# Table of Contents

## I. Program Contact Info

## II. Program Overview

## III. Summary of Measures

### IV. Domain 1: Clinical Fixed-Pool Measures

1. Monitoring for Patients on Persistent Medications
2. Well Child Visits
3. Childhood Immunization (DTaP)
4. Cervical Cancer Screening
5. Colorectal Cancer Screening
6. Controlling High Blood Pressure
7. Diabetes Management: Retinal Eye Exam
8. Diabetes Management: HbA1C Good Control
9. Diabetes Management: Nephropathy

## V. Domain 2: Appropriate Use of Resources

10. Admissions/1000 Members
11. Readmission Rate
12. Pharmacy Utilization
13. U-Tox Screens

## VI. Domain 3: Access and Operations

14. Avoidable ED Visits/1000 Members Per Year
15. Practice Open to New PHC Members
16. PCP Office Visits Per Member Per Year

## VII. Domain 4: Patient Experience

17. Patient Experience

## VIII. Domain 5: Unit of Service

18. Advanced Care Planning
19. Extended Office Hours
20. Patient-Center Medical Home Recognition
22. Utilization of California Immunization Registry
23. Buprenorphine Qualified Providers
24. Screening, Brief Intervention, Referral, and Treatment (SBIRT)
25. Health Information Exchange

## IX. Appendix

1. List of Opioids
2. Patient Experience – Survey Option
3. Patient Experience – Training Option
4. Advanced Care Planning – Clinician Attestation
5. Advanced Care Planning – Medical Records
6. Patient-Centered Medical Home Documentation
VII. Peer-led Self-Management Support Group Submission ...........................................72
VIII. CAIR Utilization Submission Template ................................................................73
IX. HIE Submission Template ....................................................................................74
X. Submission Timeline ............................................................................................75
XI. Data Source Table ................................................................................................76
I. Quality Improvement Program Contact Information

Email: QIP@partnershiphp.org
Fax: (707) 863-4316
Website: Primary Care Provider Quality Improvement Program

II. Program Overview

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

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

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

Guiding Principles

The QIP uses ten guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within the program.
1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Distribute 100% of fixed pool per member per month funds
4. Actionable measures
5. Feasible data collection
6. Collaboration with providers
7. Simplicity in the number of measures
8. Comprehensive measurement set
9. Align measures that are meaningful
10. Stable measures

Program Timeline

The PCP QIP runs on an annual program period, beginning July 1 and ending June 30. For some measures, there are look-back periods that extend before July 1 of the program year. Payment is sent out 120 days after the program period ends, on October 31. In order to maintain a stable measurement set, measure development occurs on a two-year cycle; major changes are only made every other year.

Eligibility Criteria

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

If a provider site is contracted for at least 11 out of 12 months during the measurement year, it reports on all applicable measures. If a provider site is contracted for more than six but less than 11 months during the measurement year, it only reports on measures that rely on administrative data; the Clinical and Patient Experience measures in the Fixed Pool Measurement Set do not apply. If a contract is terminated during the measurement year, the provider is ineligible.
Eligible Population
The eligible population used to calculate the final scores for all measures is defined as capitated Medi-Cal members. For Clinical measures, the member also has to be continuously enrolled with their PHC assigned provider, with continuous enrollment defined as being assigned for 11 out of the 12 months of the measurement year. Assigned provider is defined as the reporting entity designated for the QIP. Medi-Medi members (dually eligible members) are excluded from all measures.

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

For the Fixed Pool measures, the total sum of financial incentives distributed for any given measurement year – known as the “payment pool” – is based on all capitated member months accrued throughout the measurement year. Member months is defined as the total number of capitated Medi-Cal patients assigned to a site each month (i.e. if a provider has 100 Medi-Cal Partnership patients assigned each month for all 12 months of the measurement year, the provider’s total member months will be 1200). Each year, PHC budgets a base per member per month (PMPM) amount, which determines the QIP payment pool (i.e. if the base PMPM amount is $4 and there is a total of 500,000 member months in the measurement year, the QIP payment pool will be $2 million). All of the payment pool is distributed among all participating QIP sites at the end of the measurement year. Because the payment pool is fixed, the incentive payment a site is able to earn is based on the site’s performance in the measures, its number of member months, and the relative performance of other sites. The base PMPM amount is announced at the beginning of the measurement year and may change mid-year pending unforeseen State budget impacts to the plan.

For the Unit of Service measures, the payment is independent of and distinct from the financial incentives a site receives from the QIP fixed payment pool. A site receives payment according to the measure specifications if the requirements for one or more Unit of Service measures are met.

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

eReports
eReports, an online system built for the QIP Clinical measures, is the mechanism by which providers can monitor their performance and submit supplemental data to PHC. eReports may be accessed at https://qip.partnershiphp.org/.

All providers, regardless of denominator size, will be held against the established thresholds. We are aware that small denominators may negatively impact the overall performance on that measure. Therefore, if a provider 1) has fewer than 10 members in the denominator for any clinical measure after continuous enrollment is applied and 2) does not meet the threshold, there will be an additional opportunity to submit evidence of outreach efforts to non-compliant members conducted during the measurement year. Please reach out to the QIP team in July 2017 if you would like to submit outreach information.

Non-Clinical Reports
In addition to the eReports system, the QIP Team produces site-specific Non-Clinical Reports on a bimonthly basis, containing performance data on the Non-Clinical measures (i.e. measures in the Appropriate Use of Resources, Access & Operations, and Patient Experience domains). These reports provide a retrospective look at a site’s performance based on available data. They will be distributed via e-mail to the preferred contacts at each QIP participating site.
Governance Structure
The QIP and its measurement set are developed collaboratively with internal and external stakeholders and receive feedback and approval from the following parties:

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

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

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

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

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

For the tables below, please refer to these notes:

1: For new measures, target is set at the 50th percentile performance of all Medicaid health plans, released by NCQA in 2015. No partial points are available for new measures. For existing measures, target is set at the 90th percentile performance of all Medicaid health plans. Sites have the opportunity to receive half points on existing measures if the 75th percentile performance is met.

2: For existing measures, sites can also earn partial points based on relative improvement. Relative improvement measures the percentage of the distance the provider has moved from the previous year’s rate toward a goal of 100 percent. The method of calculating relative improvement is based on a Journal of the American Medical Association authored by Jencks et al in 2003, and is as follows:

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

The formula is widely used by the Integrated Healthcare Association commercial pay for performance program as well as by the Center for Medicare and Medicaid Services. Points are awarded according to the following scale:

- \( \geq 15\% \) Relative Improvement = Full Points
- 10.0-14.9\% Relative Improvement = 75\% Points
- 5.0-9.9\% Relative Improvement = 50\% Points
- 0.1-4.9\% Relative Improvement = 25\% Points

3: Site specific risk adjusted targets will be available in December 2016.

4: All measures except Colorectal Cancer Screening use as targets the performance percentiles obtained from the NCQA national averages for Medicaid health plans reported in 2015. The Colorectal Cancer Screening targets are based on the 25th and 50th percentile performance by Medicare HMO Plans, as data for Medicaid is not available.
# 2016-2017 PCP QIP Measurement Specifications: FAMILY PRACTICE

## CRITERIA & WEIGHT

### CLINICAL DOMAIN (45 Points Total)

- Monitoring Patients on Persistent Medications (5 pts)
- Well Child Visits (5 pts)
- Childhood Immunization – DTaP (5 pts)
- Cervical Cancer Screening (5 pts)
- Colorectal Cancer Screening (5 pts)
- Controlling High Blood Pressure (5 pts)
- Retinal Eye Exam (18 – 75 yrs) (5 pts)
- HbA1C Control (18 – 75 yrs) (5 pts)
- Nephropathy (18 – 75 yrs) (5 pts)

### APPROPRIATE USE OF RESOURCES (30 Points Total)

- Admissions/1000 OR Follow-up post discharge* (7.5 pts)

### CASE MIX ADJUSTED?

- No

### 2016-2017 TARGETS

#### ¹ ² Full Point Targets for Existing Measures:

- Well Child Visits: 83.8%
- Childhood Immunization – DTaP: 86.1%
- Cervical Cancer Screening: 73.1%
- Controlling High Blood Pressure: 70.3%
- Retinal Eye Exam: 67.9%
- HbA1c Control: 70.3%
- Nephropathy: 87.7%
- Colorectal Cancer Screening: 67.5%

#### Half Points Targets for Existing Measures:

- Well Child Visits: 78.5%
- Childhood Immunization – DTaP: 83.5%
- Cervical Cancer Screening: 67.9%
- Controlling High Blood Pressure: 65.3%
- Retinal Eye Exam: 63.4%
- HbA1c Control (≤9%): 65.3%
- Nephropathy: 84.9%
- Colorectal Cancer Screening: 60.5%

#### Full Point Target for New Measure:

- Monitoring Patients on Persistent Medications: 87.7%

---

2016-2017 PCP QIP Measurement Specifications: FAMILY PRACTICE

Page 7
<table>
<thead>
<tr>
<th><strong>Follow-up post discharge can be the back-up measure for either admissions/1000 or readmission rate, but not both.</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Readmission Rate OR Follow-up post discharge* (7.5 pts)</td>
<td>Yes: By Practice Type³</td>
</tr>
<tr>
<td>*Follow-up post discharge can be the back-up measure for either admissions/1000 or readmission rate, but not both.</td>
<td>Full points = ≤110% of target</td>
</tr>
<tr>
<td></td>
<td>Half points = 111-119% of target</td>
</tr>
<tr>
<td>• Pharmacy Utilization (10 pts)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Full points = At least 85.0% generic rate or 98.0% formulary compliance rate</td>
</tr>
<tr>
<td></td>
<td>Half points = 83.0-84.9% generic rate or 96.0-97.9% formulary compliance rate</td>
</tr>
<tr>
<td>• Opioid Safety (5 pts)</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Full points: 60.0% of patients on chronic pain medications who have had a U-Tox Screen</td>
</tr>
<tr>
<td></td>
<td>Half points: 50.0-59.9% of patients on chronic pain medications who have had a U-Tox Screen</td>
</tr>
<tr>
<td><strong>Back-Up Measure: Follow-Up Post Discharge</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full points: 50% of discharged members contacted</td>
</tr>
<tr>
<td></td>
<td>Half points: 25-49% of discharged members contacted</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Avoidable ED Visits (5 points)</strong></th>
<th>Yes: By PCP/Site³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Points: At or below site-specific threshold</td>
</tr>
<tr>
<td><strong>Practice “open” to PHC members (5 points)</strong></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>1 point per quarter + 1 extra point for all quarters:</td>
</tr>
<tr>
<td></td>
<td>Open 1 full quarter = 1 point</td>
</tr>
<tr>
<td></td>
<td>Open 2 full quarters = 2 points</td>
</tr>
<tr>
<td>PCP Office Visits (5 points)</td>
<td>Yes: By PCP/site³</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>PATIENT EXPERIENCE (10 Points Total)</td>
<td>CAHPS Survey for qualified sites, or Survey or Training Option for all other sites</td>
</tr>
</tbody>
</table>
## Unit of Service Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning attestations</td>
<td>$100 per attestation for ACP discussions and $100 per submitted Advanced Directive or POLST for Medi-Cal members 18 years and older</td>
</tr>
<tr>
<td>PCMH Certification</td>
<td>Level 1: $2000 Level 2: $3000 Level 3: $3500</td>
</tr>
<tr>
<td>Access/Extended Office Hours</td>
<td>10% of Capitation</td>
</tr>
<tr>
<td>Registration &amp; Utilization of the California Immunization Registry (CAIR)</td>
<td>Each site's maximum potential earning for this measure varies, depending on the size of the practice. The maximum potential earning is the sum of the base rate and Per Member Per Year (PMPY) rate</td>
</tr>
<tr>
<td></td>
<td><strong>Practice Size</strong></td>
</tr>
<tr>
<td></td>
<td>Small (20-50 members ages 0-13)</td>
</tr>
<tr>
<td></td>
<td>Medium (51-600 members ages 0-13)</td>
</tr>
<tr>
<td></td>
<td>Large (600+ members ages 0-13)</td>
</tr>
<tr>
<td><strong>2016-2017 Performance Threshold:</strong></td>
<td>Will be released in September 2016</td>
</tr>
<tr>
<td>Peer-led self-management support groups (both new and existing)</td>
<td>$1000 per group</td>
</tr>
<tr>
<td>Buprenorphine Qualified Providers</td>
<td>$500 per credential prescriber (max. 5 per site)</td>
</tr>
<tr>
<td>SBIRT</td>
<td>$5 per screening</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>One time $2500 incentive for signing on with a local or regional health information exchange</td>
</tr>
</tbody>
</table>
Measure 1. Annual Monitoring for Patients on Persistent Medications

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

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

**Thresholds**
- Full points: 50th percentile (87.7%)

**Denominator**
The number of continuously enrolled Medi-Cal members 18 years of age or older as of June 30, 2017 (DOB on or before June 30, 1999) who, during the measurement year, received at least 180 treatment days of ACE inhibitors or ARBs or at least 180 treatment days of Diuretics.

Members may switch therapy with any medication listed in Table CDC-L during the measurement year and have the days’ supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition). Separately, members may switch therapy with any medication listed in Table MPM-C during the measurement year and have the days’ supply for those medications count toward the total 180 treatment days. The 180 treatment days must come from therapies within one table. Having 180 treatment days from treatments across two tables will not count towards the denominator.

Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e. a prescription of 90 days’ supply dispensed on June 1, 2017 counts as 30 treatment days). Sum the days’ supply for all medications and subtract any day’s supply that extends beyond June 30, 2017 of the measurement year.

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

**Numerator**
At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test.
- A serum potassium test and a serum creatinine test.

The tests do not need to occur on the same service date, only within the measurement year.

**Codes Used**
Denominator:
- Codes to identify ACE inhibitors or ARBs: Table CDC-L on Code List
- Codes to identify Diuretics: Table MPM-C on Code List
Numerator:
- Codes to identify lab panel test: Table 9B on Code List
- Codes to identify serum creatinine test: Table 9C on Code List
- Codes to identify serum potassium: Table 9D on Code List

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

Exclude members from each eligible population rate who had an acute inpatient encounter (Table 5A on Code List) or non-acute inpatient encounter (Table 8G on Code List) during the measurement year.

Each member can only be counted in a provider’s denominator once. If a member has 180 treatment days on ACE inhibitors or ARBs, as well as 180 treatment days on Diuretics, he or she will only appear once in the denominator list.
Measure 2. *Well Child Visits*

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

**Thresholds**
- Full points: 90th percentile (83.8%)
- Half points: 75th percentile (78.5%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25%)

**Denominator**
The number of continuously enrolled Medi-Cal members 3-6 years of age as of June 30, 2017 (i.e. DOB between July 1, 2010 and June 30, 2014).

**Numerator**
The number of children in the eligible population with at least one well child visit with a PCP during the measurement year.

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

- A health history.
- A physical developmental history.
- A mental developmental history.
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

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

Visits to school-based clinics with practitioners considered PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.
Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

### Codes Used

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

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

### Exclusions (only if not numerator hit)

N/A
Measure 3. *Childhood Immunization – DTaP*

**Description**

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

**Thresholds**

- Full points: 90th percentile (86.1%)
- Half points: 75th percentile (83.5%)
- Relative Improvement Targets per Measure:
  - \( \geq 15\% \) (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

**Denominator**

The number of continuously enrolled Medi-Cal members who turn 2 years of age between July 1, 2016 and June 30, 2017 (DOB between July 1, 2014 and June 30, 2015).

**Numerator**

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

**Codes Used**

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

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

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

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

- Anaphylactic reaction to the vaccine or its components: Table 3A on Code List.
- Encephalopathy (Table 3K on Code List) with a vaccine adverse-effect code (Table 3J on Code List).
Measure 4. Cervical Cancer Screening

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

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

Thresholds
- Full points: 90th percentile (73.1%)  
- Half points: 75th percentile (67.9%)  
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)  
  - 10.0%-14.9% (75% Points)  
  - 5.0%-9.9% (50% Points)  
  - 0.1%-4.9% (25% Points)

Denominator
The number of continuously enrolled Medi-Cal women 24-64 years of age as of June 30, 2017 (i.e. DOB between July 1, 1952 and June 30, 1993).

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

Step 1:
Identify women 24-64 years of age (DOB between July 1, 1952 and June 30, 1993) as of June 30, 2017 who had cervical cytology in the measurement year or the two years prior (July 1, 2014 – June 30, 2017).

Documentation in the medical record must include:

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

Step 2:
From the women who did not meet Step 1 criteria, identify women 30-64 years of age (DOB between July 1, 1952 and June 30, 1987) as of June 30, 2017 who had cervical cytology and an HPV test on the same date of service* during the measurement year or the 4 years prior to the measurement year (July 1, 2012 – June 30, 2017) and who were 30 years or older on the date of both tests. Documentation in the medical record must include:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
For administrative data, due to potential claims lag, services delivered within 4 days apart may count toward numerator compliance. For example, if the service date for Pap test and HPV test was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year. However, for eReports data upload, the tests must occur on the same date.

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

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

**Codes Used**

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

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

**Exclusions (only if not numerator hit)**
Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix (Table 6A on Code List) any time during the member’s history through June 30, 2017.

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

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

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

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

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

Step 1: Is there a Pap test in the measure year or the two years prior (July 1, 2014 – June 30, 2017)?

- YES: Member is compliant
- NO: Member is not compliant

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

- NO: Member is compliant
- YES: Step 2b

Step 2b: Is there a Pap test and HPV test with the same service date during the measurement year or the four years prior to the measurement year (July 1, 2012 – June 30, 2017) and who were 30 years or older on the date of both tests.

- YES: Member is compliant
- NO: Member is not compliant

Step 3: Add the numbers from Step 1 and Step 2b to obtain a total rate
**Measure 5. Colorectal Cancer Screening**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of members 51–75 years of age as of June 30, 2017 who had appropriate screening for colorectal cancer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full points: 50th percentile of NCQA Medicare performance (67.5%) (Note that no NCQA Medicaid threshold exists for this measure)</td>
</tr>
<tr>
<td>• Half points: 25-50th percentile of NCQA Medicare performance (60.5%)</td>
</tr>
</tbody>
</table>
| • Relative Improvement Targets per Measure:  
  o ≥ 15% (Full Points)  
  o 10.0%-14.9% (75% Points)  
  o 5.0%-9.9% (50% Points)  
  o 0.1%-4.9% (25% Points) |

<table>
<thead>
<tr>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of continuously enrolled Medi-Cal members 51-75 years of age by June 30, 2017 (i.e. DOB between July 1, 1941 and June 30, 1966).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator</th>
</tr>
</thead>
</table>
| The percentage of members 51–75 years of age who had one or more screenings for colorectal cancer. Any of the following meet the criteria:  
  • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) during the measurement year.  
  • Flexible sigmoidoscopy during the measurement year or the 4 years prior to the measurement year.  
  • Colonoscopy during the measurement year or the 9 years prior to the measurement year. |

<table>
<thead>
<tr>
<th>Codes Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: No codes applicable as eligibility is solely defined by age.</td>
</tr>
</tbody>
</table>
| Numerator:  
  Fecal immunochemical test: Table 7D on Code List  
  Flexible sigmoidoscopy: Table 7C on Code List  
  Colonoscopy: Table 7A on Code List |

<table>
<thead>
<tr>
<th>Exclusions (only if not numerator hit)</th>
</tr>
</thead>
</table>
| Either of the following any time during the member’s history through June 30, 2017 of the measurement year:  
  • Colorectal cancer: Table 7B on Code List.  
  • Total colectomy: Table 7E on Code List. |
Measure 6. **Controlling High Blood Pressure**

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

**Thresholds**
- Full points: 90th percentile (70.3%)
- Half points: 75th percentile (65.3%)
- Relative Improvement Targets per Measure:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

**Denominator**
The number of continuously enrolled Medi-Cal members 18-85 years of age as of June 30, 2017 (i.e. DOB between July 1, 1931 and June 30, 1999) with at least one outpatient visit, with a diagnosis of hypertension, during the 6 months prior to the measurement year (i.e. January 1, 2016 – June 30, 2016).

**Numerator**
The number of eligible population in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:
- Members 18–59 years of age as of June 30, 2017 whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of June 30, 2017 and flagged with a diagnosis of diabetes (see note below) whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of June 30, 2017 and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

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

Do not include BP readings:
- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g. sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g. stress test, administration of IV contrast for a radiology procedure, endoscopy).
• Reported by or taken by the patient.

Members who met any of the following criteria during the measurement year or the year prior to the measurement year (July 1, 2015 – June 30, 2017) are identified as diabetic:

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

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

• Dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis.

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

• Do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year (July 1, 2015 – June 30, 2017).

• A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year (July 1, 2015 – June 30, 2017).

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

**Codes Used**

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

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

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

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

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

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

• Exclude from the eligible population all members with a diagnosis of pregnancy (Table 1F on Code List) during the measurement year.

• Exclude from the eligible population all members with evidence of end-stage renal disease (ESRD) (Table 8D on Code List) or kidney transplant (Table 8F on Code List) on or prior to June 30, 2017. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis.
• Exclude from the eligible population all members who had a non-acute inpatient admissions during the measurement year. To identify non-acute inpatient admissions:
  o Identify all acute and non-acute inpatient states (Inpatient Stay Value Set Table on Code List).
  o Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim.
  o Identify the discharge date for the stay.
Measure 7. Diabetes Management – Retinal Eye Exam

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

### Thresholds
- Full points: 90th percentile (67.9%)
- Half points: 75th percentile (63.4%)
- Relative Improvement Targets:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.0% (50% Points)
  - 0.1%-4.0% (25% Points)

### Denominator
The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between July 1, 1941 - June 30, 1999) with diabetes identified as of June 30, 2017.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior (July 1, 2015 – June 30, 2017).

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, July 1, 2015 – June 30, 2017).

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

Pharmacy data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (July 1, 2015 – June 30, 2017).

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

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

- A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year (July 1, 2015 – June 30, 2016).
Codes Used

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

Numerator:
- Codes to identify diabetic retinal screening: Table 10C on Code List, billed by an eye care professional (specialty code 18 and 59), during the measurement year.
- Codes to identify diabetic retinal screening with eye care professional: Table 10D on Code List, billed by any provider type, during the measurement year.
- Codes to identify negative diabetic retinal screening: Table 10E on Code List, billed by any provider type, during the measurement year.

For exams performed with a negative result in the year prior to the measurement year (July 1, 2015 – June 30, 2016), a result must be available.

Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (July 1, 2015 – June 30, 2017), and who meet either of the following criteria:

- A diagnosis of gestational diabetes or steroid-induced diabetes (Table 8B on Code List) in any setting, during the measurement year or the year prior to the measurement year.
**Measure 8. Diabetes Management – HbA1c Good Control (≤9%)**

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

**Thresholds**
- Full points: 90\(^{th}\) percentile (70.3 %)
- Half points: 75\(^{th}\) percentile (65.3%)
- Relative Improvement Targets:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

**Denominator**
The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between July 1, 1941 - June 30, 1999) with diabetes identified as of June 30, 2017.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior, i.e. July 1, 2015 – June 30, 2017.

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, July 1, 2015 – June 30, 2017).

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

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

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

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

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

Exclusions (only if not numerator hit)
Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (July 1, 2015 – June 30, 2017), and who meet either of the following criteria:

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

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

**Thresholds**
- Full points: 90th percentile (87.7%)
- Half points: 75th percentile (84.9%)
- Relative Improvement Targets:
  - ≥ 15% (Full Points)
  - 10.0%-14.9% (75% Points)
  - 5.0%-9.9% (50% Points)
  - 0.1%-4.9% (25% Points)

**Denominator**
The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between July 1, 1941 - June 30, 1999) with diabetes identified as of June 30, 2017.

There are 2 ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior, i.e. July 1, 2015 – June 30, 2017.

Claim/encounter data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, July 1, 2015 – June 30, 2017).

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

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

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

Any of the following meet the criteria for a nephropathy screening or monitoring test or evidence of nephropathy.

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

• Documentation of a visit to a nephrologist.

• Documentation of a renal transplant.

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

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

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

### Codes Used

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

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

### Exclusions (only if not numerator hit)

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (July 1, 2015 – June 30, 2017), and who meet either of the following criteria:

• A diagnosis of gestational diabetes or steroid-induced diabetes (Table 8B on Code List) in any setting, during the measurement year or the year prior to the measurement year.
Monitoring for Diabetic Nephropathy

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

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

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

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

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

- **YES**
  - **STOP!** Member is compliant
- **NO**
  - **STOP!** Member is not compliant.
Measure 10. Admissions/1000 members

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

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

Targets are set using plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Targets to be released in December 2016.

OR

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

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

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

Calculation:

\[
\text{Admissions/1000} = \left( \frac{\text{Total # of admissions}}{\text{Total member months}} \right) \times 12,000
\]

Exclusions
Stays at the following facility types:
- Long Term Care
- Intermediate Care
- Sub-acute
- Rehabilitation
- Behavioral health.

Admissions for maternity care and newborn nursery days as identified by revenue code.
Measure 11. Readmission Rate

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

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

Targets are set by practice type using plan-wide mean. Targets are to be released in December 2016.

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

**Data Criteria**
A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, first quarter dates of service are not reported until December 31.

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

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

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

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

Stays at the following facility types:
- Long Term Care
- Intermediate Care
- Sub-acute
- Rehabilitation
- Behavioral health.
Measure Alternative: **Back-Up Measure: Follow-Up Post Discharge**

**Description**

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

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

**Thresholds**

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

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

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

**Data Criteria**

For practice sites that have not met the targets for Admissions per 1000 or Readmission Rate, PHC will collect preliminary inpatient stay data after the conclusion of the measurement year (June 30, 2016) and identify stays with no associated office visit claim with a date of service within 4 calendar days of discharge. PHC will distribute to practice sites a list of their patients’ hospitalizations. Practice sites will return the list to PHC indicating the date a telephonic encounter or office visit occurred if applicable. This returned data will be incorporated into the final follow-up percentage calculation. Data submitted is subject to audit of patients’ medical charts. Only one visit or phone call per discharge will be counted.

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

Calculation:

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

**Exclusions**

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

Stays at the following facility types:

- Long Term Care
- Intermediate Care
- Sub-acute
• Rehabilitation
• Behavioral health
Measure 12. Pharmacy Utilization

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of generic prescription fills compared to total fills (generic + brand) for prescriptions written by professional staff assigned to the primary care site for the site’s assigned members only.</td>
</tr>
<tr>
<td>The percentage of formulary compliant prescription fills compared to total fills (formulary + non-formulary) for prescriptions written by professional staff assigned to the primary care site for the site’s assigned members only.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full points: At least 85% generic rate or 98% formulary compliance rate.</td>
</tr>
<tr>
<td>• Half points: 83.0-84.9% generic rate or 96.0-97.9% formulary compliance rate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, first quarter dates of service (July-September) is not reported until December 31.</td>
</tr>
<tr>
<td>PHC will calculate total number of pharmacy claims data from MedImpact (PHC’s Pharmacy Benefit Manager).</td>
</tr>
</tbody>
</table>

Calculations:

- **Generic Prescription Rate** = \( \frac{\text{generic fills}}{\text{generic + brand fills}} \)

- **Formulary Compliance Rate** = \( \frac{\text{formulary fills}}{\text{formulary + non-formulary fills}} \)

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions for products not classifiable as either brand of generic, such as supply-type items. Drugs dispensed directly by the primary care site.</td>
</tr>
</tbody>
</table>
Measure 13. **U-Tox Screens**

**Description**
Percentage of unique members on chronic pain medications who have had a U-Tox Screen during the measurement year.

**Thresholds**
- Full points: 60.0% of patients on chronic pain medications who have had a U-Tox Screen
- Half points: 50.0-59.9% of patients on chronic pain medications who have had a U-Tox Screen

**Data Criteria**
A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, first quarter dates of service (July-September) are not reported until December 31.

PHC will calculate the total number of members on opioid pain medications for at least 75 days using pharmacy claims data from MedImpact (PHC’s PBM). Refer to Appendix I for a list of medications that qualify as opioids.

From the eligible population (denominator), PHC will calculate how many members had at least one U-Tox screen (Table U-Tox on Code List) during the measurement year.

Calculation:

\[
\frac{\text{Unique Members on opioid pain medications for at least 75 days who have had a U-Tox Screen}}{\text{Members on opioid pain medications for at least 75 days}}
\]

**Exclusions**
- Members on opioid pain medications for less than 75 days within the measurement year.
- Active cancer patients age 18 and above prescribed with opioid pain medications as part of treatment plan.
Measure 14. *Avoidable ED Visits/1000 Members Per Year*

**Description**

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

**Thresholds**

- Full points: At or below target

Targets are set using plan-wide mean, adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Targets to be released in December 2016.

**Data Criteria**

A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, first quarter dates of service (July-September) are not reported until December 31.

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

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

**Calculation**

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

**Exclusions**

Members age <1
Measure 15. *Practice Open to New PHC Members*

**Description**
Practice must remain open to new PHC members for a full quarter to obtain points.

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

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

**Exclusions**
N/A
Measure 16. **PCP Office Visits Per Member Per Year**

**Description**
The average number of assigned members' visits to PCP per member per year.

**Thresholds**
- Full points: At or above target

Targets are set using a plan-wide mean adjusted for each site based on age, gender, and Medi-Cal Aid Code mix. Targets will be released in December 2016.

**Data Criteria**
A 3 month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, first quarter dates of service (July-September) are not reported until December 31.

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

PHC will extract the total number of PHC office visits using allowable PHC claim and encounter data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site. An estimate for incurred but not yet paid/processed claims data will be included.

Calculation:

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

**Exclusions**
N/A
Measure 17. Patient Experience

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

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

  OR

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

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

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

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

Refer to the Thresholds section below for detailed specifications.

Thresholds

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

Sufficient patient volume is defined as having at least 1200 unique visits by PHC members between April 1, 2016 and March 31, 2017 at the entity level. If a site does not belong to any entity, it is considered an entity for this measure. The survey results will be analyzed at the entity level. Eligible population includes assigned members with at least 1 unique visit or special members with at least 2 visits during this period. Members 13-17 years of age are excluded. Adults and children will be surveyed separately.

Payment methodology: Providers will earn points by either 1) meeting the performance targets or 2) showing relative improvement from the baseline survey conducted in 2016. If both the adult and child CG-CAHPS surveys are conducted at your site, you will be paid based on the higher of the 2 results. We will pay for the Access and Communication composites according to the following targets:
• Full points (5 points for each composite): Re-survey result > PHC 50th percentile score*, or showing 4% or more in relative improvement from baseline survey

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

*The following targets are set based on PHC performance on the 2016 survey:

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

OR

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

- Survey Option
- Training Option

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

Part I (5 points):

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

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

Part II (5 points):

3) Implement change(s) for improvement.

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

OR

2b) Training Option
There are 2 parts to this option. Please follow the steps below and fill out the submission template (Appendix III) accordingly.

Part I (5 points):

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

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

Part II (5 points):

3) Complete the improvement plan and collect patient feedback.

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

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

**Submission Process**

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

**Exclusions**

N/A
Measure 18. Advanced Care Planning

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

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

Measure Requirements

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

Attestation Submission:
Submit an Attestation Form (Appendix IV) or medical record evidence of the Advance Care Planning conversation. Only one submission per patient per measurement year.

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

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

- Conversation about patient goals, general preferences around end of life, and prognosis (if appropriate)
- Documentation of conversation with family or recommendation for patient to talk with family
- Status of the Advance Directive:
  - Discussed
  - Given to patient
  - Completed
  - Copy in chart
  - Patient refused
- Summary of patient wishes, whether from conversation or from an Advanced Directive. Some options include:
  - Full treatment
  - Comfort care
  - Hospice
  - DNR
• If a POLST is appropriate, some status options include:
  o Discussed
  o Given to patient
  o Completed
  o Copy in chart
  o Patient refused

• Plan for next conversation.

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

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

Submissions are due to Partnership no later than July 31, 2017. Payments will be made on an annual basis.

### Exclusions
If an ACP discussion is billed using CPT codes, that discussion is not eligible for the QIP incentive. The QIP will work with PHC’s Claims Department to identify conversations that have been reimbursed.
Measure 19. *Extended Office Hours*

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

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

Example 1: A parent organization has two sites within 5 miles of each other (Site A and Site B). Site A meets the criterion for holding extended office hours. Site B does not hold extended office hours. Since Site B is within a 5 mile radius, patients who are seen at Site B can easily access Site A during the extended hours of service. Both Site A and Site B are eligible for the payment.

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

**Measure Requirements**
PCP site must be open an additional 8 hours per week or more, beyond the normal business hours on Monday-Friday, for the entire quarter. No points awarded if, during a quarter, the practice site no longer offers extended office hours or reduces the hours and no longer meets the additional eight hour minimum.

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

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

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

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

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

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

- Have on-call arrangements available where by the on-call physicians come to the office to see urgent problems (arrangement to be submitted in writing annually to the PR representative of your county, including what types of urgent issues will be seen in the office) after hours. Deadline to submit arrangement is September 30, 2016.

- Demonstrate the use of arrangement with at least three PHC members seen in the office after hours
per quarter, to be submitted quarterly by the site to their Provider Relations representative of your county. Deadlines are as follows:

- Q1: September 30, 2016
- Q2: December 31, 2016
- Q3: March 31, 2017
- Q4: June 30, 2017

Please note this measure is subject to an audit by the Provider Relations department.
Measure 20. Patient-Center Medical Home Recognition

**Description**
One-time payment for achieving Level 1 ($2,000), Level 2 ($3,000), or Level 3 ($3,500) recognition from NCQA, or equivalent from AAAHC or JCAHO

Refer to Appendix VI for submission template for this measure.

**Measure Requirements**
Primary care provider sites with a minimum of 50 assigned Partnership members. Sites must receive accreditation within the measurement year. Documentation of PCMH recognition from NCQA, AAAHC, or JCAHO must be faxed or emailed to QIP@partnershiphp.org by July 31, 2017. Payments for each level are not aggregate.

**Submission Process**
You may refer to (Appendix VI) for the documentation template, which can be faxed or emailed to QIP@partnershiphp.org by July 31, 2017.

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

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

Refer to Appendix VII for submission template for this measure.

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

Qualifying peer groups must meet at least 4 times in the 2016-2017 period and have a peer-facilitation component and a self-management component. Group can serve both PHC and non-PHC members, but must include at least 16 PHC total member visits per year (For example, if there are 4 PHC members in the group and the group meets for 4 sessions, the group will meet this criterion). The groups may be general, for patients with a variety of conditions, or focused on specific diseases or conditions, such as: Diabetes, Rheumatoid Arthritis, Chronic Pain, Hepatitis C, Cancer, Congestive Heart Failure, COPD, Asthma, Depression, Anxiety/Stress, Substance use, Pregnancy.

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

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

Maximum number of groups eligible for payment:

- 2 per credentialed Partnership provider
- Up to a maximum of 10 per site and 20 per corporate entity

Documentation will be reviewed and approved by the CMO or physician designee. Proposed groups may submit elements 1-7 above prospectively for review and feedback at any time in the year, before groups start, to ensure program will be eligible for bonus.
Examples of the curriculum and evidence base for this approach can be found at: http://patienteducation.stanford.edu/programs/

**Submission Process**

All documentation must be submitted on the Peer-led Self-Management Support Group template (Appendix VII) by July 31, 2017, and can be faxed or emailed to QIP@partnershiphp.org.

**Exclusions**

Primary care provider sites with fewer than 50 assigned Partnership members.
Measure 22. Utilization of Californian Immunization Registry

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

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

Utilization during the measurement period is calculated using this formula:

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

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

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

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

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

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

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

**Exclusions**
Providers with 20 or fewer patients who are 0-13 years old
### Measure 23. Buprenorphine Qualified Providers

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment of $500 per credentialed prescriber who meets one of the following criteria:</td>
</tr>
</tbody>
</table>
| • Newly trained buprenorphine provider  

**OR**  

• Existing prescribers who are willing to take outside referrals. |

<table>
<thead>
<tr>
<th>Measurement Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with a minimum of 50 assigned Partnership members.</td>
</tr>
<tr>
<td>• Prescribers must be credentialed by the PHC Credentials Committee before June 30, 2017.</td>
</tr>
<tr>
<td>• Prescribers credentialed prior to July 1, 2016 should be listed in the PHC provider directory as buprenorphine providers.</td>
</tr>
<tr>
<td>• Maximum 5 prescribers per site are eligible for this incentive amount.</td>
</tr>
<tr>
<td>• Sites will be given credit for a previously credentialed prescriber that leaves at any point during the measurement year so long as he/she was part of that site for a minimum of six months during the measurement year.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care provider sites with fewer than 50 assigned Partnership members.</td>
</tr>
</tbody>
</table>
### Measure 24. Screening, Brief Intervention, Referral, and Treatment (SBIRT)

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

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

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

- H0049 (Alcohol screening)

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

<table>
<thead>
<tr>
<th>Submission Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC will extract this data 3 months after the end of the reporting year (i.e. September 30, 2017) by identifying claims for H0049 submitted through the claims department.</td>
</tr>
</tbody>
</table>

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

Claims submitted in excess of two screenings per individual patient within a six month time frame.
Measure 25. Health Information Exchange Participation

**Description**
Sites will be reimbursed for participating in a local or regional health information exchange (HIE). The reimbursement will be a one-time $2500 payment per contracted site.

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

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

  **OR**

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

  **OR**

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

Recognized Community Health Information Exchange organizations include the following:

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

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

**Submission Process**
Submit the HIE Attestation form (Appendix IX) by July 31, 2017. PHC will validate the data exchange by working directly with the specified HIE.

**Exclusions**
N/A
# Appendix I: List of Opioids

<table>
<thead>
<tr>
<th>BRAND</th>
<th>GENERIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPITAL W-CODEINE</td>
<td>ACETAMINOPHEN WITH CODEINE</td>
</tr>
<tr>
<td>TYLENOL-CODEINE NO.3</td>
<td>ACETAMINOPHEN WITH CODEINE</td>
</tr>
<tr>
<td>TYLENOL-CODEINE NO.4</td>
<td>ACETAMINOPHEN WITH CODEINE</td>
</tr>
<tr>
<td>ALFENATA</td>
<td>ALFENTANIL HCL</td>
</tr>
<tr>
<td>BUTRANS</td>
<td>BUPRENORPHINE</td>
</tr>
<tr>
<td>BUPRENEX</td>
<td>BUPRENORPHINE HCL</td>
</tr>
<tr>
<td>FIORICET WITH CODEINE</td>
<td>BUTALBIT/ACETAMIN/CAFF/CODEINE</td>
</tr>
<tr>
<td>CODEINE SULFATE</td>
<td>CODEINE SULFATE</td>
</tr>
<tr>
<td>ASCOMP WITH CODEINE</td>
<td>CODEINE/BUTALBITAL/ASA/CAFFEIN</td>
</tr>
<tr>
<td>BUTALBITAL COMPOUND-CODEINE</td>
<td>CODEINE/BUTALBITAL/ASA/CAFFEIN</td>
</tr>
<tr>
<td>TREZIX</td>
<td>DHCODEINE BT/ACETAMINOPHEN/CAFF</td>
</tr>
<tr>
<td>ASPIRIN-CAFFEINE-DIHYDROCODEIN</td>
<td>DIHYDROCODEINE/ASPIRIN/CAFFEIN</td>
</tr>
<tr>
<td>SYNALGOS-DC</td>
<td>DIHYDROCODEINE/ASPIRIN/CAFFEIN</td>
</tr>
<tr>
<td>DURAGESIC</td>
<td>FENTANYL</td>
</tr>
<tr>
<td>SUBSYS</td>
<td>FENTANYL</td>
</tr>
<tr>
<td>ABSTRAL</td>
<td>FENTANYL CITRATE</td>
</tr>
<tr>
<td>ACTIQ</td>
<td>FENTANYL CITRATE</td>
</tr>
<tr>
<td>FENTORA</td>
<td>FENTANYL CITRATE</td>
</tr>
<tr>
<td>LAZANDA</td>
<td>FENTANYL CITRATE</td>
</tr>
<tr>
<td>SUBLIMAZE</td>
<td>FENTANYL CITRATE/PF</td>
</tr>
<tr>
<td>HYSINGLA ER</td>
<td>HYDROCODONE BITARTRATE</td>
</tr>
<tr>
<td>ZOHYDRO ER</td>
<td>HYDROCODONE BITARTRATE</td>
</tr>
<tr>
<td>HYCET</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>LORCET</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>LORTAB</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>NORCO</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>VICODIN</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>VICODIN ES</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>VICODIN HP</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>XODOL 10-300</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>XODOL 5-300</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>XODOL 7.5-300</td>
<td>HYDROCODONE/ACETAMINOPHEN</td>
</tr>
<tr>
<td>IBUDONE</td>
<td>HYDROCODONE/IBUPROFEN</td>
</tr>
<tr>
<td>REPREXAIN</td>
<td>HYDROCODONE/IBUPROFEN</td>
</tr>
<tr>
<td>VICOPROFEN</td>
<td>HYDROCODONE/IBUPROFEN</td>
</tr>
<tr>
<td>XYLOX 10</td>
<td>HYDROCODONE/IBUPROFEN</td>
</tr>
<tr>
<td>DILAUDID</td>
<td>HYDROMORPHONE HCL</td>
</tr>
<tr>
<td>EXALGO</td>
<td>HYDROMORPHONE HCL</td>
</tr>
<tr>
<td>DILAUDID-HP</td>
<td>HYDROMORPHONE HCL/PF</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>MEPERIDINE HCL</td>
<td>MEPERIDINE HCL</td>
</tr>
<tr>
<td>MEPERITAB</td>
<td>MEPERIDINE HCL</td>
</tr>
<tr>
<td>DEMEROL</td>
<td>MEPERIDINE HCL/PF</td>
</tr>
<tr>
<td>DISKETS</td>
<td>METHADONE HCL</td>
</tr>
<tr>
<td>DOLOPHINE HCL</td>
<td>METHADONE HCL</td>
</tr>
<tr>
<td>METHADOSE</td>
<td>METHADONE HCL</td>
</tr>
<tr>
<td>AVINZA</td>
<td>MORPHINE SULFATE</td>
</tr>
<tr>
<td>KADIAN</td>
<td>MORPHINE SULFATE</td>
</tr>
<tr>
<td>MS CONTIN</td>
<td>MORPHINE SULFATE</td>
</tr>
<tr>
<td>EMBEDA</td>
<td>MORPHINE SULFATE/NALTREXONE</td>
</tr>
<tr>
<td>ASTRAMORPH-PF</td>
<td>MORPHINE SULFATE/PF</td>
</tr>
<tr>
<td>DURAMORPH</td>
<td>MORPHINE SULFATE/PF</td>
</tr>
<tr>
<td>INFUMORPH</td>
<td>MORPHINE SULFATE/PF</td>
</tr>
<tr>
<td>OXECTA</td>
<td>OXYCODONE HCL</td>
</tr>
<tr>
<td>OXYCONTIN</td>
<td>OXYCODONE HCL</td>
</tr>
<tr>
<td>ROXICODONE</td>
<td>OXYCODONE HCL</td>
</tr>
<tr>
<td>ENDOCET</td>
<td>OXYCODONE HCL/ACETAMINOPHEN</td>
</tr>
<tr>
<td>PERCOCET</td>
<td>OXYCODONE HCL/ACETAMINOPHEN</td>
</tr>
<tr>
<td>PRIMLEV</td>
<td>OXYCODONE HCL/ACETAMINOPHEN</td>
</tr>
<tr>
<td>ROXICET</td>
<td>OXYCODONE HCL/ACETAMINOPHEN</td>
</tr>
<tr>
<td>XARTEMIS XR</td>
<td>OXYCODONE HCL/ACETAMINOPHEN</td>
</tr>
<tr>
<td>ENDODAN</td>
<td>OXYCODONE HCL/ASPIRIN</td>
</tr>
<tr>
<td>PERCODAN</td>
<td>OXYCODONE HCL/ASPIRIN</td>
</tr>
<tr>
<td>OPANA</td>
<td>OXYMORPHONE HCL</td>
</tr>
<tr>
<td>OPANA ER</td>
<td>OXYMORPHONE HCL</td>
</tr>
<tr>
<td>TALWIN</td>
<td>PENTAZOCINE LACTATE</td>
</tr>
<tr>
<td>ULTIVA</td>
<td>REMIFENTANIL HCL</td>
</tr>
<tr>
<td>SUFENTA</td>
<td>SUFENTANIL CITRATE</td>
</tr>
<tr>
<td>NUCYNTA</td>
<td>TAPENTADOL HCL</td>
</tr>
<tr>
<td>NUCYNTA ER</td>
<td>TAPENTADOL HCL</td>
</tr>
<tr>
<td>CONZIP</td>
<td>TRAMADOL HCL</td>
</tr>
<tr>
<td>ULTRAM</td>
<td>TRAMADOL HCL</td>
</tr>
<tr>
<td>ULTRAM ER</td>
<td>TRAMADOL HCL</td>
</tr>
<tr>
<td>ULTRACET</td>
<td>TRAMADOL HCL/ACETAMINOPHEN</td>
</tr>
</tbody>
</table>
Appendix II: Patient Experience – Survey Option

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

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

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

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

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

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

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

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

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

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

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

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

Submitted by __________________________ (Name & Title) on _____________ (Date)
Dear Patient,

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

Please rank the following statements based on your visit today:

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

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

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

   “I was given an appointment when I wanted it”

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

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

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

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

Submitted by Elizabeth Jones (QI Director) (Name & Title) on Dec 10, 2016 (Date)
1. Describe specific changes/actions/interventions you implemented to improve your performance in the measure(s) you selected in Part I. Include specific timelines and who implemented the changes and how changes were implemented.

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

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

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

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

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

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

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

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

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

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

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

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

1. Training attended and date of training:

2. Training organization:

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

4. Objective(s) of the training:

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

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

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

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

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

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

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

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

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

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

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


2. Training organization: Institute for Healthcare Communication

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

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

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

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

6. Improvement Plan

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

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

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

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

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

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

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

Dear Patient,

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

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The non-clinical staff at this office were friendly to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The non-clinical staff at this office addressed my concerns adequately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I was given more than one option in terms of how and when to schedule the next appointment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I felt comfortable asking the non-clinical staff questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. When I called for an appointment, the wait time was reasonable.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I feel confident that my personal information is kept private.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Charges were explained to me clearly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXAMPLE
Training Option: Part II Submission (Progress Report)

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

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

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

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

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

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

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

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

PATIENT FEEDBACK TOOL FOR EVALUATION (Part II submission)

Dear Patient,

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

Please rank the following statements based on your visit today:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The non-clinical staff at this office were friendly to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The non-clinical staff at this office addressed my concerns adequately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I was given more than one option in terms of how and when to schedule the next appointment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I felt comfortable asking the non-clinical staff questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV: Advanced Care Planning – Physician/Clinician Attestation

Discussions by doctors, nurses, physician assistants, and other clinicians about Advance Care Planning with PHC Medi-Cal only members ages 18 and older may qualify for a financial bonus under PHC’s Quality Improvement Program (QIP). You may submit one attestation per member per fiscal year, up to a maximum of 100 attestations. To be eligible for the incentive, please do the following:

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

ACP discussions must take place between July 1, 2016, and June 30, 2017. All attestations submitted are reviewed by PHC. Upon approval, the attestation will qualify for the incentive. Attestation forms should be submitted no later than July 31, 2017 via email at QIP@partnershiphp.org or fax at 707-863-4316.

-------------------------------------------------------------------------------------------------------------------------------

Patient Name: _____________________________________________________________________

Patient DOB: _____________________________ Patient CIN: _____________________________

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

A. **Advance Directive (AD)** *One of the four boxes below must be checked for this form to be considered complete
(Click [here](#) for AD sample)

- Patient completed AD
- Patient committed to filling AD out after ACP discussion
- Patient had previously completed his/her AD and reaffirmed they do not wish to make any changes
- Patient declined to complete AD. Information given: pamphlet/handout about Advance Directives

B. **POLST** *One of the four boxes below must be checked for this form to be considered complete
(Click [here](#) for the English California POLST Form). Completed POLST forms must be available in the medical
record in case of auditing.

- POLST inappropriate for patient
- POLST appropriate and signed
- POLST appropriate but declined
- Existing POLST in medical record was reviewed with the patient and updated as needed

Clinician Signature: ___________________________ Date: ___________________________

---

2016-2017 PCP QIP Measurement Specifications: FAMILY PRACTICE
Appendix V: Advanced Care Planning – Medical Record Components

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

Basic Information

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

Patient general preferences around end of life

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

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

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

Details of discussion: __________________________________________________________
____________________________________________________________________________
Quality Improvement Program
Patient Centered Medical Home Recognition Template

Please complete all of the following fields on this form by **July 31, 2017** and send to:

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

1. **Name of Recognition entity (NCQA, JCAHO or AAAHC):**

2. **Date of recognition received:**

3. **Circle level accomplished:**

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

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

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

**Additional Notes/Comments:**

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

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

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

Please complete all of the following fields on this form by **July 31, 2017** and send to:

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

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

1. Name of group

2. Name and background information/training of group facilitator

3. Site where group visits took place

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

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

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

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

8. Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and date of group
Appendix VIII: Submission Template for CAIR Utilization

Quality Improvement Program
California Immunization Registry (CAIR) Reporting Template

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

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

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

1. Name of Your Practice:

2. Address of Your Practice:

3. Date of registration:

4. Provider ID assigned by CAIR:

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

Quality Improvement Program
Health Information Exchange (HIE) Reporting Template

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

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

PHC will verify the following information with the HIE specified. Please refer to the Measure Specifications for details.

1. Name of practice linked to the HIE:

2. Type of linkage established (check at least one that applies):
   - [ ] Sending HL7/ Patient Visit Information history to the HIE
   - [ ] Sending CCD document to the HIE
   - [ ] Retrieving clinical information such as labs from the HIE

3. Date of registration:

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

Submitted by: ___________________________ Date: ___________________________
Title: ___________________________ Phone: ___________________________
Email: ___________________________

**IMPORTANT**: If you are submitting this template on behalf of multiple QIP participating sites, please list and submit all the information above for each of your sites.
# Appendix X: 2016-2017 QIP Submission Timeline

<table>
<thead>
<tr>
<th>DUE DATE</th>
<th>QIP MEASURE</th>
<th>REPORTING TEMPLATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30, 2016</td>
<td>CAIR Utilization</td>
<td>Appendix VIII</td>
</tr>
<tr>
<td>January 31, 2017</td>
<td>Patient Experience (Part I)</td>
<td>Appendix II, Appendix III</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Patient Experience (Part II)</td>
<td>Appendix II, Appendix III</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Advance Care Planning</td>
<td>Appendix IV, Appendix V</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>PCMH Recognition</td>
<td>Appendix VI</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Peer-led Self-Management Support Group</td>
<td>Appendix VII</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Health Information Exchange</td>
<td>Appendix IX</td>
</tr>
<tr>
<td>14 days after receiving report from PHC, in September/October 2017</td>
<td>Follow-up post discharge</td>
<td>Complete report will be provided by PHC (If you do not meet the target for Admissions/1000 or Readmission Rate by the end of the measurement year, PHC will provide a list of patients discharged during the measurement year who have no claims data for a follow-up encounter).</td>
</tr>
</tbody>
</table>
**Appendix XI: Data Source Table**

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

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

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

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC</th>
<th>Monthly Reports</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pharmacy Utilization</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Opioid Safety</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Admissions/ 1000</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Readmission Rate</td>
<td>PHC</td>
<td>Monthly Reports</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

### Access/Operations Measures: All Practice Types

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

### Patient Experience: All Practice Types

<table>
<thead>
<tr>
<th>Measure</th>
<th>PHC Vendor</th>
<th>Year-End Report</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey/Training Option (sites not qualified for CAHPS)</td>
<td>Provider</td>
<td>Monthly Reports</td>
<td>Submission Template</td>
</tr>
<tr>
<td>CAHPS Survey (for qualified sites)</td>
<td>PHC Vendor</td>
<td>Year-End Report</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Unit of Service Measures

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