PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Accelerated Learning Webinar

Comprehensive Diabetes Care

HbA1c Good Control ≤ 9.0%

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March 15, 2023

Objectives

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At the end of this activity, you will be able to:

- Provide an overview of clinical measure background, specifications, and performance threshold definitions for the 2023 PCP QIP *Comprehensive Diabetes Management - HbA1c Good Control* measure.

- Review documentation requirements to maximize adherence and measure performance for the *Comprehensive Diabetes Management – HbA1c Good Control.*

- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for diabetes complications and technical tips to improve *Diabetes Management HbA1c Good Control* rates.

Partnership HealthPlan of California (PHC) Regions

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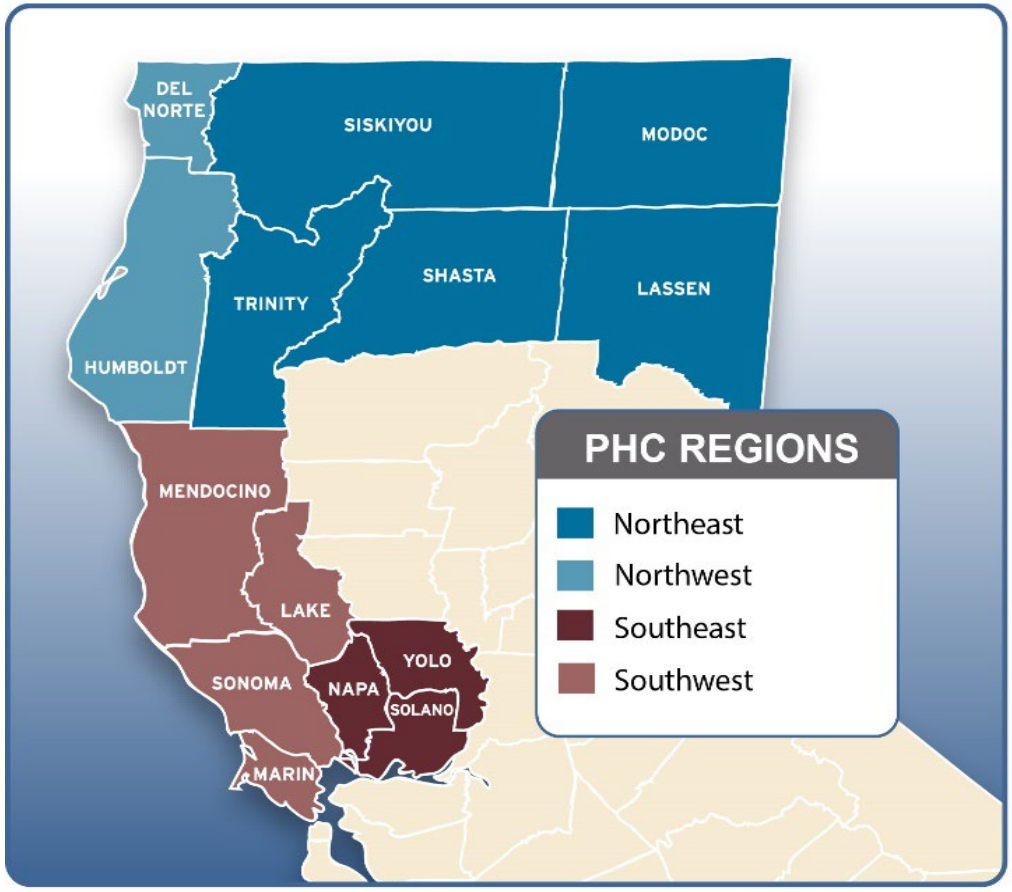

Southeast: Solano, Yolo, Napa

Southwest: Sonoma, Marin, Mendocino, Lake

Northeast: Lassen, Modoc, Siskiyou, Trinity, Shasta

Northwest: Humboldt, Del Norte

PHC Mission, Vision, Focus

- **Mission**
- To help our members, and the communities we serve, be healthy
- **Vision**
- To be the most highly regarded managed care plan in California
- **Focus**
  - Quality in everything we do
  - Operational excellence
  - Financial stewardship

Overview of Diabetes

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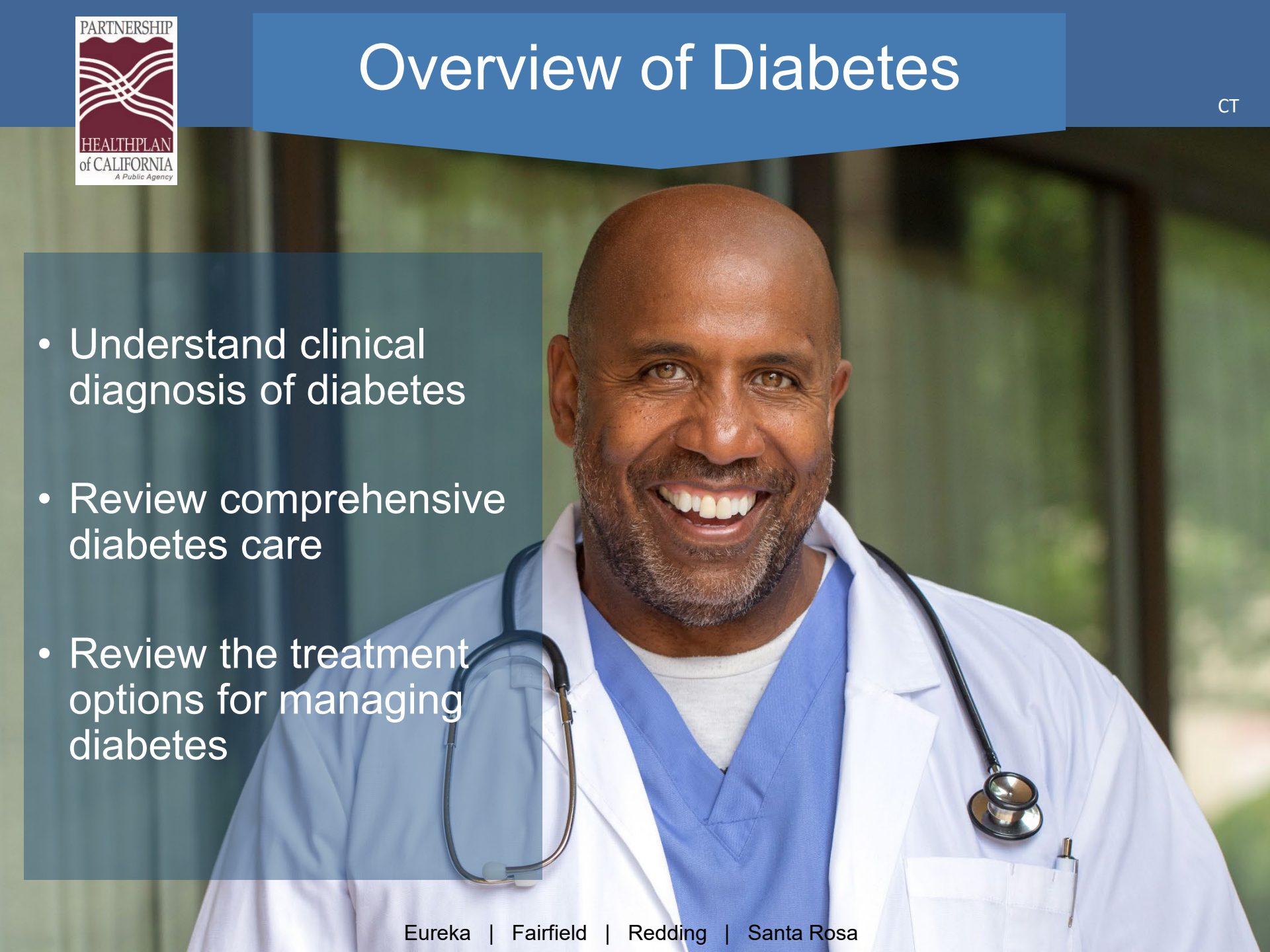

- Understand clinical diagnosis of diabetes
- Review comprehensive diabetes care
- Review the treatment options for managing diabetes

Diabetes Mellitus: What is the Problem?

Compromised ability to metabolize carbohydrates and control blood sugar leading to sustained hyperglycemia

- Type 2 Diabetes progressive loss of sensitivity to insulin and decreased production of insulin
- Type 1 Diabetes acquired decreased production of insulin

Types of Diabetes Mellitus

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Type 1 Diabetes

- 5 - 10% of the people who have diabetes
- Requires treatment with insulin

Type 2 Diabetes

- 90 - 95% of people with diabetes
- Can be prevented or delayed

Gestational Diabetes

- 2 - 10% of pregnancies in U.S.
- Usually goes away after the birth

What's the Problem with Being Too Sweet?

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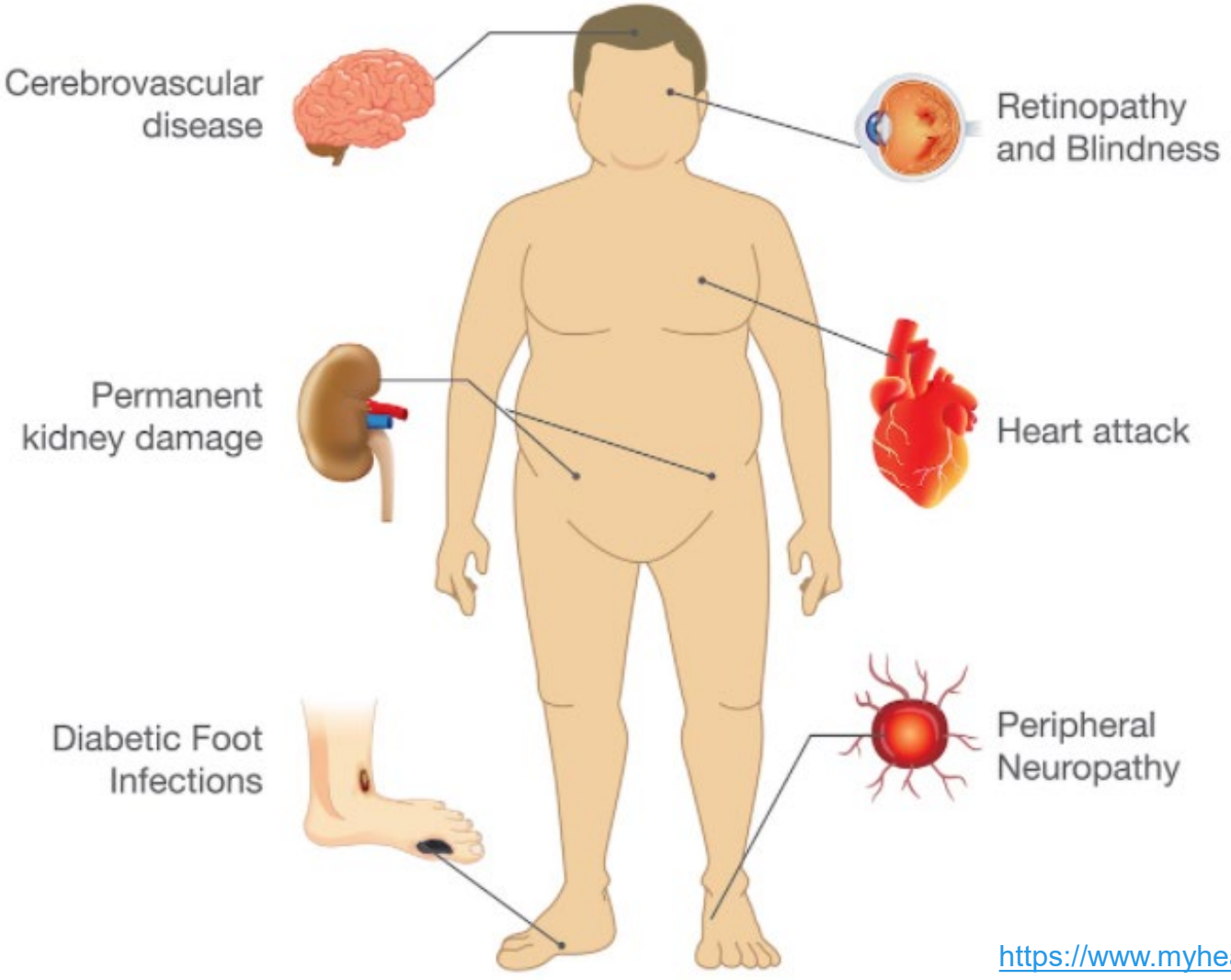

https://www.myhealthexplained.com

Symptoms of Diabetes Mellitus

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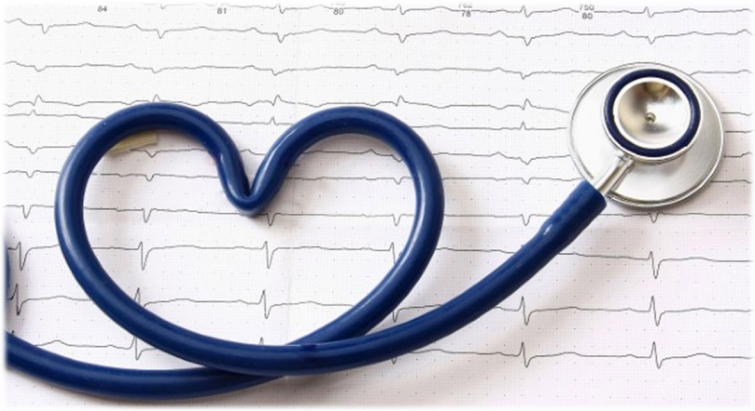
- Polydipsia - excessive thirst
- Polyuria - frequent urination
- Nocturia - night time urination
- Weight loss - body unable to metabolize and store carbohydrates
- Blurred vision - due to swelling of the eye

Diagnosis and Monitoring of Diabetes Mellitus

What HbA1c Measures

- Percentage of glycated hemoglobin
- Reflects average levels of blood glucose over the previous two to three months



How the HbA1c Used

- Diagnosis of diabetes
- Monitor the efficacy of treatment
- Monitor chronic glycemic control to minimize complications

Diagnosing Diabetes Mellitus Using Hemoglobin A1c Test

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What do HbA1c numbers mean?

	HbA1c	eAG estimated Average Glucose
Normal	below 5.7%	114
Prediabetes	Between 5.7 and 6.4%	117 - 137
Diabetes	6.5% or higher	140

7	154
8	183
9	212
10	240
11	269
12	298

HbA1c Good Control (<8.0%) Rates by Region and Ethnicity

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NE	NW	SE	SW
59.90	62.78	62.70	63.60

NW

Asian/Pacific Islander	71.43
Black	71.80
Hispanic	68.54
Native American	46.83
Other	58.82
Unknown	62.94
White	63.45

NE

Asian/Pacific Islander	65.39
Black	46.88
Hispanic	62.22
Korean	40.00
Laotian	70.27
Native American	44.44
Other	64.10
Somoan	100.00
Unknown	54.48
Vietnamese	75.00
White	60.64

75th%	61.63
50th%	56.81
25th%	48.10
below 25th%	

SW

Asain Indian	75.41
Asian/Pacific Islander	68.75
Black	60.32
Filipino	62.50
Hispanic	64.58
Native American	50.00
Other	65.54
Unknown	61.22
Vietnamese	77.55
White	62.72

SE

Asain Indian	72.48
Asian/Pacific Islander	68.65
Black	58.14
Chinese	83.87
Filipino	78.28
Hispanic	62.70
Native American	40.00
Other	61.52
Unknown	57.57
Vietnamese	70.69
White	58.60

Disparities for American Indian/Alaska Native

Native Americans are **twice** as likely as whites to have diabetes.

In about **2 out of 3** Native Americans with kidney failure, diabetes is the cause.

Kidney failure from diabetes dropped by **54%** in Native Americans between 1996 and 2013.

Native American Diabetes Wellness Program

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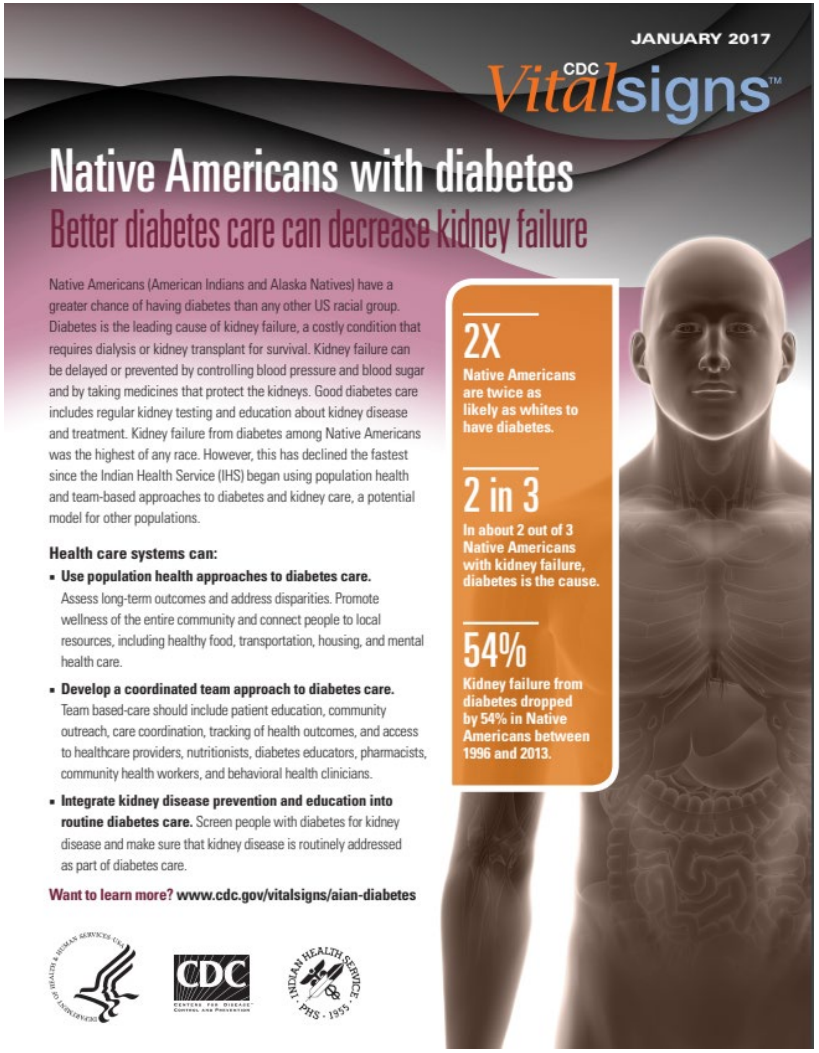


Resources for Native Americans (AIAN)

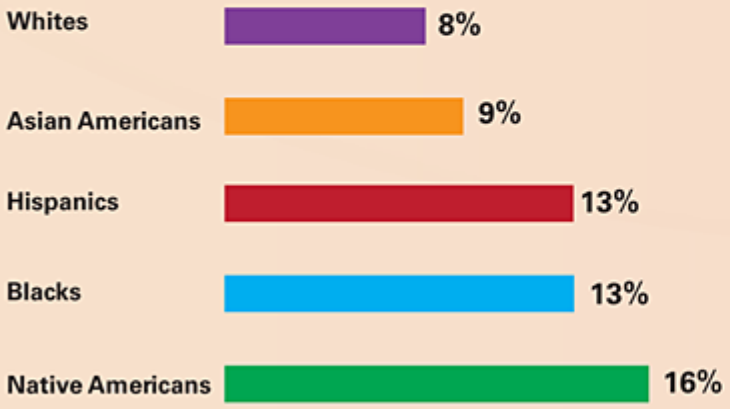
https://www.cdc.gov/diabetes/ndwp/traditional-foods/index.html

Disparities for American Indian/Alaska Native

CT

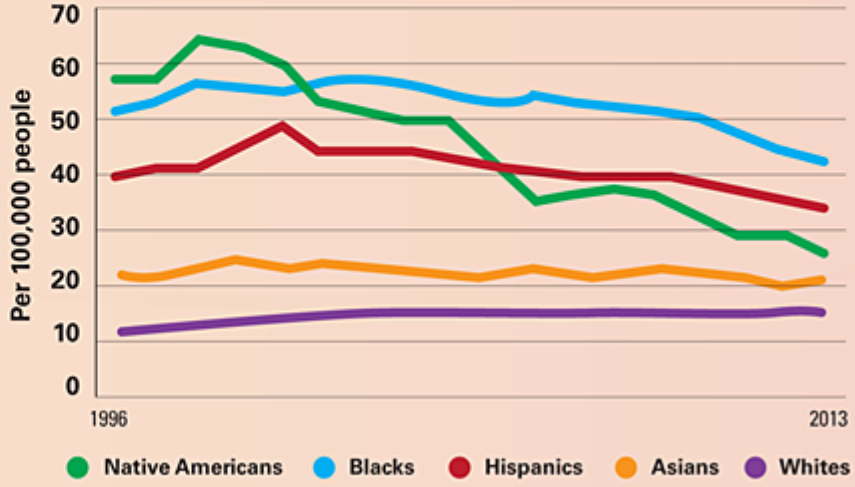
Team-based and population approaches reduce kidney failure from diabetes in Native Americans: can be a model for other groups.

Native American adults have more diabetes than any other race or ethnicity.



SOURCE: National Health Interview Survey and Indian Health Service, 2010-2012.

Kidney failure from diabetes in Native Americans has dropped more than any other race or ethnicity.



SOURCE: United States Renal Data System (USRDS), 1996-2013, adults 18 and older.

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PCP QIP Measure Spotlight
HbA1c Good Control (<8%)

		HbA1c Good Control (<8%)	Retinal Eye Exams
Sub-Region	County	PCP QIP 2022	PCP QIP 2022
NE	Lassen	66.22	47.77
	Modoc	60.22	56.99
	Shasta	66.69	53.85
	Siskiyou	60.93	49.46
	Trinity	68.00	28.85
NW	Del Norte	65.25	13.37
	Humboldt	65.66	24.92
SE	Napa	67.57	53.66
	Solano	65.49	48.15
	Yolo	66.01	29.72
SW	Lake	64.92	47.21
	Marin	62.76	39.09
	Mendocino	60.83	42.09
	Sonoma	70.05	52.09

HbA1c
75th% 61.63
50th% 56.81
25th% 48.10
below 25th%

HbA1c			
NE	NW	SE	SW
65.35	65.58	65.93	66.42

HbA1c

- 3 out of 14 counties at the 50th%
- All other counties at the 75th%

Retinal Eye Exam

- The NE leads the regions in this measure
- All counties have significant opportunities to incorporate this new measure into their workflows

Retinal Eye Exam
75th% 57.91
50th% 51.36
25th% 45.01
below 25th%

Retinal Eye Exam			
NE	NW	SE	SW
51.69	22.56	43.10	47.45

Goals of Diabetes Mellitus Treatment

Reducing Blood Sugar Levels

- Targeted HbA1c control:
  - Target 7 - 8% in general (ACP recommendation 2018)
  - Limiting wide variation in daily blood sugars
  - Lowering high blood sugars while avoiding low blood sugars

Reducing Co-Morbidities

- Blood pressure control
- Tobacco cessation
- Cholesterol screening and management
- Kidney protection and monitoring
- Foot care
- Limiting infection risks
- Weight management, increasing activity

Diabetic Retinopathy and Diabetic Neuropathy

Regular Retinopathy screening is recommended.

- Most frequent cause of new cases of blindness among adults aged 20 - 74 years in developed countries.
- Glaucoma, cataracts, and other disorders of the eye occur earlier and more frequently in people with diabetes.
- More likely with chronic hyperglycemia, nephropathy, hypertension, and dyslipidemia.

Diabetic Retinopathy Clinical Guidelines

- Type 1 diabetes – annual screenings beginning five years after diagnosis onset.
- Type 2 diabetes – annual screenings beginning immediately.
- PCP QIP spec summary here (annual check).
- Patient education about the association between good glucose control and high blood pressure and reduction in the risk of retinopathy or progression.
- The preferred screening method is digital retinal photography.

Foot Care and Peripheral Neuropathy Screening

- Peripheral Neuropathy is a common complication of T1DM and T2DM.
- Foot exams are recommended at every visit to examine for skin changes, ulcers deformities.
- Yearly neuropathy screening for all individuals with T2DM and for individual with T1DM for ≥ 5 years -- monofilament testing preferred.
- Orthotic Shoes for people with DM can limit complications due to neuropathy.
  - PHC covers orthotics shoes for member with diabetes and any of the following callouses, ulcers , amputation or neuropathy (monofilament test), or peripheral vascular disease.
  - Medical providers write a prescription to be taken to a contracted vendor.

Modes of Treatment: Nutrition Education and Counselling

Provided by Registered Dietician (RD) or Certified Diabetes Educators (CDE):

- Nutrition and activity education improves blood sugar control
- Engages patients in self management

PHC Covered Benefit for Adult and Pediatric Patients:

- Individual or group visits
- No RAF required
- May not be eligible for enhanced or “PPS” rate
- Great telehealth care options

WebMD.com

Optimizing Blood Glucose Control

Glucose monitoring is a tool to achieve A1C goals while avoiding low blood sugars

Type 1 Diabetes Mellitus

- Frequent Blood Glucose testing is necessary to achieve A1C control without hypoglycemia – at least 4 times per day.
  - Prior to meals and bedtime
  - Sometime after meals, before exercise and sometimes at night

Type 2 Diabetes

- The benefit and frequency of Blood Glucose testing is based on the type of medications being used and patients risk for low blood sugar.
  - Orals/ injectable that do not cause low BG – not routinely necessary
  - Orals/ Injectable/ Insulin that can cause hypoglycemia varies based on medications and individual needs usually less often than is needed for Type 1 DM

Continuous Glucose Monitors

- Demonstrated benefit in Type 1 Diabetes for achieving A1 control with limiting hypoglycemic episodes for motivated and adherent patients.

- May benefit a subset of patients with Type 2 Diabetes who have established frequent hypoglycemia, nocturnal hypoglycemia, hypoglycemia unawareness in motivated and adherent patients.

Glucometers as a Tool for Blood Glucose Control

Blood Glucose Monitors

- They are a Medi-Cal benefit accessed through MediCalRx.
- No device has been proven superior; all are accurate (+/-10%).
- Should be approved by International Organization for Standardization or the Food and Drug Administration (FDA).

Continuous Glucose Monitors

- CGMs have a specific use based on medical necessity.
- Require management by clinician experienced in managing complex cases of DM (Endocrinologist, Diabetologist).
- May be covered by PHC requires a TAR for T1DM and T2DM on a case-by-case basis in which the medical necessity is met and supportive documentation is submitted.

Treatment Options for Managing Diabetes Mellitus

Management of diabetes includes:

- Healthy eating
- Regular exercise
- Weight management
- Blood sugar monitoring
- Diabetes medication or insulin therapy

Choice of Medication

Based on individual factors:

- Baseline A1C level
- Age
- Comorbidities
  - Atherosclerotic cardiovascular disease
  - Kidney disease
- Risk for low blood sugar
- Need for weight loss
- Glucose-lowering efficacy of medication

Medications to Treat Diabetes Oral

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Drug Class	Generic Name	Trade Name	~ A1C lowering
Biguanide	Metformin	Glucophage	1.0 to 2.0
Sulfonylurea	Glipizide Glimepiride	Glucotrol Amaryl	1.0 to 2.0
Meglitinide	Repaglinide Nateglinide	Prandin Starlix	0.5 to 1.5
Thiazolidinedione	Pioglitazone Rosiglitazone	Actos Avandia	0.5 to 1.4
α-Glucosidase Inhibitor	Acarbose Miglitol	Precose Glyset	0.5 to 0.8
DPP- 4 Inhibitor	Sitagliptin Linagliptin	Januvia Tradjenta	0.5 to 0.8
SGLT-2 Inhibitor	Empagliflozin Canagliflozin Dapagliflozin	Jardiance Invokana Farxiga	0.5 to 1.0

Medications to Treat Diabetes: Oral/Injectable

LR

Drug Class	Generic Name	Trade Name	~ A1C lowering
GLP-1 Agonist injectable	Dulaglutide Liraglutide Semaglutide	Trulicity Victoza Ozempic	1.0 to 1.5
GLP-1 Agonist oral	Semaglutide	Rybelsus	1.0 to 1.3
GLP-1/GIP Agonist injectable	Tirzepatide	Mounjaro	2.0 to 2.3
GLP-1 Agonist/Insulin combination	Insulin Glargine/Lixisenatide Insulin Degludec/Liraglutide	Soliqua Xultophy	1.9 +
Amylin Analog	Pramlintide	Symlin	0.5 to 1.0

Medications to Treat Diabetes: Insulin Products

LR

Drug Class	Generic Name	Trade Name	~ A1C lowering
Rapid-acting Bolus Insulin	Insulin lispro Insulin Aspart	Admelog, Humalog Novolog	1.5 to 3.5
Short-acting Bolus Insulin	Insulin Regular	Novolin R, Humulin R U-100	
Intermediate Basal Insulin/Mixtures	Insulin NPH	Novolin N, Humulin N Novolin 70/30 Novolog 70/30 Humalog 50/50	
Long-acting Basal Insulin	Insulin Glargine U-100 Insulin Detemir U-100	Lantus, Semglee Levemir	
Rapid-acting Inhaled Insulin	Insulin Regular	Afrezza	

Monitoring Effectiveness of Treatment

Is the A1C at goal?

- Re-evaluate A1C three months after starting a new medication or making a change to the regimen

- A1C is not at target
  - Re-evaluate medication regimen
  - Assess how the patient is taking their medications

Prescription Claims Analysis

- Share prescription fill records that the prescriber may not have access to

- Provide actionable data analysis:
  - Identify discrepancies between EMR records vs what is actually filled at the pharmacy.
  - Identify gaps in medication adherence (90-days supply or use of single-pill combo).
  - Identify suboptimal therapy (dose increase or addition of another therapeutic class) to help patient reach treatment goal.

Prescription Claims Analysis

LR

Example of Pivot table created from Pharmacy Claims Data for patients not at A1C goal (≥9.0%):

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Day Supply Total
Patient #1	90			90					90				270
Metformin	**90**												90
1000 MG	90												90
Glipizide				**90**					**90**				180
5 MG				90					90				180
Patient #2	30	30	30	30	30	30	30	30		30	30	30	330
Metformin	**30**	**30**	**30**	**30**	**30**	**30**	**30**	**30**		**30**	**30**	**30**	330
500 MG	30	30	30	30	30	30	30	30		30	30	30	330

Partnership's Quality Incentive Program

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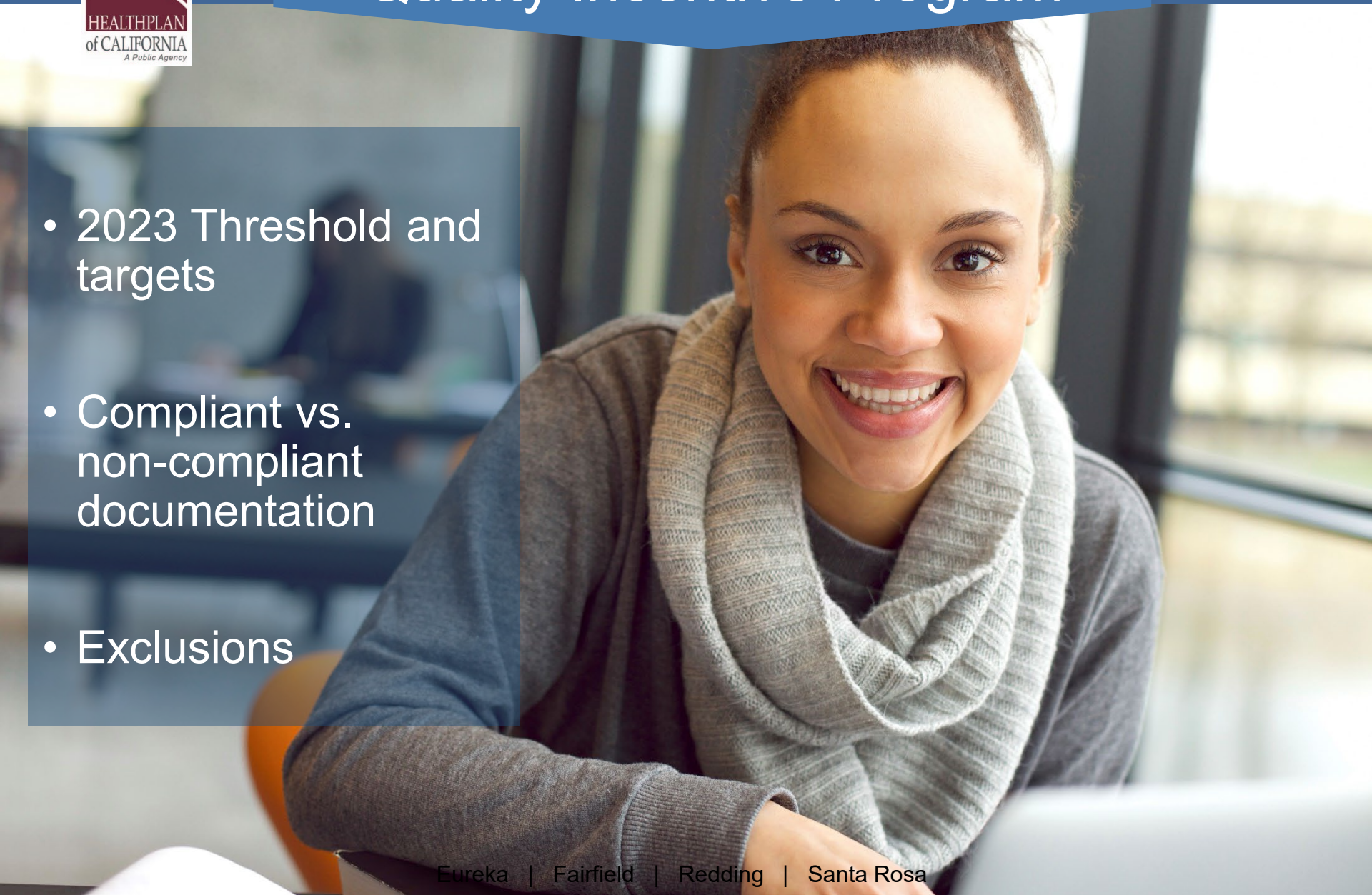

- 2023 Threshold and targets
- Compliant vs. non-compliant documentation
- Exclusions

Measure Specifications – HbA1c Good Control

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Measure Description:

- The percentage of members 18 - 75 years of age who had a diagnosis of Type 1 or Type 2 diabetes with evidence of HbA1c levels at or below 9.0% during the measurement year.

Denominator:

- The number of continuously enrolled Medi-Cal members 18 - 75 years of age as with diabetes identified as of 12/31/2023 (with DOB between 1/1/1948 and 12/31/2005).

Numerator:

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

Claims/Encounter Data

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Members who met any of the following criteria during the measurement year or the year prior (count services that occur over both years [January 1, 2022 - December 31, 2023]).

- At least two outpatient visits, observations visits, telephone visits, e-visits or virtual check-ins, ED visits, or non-acute inpatient encounters, on different dates of service with a diagnosis of diabetes.
- The visit types does not need to be the same for the two visits.
- At least one acute inpatient encounter with a diagnosis of diabetes.

Measure Specifications – Retinal Eye Exam

Measure Description:

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

Denominator:

- The number of continuously enrolled Medi-Cal members 18 - 75 years of age as with diabetes identified as of 12/31/2023 (with DOB between 1/1/1948 and 12/31/2005).

Numerator:

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

QIP Documentation

Compliant Documentation of HbA1C:

- The number of diabetics in the eligible population with evidence of the most recent measurement HbA1c ≤ 9.0%.
  - A distinct numeric result (7.8%, 7.0%) is required for numerator compliance.

Noncompliant Documentation of HbA1c:

- The most recent HbA1c level in the measurement year is > 9.0% or is missing, or if an HbA1c test was not performed during the measurement year.
  - Ranges and thresholds (8 – 9%, <9 or >7) ***do not meet criteria*** for these indicators.

Exclusions for HbA1c

- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year with a current lab value (less than 12 months old) indicating no diabetes and more recent than the last diabetic triggering event visible in eReports.
- Members receiving palliative care during the measurement year.

Source: 2023 PCP QIP Measure Specifications Website Final Version

Exclusions for Retinal Eye Exams

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

- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.
- Have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports).

Source: 2023 PCP QIP Measure Specifications Website Final Version

eReports and PQD Notes

- All QIP diabetes care measures will have the same denominator because they share the same eligible population.

Best and Promising Practices

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- Promising practices to increase rates
- Best practice sharing from a high performing organization

Voices from the Field

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NORTHEASTERN RURAL HEALTH CLINICS

DIABETES HBA1C CONTROL

- **Sadie Albonico, MSHI, RHIA, CCS, CHC,**
- Chief Quality Officer
- salbonico@northeasternhealth.org

BACKGROUND

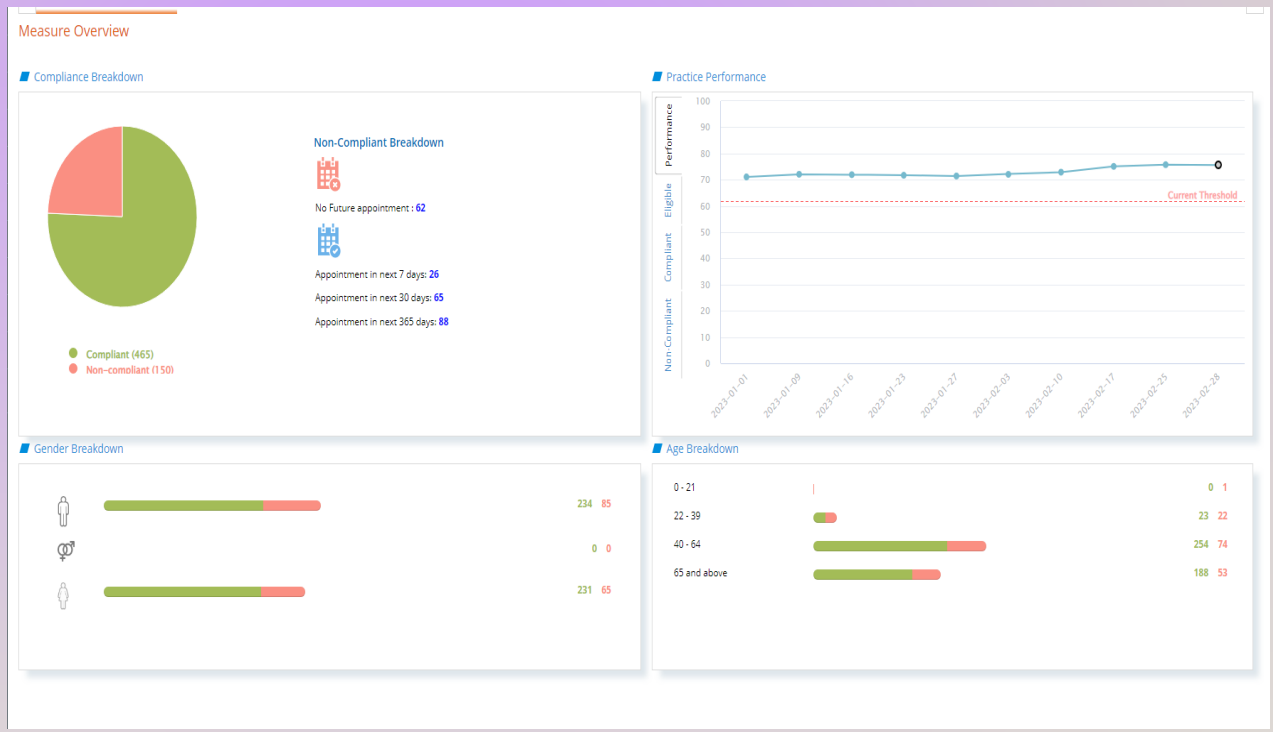
- Location:
  Susanville, CA
- Total HC Population:
  44,767 unique UDS visits/ in last 12 mo
- # of facilities
  2 – Susanville and Westwood, CA
- Providers and staff
  12 Providers, 3 Dentists, 91 Staff Members

DIABETES: DEEP DIVE

- 614 active patients diagnosed with diabetes
- 465/614 patient compliance resulting in 75% rate

Compliance breakdown

Patient Performance



Gender breakdown

Age breakdown

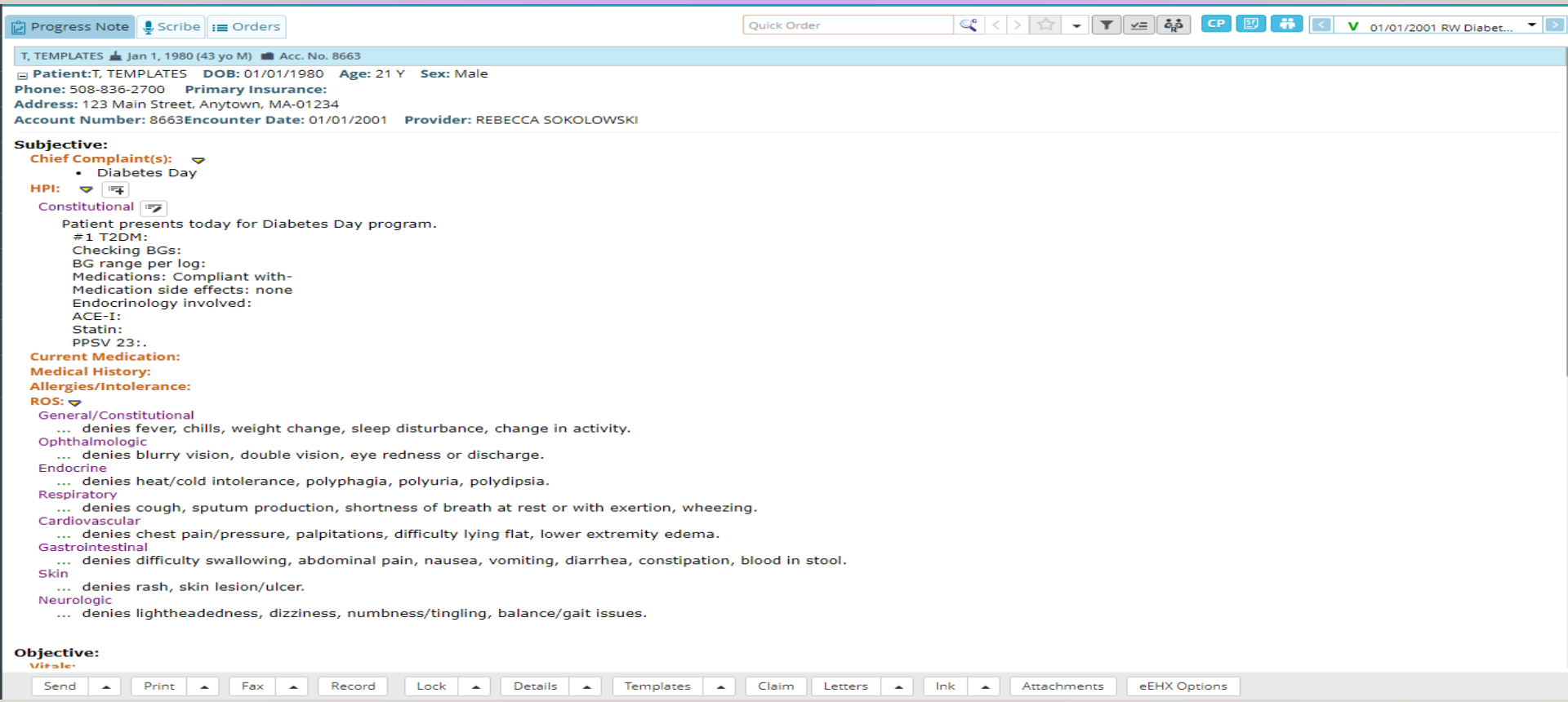
DIABETES MANAGEMENT STRATEGY

- Huddle
- Structured templates and order sets
- In Office HbA1C's performed on all Diabetic

  diabetic patients during rooming
- In Office HbA1C's performed on

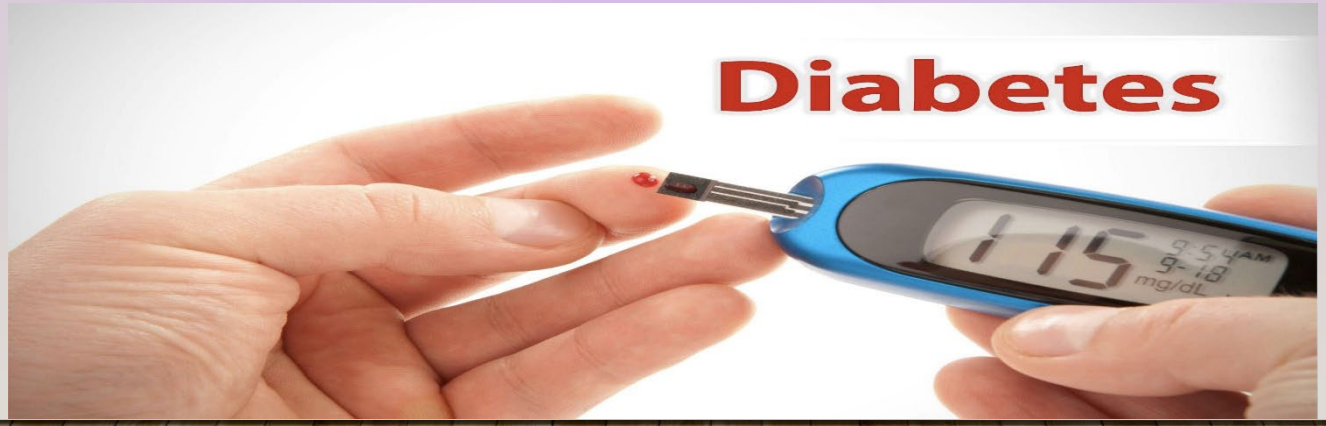
  diabetic patients in urgent care

TEMPLATES


Progress Note
Scribe
Orders
Quick Order
CP
V 01/01/2001 RW Diabet...
T, TEMPLATES Jan 1, 1980 (43 yo M) Acc. No. 8663
Patient:T, TEMPLATES DOB: 01/01/1980 Age: 21 Y Sex: Male
Phone: 508-836-2700 Primary Insurance:
Address: 123 Main Street, Anytown, MA-01234
Account Number: 8663Encounter Date: 01/01/2001 Provider: REBECCA SOKOLOWSKI
Subjective:
Chief Complaint(s):
Diabetes Day
HPI:
Constitutional
Patient presents today for Diabetes Day program.
#1 T2DM:
Checking BGs:
BG range per log:
Medications: Compliant with-
Medication side effects: none
Endocrinology involved:
ACE-I:
Statin:
PPSV 23:.
Current Medication:
Medical History:
Allergies/Intolerance:
ROS:
General/Constitutional
... denies fever, chills, weight change, sleep disturbance, change in activity.
Ophthalmologic
... denies blurry vision, double vision, eye redness or discharge.
Endocrine
... denies heat/cold intolerance, polyphagia, polyuria, polydipsia.
Respiratory
... denies cough, sputum production, shortness of breath at rest or with exertion, wheezing.
Cardiovascular
... denies chest pain/pressure, palpitations, difficulty lying flat, lower extremity edema.
Gastrointestinal
... denies difficulty swallowing, abdominal pain, nausea, vomiting, diarrhea, constipation, blood in stool.
Skin
... denies rash, skin lesion/ulcer.
Neurologic
... denies lightheadedness, dizziness, numbness/tingling, balance/gait issues.
Objective:
Vitals:
Send
Print
Fax
Record
Lock
Details
Templates
Claim
Letters
Ink
Attachments
eEHX Options

BEST PRACTICES

- HbA1C's completed in house for all diabetic patients
- Care Team Huddles to identify patients who are diabetic
- HbA1C Orders pre-placed on patient's chart
- Diabetic patients seen a minimum of twice a year to properly manage



OUTREACH EVENTS

- Community Diabetes days

- Messenger Campaigns for diabetic patients

RECOMMENDATIONS FOR STARTING NEW WORKFLOWS

- Implement Care Team Huddles to identify diabetic patients
- Create templates/order sets within the EMR
- Implement chart scrubs 72 hours in advance
- Pull over template to progress notes prior to patient appointment
- Perform In House HbA1C's on every diabetic patient
- Create a team to develop Community Diabetes days

RETINAL EYE EXAMS

- System
- Staffing
- Appointment volume
- Challenges

QUESTIONS?

Best and Promising Practices

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HbA1c Measurement Workflows

- On-site HbA1c testing, possibly performed while rooming patients
- Prompts for HbA1c at huddle
- Perform/order testing regardless of the reason for the office visit
- Leverage telehealth; utilize team members at the top of their scope of practice

Practice Workflows

- Cross departmental coordination of care
  - Incorporate care team members using standing orders for nursing, pharmacists, and registered dieticians
- Ensure patients are informed of results and next step(s)
- Submit claims and encounter data within 90 days of service
- Refer/enroll with Chronic Case Management

Best and Promising Practices

Diabetic Eye Exams

- If your practice offers vision services, schedule the patient's diabetic retinopathy exam visit during check-out, or as part of the rooming process.
- Follow up on referral processes and ensure completion of visit and results received.
- Check periodically on local practices who accept Medi-cal.

Best and Promising Practices

KR

Outreach

- Designate a team member to contact patients due for testing (phone call, post card, letter signed by provider, text).
- Call patients within a week to reschedule missed in-house blood draws.

Patient Education

- Reinforce medication use and physical activity.
- Refer to nutrition education, in-house, or via telehealth.
- Use all visits to increase health literacy.
- Ensure information is person-centered.
- Reinforce the importance of self-testing and self-management.

Best and Promising Practices

KR

Equity Approaches

- Identify possible barriers by specific communities (race, ethnicity, location by zip code, and preferred language)
- Ensure member information is consistent, welcoming, plain and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Identify and address barriers to care (transportation, language, and cultural beliefs). Partner with established community agencies such as schools, community centers, and faith-based organizations.

Questions

Evaluation

Please complete your evaluation.
Your feedback is important to us!

Contact Us

Regional Medical Director:

Dr. Colleen Townsend
ctownsend@partnershiphp.org

Medication Questions:

PHC Pharmacy Call Center:
707-863-4414

MediCalRx Customer Service Center: 800-977-2273

- **Academic Detailing:**
  RxConsult@partnershiphp.org

QI/Performance Team:

ImprovementAcademy@partnershiphp.org

Resources

- Upcoming Trainings and Events
- PHC Formulary
- Diabetes Education Resources
- A Quick Guide to Starting QI Projects
- Summary of 2023 QIP
- Health Equity Resources

Upcoming Trainings

Accelerated Learning Webinar Series

Target Audience: Clinicians, practice managers, quality improvement team, and staff who are responsible for participating and leading quality improvement efforts within their organization.

The Accelerated Learning Series offers Quality Improvement teams the opportunity to take the next step towards improving quality service and clinical outcomes around specific measures of care. These learning sessions will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures with a focus on direct application on best practices with examples from quality improvement teams who are doing the work.

Sessions will be offered during the lunch hour and will be approximately 60-90 minutes in length. CME/CEs will be offered for live attendance.

Planned sessions include:
- 03/29/23 - Asthma Medication Ratio
- 04/25/23 - Early Cancer Detection: Cervical, Colorectal, Breast Cancer Screening

Register: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx
Contact: improvementacademy@partnershiphp.org

Quality Improvement Trainings

On-Demand Courses

http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

- Accelerated Learning
- PCP QIP High Performers - How'd They Do That?
- Project Management 101
- Tools for Prioritizing Quality Measures
- Understanding the Benefits Delivery System

Resources

Diabetic Retinopathy Screening
http://www.partnershiphp.org/Providers/Quality/Pages/DiabeticRetinopathy.aspx

Northwest Regional Telehealth Resource Center, *Quick Start Guide to Telehealth During the Current Public Health Emergency March 2020* https://nrtrc.org

California Telehealth Resource Center
http://www.caltrc.org/knowledge-center/best-practices/sample-forms

California Primary Care Association
www.CPCA.org

Center for Care Innovations
https://www.careinnovations.org/wp-content/uploads/Sample-Remote-Visit-Workflow.pdf

Medi-Cal Formulary

https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf

Medications to Treat Diabetes: Insulin Products

Drug Class	Medication	Strengths/Dosages	Medi-Cal Formulary
Biguanides	Metformin	500mg, 850mg, 1000mg	Covered
	Metformin ER	500mg, 750mg, 1000mg	Covered
	Metformin HCl Oral Solution	100mg/mL	Covered
Sulfonylureas	Chlorpropamide	100mg, 250mg	Covered
	Glimepiride	1mg, 2mg, 4mg	Covered
	Glipizide	5mg, 10mg	Covered
	Glipizide ER	2.5mg, 5mg, 10mg	Covered
	Glipizide/Metformin	5mg/500mg	Covered
	Glyburide	1.25mg, 2.5mg, 5mg	Covered
	Glyburide Micronized Tablet	1.5mg	Covered
	Glyburide/Metformin	1.25mg/250mg, 2.5mg/500mg, 5mg/500mg	Covered
Thiazolidinediones (TZDs)	Pioglitazone	15mg, 30mg, 45mg	Covered
	Pioglitazone/Glimepiride	30mg/2mg, 30mg/4mg	Covered
	Pioglitazone/Metformin	15mg/500mg, 15mg/850mg	Covered
	Rosiglitazone	2mg, 4mg, 8mg	Covered
Alpha-Glucosidase Inhibitors	Acarbose	25mg, 50mg, 100mg	Covered
	Miglitol	25mg, 50mg, 100mg	Covered
Meglitinides	Repaglinide	0.5mg, 1mg, 2 mg	Covered
	Nateglinide	60mg, 120mg	Covered
DPP-4 Inhibitors	Alogliptin	6.25mg, 12.5mg, 25mg	Covered
	Alogliptin/Metformin	12.5mg/500mg, 12.5mg/1000mg	Covered
	Alogliptin/Pioglitazone	12.5mg/15mg, 12.5mg/30mg, 12.5mg/45mg, 25mg/15mg, 25mg/30mg, 25mg/45mg	Covered
	Januvia (Sitagliptin)	25mg, 50mg, 100mg	Covered
	Onglyza (Saxagliptin)	2.5mg, 5mg	Covered
	Tradjenta (Linagliptin)	5mg	Covered
	Jentadueto/XR (linagliptin/metformin)	2.5mg/500mg, 2.5mg/850mg, 2.5mg/1000mg	Covered
	Kombiglyze/XR (saxagliptin/metformin)	5mg/500mg, 2.5mg/1000mg, 5mg/1000mg	Covered
	Janumet (sitagliptin/metformin)	50mg/500mg, 50mg/1000mg	Covered
	Janumet/XR (sitagliptin/metformin)	50mg/500mg, 50mg/1000mg, 100mg/1000mg	Covered
	Steglujan (ertugliflozin/sitagliptin)	5mg/100mg 15mg/100mg	Not Covered

Medications to Treat Diabetes: Insulin Products

SGLT-2 Inhibitors	Steglatro (ertugliflozin)	5mg, 15mg	Not Covered
	Segluromet (ertugliflozin/metformin)	2.5mg/1000mg, 2.5mg/500mg, 7.5mg/1000mg, 7.5mg/500mg,	Not Covered
	Farxiga (Dapagliflozin Propanediol)	5mg, 10mg	Covered
	Invokana (Canagliflozin)	100 mg, 300 mg	Not Covered
	Jardiance (Empagliflozin)	10mg, 25mg	Covered
	Glyxambi (empagliflozin/linagliptin)	10mg/5mg, 25mg/5mg	Covered
	Invokamet, Invokamet XR (canagliflozin/metformin)	50mg/1000mg, 50mg/500mg, 150mg/1000mg, 150mg/500mg,	Not Covered
	Synjardy (empagliflozin/metformin)	5mg/500mg, 5mg/1000mg, 12.5mg/500mg, 12.5mg/1000mg	Covered
	Synjardy XR	5mg/1000mg, 10mg1000mg, 12.5mg/1000mg, 25mg/1000mg	Covered
	Xigduo XR (dapagliflozin/metformin)	5mg/500mg, 5mg/1000mg, 10mg/500mg, 10mg/1000mg	Covered
	Qtern (dapagliflozin/saxagliptin)	5mg/5mg, 10mg/5mg	Not Covered
	Trijardy XR (empagliflozin/linagliptin/metformin)	5mg/2.5mg/1000mg, 10mg/5mg/1000mg, 12.5mg/2.5mg/1000mg, 25mg/5mg/1000mg	Covered
GLP-1 Agonists	Victoza (Liraglutide)	18mg/3mL pen	Covered
	Trulicity (Dulaglutide)	0.75mg/0.5mL, 1.5mg/0.5mL, 3mg/0.5mL, 4.5mg/0.5mL	Covered
	Adlyxin (Lixisenatide)	10 mcg, 20 mcg pen	Not Covered
	Bydureon (Exenatide Microspheres)	2mg pen	Covered
	Bydureon BCise (Exenatide ER)	2mg pen	Not Covered
	Byetta (Exenatide)	5mcg/mL 10mcg/mL	Covered
	Ozempic (Semaglutide) SC	0.25-0.5mg/1.5mL, 1mg/1.5mL, 1mg/3mL	Covered
	Rybelsus (Semaglutide) Oral	3mg, 7mg, 14mg	Covered
GLP-1 Agonist + Insulin Combos	Soliqua (Insulin Glargine/lixisenatide)	100 units/33 mcg	Not Covered
	Xultophy (Insulin Degludec/Liraglutide)	100 units/3.6 mg	Not Covered

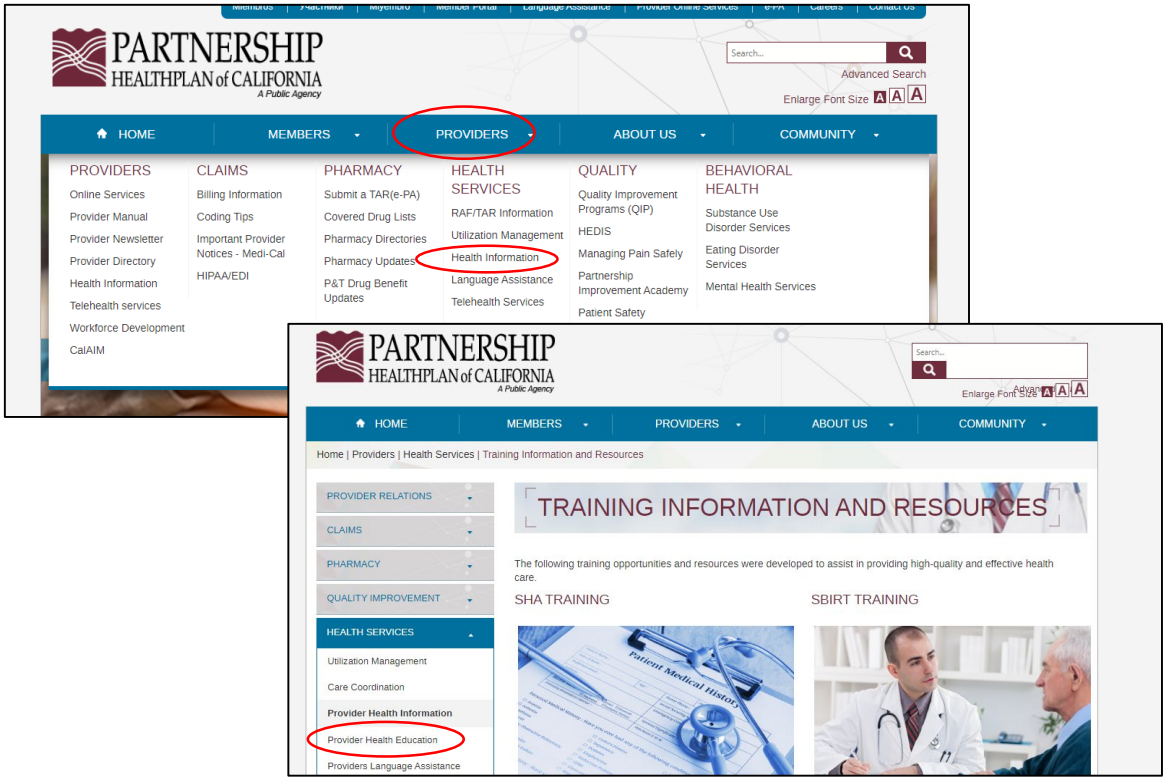
Medications to Treat Diabetes: Injectable

Rapid-Acting Bolus Insulins	Admelog (Insulin Lispro)	100 units/mL	Covered
	Lyumjev, Humalog generic (Insulin lispro)	100 units/mL, 200 units/mL	Covered
	Novolog generic (Insulin aspart U-100)	100 units/mL	Covered
	Apidra (Insulin Glulisine)	100 units/mL	Not Covered
	Fiasp (Insulin Aspart)	100 units/mL	Covered
	Afrezza (insulin inhalation)	4, 8, 12 units	Not Covered
Short-Acting Bolus Insulins	Novolin R (Insulin Regular)	100 units/mL	Covered
	Humulin R U-100 (Insulin Regular)	100 units/mL	Covered
	Humulin R U-500	500 units/mL	Covered
Intermediate Basal Insulins/Mixtures	Novolin N (Insulin NPH Human Isophane)	100 units/mL	Covered
	Humulin N (Insulin NPH Human Isophane)	100 units/mL	Covered
	Novolin 70/30 (Insulin NPH/ Regular Insulin Human)	100 units/mL	Covered
	Novolog Mix 70/30	100 units/mL	Covered
	Humulin 70/30 (Insulin NPH/ Regular Insulin Human)	100 units/mL	Covered
	Humalog 50/50	100 units/mL	Covered
	Humalog 75/25	100 units/mL	Covered
Long-Acting Basal Insulins	Basaglar, Semglee (Insulin Glargine)	100 units/mL	Covered
	Lantus (Insulin Glargine U-100)	100 units/mL	Covered
	Levemir (Insulin Determir U-100)	100 units/mL	Covered
	Toujeo (Insulin Glargine U-300)	300 units/mL	Not Covered
	Tresiba (Insulin Degludec U-100, U-200)	100 units/mL, 200 units/mL	Covered
Amylin Analog	Symlin (Pramlintide Acetate)	60 pen injector, 1.5mL 120 pen injector, 2.7mL	Covered
GLP-1/GIP Agonist	Mounjaro (tirzepatide)	2.5mg, 5mg, 7.5mg, 10mg, 12.5mg, 15mgper 0.5ml pen injector	Not Covered

Please refer to the Medi-Cal formulary for up-to-date drug coverage: https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf

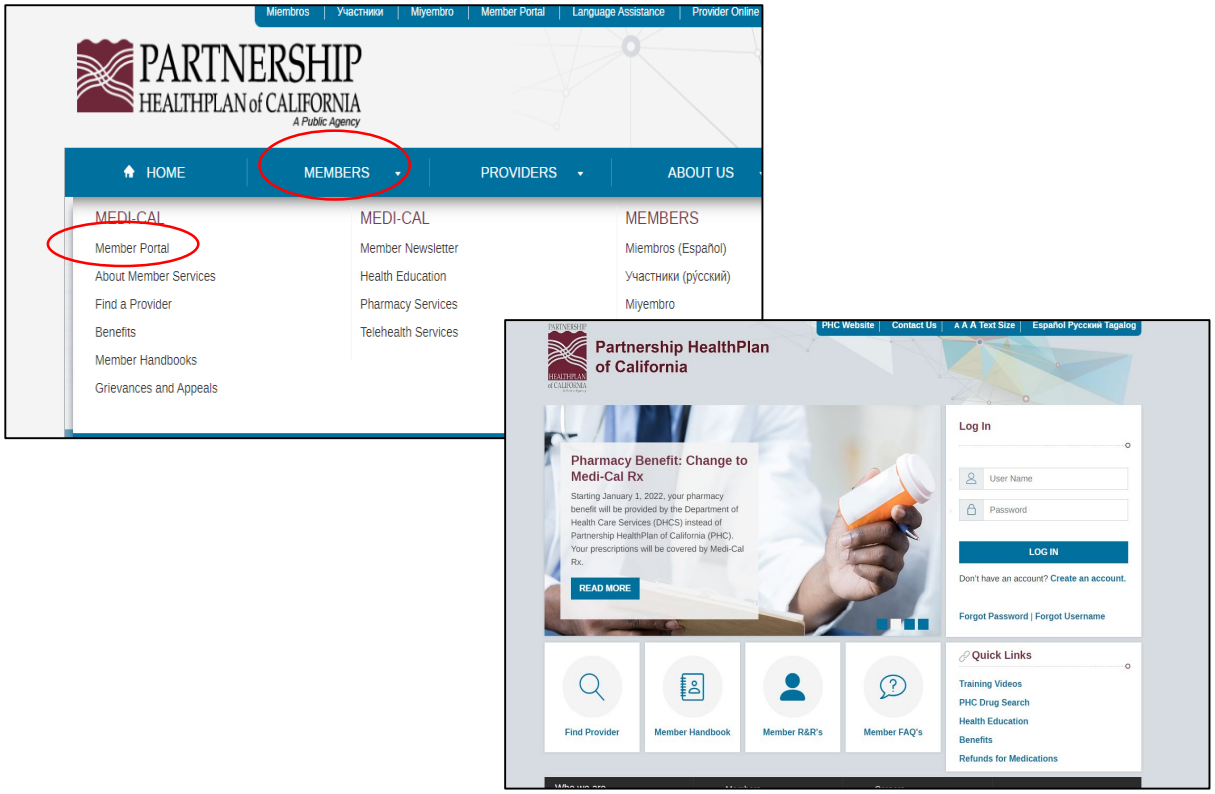
Health Education Resources

- Provider health education materials are accessible on PHC's website partnershiphp.org.



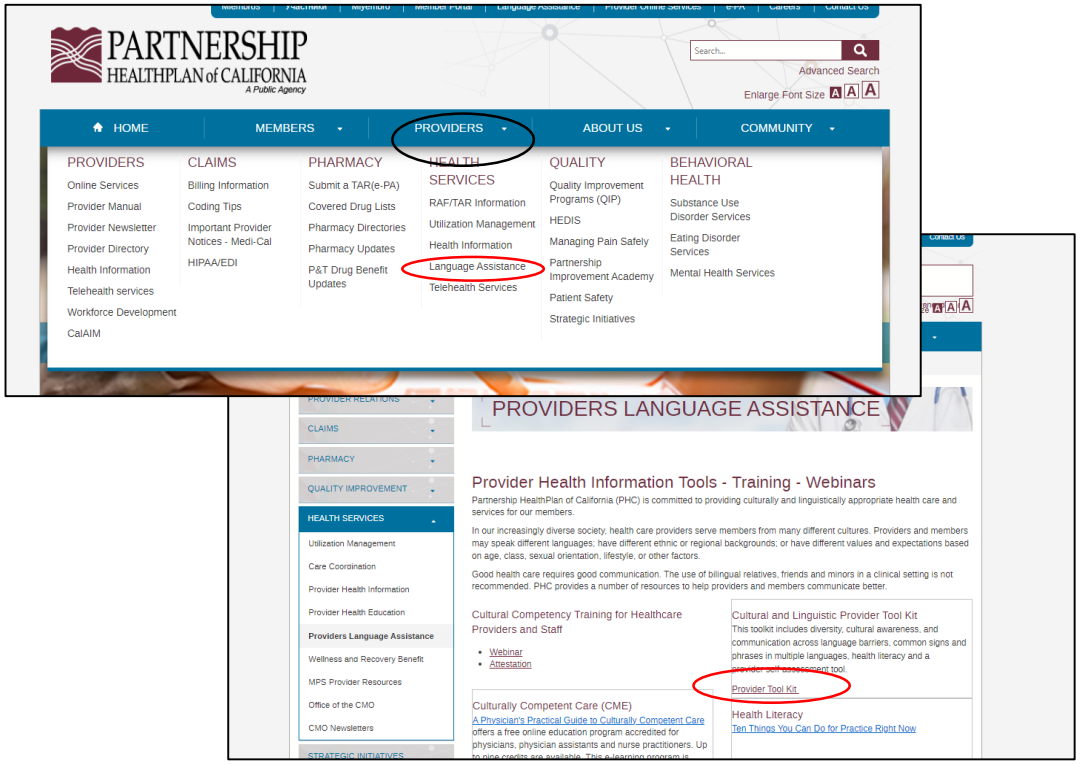
Healthy Living Tool

- Members can access the healthy living tool through the member portal.
- Members can call Population Health at (855) 798-8764 if they need help.



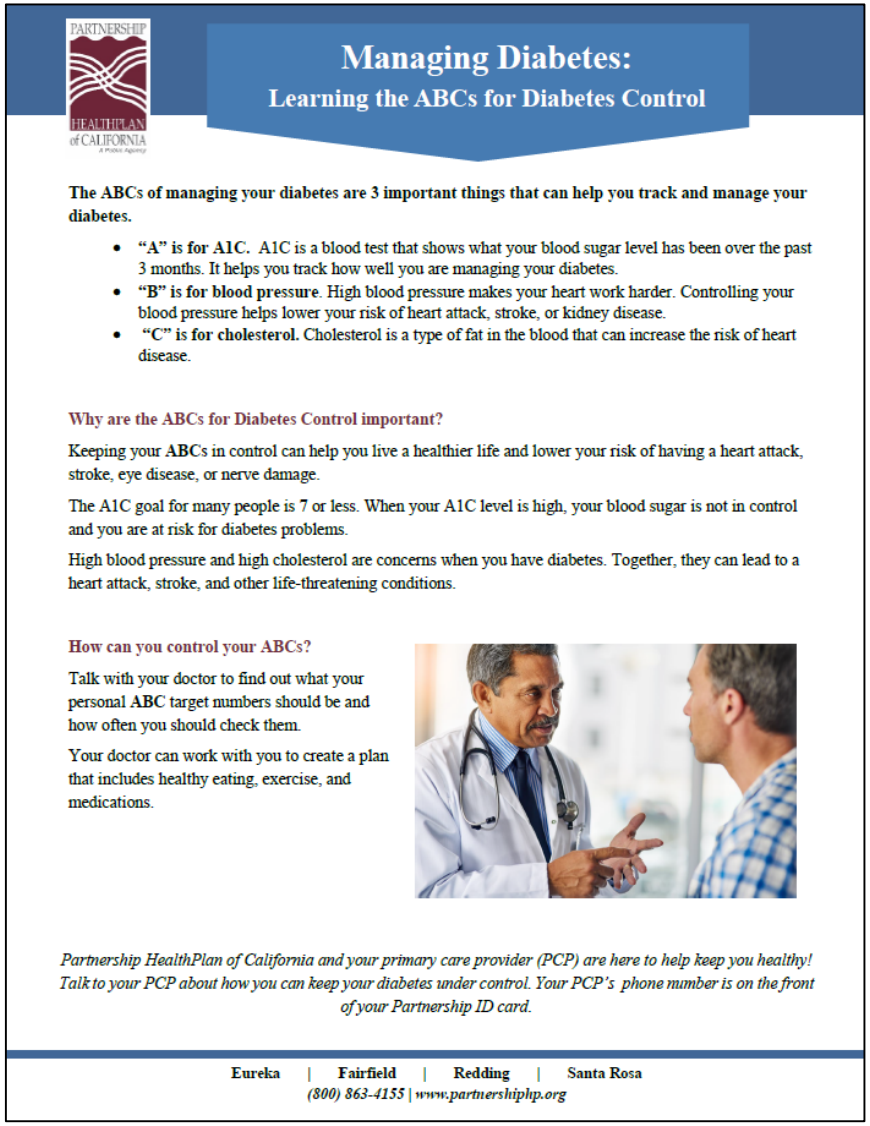
Provider Language Assistance

- Provider language assistance materials are also accessible on PHC's website, partnershiphp.org.



PHC Member Education Materials

Provider diabetes resources and materials can be found here: http://phcwebsite/Providers/HealthServices/Pages/Health%20Education/Diabetes.aspx



Managing Diabetes:
Learning the ABCs for Diabetes Control

The ABCs of managing your diabetes are 3 important things that can help you track and manage your diabetes.

- **"A" is for A1C.** A1C is a blood test that shows what your blood sugar level has been over the past 3 months. It helps you track how well you are managing your diabetes.
- **"B" is for blood pressure**. High blood pressure makes your heart work harder. Controlling your blood pressure helps lower your risk of heart attack, stroke, or kidney disease.
- **"C" is for cholesterol.** Cholesterol is a type of fat in the blood that can increase the risk of heart disease.

Why are the ABCs for Diabetes Control important?

Keeping your **ABCs** in control can help you live a healthier life and lower your risk of having a heart attack, stroke, eye disease, or nerve damage.

The A1C goal for many people is 7 or less. When your A1C level is high, your blood sugar is not in control and you are at risk for diabetes problems.

High blood pressure and high cholesterol are concerns when you have diabetes. Together, they can lead to a heart attack, stroke, and other life-threatening conditions.

How can you control your ABCs?

Talk with your doctor to find out what your personal **ABC** target numbers should be and how often you should check them.

Your doctor can work with you to create a plan that includes healthy eating, exercise, and medications.

Partnership HealthPlan of California and your primary care provider (PCP) are here to help keep you healthy! Talk to your PCP about how you can keep your diabetes under control. Your PCP's phone number is on the front of your Partnership ID card.

Eureka | Fairfield | Redding | Santa Rosa
(800) 863-4155 | www.partnershiphp.org

PHC Member Education Materials

Managing Diabetes: Diet and Exercise

Eating a healthy diet and getting regular exercise can help you be healthy if you have diabetes.

Diet

Set a routine. Eating meals at the same time each day may help manage your blood sugar. Eat the same portion size at each meal. Using a measuring cup can help. Try not to skip meals so you don't over eat at the next meal.

A dietitian can help you plan a healthy diet. Ask your doctor to connect you to one.

Choose Healthy Foods:

Eat more:	Eat less:
• Colorful vegetables (broccoli, green beans, spinach, tomatoes, carrots, eggplants) • Whole grains (brown rice, whole-wheat bread, whole grain tortillas, whole grain pasta, oatmeal) • Fruits (apples, pears, blueberries, strawberries, oranges) • Beans, lentils, nuts	• Sugary drinks (soda, sweet tea, juice) • Processed foods (white bread, white rice, French fries, chips, frozen dinners) • Sweets (cookies, candy, cake, ice cream) • High-fat foods (bacon, sausage, butter, full-fat cheese) • Starchy vegetables (potatoes, corn, peas)

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Managing Diabetes: Diet and Exercise

Exercise

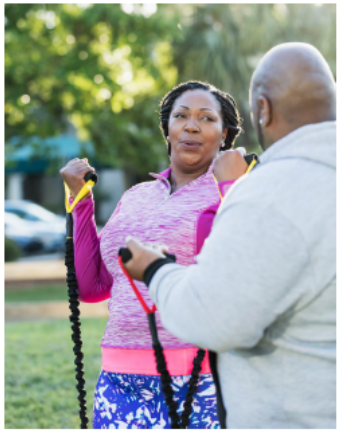
Ask your doctor what exercises are safe for you.

Try to exercise for at least 30 minutes a day, most days of the week.

Start with small steps. If you have not exercised in a while, start with 5 to 10 minutes at a time. Slowly increase the time and the kind of exercise you do. Light walking is a good way to start.

Find an activity you enjoy. Walking, dancing, doing housework, bicycling, or playing sports are activities with moderate intensity.

Drink plenty of water during exercise to avoid getting overly thirsty.



Check your blood sugar before and after you exercise. This is very important if you take insulin. Keep a healthy snack nearby during exercise in case your blood sugar level drops too low, and you get shaky, dizzy, or weak.

Partnership HealthPlan of California and your primary care provider (PCP) are here to help keep you healthy! Talk to your PCP about how you can keep your diabetes under control. Your PCP's phone number is on the front of your Partnership ID card.

Member education materials are available in English, Spanish, Tagalog, Russian and in large print at http://www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Diabetes.aspx

Diabetes Management Resources

The DSMES Toolkit is a comprehensive resource for achieving success in Diabetes Self-Management Education and Support (DSMES). Available at https://www.cdc.gov/diabetes/dsmes-toolkit/

Toolkits for Community-based Organizations

- Road to Health Toolkit (English)
- Road to Health Toolkit (Spanish)
- Road to Health: Blaze Your Own Trail to Healthy Living
  - Culturally adapted to counsel and motivate American Indian people who are at risk for type 2 diabetes

https://www.cdc.gov/diabetes/library/factsheets.html

Fact Sheets

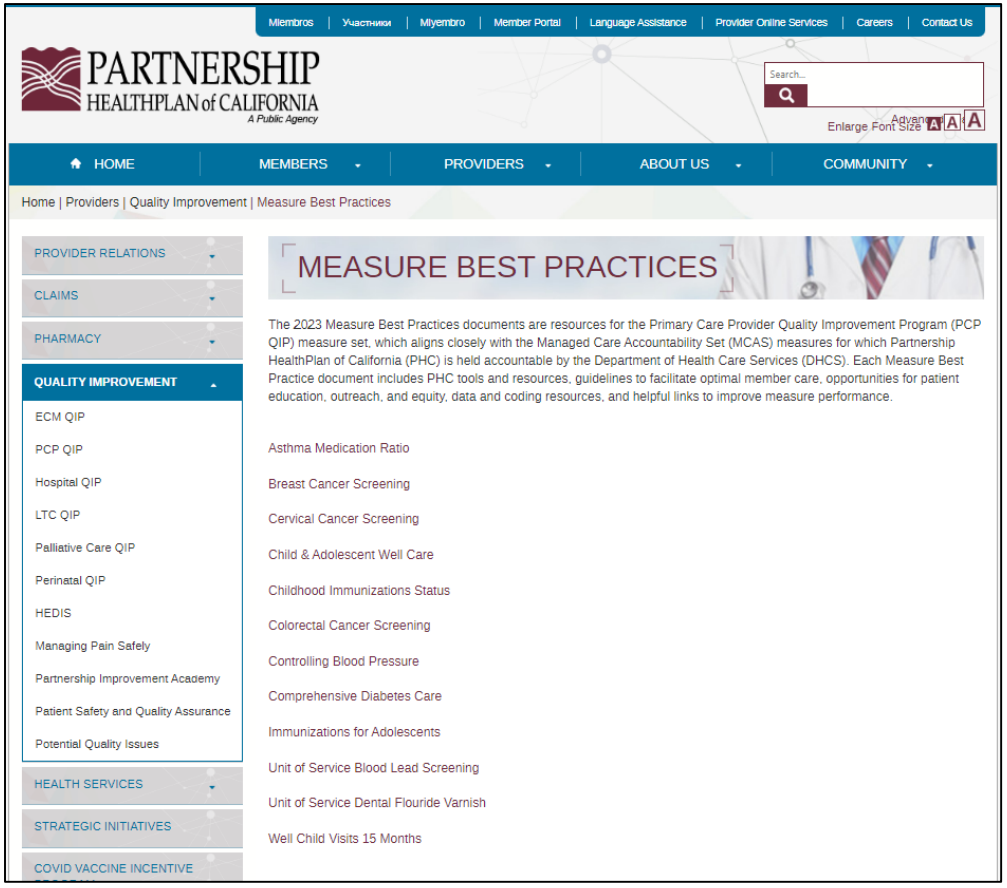
- Provide a variety of patient resources in English and Spanish
  - General information, prediabetes, complications, lifestyle, nutrition, and managing diabetes
  - https://www.cdc.gov/diabetes/library/factsheets.html

PHC QI Resources

A Quick Guide to Starting Your Quality Improvement Projects

http://www.partnershiphp.org/Providers/Quality/Pages/PIAcademyLandingPage.aspx

Measure Best Practices



- Measure Best Practices direct link: http://www.partnershiphp.org/Providers/Quality/Pages/Measure-Best-Practices.aspx

PHC QI Resources

- **DHCS Formulary Search Tool**
- https://medi-calrx.dhcs.ca.gov/provider/drug-lookup/
- **Quality Improvement Program email:** QIP@partnershiphp.org
- **2023 PCP QIP Webpage:** http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2022.aspx
- **Measure Highlights:** http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx
- **QI Monthly Newsletters:** http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPMonthlyNewsletter.aspx

PHC Resources

QI/Performance Team: ImprovementAcademy@partnershiphp.org

Quality Improvement Program: QIP@partnershiphp.org

2022 PCP QIP Webpage:
http://www.partnershiphp.org/Providers/Quality/Pages/PCP-QIP-2022.aspx

QI Monthly Newsletters:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

Measure Highlights:
http://www.partnershiphp.org/Providers/Quality/Pages/Quality-Measure-Highlights.aspx

eReports: https://qip.partnershiphp.org/

Resources

Diabetic Retinopathy Screening
http://www.partnershiphp.org/Providers/Quality/Pages/DiabeticRetinopathy.aspx

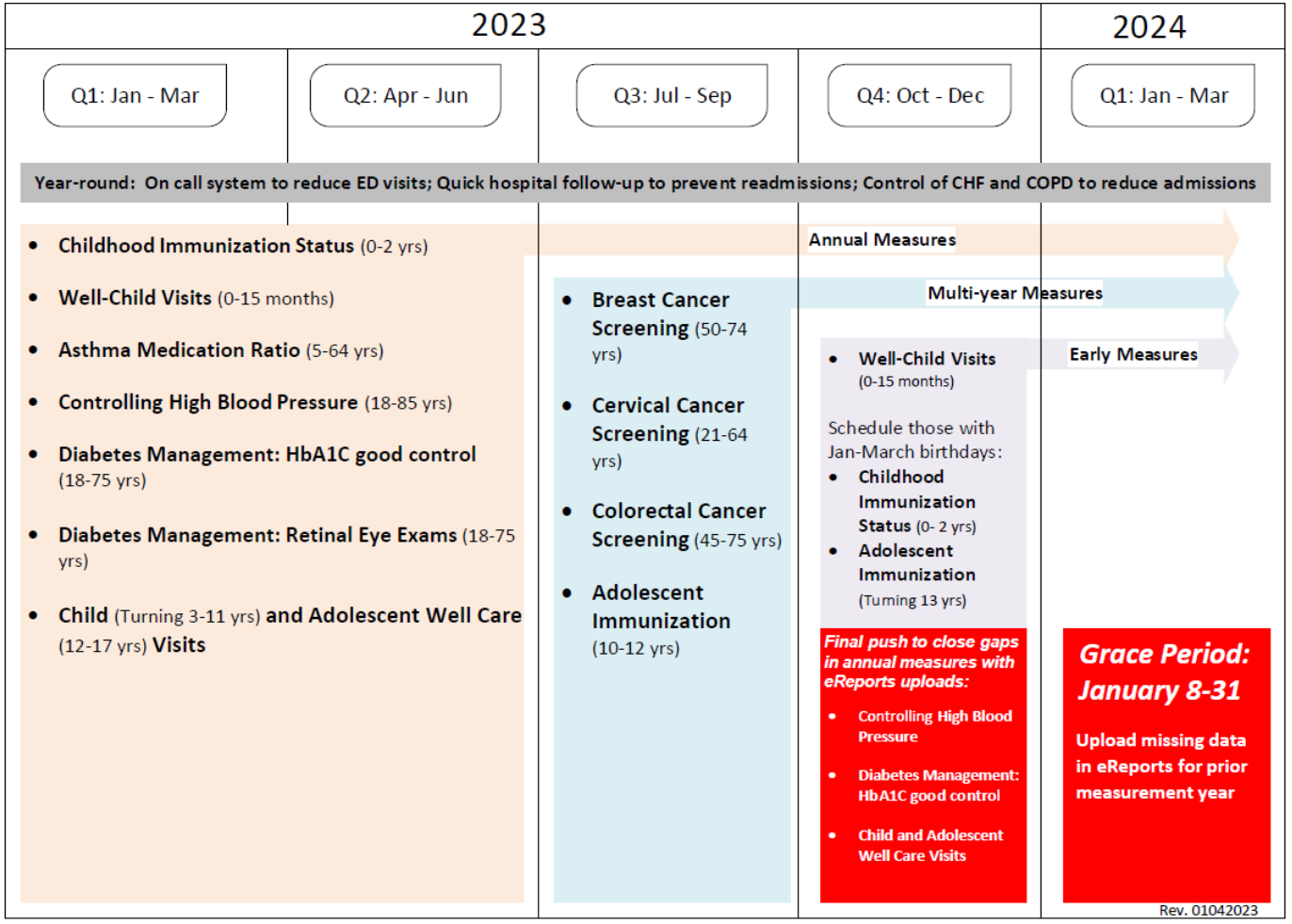
Northwest Regional Telehealth Resource Center, *Quick Start Guide to Telehealth During the Current Public Health Emergency March 2020*
https://nrtrc.org

California Primary Care Association
www.CPCA.org

Center for Care Innovations
https://www.careinnovations.org/wp-content/uploads/Sample-Remote-Visit-Workflow.pdf

Timeline for addressing 2023 and 2024 PCP QIP Measures

Timeline for addressing 2023 and 2024 PCP QIP Measures



2023 PCP QIP targets

CLINICAL DOMAIN											
Practice Type			Measure	Measure Category	Age Range	Targets		Full / Partial Points		
Family	Internal	Peds				Full	Partial	Family	Internal	Peds
✓	✓	✓	Asthma Medication Ratio			69.67%	64.26%	6 / 4	8 / 6	13 / 10
✓	✓		Comprehensive Diabetes Care: HbA1c Control	CHRONIC DISEASE MANAGEMENT		64.48%	60.10%	6 / 4	11 / 8	–
✓	✓		Comprehensive Diabetes Care: Retinal Eye Exams			56.51%	51.06%	5 / 3	5 / 3	–
✓	✓		Controlling High Blood Pressure			65.10%	59.85%	6 / 4	10 / 8	–
✓		✓	Childhood Immunization Status: Combo 10	PREVENTATIVE SCREENING		42.09%	34.79%	6 / 5	–	16 / 12
✓		✓	Immunizations for Adolescents: Combo 2			41.12%	55.72%	6 / 5	–	16 / 12
✓	✓		Breast Cancer Screening			56.52%	50.95%	6 / 5	12 / 9	–
✓	✓		Cervical Cancer Screening			62.53%	57.64%	6 / 4	12 / 9	–
✓	✓		Colorectal Cancer Screening			40.23%	32.80%	5 / 4	12 / 9	–
✓		✓	Child and Adolescent Well Care Visits	UTILIZATION		57.44%	48.93%	9 / 7	–	16 / 12
✓		✓	Well-Child Visits in the First 15 Months of Life			61.19%	55.72%	9 / 7	–	16 / 12

PCP QIP Comprehensive Diabetes Care: HbA1c Control

KR

Comprehensive Diabetes Care: HbA1c Control

PCP QIP 2023	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine	6 points	64.48%	75th
	Internal Medicine	11 points		
Partial Points	Family Medicine	4 points	60.10%	50th
	Internal Medicine	8 points		

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
  Please note: If a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through the relative improvement in the current measurement year.

PCP QIP Comprehensive Diabetes Care: Retinal Eye Exam

KR

Comprehensive Diabetes Care: Retinal Eye Exam

PCP QIP 2023	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine Internal Medicine	5 points 5 points	56.51%	75th
Partial Points	Family Medicine Internal Medicine	3 points 3 points	51.06%	50th

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.
  Please note: If a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through the relative improvement in the current measurement year.

Summary of 2023 QIP

Practice Type			NON-CLINICAL			Full / Partial Points		
Family	Interna	Peds				Family	Internal	Peds
Access and Operations								
✓	✓	✓	Avoidable ED Visits	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	7 / 5
✓	✓	✓	PCP Office Visits	Greater than 1.8 visits PMPY on average	Between 1.5 and 1.8 visits PMPY on average	5 / 3	5 / 3	6 / 4
Appropriate Use of Resources								
✓	✓	✓	Ambulatory Care Sensitive Admissions	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	–
✓	✓	✓	Risk Adjusted Readmission Rate	Full Point Target TBD	Partial Point Target TBD	5 / 4	5 / 4	–
Patient Experience								
✓	✓	✓	Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10 / 8	10 / 8	10 / 8
✓	✓	✓	Patient Experience (Survey)	Submits Parts 1 and 2	Submits Parts 1 or 2	–	–	–

Summary of 2023 QIP

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

2023 Core Measurement Set - Family Medicine

Core Measurement Set – Family Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	6	4
Breast Cancer Screening	75th Percentile (56.52%)	50th Percentile (50.95%)	6	5
Cervical Cancer Screening	75th Percentile (62.53%)	50th Percentile (57.64%)	6	4
Child and Adolescent Well Care Visits	75th Percentile (57.44%)	50th Percentile (48.93%)	9	7
Childhood Immunization Status: Combo 10	75th Percentile (42.09%)	50th Percentile (34.79%)	6	5
Colorectal Cancer Screening	50th Percentile (40.23%)	25th Percentile (32.80%)	5	4
Comprehensive Diabetes Care: HbA1c Control	75th Percentile (64.48%)	50th Percentile (60.10%)	6	4
Comprehensive Diabetes Care - Retinal Eye Exams	75th Percentile (56.51%)	50th Percentile (51.09%)	5	3
Controlling High Blood Pressure	75th Percentile (65.10%)	50th Percentile (59.85%)	6	4
Immunizations for Adolescents – Combo 2	75th Percentile (41.12%)	50th Percentile (35.04%)	6	5
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.19%)	50th Percentile (55.72%)	9	7
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES[2]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	TBD	TBD	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.8 visits per member per year on average	Between 1.5 and 1.8 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

2023 Core Measurement Set - Internal Medicine

2023 Core Measurement Set – Internal Medicine

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

2023 Core Measurement Set - Pediatrics

2023 Core Measurement Set – Pediatrics

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Asthma Medication Ratio	75th Percentile (69.67%)	50th Percentile (64.26%)	13	10
Child and Adolescent Well Care Visits	75th Percentile (57.44%)	50th Percentile (48.93%)	16	12
Childhood Immunization Status: Combo 10	75th Percentile (42.09%)	50th Percentile (34.79%)	16	12
Immunizations for Adolescents – Combo 2	75th Percentile (41.12%)	50th Percentile (35.04%)	16	12
Well-Child Visits in the First 15 Months of Life	75th Percentile (61.19%)	50th Percentile (55.72%)	16	12
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	60th Percentile (9.18)	70th Percentile (11.44)	7	5
PCP Office Visits	Greater than 1.5 visits per member per year on average	Greater than 1.5 visits per member per year on average	6	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	25th Percentile (Access 37.86%) 25th Percentile (Communication 68.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

Resources on Health and Racial Equity

- **California Improvement Network (CIN):** https://www.chcf.org
- Toolkit to Advance Racial Health Equity in Primary Care Improvement https://www.chcf.org/publication/toolkit-racial-equity-primary-care-improvement/
- **American Medical Association**: https://www.ama-assn.org/about/ama-center-health-equity AMA Center for Health Equity: The AMA Center for Health Equity works to embed health equity across the AMA organization so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes. Also jointly released with Association of American Medical Colleges, led by its Center for Health Justice, a new health equity guide to language, narrative, and concepts entitled, "Advancing Health Equity: A Guide to Language, Narrative, and Concepts."
- **Center for Health Care Strategies : https://www.chcs.org/**
- **Diversifying Medicaid's Leaders to Better Address Health Equity** - Highlights strategies for ensuring a robust pipeline of strong and diverse Medicaid leaders. See also a related **infographic**.
- **Words Matter: How Language Used in Health Care Settings Can Impact the Quality of Pediatric Care** -This webinar featured perspectives on the impact of language used during care and in medical records, and how provider interactions rooted in respect can support health and well-being. This is not exclusive to pediatric delivery.
- **Health Begins**: https://healthbegins.org
- Health Equity Strategies from the AHC Model: Working with Mathematica on behalf of the Centers for Medicare & Medicaid Services (CMS), Health Begins has this tip sheet provides a multi-level framework for understanding health equity, including actionable strategies related to social needs interventions that organizations such as health systems, payers, and community service providers can leverage to improve health equity.

Resources on Health and Racial Equity

- **Implicit Bias Association Test** https://implicit.harvard.edu/implicit/takeatest.html.
- Tool for showing bias and how our unconscious drives our day to day decision making. This tool was developed by a group of researchers from Harvard University and has proven validity. The test is free and results are kept confidential, but tagged for research purposes. Please refer to the disclaimer.

- **Diversity Science**: https://www.diversityscience.org/equal-perinatal-care/
- Developed an interactive training courses and resources for perinatal providers focused on implicit bias and reproductive justice. These resources are developed in accordance with the training requirements outlined in the California Dignity in Pregnancy and Childbirth Act (Senate Bill 464).