2016-2017 Primary Care Provider Quality Improvement Program (QIP)
Measurement Specifications

PEDIATRIC MEDICINE PRACTICES

Developed by: The QIP Team

QIP@partnershiphp.org
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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. 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
The PCP QIP runs on an annual program period, beginning July 1 and ending June 30. For some measures, there are look-back periods that extend before July 1 of the program year. Payment is sent out 120 days after the program period ends, on October 31. 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 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.
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 during the measurement year, 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 of the measurement year. 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. eReports 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.

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 new measures, target is set at the 50th percentile performance of all Medicaid health plans, released by NCQA in 2015. No partial points are available for new measures. For existing measures, target is set at the 90th percentile performance of all Medicaid health plans. Sites have the opportunity to receive half points on existing 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 risk adjusted targets will be available in December 2016.

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 target is based on the 25th and 50th percentile performance by Medicare HMO Plans, as data for Medicaid is not available.
<table>
<thead>
<tr>
<th>CRITERIA &amp; WEIGHT</th>
<th>CASE MIX ADJUSTED?</th>
<th>2016-2017 TARGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL DOMAIN (65 Points Total)</strong></td>
<td></td>
<td>¹Full Points Targets for Existing Measures:</td>
</tr>
<tr>
<td>• Well Child Visits (3-6 years) (10 pts)</td>
<td>No</td>
<td>• Well Child Visits (3-6 years): 83.8 %</td>
</tr>
<tr>
<td>• Childhood Immunization – DTaP (10 pts)</td>
<td></td>
<td>• Childhood Immunization – DTaP: 86.1%</td>
</tr>
<tr>
<td>• Childhood Immunization – MMR (10 pts)</td>
<td></td>
<td>• Childhood Immunization – MMR: 94.9%</td>
</tr>
<tr>
<td>• Adolescent Immunization (10 pts)</td>
<td></td>
<td>• Adolescent Immunization: 87.7%</td>
</tr>
<tr>
<td>• Nutrition Counseling (3-17 yrs) (10 pts)</td>
<td></td>
<td>• Nutrition Counseling (3-17 yrs): 79.6%</td>
</tr>
<tr>
<td>• Physical Activity Counseling (3-17 yrs) (10 pts)</td>
<td></td>
<td>• Physical Activity Counseling (3-17 yrs): 64.8%</td>
</tr>
<tr>
<td>• Asthma Care (5 pts)</td>
<td></td>
<td>• Asthma Care: 64.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>¹Half Points Targets for Existing Measures:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Well Child Visits (3-6 years): 78.5 %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Childhood Immunization – DTaP: 83.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Childhood Immunization – MMR: 93.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adolescent Immunization: 81.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nutrition Counseling (3-17 yrs): 72.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical Activity Counseling (3-17 yrs): 64.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asthma Care: 57.8%</td>
</tr>
<tr>
<td><strong>APPROPRIATE USE OF RESOURCES (10 Points Total)</strong></td>
<td></td>
<td>Full points: At least 85.0% generic rate or 98.0% formulary compliance rate</td>
</tr>
<tr>
<td>• Pharmacy Utilization (10 points)</td>
<td>No</td>
<td>Half points: 83.0-84.9% generic rate or 96.0-97.9% formulary compliance rate</td>
</tr>
<tr>
<td><strong>ACCESS &amp; OPERATIONS (15 Points Total)</strong></td>
<td></td>
<td>Full Points: At or below site specific threshold</td>
</tr>
<tr>
<td>• Avoidable ED Visits (5 points)</td>
<td>Yes:</td>
<td></td>
</tr>
</tbody>
</table>

1. The targets for existing measures are based on historical data and represent the expected performance levels for the 2016-2017 period.
### 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
  - Partial Points: Any age restrictions = ½ points per quarter

### PCP Office Visits (5 points)

- **Yes:**
  - Full Points: At or above site specific threshold. The PHC plan-wide mean used to calculate site-specific threshold is 2.2 visits/year.

### PATIENT EXPERIENCE (10 Points Total)

- **CAHPS Survey** for qualified sites, or
- **Survey or Training Option** for all other sites

- **No**
  - CAHPS surveys will be paid based on site’s Access and Communication composites according to the following targets:
    - Full points (5 points for each composite): Resurvey result > PHC 50th percentile score, or showing 4% or more in relative improvement from baseline survey
    - Half points (2.5 points for each composite): Resurvey result between PHC 25th and 50th percentile scores, or showing 2.0 – 3.9% in relative improvement from baseline survey

  PHC performance scores will be released in September 2016.

  Survey or Training Option will be paid based on completion of submission templates
## 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>PCMH Certification</td>
<td>Level 1: $2000  Level 2: $3000  Level 3: $3500</td>
</tr>
<tr>
<td>Access/Extended Office Hours</td>
<td>10% of Capitation</td>
</tr>
<tr>
<td>Registration &amp; Utilization of the California Immunization Registry (CAIR)</td>
<td>Each site’s maximum potential earning for this measure varies, depending on the size of the practice. The maximum potential earning is the sum of the base rate and Per Member Per Year (PMPY) rate</td>
</tr>
<tr>
<td>Practice Size</td>
<td>Base Rate  PMPY Rate</td>
</tr>
<tr>
<td>Small (20-50 members ages 0-13)</td>
<td>$1000  $2.0</td>
</tr>
<tr>
<td>Medium (51-600 members ages 0-13)</td>
<td>$1500  $1.5</td>
</tr>
<tr>
<td>Large (600+ members ages 0-13)</td>
<td>$2000  $1.2</td>
</tr>
<tr>
<td><strong>2016-2017 Performance Threshold:</strong></td>
<td>Will be released in September 2016</td>
</tr>
<tr>
<td>Peer-led self-management support groups (both new and existing)</td>
<td>$1000 per group</td>
</tr>
<tr>
<td>Buprenorphine Qualified Providers</td>
<td>$500 per credential prescriber (max. 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. Well Child Visits

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

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

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

**Thresholds**

- Full points: 90\(^{th}\) percentile (83.8%)
- Half points: 75\(^{th}\) percentile (78.5%)
- 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 3-6 years of age as of June 30, 2017 (i.e. DOB between July 1, 2010 and June 30, 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.

| 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 2. 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 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: 90\(^{th}\) percentile (86.1%)
- Half points: 75\(^{th}\) percentile (83.5%)
- 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 who turn 2 years of age between July 1, 2016 and June 30, 2017 (DOB between July 1, 2014 and June 30, 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 3. *Childhood Immunization – MMR*

**Description**
The percentage of children 2 years of age who had 1 measles, mumps and rubella (MMR) vaccine by their 2\textsuperscript{nd} 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.\textsuperscript{4,5} Approximately 300 children in the United States die each year from vaccine-preventable diseases.\textsuperscript{3} 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.\textsuperscript{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: $90^{th}$ percentile (94.9%)
- Half points: $75^{th}$ percentile (93.0%)
- Relative Improvement Targets per Measure:
  - $\geq 15\%$ (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 July 1, 2016 and June 30, 2017 (DOB between July 1, 2014 and June 30, 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 on the same date of service or on different dates of service.
- A seropositive test result.

**Codes Used**
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

<table>
<thead>
<tr>
<th>Exclusions (only if not numerator hit)</th>
</tr>
</thead>
</table>

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 4. 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 (87.7%)
- Half points: 75th percentile (81.5%)
- 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 who turn 13 years of age between July 1, 2016 and June 30, 2017 (DOB between July 1, 2003 and June 30, 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 member’s 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.

OR
- 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.

### Codes Used

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:

- An anaphylactic reaction to the vaccine or its components on or before the member’s 13th birthday (Table 3A on Code List).

- An anaphylactic reaction to the vaccine or its components (Table 4A on Code List), with a date of service prior to October 1, 2011.
**Measure 5. 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.\(^1\)\(^7\) It is the primary health concern among parents in the United States, topping drug abuse and smoking.\(^1\)\(^8\) 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: 90\(^{th}\) percentile (79.6%)
- Half points: 75\(^{th}\) percentile (72.9%)
- Relative Improvement Targets per Measure:
  - \(\geq 15\%\) (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 June 30, 2017 (i.e. DOB between July 1, 1999 and June 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 a note indicating the date and at least one of the following:

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

**Denominator:** Codes to identify Outpatient Visits from Claims/Encounter Data: (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 6. Physical Activity Counseling

**Description**

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

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

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

**Thresholds**

- Full points: 90\(^{th}\) percentile (71.5%)
- Half points: 75\(^{th}\) percentile (64.4%)
- 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 June 30, 2017, (i.e. DOB between July 1, 1999 and June 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 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.

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

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

<table>
<thead>
<tr>
<th>Exclusions (only if not numerator hit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members who have a diagnosis of pregnancy during the measurement year.</td>
</tr>
</tbody>
</table>

| Codes to identify exclusions: Table 1F on Code List. |
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 (64.5%)
- Half points: 75th percentile (57.8%)
- 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 June 30, 2017 (i.e. DOB between July 1, 1998 and June 30, 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 June 30, 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 June 30, 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.

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

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 June 30, 2017.
Step 5
Sum the number of members whose PDC is $\geq 50\%$ for their treatment period.

**Codes Used**

Denominator:
- ED visit (Table 5G on Code List) with a principal diagnosis of asthma: Table 5C on Code List.
- Outpatient visits: Table 1D on Code List
- Observation visits: Table 5I on Code List
- Asthma medication dispensing events: Table MMA-A on Code List.
- Acute inpatient encounter: Table 5A on Code List.

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, first quarter dates of service (July-September) are not reported until December 31.

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. Targets to be released in December 2016.

**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, first quarter dates of service (July-September) are not reported until December 31.

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**

\[
\text{Avoidable ED Visits per 1000 = (Avoidable ED visits / Non-Dual Capitated Member Months)*12,000}
\]

**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**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average number of assigned members' visits to PCP per member per year.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full points (5 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. Targets will be released in December 2016.

<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, first quarter dates of service (July-September) are not reported until December 31.</td>
</tr>
</tbody>
</table>

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:

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

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

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Measure 12. Patient Experience

**Description**

This measure aims to improve the patient experience. There are 2 ways in which to earn points:

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

  **OR**

- Submission-based options:
  - Survey option
  - Training option

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

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

**Training Option:** This option allows providers to fulfill the requirements by attending training on improving the patient experience and applying lessons learned at their site. A patient feedback component must be included.

Refer to the Thresholds section below for detailed specifications.

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

**Thresholds**

1) **CAHPS**

Providers that have sufficient PHC patient volume can earn up to a maximum of 10 points for meeting performance or relative improvement thresholds in key measures in the Clinician & Group CAHPS PCMH survey. The validated tool can be found here: [http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html](http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html). Sites will be notified by May 1, 2016 whether they meet sufficient volume for inclusion in the CAHPS survey. A third-party vendor hired by PHC will conduct the survey independently between May and July 2017. A slightly modified version of the survey will be distributed. Sites will receive their results in August 2017.

Sufficient patient volume is defined as having at least 1200 unique visits by PHC members between April 1, 2016 and March 31, 2017 at the entity level. If a site does not belong to any entity, it is considered an entity for this measure. The survey results will be analyzed at the entity level. Eligible population includes assigned members with at least 1 unique visit or special members with at least 2 visits during this period. Members 13-17 years of age are excluded. Adults and children will be surveyed separately.
Payment methodology: Providers will earn points by either 1) meeting the performance targets or 2) showing relative improvement from the baseline survey conducted in 2016. If both the adult and child CG-CAHPS surveys are conducted at your site, you will be paid based on the higher of the 2 results. We will pay for the Access and Communication composites according to the following targets:

- Full points (5 points for each composite): Re-survey result > PHC 50th percentile score*, or showing 4% or more in relative improvement from baseline survey
- Half points (2.5 points for each composite): Re-survey result between PHC 25th and 50th percentile scores*, or showing 2.0 – 3.9% in relative improvement from baseline survey

*Targets will be set based on PHC performance on the 2016 survey and will be released in December 2016. Below is a summary of PHC performance on the 2015 survey, for your information:

<table>
<thead>
<tr>
<th></th>
<th>Access</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 Survey Median</td>
<td>41.1%</td>
<td>67.7%</td>
</tr>
<tr>
<td>2016 Survey 25th Percentile</td>
<td>38.3%</td>
<td>66.0%</td>
</tr>
</tbody>
</table>

**OR**

Sites that don’t meet the patient volume threshold can complete one of the following options to earn points:

- Survey Option
- Training Option

**2a) Survey Option**

There are 2 parts to this option. Please follow the steps below and fill out the submission templates (Appendix I) accordingly. Sites can describe existing survey efforts, such as the PCMH NCQA survey.

Part I (5 points):

1) Implement a survey which must include at least 2 questions regarding access to care (questions do not need to come from the CAHPS survey, although we encourage using CAHPS or another well vetted survey). Collect at least 100 responses per site.

2) Analyze baseline data, select measures from survey to target for improvement, identify change(s) to implement, and report on successes and challenges in the Survey Option Part I submission template.

Part II (5 points):

3) Implement change(s) for improvement.

4) Re-measure patient experience using the same survey at least once after implementing changes.

**OR**

**2b) Training Option**

There are 2 parts to this option. Please follow the steps below and fill out the submission template (Appendix II) accordingly.
Part I (5 points):

1) Participate in a PHC-approved program or training aimed at improving patient experience in a core CAHPS domain (provider-patient communications, office staff-patient communication, access to care, or care coordination). At least 2 staff members are involved in the training; training should total at least 4 hours per staff member/provider involved. If uncertain whether a training would qualify, you may contact qip@partnershiphp.org for approval prior to the training.

2) Draft an improvement plan, which includes measures, goals, planned activities, and an evaluation strategy that incorporates patient feedback. Report these on the Training Option Part I submission template.

Part II (5 points):

3) Complete the improvement plan and collect patient feedback.

4) Submit a progress report using Training Option Part II submission template to show how improvements were measured.

The training should take place any time between January 1, 2016 and December 31, 2016. The improvement plan should be implemented and patient feedback collected between January 1, 2017 and June 1, 2017.

**Submission Process**

For the Survey/Training Options, submit the Patient Experience Submission Template (Appendix I - II) via fax or email to QIP@partnershiphp.org. Part I is due on January 31, 2017 and Part II July 31, 2017.

**Exclusions**

N/A
Measure 13. 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 III) 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 IV) 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
• Copy in chart
• Patient refused

• Summary of patient wishes, whether from conversation or from an Advanced Directive. Some options include:
  o Full treatment
  o Comfort care
  o Hospice
  o DNR
  o DNI
  o Other (tube feeds and blood transfusion and transfer to hospital are common items)

• If a POLST is appropriate, some status options include:
  o Discussed
  o Given to patient
  o Completed
  o Copy in chart
  o 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 III), medical record evidence (Appendix IV), 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 July 31, 2017. 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 14. 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, 2016.

- Demonstrate the use of arrangement with at least three PHC members seen in the office after hours per quarter, to be submitted quarterly by the site to their Provider Relations representative of your county. Deadlines are as follows:
  - Q1: September 30, 2016
  - Q2: December 31, 2016
  - Q3: March 31, 2017
  - Q4: June 30, 2017

Please note this measure is subject to an audit by the Provider Relations department.
Measure 15. **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 V 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 July 31, 2017. 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 V) for the documentation template, which can be faxed or emailed to <a href="mailto:QIP@partnershiphp.org">QIP@partnershiphp.org</a> by July 31, 2017.</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>
### Unit of Service


#### 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 VI 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 2016-2017 period 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.

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

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

Maximum number of groups eligible for payment:

- Up to a maximum of 10 per site and 20 per corporate entity

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 VI) by July 31, 2017, and can be faxed or emailed to QIP@partnershiphp.org.

**Exclusions**
Primary care provider sites with fewer than 50 assigned Partnership members
UNIT OF SERVICE

Measure 17. Utilization of Californian Immunization Registry

**Description**

Sites will be reimbursed by meeting the specified threshold for utilizing the California Immunization Registry (CAIR).

CAIR is an immunization information system that can be accessed online to help health care providers immunize their members by tracking immunization records, identifying immunization gaps and missed opportunities, and saving time and cost by maintaining better community health. It is not part of routine PCP contracts, but Incentivizing this measure allows providers to receive additional support for achieving their goals.

**Measure Requirements**

All contracted providers with 20 or more patients ages 0-13 are eligible for this measure.

Utilization during the measurement period is calculated using this formula:

\[
\frac{\text{# of shots entered for assigned members aged 0-13}}{\text{Total number of assigned members aged 0-13}}
\]

Providers may earn financial incentive by meeting the specified threshold. Each site’s maximum potential earning for this measure varies, depending on the size of the practice. The maximum potential earning is the sum of the base rate and Per Member Per Year (PMPY) rate.

<table>
<thead>
<tr>
<th>Practice Size</th>
<th>Base Rate</th>
<th>PMPY Rate</th>
<th>Example (Potential Earning)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small (20-50 members ages 0-13)</td>
<td>$1000</td>
<td>$2.0</td>
<td>A site with 30 members: $1000+$2*30 members = $1060</td>
</tr>
<tr>
<td>Medium (51-600 members ages 0-13)</td>
<td>$1500</td>
<td>$1.5</td>
<td>A site with 100 members: $1500+$1.5*100 members = $1650</td>
</tr>
<tr>
<td>Large (600+ members ages 0-13)</td>
<td>$2000</td>
<td>$1.2</td>
<td>A site with 700 members: $2000+$2*700 members = $3400</td>
</tr>
</tbody>
</table>

Thresholds for Measurement Year 2016-2017 will be released in September 2016.

For your information, the Performance Threshold (full earnings) for 2015-16 was: 1.42 per assigned member per year.

**Submission Process**

Submit Provider ID assigned by CAIR and registration date using the submission template (Appendix VII) by September 30, 2016.

PHC will receive activity reports from CAIR using each site’s Provider ID to measure utilization.
Exclusions

Providers with 20 or fewer patients who are 0-13 years old
Measure 18. Buprenorphine Qualified Providers

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>One-time payment of $500 per credentialed prescriber who meets one of the following criteria:</td>
</tr>
<tr>
<td>• Newly trained buprenorphine provider</td>
</tr>
<tr>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with a minimum of 50 assigned Partnership members.</td>
</tr>
<tr>
<td>• Prescribers must be credentialed by the PHC Credentials Committee before June 30, 2017.</td>
</tr>
<tr>
<td>• Prescribers credentialed prior to July 1, 2016 should be listed in the PHC provider directory as buprenorphine providers.</td>
</tr>
<tr>
<td>• Maximum 5 prescribers per site are eligible for this incentive amount.</td>
</tr>
<tr>
<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>

<table>
<thead>
<tr>
<th>Submission Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC will extract this data at the end of the year by working with the PHC credentialing 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>
</tbody>
</table>
UNIT OF SERVICE

Measure 19. 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. September 30, 2017) 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 20. 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 VII) by July 31, 2017. 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: Patient Experience – Survey Option

Quality Improvement Program – Patient Experience
Survey Option Submission Template and Example

Due date for Part I submission: January 31, 2017
Due date for Part II submission: July 31, 2017

Below you will find the submission template and example for the Survey Option. This is a guide for your submission, and if you decide to not use it, points will still be rewarded as long as all areas are addressed in your submission. For detailed instructions, please refer to the Measure Specifications.
Survey Option: Part I Submission Template
(Due January 31, 2017)

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

2. Provide descriptions for the following:
   a. Population surveyed
   b. How the survey was administered (via phone, point of care, web, mail, etc.)
   c. The time period for when the surveys were administered
   d. Total number of surveys distributed
   e. Total number of survey responses collected/received
   f. Response Rate

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

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

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

Submitted by ___________________________ (Name & Title) on _____________ (Date)
1. Describe specific changes/actions/interventions you implemented to improve your performance in the measures you selected in Part I. Include specific timelines, who implemented the changes, and how changes were implemented.

2. Provide descriptions for the following for your re-measurement period:
   a. Population surveyed
   b. How the survey was administered (via phone, point of care, web, mail, etc.)
   c. The time period for when the surveys were administered
   d. Total number of surveys distributed
   e. Total number of survey responses collected/received
   f. Response Rate

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

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

Submitted by ________________________ (Name & Title) on ___________ (Date)
1. Attach a copy of the survey instrument administered: See below

Dear Patient,

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

Please rank the following statements based on your visit today:

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The non-clinical staff at this office were friendly to me.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. The non-clinical staff at this office addressed my concerns adequately.</td>
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<td></td>
<td></td>
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<tr>
<td>4. I was given more than one option in terms of how and when to schedule the next appointment.</td>
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<tr>
<td>5. I felt comfortable asking the non-clinical staff questions.</td>
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<tr>
<td>6. When I called for an appointment, the wait time was reasonable.</td>
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<tr>
<td>7. I was given an appointment when I wanted it.</td>
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<tr>
<td>8. I feel confident that my personal information is kept private.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Charges were explained to me clearly.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Provide descriptions for the following
   a. Population surveyed
   b. How was the survey administered? (via phone, point of care, web, mail, etc.)
   c. What was the time period for when the surveys were administered
   d. Total number of surveys distributed
   e. Total number of survey responses collected/received
   f. Response Rate

   Between September 1, 2016 and November 1, 2016, our site mailed a survey to all our adult patients who came in for an office visit between July 1 and October 1, 2016. The first mailing was sent on September 1, followed by a second mailing on October 15. 500 surveys were mailed and 250 surveys were returned; yielding a 50% response rate

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

   “I was given an appointment when I wanted it”

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

   80% of patients surveyed will select “strongly agree”.

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

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

Submitted by Elizabeth Jones (QI Director) (Name & Title) on Dec 10, 2016 (Date)
EXAMPLE
Survey Option: Part II Submission

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

   We had a consultant train our site over a two-month period (January-February 2017) on how to add same day appointments. The trainings included improvements to our scheduling system such as reducing the number of appointment types from 50 to 4. We developed and implemented scripts for the front desk staff so that they can educate our patients on the change in scheduling. We also collected data daily on our patient demand, supply and activity. This helped us determine where we can shift appointment slots based on our demand and corresponding supply. We also tried extending visit intervals for our well controlled patients with diabetes. Rather than bringing them in every 3 months, we now bring them in every 6 months.

2. Provide descriptions for the following for your re-measurement period:
   a. Population surveyed:
   b. How the survey was administered (via phone, point of care, web, mail, etc.)
   c. The time period for when the surveys were administered
   d. Total number of surveys distributed:
   e. Total number of survey responses collected/received:
   f. Response Rate:

   Between April 15, 2017 and May 1, 2017, our site mailed a survey to all our adult patients who came in for an office visit between March 1 and April 1. We were only able to do one re-measurement cycle. The mailing was sent on April 15. Two hundred surveys were mailed and 110 surveys were returned; yielding a 55% response rate.

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

   In the question, "I was given an appointment when I wanted it," we exceeded our goal in that 83% of our patients reported “Strongly agree,” compared to our goal of 80% and our baseline score of 72%.
4. What challenges did you experience and how did you overcome these?

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

Submitted by Elizabeth Jones (QI Director) (Name & Title) on July 10, 2017 (Date)
Appendix II: Patient Experience – Training Option

Quality Improvement Program – Patient Experience
Training Option Submission Template and Example

Due date for Part I submission: January 31, 2017
Due date for Part II submission: July 31, 2017

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

If you are not sure whether certain training would qualify for this measure, you may ask for approval from PHC prior to the training. Please email us at qip@partnershipphp.org with the following information:

1. Name of training entity/organization
2. Description of the training
3. Number of hours of the training
4. Number of team members who attend the training and their roles/titles
Training Option: Part I Submission (Improvement Plan) Template  
(Due January 31, 2017)

1. Training attended and date of training: ________________________________

2. Training organization: ________________________________

3. Area of focus (please check one):
   - Provider-patient communications
   - Office staff-patient communication
   - Access to care
   - Care coordination

4. Objective(s) of the training:
   - ________________________________
   - ________________________________
   - ________________________________

5. Name and title of participating employees and length of training per attendee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Hours in training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

6. Improvement Plan
   a. Based on the training, which patient experience measures are you targeting for improvement?
b. What activities/changes/interventions are planned to make improvements in the measures targeted? Please describe the changes, who will make the changes, and timelines for changes.


c. How will you measure the effect of changes implemented? Describe the goal, the measurement strategy including the population impacted, measurement periods and timelines, and how patient feedback will be incorporated in the assessment of impact.

7. Attach patient feedback tool (e.g. comment cards, survey, etc)

Submitted by __________________________ (Name & Title) on _____________ (Date)
Training Option: Part II Submission (Progress Report) Template
(Due July 31, 2017)

1. Based on your improvement plan, what activities/changes/interventions were completed? Please describe the activities (who did what and by when).

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

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

4. Attach patient feedback tool (e.g. comment cards, survey, etc)

Submitted by ________________________ (Name & Title) on ____________ (Date)
EXAMPLE
Training Option: Part I Submission (Improvement Plan)


2. Training organization: Institute for Healthcare Communication

3. Area of focus (please check one):
   — Provider-patient communications
   — Office staff-patient communication
   — Access to care
   — Care coordination

4. Objective(s) of the training: Apply the four-point model (Connect, Appreciate, Respond, Empower) to communicate in ways that will enhance satisfaction and encourage patient partnership

5. Name and title of participating employees and length of training per attendee

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Hours in training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alan Smith</td>
<td>Receptionist</td>
<td>4</td>
</tr>
<tr>
<td>Mike Johnson</td>
<td>Nurse</td>
<td>4</td>
</tr>
<tr>
<td>Elizabeth Jones</td>
<td>QI Specialist</td>
<td>4</td>
</tr>
<tr>
<td>Jennifer Owens</td>
<td>Chief Information Officer</td>
<td>4</td>
</tr>
</tbody>
</table>

6. Improvement Plan
   a. Based on the training, which patient experience measure(s) are you targeting for improvement?

   We learned from the training that interaction with non-clinical staff significantly affects whether patients keep appointments. Our specific objectives are:
   
   • Reduce no-show rate from 20% to 10% or less by December 31, 2016
• For the question, “The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be,” 100% of patients will respond that they agree or strongly agree
• For the question, “The non-clinical staff at this office were friendly to me,” 100% of patients will respond that they agree or strongly agree
• For the question, “The non-clinical staff at this office addressed my concerns adequately,” 100% of patients will respond that they agree or strongly agree.

b. What activities/changes/interventions are planned to make improvements in the measure(s) targeted? Please describe the changes, who will implement the changes, and timelines for changes.

Starting January 1, 2017, all non-clinical staff will wear a badge so that patients can get to know their names and feel connected at a personal level. We will encourage positive interactions between staff and patients, including standardized phone greetings, smiles, basic pre- and post-visit questions such as “how is your day” and “do you have any questions regarding what the doctor said”. We will give patients the option to schedule a follow-up appointment before leaving the clinic, or offer to call them closer to the time they need to be seen to schedule the appointment. We will also call to remind patients the day before appointment, as well as the morning of the appointment.

c. How will you measure the effect of changes implemented? Describe the measurement strategy including the population impacted, measurement periods and timelines, and how patient feedback will be incorporated in the assessment of impact.

We will look at our electronic scheduling system and compare no show rates between the first week of Oct 2016 and the first week of March 2017 (two months before and after the interventions). A patient-experience survey (attached) will also be distributed and data will be collected on the measures selected, in addition to evaluating whether there was a “spill over” effect into other measures.

7. Attach patient feedback tool(s) – See attached
PATIENT FEEDBACK TOOL FOR EVALUATION (Part I submission)

Dear Patient,

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be</td>
<td></td>
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<td>3. The non-clinical staff at this office addressed my concerns adequately.</td>
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<tr>
<td>4. I was given more than one option in terms of how and when to schedule the next appointment.</td>
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<td>5. I felt comfortable asking the non-clinical staff questions.</td>
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<td>7. I feel confident that my personal information is kept private.</td>
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<tr>
<td>8. Charges were explained to me clearly.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
EXAMPLE
Training Option: Part II Submission (Progress Report)

1. Based on your improvement plan, what activities/changes/interventions were completed? Please describe the activities (who did what and by when).

   100% of our non-clinical staff were trained in the CARE model. The CARE model included a lot of role playing to give staff the confidence to try new techniques. They attended a four-hour training and following the training, we established a Patient Experience Improvement Team that met bi-weekly to develop changes and also review the data weekly on no-show rates and also the patient feedback data. All staff greet patients with the same warm greeting and there is a FAQ document for all staff on questions asked by patients.

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

   Both process evaluation and outcome evaluation show that our interventions were effective. From our scheduling system, we see that the no show rate dropped from 20% to 12%. Although we did not meet our goal of 10%, it was a significant decrease. We have a reason to believe that the low no show rate is associated with better staff-patient communication, as shown by the patient-experience survey. Among the 50 responses that we received, 90% patients “strongly agree” or “agree” that our staff were friendly and helpful. Almost all patients (96%) indicated that they were given more than one option on how/when to schedule an appointment.

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

   We learned a lot while facing many challenges. The most important lesson is that small improvements in staff-patient communication can help patient satisfaction and lower no show rates, both of which have an impact on our patients’ relationships with our office. We found that smiling and standardized greetings significantly change how patients perceive our staff. And most importantly, we discovered ways that make scheduling appointments more convenient for patients.

   We did, however, encounter major difficulties. The original survey was too long, so we had to remove some questions and only focused on staff-patient experience. Also, because we did not have a baseline survey, it is difficult to attribute the high patient satisfaction to our interventions. Finally, it took us a long time to convince the administrative staff that all the extra work is worth it because it indirectly improves our patients’ experiences with their care.
4. Attach patient feedback tool (e.g. comment cards, survey, etc) – See attached

Submitted by Elizabeth Jones (QI Director) (Name & Title) on July 10, 2017 (Date)

PATIENT FEEDBACK TOOL FOR EVALUATION (Part II submission)

Dear Patient,

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

Please rank the following statements based on your visit today:

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<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The non-clinical staff at this office were friendly to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The non-clinical staff at this office addressed my concerns adequately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I was given more than one option in terms of how and when to schedule the next appointment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I felt comfortable asking the non-clinical staff questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix III: Advanced Care Planning – Provider 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, 2016, and June 30, 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 July 31, 2017 via email at QIP@partnershiphp.org or fax at 707-863-4316.

Patient Name: ________________________________________________________________

Patient DOB: ___________________ Patient CIN: _________________________________

I, ____________________ (Provider 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

Provider Signature: ___________________________ Date: ___________________
Appendix IV: 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
- Provider’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 **July 31, 2017** 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:**

   ![Image of a circle with options 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 VI: 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 **July 31, 2017** 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**
Quality Improvement Program
California Immunization Registry (CAIR) Reporting Template

If you intend to participate in the CAIR Utilization measure for the 2016-2017 QIP measurement year, please complete all of the following fields on this form by September 30, 2016 and send to:

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

PHC will receive activity reports directly from CAIR for your utilization. Payment for this measurement will be based on either meeting the specified threshold or demonstrating relative improvement. Please refer to the Measure Specifications for details.

1. Name of Your Practice:___________________________________________________________
2. Address of Your Practice:________________________________________________________
3. Date of registration:_____________________________________________________________
4. Provider ID assigned by CAIR:____________________________________________________

IMPORTANT: If you are submitting this template on behalf of multiple QIP participating sites, please list all the information above for each of your sites.
Appendix VIII: Submission Template for HIE

Quality Improvement Program
Health Information Exchange (HIE) Reporting Template

If you intend to participate in the HIE measure for the 2016-2017 QIP measurement year, please complete all of the following fields on this form and submit by July 31, 2017 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: __________________________________

IMPORTANT: If you are submitting this template on behalf of multiple QIP participating sites, please list and submit all the information above for each of your sites.
## Appendix IX: 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>September 30, 2016</td>
<td>CAIR Utilization</td>
<td>Appendix VII</td>
</tr>
<tr>
<td>January 31, 2017</td>
<td>Patient Experience (Part I)</td>
<td>Appendix I, Appendix II</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Patient Experience (Part II)</td>
<td>Appendix I, Appendix II</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Advance Care Planning</td>
<td>Appendix III, Appendix IV</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>PCMH Recognition</td>
<td>Appendix V</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Peer-led Self-Management Support Group</td>
<td>Appendix VI</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Health Information Exchange</td>
<td>Appendix VIII</td>
</tr>
</tbody>
</table>

14 days after receiving report from PHC, in September/October 2017

| | 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 X: 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. Immunizations for Adolescents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Childhood Immunization – DTaP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Childhood Immunization- MMR</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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Retinal Eye Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Good Control</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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Cervical Cancer Screening (ages 24-65)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Colorectal Cancer Screening (ages 50-75)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Retinal Eye Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. HbA1C Good Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Nephropathy screening</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appropriate Use of Resources: Pediatric Medicine

<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. Pharmacy Utilization</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Opioid Safety</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Access/Extended Office Hours</td>
<td>Provider</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Readmission Rate</td>
<td>PHC and Provider</td>
<td>Report emailed by PHC in September 2017</td>
<td>Report emailed by PHC in September 2017</td>
</tr>
</tbody>
</table>

## Appropriate Use of Resources: Family and Internal Medicine

<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. Pharmacy Utilization</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Opioid Safety</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Access/Extended Office Hours</td>
<td>Provider</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
</tbody>
</table>

## Access/Operations Measures: All Practice Types

<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. Avoidable ED Visits</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Practice “open” to PHC members</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>3. PCP Office Visits</td>
<td>PHC Vendor</td>
<td>Year-End Report</td>
<td>N/A</td>
</tr>
</tbody>
</table>

## Patient Experience: All Practice Types

<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>Survey/Training Option (sites not qualified for CAHPS)</td>
<td>Provider</td>
<td>Monthly Reports</td>
<td>Submission Template</td>
</tr>
<tr>
<td>CAHPS Survey (for qualified sites)</td>
<td>PHC Vendor</td>
<td>Year-End Report</td>
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</tbody>
</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. PCMH Certification</td>
<td>Provider</td>
<td>Year-End Report</td>
<td>Submission Template</td>
</tr>
<tr>
<td>3. Access/Extended Office Hours</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>5. CAIR Utilization</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 XI: Works Cited for All Practice Types


