cervical cancer, with reduced proximal health care costs.

Thresholds

- Full points: 90th percentile (69.9%)
- Half points: 75th percentile (63.7%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

Denominator
The number of continuously enrolled Medi-Cal women 24-64 years of age as of December 31, 2017 (DOB between January 1, 1953 and December 31, 1993).

Numerator
The number of women in the eligible population who were appropriately screened according to evidence-based guidelines. Please refer to the steps and flow chart below.

Step 1:
Identify women 24-64 years of age (DOB between January 1, 1953 and December 31, 1993) as of December 31, 2017 who had cervical cytology in the measurement year or the two years prior (January 1, 2015 – December 31, 2017).

Documentation in the medical record must include:
• A note indicating the date when the cervical cytology was performed.

Step 2:
From the women who did not meet Step 1 criteria, identify women 30-64 years of age (DOB between January 1, 1953 and December 31, 1987) as of December 31, 2017 who had cervical cytology and an HPV test on the same date of service* during the measurement year or the 4 years prior to the measurement year (January 1, 2013 – December 31, 2017) and who were 30 years or older on the date of both tests. Documentation in the medical record must include:

• A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.

*For administrative data, due to potential claims lag, services delivered within 4 days apart may count toward numerator compliance. For example, if the service date for Pap test and HPV test was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year. However, for eReports data upload, the tests must occur on the same date.

Step 3:
Add the numbers from Steps 1-2 to obtain a total rate for women who were identified with appropriate screening for cervical cancer.

NOTE: For Steps 1 and 2, count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening. Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening. Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

Codes Used
Denominator: No codes applicable as eligibility is defined by age and gender.

Numerator:
Codes to Identify Cervical Cancer Screening from Claims/Encounter Data: Table 6B on Code List.
Codes to Identify HPV test from Claims/Encounter Data: Table 6C on Code List.

Exclusions (only if not numerator hit)
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Table 6A on Code List) any time during the member’s history through December 31, 2017.

Codes to identify exclusions: Table 6A on Code List.

Documentation of “complete,” “total” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:

• Documentation of a “vaginal Pap smear” in conjunction with documentation of “hysterectomy”.

• Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.
Monitoring for Appropriate Cervical Cancer Screening of Eligible Members

Step 1: Is there a Pap test in the measurement year or the two years prior (January 1, 2015 – December 31, 2017)?

Yes → Member is compliant

No → Step 2a:

Step 2a: Is the member 30-64 years of age?

Yes → Step 2b:

Step 2b: Is there a Pap test and HPV test with the same service date during the measurement year or the four years prior to the measurement year (January 1, 2013 – December 31, 2017) and who were 30 years or older on the date of both tests.

Yes → Member is compliant

No → Member is not compliant

No → Member is not compliant

Step 3: Add the numbers from Step 1 and Step 2b to obtain a total rate
Measure 6. Colorectal Cancer Screening

Description
The percentage of members 51–75 years of age as of December 31, 2017 who had appropriate screening for colorectal cancer.

Treatment for colorectal cancer in its earliest stage can lead to a 65 percent survival rate after five years. However, screening rates for colorectal cancer lag behind other cancer screening rates—only about half of people age 50 or older, for whom screening is recommended, have been screened. Colorectal cancer screening in asymptomatic adults between the ages of 50 and 75 can catch polyps before they become cancerous or detect colorectal cancer in its early stages, when treatment is most effective.12,13

Meeting and exceeding targets for colorectal cancer screenings is outside the parameters of routine PCP contracts. The QIP incentivizes this measure in order to ensure patients receive life-saving preventive care that can reduce the costs of future treatments.

Thresholds

- Full points: 90th percentile of plan-wide performance (51.2%) (Note that no NCQA Medicaid threshold exists for this measure)

- Half points: 75th percentile of plan-wide performance (39.1%)

- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

Denominator

The number of continuously enrolled Medi-Cal members 51-75 years of age by December 31, 2017 (. DOB between January 1, 1942 and December 31, 1966).

Numerator

The percentage of members 51–75 years of age who had one or more screenings for colorectal cancer. Any of the following meet the criteria:

- Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year.

- Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year.

- Colonoscopy during the measurement year or the 9 years prior to the measurement year.

- CT colonography during the measurement year or the 4 years prior to the measurement year.

- FIT-DNA test during the measurement year or the 2 years prior to the measurement year.
Codes Used

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

Numerator:
- Fecal immunochemical test: Table 7D on Code List
- Flexible sigmoidoscopy: Table 7C on Code List
- Colonoscopy: Table 7A on Code List
- CT colonography: Table 7F on Code List
- FIT-DNA: Table 7G on Code List

Exclusions (only if not numerator hit)

Either of the following any time during the member’s history through December 31, 2017 of the measurement year:

- Colorectal cancer: Table 7B on Code List.
- Total colectomy: Table 7E on Code List.
Measure 7. Diabetes Management – HbA1c Good Control (≤9%)

**Description**

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

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. 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. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life, and reduce healthcare costs. The QIP includes three measures for diabetes management.

Achieving outstanding levels of population control of HbA1c is a challenging endeavor, not expected as part of the routine PCP contract. Improvements in Hemoglobin A1c Control have been associated with decreased morbidity and mortality from treatment of diabetic complications, and as a result, reduced proximal health care costs.

**Thresholds**

- **Full points**: 90th percentile (70.7 %)
- **Half points**: 75th percentile (63.1%)
- **Relative Improvement Targets**:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

**Denominator**

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1942 and December 31, 1999) with diabetes identified as of December 31, 2017.

There are two ways to identify members with diabetes: by 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 may count services that occur during the measurement year or the year prior, i.e. January 1, 2016 – December 31, 2017.

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, 2016 – December 31, 2017).

- At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters, on different dates with service, with a diagnosis of diabetes. The visit types do need not be the same for the two visits.
- At least one acute inpatient encounter with a diagnosis of diabetes.
Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

### Numerator

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

### Codes Used

**Denominator:**
- Codes to identify outpatient visits: Table 1D on Code List
- Codes to identify observation visits: Table 5I on Code List
- Codes to identify ED visits: Refer to Table 5G on Code List
- Codes to identify nonacute inpatient encounters: Table 8G on Code List
- Codes to identify acute inpatient encounters: Table 5A on Code List
- Codes to identify diabetes diagnosis: Table 8A on Code List
- Codes to identify insulin or hypoglycemics/antihyperglycemics: Table CDC-A on Code List

**Numerator:**
- Codes to identify HbA1c good control: Table 10F on Code List
- Codes to identify HbA1c test: Table 10K on Code List

### Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2016 – December 31, 2017), and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes (Table 8B on Code List) in any setting, during the measurement year or the year prior to the measurement year.
**Measure 8. Diabetes Management – Retinal Eye Exam**

**Description**

The percentage of members 18-75 years of age who had a diagnosis of diabetes who have had regular retinal eye exams.

Meeting and exceeding targets for population-level retinal eye exams is challenging: providers often do not have the time or equipment necessary to conduct retinopathy exams. These challenges are not addressed as part of routine PCP contracts. This measure encourages more retinal eye exams, which some studies indicate reduce complications of diabetes and associated health care costs. One study found that screening and treatment for eye disease in patients with type II diabetes generates annual savings of $24.9 billion to the federal government.16

**Thresholds**

- **Full points:** 90th percentile (68.1%)
- **Half points:** 75th percentile (61.7%)
- **Relative Improvement Targets:**
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.0% (50% Points)
  - 0.1%-4.0% (25% Points)

**Denominator**

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1942 and December 31, 1999) with diabetes identified as of December 31, 2017.

There are two ways to identify members with diabetes: by 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 may count services that occur during the measurement year or the year prior (January 1, 2016 – December 31, 2017).

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, 2016 – December 31, 2017).

- At least 2 outpatient visits, observation visits, ED visits, or non-acute inpatient encounters, on different dates with service, with a diagnosis of diabetes. The visit types do need not be the same for the 2 visits.

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

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (January 1, 2016 – December 31, 2017).

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

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

  **OR**

- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year (January 1, 2016 – December 31, 2016).

### Codes Used

**Denominator:**
- Codes to identify outpatient visits: Table 1D on Code List.
- Codes to identify observation visits: Table 5I on Code List.
- Codes to identify ED visits: Refer to Table 5G on Code List.
- Codes to identify nonacute inpatient encounters: Table 8G on Code List.
- Codes to identify acute inpatient encounters: Table 5A on Code List.
- Codes to identify diabetes diagnosis: Table 8A on Code List.
- Codes to identify insulin or hypoglycemics/antihyperglycemics: Table CDC-A on Code List.

**Numerator:**
- Codes to identify diabetic retinal screening: Table 10C on Code List, billed by an eye care professional (specialty code 18 and 59), during the measurement year.
- Codes to identify diabetic retinal screening with eye care professional: Table 10D on Code List, billed by any provider type, during the measurement year.
- Codes to identify negative diabetic retinal screening: Table 10E on Code List, billed by any provider type, during the measurement year.
- Codes to identify diabetic retinal screening: Table 10C on Code List, billed by an eye care professional (specialty code 18 and 59), with a diagnosis of Diabetes Mellitus without complications (Table 10H on Code List).

For exams performed with a negative result in the year prior to the measurement year (January 1, 2016 – December 31, 2016), a result must be available.

### Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2016 – December 31, 2017), and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes (Table 8B on Code List) in any setting, during the measurement year or the year prior to the measurement year.
Measure 9. Diabetes Management – Nephropathy Screening Test or Evidence of Nephropathy

**Summary**

- **Description:** The percentage of members 18-75 years of age who had a diagnosis of diabetes with a recent nephropathy screening test or evidence of nephropathy.

- **Thresholds:**
  - Full points: 90th percentile (93.5%)
  - Half points: 75th percentile (92.0%)
  - Relative Improvement Targets:
    - ≥ 15% (Full Points)
    - 10.0%-14.9% (75% Points)
    - 5.0%-9.9% (50% Points)
    - 0.1%-4.9% (25% Points)

- **Denominator:** The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1942 and December 31, 1999) with diabetes identified as of December 31, 2017.

- **Numerator:** The number of diabetics in the eligible population with a nephropathy screening or monitoring test or evidence of nephropathy, including diabetics who had one of the following during the measurement year.

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**Thresholds**

- **Denominator:** The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1942 and December 31, 1999) with diabetes identified as of December 31, 2017.

- **Numerator:** The number of diabetics in the eligible population with a nephropathy screening or monitoring test or evidence of nephropathy, including diabetics who had one of the following during the measurement year.
Any of the following meet the criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:
  - 24-hour urine for albumin or protein.
  - Timed urine for albumin or protein.
  - Spot urine for albumin or protein.
  - Urine for albumin/creatinine ration.
  - 24-hour urine for total protein.
  - Random urine for protein/creatinine ratio.

- Documentation of a visit to a nephrologist.

- Documentation of a renal transplant.

- Documentation of medical attention for any of the following (no restriction on provider type):
  - Diabetic nephropathy.
  - ESRD.
  - Chronic renal failure (CRF).
  - Chronic kidney disease (CKD).
  - Renal insufficiency.
  - Proteinuria.
  - Albuminuria.
  - Renal dysfunction.
  - Acute renal failure (ARF).
  - Dialysis, hemodialysis or peritoneal dialysis.

- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at a minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

A process flow diagram is included below to help implement this specification.

### Codes Used

**Denominator:**
- Codes to identify outpatient visits: Table 1D on Code List.
- Codes to identify observation visits: Table 5I on Code List.
- Codes to identify ED visits: Refer to Table 5G on Code List.
- Codes to identify nonacute inpatient encounters: Table 8G on Code List.
- Codes to identify acute inpatient encounters: Table 5A on Code List.
- Codes to identify diabetes diagnosis: Table 8A on Code List.
- Codes to identify insulin or hypoglycemics/antihyperglycemics: Table CDC-A on Code List.

**Numerator:**
- Codes to identify evidence of ESRD: Table 8C on Code List.
- Codes to identify evidence of kidney transplant: Table 8F on Code List.
- Codes to identify a nephropathy screening or monitoring test: Table 10J on Code List.
- Codes to identify evidence of treatment for nephropathy or ACE/ARB therapy: Table 10G on Code List.
- Codes to identify evidence of Stage 4 chronic kidney disease: Table 10B on Code List.
- Codes to identify ACE inhibitor or ARB dispensing event: Table CDC-L on Code List.

### Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2016 – December 31, 2017), and who meet either of the following criteria:
A diagnosis of gestational diabetes or steroid-induced diabetes (Table 8B on Code List) in any setting, during the measurement year or the year prior to the measurement year.

**Monitoring for Diabetic Nephropathy**

**STEP 1:**
Is there documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy or dialysis or renal transplant?

- **YES**
  - STOP! Member is compliant
- **NO**

**STEP 2:**
Was a urine test for albumin or protein performed during the measurement year?

- **YES**
  - STOP! Member is compliant
- **NO**

**STEP 3:**
Review for evidence of ACE inhibitor/ARB therapy. Is there evidence of therapy in the measurement year?

- **YES**
  - STOP! Member is compliant
- **NO**

STOP! Member is not compliant.
Measure 10. Admissions/1000 members

**Description**

Total number of admissions in an acute care hospital during the measurement year per 1000 members per year.

Reducing the number of admissions in acute care settings is a difficult challenge for primary care providers. It is not part of routine PCP contracts. The QIP incentivizes this measure so patients’ problems can be managed early and intensively by primary care physicians in the hope of reducing the need for hospital admissions.

**Thresholds**

- Full points: 110% or less than target
- Half points: 111-119% of target

Targets are set using plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets were sent with January 2017 Non-Clinical Reports.

**OR**

If Admissions per 1000 threshold/or Readmission rate threshold is not met, providers may earn points based on performance on a back-up measure: Follow up visit within 4 days of discharge (see specifications below).

**Data Criteria**

A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

PHC will calculate the total number of admissions using PHC allowable claims and encounter data from acute care hospitals for services provided to the physician’s assigned members.

Calculation: \[ \text{Admissions/1000} = \frac{\text{Total \# of admissions}}{\text{Total member months}} \times 12,000 \]

**Exclusions**

Admissions for maternity care and newborn nursery days as identified by revenue code.

Stays at following facilities: Long Term Care, Intermediate Care, Sub-acute, Rehabilitation, Behavioral health
Measure 11. **Readmission Rate**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio of acute hospital admissions that are within 30 days of a discharge to total number of inpatient stays that meet Continuous Plan enrollment criteria.</td>
</tr>
</tbody>
</table>

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. Unplanned readmissions are associated with increased mortality and higher health care costs.\(^{23}\)

Similar to Admissions, reducing readmissions is not part of routine PCP contracts. The QIP leverages this burden in order to incentivize providers to optimize post-discharge care to prevent hospital readmission, which carries significant health care costs.

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full points: 110% or less than target</td>
</tr>
<tr>
<td>Half points: 111-119% of target</td>
</tr>
</tbody>
</table>

Targets are set by practice type using plan-wide mean. Practice type risk adjusted targets were sent with January 2017 Non-Clinical Reports.

**OR**

If Admissions per 1000 threshold or Readmission Rate threshold is not met, sites may earn points based on performance on a back-up measure “Follow up visit within 4 days of discharge” (See specifications below).

<table>
<thead>
<tr>
<th>Data Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 3 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.</td>
</tr>
</tbody>
</table>

Using paid claim and capitated encounter data, PHC will identify all acute inpatient stays not subject to the exclusion criteria with a discharge date within the measurement period. The denominator is the count of all continuous stays (discharge date on or between January 1 and November 30 of the measurement year); the numerator is the count of all 30-day readmissions (admission date on or between January 1 and December 31 of the measurement year).

For acute-to-acute transfers, the original admission date is the admission date for the entire stay and the transfer’s discharge date is the discharge date for the entire stay.

Transfers to rehabilitation, sub-acute, or nursing facilities will be counted as discharges.

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions for maternity care and newborn nursery days as identified by revenue code.</td>
</tr>
</tbody>
</table>

| |
| Transitions at following facilities: Long Term Care, Intermediate Care, Sub-acute, Rehabilitation, Behavioral health |

---

\(^{23}\) Source: Health Affairs, 2017.
Measure Alternative: Back-Up Measure: Follow-Up Post Discharge

**Description**

This measure is used as a back-up only if target for either Admissions/1000 or Readmission Rate is not met.

Percentage of inpatient stays followed by an office visit or telephonic encounter within 4 calendar days of discharge for acute care hospital admissions incurred during the measurement year.

Unplanned readmissions can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management.23

Following-up with each patient soon after a discharge from an inpatient facility has been found to reduce the probability of costly hospital readmission. It is external from the requirements of routine PCP contracts.

**Thresholds**

- Full points: 50% of discharged members contacted
- Half points: 25-49% of discharged members contacted

Follow-Up Post Discharge can be the back-up measure for either Admissions/1000 or Readmission Rate, but not both. If a provider exceeds thresholds for both Admissions/1000 and Readmission Rate, the back-up measure will only be counted for one of the measures.

Follow-up visits include both primary care and specialty care visits and excludes follow-up visits to hospitals. A telephonic encounter may count if it is made by the clinician or a licensed staff member who can assess the patient’s status, do a medication review, and educate the patient about when to follow up in person.

**Data Criteria**

For practice sites that have not met the targets for Admissions per 1000 or Readmission Rate, PHC will collect preliminary inpatient stay data after the conclusion of the measurement year (December 31, 2017) and identify stays with no associated office visit claim with a date of service within 4 calendar days of discharge. PHC will distribute to practice sites a list of their patients’ hospitalizations. Practice sites will return the list to PHC indicating the date a telephonic encounter or office visit occurred if applicable. This returned data will be incorporated into the final follow-up percentage calculation. Data submitted is subject to audit of patients’ medical charts. Only one visit or phone call per discharge will be counted.

The following codes are used to identify office visits for the back-up measure reviewing Follow-Up Post Discharge events: 99201, 99215, 99241, 99245, 99341, 99350, 99354, 99357, 99366, 99443, and CH01.

Calculation:

\[
\text{Percentage of discharges with follow up} = \frac{\text{Total \# of office visits and phone calls}}{\text{Total \# of discharges}}
\]

**Exclusions**

- Admissions for maternity care and newborn nursery days as identified by revenue code.

- Stays at following facilities: Long Term Care, Intermediate Care, Sub-acute, Rehabilitation, Behavioral health
Measure 12. Pharmacy Utilization

Description
The percentage of generic prescription fills compared to total fills (generic + brand) for prescriptions written by professional staff assigned to the primary care site for the site’s assigned members only.

The percentage of formulary compliant prescription fills compared to total fills (formulary + non-formulary) for prescriptions written by professional staff assigned to the primary care site for the site’s assigned members only.

Managing the rate of generic prescriptions for a panel of patients is a challenge for providers that falls outside of general PCP contracts. The QIP incentivizes this measure in order to reduce the number of costly prescriptions paid for by the plan when safe and effective alternatives exist for less cost.

Thresholds
- Full points: At least 85% generic rate or 98% formulary compliance rate.
- Half points: 83.0-84.9% generic rate or 96.0-97.9% formulary compliance rate.

Data Criteria
A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

PHC will calculate total number of pharmacy claims data from MedImpact (PHC’s Pharmacy Benefit Manager).

Calculations:

\[
\text{Generic Prescription Rate} = \frac{\text{generic fills}}{\text{generic} + \text{brand fills}}
\]

\[
\text{Formulary Compliance Rate} = \frac{\text{formulary fills}}{\text{formulary} + \text{non-formulary fills}}
\]

Exclusions
Prescriptions for products not classifiable as either brand of generic, such as supply-type items. Drugs dispensed directly by the primary care site.
Measure 13. Avoidable ED Visits/1000 Members Per Year

**Description**

The average rate of assigned members' ER visits per member per year considered avoidable based on diagnosis code (refer to the Avoid ED tab on the Code List for a complete description).

Patient behavior is the largest factor affecting ED visits - it's well known within the healthcare industry that, oftentimes, patients will seek care for acute injuries or illnesses at an ED when their primary care provider is not available outside of office hours. Controlling the number of avoidable ED visits requires addressing patient access to care and influencing an individual's health behaviors, both of which are external to routine PCP contracts. This measure exists to encourage providers to focus on this access issue, and to help curb the high costs associated with preventable ED visits.

**Thresholds**

- Full points: At or below target

Targets are set using plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets were sent with January 2017 Non-Clinical Reports.

**Data Criteria**

A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

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

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

**Calculation**

\[
\text{Avoidable ED Visits per 1000} = \frac{\text{Avoidable ED visits}}{\text{Non-Dual Capitated Member Months}} \times 12,000
\]

**Exclusions**

Members age <1
**Measure 14. Practice Open to New PHC Members**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice must remain open to new PHC members for a full quarter to obtain points. Providers are not required to accept new patients as part of their regular contracts. The QIP incentivizes this practice in order for patients to have options when establishing care, and to help curb costs by increasing opportunity for instituting strong preventive health practices in new patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Open 1 quarter: 1 point</td>
</tr>
<tr>
<td>• Open 2 quarters: 2 points</td>
</tr>
<tr>
<td>• Open 3 quarters: 3 points</td>
</tr>
<tr>
<td>• Open 4 quarters: 5 points (bonus point for being open all year)</td>
</tr>
<tr>
<td>• Partial points (1/2 point) earned for practices open for a full quarter but with age restrictions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations department verifies the status of PCP site member acceptance by auditing providers on a monthly/quarterly basis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
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</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

MAXIMUM NUMBER OF POINTS: 5
Measure 15. **PCP Office Visits Per Member Per Year**

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>The average number of assigned members' visits to PCP per member per year. Providers are often empaneled with a large number of patients for whom they are expected to establish care. Routine PCP contracts however do not demand a certain number of visits each year. This measure incentivizes providers to reach out to patients that have not established care, potentially identifying health concerns that can become costly if left untreated.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full points: At or above target</td>
</tr>
</tbody>
</table>

Targets are set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets were sent with January 2017 Non-Clinical Reports.

<table>
<thead>
<tr>
<th>Data Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30. PHC will calculate the total eligible non-dual capitated member months after the month-end eligibility reconciliation load from the State. Member months are calculated by counting the total number of members who are eligible at the end of each month. PHC will extract the total number of PHC office visits using allowable PHC claim and encounter data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site. An estimate for incurred but not yet paid/processed claims data will be included.</td>
</tr>
</tbody>
</table>

Calculation:

\[
PCP \text{ Office Visits PMPY} = \left( \frac{\# \text{ Office Visits}}{\text{Non-Dual Capitated Member Months}} \right) \times 12
\]

<table>
<thead>
<tr>
<th>Exclusions</th>
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<tbody>
<tr>
<td>N/A</td>
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</tbody>
</table>


Measure 16. Advanced Care Planning

**Description**

This measure pays for both the process and the outcome of advance care planning discussions.

Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members over the age of 18. Providers will receive $100 for each submitted attestation to ACP conversations (100 per year limit). In addition, providers will receive $100 for each submitted advanced directive OR a Physician Orders for Life-Sustaining Treatment (POLST) form (combined 100 per year limit).

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

**Measure Requirements**

**Advance Directive and/or POLST Submission:**
Submit an Advance Directive and/or POLST. Only one submission of each form per patient per measurement year. Include identification information such as the member’s name, date of birth, and CIN in submission.

**Attestation Submission:**
Submit an Attestation Form (Appendix IV) or medical record evidence of the Advance Care Planning conversation. Only one submission per patient per measurement year. Discussions by doctors, nurse practitioners, physician assistants, or other licensed staff (including RN, LVN, PsyD, LSW, and chaplains) who have received training on ACP would qualify.

Note that ACP is a covered benefit and can be reimbursed. If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC’s Claims Department to identify conversations that have been reimbursed.

If submitting medical record, you may refer to (Appendix II) for components to be documented. The minimum would be documentation that an advance care planning conversation took place on the date of service being billed, with a summary of the outcome. In terms of ideal components of an advance care planning discussion to document in the chart, they are:

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

If a POLST is appropriate, some status options include:
- Discussed
- Given to patient
- Completed
- Copy in chart
- Patient refused

Plan for next conversation.

This measure is not exclusive to patients with a life-limiting disease or condition.

**Submission Process**
Submit completed attestations (Appendix I), medical record evidence (Appendix II), Advance Directives, and/or POLST forms via fax or email to QIP@partnershiphp.org. To receive reimbursement, documentation must be submitted for each completed conversation.

Submissions are due to Partnership no later than January 31, 2018. Payments will be made on an annual basis.

**Exclusions**
If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC’s Claims Department to identify conversations that have been reimbursed.
**Measure 17. Extended Office Hours**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP sites receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.</td>
</tr>
<tr>
<td>PCP sites and PCP sites that are part of a large organization and within a 5 mile radius of each other are eligible for the increased cap.</td>
</tr>
<tr>
<td>Example 1: A parent organization has two sites within 5 miles of each other (Site A and Site B). Site A meets the criterion for holding extended office hours. Site B does not hold extended office hours. Since Site B is within a 5 mile radius, patients who are seen at Site B can easily access Site A during the extended hours of service. Both Site A and Site B are eligible for the payment.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measure Requirements</th>
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<tbody>
<tr>
<td>PCP site must be open an additional 8 hours per week or more, beyond the normal business hours, defined as Monday-Friday, 8:00 a.m. to 5:00 p.m., for the entire quarter.</td>
</tr>
<tr>
<td>No points awarded 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Submission Process</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
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</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
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</thead>
<tbody>
<tr>
<td>An exception to this measure is made for any PHC site with less than 2000 members and more than 30 minute drive to the nearest ED. They would need to demonstrate the following:</td>
</tr>
</tbody>
</table>

  - 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 September 30, 2017. |

  - Demonstrate the use of arrangement with at least three PHC members seen in the office after hours per quarter, to be submitted quarterly by the site to their Provider Relations representative of your county. Please note this measure is subject to an audit by the Provider Relations department. Deadlines are as follows: |

Measure 18. *Patient-Center Medical Home Recognition*

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
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<tbody>
<tr>
<td>One-time payment for achieving Level 1 ($2,000), Level 2 ($3,000), or Level 3 ($3,500) recognition from NCQA, or equivalent from AAAHC or JCAHO.</td>
</tr>
</tbody>
</table>

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

Refer to Appendix III for submission template for this measure.

<table>
<thead>
<tr>
<th><strong>Measure Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with a minimum of 50 assigned Partnership members. Sites must receive accreditation within the measurement year. Documentation of PCMH recognition from NCQA, AAAHC, or JCAHO must be faxed or emailed to <a href="mailto:QIP@partnershiphp.org">QIP@partnershiphp.org</a> by January 31, 2018. Payments for each level are not aggregate.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Submission Process</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>You may refer to (Appendix III) for the documentation template, which can be faxed or emailed to <a href="mailto:QIP@partnershiphp.org">QIP@partnershiphp.org</a> by January 31, 2018.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Exclusions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with fewer than 50 assigned Partnership members.</td>
</tr>
</tbody>
</table>
**Description**

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

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

Refer to Appendix IV for submission template for this measure.

### Measure Requirements

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

Qualifying peer groups must meet at least 4 times in the 2017 calendar year and have a peer-facilitation component and a self-management component. Group can serve both PHC and non-PHC members, but must include at least 16 PHC total member visits per year (For example, if there are 4 PHC members in the group and the group meets for 4 sessions, the group will meet this criterion). The groups may be general, for patients with a variety of conditions, or focused on specific diseases or conditions, such as: Diabetes, Rheumatoid Arthritis, Chronic Pain, Hepatitis C, Cancer, Congestive Heart Failure, COPD, Asthma, Depression, Anxiety/Stress, Substance use, Pregnancy.

Groups that were approved and rewarded during the 2016-2017 measurement year are not eligible during the transition period.

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

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

Maximum of 5 groups per site and 10 per corporate entity eligible for payment.
Documentation will be reviewed and approved by the CMO or physician designee. Proposed groups may submit elements 1-7 above prospectively for review and feedback at any time in the year, before groups start, to ensure program will be eligible for bonus.

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

**Submission Process**

All documentation must be submitted on the Peer-led Self-Management Support Group template (Appendix IV) by January 31, 2018, and can be faxed or emailed to QIP@partnershiphp.org.

**Exclusions**

Primary care provider sites with fewer than 50 assigned Partnership members.
Measure 20. Buprenorphine Qualified Providers

**Description**

Payment of $500 per credentialed prescriber who meets one of the following criteria:

- Newly trained buprenorphine provider

  **OR**

- Existing prescribers who are willing to take outside referrals.

Becoming qualified to prescribe buprenorphine treatments is not a requirement of traditional PCP contracts. This measure helps offset the cost for interested providers, whom can then offer opioid treatments in order to reduce the tremendous cost associated with opioid addiction.

**Measurement Requirement**

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

- Prescribers must be credentialed by the PHC Credentials Committee before December 31, 2017.

- Prescribers credentialed prior to July 1, 2017 should be listed in the PHC provider directory as buprenorphine providers.

- Maximum 5 prescribers per site are eligible for this incentive amount.

- Sites will be given credit for a previously credentialed prescriber that leaves at any point during the measurement year so long as he/she was part of that site for a minimum of six months during the measurement year.

**Submission Approval**

PHC will extract this data at the end of the year by working with the PHC credentialing department.

**Exclusions**

Primary care provider sites with fewer than 50 assigned Partnership members.
**Measure 21. Screening, Brief Intervention, Referral, and Treatment (SBIRT)**

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Sites will be reimbursed based on the number of screenings conducted for their adult substance abuse patients. The reimbursement will be $5 per each approved claim for screening within the measurement period.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Measure Requirements</th>
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</thead>
<tbody>
<tr>
<td>Primary care provider sites with a minimum of 50 assigned Partnership members.</td>
</tr>
</tbody>
</table>

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

- H0049 (Alcohol screening)

PHC’s claim system will validate and pay for up to two screenings for an individual every six months.

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

<table>
<thead>
<tr>
<th>Submission Process</th>
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<tbody>
<tr>
<td>PHC will extract this data 3 months after the end of the reporting year (i.e. March 31, 2018) by identifying claims for H0049 submitted through the claims department.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with fewer than 50 assigned Partnership members.</td>
</tr>
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</table>

Claims submitted in excess of two screenings per individual patient within a six month time frame.
**Measure 22. Health Information Exchange Participation**

<table>
<thead>
<tr>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Sites will be reimbursed for participating in a local or regional health information exchange (HIE). The reimbursement will be a one-time $2500 payment per contracted site.</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Measure Requirements</th>
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</thead>
<tbody>
<tr>
<td>In order to qualify for the incentive, linkage with the HIE has to be established by:</td>
</tr>
</tbody>
</table>

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

  **OR**

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

  **OR**

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

Recognized Community Health Information Exchange organizations include the following:

- Sac Valley Med Share
- North Coast Clinical Information Network
- Redwood Med Net
- Connect Healthcare
- Marin General Hospital/County HIE (in process of being formed)

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

<table>
<thead>
<tr>
<th>Submission Process</th>
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</thead>
<tbody>
<tr>
<td>Submit the HIE Attestation form (Appendix V) by January 31, 2018. PHC will validate the data exchange by working directly with the specified HIE.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
Appendix I: Advanced Care Planning – Attestation

Discussions by doctors, nurse practitioners, physician assistants, or other licensed staff (including RN, LVN, PsyD, LSW, and chaplains) who have received training on ACP would qualify for a financial bonus under PHC's Quality Improvement Program (QIP). You may submit one attestation per member per fiscal year, up to a maximum of 100 attestations. To be eligible for the incentive, please do the following:

1. Discuss end-of-life choices with your patient
2. Document the ACP discussion in the patient’s medical record
3. Complete this attestation form

ACP discussions must take place between July 1, 2017, and December 31, 2017. All attestations submitted are reviewed by PHC. Upon approval, the attestation will qualify for the incentive. Attestation forms should be submitted no later than January 31, 2018 via email at QIP@partnershiphp.org or fax at 707-863-4316.

Patient Name: _____________________________________________________________

Patient DOB: _____________________________  Patient CIN: _____________________________

I, ______________________(Clinician Name), practicing at __________________________
_________________________________________ (Organization) in _____________________ (City), hereby attest that the patient listed above had their choices around advance illness care discussed on ___________/_________/_________ (Date of Service). If someone other than me facilitated the conversation about ACP in our office, that person is trained and competent at conducting these discussions and the conversation was reviewed and confirmed by me with the patient. This ACP discussion is documented in the patient’s medical record, which I agree to being audited by PHC, and includes the following activities:

A. Advance Directive (AD) *One of the four boxes below must be checked for this form to be considered complete (Click here for AD sample)
   - Patient completed AD
   - Patient committed to filling AD out after ACP discussion
   - Patient had previously completed his/her AD and reaffirmed they do not wish to make any changes
   - Patient declined to complete AD. Information given: pamphlet/handout about Advance Directives

B. POLST *One of the four boxes below must be checked for this form to be considered complete
   (Click here for the English California POLST Form). Completed POLST forms must be available in the medical record in case of auditing.
   - POLST inappropriate for patient
   - POLST appropriate and signed
   - POLST appropriate but declined
   - Existing POLST in medical record was reviewed with the patient and updated as needed

Clinician Signature: _____________________________  Date: ____________________________
Appendix II: Advanced Care Planning – Medical Record Components

The following is a list of components we look for when determining whether an ACP discussion documented in a medical record qualifies for the ACP incentive:

Basic Information

- Patient’s name, date of birth, and CIN
- Whether written materials on **advance directive and POLST** was given to patient to review, and whether an Advance Directive and/or POLST is completed or updated
- Clinician’s name and organization
- Date of discussion

Patient general preferences around end of life

- At this time, patient wishes all treatments to be done that have any amount of potential life lengthening effect, regardless of pain or discomfort
- At this time, patient would like to balance the potential benefits with the side effects of treatment options on a case by case basis.
- At this time, patient would like only treatments that will alleviate pain, anxiety and discomfort, even if this shortens life somewhat

*If patient is unable to make decisions, and unable to discuss details of care with health care decision maker, use this course of action:*

- All treatments given if my attending physician determines possible benefit.
- Comfort care (includes no tube feeds)
- Comfort care plus a short term trial of tube feed
- All treatments given except
  - Chest compressions
  - Cardiac shock
  - Intubation (breathing tube)
  - Tube feeds
  - Intravenous treatments: _If heart stops ___antibiotics _other: _________
  - Blood transfusion (List reason:________________________)
  - Other specific limitations of care expressed:________________________

Details of discussion: __________________________________________________________

____________________________________________________________________________
Quality Improvement Program
Patient Centered Medical Home Recognition Template

Please complete all of the following fields on this form by **January 31, 2018** 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. **Date of recognition received:**

3. **Circle level accomplished:**

   - Level 1
   - Level 2
   - Level 3
   - Levels 4

4. **If recognition received electronically, provide a screenshot of recognition received**

5. **Attach a copy of PCMH recognition documentation provided by the recognizing entity.**

**Additional Notes/Comments:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Quality Improvement Program
Peer-led Self-Management Support Group Template

Please complete all of the following fields on this form by **January 31, 2018** and send to:

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

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

1. **Name of group**

2. **Name and background information/training of group facilitator**

3. **Site where group visits took place**

4. **Narrative on the group process that includes: location and frequency of the group meetings**

5. **List of major topics/themes discussed at each meeting**

6. **A description of the way that self-management support is built into the groups**

7. **An assessment of successes and opportunities for improvement of the group**

8. **Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and date of group**
Appendix V: Submission Template for HIE

Quality Improvement Program
Health Information Exchange (HIE) Reporting Template

If you intend to participate in the HIE measure for the 2017 QIP Transition Period, please complete all of the following fields on this form and submit by January 31, 2018 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. 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. Date of registration: _______________________________

4. Name of the HIE linked to (check the option that applies):
   - ☐ Sac Valley Med Share
   - ☐ North Coast Clinical Information Network
   - ☐ Redwood Med Net
   - ☐ Connect Healthcare
   - ☐ Marin General Hospital/County HIE (in process of being formed)

Submitted by: _______________________________ Date: _______________________________
Title: _______________________________ Phone: _______________________________
Email: ________________________________________________________________________
### Appendix VI: 2017 QIP Transition Period Submission Timeline

<table>
<thead>
<tr>
<th>DUE DATE</th>
<th>QIP MEASURE</th>
<th>REPORTING TEMPLATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 31, 2018</td>
<td>Advance Care Planning</td>
<td>Appendix I, Appendix II</td>
</tr>
<tr>
<td>January 31, 2018</td>
<td>PCMH Recognition</td>
<td>Appendix III</td>
</tr>
<tr>
<td>January 31, 2018</td>
<td>Peer-led Self-Management Support Group</td>
<td>Appendix IV</td>
</tr>
<tr>
<td>January 31, 2018</td>
<td>Health Information Exchange</td>
<td>Appendix V</td>
</tr>
</tbody>
</table>
| 14 days after receiving report from PHC, in March 2018 | Follow-up post discharge | Complete report will be provided by PHC  
(If you do not meet the target for Admissions/1000 or Readmission Rate by the end of the measurement year, PHC will provide a list of patients discharged during the measurement year who have no claims data for a follow-up encounter). |
### Appendix VII: Data Source Table

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

<table>
<thead>
<tr>
<th>Fixed Pool PMPM Measures</th>
<th>Data Source*</th>
<th>System Used for Data Monitoring</th>
<th>System Used for Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Care: Pediatric Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Nutrition Counseling (ages 3-17)</td>
<td>PHC and Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Physical Activity Counseling (ages 3-17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Well Child Visits (ages 3-6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Childhood Immunization – DTaP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Childhood Immunization- MMR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Immunizations for Adolescents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Asthma Care (ages 5-18)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Care: Family Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Monitoring Patients on Persistent Medications</td>
<td>PHC and Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Well Child Visits (ages 3-6)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Childhood Immunization – DTaP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Controlling High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Cervical Cancer Screening (ages 24-65)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Colorectal Cancer Screening (ages 50-75)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7. HBA1C Good Control</td>
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<td></td>
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</tr>
<tr>
<td>8. Retinal Eye Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Nephropathy screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Care: Internal Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Monitoring for Patients on Persistent Medications</td>
<td>PHC and Provider</td>
<td>eReports</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Controlling High Blood Pressure</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Cervical Cancer Screening (ages 24-65)</td>
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</tr>
<tr>
<td>4. Colorectal Cancer Screening (ages 50-75)</td>
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</tr>
<tr>
<td>5. HbA1C Good Control</td>
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</tr>
<tr>
<td>6. Retinal Eye Exam</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Nephropathy screening</td>
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</table>
### Appropriate Use of Resources: Pediatric Medicine

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC</th>
<th>Monthly Reports</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pharmacy Utilization</td>
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</table>

### Appropriate Use of Resources: Family and Internal Medicine

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<thead>
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<th>Measure</th>
<th>PHC</th>
<th>Monthly Reports</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admissions/ 1000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Readmission Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pharmacy Utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Back-Up Measure: Follow-Up Post Discharge**

*Back-up measure for either Admissions/1000 or Readmission Rate, but not both.*

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC and Provider</th>
<th>Report emailed by PHC in March 2018</th>
<th>Report emailed by PHC in March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admissions/ 1000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Readmission Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Pharmacy Utilization</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Access/Operations Measures: All Practice Types

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC</th>
<th>Monthly Reports</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>1. Avoidable ED Visits</td>
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<td></td>
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</tr>
<tr>
<td>2. Practice “open” to PHC members</td>
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</tr>
<tr>
<td>3. PCP Office Visits</td>
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</table>

### Unit of Service Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source*</th>
<th>System Used for Data Monitoring</th>
<th>System Used for Data Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advance Care Planning</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>2. Access/Extended Office Hours</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>3. PCMH Certification</td>
<td>PHC and Provider</td>
<td>Summary along with quarterly checks</td>
<td>Provider Relations Department</td>
</tr>
<tr>
<td>4. Peer-led self-management support groups</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>6. Buprenorphine Qualified Providers</td>
<td>PHC and Provider</td>
<td>Year-End Report</td>
<td>Provider Relations Department</td>
</tr>
<tr>
<td>7. SBIRT: $5 per screening</td>
<td>PHC</td>
<td>Year-End Report</td>
<td>N/A</td>
</tr>
<tr>
<td>8. Health Information Exchange</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
</tbody>
</table>
Appendix VIII: Works Cited for All Practice Types


