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

PEDIATRIC MEDICINE PRACTICES

Developed by: The QIP Team

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# Table of Contents

I. Program Contact Info ........................................................................................................ 2  
II. Program Overview ........................................................................................................... 2  
III. Summary of Measures ................................................................................................. 6  
IV. Domain 1: Clinical Fixed Pool Measures  
   1. Nutrition Counseling .................................................................................................... 10  
   2. Physical Activity Counseling ....................................................................................... 12  
   3. Well Child Visits ......................................................................................................... 14  
   4. Childhood Immunization: DTaP ............................................................................... 16  
   5. Childhood Immunization: MMR ............................................................................... 17  
   6. Adolescent Immunization ......................................................................................... 19  
   7. Asthma Care .............................................................................................................. 21  
V. Domain 2: Appropriate Use of Resources  
   8. Pharmacy Utilization .................................................................................................. 24  
VI. Domain 3: Access and Operations  
   9. Avoidable ED Visits/1000 Members Per Year ............................................................ 25  
   10. Practice Open to New PHC Members .................................................................... 26  
   11. PCP Office Visits Per Member Per Year ................................................................... 27  
VII. Domain 4: Unit of Service  
   12. Advanced Care Planning .......................................................................................... 28  
   13. Extended Office Hours ............................................................................................ 30  
   14. Patient-Centered Medical Home Recognition ...................................................... 32  
   15. Peer-Led Self-Management Support Groups ........................................................... 33  
   16. Buprenorphine Qualified Providers ....................................................................... 35  
   17. Screening, Brief Intervention, Referral, and Treatment (SBIRT) ............................ 36  
   18. Health Information Exchange .................................................................................. 37  
VIII. Appendix  
   I. Advanced Care Planning – Attestation ...................................................................... 39  
   II. Advanced Care Planning – Medical Records ............................................................ 40  
   III. Patient-Centered Medical Home Documentation .................................................. 41  
   IV. Peer-Led Self-Management Support Group Submission ........................................... 42  
   V. HIE Submission Template ......................................................................................... 43  
   VI. Submission Timeline ................................................................................................ 44  
   VII. Data Source Table .................................................................................................... 45  
   VIII. Works Cited ............................................................................................................. 47
I. Quality Improvement Program Contact Information

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Fax: (707) 863-4316
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. 5-8 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 July 2017 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.

Payment Dispute Policy
Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and, during the validation period at the end of the measurement year, review data on which your final point earnings will be based. Dispute of final data described below will not be considered:

1. QIP scores on eReports
   eReports refreshes data on a daily basis and providers have access to eReports through the well-published grace period (usually 30-45 days after the end of the measurement year) to check for data disparities. Additionally, providers have access to eReports for during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, PHC may assist a provider with uploading data before the close of the grade period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.

2. Exclusions on eReports
   Some exclusions from denominators, when approved, involve a manual process by PHC staff. Since the QIP receives a large volume of exclusion requests, providers are responsible for checking that members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered.

3. Data reported on the Year-End Preliminary Report
   At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the final point earnings for measures that are tracked manually, such as Patient Experience and Practice Open to PHC Members. Providers will be given one week to review this report for potential discrepancies. If a provider does not alert the QIP of any issues during the validation period, data on the Preliminary Report will be reflected in the final payment. Post-payment disputes on data on the Preliminary Report will not be considered.

4. Practice type and payment pool designations
   Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice. Each practice type is responsible for different QIP measures. For payment purposes, sites participate in either part of the institutional or the independent payment pool. Criteria regarding these designations is available in the PCP QIP Measurement Specification Documents. The QIP team is available throughout the measurement
year to answer questions about these designations as defined in the QIP. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.

5. Thresholds

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

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

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

*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.
<table>
<thead>
<tr>
<th>CRITERIA &amp; WEIGHT</th>
<th>RISK ADJUSTED?</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL DOMAIN (75 Points Total)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Nutrition Counseling (3-17 yrs) (10 pts)</td>
<td>No</td>
<td><strong>Full Points Targets for Existing Measures:</strong></td>
</tr>
<tr>
<td>2. Physical Activity Counseling (3-17 yrs) (10 pts)</td>
<td></td>
<td>• Nutrition Counseling (3-17 yrs): 79.5%</td>
</tr>
<tr>
<td>3. Well Child Visits (3-6 years) (15 pts)</td>
<td></td>
<td>• Physical Activity Counseling (3-17 yrs): 71.6%</td>
</tr>
<tr>
<td>4. Childhood Immunization – DTaP (10 pts)</td>
<td></td>
<td>• Well Child Visits (3-6 years): 83.0%</td>
</tr>
<tr>
<td>5. Childhood Immunization – MMR (10 pts)</td>
<td></td>
<td>• Childhood Immunization – DTaP: 85.2%</td>
</tr>
<tr>
<td>6. Adolescent Immunization (10 pts)</td>
<td></td>
<td>• Childhood Immunization – MMR: 94.3%</td>
</tr>
<tr>
<td>7. Asthma Care (10 pts)</td>
<td></td>
<td>• Adolescent Immunization: 86.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asthma Care: 68.0%</td>
</tr>
<tr>
<td><strong>APPROPRIATE USE OF RESOURCES (10 Points Total)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Pharmacy Utilization (10 points)</td>
<td>No</td>
<td><strong>Full points: At least 85.0% generic rate or 98.0% formulary compliance rate</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Half points: 83.0-84.9% generic rate or 96.0-97.9% formulary compliance rate</strong></td>
</tr>
<tr>
<td>ACCESS &amp; OPERATIONS (15 Points Total)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Avoidable ED Visits (5 points)</td>
<td>Yes: By PCP/Site³</td>
<td>Full Points: At or below site specific threshold</td>
</tr>
</tbody>
</table>
| 10. Practice open to PHC members (5 points) | No | 1 point per quarter + 1 extra point for all quarters:  
| | | Open 1 full quarter = 1 point  
| | | Open 2 full quarters = 2 points  
| | | Open 3 full quarters = 3 points  
| | | Open 4 full quarters = 5 points  
<p>| | | Partial Points: Any age restrictions = ½ points per quarter |
| 11. PCP Office Visits (5 points)     | Yes: By PCP/site³ | Full Points: At or above site specific threshold. The PHC plan-wide mean used to calculate site-specific threshold is 2.2 visits/year. |</p>
<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. *Nutrition Counseling*

**Description**

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

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

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

**Thresholds**

- Full points: 90th percentile (79.5%)
- Half points: 75th percentile (70.9%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9%  (50% Points)
  - 1.0%-4.9% (25%)

**Denominator**

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31, 2017 (DOB between January 1, 2000 and December 30, 2014) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

**Numerator**

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

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

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity counseling.

**Codes Used**

<table>
<thead>
<tr>
<th>Codes Used</th>
</tr>
</thead>
</table>
Denominator: Codes to identify Outpatient Visits from Claims/Encounter Data: (Table 1D on Code List).

Numerator: Codes to identify counseling for nutrition from claim/encounter data: (Table 1C on Code List).

---

**Exclusions (only if not numerator hit)**

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

Codes to identify exclusions: Table 1F on Code List.
Measure 2. Physical Activity Counseling

Description

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

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

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

Thresholds

- Full points: 90th percentile (71.6%)
- Half points: 75th percentile (63.5%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 1.0%-4.9% (25%)

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31, 2017, (DOB between January 1, 2000 and December 31, 2014) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

Numerator

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

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

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance specific to the child’s physical activity.
- Weight or obesity counseling.

**Codes Used**

Denominator: Codes to identify Outpatient Visits from Claims/Encounter Data: Table 1D on Code List.

Numerator: Codes to identify counseling for physical activity from claim/encounter data: Table 1E on Code List.

**Exclusions (only if not numerator hit)**

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

Codes to identify exclusions: Table 1F on Code List.
Measure 3. 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)
  - 1.0%-4.9% (25%)

**Denominator**

The number of continuously enrolled Medi-Cal members 3-6 years of age as of January 1, 2017 (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.

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.

<table>
<thead>
<tr>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: No codes applicable as eligibility is solely defined by age.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Exclusions (only if not numerator hit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>
Measure 4. *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.\(^4,5\) 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.\(^6,7\)

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)
  - 1.0%-4.9% (25%)

**Denominator**

The number of continuously enrolled Medi-Cal members who turn 2 years of age 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 second 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 2\(^{nd}\) 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 (refer to Table 3J on Code List).
Measure 5. *Childhood Immunization – MMR*

**Description**

The percentage of children 2 years of age who had 1 measles, mumps and rubella (MMR) vaccine by their 2nd 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 a 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 (94.3%)
- Half points: 75th percentile (92.7%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 1.0%-4.9% (25%)

**Denominator**

The number of continuously enrolled Medi-Cal members who turn 2 years of age 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 any of the following with a date of service on or before the child’s second birthday:

- At least one MMR vaccination (Measles, Mumps and Rubella).
- At least one measles and rubella vaccination and at least one mumps vaccination or history of the illness on the same date of service or on different dates of service.
- At least one measles vaccination or history of the illness and at least one mumps vaccination or history of the illness and at least one rubella vaccination or history of the illness on the same date of service or on different dates of service.
- A seropositive test result.
Denominator: No codes applicable as eligibility is solely defined by age.

Numerator:
- MMR vaccination: table 3E on Code List
- Measles and Rubella vaccination: Table 3F on Code List
- Mumps vaccination: Table 3G on Code List
- Measles vaccination: Table 3H on Code List
- Rubella vaccination: Table 3I on Code List
- History of Mumps: Table Mumps on Code List
- History of Measles: Table Measles on Code List
- History of Rubella: Table Rubella on Code List

Exclusions (only if not numerator hit)
Any of the following on or before the member’s second birthday would meet the exclusion criteria.

- Immunodeficiency: Table 3B on Code List.
- Anaphylactic reaction to the vaccine or its components: Table 3A on Code List.
- HIV: Table 3L on Code List.
- Lymphoreticular cancer, multiple myeloma or leukemia: Table 3M on Code List.
- Anaphylactic reaction to neomycin.
Measure 6. Adolescent Immunization

**Description**

The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had one does of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

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

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 (86.6%)
- Half points: 75th percentile (82.1%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 1.0%-4.9% (25%)

**Denominator**

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1, 2017 and December 31, 2017 (DOB between January 1, 2004 and December 31, 2004).

**Numerator**

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

At least one meningococcal conjugate or meningococcal polysaccharide vaccine with a date of service on or between the members’ 11th and 13th birthdays.

 AND

Any of the following with a date of service on or between the member’s 10th and 13th birthdays meet criteria:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine.

 OR

- At least one tetanus diphtheria toxoids (Td) vaccine.
• At least one tetanus vaccine and at least one diphtheria vaccine on the same date of service or on different dates of service.

Note: For meningococcal conjugate or polysaccharide and Tdap or Td, count only evidence of the antigen or combination vaccine.

For immunization information obtained from the medical record, count members where there is evidence that the antigen was rendered from either of the following:
• A note indicating the name of the specific antigen and the date of the immunization.
• A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

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

Numerator:
- Codes to identify Diphtheria Vaccine: Table 4B on Code List.
- Codes to identify Meningococcal vaccine: Table 4C on Code List.
- Codes to identify Td vaccine: 4D on Code List.
- Codes to identify Tdap vaccine: Table 4E on Code List.
- Codes to identify Tetanus Vaccine: Table 4F on Code List.

Exclusions (only if not numerator hit)
Exclude adolescents who had a contraindication for a specific vaccine. Either of the following meets the exclusion criteria:

• Anaphylactic reaction to the vaccine or its components on or before the member’s 13th birthday (Table 3A on Code List).
• Anaphylactic reaction to the vaccine or its components (Table 4A on Code List), with a date of service prior to October 1, 2011.
Measure 7. Asthma Care

Description
The percentage of members 5–18 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 50% of the treatment period.

Note: Treatment period is the time beginning on the index prescription start date (IPSD) through the last day of the measurement year.

Asthma is a treatable, reversible condition that affects more than 25 million people in the United States. Managing this condition with appropriate medications could save the U.S. billions of dollars in medical costs. The prevalence and cost of asthma have increased over the past decade, demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions and missed days of work or school.22

Meeting targets for controlling asthma medications across a population of patients is not part of routine PCP contracts. This measure is used by the QIP to assist providers in monitoring the efficacy of prescribed asthma medications.

Thresholds

- Full points: 90th percentile (68.0%)
- Half points: 75th percentile (59.1%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 1.0%-4.9% (25%)

Denominator
The number of continuously enrolled Medi-Cal members 5-18 years of age by December 31, 2017 (DOB between January 1, 1999 and December 31, 2012).

The eligible population for the measure is identified using the following steps:

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

- At least one ED visit with a principal diagnosis of asthma.
• At least 4 outpatient visits or observation visits on different dates of service, with any diagnosis of asthma and at least 2 asthma medication dispensing events. Visit types do need not to be the same for the 4 visits.

• At least one acute inpatient encounter, with a principal diagnosis of asthma.

• At least 4 asthma medication dispensing events.

**Step 2**
A member identified as having persistent asthma because of at least 4 asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of members in the eligible population who achieved a proportion of days covered (PDC) of at least 50% for their asthma controller medications during the measurement year.</td>
</tr>
</tbody>
</table>

The following steps are used to identify numerator compliance.

**Step 1**
Identify the index prescription start date IPSD, earliest dispensing event for any asthma controller medication during the measurement year.

**Step 2**
To determine the treatment period, calculate the number of days from the index prescription start date (IPSD) through December 31, 2017.

**Step 3**
Count the days covered by at least one prescription for an asthma controller medication during the treatment period. To ensure that days’ supply that extends beyond the measurement year is not counted, subtract any days’ supply that extends beyond December 31, 2017.

**Step 4**
Calculate the member’s proportion of days covered (PDC) using the following equation. Round (using the .5 rule) to 2 decimal places.

\[
\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)} \over \text{Total Days in Treatment Period (step 2)}
\]

Treatment period is the time beginning on the index prescription start date (IPSD) through the last day of the measurement year. Please note concerning the number of days covered:

• If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication using the prescriptions with the longest days supply.

• For multiple different prescriptions dispensed on different days with overlapping days’ supply, count each day within the treatment period only once toward the numerator.

• If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication. For example, 3 controller prescriptions for the same medication are dispensed on the same day, each with
a 30-day supply, sum the days’ supply for a total of 90 days covered by a controller. Subtract any days’ supply that extends beyond December 31, 2017.

**Step 5**
Sum the number of members whose PDC is > 50% for their treatment period.

<table>
<thead>
<tr>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator:</td>
</tr>
<tr>
<td>ED visit (Table 5G on Code List) with a principal diagnosis of asthma: Table 5C on Code List.</td>
</tr>
<tr>
<td>Outpatient visits: Table 1D on Code List</td>
</tr>
<tr>
<td>Observation visits: Table 5I on Code List</td>
</tr>
<tr>
<td>Asthma medication dispensing events: Table MMA-A on Code List.</td>
</tr>
<tr>
<td>Acute inpatient encounter: Table 5A on Code List.</td>
</tr>
</tbody>
</table>

| Numerator: |
| Asthma controller medication: Table MMA-B on Code List. |

| Exclusions (only if not numerator hit) |
| Exclude members who met any of the following criteria anytime during the member’s history through June 30, 2017: |
| • Acute Respiratory Failure: Table 5L on Code List. |
| • Chronic Respiratory Conditions Due to Fumes/Vapors: Table 5D on Code List. |
| • COPD: Table 5E on Code List. |
| • Cystic Fibrosis: Table 5F on Code List. |
| • Emphysema: Table 5H on Code List. |
| • Obstructive Chronic Bronchitis: Table 5J on Code List. |
| • Other Emphysema: Table 5K on Code List. |

Exclude members who had no asthma controller medications (Table MMA-B on Code List) dispensed during the measurement year.
Measure 8. 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:

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

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

**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 9. 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 table 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 Avoid ED table on 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 10. Practice Open to New PHC Members

**Description**
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.

**Thresholds**
- Open 1 quarter: 1 point
- Open 2 quarters: 2 points
- Open 3 quarters: 3 points
- Open 4 quarters: 5 points (bonus point for being open all year)
- Partial points (1/2 point) earned for practices open for a full quarter but with age restrictions.

**Data Criteria**
Provider Relations department verifies the status of PCP site member acceptance by auditing providers on a monthly/quarterly basis.

**Exclusions**
N/A
Measure 11. PCP Office Visits Per Member Per Year

**Description**

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.

**Thresholds**

- Full points (5 points): At or above target

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.

**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 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.

Calculation:

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

**Exclusions**

N/A
**Measure 12. 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 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.
UNIT OF SERVICE

Measure 13. Extended Office Hours

Description
Providers sites only capitated for primary care services sites receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

PCP sites that are part of a large organization and within a 5 mile radius of each other are eligible for the increased cap.

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.

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

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

Measure Requirements
PCP site must be open an additional 8 hours per week or more, beyond the normal business hours on Monday-Friday, for the entire quarter. 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 additional eight hour minimum.

Example 1: Open 8 a.m. and 6 p.m., Monday through Friday, closed during lunch hour (i.e. 9 hours per weekday), plus 3 hours on Saturday

Example 2: Open 8 a.m. and 5 p.m., Monday through Friday, open during lunch hour (i.e. 9 hours per weekday), plus 3 hours on Saturday

Example 3: Open 8 a.m. and 5 p.m., Monday through Saturday, closed during lunch hour (i.e. 8 hours per day)

Example 4: Open 9 a.m. and 5 p.m., Monday through Saturday, open during lunch hour (i.e. 8 hours per day)

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

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

- Have on-call arrangements available where by the on-call physicians come to the office to see urgent
problems (arrangement to be submitted in writing annually to the PR representative of your county,
including what types of urgent issues will be seen in the office) after hours. Deadline to submit arrangement is 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 14. Patient-Center Medical Home Recognition**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<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>Measure Requirements</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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Submission Process</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>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with fewer than 50 assigned Partnership members.</td>
</tr>
</tbody>
</table>
Measure 15. Peer-Led Self-Management Support Groups

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment for starting or continuing a peer-run self-management support group at a contracted primary care provider site ($1,000 per group).</td>
</tr>
</tbody>
</table>

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.

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

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 16. Buprenorphine Qualified Providers

<table>
<thead>
<tr>
<th>Description</th>
<th>One-time payment of $500 per credentialed prescriber who meets one of the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Newly trained buprenorphine provider</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>• Existing prescribers who are willing to take outside referrals.</td>
</tr>
</tbody>
</table>

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 costs associated with opioid addiction.

<table>
<thead>
<tr>
<th>Measurement Requirement</th>
<th>Primary care provider sites with a minimum of 50 assigned Partnership members.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Prescribers must be credentialed by the PHC Credentials Committee before December 31, 2017.</td>
</tr>
<tr>
<td></td>
<td>• Prescribers credentialed prior to July 1, 2017 should be listed in the PHC provider directory as buprenorphine providers.</td>
</tr>
<tr>
<td></td>
<td>• Maximum 5 prescribers per site are eligible for this incentive amount.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>

| 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.                   |
UNIT OF SERVICE

Measure 17. Screening, Brief Intervention, Referral, and Treatment (SBIRT)

Description
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.

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

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

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

- H0049 (Alcohol screening).

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

Submission Process
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.

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

Claims submitted in excess of two screenings per individual patient within a six month time frame.
Measure 18. **Health Information Exchange Participation**

**Description**

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.

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.

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

**Measure Requirements**

In order to qualify for the incentive, linkage with the HIE has to be established by:

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

  OR

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

  OR

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

Recognized Community Health Information Exchange organizations include the following:

- Sac Valley Med Share
- North Coast Clinical Information Network
- Redwood Med Net
- Connect Healthcare
- 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>
</tr>
</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, nurses, physician assistants, and other clinicians about Advance Care Planning with PHC Med-Cal only members ages 18 and older may 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@partnershipphp.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: ___________________
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:_____________________________________________________

__________________________________________________________________________
Appendix III: Patient-Centered Medical Home Documentation Template

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:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

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

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: 2016-2017 QIP 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>
<tr>
<td>14 days after receiving report from PHC, in March 2018</td>
<td>Follow-up post discharge</td>
<td>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).</td>
</tr>
</tbody>
</table>
**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>1. Nutrition Counseling (ages 3-17)</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Physical Activity Counseling (ages 3-17)</td>
<td>3. Well Child Visits (ages 3-6)</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>4. Childhood Immunization – DTaP</td>
<td>5. Childhood Immunization- MMR</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>6. Immunizations for Adolescents</td>
<td>7. Asthma Care (ages 5-18)</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td><strong>Clinical Care: Family Medicine</strong></td>
<td>1. Monitoring Patients on Persistent Medications</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Well Child Visits (ages 3-6)</td>
<td>3. Childhood Immunization – DTaP</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>4. Controlling High Blood Pressure</td>
<td>5. Cervical Cancer Screening (ages 24-65)</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>6. Colorectal Cancer Screening (ages 50-75)</td>
<td>7. HBA1C Good Control</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>8. Retinal Eye Exam</td>
<td>9. Nephropathy screening</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td><strong>Clinical Care: Internal Medicine</strong></td>
<td>1. Monitoring for Patients on Persistent Medications</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>2. Controlling High Blood Pressure</td>
<td>3. Cervical Cancer Screening (ages 24-65)</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>4. Colorectal Cancer Screening (ages 50-75)</td>
<td>5. HbA1C Good Control</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
<tr>
<td>6. Retinal Eye Exam</td>
<td>7. Nephropathy screening</td>
<td>PHC and Provider</td>
<td>eReports</td>
</tr>
</tbody>
</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>
</table>

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC</th>
<th>Monthly Reports</th>
<th>N/A</th>
</tr>
</thead>
</table>

1. Admissions/ 1000
2. Readmission Rate
3. Pharmacy Utilization

**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</th>
<th>Report emailed by PHC in March 2018</th>
<th>Report emailed by PHC in March 2018</th>
</tr>
</thead>
</table>

### Access/Operations Measures: All Practice Types

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC</th>
<th>Monthly Reports</th>
<th>N/A</th>
</tr>
</thead>
</table>

1. Avoidable ED Visits
2. Practice “open” to PHC members
3. PCP Office Visits

### 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>
</table>

1. Advance Care Planning
2. Access/Extended Office Hours
3. PCMH Certification
4. Peer-led self-management support groups
5. Buprenorphine Qualified Providers
6. SBIRT: $5 per screening
7. Health Information Exchange

<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>
</table>

1. Advance Care Planning Provider Year-End Report Submission Template
2. Access/Extended Office Hours Provider Year-End Report Submission Template
3. PCMH Certification PHC and Provider Summary along with quarterly checks Provider Relations Department
4. Peer-led self-management support groups Provider Year-End Report Submission Template
5. Buprenorphine Qualified Providers PHC and Provider Year-End Report Provider Relations Department
6. SBIRT: $5 per screening PHC Year-End Report N/A
7. Health Information Exchange Provider Year-End Report Submission Template
Appendix VIII: Works Cited for All Practice Types


20. March 8, 2012. “Protect Your Child at Every Age.” [Link to CDC’s website]

21. 2014. “2014 Recommended Immunizations for Children from 7 Through 18 Years Old.” [Link to CDC’s website]

