



**2019 Primary Care Provider Quality Improvement Program (PCP QIP)
Measurement Specifications**

INTERNAL MEDICINE PRACTICES

Developed by: The QIP Team

QIP@partnershiphp.org

Published: December 11, 2018

Updated: July 01, 2019

Table of Contents

I. Quality Improvement Program Contact Information	3
II. Program Overview	3
III. Summary of Measures	8
IV. Clinical Domain	12
Measure 1. <i>Controlling High Blood Pressure</i>	12
Measure 2. <i>Cervical Cancer Screening</i>	15
Measure 3. <i>Colorectal Cancer Screening</i>	19
Measure 4. <i>Diabetes Management – HbA1c Good Control (≤9%)</i>	21
Measure 5. <i>Diabetes Management – Retinal Eye Exam</i>	23
Measure 6. <i>Breast Cancer Screening</i>	25
V. Appropriate Use of Resources	31
Measure 8. <i>Ambulatory Care Sensitive Admissions</i>	31
Measure 9. <i>Readmission Rate</i>	33
VI. Access and Operations	35
Measure 10. <i>Primary Care Utilization</i>	35
VII. Patient Experience	37
Measure 11. <i>Patient Experience</i>	37
VIII. Unit of Service	39
Measure 12. <i>Advanced Care Planning</i>	39
Measure 13. <i>Extended Office Hours</i>	42
Measure 14. <i>Patient-Centered Medical Home Recognition</i>	44
Measure 15. <i>Peer-Led Self-Management Support Groups</i>	45
Measure 16. <i>Alcohol Misuse Screening and Counseling</i>	47
Measure 17. <i>Health Information Exchange Participation</i>	48
Measure 18. <i>Initial Health Assessment Improvement Plan</i>	50
Measure 19. <i>Palliative Care Identification and Referral</i>	51
Appendix II. Patient-Centered Medical Home Documentation Template	60
Appendix III: Submission Template for Peer-led Self-Management Support Group	61
Appendix IV: Submission Template for HIE	62
Appendix V: Initial Health Assessment (IHA) Improvement Plan Template	63
Appendix VI. Palliative Care Referral Submission Template	64
Appendix VII: 2019 PCP QIP Submission and Exclusion Timeline	65
Appendix VIII: Data Source Table	66
Appendix IX: Diabetes Management Table	68

Appendix X: QIP Diabetes Exclusion Flow Chart 69
Appendix XI: Works Cited for All Practice Types 70

I. Quality Improvement Program Contact Information

Email: QIP@partnershiphp.org

Fax: (707) 863-4316

Website: [Primary Care Provider Quality Improvement Program](#)

II. Program Overview

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

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

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

Guiding Principles

The QIP uses nine guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within the program.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable measures
4. Feasible data collection
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measurement set
8. Align measures that are meaningful
9. Stable measures

The guiding principles outlined above are used to select measures for improvement. These measures are selected in areas that are not addressed under PCP contracts, such as population-level screening targets and other population-level preventive care services. The QIP serves to increase health plan operational efficiencies by prioritizing areas that drive high quality care and have potential to reduce overall healthcare costs.

Program Timeline: 2018

The 2019 measurement year begins on January 1, 2019 and ends on December 31, 2019. Please see [Appendix VII](#) for details on deadlines specific to any measures. Payment is sent out 120 days after the program period ends, on April 30, 2019.

Definitions

Parent Organization: A health center that may or may not operate multiple sites.

Primary Care Provider Site: Clinic location that has been designated with a unique PCPID with members actively assigned by Partnership HealthPlan of California.

The Department of Health Care Services (DHCS) requires each physical location that is open for at least 20 hours per week to have its own assigned ID in order to have members assigned to it. PHC requires all facilities meeting the 20 hour per week criteria to be included in the [Provider Directory](#).

Provider: Please refer to Primary Care Provider Site definition above. This term is not interchangeable with an individual physician or other licensed health care professionals and teams.

Provider Eligibility Criteria

All current primary care providers, including pediatric, family, and internal medicine sites, that have capitated Medi-Cal only members assigned and are contracted with PHC for the entire measurement year are automatically enrolled in the QIP. A provider must be enrolled in the program as of December 1st of the measurement year in order to be eligible for incentive payments Eligibility criteria for specific measure domains vary.

If a contract is terminated during the measurement year, eligibility will be reviewed on a case-by-case basis. In order to offer comprehensive QIP data, sites are required to report to the QIP at the PCPID level.

Clinical Measures

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

- Provider sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice):
 - Must be contracted with members assigned for at least nine months.
- Provider sites joining Partnership as part of a parent organization where members from an existing QIP participant are potentially being reassigned to the new site (example – new site opens within multi-site FQHC model)
 - Must be contracted with members assigned by October 1.
 - New sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the parent organization will be used to support continuous enrollment requirements for Clinical Measures.

Non-Clinical Measures

PCP sites that join PHC's network mid-year are eligible for measures in the Non-Clinical domains under the following circumstances:

- All providers, regardless of any affiliation:
 - Must be contracted with members assigned for at least nine months of the measurement year.

Eligible Member Population

The eligible population used to calculate the final scores for all measures is defined as capitated Medi-Cal members. In addition, beginning in 2019, members that qualify for California Children Services and certain Native Americans will be assigned to PCP sites without capitation. These members are eligible to be included in sites' denominator lists assuming denominator criteria are met. Member month assignments will also count towards the member month totals used for payment calculations.

For measures in the Clinical domain, the member also has to be continuously enrolled within a PCP organization, with continuous enrollment defined as being assigned for nine out of the 12 months between 1/1/2019 and 12/31/2019. For multi-site organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a site's final denominator is December 1st; this means members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Medi-Medi or dually eligible members are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate should be presented to the QIP Team.

For measures in the Non-Clinical domain, continuous enrollment criteria are detailed within each measure's

specifications.

Measure Development and Selection

The measurement set for the QIP is reviewed and developed annually. In order to maintain a stable measurement set, major changes are only made every other year. With input from the network, the Provider Advisory Group, and internal departments, the measurement set requires approval from the Physician Advisory Committee. Once approved, the finalized set for the next year is shared with the network and specifications are developed. It is possible for the measurement set to change slightly during the measurement year due to new information becoming available (i.e. a measure's retirement from the Department of Health Care Services External Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be announced through e-mail to all providers as well as through the program's monthly newsletter.

Measures may evaluate a provider's utilization of a certain service or provision of treatment. PHC recognizes the potential for underutilization of care and services and takes appropriate steps to monitor for this. The processes utilized for decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not offer incentives or compensation to providers, consultants, or health plan staff to deny medically appropriate services requested by members, or to issue denials of coverage.

Payment

The PCP QIP is comprised of two measurement sets each with its own payment methodology.

The PCP QIP Core Measurement Set includes measures in the Clinical, Appropriate Use of Resources, Operations and Access, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. There is a fixed per member per month (PMPM) amount for all sites. The number of member months is multiplied by the PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

Example: ***For illustrative purposes only***, assume the PMPM for the 2019 year is \$10.00.

- A site that earns 100% of their QIP Core Measurement Set points would earn 100% of the site's potential amount. If the site had a monthly average of 1,000 members, that would result in a total of 12,000 member months. The \$10 is then multiplied by 12,000, equaling a payment of \$120,000. This breaks down to a realized \$10.00 PMPM.
- A site that earns 55% of their QIP Core Measurement Set points would earn 55% of the site's total potential amount. If the site had an average of 1,000 members and 12,000 member months, this would equal a final payment amount of \$66,000. This breaks down to a realized \$5.50 PMPM.

The PMPM amount may change annually based on the plan's financial performance. It is announced annually at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.

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

Billing

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

eReports

eReports, an online system built for the QIP Clinical measures, is the mechanism by which providers can monitor their performance and submit supplemental data to PHC. The eReports portal may be accessed at <https://qip.partnershiphp.org/>. The launch date of eReports falls within the first quarter of the measurement year to ensure availability of data throughout the measurement year; the exact date may vary from year to year and is announced via the QI Newsletter. Providers have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e. January 31 following the measurement year, and is intended to allow for final data collection and uploads.

All providers, regardless of 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. Providers with denominators of less than 10 members must provide evidence of three targeted outreach attempts when requesting a member be excluded from the denominator. Outreach information must be submitted to the QIP team by 5 p.m. on January 31, 2020.

Partnership Quality Dashboard

In addition to the eReports system, the QIP Team utilizes a new portal called the Partnership Quality Dashboard (PQD) specifically for tracking measures in the Non-Clinical domains. The PQD is accessible through the eReports system and provides available claims and encounter data based information. Non-Clinical reports will no longer be produced and shared with individual sites. The PQD has other capabilities as well, such as trending performance from previous years across all domains and projecting point earnings based on current performance. Please review the [PQD Overview Webinar](#) for more details on the functionality, and contact the QIP Team with questions.

Payment Dispute Policy

Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and, during the validation period after the end of the measurement year, review data on which your final point earnings will be based. If during the Preliminary Report review period or eReports validation period a provider does not inform PHC of a calculation or point attribution error that would result in potential under or over payment, the error may be corrected by PHC post-payment. This means PHC may recoup overpaid funds any time after payment is distributed. Dispute of final data described below will not be considered:

1. QIP scores on eReports
eReports refreshes data on a weekly basis and providers have access to eReports through the well-published grace period (30 days after the end of the measurement year, through January 31) to check for data disparities. Additionally, providers have access to eReports for during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, PHC may assist a provider with uploading data before the close of the grace period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.
2. Exclusions on eReports
Some exclusions from denominators, when approved, involve a manual process by PHC staff. Since the QIP receives a large volume of exclusion requests, providers are responsible for checking that members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. The deadline for exclusion requests for most measures is the 5 p.m. on the last day of the

grace period (January 31). The deadline for exclusion requests for Cervical Cancer Screenings and the three Diabetes Management measures is January 15, 2020.

3. **Data reported on the Year-End Preliminary Report**
At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the earnings for manually tracked measures (i.e. PCMH Certifications, Initial Health Assessments, etc.). Providers will be given one week, hereafter referred to as Preliminary Report Review Period, to review this report for performance discrepancies and calculation or point attribution errors.
4. **Practice type designations**
Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice according to the accepted age groupings listed in the Provider Directory and a historical review of member months. Each practice type is responsible for different QIP measures. The QIP team is available throughout the measurement year to answer questions about these designations as defined in the QIP. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.
5. **Thresholds**
Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year. The QIP may consider adjusting thresholds mid-year based on provider feedback. However, post-payment disputes related to thresholds cannot be accommodated.

Should a provider have a concern that does not fall in any of the categories above (i.e. the score on your final report does not reflect what was in eReports), a Payment Dispute Form must be filled out within 30 days of receiving the final statement. All conversations regarding the dispute will be documented and reviewed by PHC. All payment adjustments will require approval from PHC's Executive Team.

Governance Structure

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

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

1: For most existing clinical measures, the full-point target is set at the 90th percentile performance of all Medicaid health plans. Sites have the opportunity to receive half points on measures if the 75th percentile performance is met. For all new clinical measures, the full-point target is set at the 50th percentile performance, and no partial points are available. The 2019 thresholds for the Immunizations for Adolescents Combo 2 and Childhood Immunizations Combo 3 measures have been set to the 50th percentile performance for partial points and the 75th percentile performance for full points. No points through relative improvement are available for these measures.

2: For existing clinical measures, sites can also earn partial points based on relative improvement (RI). Please note that if a provider site was not eligible for a specific measure in the previous measurement year, the site is not eligible for earning points through relative improvement during the current measurement year. Relative improvement measures the percentage of the distance the provider has moved from the previous year's rate toward a goal of 100 percent. The method of calculating relative improvement is based on a *Journal of the American Medical Association* article authored by Jencks et al in 2003, and is as follows:

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

The formula is widely used by the Integrated Healthcare Association's commercial pay for performance program as well as by the Center for Medicare and Medicaid Services.

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure.
- A minimum of 10% RI will be needed to earn partial points.

3: Site specific and practice type risk adjusted targets will be sent to each participating site in Spring 2019.

4: All clinical measures except Colorectal Cancer Screening use as targets the performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2018. The Colorectal Cancer Screening targets are based on the 75th and 90th percentile plan-wide performance from the 2018 QIP, as NCQA data for Medicaid is not available.

Measures	Targets	Points	Risk Adjusted?
CLINICAL DOMAIN (80 Points Total)			
1. Controlling High Blood Pressure (18-85 yrs)	-Full Points: 71.04% ¹ -Partial Points: 65.78% ¹ or, if performance meets 50 th (58.64%), 10% Relative Improvement ²	12.5	No
2. Cervical Cancer Screening (21-65 yrs)	-Full Points: 70.68% ¹ -Partial Points: 66.01% ¹ or, if performance meets 50 th (60.10%), 10% Relative Improvement ²	10	
3. Colorectal Cancer Screening (51-75 yrs)	-Full Points: 58.69% ⁴ -Partial Points: 48.78% ⁴ or, if performance meets 50 th (37.50%), 10% Relative Improvement ²	10	
4. Diabetes Management: HbA1C Good Control (18-75 yrs)	-Full Points: 70.32% ¹ -Partial Points: 66.91% ¹ or, if performance meets 50 th (61.80%), 10% Relative Improvement ²	12.5	
5. Diabetes Management: Retinal Eye Exams (18-75 yrs)	-Full Points: 68.61% ¹ -Partial Points: 64.23% ¹ or, if performance meets 50 th (57.88%), 10% Relative Improvement ²	10	
6. Breast Cancer Screening	-Full Points: 68.94% ¹ -Partial Points: 64.12% ¹ or, if performance meets 50 th (58.04%), 10% Relative Improvement ²	12.5	
7. Asthma Medication Ratio	-Full Points: 62.28% ¹	12.5	

APPROPRIATE USE OF RESOURCES (10 Points Total)			
10. Ambulatory Care-Sensitive Admissions	-Full Points: Less than or equal to 110% of target ³ -Partial Points: 111-119% of site-specific target ³	5	Yes: By PCP/Site ³
11. Readmission Rate	-Full Points: Less than or equal to 110% of target ³ -Partial Points: 111-119% of site-specific target ³	5	Yes: By Practice Type ³
ACCESS & OPERATIONS (5 Points Total)			
12. Primary Care Utilization: ED Visits and PCP Office Visits	-Full Points: At or below target for ED visits AND at or above target for PCP office visits ³ -Partial Points: At or below target for ED visits ³	5	Yes: By plan and PCP/site ³
PATIENT EXPERIENCE (5 Points Total)			
13. CAHPS Survey for qualified sites, or Survey Option for all other sites	CAHPS surveys will be paid based on site's Access and Communication composites according to the following targets: -Full Points: Re-survey result > PHC 50th percentile score -Partial Points: Re-survey result between PHC 25th and 50th percentile scores Access 50 th Percentile: 48.22% Access 25 th Percentile: 43.07% Communication 50 th Percentile: 71.78% Communication 25 th Percentile: 69.01%	5	No

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning attestations	\$5,000 for 50-99 attestations; \$10,000 for 100+ attestations; in addition, \$5,000 for 50-99 advance directives/POLST; \$10,000 for 100+ advance directives/POLST for Medi-Cal members 18 years and older.
Access/Extended Office Hours	10% of Capitation for sites that 1) earned at least 35 points in previous QIP year and 2) are open for extended office hours as defined as eight hours beyond normal business hours per week.
PCMH Certification	\$1000 yearly for achieving or maintaining PCMH accreditation
Peer-led self-management support groups (both new and existing)	\$1000 per group (Maximum of ten groups per parent organization)
Alcohol Misuse Screening and Counseling	\$5 per screening for screening a minimum of 10% of eligible adult members
Health Information Exchange	One time \$3000 incentive for signing on with a local or regional health information exchange; Annual \$1000 incentive for showing continued participation with a local or regional health information exchange. The incentive is available once per parent organization.
Initial Health Assessment	\$2000 for submitting all required parts of improvement plan
Palliative Care Identification & Referral	\$2000 for sharing plan for identifying and communicating with potential palliative care patient and reporting the number of referrals made. The incentive is available once per parent organization.

Measure 1. Controlling High Blood Pressure

Description

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

Known as the “silent killer,” high blood pressure, or hypertension, increases the risk of heart disease and stroke, which are the leading causes of death in the United States.⁸ Controlling high blood pressure is an important step in preventing heart attacks, stroke and kidney disease, and in reducing the risk of developing other serious conditions.⁹ Some studies also indicate that failure to achieve blood pressure targets contribute to avoidable costs and the number of cardiovascular events.¹⁰ Health care providers and plans can help individuals manage their high blood pressure by prescribing medications and encouraging low-sodium diets, increased physical activity and smoking cessation.

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

Thresholds

- Full points: 90th percentile (71.04%)
- Half Points: 75th percentile (65.78%) or, if performance meets 50th percentile, 10% Relative Improvement

Beginning in 2019, a site’s performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (58.64%)

Denominator

The number of continuously enrolled Medi-Cal members 18-85 years of age as of December 31, 2019 (i.e. DOB between January 1, 1934 and December 31, 2001) with at least two visits on different dates of service with a diagnosis of hypertension, during the measurement year or the year prior to the measurement year (i.e. January 1, 2018 – December 31, 2019). Count services that occur over both years. Only one of the two visits may be a telephone visit, an online assessment, or a telehealth visit.

Numerator

The number of eligible population in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a member’s blood pressure to be controlled the systolic and diastolic blood pressure must be <140/90.

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

The BP reading must occur *on or after* the date of the second diagnosis of hypertension.

Administrative Specifications:

Identify the most recent BP reading taken during an outpatient visit, a non-acute inpatient encounter, or remote monitoring event in combination with codes from the diastolic and systolic value sets below during the measurement year (1/1/2019 – 12/31/2019). To become numerator compliant, the member must have a compliant code for both diastolic and systolic on the same claim number, and the same non-compliant code for both diastolic and systolic to fall back to a denominator.

Medical Record Specifications:

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension occurred.

To determine if the member's BP is adequately controlled, the representative BP must be identified. Representative BP is defined as the most recent BP reading during the measurement year (as long as it occurred after the second diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. The systolic and diastolic results do not need to be from the same reading. If no BP is recorded during the measurement year, assume that the member is "not controlled."

The member is not compliant if the BP reading is $\geq 140/90$ mm Hg or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit.
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the test or procedure, with the exception of fasting blood tests.
- Reported by or taken by the patient.

BP readings from remote monitoring devices that are digitally stored and transmitted to the provider may be included. There must be documentation in the medical record that clearly states the reading was taken by an electronic device, and results were digitally stored and transmitted to the provider, and interpreted by the provider.

Note: Member-reported results to the provider from a remote monitoring device are not acceptable.

Codes Used

Denominator:

Codes to identify outpatient visits: Outpatient Without UBREV Value Set.

Codes to identify Hypertension: Essential Hypertension Value Set.

Codes to identify telephone visit: Telephone Visits Value Set

Codes to identify online assessment: Online Assessments Value Set

Numerator:

Codes to identify outpatient visits: Outpatient Without UBREV Value Set.

Codes to identify telephone visit: Telephone Visits Value Set

Codes to identify online assessment: Online Assessments Value Set

Code to identify Diastolic and Systolic Numerator Compliance:

CPT® is trademarked and copyright 2018 by the American Medical Association. All rights reserved.

Value Set	Numerator Compliance
<u>Systolic Less Than 140 Value Set</u>	Systolic compliant
<u>Systolic Greater Than/Equal To 140 Value Set</u>	Systolic not compliant
<u>Diastolic Less Than 80 Value Set</u>	Diastolic compliant
<u>Diastolic 80–89 Value Set</u>	Diastolic compliant
<u>Diastolic Greater Than/Equal To 90 Value Set</u>	Diastolic not compliant

Exclusions (only if not numerator hit)

- Exclude from the eligible population all members with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set.) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31, 2019. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
- Exclude from the eligible population all members who had a non-acute inpatient admissions during the measurement year. To identify non-acute inpatient admissions:
 - Identify all acute and non-acute inpatient states (Inpatient Stay Value Set).
 - Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim.
 - Identify the discharge date for the stay.

Measure 2. Cervical Cancer Screening

Description

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

- Women age 21-64 who had cervical cytology performed every three years.
- Women age 30-64 who had cervical cytology and human papillomavirus (HPV) co-testing performed every five years.
- Women age 30-64 who had high-risk human papillomavirus (hrHPV) testing performed every five years.

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

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

Thresholds

- Full points: 90th percentile (70.68%)
- Half Points: 75th percentile (66.01%) or, if performance meets 50th percentile, 10% Relative Improvement

Beginning in 2019, a site’s performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (60.10%)

Denominator

The number of continuously enrolled Medi-Cal women 24-64 years of age as of December 31, 2019 (DOB between January 1, 1955 and December 31, 1995).

Numerator

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

Step one:

Identify women 24-64 years of age as of December 31, 2019 (DOB between January 1, 1954 and December 31, 1995) who had cervical cytology in the measurement year or the two years prior (January 1, 2017 – December 31, 2019).

Documentation in the medical record must include:

- A note indicating the date when the cervical cytology was performed.

Step two:

From the women who did not meet step one criteria, identify women 30-64 years of age as of December 31, 2019 (DOB between January 1, 1954 and December 31, 1989) who had cervical cytology and HPV co-testing on the same date of service*, or a hrHPV test during the measurement year or the four years prior to the measurement year (January 1, 2015 – December 31, 2019) and who were 30 years or older on the date of both tests. Documentation in the medical record must include:

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

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

Step three:

From the women who did not meet step one or two criteria, identify women 30-64 years of age as of December 31, 2019 (DOB between January 1, 1954 and December 31, 1989) who had cervical cytology and an HPV test OR a high-risk HPV test (hrHPV) with dates of service four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests.

Step four:

Add the numbers from steps one through three to obtain a total rate for women who were identified with appropriate screening for cervical cancer.

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

Codes Used

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

Numerator:

Codes to Identify Cervical Cancer Screening from Claims/ Encounter Data: Cervical Cytology Value Set.

Codes to Identify HPV test from Claims/Encounter Data: HPV Tests Value Set.

Codes to identify hrHPV Test: High Risk HPV Tests Value Set

Exclusions (only if not numerator hit)

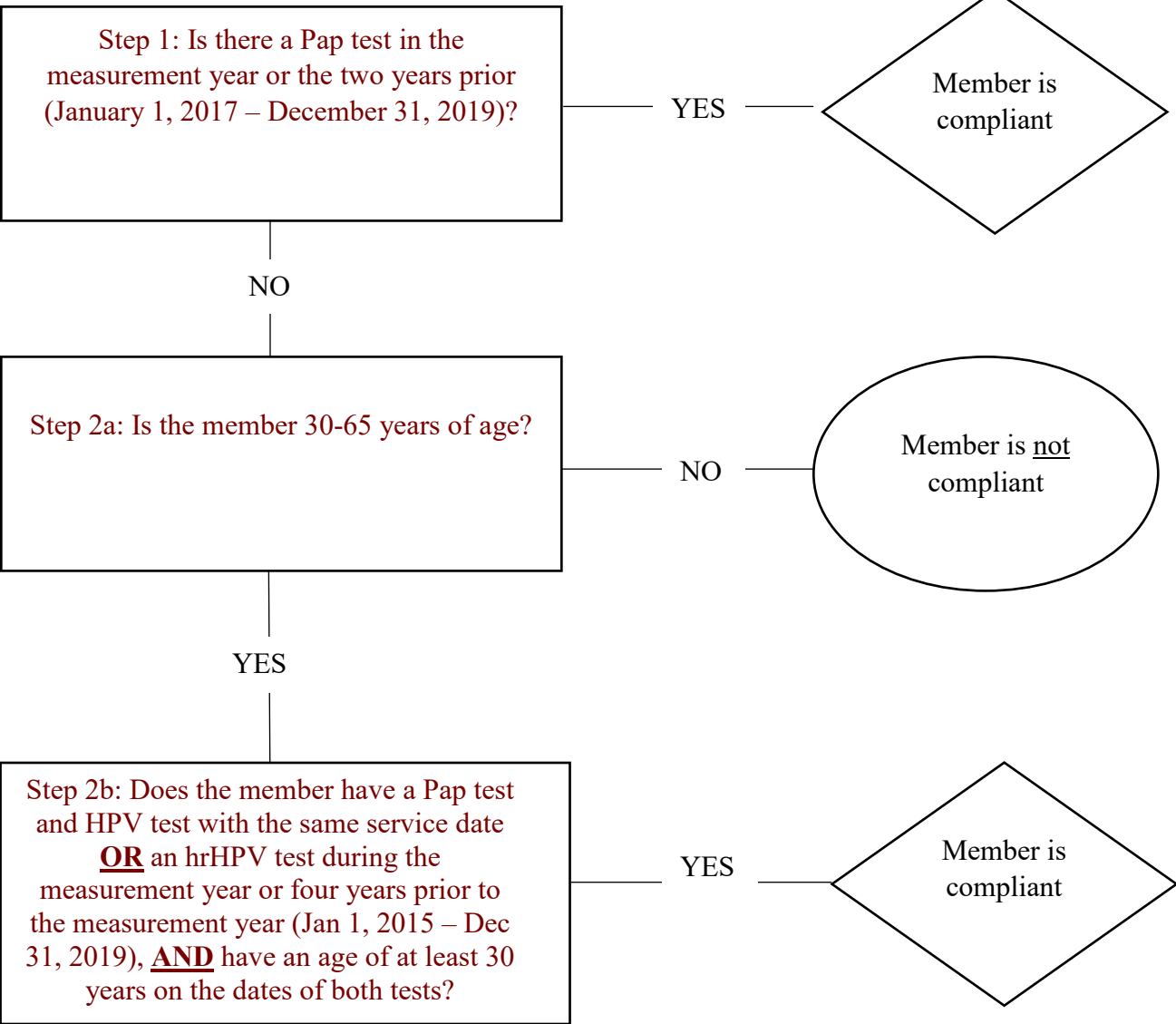
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Absence of Cervix Value Set) any time during the member’s history through December 31, 2019.

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

- Documentation of a “vaginal Pap smear” in conjunction with documentation of “hysterectomy”.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

Monitoring for Appropriate Cervical Cancer Screening of Eligible Members



Step 3: Add the numbers from Step 1 and Step 2b to obtain a total rate

Measure 3. Colorectal Cancer Screening

Description

The percentage of members 51–75 years of age as of December 31, 2019 who had appropriate screening for colorectal cancer.

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

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

Thresholds

- Full points: 90th percentile (58.69%)
- Half Points: 75th percentile (48.78%) or, if performance meets 50th percentile, 10% Relative Improvement

Beginning in 2019, a site’s performance must meet the 50th percentile performance across the HealthPlan’s annual performance, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (37.50%)

Denominator

The number of continuously enrolled Medi-Cal members 51-75 years of age by December 31, 2019 (DOB between January 1, 1944 and December 31, 1968).

Numerator

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

- Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.
- CT colonography during the measurement year or the four years prior to the measurement year.
- FIT-DNA test during the measurement year or the two years prior to the measurement year.

Codes Used

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

Numerator:

Fecal immunochemical test: FOBT Value Set.

Flexible sigmoidoscopy: Flexible Sigmoidoscopy Value Set.

Colonoscopy: Colonoscopy Value Set.

CT colonoscopy: CT Colonography Value Set.

FIT-DNA: FIT-DNA Value Set.

Exclusions (only if not numerator hit)

Either of the following any time during the member's history through December 31, 2019 of the measurement year:

- Colorectal cancer: Colorectal Cancer Value Set.
- Total colectomy: Total Colectomy Value Set.

Measure 4. Diabetes Management – HbA1c Good Control (≤9%)

Description

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

Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body’s inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life, and reduce healthcare costs.^{14, 15} The QIP includes three measures for diabetes management.

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

Thresholds

- Full points: 90th percentile (70.32%)
- Half Points: 75th percentile (66.91%) or, if performance meets 50th percentile, 10% Relative Improvement

Beginning in 2019, a site’s performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (61.80%)

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1944 and December 31, 2002) with diabetes identified as of December 31, 2019.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior, i.e. January 1, 2018 –December 31, 2019.

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2018 – December 31, 2019).

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

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

Numerator

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

Codes Used

Denominator:

Codes to identify outpatient visits: Outpatient Value Set.

Codes to identify observation visits: Observation Value Set.

Codes to identify ED visits: ED Value Set.

Codes to identify non-acute inpatient encounters: Nonacute Inpatient Value Set.

Codes to identify acute inpatient encounters: Acute Inpatient Value Set.

Codes to identify diabetes diagnosis: Diabetes Value Set.

Codes to identify insulin or hypoglycemics/antihyperglycemics: Diabetes Medications Value Set.

Numerator:

Codes to identify HbA1c good control: HbA1c Level Greater Than 9.0 Value Set.

Codes to identify HbA1c test: HbA1c Tests Value Set.

Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2018 – December 31, 2019), and who meet either of the following criteria:

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

Measure 5. Diabetes Management – Retinal Eye Exam

Description

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

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

Thresholds

- Full points: 90th percentile (68.61%)
- Half Points: 75th percentile (64.23%) or, if performance meets 50th percentile, 10% Relative Improvement

Beginning in 2019, a site’s performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (57.88%)

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1944 and December 31, 2001) with diabetes identified as of December 31, 2019.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior (January 1, 2018 – December 31, 2019).

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2018 – December 31, 2019).

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

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (January 1, 2018 – December 31, 2019).

Numerator

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

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist or teleoptometry service such as EyePACs) in the measurement year.
- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year (January 1, 2018 – December 31, 2018).
- Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifier Value Set).
- Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service.

Codes Used

Denominator:

Codes to identify outpatient visits: Outpatient Value Set.

Codes to identify observation visits: Observation Value Set.

Codes to identify ED visits: ED Value Set.

Codes to identify non-acute inpatient encounters: Nonacute Inpatient Value Set.

Codes to identify acute inpatient encounters: Acute Inpatient Value Set.

Codes to identify diabetes diagnosis: Diabetes Value Set.

Codes to identify insulin or hypoglycemics/antihyperglycemics: Diabetes Medications Value Set.

Numerator:

Codes to identify diabetic retinal screening: Diabetic Retinal Screening Value Set, billed by an eye care professional during the measurement year.

Codes to identify diabetic retinal screening with eye care professional: Diabetic Retinal Screening With Eye Care Professional Value Set, billed by any provider type, during the measurement year.

Codes to identify negative diabetic retinal screening: Diabetic Retinal Screening Negative Value Set, billed by any provider type, during the measurement year.

Codes to identify diabetic retinal screening: Diabetic Retinal Screening Value Set, billed by an eye care professional (specialty code 18 and 59), with a diagnosis of Diabetes Mellitus without complications (Mellitus Without Complications Value Set).

For exams performed with a negative result in the year prior to the measurement year (January 1, 2018 – December 31, 2018), a result must be available.

Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2018 – December 31, 2019), and who meet either of the following criteria:

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

Measure 6. Breast Cancer Screening

Description

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

Breast cancer is a leading cause of premature mortality among US women. Breast cancer is the most common cancer among women in California, regardless of race and ethnicity. Early detection by mammography has been shown to be associated with reduced breast cancer morbidity and mortality. A mammogram can detect any cancer sign even before any lump can be felt in the breast. Studies have shown that routine mammograms are associated with 10% to 25% less chance of dying of breast cancer.²⁵ Routine PCP contracts do not account for this. Therefore, the QIP incentivizes these screenings that can prevent breast cancer development and result in huge healthcare cost savings from late-stage treatment.

Thresholds

- Full points: 90th percentile (68.94%)
- Half Points: 75th percentile (64.12%) or, if performance meets 50th percentile, 10% Relative Improvement

Beginning in 2019, a site’s performance must meet the 50th percentile performance across all Medicaid plans, in order to be eligible to earn points based on relative improvement.

- RI: 50th percentile (58.04%)

Denominator

The number of continuously enrolled (October 1, 2017 through December 31, 2019, no gap allowed from October 1, 2017 to December 31, 2017, one month gap allowed from January 1, 2018 to December 31, 2018, and January 1, 2019 to December 31, 2019) Medi-Cal women 50-74 years of age as of December 31, 2019 (DOB between January 1, 1945 and December 31, 1969).

Numerator

The number of eligible population in the denominator with one or more mammograms any time on or between October 1, 2017 and December 31, 2019.

Codes Used

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

Numerator: Codes to identify Mammogram: Mammography Value Set.

Exclusions (only if not numerator hit)

Bilateral mastectomy any time during the member’s history through December 31, 2019.

Any if the following meet criteria for bilateral mastectomy:

- Bilateral Mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) **with** a bilateral modifier (Bilateral Mastectomy Value Set). Codes must be on the same claim.

- Two unilateral mastectomies ((Unilateral Mastectomy Value Set) *with* service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1, 2018, the service date for the second unilateral mastectomy must be on or after February 15.
- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
- Any combination of codes that indicate a mastectomy on **both** the left **and** right side on the same different dates of service.

Left Mastectomy (Any of the following)	Right Mastectomy (Any of the following)
<ul style="list-style-type: none"> • Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same claim) 	<ul style="list-style-type: none"> • Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Left Modifier Value Set</u>) (same claim)
<ul style="list-style-type: none"> • Absence of the left breast (<u>Absence of Left Breast Value Set</u>) 	<ul style="list-style-type: none"> • Absence of the right breast (<u>Absence of Right Breast Value Set</u>)
<ul style="list-style-type: none"> • Left Unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>) 	<ul style="list-style-type: none"> • Right Unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)

Measure 7. Asthma Medication Ratio**Description**

The percentage of continuously enrolled Medi-Cal members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater between January 1, 2019 and December 31, 2019.

The Asthma Medication Ratio is a measure to help providers assess the quality of asthma care received by their patients with persistent/chronic asthma. Studies have shown that the AMR to be a better predictor of acute asthma exacerbations than any prior measure of controller medication use.²⁸ Routine PCP contracts do not account for this. The QIP incentivizes this measure to increase the quality of asthma care and reduce the cost of asthma exacerbations.

Thresholds

- Full points: 50th percentile (62.28%)
- No partial point is available for this measure

Definition***Oral Medication Dispensing Event:***

One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days' supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.

Refer to the definition of oral medication dispensing event in MMA for examples.

Inhaler Dispensing Event:

When identifying the eligible population, use the definition below to count inhaler dispensing events.

All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.

Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.

Use the Drug ID field in the NDC list to determine if the prescriptions are the same or different.

Injection Dispensing Event:

Each injection counts as one dispensing event. Multiple dispensed injections of the same or different

medications count as separate dispensing events. For example, if a member received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.

Allocate dispensing events to the appropriate year based on the date on which the prescription is filled.

Units of Medications:

When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication. For example, two inhalers canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event

Use the package size and units columns in the NDC list to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10g and pharmacy data indicates the dispensed amount is 30g, this indicates three inhalers canisters were dispensed.

Denominator

The number of continuously enrolled Medi-Cal members 5-64 years of age as of December 31, 2019 (DOB between January 1, 1955 and December 31, 2014).

Follow the steps below to identify the eligible population:

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 need not be the same across both years.

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

Step 2: A member identified as having persistent asthma because of at least four 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 settings, in the same years as one leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year).

Step 3: Exclude members who met any of the following criteria:

- Members who had any diagnosis from any of the following value sets, any time during the member's history through December 31 of the measurement year.
 - Emphysema Value set.
 - Other Emphysema Value Set.
 - COPD Value Set.
 - Obstructive Chronic Bronchitis Value Set.
 - Chronic Respiratory Conditions Due To Fumes/Vapors Value Set.
 - Cystic Fibrosis Value Set.
 - Acute Respiratory Failure Value Set.
- Members who had no asthma medications (controller or reliever) dispensed (Table AMR-A) during the measurement year.

Numerator

The number of eligible population in the denominator who have a medication ratio of 0.50 or greater between January 1, 2019 and December 31, 2019. Following the steps to calculate the ratio.

Step one: For each member, count the units of controller medications (Table AMR-A) dispensed between January 1, 2019 and December 31, 2019. Refer to the definition of *Units of medications*.

Step two: For each member, count the units of reliever medications (Table AMR-A) dispensed between January 1, 2019 and December 31, 2019. Refer to the definition of *Units of medications*.

Step three: For each member, sum the units calculated in step one and step two to determine units of total asthma medications.

Step four: For each member, calculate the ratio of controller medications to total asthma medications using the following formula.

$$\frac{\text{Units of Controller Medications (step1)}}{\text{Units of Total Asthma Medications (step3)}}$$

Step five: Sum the total number of members who have a ratio of 0.50 or greater in step four.

Table AMR-A: Asthma Controller and Reliever Medications

ASTHMA CONTROLLER MEDICATIONS	
Description	Prescriptions
Antiasthmatic Combinations	Dyphylline-guaifenesin, Guaifenesin-theophylline
Antibody inhibitors	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone, Flunisolide, Budesonide, Fluticasone, CFC free Ciclesonide, Mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Max cell stabilizers	Cromolyn
Methylxanthines	Aminophylline, Dyphylline, Theophylline
ASTHMA RELIEVER MEDICATIONS	
Description	Prescriptions
Short-acting, inhaled beta-2 agonists	Albuterol, Levabuterol, Pirbuterol

Table MMA-A: Asthma Medications

Description	Prescriptions
Antiasthmatic Combinations	Dyphylline-guaifenesin, Guaifenesin-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone, Flunisolide, Budesonide, Fluticasone, CFC free Ciclesonide, Mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Max cell stabilizers	Cromolyn
Methylxanthines	Aminophylline, Dyphylline, Theophylline

Short-acting, inhaled beta-2 agonists	Albuterol, Levabuterol, Pirbuterol
---------------------------------------	------------------------------------

Codes Used

Denominator:

Codes to identify ED visit: ED Value Set.

Codes to identify a principal diagnosis of asthma: Asthma Value Set.

Codes to identify acute inpatient encounter: Acute Inpatient Value Set.

Codes to identify outpatient visit: Outpatient Value Set.

Codes to identify observation visit: Observation Value Set.

Numerator: No codes applicable as eligibility is solely based on medication ratio.

Exclusions (only if not numerator hit)

N/A

Measure 8. Ambulatory Care Sensitive Admissions

Description

Rate of ambulatory care sensitive admissions (as opposed to observations) during the measurement year.

Hospitalizations due to issues that are treatable through ambulatory or primary care are considered to be a measure of access to appropriate primary care. Though all hospitalizations due to these conditions are not avoidable, proactive outpatient care, interventions, and steps to specifically avoid an acute episode are not part of routine PCP contracts. The QIP incentivizes this measure so patients' problems can be managed early and intensively by primary care physicians in the hope of reducing the need for hospital admissions.

Thresholds

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

Targets are set using plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets will be sent in Spring 2019.

Data Criteria

Sites must have a minimum of 100 eligible members on the last day of the measurement period (December 31, 2019). The list of ambulatory care sensitive conditions is obtained from the Agency for Health Care Research and Quality's (AHRQ) Prevention Quality Indicators (PQI) and Pediatric Quality Indicators). PHC will calculate the number of admissions related to these diagnoses using PHC allowable claims and encounter data from acute care hospitals for services provided to the site's assigned members.

Denominator

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

Numerator

Total hospital days for inpatient admissions with a qualifying diagnosis from the provided list of PDIs and PQIs.

Codes Used

Preventive Quality Indicators:

https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2018.aspx

- PQI 01 – Diabetes Short-term Complications
- PQI 03 – Diabetes Long-term Complications
- PQI 05 – COPD or Asthma in Older Adults Admission Rate
- PQI 07 – Hypertension
- PQI 08 – Heart Failure
- PQI 10 – Dehydration
- PQI 11 – Community Acquired Pneumonia Admission Rate
- PQI 12 – Urinary Tract Infection
- PQI 14 – Uncontrolled Diabetics
- PQI 15 – Asthma in Younger Adults

PQI 16 – Lower-Extremity Amputation among Patients with Diabetes

Pediatric Quality Indicators:

https://www.qualityindicators.ahrq.gov/Archive/PDI_TechSpec_ICD10_v70.aspx

PDI 14 – Asthma Admissions Rate

PDI 15 – Diabetes Short-term Complications

PDI 16 – Gastroenteritis

PDI 18 – Urinary Tract Infection

Exclusions

Exclude hospital stays for the following reasons:

- A principal diagnosis of pregnancy
- A principal diagnosis of a condition originating in the perinatal period
- Admissions associated with organ transplants
- Transfers from acute health care facilities

Measure 9. Readmission Rate

Description

Ratio of acute hospital admissions that are within 30 days of a discharge to total number of inpatient stays that meet Continuous Plan enrollment criteria.

A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs.²³

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

Thresholds

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

Targets are set by practice type using plan-wide mean. Practice type risk adjusted targets will be sent in Spring 2019.

Data Criteria

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

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

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

Definitions:

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1, 2019 and December 31, 2019. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1, 2019 and December 31, 2019.
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.

Index Readmission Date	The admission date associated with the Index Readmission Stay.
------------------------	--

Denominator

Start with eligible population, i.e. Medi-Cal only members who do not have Medicare or other source of insurance and who are 18 years or older as of the Index Discharge Date.

Step 1: Identify all acute inpatient stays in an acute facility with a discharge date on or between January 1, 2019 and November 31, 2019. Include admissions in inpatient hospital, inpatient rehab or inpatient psychiatry (indicated by Service Location on claims). Identify the discharge date for the stay.

Step 2: Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer’s discharge date as the Index Discharge Date for the entire stay.

Step 3: Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Apply continuous enrollment at the health plan level, i.e. enrolled with PHC 90 days prior to the Index Admission Date, through 30 days after Index Admission Date.

Step 5: Assign each acute inpatient stay to the PCP where the discharge occurred.

Numerator

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1: Identify all acute inpatient stays with an admission date on or between January 2, 2019 and December 31, 2019.

Step 2: Acute-to-acute transfers: Keep the original admission date is the Index Admission Date for the entire stay, but use the transfer’s discharge date as the Index Discharge Date for the entire stay.

Step 3: Exclude acute inpatient hospital admissions with a principal diagnosis of pregnancy or a principal diagnosis for a condition originating in the perinatal period.

Step 4: For each Index Hospital Stay, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

Codes Used

Codes to identify service location as acute facility: AD Inclusion – Location Code on Code List

Codes to identify acute-to-acute transfers: AD Inclusion – Discharge Code on Code List

Codes to identify diagnosis of pregnancy or diagnosis of a condition originating in the perinatal period: AD Exclusion - Primary Diagnosis ICD9/10 on Code List

Exclusions

Exclude hospital stays for the following reasons:

- A principal diagnosis of pregnancy
- A principal diagnosis of a condition originating in the perinatal period
- The member died during the stay

Measure 10. Primary Care Utilization

Description

Two part measure rewarding low ED usage as well as high primary care access as measured by the number of PCP office visits.

Providers are often empaneled with a large number of patients for whom they are expected to establish care. 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. Additionally, routine PCP contracts do not demand a certain number of visits each year. This measure exists to encourage providers to focus on this access issue, and to help curb the high costs associated with preventable ED visits. Providers are incentivized to integrate ED visit prevention into a strategy to make sure patients are establishing care with their assigned PCP.

Thresholds

- Full points: At or below target for ED visits AND at or above target for PCP office visits
- Partial points: At or below target for ED visits

Targets are set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Site specific risk adjusted targets will be sent in Spring 2019.

Data Criteria

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

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.

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

Step 1: Identify total members assigned to PCP during each month.

Step 2: For those members, obtain all ED facility claims and professional claims.

Step 3: An ED visit is avoidable if every diagnosis code associated with an ED episode (both professional and facility claims) is included in the list of avoidable diagnoses codes.

Calculation

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

PCP Office Visits: 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.

Step 1: Identify total members assigned to PCP during each month.

Step 2: For those members, identify all their PCP office visits by procedure codes during that month, regardless of who the provider of the visit is, that occur in the following locations: office, home or private residence of patient, FQHC, State or local health clinic, or Rural Health Clinic.

Step 3: To calculate monthly performance for a specific provider site, divide the total number of PCP office visits by assigned members that month by the total number of non-dual capitated member months that month.

Step 4: To calculate YTD performance for a specific provider site, add up all the monthly numerators (visits by assigned members) and monthly denominators (non-dual capitated member months).

Note: it is possible that the numerator may contain visits for members who are not in the denominator, because of retroactive enrollment changes.

Calculation:

$$PCP\ Office\ Visits\ PMPY = (\#\ Office\ Visits / Non-Dual\ Capitated\ Member\ Months) * 12$$

Codes Used

- Codes to identify service location as ED: Avoidable ED Inclusion – Location Code on Code List
- Codes to identify ED claims type (facility or professional): Avoidable ED Inclusion – ED Claims Type on Code List
- Codes to identify ED Avoidable Diagnosis Codes: Avoidable ED Inclusion – Primary Diagnosis ICD9/10 on Code List
- Codes to identify office visits location: OV Inclusion – Location Code on Code List
- Codes to identify office visits: OV Inclusion – Procedure Code on Code List
- Codes to identify void or denied claims in exclusions: OV Exclusion – Explain Code on Code List

Exclusions

- Members age <1 for Avoidable ED Visits
- Void claims and denied claims with certain explanation codes (See Code List – OV Exclusion) for PCP office visits

Measure 11. Patient Experience

Description

This measure aims to improve the patient experience. There are two 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

- PCP conducts a survey to understand the patient experience and reports results and findings using the submission template

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.

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 thresholds in key measures in the Clinician & Group CAHPS 3.0 survey. The validated tool can be found here: <http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html>. Sites will be notified by May 1, 2019 whether or not they meet sufficient volume for inclusion in the CAHPS survey. A third-party vendor hired by PHC will conduct the survey independently.

Sufficient patient volume is defined as having at least one visit by 1200 unique PHC members between April 1, 2018 and March 31, 2019 at the parent organization level. If a site does not belong to any parent organization, it is considered a parent organization for this measure. The survey results will be analyzed at the parent organization level. Eligible population includes assigned members with at least one unique visit or special members with at least two 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 meeting the performance targets set based on the baseline survey conducted in 2018. If both the adult and child CG-CAHPS surveys are conducted at your site, you will be paid based on the higher of the two results. We will pay for the Access and Communication composites according to the following targets:

- Full points (2.5 points for each composite): Re-survey result > PHC 50th percentile score
- Half points (1.25 points for each composite): Re-survey result between PHC 25th and 50th percentile scores

The 2019 targets will be based on 2018 survey results:

	Access	Communication
2018 Survey 50th Percentile	45.0%	70.3%
2018 Survey 25th Percentile	41.1%	67.0%

OR

2) Survey Option

Sites that do not meet the patient volume threshold can conduct an internal survey and report results using the template found in [Appendix I](#). There are two parts to this option. Please follow the steps below accordingly. Sites can describe existing survey efforts, such as the NCQA PCMH survey.

Part I (2.5 points):

- 1) Implement a survey which must include at least two 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 (2.5 points):

- 3) Implement change(s) for improvement.
- 4) Re-measure patient experience using the same survey at least once after implementing changes.

Submission Process

Only sites that use the Survey Option (i.e. sites that do not meet the patient volume threshold) are required to submit data. For the Surveys, submit the Patient Experience Submission Template ([Appendix I](#)) via fax or e-mail to QIP@PartnershipHP.org. Part I is due on July 31, 2019 and Part II January 31, 2020.

Exclusions

N/A

Measure 12. Advanced Care Planning**Description**

This measure pays for both the process and the outcome of advance care planning discussions. Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members over the age of 18. Providers will receive \$5,000 for submitting records of 50-99 approved discussions, and \$10,000 for submitting 100 or more approved discussions. In addition, providers will receive \$5,000 for submitting 50-99 records of approved advanced directives or POLST forms, and \$10,000 for submitting 100 or more records of approved advanced directives or POLST forms. The count of discussions is separate from the combined count of advanced directives and POLST forms.

The purpose of this measure is to encourage providers to integrate these important planning discussions with patients into their standard practices. Advanced care planning is valuable 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

Providers will receive payment for facilitating advanced care planning (ACP) with eligible Medi-Cal only PHC members over the age of 18 after a threshold is met. Providers will receive \$5,000 for submitting records of 50-99 approved ACP conversations. Providers will receive \$10,000 for submitting records of 100 or more approved ACP conversations.

In addition, providers will receive \$5,000 for submitting 50-99 approved records of advanced directives or Physician Orders for Life-Sustaining Treatment (POLST) forms. Providers will receive \$10,000 for submitting records of 100 or more approved advanced directives or POLST forms. The counts of POLST and advanced directive completion will be combined, while the ACP conversations are separate.

ACP discussions must take place between January 1, 2019, and December 31, 2019 in order to be eligible for this measure.

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. Note that this measure is not exclusive to patients with a life-limiting disease or condition.

Provider sites that have 50-100 assigned members are eligible for this measure with the following conditions:

- Attestation: 50% of assigned membership over the age of 18 must have an attestation for an ACP discussion, which will be reimbursed for \$100 each.
- Advanced Directive and/or POLST: 30% of the assigned membership over the age of 18 must have a submitted AD or POLST which will be reimbursed for \$100 each.
- The total payment for each count must be under \$5,000.

Advance Directive and/or POLST:

Only one record of each form per patient per measurement year. If a patient has a previously completed form and does not wish to make any changes, documentation of a conversation during the measurement

period confirming that no change will qualify.

Attestation:

Only one conversation per patient per measurement year. In addition to patient identification information including name, CIN, and date of birth, the following components are required to be documented in the chart for a provider to attest to the completion of an ACP discussion:

- 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:
 - Full treatment
 - Comfort care
 - Hospice
 - DNR
 - DNI
 - Other (tube feeds and blood transfusion and transfer to hospital are common items)
- If a POLST is appropriate, some status options include:
 - Discussed
 - Given to patient
 - Completed
 - Copy in chart
 - Patient refused
- Plan for next conversation.

Submission Process

Beginning in 2019, this Unit of Service measure will utilize the eReports system for submitting records of ACP discussions and forms. Once available in Spring 2019, providers must utilize the templates found within eReports to submit documentation for individual patients. Faxed or e-mailed attestation forms will not be accepted. Submissions are due to Partnership no later than January 31, 2020. Payments will be made on an annual basis.

eReports Upload Specifications:

- Attestation/Advance Directive/ POLST date of service in the measurement year.
- Member must be eligible on the Attestation/Advance Directive/ POLST date of service.
- Member Age: 18 years of older as of the date of service.
- Member must have PHC as the primary insurance carrier and not have any record of other insurance during the measurement year.

- Member will only be counted once in the measurement year.

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. If a member's eligibility status changes during the measurement year, the site's count of accepted attestations may change.

Measure 13. Extended Office Hours**Description**

For PCP sites that earned a minimum of 35 points in the prior QIP measurement period, providers 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 five mile radius of each other are eligible for the increased cap.

Example 1: A parent organization has two sites within five 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 five 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 sites must have earned a minimum of 35 points in the 2018 QIP measurement period in order to be eligible for this measure. PCP site must be open an additional eight hours per week or more, beyond the normal business hours, defined as Monday-Friday, 8:00 a.m. to 5:00 p.m., for the entire quarter.

No award if, during a quarter, the practice site no longer offers extended office hours or reduces the hours and no longer meets the eight hour minimum.

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 March 30, 2020.
- 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: March 31, 2019
- Q2: June 30, 2019
- Q3: September 30, 2019
- Q4: December 31, 2019

Please note this measure is subject to an audit by the Provider Relations department.

Measure 14. Patient-Centered Medical Home Recognition**Description**

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

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, achieve recognition from established quality organizations, and maintain accreditation.

Refer to [Appendix II](#) for submission template for this measure.

Measure Requirements

Primary care provider sites with a minimum of 50 assigned Partnership members. Sites must receive accreditation, maintain accreditation, or re-certify within the measurement year. Documentation of PCMH recognition, accreditation maintenance, or re-certification from NCQA, AAAHC, or JCAHO must be faxed or emailed to QIP@partnershiphp.org by January 31, 2020.

Submission Process

You may refer to ([Appendix II](#)) for the documentation template, which can be faxed or emailed to QIP@partnershiphp.org by January 31, 2020.

Exclusions

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

Measure 15. Peer-Led Self-Management Support Groups**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 III](#) 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 four times in the 2019 calendar year and have a peer-facilitation component and a self-management component. Group can serve both PHC and non-PHC members, but must include at least 16 PHC total member visits per year (For example, if there are four PHC members in the group and the group meets for four 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 parent organization

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 III](#)) by January 31, 2020, and can be faxed or emailed to QIP@partnershiphp.org.

Exclusions

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

Measure 16. Alcohol Misuse Screening and Counseling**Description**

This measure incentivizes providers to screen and counsel patients for alcohol misuse using standardized tools. Providers receive the incentive provided that they screen a minimum of 10% of eligible members.

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:

- G0442 (Alcohol screening)
- G0443 (Alcohol counseling)

PHC's claim system will validate and pay for up to two screenings for an individual every six months. Sites that hit the 10% target will earn a site-specific incentive.

We use the following formula to determine each site's screening rate:

$$\frac{\text{Number of screenings billed with HCPCS codes G0442 and G0443}}{\text{Number of assigned adult members}}$$

We use the following formula to determine the financial incentive the site is eligible for:

$$\text{Number of Screenings} * \$5$$

Submission Process

PHC will extract this data three months after the end of the reporting year (i.e. March 31, 2020) by identifying claims for G0442 and G0443 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 17. Health Information Exchange Participation**Description**

Sites will be reimbursed for participating in a local or regional health information exchange (HIE). Sites that first establish linkage during the 2019 measurement year are eligible to earn \$3,000. Sites that can show continued linkage and utilization of an HIE prior to the 2019 measurement year are eligible to earn \$1,500.

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

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

Measure Requirements

Provider sites must specify on the Submission Template when linkage was established. 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
- Jefferson HIE

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

Submission Process

Submit the HIE Attestation form ([Appendix IV](#)) by January 31, 2020. PHC will validate the data exchange by working directly with the specified HIE.

Exclusions

N/A

Measure 18. Initial Health Assessment Improvement Plan**Description**

Providers are mandated by the state of California to schedule patients within 120 days of becoming a PHC member for an IHA (Initially Health Assessment) including the following criteria:

- Physical and mental history
- Identification of high-risk behaviors
- Assessment of need for preventative screenings or services, and health education
- Diagnosis and plan for treatment of any diseases
- A completed SHA (Staying Healthy Assessment)
- Providers that have sufficient PHC patient volume can earn an annual Unit of Service measure payout of \$2000 based on submission of template form outlining data collection plan and documentation of process to improve site compliance for the IHA. The intent in this introductory year is to encourage IHA improvement plan development. Expect this measure to evolve in future iterations to include a reporting element, demonstrating impact of implementing an approved plan.

Completion of the IHA will help providers to determine current, acute, chronic and preventative needs in a comprehensive and timely manner, potentially addressing problems sooner and lowering overall healthcare costs.

Refer to [Appendix V](#) for submission template for this measure.

Measure Requirements

Providers that have sufficient PHC patient volume can earn a one-time annual payment based on points earned for completing and turning in an IHA Improvement Plan.

Sufficient patient volume to participate is defined as having at least one visit by 1200 unique PHC members between April 1, 2018 and March 31, 2019 at the entity level. If a site does not belong to any entity, it is individually considered an entity for this measure. This criterion mirrors the eligibility requirement for the Patient Experience – CAHPS survey, which means that a site is eligible to participate if it received CAHPS results from PHC in 2018.

Submission Process

Submit completed template via fax or email to QIP@partnershiphp.org. Submissions are due to Partnership no later than 1/31/2020. Payments will be made on an annual basis. Refer to [Appendix V](#) for IHA template.

Exclusions

Sites with a patient volume less than 1200 unique members with visits between April 1 2018 and March 31, 2019.

Measure 19. Palliative Care Identification and Referral**Description**

Sites will be rewarded for submitting a plan for identifying and communicating with adult patients who would qualify for intensive outpatient palliative care.

Palliative care is defined as: “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.” (Centers for Medicare and Medicaid Services) Major topics covered in a typical palliative care conversation include defining the patient’s goals of care, and planning for future intensity of care provided (Advance Care Planning) which may include defining specific patient plans for future and documenting them in the form of an Advance Directive or Physician Order for Life Sustaining Treatment (POLST).

Increasing the utilization of intensive outpatient palliative care is a key strategic initiative of Partnership HealthPlan that falls outside of the usual scope of primary care contracts. Leveraging the primary care network to identify patients that would benefit from intensive outpatient palliative care will further PHC’s initiative and offer an appropriate level of care for vulnerable patients. A provider site that meets this measure indicates full understanding of palliative care needs and goals.

PHC has contracted providers of Intensive Outpatient Palliative Care services in all the counties served, beginning in 2018. A list of providers with contact information can be found in PHC’s [Provider Directory](#). For reference, a description of the Intensive Outpatient Palliative Care Program can be found in policy MCUP 3137 on the PHC website. Patients with Medicare are not eligible for PHC’s Intensive Outpatient Palliative care program, but your local palliative care organization may have some capacity to accept some of these; check with them to be sure.

Only sites classified as adult medicine or family medicine will qualify. Sites must have at least 1000 assigned adults to qualify.

Measure Requirements

This measure requires providers to submit a form detailing the process and criteria used for identifying which, if any, primary care patients are suitable candidates for outpatient palliative care as defined below. Providers should complete the submission template found as [Appendix VI](#). A minimum of one referral accepted into outpatient palliative care services must be documented in order for the submission to qualify.

Some general criteria for identifying palliative care patients among those with qualifying diagnostic criteria include (1) poor functional status (a palliative performance score of 70 or less) and (2) the potential for death within the next 12 months would not be unexpected.

The submission form should indicate the process used to identify

1. each of the disease specific criteria (below)
2. criteria to determine which patients with applicable diagnoses are suitable for referral to an intensive outpatient palliative care program
3. criteria to determine which patients with applicable diagnoses are NOT suitable for referral to an intensive outpatient palliative care program
4. A detailed process being planned for outreaching to patients suitable for intensive outpatient palliative care, including the proposed timeline, person responsible and measures of progress/success that will be

followed.

5. A detailed process for referring patients to the appropriate palliative care organization, once member has agreed to participate

Disease Specific Criteria

1. Congestive Heart Failure (CHF); Member must meet (a) and (b)
 - a) The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, AND
 - b) The member has an ejection fraction of < 30% for systolic failure OR significant comorbidities.
2. Chronic Obstructive Pulmonary Disorder (COPD): Member must meet (a) or (b)
 - a) The member has a Forced Expiratory Volume (FEV)₁ less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
 - b) The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
3. Advanced Cancer: Member must meet (a) and (b)
 - a) The member has a diagnosis of stage III or IV solid organ cancer, lymphoma, or leukemia, AND
 - b) The member has Performance Scale (KPS) score less than or equal to 70, or has failure of two lines of standard chemotherapy.
4. Liver Disease: Member must meet (a) and (b) combined, or (c) alone
 - a) The member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND
 - b) The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
 - c) The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.
5. End Stage Degenerative Neurologic Condition, dependent on a ventilator for respiratory support
 - a) ALS, Multiple Sclerosis, Muscular Dystrophy, End Stage Myasthenia, Other end stage neuro-degenerative condition dependent on a ventilator for respiratory support
 - b) Dementia and Frailty are not covered under this extended benefit

Submission Process

Submit completed template via fax or email to QIP@partnershiphp.org. Submissions are due to Partnership no later than **July 1, 2019**. Payments will be made on an annual basis. Refer to [Appendix VI](#) for Palliative Care Referral submission template.

Exclusions

N/A

IX. APPENDICES



Appendix I: Patient Experience Survey Submission Template

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program – Patient Experience Survey Submission Template and Example

Due date for Part I submission: July 31, 2019
Due date for Part II submission: January 31, 2020

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

Survey: Part I Submission Template
(Due July 31, 2019)

1. Attach a copy of the survey instrument administered (Survey must include at least two questions on access to care. For examples of access questions, please refer to the CAHPS questions listed on the last page of this document)
2. Provide descriptions for the following:
 - a. Population surveyed
 - b. How the survey was administered (via phone, point of care, web, mail, etc.)
 - c. The time period for when the surveys were administered
 - d. Total number of surveys distributed
 - e. Total number of survey responses collected/received
 - f. Response Rate
3. Based on the results from your survey, what specific measure(s) have you selected to improve?
4. For each measure or composite of questions selected for improvement, what is your specific objective?
5. For the measures selected for improvement, describe the specific changes/interventions/actions you believe will improve your performance.

Submitted by _____ (Name & Title) **on** _____ (Date)

Survey: Part II Submission Template
(Due January 31, 2020)

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)

EXAMPLE

Note: Sample text is provided in blue font
Survey: Part I Submission

1. Attach a copy of the survey instrument administered: See below

Dear Patient,

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

Please rank the following statements based on your visit today:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be.				
2. The non-clinical staff at this office were friendly to me.				
3. The non-clinical staff at this office addressed my concerns adequately.				
4. I was given more than one option in terms of how and when to schedule the next appointment.				
5. I felt comfortable asking the non-clinical staff questions.				
6. When I called for an appointment, the wait time was reasonable.				
7. I was given an appointment when I wanted it.				
8. I feel confident that my personal information is kept private.				
9. Charges were explained to me clearly.				

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

Between March 1, 2019 and May 1, 2019, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2019. The first mailing was sent on March 1, followed by a second mailing on April 15. 500 surveys were mailed and 250 surveys were returned; yielding a 50% response rate.

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

“I was given an appointment when I wanted it.”

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

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

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

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

Submitted by Elizabeth Jones (QI Director) (Name & Title) **on** July 10, 2019 (Date)

EXAMPLE

Note: Sample text is provided in blue font
Survey: Part II Submission

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

We had a consultant train our site over a two-month period (June- July 2018) on how to add same day appointments. The trainings included improvements to our scheduling system such as reducing the number of appointment types from 50 to 4. We developed and implemented scripts for the front desk staff so that they can educate our patients on the change in scheduling. We also collected data daily on our patient demand, supply and activity. This helped us determine where we can shift appointment slots based on our demand and corresponding supply. We also tried extending visit intervals for our well controlled patients with diabetes. Rather than bringing them in every 3 months, we now bring them in every 6 months.

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

Between October 15, 2019 and November 1, 2019, our site mailed a survey to all our adult patients who came in for an office visit between September 1 and October 1. We were only able to do one re-measurement cycle. The mailing was sent on October 15. Two hundred surveys were mailed and 110 surveys were returned; yielding a 55% response rate.

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

In the question, "I was given an appointment when I wanted it," we exceeded our goal in that 83% of our patients reported "Strongly agree," compared to our goal of 80% and our baseline score of 72%.

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

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

Submitted by [Elizabeth Jones \(QI Director\)](#) (Name & Title) **on** [January 10, 2020](#) (Date)

Appendix II. Patient-Centered Medical Home Documentation Template



4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Patient Centered Medical Home Recognition Template

Please complete all of the following fields on this form by **January 31, 2020** and send to:

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

1. **Name of Recognition entity (NCQA, JCAHO or AAAHC):**
2. **Recognition status (First time, Maintenance or Re-certification):**
3. **Date of recognition received:**
4. **Level accomplished (if applicable):**
5. **How often is recognition obtained?**
6. **Attach a copy of PCMH recognition documentation provided by the recognizing entity (must contain a date of recognition within the measurement year).**

Additional Notes/Comments:

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



4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Peer-led Self-Management Support Group Template

Please complete all of the following fields on this form by **January 31, 2020** and send to:

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

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

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



Appendix IV: Submission Template for HIE

4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Health Information Exchange (HIE) Reporting Template

If your site is linked to an HIE during or prior to the 2019 Measurement year, you may qualify for an incentive for the 2019 PCP QIP. Please complete all of the following fields on this form and submit by **January 31, 2020** 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. Sites will qualify for an incentive based on **either** HIE linkage (as a first time user) or HIE maintenance (as a continuing user). Please refer to the Measure Specifications for details.

1. Name of practice linked to the HIE: _____
2. Type of linkage established (check at least one that applies):
 - Sending HL7/ Patient Visit Information history to the HIE
 - Sending CCD document to the HIE
 - Retrieving clinical information such as labs from the HIE
3. Type of incentive
 - Linkage: First joined HIE *during* 2019 (list date) _____
 - Maintenance: First joined HIE *prior to* 2019 (list date) _____
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
 - Jefferson HIE

Submitted by: _____ Date: _____

Title: _____ Phone: _____

Email: _____

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



4665 Business Center Dr.
Fairfield, CA 94534

Quality Improvement Program

Initial Health Assessment Improvement Plan Template

Please complete the form and follow instructions below. Submit material by **January 31, 2020** to:

Email: QIP@partnershiphp.org

Fax: 707-863-4316

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

Practice Name: _____

Practice Address: _____

Contact Name: _____ Contact E-mail: _____

Improvement Plans should be a minimum of 400 words.

1. Attach a plan or report on how you are determining eligible patients. (How is your site running reports, or retrieving information to determine the eligible population?)
2. Provide documentation of the process in which the site is reaching out to the newly assigned members (i.e. mailers/phone calls etc.).
3. Provide a data collection plan to demonstrate how many members keep IHA appointments within the plan's timeframe AND the capture of the minimum necessary documentation. This includes:
 - o A physical and mental history
 - o Identification of high risk behavior
 - o Assessment of need for preventative screenings or services, and health education
 - o Diagnosis and plan for treatment of any disease
 - o A completed Staying Health Assessment (SHA) form
4. Provide data collection plan for measuring any declinations to come in for an IHA appointment as well as completion of the SHA.
5. Has this been on a recent MRR CAP? If so, provide documentation/plan implementation of what you have done since the accepted CAP date to increase compliance with the IHA.

Appendix VII: 2019 PCP QIP Submission and Exclusion Timeline

<u>2019 QIP Submissions</u>		
DUE DATE	QIP MEASURE	REPORTING TEMPLATE
July 1, 2019	Palliative Care Referral	Appendix VI
January 31, 2020	All Clinical Domain Measures and Advanced Care Planning	Find on eReports
January 31, 2020	Patient Experience – Survey Option	Appendix I
January 31, 2020	PCMH Recognition	Appendix II
January 31, 2020	Peer-led Self-Management Support Group	Appendix III
January 31, 2020	Health Information Exchange	Appendix IV
January 31, 2020	Initial Health Assessment Improvement Plan	Appendix V

<u>2019 QIP Exclusions</u>	
LAST DAY TO SUBMIT (ACCEPTED ALL YEAR)	APPLICABLE MEASURES
January 15, 2020	Cervical Cancer Screening Retinal Eye Exams A1C Good Control Nephropathy Screening
January 31, 2020	All other measures from the Clinical Domain

Appendix VIII: 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.

PCP QIP Core Measures	Data Source*	System Used for Data Monitoring	System Used for Data Submission
Clinical Care: Pediatric Medicine			
1. Nutrition Counseling (ages 3-17)	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Physical Activity Counseling (ages 3-17)			
3. Well Child Visits (ages 3-6)			
4. Immunizations for Adolescents			
5. Childhood Immunization Combo-3			
6. Asthma Medication Ratio			
Clinical Care: Family Medicine			
1. Well Child Visits (ages 3-6)	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Controlling High Blood Pressure			
3. Cervical Cancer Screening			
4. Colorectal Cancer Screening			
5. HBA1C Good Control			
6. Retinal Eye Exam			
7. Screening for Nephropathy			
8. Breast Cancer Screening			
9. Childhood Immunization Combo-3			
10. Immunization for Adolescents			
11. Asthma Medication Ratio			
Clinical Care: Internal Medicine			
1. Controlling High Blood Pressure	PHC and Provider	eReports and Partnership Quality Dashboard	eReports
2. Cervical Cancer Screening (
3. Colorectal Cancer Screening			
4. HbA1C Good Control			
5. Retinal Eye Exam			
6. Nephropathy Screening			
7. Breast Cancer Screening			
8. Asthma Medication Ratio			

Appropriate Use of Resources: Family and Internal Medicine			
1. Ambulatory Care Sensitive Admissions	PHC	Partnership Quality Dashboard	N/A
2. Readmission Rate			
Access/Operations Measures: All Practice Types			
1. Primary Care Utilization	PHC	Partnership Quality Dashboard	N/A
Patient Experience: All Practice Types			
Survey Option (sites not qualified for CAHPS)	Provider	Partnership Quality Dashboard	Submission Template
CAHPS Survey (for qualified sites)	PHC Vendor	Partnership Quality Dashboard	N/A

Unit of Service Measures	Data Source*	System Used for Data Monitoring	System Used for Data Submission
Advance Care Planning	Provider	Year-End Report	eReports
Access/Extended Office Hours	PHC	Year-End Report	Provider Relations Department
PCMH Certification	PHC and Provider	Year-End Report	Submission Template
Peer-led self-management support groups	Provider	Year-End Report	Submission Template
Alcohol Misuse Screening and Counseling	PHC	n/a	N/A
Health Information Exchange	Provider	Year-End Report	Submission Template
Initial Health Assessment	Provider	Year-End Report	Submission Template
Timely Data Submission via eReports	Provider	eReports	eReports
Palliative Care Identification and Referral	Provider	Year-End Report	Submission Template

Appendix IX: Diabetes Management Table

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

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

Appendix X: QIP Diabetes Exclusion Flow Chart



Appendix XI: Works Cited for All Practice Types

1. Centers for Disease Control and Prevention. 2012. "Adults and Older Adult Adverse Drug Events." http://www.cdc.gov/MedicationSafety/Adult_AdverseDrugEvents.html
2. Child Trends. 2012. "Well-child visits." <http://www.childtrends.org/?indicators=well-child-visits>
3. Centers for Disease Control and Prevention (CDC). 2014. "Youth Risk Behavior Surveillance—United States, 2013." <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>
4. Mayo Clinic. 2014. "Infant and Toddler Health. Childhood Vaccines: Tough questions, straight answers. Do vaccines cause autism? Is it OK to skip certain vaccines? Get the facts on these and other common questions." <http://www.mayoclinic.com/health/vaccines/CC00014>
5. Institute of Medicine. January 2013. "The Childhood Immunization Schedule and Safety: Stakeholder Concerns, Scientific Evidence, and Future Studies." Report Brief. http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2013/Childhood-Immunization-Schedule/ChildhoodImmunizationScheduleandSafety_RB.pdf
6. gov. 2013. "Immunization and Infectious Diseases." <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23>
7. Diekema, D.S. 2012. "Improving Childhood Vaccination Rates." *N Engl J Med* 366:39;1–3. <http://www.nejm.org/doi/full/10.1056/NEJMp1113008>
8. Centers for Disease Control and Prevention (CDC). 2012. "About High Blood Pressure." <http://www.cdc.gov/bloodpressure/about.htm>
9. James, P.A., S. Oparil, B.L. Carter, W.C. Cushman, C. Dennison-Himmelfarb, J. Handler, D.T. Lackland, et al. 2014. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults. Report from the Panel Members Appointment to the Eighth Joint National Committee (JNC 8). 311:507–20.
10. Pharmacoeconomics. 2003. "Financial and health costs of uncontrolled blood pressure in the United Kingdom". <https://www.ncbi.nlm.nih.gov/pubmed/12648033>
11. American Cancer Society. 2014. "Cervical Cancer Prevention and Early Detection." <http://www.cancer.org/acs/groups/cid/documents/webcontent/003167-pdf.pdf> Last modified December 11.
12. American Cancer Society. 2014. "Colorectal Cancer Facts & Figures 2014-2016." <http://www.cancer.org/acs/groups/content/documents/document/acspc-042280.pdf>
13. American Cancer Society. 2014. "Colorectal Cancer Early Detection, Diagnosis, and Staging." <http://www.cancer.org/acs/groups/cid/documents/webcontent/003170-pdf.pdf>
14. Diabetes Care. 2010. "Cost-effectiveness of interventions to prevent and control diabetes mellitus: a systematic review." <https://www.ncbi.nlm.nih.gov/pubmed/20668156>
15. Centers for Disease Control and Prevention (CDC). 2014. "National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014." Atlanta, GA: U.S. Department of Health and Human Services. <http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>
16. American Diabetes Association. 1994. "Preventive Eye Care in People With Diabetes Is Cost – Saving to the Federal Government: Implications for health-care reform." <http://care.diabetesjournals.org/content/17/8/909>

17. Centers for Disease Control and Prevention (CDC). 2013. "Adolescent and School Health: Childhood Obesity Facts." <http://www.cdc.gov/healthyyouth/obesity/facts.htm>
18. American Heart Association. 2013. "Overweight in Children." http://www.heart.org/HEARTORG/GettingHealthy/WeightManagement/Obesity/Overweight-in-Children_UCM_304054_Article.jsp
19. Centers for Disease Control and Prevention (CDC). 2014. "Meningococcal Disease: Prevention." <http://www.cdc.gov/meningococcal/about/prevention.html>
20. March 8, 2012. "Protect Your Child at Every Age." <https://www.cdc.gov/vaccines/parents/protecting-children/index.html>
21. 2014. "2014 Recommended Immunizations for Children from 7 Through 18 Years Old." <http://www.cdc.gov/vaccines/who/teens/downloads/parent-version-schedule-7-18yrs.pdf>
22. Centers for Disease Control and Prevention (CDC). 2011. "CDC Vital Signs: Asthma in the US." <http://www.cdc.gov/vitalsigns/pdf/2011-05-vitalsigns.pdf>
23. Boutwell, A., F. Griffin, S. Hwu, D. Shannon. 2009. "Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions." Cambridge, MA. Institute for Healthcare Improvement.
24. Evidence Report/ Technology Assessment: Health Information Exchange. Rep. no. 220. Agency for Healthcare Research and Quality, Dec. 2015. <https://www.effectivehealthcare.ahrq.gov/ehc/products/572/2154/health-information-exchange-report-151201.pdf>
25. Jin, Jill. 2014. Breast Cancer Screening: Benefits and Harms. JAMA. 2014; 312(23):2585. <http://jamanetwork.com/journals/jama/fullarticle/2040228>
26. Benefits vs. Risks. 2017. Immunize For Good. <http://www.immunizeforgood.com/fact-or-fiction/benefits-vs.-risks>
27. Langley, Joanne. 2015. Adolescent immunization – Protecting youth and preparing them for a healthy future. International Journal of Pediatrics and Adolescent Medicine. <http://www.sciencedirect.com/science/article/pii/S2352646715000319>