ALL PRACTICE TYPES

Primary Care Provider

Quality Incentive Program (PCP QIP) Detailed Specifications

Published: December 31, 2022

2023

MEASUREMENT YEAR

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I. Quality Improvement Program Contact Information

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II. Program Overview

The Primary Care Provider Quality Incentive Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California (PHC) providers, offers sizable financial incentives and technical assistance to primary care providers so 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 Incentive Program evaluates performance on PHC's Medi-Cal line of business, PHC encourages high quality, cost-efficient care for all your patients. Incentives are based on meeting specific performance thresholds in measures that address the above areas.

Guiding Principles

The QIP uses nine (9) 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: Calendar Year

The measurement year begins on January 1 and ends on December 31 of the current year. Please see Appendix V for details on deadlines specific to any measures. Payment is sent out 120 days after the program period ends, in the month of April the following year.

Definitions

Parent Organization (PO): A health providing organization (e.g. a health center, an integrated health system, or a health care administrative entity that owns and oversees the operations of one or more sites in a defined administrative region) that may or may not operate multiple sites.

Primary Care Provider Site (PCP Site): A clinic location that has been designated with a unique PCP ID with members actively assigned by Partnership HealthPlan of California. Eligibility and requirements for Primary Care Provider sites are listed in the PHC Policy MPQP1023, (Access Standards and Monitoring), subject to California Health and Safety Code 1206(h) and HRSA regulations on intermittent sites. All Primary Care Provider Sites are listed in the Provider Directory.

Provider: A term that may refer to a PCP PO, a PCP Site, a PCP Clinician, or any other entity or professional that is contracted to provide health care services to PHC members.

Eligibility for PHC Program

Eligible providers must have a PHC contract within the first three (3) months of the measurement year. The provider must remain contracted through the end of the measurement year to be eligible for payment.

Eligible providers must be in Good Standing continuously from the beginning of the measurement year to the month the payment is to be disbursed.

Definition of Good Standing:

PHC has the sole authority to determine if a provider is in Good Standing based on the criteria set forth below.

1. Provider is open for services for PHC members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, PHC will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against PHC.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with PHC on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following PHC policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement or overbilling.
9. Provider is not conducting other activities adverse to the business interests of PHC.

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

- PCP sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice or new PCP PO):
  - Must be contracted with members assigned for at least nine (9) months.

- PCP sites joining Partnership as part of a PCP PO where members from an existing QIP participant (an existing primary care site) 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 PCP sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the PCP 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 PCP sites, regardless of any affiliation with a PCP PO:
  - Must be contracted with members assigned for at least nine (9) months of the measurement year.

Eligible Member Population
The eligible population used to calculate the final scores for all measures is defined as capitated or assigned medical home Medi-Cal members. These members are eligible to be included in PCP sites' denominator lists assuming other 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 must be continuously enrolled within a PCP parent organization, with continuous enrollment defined as member assignment for nine (9) out of the 12 months between January 1 and December 31 of the current measurement year (assignment to a site occurs on the first of the month). For multi-site PCP parent organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a PCP site's final denominator is December 1st. This means that members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Members who are dually enrolled in Medicare and Medi-Cal (Medi-Medi members), or have other health care coverage are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate (compared to the rate calculated in eReports prior to continuous enrollment being applied) should be presented to the QIP Team. Each case will be screened by QIP internal governance for consideration. Sites will be notified of all results prior to final payment.

For measures in the Non-Clinical domain, continuous enrollment criteria is included 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 clinically relevant alignment with key external healthcare measurement entities, and a stable measurement set, major changes occur only when significant changes are made across a majority of the key external healthcare measurement entities measurement sets.[1] 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 Managed Care Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be communicated through e-mail to all providers as well as through the program's quarterly newsletter.

Measures may evaluate a PCP site'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 (2) 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. Starting in 2023, the amount per member per month (PMPM) available in the PCP QIP will vary by site, according the principles noted below. The number of member months is multiplied by the site's 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 measurement 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.

[1] Key External Healthcare Measurement Entities: Healthcare Effectiveness Data and Information Set (HEDIS); National Committee for Quality Assurance - Health Plan Accreditation (NCQA); National Quality Forum (NQF); Patient-centered medical home (PCMH) and Uniform Data System (UDS).

- For the Unit of Service Measurement Set, the payment is independent of, and distinct from, the financial incentives a site receives from the Core Measurement Set. A PCP site receives payment according to the measure specifications if the requirements for at least one (1) Unit of Service measure are met.

- **Starting in 2023**, the methodology for calculating the site PMPM amount will have two (2) components: A base rate (likely $4 PMPM) and a site adjusted supplemental rate (may range from an additional $0 to a maximum of $20 PMPM).

  The following six (6) factors will be used to generate the site adjusted supplemental rate:

  - An adjustment for unfavorable socio-demographic mix of patient population
  - An adjustment for the severity of the patient mix of the site, based on an estimate of the additional workload of caring for that patient population
  - An adjustment for the difficulty in hiring primary care clinicians at the site
  - An adjustment for low practice resources
  - An adjustment for major disruptions in service related to natural disasters
  - Only PCPs with at least 100 assigned members as of December of the prior measurement year will be eligible for the above adjustments

  More details on the methodology of the adjustment will be presented in webinars and communications in 2023. To assist with PCP budgeting, the QIP team will give an initial estimate of the range of supplemental rates for each site in the middle of 2023.

- The projected PMPM may change mid-year pending unforeseen State budget impacts to the plan.

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. Specific codes for clinical measures are listed in measure specific Code Sets specified within each measure and can be found in the Diagnosis Crosswalk in eReports. Specific codes for non-clinical measures are listed in non-clinical specifc Code Sets and specified within each measure. These codes are not wholly representative of reimbursable codes of PHC. Any codes outside of the clinical and non-clinical Code Sets are not used for measure evaluation and credit.

eReports

eReports is an online application by which PCP sites can monitor their own performance within the QIP Clinical measures and submit supplemental data to PHC. The eReports portal may be accessed at https://qip.partnershiphp.org/. The launch date of eReports typically falls within the first quarter of the measurement year to ensure availability of data throughout the year. PCP sites 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 9th – 31st following the measurement year, and is intended to allow for final data collection and uploads.

Small Denominators
All providers, regardless of membership size, will have measures compared against the specified measure thresholds. We are aware that small denominators may negatively impact the overall performance on a particular measure.

Clinical Measures: If a provider 1) has less than 15 members (<15) 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 15 members (<15) must provide evidence of three (3) targeted outreach attempts when requesting a member be excluded from the denominator.

The three (3) outreach attempts must include:

1. One (1) written outreach attempt
2. One (1) verbal outreach attempt
3. A third outreach attempt of the sites choice with the date and type of outreach documented

Evidence of documentation may be formatted in the manner of the site's discretion but must be clear. Outreach information must be submitted to the QIP team via email or fax between**January 15 – 31,** the following measurement year.

New for 2023 Non-clinical Measures: For PCP sites with less than 500 (<500) assigned members, the Risk Adjusted Readmission and Ambulatory Care Sensitive Admission measures will not apply. Points will be re-distributed to remaining measures.

Partnership Quality Dashboard
The Partnership Quality Dashboard (PQD) is a Tableau dashboard that is integrated into eReports and designed to visualize Primary Care Provider Quality Incentive Program (PCP QIP) data. The PQD dashboard is designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. Performance data in PQD can be rolled up, in executive summary views and in drilldown views to the patient demographic level.

Modifications of PCP QIP for PCP Parent Organizations with Very Low PCP QIP scores

Beginning in measurement year 2023, PCP Parent Organizations with greater than 500 assigned members and very low clinical measure scores in the *prior* measurement year will be subject to a corrective action plan. This corrective action plan may include a modified set of measures for the current or subsequent year, intensive practice facilitation, a report to the governing board of the organization, and a change in structure of how incentive payments are directed for the parent organization. The corrective action plan for each site will be customized, depending on individual provider organization circumstances. Provider organizations falling subject to a corrective action plan will be notified as soon as feasible in the first quarter of the measurement year. The overall goal is to find alternative mechanisms to the traditional PCP QIP structure to better engage such sites in improving outcomes of their patients.

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 following the end of the measurement

year. Providers are strongly encouraged to review their year-end data closely during the Preliminary Report Review and eReports validation periods as this data is used to finalize point earnings. If a provider does not notify PHC of a calculation or point attribution error during these periods, resulting in a potential under or over payment, the error may be corrected by PHC post-payment through a formal appeal process. The formal appeal process is available for up to 30 days after the PCP has received their final payment statement. Additionally, PHC may recoup overpayments any time after payment is distributed. Disputes of final data described below will not be considered:

1. **QIP Scores on eReports:** eReports refreshes data twice per week and providers have access to eReports through the well-published grace period (i.e. several days following the close of the measurement year) to check for data discrepancies. Additionally, providers have access to eReports 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 approved exclusions involve a manual process by PHC staff. Providers are responsible for checking if members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. The deadline for exclusion requests, which need to be executed by the QIP Team, is January 15 following the measurement year.

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 Unit of Service measures. Providers will be given one week, commonly referred to as Preliminary Report Review Period, to review this report for calculation discrepancies.

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. 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 quantified circumstances as reviewed by QIP governance and approved by PHC's Executive Team. Post-payment disputes related to thresholds, however, cannot be accommodated.

Should a provider have a concern that does <u>not</u> fall in any of the categories above (i.e. the score on your final report does not reflect your eReports data at the conclusion of the validation period), a Payment Dispute Form must be completed within 30 days of receiving the final statement. All payment adjustments will require approval from PHC's Executive Team. Please reach out to the QIP team for a Payment Dispute Form at: qip@partnershiphp.org

<u>Governance Structure</u>

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

- ***PCP Provider Network*****:** PCP 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 comprised of representatives from Quality Improvement, the Office of the CMO, Finance, Provider Relations, and IT Departments reviews program policies and proposes measure ideas.

- ***QIP Advisory Group*****:** The QIP external advisory group is comprised of physicians and administrators from all practice types and counties. Their purpose is to provide recommendations on measures and advise on QIP operations.

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

- ***PHC Board of Commissioners*****:** The PHC Board approves the financial components of the QIP and reviews and approves the actions of the Physician Advisory Committee, including the QIP measures.

III. Summary of Measures

2023 Primary Care Provider Quality Improvement Program Summary of Measures

For the tables below, please refer to these notes:

1: For most existing clinical measures, the full-point target is set at the 75th percentile performance of all Medicaid health plans reporting to the National Committee for Quality Assurance (NCQA); sites can receive partial points on these measures if the 50th percentile performance is met. For most new clinical measures, the full-point target is set at the 50th percentile performance, with no partial points available. No points through relative improvement are available for new measures.

2: For most existing clinical measures, sites can also earn points based on relative improvement (RI). Please note that if a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through relative improvement in 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:

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

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

- AND -

- Have an RI score of 10% or higher, as compared to the previous year's performance, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.

3: Site specific and practice type risk adjusted targets will be sent to each participating site in spring 2023.

4: Most of the clinical measures use performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2022 as targets.

2023 Primary Care Provider Quality Improvement Program Summary of Measures

Core Measurement Set – Family Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	6	4
Breast Cancer Screening	75th Percentile (56.52%)	50th Percentile (50.95%)	6	5
Cervical Cancer Screening	75th Percentile (62.53%)	50th Percentile (57.64%)	6	4
Child and Adolescent Well Care Visits	75th Percentile (57.44%)	50th Percentile (48.93%)	9	7
Childhood Immunization Status: Combo 10	75th Percentile (42.09%)	50th Percentile (34.79%)	6	5
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.80%)	5	4
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (64.48%)	50th Percentile (60.10%)	6	4
Comprehensive Diabetes Care - Retinal Eye Exams	75th Percentile (56.51%)	50th Percentile (51.09%)	5	3
Controlling High Blood Pressure	75th Percentile (65.10%)	50th Percentile (59.85%)	6	4
Immunizations for Adolescents – Combo 2	75th Percentile (41.12%)	50th Percentile (35.04%)	6	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.19%)	50th Percentile (55.72%)	9	7
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES[2]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	TBD	TBD	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.8 visits per member per year on average	Between 1.5 and 1.8 visits per member per year on average	5	3

NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

2023 Core Measurement Set – Internal Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	8	6
Breast Cancer Screening	75th Percentile (56.52%)	50th Percentile (50.95%)	12	9
Cervical Cancer Screening	75th Percentile (62.53%)	50th Percentile (57.64%)	12	9
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.80%)	12	9
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (64.48%)	50th Percentile (60.10%)	11	8
Comprehensive Diabetes Care - Retinal Eye Exams	75th Percentile (56.51%)	50th Percentile (51.09%)	5	3
Controlling High Blood Pressure	75th Percentile (65.10%)	50th Percentile (59.85%)	10	8
NON-CLINICAL DOMAIN:APPROPRIATE USE OF RESOURCES[3]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	TBD	TBD	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.8 visits per member per year on average	Between 1.5 and 1.8 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

2023 Core Measurement Set – Pediatrics

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	13	10
Child and Adolescent Well Care Visits	75th Percentile (57.44%)	50th Percentile (48.93%)	16	12
Childhood Immunization Status: Combo 10	75th Percentile (42.09%)	50th Percentile (34.79%)	16	12
Immunizations for Adolescents – Combo 2	75th Percentile (41.12%)	50th Percentile (35.04%)	16	12
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.19%)	50th Percentile (55.72%)	16	12
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	7	5
PCP Office Visits	Greater than 1.5 visits per member per year on average	Greater than 1.5 visits per member per year on average	6	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

[5] National Quality Forum (NQF) Asthma Medication Ratio (#1800). http://www.qualityforum.org

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000. • $100 per Advance Directive/POLST, maximum payment $10,000
Extended Office Hours	Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
PCMH Certification	$1000 yearly for achieving or maintaining PCMH accreditation.
Peer-led Self-Management Support Groups	$1000 per group, either new or existing. (Maximum of 10 groups per parent organization).
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. This incentive is available at the parent organization level.
Health Equity	$2000 per parent organization for submission of a report of their implementation of their Health Equity initiative.
Blood Lead Screening	Tier 1-3, $1000, $3000, $5000 per parent organization for the number of children between 24 to 72 months who had capillary or venous lead blood test for lead poisoning.
Dental Varnish	$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.
Electronic Clinical Data System (ECDS)	$5,000 per parent organization for participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year. For parent organizations that submitted initial data for ECDS in the prior measurement year, an additional $5000 incentive will be available if they continue to submit an ECDS file for 2023 data monthly, starting no later than June of 2023.

IV. Clinical Domain

Measure 1. Asthma Medication Ratio[5]

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, 2023 and December 31, 2023.

For PHC's Clinical Practice Guidelines for the diagnosis and management of Asthma: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 5-64 years of age as of December 31 of the measurement year (DOB between January 1, 1959 and December 31, 2018) identified 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.

- At least one ED visit with a principal diagnosis of asthma (Asthma).
- At least one acute inpatient encounter with a principal diagnosis of asthma.
- At least four (4) outpatient visits) or observation visits or telehealth visits; on different dates of service, with any diagnosis of asthma and at least two (2) asthma medication dispensing events for any controller medication or reliever medication. Visit type need not be the same for the four (4) visits.
- At least four (4) asthma medication dispensing events for any controller medication or reliever medication.

Numerator

The number of assigned members who have a medication ratio of 0.50 or greater between January 1, 2023 and December 31, 2023.

Important Note: *The Asthma Controller and Relievers Medications tables will be reviewed and updated by PHC's Pharmacy Department during the year as new medications are approved.*

[5] National Quality Forum (NQF) Asthma Medication Ratio (#1800). http://www.qualityforum.org

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Exclusions

1) Members who had any of the following diagnoses any time during the patient's history (as reflected in claims data) through the end of the measurement year (i.e., December 31):

- COPD
- Emphysema
- Obstructive Chronic Bronchitis
- Chronic Respiratory Conditions Due to Fumes/Vapors
- Cystic Fibrosis
- Acute Respiratory Failure

2) Exclude any members who had no asthma medications (controller or reliever) dispensed during the measurement year.

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), the quality of asthma care can vary widely across communities and population groups (Improving Asthma Care Quality, n.d.). Gaps in care can lead to complications or death and can increase costs. Information from government agencies illustrates why asthma has been a target for quality improvement efforts:

- The prevalence has been increasing;
- Asthma can be effectively treated and controlled;
- Uncontrolled asthma is costly (Improving Asthma Care Quality, n.d.).

DHCS requires PHC to report this as part of the annual Managed Care Accountability Set (MCAS) report in Measurement Year (MY) 2023.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Respiratory Conditions, MCAS, and NQF Asthma Medication Ratio (#1800).

IV. Clinical Domain

Measure 2. Breast Cancer Screening[6]

Description

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

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 52 – 74 years of age as of December 31 of the measurement year (DOB between January 1, 1949 and December 31, 1971).

Numerator

The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2021 and December 31, 2023.

Exclusions

- Members receiving palliative care during the measurement year.
- Bilateral mastectomy any time during the member's history through December 31, 2023.
- Mammography in Transgender Individuals: Transgender females (born males but currently with gender identity of female), may use diagnosis of congenital absence of breast ICD10 = Q83.8) to exclude from denominator. Transgender males or gender non-conforming who were born females but currently with gender identity of male should be screened for breast cancer, but they will not be part of the official denominator for this measure due to system constraints.

Measure Rationale and Source

According to JAMA Network's Jill Jin, MD, MPH (2014), screening for breast cancer means looking for signs of breast cancer in all women, even if they have no symptoms (Jin, 2014). The goal of screening is to catch cancers early (Jin, 2014). Early-stage cancers are easier to treat than later-stage cancers, and the chance of survival is higher (Jin, 2014). Routine screening for breast cancer lowers one's risk of dying of breast cancer (Jin, 2014).

DHCS requires PHC to report this as part of the annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Breast Cancer Screening (#2372), and UDS Breast Cancer Screening (CMS125v8).

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[6] National Quality Forum (NQF) Breast Cancer Screening (#2372). http://www.qualityforum.org

IV. Clinical Domain

Measure 3. Cervical Cancer Screening[7]

Description

Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned women 24 - 64 years of age as of December 31 of the measurement year (DOB between January 1, 1959 and December 31, 1999).

Numerator

The number of assigned women in the eligible population who were appropriately screened according to evidence-based guidelines any time during the measurement year.

Exclusions

These are based on:

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.
- Documentation of "complete," "total" or "radical" abdominal or "vaginal hysterectomy" date meets the criteria for hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year.
- Documentation of a "vaginal Pap smear" in conjunction with documentation of "hysterectomy" date any time during the member's history through December 31 of the measurement year.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening date any time during the member's history through December 31 of the measurement year.
- Members receiving palliative care during the measurement year.
- Cervical Cancer Screening in Transgender Individuals: Transgender females (born males but currently with gender identity of female), may use diagnosis of congenital absence of cervix ICD10 = Q51.5) to exclude from denominator. Transgender males or gender non-conforming who were born females but currently with gender identity of male should be screened for cervical cancer if their cervix is still intact, but they will not be part of the official denominator for this measure due to system constraints.

[7] National Quality Forum (NQF) Cervical Cancer Screening (#0032). http://www.qualityforum.org

Measure Rationale and Source

According to American College of Obstetricians and Gynecology (ACOG), it usually takes 3–7 years for high-grade changes in cervical cells to become cancer (Cervical Cancer Screening, n.d.). Cervical cancer screening may detect these changes before they become cancer (Cervical Cancer Screening, n.d.). Women with low-grade changes can be tested more frequently to see if their cells go back to normal (Cervical Cancer Screening, n.d.). Women with high-grade changes can get treatment to have the cells removed (Cervical Cancer Screening, n.d.).

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Cervical Cancer Screening (#0032), and UDS Cervical Cancer Screening (CMS124v7).

IV. Clinical Domain

Measure 4. Child and Adolescent Well-Care Visits[8]

Description

The percentage of members 3 - 17 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31 of the measurement year (DOB between January 1, 2006 and December 31, 2020).

Numerator

The number of children in the eligible population with at least one well-child visit with a PCP or OB/GYN during the measurement year (January 1, 2023 and December 31, 2023).

Because well-care visit measure is administrative only, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2022 n.d).

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

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to the American Academy of Pediatrics (AAP), parents know who they should go to when their child is sick. But pediatrician visits are just as important for healthy children (Sturgeon, 2015).

Here are some of the benefits of well-child visits:

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;

[8] 2022 HEDIS measure criteria for Child and Adolescent Well Care with the allowable adjustments.

- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;
- Raising concerns. Make a list of topics you want to talk about with your child's pediatrician such development, behavior, sleep, eating or relations with other family members. Present your top three (3) to five (5) questions or concerns to the pediatrician at the start of the visit;
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, and MCAS.

IV. Clinical Domain

Measure 5. Childhood Immunization Status[9]

Description

The percentage of children 2 years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) *haemophilus* influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2021 and December 31, 2021).

Numerator

The number of assigned children who who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) *haemophilus* influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday.

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

14 Days Rule:

***There must be at least 14 days between each date of service, excluding the MMR vaccination.** **The purpose for this rule: is to avoid duplication of events when only assessing administrative data or when combining administrative and medical record data.**

Exclusions (only if not numerator hit)

[9] National Quality Forum (NQF) Childhood Immunization Status (#0038). http://www.qualityforum.org

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC), diseases that used to be common in this country and around the world, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, rotavirus and Haemophilus influenzae type b (Hib) can now be prevented by vaccination (Why are Childhood Vaccines So Important? n.d.). Thanks to a vaccine, one of the most terrible diseases in history – smallpox – no longer exists outside the laboratory (Why are Childhood Vaccines So Important? n.d.). Over the years vaccines have prevented countless cases of disease and saved millions of lives (Why are Childhood Vaccines So Important? n.d.).
DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, MCAS, NQF Childhood Immunization Status (#0038), and UDS Childhood Immunizations (CMS117v7).

IV. Clinical Domain

Measure 6. Colorectal Cancer Screening[10]

Description
The percentage of assigned members 45–75 years of age who had appropriate screening for colorectal cancer.

Points and Thresholds by Practice Type
Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator
The number of assigned members 46-75 years of age by December 31 of the measurement year (DOB between January 1, 1948 and December 31, 1977).

Numerator
The number of assigned members 46–75 years of age who had one or more screenings for colorectal cancer according to clinical guidelines.

Exclusions
Excludes members with a history of colorectal cancer or total colectomy. This measure also excludes members receiving palliative care any time during the measurement year.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC), colorectal cancer screening saves lives (Colorectal Cancer Awareness, n.d.). The U.S. Preventive Services Task Force (USPSTF) expanded the recommended ages for colorectal cancer screening to 45 to 75 years (previously, it was 50 to 75 years). If the member is older than 75, screening is to be determined by the physician (Colorectal Cancer Screening, n.d.).

DHCS requires PHC to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, NQF Colorectal Cancer Screening (#0034), and UDS Colorectal Cancer Screening (CMS130v7).

[10] National Quality Forum (NQF) Colorectal Cancer Screening (#0034). http://www.qualityforum.org

IV. Clinical Domain

Measure 7. Comprehensive Diabetes Management – HbA1C Good Control [11]

Description
The percentage of assigned members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold. For PHC's Clinical Practice Guidelines for diabetes mellitus: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type
Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator
The number of assigned members 18-75 years of age as of December 31 of the measurement year with diabetes identified as of December 31 of the measurement year (DOB between January 1, 1948 and December 31, 2005).

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

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2022 – December 31, 2023), and who meet either of the following criteria:

- Members receiving palliative care during the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year with a current lab value (less than 12 months old) indicating no diabetes and more recent than the last diabetic triggering event visible in eReports. See Appendix V for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VI for the Diabetes Exclusions Flow Chart.

Measure Rationale and Source

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 (National Diabetic Statistics Report, 2020). 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

(National Diabetic Statistics Report, 2020). Many interventions intended to prevent/control diabetes are cost saving or very cost-effective and supported by strong evidence (Li et al., 2010).

DHCS requires PHC to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure CDC: Comprehensive Diabetes Care, MCAS, and NQF Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (#0059), and Diabetes Poor Control (CMS122v7).

IV. Clinical Domain

Measure 8. Comprehensive Diabetes Management – Retinal Eye Exam[11]

Description

The percentage of members 18-75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy.

For PHC's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1948 and December 31, 2005) with diabetes identified as of December 31 of the measurement year.

Numerator

An eye screening for diabetic retinal disease as identified by administrative data.

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes 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 V for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VI for the Diabetes Exclusions Flow Chart.

Measure Rationale and Source

DHCS requires PHC to report this as part of annual MCAS reporting

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Respiratory Conditions, MCAS, and NQF Comprehensive Diabetes Care: Eye Exam (#0055)

[11] National Quality Forum (NQF) Comprehensive Diabetes Care: Eye Exam (#0055). http://www.qualityforum.org

IV. Clinical Domain

Measure 9. Controlling High Blood Pressure[12]

Description

The percentage of assigned members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 18-85 years of age as of December 31 of the measurement year (DOB between January 1, 1938 and December 31, 2005) who had at least two (2) visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year (01/01/2022 – 06/30/2023).

Numerator

Thenumber of assigned members population whose most recent BP reading taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event was <140/90 mm Hg during the measurement year.

The BP reading must occur on or after the most recent diagnosis of hypertension that is greater than or equal to the second diagnosis of hypertension.

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.

Exclusions

- Exclude from the eligible population all members with evidence of end-stage renal disease, dialysis, nephrectomy or kidney transplant; history of kidney transplant on or prior to December 31 of the measurement year.

- Exclude from the eligible population female members with a diagnosis of pregnancy during the measurement year.

- Exclude members receiving palliative care during the measurement year.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC) 2012 Vital Signs report:

- Nearly 1 in 3 adults (about 67 million) have high blood pressure;
- About 36 million adults with high blood pressure don’t have it under control;
- High blood pressure contributes to nearly 1,000 deaths a day (Getting Blood Pressure Under Control, 2012).

[12] National Quality Forum (NQF) Controlling High Blood Pressure (#0018). http://www.qualityforum.org

High blood pressure is a major risk factor for heart disease and stroke, both of which are leading causes of death in the US (Getting Blood Pressure Under Control, 2012). Nearly one-third of all American adults have high blood pressure and more than half of them don't have it under control (Getting Blood Pressure Under Control, 2012). Blood pressure control means having a systolic blood pressure less than 140 mmHg and a diastolic blood pressure less than 90 mmHg, among people with high blood pressure (Getting Blood Pressure Under Control, 2012). Many with uncontrolled high blood pressure don't know they have it. Millions are taking blood pressure medicines, but their blood pressure is still not under control (Getting Blood Pressure Under Control, 2012).There are many missed opportunities for people with high blood pressure to gain control (Getting Blood Pressure Under Control, 2012). Doctors, nurses and others in health care systems should identify and treat high blood pressure at every visit (Getting Blood Pressure Under Control, 2012).

DHCS requires PHC to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure cardiovascular conditions, MCAS, NQF Controlling High Blood Pressure (#0018), and UDS Controlled Hypertension (CMS165v7).

IV. Clinical Domain

Measure 10. Immunizations for Adolescents[13]

Description

The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had one (1) dose of meningococcal conjugate vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and two (2) doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2010 and December 31, 2010).

Numerator

The number of assigned adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Exclusions

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates.

Measure Rationale and Source

Thirty-five million American adolescents fail to receive at least one recommended vaccine (Schaffer et al., 2005). This gap exists despite specific adolescent immunization recommendations from the U.S. Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization

[13] National Quality Forum (NQF) Immunizations for Adolescents (#1407) http://www.qualityforum.org

Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) (Schaffer et al., 2005). Low immunization rates in adolescents have a wide array of implications—outbreaks of vaccine-preventable diseases, negative effects on quality of life and increased disease associated costs (Schaffer et al., 2005). Importantly, low immunization rates establish reservoirs of disease in adolescents that can affect others, including high-risk infants, elderly persons and persons with underlying medical conditions (Schaffer et al., 2005).

DHCS requires PHC to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, and NQF Immunizations for Adolescents (#1407).

IV. Clinical Domain

Measure 11. Well-Child Visits in the First 15 Months of Life[14]

Description

The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

- For the Medical Staff, PHC's Pediatric Preventive Health Guidelines (MCQG1015) is available in PHC's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx
- es

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn 15 months old between January 1 and December 31 of the measurement year (DOB between October 3, 2021 and October 2, 2022).

Numerator

The number of children in the eligible population with at least six (6) well-child visits with a PCP by the date of age 15 months.

14 Days Rule:

***There must be at least 14 days between each date of service.** **The purpose for this rule: is to avoid duplication of events when only assessing administrative data or when combining administrative and medical record data.**

Because Well-Child Visits in the First 15 Months of Life is an administrative measure, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2022 n.d.).

[14] National Quality Forum (NQF) Well-Child Visits in the First 15 Months of Life (#1392) http://www.qualityforum.org

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

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to the American Academy of Pediatrics (AAP), parents know who they should go to when their child is sick. But pediatrician visits are just as important for healthy children (Sturgeon, 2015).

Here are some of the benefits of well-child visits:

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;
- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;
- Raising concerns. Make a list of topics you want to talk about with your child's pediatrician such development, behavior, sleep, eating or relations with other family members. Present your top three (3) to five (5) questions or concerns to the pediatrician at the start of the visit;
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires PHC to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, and NQF Well-Child Visits in the First 15 Months of Life (#1392).

V. Appropriate Use of Resources

Measure 12. Ambulatory Care Sensitive Admissions[15]

Description

Admission rate of assigned members with any of the principle diagnoses from Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) listed in the numerator, during the measurement year.

Sites must have a minimum of 500 eligible members by December of the measurement year to be eligible for incentive.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

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. The PQI and PDI principle diagnoses for each are located on AHRQ resource page.

Preventive Quality Indicators (PQI)	Pediatric Quality Indicators (PDI):
• 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 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	• PDI 14 – Asthma Admissions Rate • PDI 15 – Diabetes Short-term Complications • PDI 16 – Gastroenteritis • PDI 18 – Urinary Tract Infection

Calculation:

$$Ambulatory\ Care\ Sensitive\ Admissions\ (ACSA) = \frac{\text{Total \# of ACSA days}}{\text{Total \# of All Inpatient Admission days}}$$

[15] Agency for Healthcare Research and Quality (AHRQ). PQI and PDI Measures. Retrieved from: https://www.qualityindicators.ahrq.gov/Modules/all_resources.aspx

Exclusions

This measure excludes members who:

- See the PQI and PDI numerator details section for exclusions from the individual composite indicators
- Hospitalizations for obstetrics
- Hospice
- Acute hospital transfers

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), the PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease (Guide to Prevention Quality Indicators, 2001). The Pediatric Quality Indicators (PDIs) focus on potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals and on preventable hospitalizations among pediatric patients, taking into account the special characteristics of the pediatric population (Pediatric Quality Indicators Overview, n.d.).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including Agency for Healthcare Research and Quality (AHRQ) PQI and PDI Measures.

V. Appropriate Use of Resources

Measure 13. Risk Adjusted Readmissions[16]

Description

For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays* (denominator)
2. Observed Readmissions: Count of 30-Day readmissions (numerator)
3. Expected Readmissions: Sum of adjusted readmission risk (numerator)
4. Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).

Sites must have a minimum of 500 eligible members by December of the measurement year to be eligible for incentive.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between January 1 and December 1 of the measurement by members age 18 to 64 years of age continuously enrolled for at least 90 days prior admission date and at least 30 days after admission date.

Numerator

Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between January 3rd and December 31 of the measurement year by members included in the denominator

Calculation: $\text{Observed 30 Day Readmissions Rate} = \frac{\text{Observed 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$

Note: Inpatient stays where the discharge date from the first setting and admission date to the second setting must be two (2) or more days apart and considered distinct inpatient stays.

Expected 30-Day Readmission: An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

[16] National Quality Forum (NQF) Plan All-Cause Readmissions (#1768) http://www.qualityforum.org

Calculation: $\text{Expected 30 Day Readmissions Rate} = \frac{\text{Expected 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

Exclusions

Exclusions for Numerator and Denominator:

- Discharges for death
- Pregnancy condition
- Perinatal condition
- Stays by members with 4 or more index admissions in the measurement year

Exclusions for Numerator:

- Planned admission using any of the following:
  - Chemotherapy
  - Rehabilitation
  - Organ Transplant
  - Planned procedure without a principal acute diagnosis

Measure Rationale and Source

According to National Committee for Quality Assurance (NCQA), a “readmission” occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time (Plan All-Cause Readmission, n.d.). 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 (Plan All-Cause Readmission, n.d). Unplanned readmissions are associated with increased mortality and higher health care costs (Plan All-Cause Readmission, n.d). They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768).

VI. Access and Operations

Measure 14. Avoidable Emergency Department (ED) Visits/1000 Members per Year[17]

Description

The rate of assigned members with an "avoidable ED visits" with a primary diagnosis that matches the diagnosis codes selected by PHC.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 1 year of age or older with an emergency department visit anytime during the measurement year.

Numerator

The number of assigned members 1 year of age or older with "avoidable ER visits" with a primary diagnosis that matches the diagnosis codes selected by PHC.

Calculation:

$$Avoidable\ EDVisits\ per\ Member\ per\ Year\ X\ 1000 = \frac{\text{Avoidable ED Visits}}{\text{(Sum of Member Months)} * 12{,}000}$$

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

Exclusions

This measure excludes member who are less than 1 year of age (DOB on or after January 1, 2022).
ED claims with at least one (1) diagnosis code not considered avoidable will deem the visit as not avoidable.

Measure Rationale and Source

ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients (Measures of Care Coordination, 2015). Some ED events may be attributed to preventable or treatable conditions (Measures of Care Coordination, 2015). A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented (Dowd, et al., 2014). Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities.

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[17] (June 2012) Statewide Collaborative Quality Improvement Project. Reducing Avoidable Emergency Room Visits. Final Remeasurement Report: January 1, 2010 – December 31, 2010. Retrieved from: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Coll_ER_Remeasure_Report.pdf

VI. Access and Operations

Measure 15. PCP Office Visits

Description

The number of Primary Care Provider visits per member per year by PHC eligible members with participating QIP providers.

Thresholds

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The average number of months per year a member is assigned to a participating QIP PCP.

Numerator

The total number of visits during the measurement year with any PCP in PHC's network. PCP Visits include face-to-face, video or telephonic services in provider's office, or patient's home or private residence settings.

Calculation:

$$PCP\ Office\ Visits\ PMPY = (\#\text{PCP Visits } \div \text{Sum of eligible Member Months}) \times 12$$

Exclusions

This measure excludes the following:

- Medicare-Medi-Cal dual capitated members

VII. Patient Experience

Measure 16. Patient Experience[18]

Description

This measure aims to improve the patient experience.

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

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria. There are two (2) ways in which to earn points:

1) CAHPS

Providers that have sufficient PHC patient volume, or for PCPs who operate in counties with no provider meeting this threshold and see the largest number of PHC members in that county, can earn up to a maximum of 10 points for meeting performance thresholds in key measures in the Clinician & Group CAHPS 3.0 survey.

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 X There are two (2) parts to this option. Please follow the steps below accordingly. Sites can describe existing survey efforts, such as the NCQA PCMH survey.

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 X) via fax or e-mail to QIP@Partnershiphp.org. Part I is due on July 31 of the measurement year and Part II January 31 following the measurement year.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right

[18] National Quality Forum (NQF) CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (#0005) http://www.qualityforum.org

(Why Improve Patient Experience, n.d.). But good patient experience also is associated with important clinical processes and outcomes (Why Improve Patient Experience, n.d.). Measures of patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety, and efficiency (Why Improve Patient Experience, n.d.).

Patient experience is correlated with key financial indicators, making it good for business as well as for patients (Why Improve Patient Experience, n.d.). For example:

- Good patient experience is associated with lower medical malpractice risk. A 2009 study found that for each drop in patient-reported scores along a five-step scale of "very good" to "very poor," the likelihood of a provider being named in a malpractice suit increased by 21.7 percent.14;
- Efforts to improve patient experience also result in greater employee satisfaction, reducing turnover. Improving the experience of patients and families requires improving work processes and systems that enable clinicians and staff to provide more effective care. A focused endeavor to improve patient experience at one hospital resulted in a 4.7 percent reduction in employee turnover;
- Patients keep or change providers based upon experience. Relationship quality is a major predictor of patient loyalty; one study found patients reporting the poorest-quality relationships with their physicians were three (3) times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships (Why Improve Patient Experience, n.d.).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NQF CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (#0005).

VIII. Units of Service **$20,000 Maximum per Site**

Measure 1. Advanced Care Planning

Description

This measure encourages the PCP to provide annual awareness to PHC members 18 years or older understand the how the advance care plan (ACP) can help alleviate unnecessary suffering, improve quality of life and provide better understanding of the decision-making challenges facing the individual and his or her caregivers (Advance Care Planning, n.d.). An advance care plan can be used at any stage of life and should be updated as circumstances change (Advance Care Planning, n.d.).

Thresholds

Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for:

- $100 per Attestation, maximum payment $10,000.
- $100 per Advance Directive/POLST, maximum payment $10,000

Measure Requirements

ACP discussions must take place between January 1 and December 31 of the measurement year in order to be eligible for this measure.

Advance Directive and/or POLST:
If a patient has a previously completed Advance Directive or POLST and does not wish to make any changes, documentation of a conversation during the measurement period confirming that no changes are needed will qualify.

Attestation:
Only one conversation per patient per measurement year. The following components are required to be documented in the chart for a provider to attest to the completion of an ACP discussion:

- Documented discussed of social supports, patient preferences and likely course of action for acute illness, a long term chronic illness or a terminal illness, and “what ifs” for serious accidents (Advance Care Planning, n.d.).
- Documented discussed review of Advance Directive or POLST already on file and updates as needed in the member’s life as health status and living circumstances change (Advance Care Planning, n.d.).

Submission Process

Providers must utilize the templates found within eReports to submit documentation for individual patients.

Exclusions

ACP is a covered benefit and can be reimbursed using CPT codes, 99497 or 99498. Any allowable billed CPT codes will be excluded.

Submission(s) received after the close of the “grace period” that ends on January 15 following

the close of the measurement year.

Measure Rationale and Source

According to Centers for Disease Control and Prevention (CDC):

- Most people say they would prefer to die at home, yet only about one-third of adults have an advance directive expressing their wishes for end-of-life care (Pew 2006, AARP 2008). Among those 60 and older, that number rises to about half of older adults completing a directive (Advance Care Planning, n.d.).
- Only 28 percent of home health care patients, 65 percent of nursing home residents and 88 percent of hospice care patients have an advance directive on record (Jones 2011).
- Even among severely or terminally ill patients, fewer than 50 percent had an advance directive in their medical record (Kass-Bartelmes 2003).
- Between 65 and 76 percent of physicians whose patients had an advance directive were not aware that it existed (Kass-Bartelmes 2003).

VIII. Units of Service 10% of Capitation

Measure 2. Extended Office Hours

Description

Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

Definition of regular business hours:
Total open office hours equals at least nine (9) hours between the hours of 8 a.m. and 5 p.m. OR 9 a.m. and 6 p.m., Monday through Friday. Being open and seeing patients during lunch does not count toward the extended hours. The site must be open to scheduled visits during the extended office time to receive credit.

Thresholds

Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

Measure Requirements

PCP sites that have at least eight (8) extended office hours for a full quarter listed in the PHC Provider Directory for Provider Relations to confirm.

PCP sites that are part of a large organization AND within a five (5) mile or less radius of each other are eligible for the incentive payment equal to 10% of capitation.

- Example 1:
  If site A (qualifying site) has the extended office hours offering at least eight (8) extended office hours, **AND** is willing to see members from sites B, C, D, etc. **WHO ARE** within the five (5) mile or less radius of site A (qualifying site), **THEN** sites B, C, D, etc. are eligible for extended office hours due to meeting the minimum distance requirement from site A (qualifying site). Lastly, site A (qualifying site) needs to have the at least eight (8) extended office hours listed for a full quarter in the PHC Provider Directory for Provider Relations to confirm, not a combination/summation of hours amongst sites is acceptable.

- 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.

PHC site with less than 2,000 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 of the measurement year.

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. Payment is also paid throughout the year on a Quarterly basis by Provider Relations. Note: This payment is not included in the PCP QIP Final Payment.

Exclusions

This measure excludes PCP sites who do not meet the measure requirements.

Measure Rationale and Source

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.

VIII. Unit of Service **$1,000 per site**

Measure 3. Patient-Centered Medical Home Recognition (PCMH)

Description

This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand (What is Patient-Centered Medical Home, n.d.).

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

Thresholds

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

Measure Requirements

PCP sites must receive accreditation, maintain accreditation, or re-certify within the measurement year from NCQA, or equivalent from AAAHC or JCAHO.

Submission Process

All documentation must be submitted on the Patient-Centered Medical Home Recognition template (Appendix I) by January 31, 2024 via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Submission(s) received after the close of the "grace period" that ends on January 15 following the close of the measurement year.

Measure Rationale and Source

According to the American College of Physicians (ACP), the objective of PCMH is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family (What is Patient-Centered Medical Home, n.d.). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner (What is Patient-Centered Medical Home, n.d.).

VIII. Unit of Service **$10,000 Maximum per Parent Organization**

Measure 4. Peer-Led Self-Management Support Groups

Description

This measure encourages the PCP organization to host peer-led self-management groups for PHC member and non-PHC members focused 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, and Substance use.

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

Thresholds

The parent organization is eligible to earn $1,000 per group, maximum 10 groups, to the parent organization.

- The peer-led self-management group must meet at least four (4) times and have at least 16 PHC total member visits per group, confirmed via sign-in sheets.
- Documentation will be reviewed and approved by PHC's CMO or physician designee.

Measure Requirements

Qualifying peer groups must have a peer-facilitation component and a self-management component via face-to-face, telephonic, or video meetings.

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

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.

Submission Process

All documentation must be submitted on the Peer-led Self-Management Support Group template (Appendix II) by January 31 following the measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

PHC's CMO or physician designee unapproved peer-led groups that do not meet the measure requirements.

Submission(s) received after the close of the "grace period" that ends on January 15 following the measurement year.

Measure Rationale and Source

Studies suggest peer-led self-management training improves chronic illness outcomes by enhancing illness management self-efficacy (Jerant, Moore-Hill, and Franks, 2009). Interventions to help patients manage health conditions have potential as cost-effective ways to improve chronic illness outcomes (Jerant, Moore-Hill, and Franks, 2009). The peer-led groups aims to enhance self-efficacy or confidence to execute illness management behaviors, regardless of specific diagnosis (Jerant, Moore-Hill, and Franks, 2009). Hosting and leading support groups for various health needs is not part of routine PCP contracts.

VIII. Unit of Service **$2,000 Maximum Per Parent Organization**

Measure 5. Health Equity Implementation

Description

Partnership HealthPlan of California (PHC) is actively engaged in HE initiatives that bring about equitable awareness and result driven change within the 14 counties we serve and we highly encourage provider organizations to join our efforts. At PHC, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to healthcare.

Thresholds

$2,000 per Parent Organization for either:

1. Submission of an initial HE report based on identifying health disparities as outlined in measure requirements below.
2. An updated annual report based on HE implementation for sites who were incentivized in the prior measurement year.

Measure Requirements

Submission shall demonstrate HE characteristics PCPs can successfully integrate as a core strategy. Should include how best practices apply to internal domains such as: Access, Referral Processes, Avoidable ED Visits, Community Partnerships, and Staff Education.

1. Make HE a leader-driven priority.
2. Identify specific health disparities, then act to close the gaps.
3. Confront institutional racism.
4. Develop processes that support equity (health systems/dedicated resources, oversight).
5. Partner with community organizations.

Submission Process

All reports must be submitted by January 31 following the measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

VIII. Unit of Service — Incentive Amount Varies by Performance Outcome

Measure 6. Blood Lead Screening

Description

Blood lead screening of young children enrolled in Medi-Cal is a federal and state law requirement.

IMPORTANT NOTE: The blood lead screening is be a new HEDIS measure required by DHCS. DHCS has a more expansive measures reporting requirement, compared to the HEDIS measure.

Denominator

The number of assigned members 24 to 72 months during the measurement year. (DOB between January 1, 2018 and December 31, 2021).

Numerator

The number of members aged 24 to 72 months old who had one or more capillary or venous lead blood test for lead poisoning in the lifetime of the member.

Thresholds

Incentive paid at Parent Organization (PO). Minimum of 50 lead screens performed (denominator population) anytime in the past 60 months on the following incentive tiers:

- Tier 1: Minimum lead screening - $1,000
- Tier 2: Lead screening rate >75% - $5,000
- Tier 3: Lead screening rate of 50%, and at least 15% Relative Improvement (RI) of 2022 lead screenings - $3,000

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with Blood Lead Screenings (BLS):

- CPT: 83655
- LOINC codes: 10368-9, 10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7.

Relative Improvement (RI) methodology: Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Exclusions

Claims denied.

VIII. Unit of Service — Incentive Amount Varies by Performance Outcome

Measure 7. Dental Fluoride Varnish Use

Description

The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Denominator

Assigned members aged 6 months to 5 years during the measurement year. (DOB between January 1, 2019 and July 1, 2022).

Thresholds

Incentive to improve dental fluoride application at site level or submission of protocol and implementation plan.

Part 1: $1,000 per Parent Organization
Parent Organization (PO) submission of proposed plan to implement fluoride varnish application in the medical office. The protocol should accomplish the following objectives:

- A plan to identify children at risk for, dental decay and who would benefit from fluoride varnish.
- Provide education plan that will afford consultation and written member (parent or guardian) information on the importance of dental hygiene and fluoride varnish use.
- Provide clinical staff training on varnish application.
- Implementation target date.

Part 2: Minimum 2% of the sites assigned members in the age range above must receive fluoride varnish administered by a non-dental practitioner at least once in the measurement year. The incentive payment amount for reaching this threshold is $5.00 per application.

- Numerator: The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with dental varnish application: CPT code: 99188 (Non-dental practitioner).

VIII. Unit of Service **$5.00 Per Screening**

Measure 8. Tobacco Use Screening

Description

This measure uses the base logic of the National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 years of age and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Tobacco use includes any type of tobacco and aligns with U.S. Preventive Services Task Force (USPSTF) recommendations with regards to screening/counseling for tobacco.

Denominator

Assigned members aged 11– 21 years of age during the measurement year. (DOB between January 1, 2002 and December 31, 2012)

Numerator

Assigned members 11– 21 years of age who had tobacco use screening or counseling one or more times during the measurement year.

Thresholds

Incentive to improve early detection of and intervention toward tobacco use.

Incentive payment: $5.00 per screening. Minimum 3% of the sites assigned monthly assigned members achieves one or more tobacco screenings in the measurement year.

- Assigned members 11– 21 years of age who had tobacco use screening or counseling one or more times during the measurement year.

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with Tobacco Use Screening: HCPCS: 4004F. No other code will be accepted.

VIII. Unit of Service **$5,000 Per Parent Organization**

Measure 9. Electronic Clinical Data Systems (ECDS)

Description

This measure supports the allowance of data exchange from Provider Electronic Health Records to PHC in order to capture clinical screenings, follow-up care and outcomes. ECDS implementation is a vital component of furthering the quality of care for covered PHC members. Note that NCQA plans to convert most hybrid measures to ECDS measures in the coming years. DHCS continues to make PHC accountable to several ECDS measures, this process will continue to increase in emphasis.

Thresholds

Incentive can be achieved by participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year.

$5,000 per Parent Organization for either:

3. Submitting a test file by **November 15, 2023** followed by the final file run between **January 8, 2024 and January 29, 2024**
4. For sites that previously submitted an initial file: Submitting monthly 2023 ECDS file starting no later than **June 2023**.

Measure Requirements

Participation to include data collection of the following clinical components for all PHC members within your organization.

1. Attention-deficit/hyperactivity disorder (ADHD)
2. Breast Cancer Screening (BCS)
3. Alcohol Screening and Counseling (11 years and older)
4. Depression Screening

The ECDS Medical Record Data Exchange Data Standards and Specificatons are posted within the PCP QIP Specifications manual in eReports. The submission data reporting templates are available on eReports' user help page. Please note, each will need to be adapted/mapped to your individual electronic medical record system.

Payment will require:

Option 1: Initial file.

1. Acceptance by PHC IT department of a test file of these 4 measures, by November 15, 2023. We recommend a first test file be submitted by September 1, in case there are errors in the first test file that need to be corrected, with subsequent resubmission.
2. PHC's HEDIS team will be randomly auditing a few records from each providers to validate the mapping process in the fall of 2023 and winter of 2024. Sites must cooperate with associated audit requests
3. A final report based on all patients seen who are covered by PHC (whether assigned or direct members) in 2023, with updated data for all of 2023, must be submitted between January 8, 2024 and January 29, 2024. The reporting programming and format must be the same as the final approved version of the test file in number 1, above.

Option 2: Regular submission (for those organizations previously submitting an initial file.

1. Submission of monthly ECDS files based on the 2023 specifications, starting no later than 2023, extending to at least January 2024.
2. PHC's HEDIS team will be randomly auditing a few records from each provider to validate the mapping process in the fall of 2023 and winter of 2024. Sites must cooperate with associated audit requests
3. A final report based on all patients seen who are covered by PHC (whether assigned or direct members) in 2023, with updated data for all of 2023, must be submitted between January 8, 2024 and January 29, 2024. The reporting programming and format must be the same as the final approved version of the test file in number 1, above.

IX. Appendices

Appendix I. Patient-Centered Medical Home Documentation Template

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** 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 II: Submission Template for Peer-led Self-Management Support Group

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** 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 paid to the parent organization, not the individual sites.

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 III: 2023 PCP QIP Submission and Exclusion Timeline

2023 QIP Uploads and Unit of Service Submissions

DEADLINE DATES	QIP MEASURES	REPORTING TEMPLATES
January 31 2024, by 5pm (Close of Business)	All Clinical Domain Measures and Advanced Care Planning	Found in eReports
January 31, 2024	PCMH Recognition	Appendix I
January 31, 2024	Peer-led Self-Management Support Group	Appendix II
January 31, 2024	Health Equity Implementation Plan	N/A
January 29, 2024	ECDS – Final Report	Found in eReports
November 15, 2023	ECDS – Test Files	Found in eReports

2023 QIP Exclusions

SUBMISSION DATES	APPLICABLE MEASURES
January 15-31, 2024	Small Denominators
January 1, 2023 – January 15, 2024	All measures from the Clinical Domain

Appendix IV: Data Source Table

PCP QIP Core Measures	Practice Type	Data Source[19]	System Used for Data Monitoring	System Used for Data Submission
	Clinical Domain			
1. Asthma Medication Ratio	Family, Internal, Pediatrics	PHC	eReports and Partnership Quality Dashboard (PQD)	Claims
2. Breast Cancer Screening	Family and Internal	PHC and Providers		eReports
3. Cervical Cancer Screening	Family and Internal			
4. Child and Adolescent Well Care Visits	Family and Pediatrics			
5. Childhood Immunization Status, Combination 10	Family and Pediatrics			
6. Colorectal Cancer Screening	Family and Internal			
7. Comprehensive Diabetic Care – HbA1c Control	Family and Internal			
8. Comprehensive Diabetic Care – Eye Exams (EYE)	Family and Internal			
9. Controlling High Blood	Family and Internal			
10. Immunization for Adolescents – Combination 2	Family and Pediatrics			
11. Well-Child Visits in the First 15 Months of Life	Family and Pediatrics			
	Appropriate Use of Resources Domain			
1. Ambulatory Care Sensitive Admissions	Family and Internal	PHC	PQD	Claims
2. Risk Adjusted Readmissions	Family and Internal			
	Access/Operations Measures Domain			
1. Avoidable ED Visits	Family, Internal, Pediatrics	PHC	PQD	Claims
1. PCP Office Visits	Family, Internal, Pediatrics	PHC	PQD	Claims
	Patient Experience Domain			
Survey Option (sites not qualified for CAHPS)	Family, Internal, Pediatrics	PHC and Provider	PQD	Submission Template
CAHPS Survey (for qualified sites)	Family, Internal, Pediatrics	PHC Vendor		PHC Vendor

[19] For any measure, if "PHC" is the only data source, Providers may not submit uploads for the measure through eReports. PHC uses administrative data (Claims/Encounter/RxClaims) for these measures only.

Appendix V: 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 (2) hours.	< 200 mg/dL or 11.1 mmol/L after two (2) hours

Appendix VI: QIP Diabetes Exclusion Flow Chart

Appendix VII: Patient Experience Survey Submission Template

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Quality Improvement Program – Patient Experience

Survey Submission Template and Example

Due Date for Part I Submission: July 31 of the measurement year.
Due Date for Part II Submission: January 31 following the measurement year

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 of the measurement year)

1. Attach a copy of the survey instrument administered (Survey must include at least two (2) 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 following the measurement year)

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:

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.

4. 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, 2023 and May 1, 2023, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2023. 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, 2023 (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 2023) 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, 2023 and November 1, 2023, 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, 2024 (Date)

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