# Primary Care Provider

# Quality Improvement Program (PCP QIP) Website Specifications

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# 2021

## MEASUREMENT YEAR

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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## I. Quality Improvement Program Contact Information

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## II. Program Overview

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

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

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

### Guiding Principles

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

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

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

### Program Timeline: Calendar Year

The measurement year begins on January 1 and ends on December 31 of the current year. Please see Appendix V for details on deadlines specific to any measures. Payment is sent out 120 days after the program period ends, on April 30 of the next year.

Definitions

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

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

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

Eligibility for PHC Program

Eligible providers must have a PHC contract within the first three months of the [PHC QIP, grant or other disbursement program]. The provider must remain contracted through the end of the [measurement year (for QIPs)] or [contract period] to be eligible for payment.

Eligible providers must be in Good Standing continuously from the beginning of the [measurement year (for QIPs)] or [grant application (for grants)] to the month the payment is to be disbursed.

Definition of Good Standing:

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

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

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

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

- PCP sites joining Partnership as part of a PCP PO where members from an existing QIP participant (an existing primary care site) are potentially being reassigned to the new site (example – new site opens within multi-site FQHC model)
    - Must be contracted with members assigned by October 1.
    - New PCP sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the PCP parent organization will be used to support continuous enrollment requirements for Clinical Measures.

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

- All PCP sites, regardless of any affiliation with a PCP PO:
    - Must be contracted with members assigned for at least nine (9) months of the measurement year.

Eligible Member Population
The eligible population used to calculate the final scores for all measures is defined as capitated or assigned medical home Medi-Cal members. These members are eligible to be included in PCP sites' denominator lists assuming other denominator criteria are met. Member month assignments will also count towards the member month totals used for payment calculations.

For measures in the Clinical domain, the member must be continuously enrolled within a PCP parent organization, with continuous enrollment defined as member assignment for nine (9) out of the 12 months between January 1 and December 31 of the current measurement year (assignment to a site occurs on the first of the month). For multi-site PCP parent organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a PCP site's final denominator is December 1st. This means that members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Members who are dually enrolled in Medicare and Medi-Cal (Medi-Medi members) are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate should be presented to the QIP Team.

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

Measure Development and Selection
The measurement set for the QIP is reviewed and developed annually. In order to maintain a clinically relevant, alignment with key external healthcare measurement entities, and a stable measurement set, major changes occur only when significant changes are made across a

majority of the key external healthcare measurement entities measurement sets.[1] With input from the network, the Provider Advisory Group, and internal departments, the measurement set requires approval from the Physician Advisory Committee. Once approved, the finalized set for the next year is shared with the network and specifications are developed. It is possible for the measurement set to change slightly during the measurement year due to new information becoming available (i.e. a measure's retirement from the Department of Health Care Services Managed Care Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be communicated through e-mail to all providers as well as through the program's monthly newsletter.

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

Payment

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

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

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

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

  A site that earns 55% of their QIP Core Measurement Set points would earn 55% of the site's total potential amount. If the site had an average of 1,000 members and 12,000 member months, this would equal a final payment amount of $66,000. This breaks down to a realized $5.50 PMPM.

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

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

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

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. The specific codes are listed in the Code List and specified within each measure. These codes are not wholly representative of reimbursable codes of PHC but codes outside of the Code List are not used for measure evaluation.

eReports

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

All providers, regardless of membership size, will have measures compared against the specified measure thresholds. We are aware that small denominators may negatively impact the overall performance on a particular measure. Therefore, if a provider 1) has fewer than 15 members in the denominator for any clinical measure after continuous enrollment is applied and 2) does not meet the threshold, there will be an additional opportunity to submit evidence of outreach efforts to non-compliant members conducted during the measurement year. Providers with denominators of less than 15 members must provide evidence of three targeted outreach attempts when requesting a member be excluded from the denominator. The three Outreach attempts must include one written, one verbal, and a third of the sites choice with the date and type of outreach is documented. Outreach information must be submitted to the QIP team by 5 p.m. on January 15, 2022.

Partnership Quality Dashboard

In addition to eReports, the Partnership Quality Dashboard (PQD) can be used for Non-Clinical measure performance tracking. PQD is accessible via hyperlink on the eReports user menu. The PQD offers additional dashboard views, designed to enable performance trending, data stratification, and QIP payout potential. Please review the PQD Overview Webinar for detailed instructions, and contact the QIP Team with questions.

Payment Dispute Policy

Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and, during the validation period after the end of the measurement year, review data on which your final point earnings will be based. If during the Preliminary Report review period or eReports validation period a provider does not inform PHC of a calculation or point attribution error that would result in potential under or over payment, the

error may be corrected by PHC post-payment. This means PHC may recoup overpaid funds any time after payment is distributed. Dispute of final data described below will not be considered:

1. QIP scores on eReports
   eReports refreshes data on a weekly basis and providers have access to eReports through the well-published grace period (30 days after the end of the measurement year, through January 31) to check for data disparities. Additionally, providers have access to eReports for during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, PHC may assist a provider with uploading data before the close of the grace period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.

2. Exclusions on eReports
   Some exclusions from denominators, when approved, involve a manual process by PHC staff. Since the QIP receives a large volume of exclusion requests, providers are responsible for checking that members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. The deadline for exclusion requests that need to be executed by the QIP Team is January 15, 2022.

3. Data reported on the Year-End Preliminary Report
   At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the earnings for manually tracked measures (i.e. PCMH Certification, Initial Health Assessment, etc.). Providers will be given one week, hereafter referred to as Preliminary Report Review Period, to review this report for performance discrepancies and calculation or point attribution errors.

4. Practice type designations
   Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice according to the accepted age groupings listed in the Provider Directory and a historical review of member months. Each practice type is responsible for different QIP measures. The QIP team is available throughout the measurement year to answer questions about these designations as defined in the QIP. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.

5. Thresholds
   Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year. The QIP may consider adjusting thresholds mid-year based on provider feedback. Post-payment disputes related to thresholds, however, cannot be accommodated.

   Should a provider have a concern that does <u>not</u> fall in any of the categories above (i.e. the score on your final report does not reflect what was in eReports), a Payment Dispute Form must be completed within 30 days of receiving the final statement. All conversations

regarding the dispute will be documented and reviewed by PHC. All payment adjustments will require approval from PHC's Executive Team.

Governance Structure

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

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

*QIP Technical Workgroup*: The QIP internal workgroup comprised of representatives from 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 and reviews and approved the actions of the Physician Advisory Committee, including the QIP measures.

## III. Summary of Measures

# 2021 Primary Care Provider Quality Improvement Program Summary of Measures

For the tables below, please refer to these notes:

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

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

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

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

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.

3: Site specific and practice type risk adjusted targets will be sent to each participating site in spring 2021.

4: Most of the clinical measures use performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2020 as targets.

# 2021 Primary Care Provider Quality Improvement Program Summary of Measures

## Core Measurement Set – Family Practice

| Measure Name | Full Point Target | Partial Point Target | Full Points | Partial Points |
|---|---|---|---|---|
| **CLINICAL DOMAIN: CLINICAL MEASURES** | | | | |
| Asthma Medication Ratio | 75th Percentile (68.52%) | 50th Percentile (63.58%) | 7 | 5 |
| Breast Cancer Screening | 75th Percentile (63.98%) | 50th Percentile (58.67%) | 7 | 5 |
| Cervical Cancer Screening | 75th Percentile (66.49%) | 50th Percentile (60.65%) | 7 | 5 |
| Child and Adolescent Well Care Visits | 50th Percentile (47.54%)[2] | New Measure, First year | 10 | 0 |
| Childhood Immunization Status: Combo 10 | 75th Percentile (42.02%) | 50th Percentile (34.79%) | 7 | 5 |
| Colorectal Cancer Screening | 50th Percentile (41.84%) | 25th Percentile (32.24%) | 6 | 5 |
| Comprehensive Diabetes Care: HbA1c Control | 75th Percentile (67.15%) | 50th Percentile (61.48%) | 7 | 5 |
| Controlling High Blood Pressure | 75th Percentile (66.91%) | 50th Percentile (61.04%) | 7 | 5 |
| Immunizations for Adolescents – Combo 2 | 75th Percentile (40.39%) | 50th Percentile (34.43%) | 7 | 5 |
| Well-Child Visits in the First 15 Months of Life | 75th Percentile (69.83%) | 50th Percentile (65.83%) | 10 | 8 |
| **NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS** [3] | | | | |
| Ambulatory Care Sensitive Admissions | 60th Percentile (6.88) | 70th Percentile (8.56) | 5 | 4 |
| Risk Adjusted Readmission Rate | Score <1.0 | Score ≥ 1.0 -1.2 | 5 | 4 |
| **NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES** | | | | |
| Avoidable ED Visits | 60th Percentile (9.18) | 70th Percentile (11.44) | 5 | 4 |
| **NON-CLINICAL DOMAIN: PATIENT EXPERIENCE** | | | | |
| Patient Experience (CAHPS) | 50th Percentile (Access) (45.00%)<br><br>50th Percentile (Communication) (70.30%) | 25th Percentile (Access) (41.00%)<br><br>25th Percentile (Communication) (67.00%) | 10 | 8 |
| Patient Experience (Survey) | Submits Parts 1 and 2 | Submits Part 1 or 2 | 10 | 8 |
| **MONITORING MEASURES** | | | | |
| Comprehensive Diabetes Care - Retinal Eye Exams | Monitoring Measure (50th - 58.88%) | Monitoring Measure (50th - 58.88%) | 0 | 0 |

[2] The target is based on PHC's plan-wide 75th percentile, as this is a first year measure.

[3] Non-clinical measure targets were set using 2019 PCP QIP plan-wide data.

| | | | | |
|---|---|---|---|---|
| PCP Office Visits | Monitoring Measure (Greater than 2.1 visits per member per year on average.) | Monitoring Measure (Greater than 2.1 visits per member per year on average.) | 0 | 0 |
| | | **TOTAL POINTS** | **100** | **68** |

**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 (68.52%) | 50th Percentile (63.58%) | 12.5 | 9 |
| Breast Cancer Screening | 75th Percentile (63.98%) | 50th Percentile (58.67%) | 12.5 | 9 |
| Cervical Cancer Screening | 75th Percentile (66.49%) | 50th Percentile (60.65%) | 12.5 | 9 |
| Colorectal Cancer Screening | 50th Percentile (41.84%) | 25th Percentile (32.24%) | 12.5 | 9 |
| Comprehensive Diabetes Care - HbA1c Control | 75th Percentile (67.15%) | 50th Percentile (61.48%) | 12.5 | 9 |
| Controlling High Blood Pressure | 75th Percentile (66.91%) | 50th Percentile (61.04%) | 12.5 | 9 |
| **NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS** [4] | | | | |
| Ambulatory Care Sensitive Admissions | 60th Percentile (6.88) | 70th Percentile (8.56) | 5 | 4 |
| Risk Adjusted Readmission Rate | Score <1.0 | Score ≥ 1.0 -1.2 | 5 | 4 |
| **NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES** | | | | |
| Avoidable ED Visits | 60th Percentile (9.18) | 70th Percentile (11.44) | 5 | 4 |
| **NON-CLINICAL DOMAIN: PATIENT EXPERIENCE** | | | | |
| Patient Experience (CAHPS) | 50th Percentile (Access) (45.00%)<br><br>50th Percentile (Communication) (70.30%) | 25th Percentile (Access) (41.00%)<br><br>25th Percentile (Communication) (67.00%) | 10 | 8 |
| Patient Experience (Survey) | Submits Parts 1 and 2 | Submits Part 1 or 2 | 10 | 8 |
| **MONITORING MEASURES** | | | | |
| Comprehensive Diabetes Care - Retinal Eye Exams | Monitoring Measure (50th - 58.88%) | Monitoring Measure (50th - 58.88%) | 0 | 0 |
| PCP Office Visits | Monitoring Measure (Greater than 2.1 visits per member per year on average.) | Monitoring Measure (Greater than 2.1 visits per member per year on average.) | 0 | 0 |
| | | **TOTAL POINTS** | **100** | **74** |

[4] Non-clinical measure targets were set using 2019 PCP QIP plan-wide data.

**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 (68.52%) | 50th Percentile (63.58%) | 12 | 9 |
| Child and Adolescent Well Care Visits | 50th Percentile (47.54%)[5] | New Measure, First year | 12.5 | 0 |
| Childhood Immunization Status: Combo 10 | 75th Percentile (42.02%) | 50th Percentile (34.79%) | 12 | 9 |
| Counseling for Nutrition for Children/Adolescents | 50th Percentile (70.92%) | New Measure, First year | 12 | 0 |
| Counseling for Physical Activity for Children/Adolescents | 50th Percentile (64.96%) | New Measure, First year | 12 | 0 |
| Immunizations for Adolescents – Combo 2 | 75th Percentile (40.39%) | 50th Percentile (34.43%) | 12 | 9 |
| Well-Child Visits in the First 15 Months of Life | 75th Percentile (69.83%) | 50th Percentile (65.83%) | 12.5 | 9 |
| **NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES** | | | | |
| Avoidable ED Visits | 60th Percentile (9.18) | 70th Percentile (11.44) | 5 | 4 |
| **NON-CLINICAL DOMAIN: PATIENT EXPERIENCE** | | | | |
| Patient Experience (CAHPS) | 50th Percentile (Access) (45.00%)<br><br>50th Percentile (Communication) (70.30%) | 25th Percentile (Access) (41.00%)<br><br>25th Percentile (Communication) (67.00%) | 10 | 8 |
| Patient Experience (Survey) | Submits Parts 1 and 2 | Submits Part 1 or 2 | 10 | 8 |
| **MONITORING MEASURES** | | | | |
| PCP Office Visits | Monitoring Measure (Greater than 2.1 visits per member per year on average.) | Monitoring Measure (Greater than 2.1 visits per member per year on average.) | 0 | 0 |
| | | **TOTAL POINTS** | **100** | **48** |

[5] The target is based on PHC's plan-wide 75th percentile, as this is a first year measure.

**Unit of Service Measures – All Practice Types**

| Measure | Incentive |
|---|---|
| Advance Care Planning | Minimum 1/1000th (0.001%) of the sites assigned monthly membership18 years and older for:<br>• $100 per Attestation, maximum payment $10,000.<br>• $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 (both new and existing) | $1000 per group (Maximum of 10 groups per parent organization). |
| Alcohol Misuse Screening and Counseling | $5 per screening for screening a minimum of 5% of eligible adult members. |
| 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. The incentive is available once per parent organization. |
| Initial Health Assessment | $2000 per parent organization for submitting all required parts of improvement plan regardless of visit volume. |

## Specification Updates

| Revision Date | Page | Measure/Section | Update |
|---|---|---|---|
| June 11, 2021 | 12 | Summary of Measures Pediatrics | Corrected the targets due to typo for:<br>• Counseling for Nutrition for Children/Adolescents: 50th Percentile (70.92%)<br>• Counseling for Physical Activity for Children/Adolescents: 50th Percentile (64.96%) |
| | 29 | Counseling for Nutrition Counseling for Children/Adolescents | Add the following note in the numerator section:<br><br>Please Note: We know that this counseling can be included in any office visit, acute or preventative, performed in-person, virtually by phone or video depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit. |
| | 31 | Counseling for Physical Counseling for Children/Adolescents | Add the following note in the numerator section:<br><br>Please Note: We know that this counseling can be included in any office visit, acute or preventative, performed in-person, virtually by phone or video depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit. |
| June 30, 2021 | 13 | Unit of Service Measures – All Practice Types/Advanced Care Planning Attestation | • Corrected the measure name from Advanced Care Planning Attestation to Advance Care Planning.<br>• Corrected the incentive description from "Minimum 1/1000$^{th}$ (0.01%)…" to "Minimum 1/1000$^{th}$ (0.001%)…" |
| | 45 | Measure 16. Patient Experience/ Numerator | • Corrected the Appendix name from "Appendix I" to "Appendix X"<br>• Corrected the hyperlink to take reader to the correct Appendix for the submission template. |
| | 47 | Measure 1. Advanced Care Planning/Threshold | Corrected the incentive description from "Minimum 1/1000$^{th}$ (0.01%)…" to "Minimum 1/1000$^{th}$ (0.001%)…" |
| | 57 | Measure 7. Initial Health Assessment Improvement Plan/ Measure Requirements and Submission | Measure Requirements section:<br>• Corrected the "Refer to Appendix V for IHA template" to "Refer to Appendix IV for IHA template."<br>• Corrected the hyperlink on the Appendix IV.<br>Submission section: |

| | | | |
|---|---|---|---|
| | | | • Corrected, “All documentation must be submitted on the IHA template (Appendix V)…” to “All documentation must be submitted on the IHA template (Appendix IV)…<br>• Corrected the hyperlink on the Appendix IV. |
| | 68 | Appendix IX: Extended Office Hour Quarterly Submission Attestation Form | Updated the submission template, per Provider Relations. |
| | 70 | Survey: Part II Submission Template | Corrected the numbering for the submission elements. |

## Measure 1. *Asthma Medication Ratio*[6]

### Description

Percentage of assigned members  5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater between January 1 and December 31 during the measurement year.

### Points and Thresholds by Practice Type

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

### Denominator

The number of assigned members 5-64 years of age as of December 31 of the measurement year (DOB between January 1, 1957 and December 31, 2016) identified as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year:

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

### Numerator

The number of members in the eligible population in the denominator who have a medication ratio of 0.50 or greater between January 1, 2021 and December 31, 2021.

### Exclusions

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

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

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

3) Exclude members in hospice.

### Measure Rationale and Source

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

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

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

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

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

## IV. Clinical Domain

### Measure 2. *Breast Cancer Screening*[7]

**Description**

Percentage of assigned women 50-74 years of age who had a mammogram to screen for breast cancer.

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned women 52 – 74 years of age as of December 31 of the measurement year (DOB between January 1, 1947 and December 31, 1971).

**Numerator**

The number of assigned women with one or more mammograms any time on or between October 1, 2019 and December 31, 2021.

**Exclusions**

This measure excludes assigned women with a history of bilateral or unilateral left and right mastectomy any time on or prior to December 31 of the measurement year.

**Measure Rationale and Source**

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

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

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

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

## IV. Clinical Domain

### Measure 3. *Cervical Cancer Screening*[8]

**Description**

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

- 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

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned women 21 - 64 years of age as of December 31 of the measurement year (DOB between January 1, 1957 and December 31, 2000).

**Numerator**

The number of assigned women who were screened for cervical cancer screening according to clinical guidelines any time during the measurement year.

**Exclusions**

Assigned women who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during their medical history through the end of the measurement year.

PHC Important Notes:

1. Documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.
2. If the doctor is willing to attest and document permanently in the patient's chart a "complete," "total" or "radical" abdominal or vaginal hysterectomy date and the patient provides limited date information, please use the following for uploading the date into eReports:
    a. Year - (01/01/YYYY) or (12/31/YYYY)
    b. Month and Year – (MM/01/YYYY) or (MM/30 or 31/YYYY)
3. If the doctor diagnoses the patient has no residual cervix, cervical agenesis or acquired absence of cervix, please upload into eReports:
    a. Date of Diagnosis – (MM/DD/YYYY)
4. Cervical Cancer Screening in Transgender Individuals: Transgender females (born males but currently with gender identity of female), may use diagnosis of congenital absence of cervix ICD10 = Q51.5) to exclude from denominator. Transgender males or gender non-conforming who were born females but currently with gender identity of male should be screened for cervical cancer if their cervix is still intact, but they will not be part of the official denominator for this measure due to system constraints.

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

## Measure Rationale and Source

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

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

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

## IV. Clinical Domain

### Measure 4. *Child and Adolescent Well-Care Visits*[9]

**Description**

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

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned members 3 - 17years of age as of December 31, 2021 (DOB between January 1, 2004 and December 31, 2018).

**Numerator**

The number of assigned children who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.

Because well-care visit measure is administrative only, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2021, n.d.).

PHC policy on Virtual Well Child Visits during COVID-19 emergency: Well-child visits may be performed in-person, virtually by phone or video, or a combination of these, depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit.

**Exclusions**

This measure does not have any exclusions.

**Measure Rationale and Source**

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

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

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;
- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;

[9] 2021 HEDIS measure criteria for Child and Adolescent Well Care with the allowable adjustments.

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

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

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

## IV. Clinical Domain

### Measure 5. *Childhood Immunization Status*[10]

**Description**

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

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned children who turned 2 years of age anytime during the measurement year (DOB between January 1, 2019 and December 31, 2019).

**Numerator**

The number of assigned children who received the recommended vaccines by their second birthday.

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

**Exclusions**

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

**Measure Rationale and Source**

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

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

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

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

Risk Adjusted Utilization, MCAS, NQF Childhood Immunization Status (#0038), and UDS Childhood Immunizations (CMS117v7).

## IV. Clinical Domain

### Measure 6. *Colorectal Cancer Screening*[11]

**Description**

Percentage of assigned members 50-75 years of age who had appropriate screening for colorectal cancer.

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned members 51-75 years of age by December 31, 2021 (DOB between January 1, 1946 and December 31, 1970).

**Numerator**

The number of assigned members who received one or more screenings for colorectal cancer according to clinical guidelines.

**Exclusions**

This measure excludes members with a history of colorectal cancer or total colectomy. The measure also excludes members who use hospice services or are enrolled in an institutional special needs plan (SNP) or living long-term in an institution any time during the measurement year.

**Measure Rationale and Source**

According to the Centers for Disease Control and Prevention (CDC), colorectal cancer screening saves lives (Colorectal Cancer Awareness, n.d.). Regular screening, beginning at age 50, is the key to preventing colorectal cancer (Colorectal Cancer Awareness, n.d.). If the member is older than 75, screening is to be determined by the physician (Colorectal Cancer Screening, n.d.).

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

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

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

## IV. CLINICAL DOMAIN

### Measure 7. *Comprehensive Diabetes Management – HbA1c Good Control*[12]

**Description**

The percentage of assigned members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was equal to or less than 9.0% (poor control) during the measurement year.

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned members 18-75 years of age (DOB between January 1, 1946 and December 31, 2003) by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

**Numerator**

The number of assigned members whose most recent HbA1c level is less than or equal to 9.0% during the measurement year.

**Exclusions**

Exclude assigned members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude 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 had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

PHC approved: have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports). See Appendix VIII for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix IX for the Diabetes Exclusions Flow Chart.

**Measure Rationale and Source**

Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin (National Diabetic Statistics Report, 2020). Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death (National Diabetic Statistics Report, 2020). Many interventions intended to prevent/control diabetes are cost saving or very cost-effective and supported by strong evidence (Li et al., 2010).

[12] National Quality Forum (NQF) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (#0059). http://www.qualityforum.org

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

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

## IV. CLINICAL DOMAIN

### Measure 8. *Controlling High Blood Pressure*[13]

#### Description

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

#### Points and Thresholds by Practice Type

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

#### Denominator

The number of assigned members 18 to 85 years of age as of December 31 (DOB between January 1, 1936 and December 31, 2003) who had at least two outpatient encounters with a diagnosis of hypertension (HTN) between January 1 of the year prior to the measurement year and June 30 of the measurement year.

#### Numerator

The number of assigned members whose most recent BP reading is adequately controlled during the measurement year. The member's BP, both the systolic and diastolic BP must be <140/90 (adequate control).

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

Member-reported digital BP readings are acceptable only if the information is collected from the member by appropriately trained staff (i.e. MA, LVN, and RN), a primary care practitioner (i.e. physician, PA, NP) or a specialist. If collected by a specialist, the specialist must be providing a primary care services related to the condition being assessed. Member provided BP readings must be recorded, dated and maintained in the member's legal health record.

We will accept blood pressure readings recorded at a dental visit, provided the dental EHR and medical EHR for the reporting practice is integrated.

#### Exclusions

Exclude all members with evidence of end-stage renal disease (ESRD) on or prior to the end of the measurement year. Documentation in the medical record must include a related note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.

Exclude all members with a diagnosis of pregnancy during the measurement year.

Exclude all members who had an admission to a nonacute inpatient setting during the measurement year.

#### Measure Rationale and Source

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

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

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

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

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

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

## IV. CLINICAL DOMAIN

### Measure 9. Counseling for Nutrition Counseling for Children/Adolescents[14]

**Description**

The percentage of assigned members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN during the measurement year and who had evidence of counseling for nutrition.

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned members 3-17 years of age as of December 31, 2021 (DOB January 1, 2004 and December 31, 2018) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

**Numerator**

The number of assigned members who have evidence of counseling for nutrition during the measurement year.

Please Note: We know that this counseling can be included in any office visit, acute or preventative, performed in-person, virtually by phone or video depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit.

**Exclusions**

The measure excludes assigned women who have a diagnosis of pregnancy during the measurement year.

**Measure Rationale and Source**

According to the American Academy of Pediatrics Bright Futures, infancy, childhood, and adolescence are marked by rapid physical growth and development, and every child and adolescent health and development depends on good nutrition (Promoting Healthy Nutrition, n.d.). Any disruption in appropriate nutrient intake may have lasting effects on growth potential and developmental achievement (Promoting Healthy Nutrition, n.d.). Physical growth, developmental requirements, nutrition needs, and feeding patterns vary significantly during each stage of growth and development (Promoting Healthy Nutrition, n.d.).

The following essential components of nutrition are useful constructs for discussing nutrition from birth through young adulthood:

- Nutrition for appropriate growth. Provide adequate energy and essential nutrients to ensure appropriate growth and prevent overweight or obesity;
- Nutrition and development of feeding and eating skills. Choose foods that provide essential nutrients and support the development of age-appropriate feeding and eating skills;

[14] National Quality Forum (NQF) Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024) http://www.qualityforum.org

- Healthy feeding and eating habits. Establish a positive, nurturing environment and healthy patterns of feeding and eating to promote eating habits that are built on variety, balance, and moderation;
- Healthy eating relationships. Promote healthy adult-child feeding relationships and social and emotional development;
- Nutrition for children and youth with special health care needs. Recognize specific nutrient demands or supplemental needs for vitamins or minerals related to a child's special health condition and provide these nutritional components (Promoting Healthy Nutrition, n.d.).

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

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024), and UDS Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155v9).

## IV. CLINICAL DOMAIN

### Measure 10. Counseling for Physical Activity for Children/Adolescents[15]

| Description |
|---|

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

| Points and Thresholds by Practice Type |
|---|

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

| Denominator |
|---|

The number of assigned members 3-17 years of age as of December 31, 2021 (DOB January 1, 2004 and December 31, 2018) who had an outpatient visit with a PCP or an OB/GYN during the measurement year.

| Numerator |
|---|

The number of assigned members who have evidence of counseling for physical activity during the measurement year.

Please Note: We know that this counseling can be included in any office visit, acute or preventative, performed in-person, virtually by phone or video depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient. Virtual visits are billed using a .95 modifier after the CPT code for the visit.

| Exclusions |
|---|

The measure excludes assigned women who have a diagnosis of pregnancy during the measurement year.

| Measure Rationale and Source |
|---|

According to the American Academy of Pediatrics Bright Futures, participating in physical activity is an essential component of a healthy lifestyle and ideally begins in infancy and extends throughout adulthood (Promoting Physical Activity, n.d.). Regular physical activity increases lean body mass, muscle, and bone strength and promotes physical health (Promoting Physical Activity, n.d.). It fosters psychological well-being, can increase self-esteem and capacity for learning, and can help children and adolescents handle stress. Parents should emphasize physical activity, beginning early in a child's life (Promoting Physical Activity, n.d.).

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

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Weight Assessment and Counseling for Nutrition for Children/Adolescents.

[15] National Quality Forum (NQF) Weight Assessment and Counseling for Nutrition for Children/Adolescents. (#0024) http://www.qualityforum.org

(#0024), and UDS Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS155v9).

## IV. Clinical Domain

### Measure 11. *Immunizations for Adolescents*[16]

#### Description

Percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the two dose human papillomavirus (HPV) vaccine series by their 13th birthday.

#### Points and Thresholds by Practice Type

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

#### Denominator

The number of assigned adolescent members who turn 13 years of age during the measurement year (DOB between January 1, 2008 and December 31, 2008).

#### Numerator

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

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2020

#### Exclusions

This measure excludes members who have a contraindication for the vaccine and patients who use hospice services during the measurement year.

#### Measure Rationale and Source

Thirty-five million American adolescents fail to receive at least one recommended vaccine (Schaffer et al., 2005). This gap exists despite specific adolescent immunization recommendations from the U.S. Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) (Schaffer et al., 2005). Low immunization rates in adolescents have a wide array of implications—outbreaks of vaccine-preventable diseases, negative effects on quality of life and increased disease associated costs (Schaffer et al., 2005). Importantly, low immunization rates establish reservoirs of disease in adolescents that can affect others, including high-risk infants, elderly persons and persons with underlying medical conditions (Schaffer et al., 2005).

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

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

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

## IV. Clinical Domain

### Measure 12. *Well-Child Visits in the First 15 Months of Life*[17]

**Description**

Percentage of assigned children 15 months old who had well-child visits with a primary care physician during the measurement year.

**Points and Thresholds by Practice Type**

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

**Denominator**

The number of assigned children who turn 15 months old during the measurement year.

**Numerator**

The number of assigned children who received six or more well-child visits with a PCP during their first 15 months of life.

NEW 14 Days Rule:
*There must be at least 14 days between each date of service. For example, if the first date of service was completed on 12/1, the next date of service, would have to be 12/15 or later. A date of service on 12/14, wouldn't count towards the numerator.

Because W15 is administrative only, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2021, n.d.).

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

**Exclusions**

This measure does not have any exclusions.

**Measure Rationale and Source**

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

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

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;
- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;

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

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

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

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

## V. Appropriate Use of Resources

### Measure 13. *Ambulatory Care Sensitive Admissions*[18]

**Description**

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

Sites must have a minimum of 100 eligible members by December of the measurement year.

**Points and Thresholds by Practice Type**

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

**Denominator**

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

**Numerator**

Total hospital days for inpatient admissions with a qualifying diagnosis from the provided list of PDIs and PQIs. The PQI and PDI principle diagnoses for each are located on AHRQ resource page.

| Preventive Quality Indicators (PQI) | Pediatric Quality Indicators (PDI): |
|---|---|
| • PQI 01 – Diabetes Short-term Complications<br>• PQI 03 – Diabetes Long-term Complications<br>• PQI 05 – COPD or Asthma in Older Adults Admission Rate<br>• PQI 07 – Hypertension<br>• PQI 08 – Heart Failure<br>• PQI 11 – Community Acquired Pneumonia Admission Rate<br>• PQI 12 – Urinary Tract Infection<br>• PQI 14 – Uncontrolled Diabetics<br>• PQI 15 – Asthma in Younger Adults<br>• PQI 16 – Lower-Extremity Amputation among Patients with Diabetes | • PDI 14 – Asthma Admissions Rate<br>• PDI 15 – Diabetes Short-term Complications<br>• PDI 16 – Gastroenteritis<br>• PDI 18 – Urinary Tract Infection |

**Calculation:**

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

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

## Exclusions

This measure excludes members who:

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

## Measure Rationale and Source

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

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

## VI. APPROPRIATE USE OF RESOURCES

### Measure 14. *Risk Adjusted Readmissions*[19]

**Description**

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

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

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

**Points and Thresholds by Practice Type**

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

**Denominator**

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

**Numerator**

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

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

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

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

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

**Final Measure Calculation:**

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

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

## Exclusions

Exclusions for Numerator and Denominator:

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

Exclusions for Numerator

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

## Measure Rationale and Source

According to National Committee for Quality Assurance (NCQA), a "readmission" occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time (Plan All-Cause Readmission, n.d.). A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination (Plan All-Cause Readmission, n.d). Unplanned readmissions are associated with increased mortality and higher health care costs (Plan All-Cause Readmission, n.d). They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d).

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

## VI. ACCESS AND OPERATIONS

### Measure 15. *Avoidable Emergency Department (ED) Visits/1000 Members per Year*[20]

**Description**

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

**Points and Thresholds by Practice Type**

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

**Denominator**

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

**Numerator**

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

Calculation:

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

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

**Exclusions**

This measure excludes member who are less than 1 year of age (DOB on or after January 1, 2021).

ED claims with at least one diagnosis code not considered avoidable will deem the visit as not avoidable.

**Measure Rationale and Source**

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

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

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities.

## VII. PATIENT EXPERIENCE

### Measure 16. *Patient Experience*[21]

**Description**

The measure asks the organizations consumers and members to report on and evaluate their experiences with health care (Why Improve Patient Experience, n.d.).The results reveal the organizations strengths and weaknesses with respect to patient experience and evaluate performance over time (Why Improve Patient Experience, n.d.).

**Thresholds**

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

- Option 1: CAHPS: Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey 3.0 (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 6 months. The adult survey is administered to patients aged 18 and over. The child survey is administered to the parents or guardians of pediatric patients under the age of 18. The CAHPS survey asks questions including one overall rating of the provider and questions used to create these four multi-item composite measures of care or services provided:
  1. Getting Timely Appointments, Care, and Information
  2. How Well Providers Communicate With Patients
  3. Helpful, Courteous, and Respectful Office Staff
  4. Providers' Use of Information to Coordinate Patient Care

**OR**

- Option 2 Survey Option: This option allows providers who do not qualify for the CAHPS option to fulfill the requirements by soliciting feedback from patients and implementing changes to improve the patient experience. Only sites with less than 1200 unique PHC members are eligible for this option.

**Denominator**

The measure's denominator is the number of survey respondents. The target populations for the surveys are members who have had at least one visit with the organization.

Option 1 CAHPS: Eligible population includes assigned members with at least one unique visit and assigned medical home members with at least two visits during this period. Members 13-17 years of age are excluded. Adults and children will be surveyed separately. Sufficient patient volume is defined as having at least 1200 unique visits by PHC members between April of the year prior and March of the current measurement at the parent organization level. Adults and children will be surveyed separately.

Option 2 Survey: At least 100 responses for Parts 1 and 2.

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

## Numerator

The measure's numerator is the percentage of patients whose responses indicated that they received the desired care or service with a focus on access to care and communication.

Option 1 CAHPS Survey: Composites in the area of access and communications that are greater than or equal to the 25th percentile of all participating organizations.

Option 2: Survey Option:

Part I Submission:

1) A t least 100 responses per organization
2) Complete and return Part I submission template.

Part II Submission:

1) Implement change(s) for improvement.
2) Re-survey with the same survey used in art 1. Collect at least 100 responses.
3) Complete and return Part II submission template.

Only sites that use the Survey Option (i.e. sites that do not meet the patient volume threshold) are required to submit data. For the Surveys, submit the Patient Experience Submission Template (Appendix X) via fax or e-mail to QIP@PartnershipHP.org. Part I is due on July 31, 2021 and Part II January 31, 2022.

## Exclusions

This measure does not have any exclusions.

## Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right (Why Improve Patient Experience, n.d.). But good patient experience also is associated with important clinical processes and outcomes (Why Improve Patient Experience, n.d.). Measures of patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety, and efficiency (Why Improve Patient Experience, n.d.).

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

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

physician's practice than patients with the highest-quality relationships (Why Improve Patient Experience, n.d.).

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

## VIII. Unit of Service $20,000 Maximum per Site

### Measure 1. *Advanced Care Planning*

#### Description

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

#### Thresholds

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

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

#### Measure Requirements

ACP discussions must take place between January 1, 2021 and December 31, 2021 in order to be eligible for this measure.

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

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

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

#### Submission Process

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

#### Exclusions

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

Submission(s) received after the close of the “grace period” that ends on January 31 following the close of the measurement year.

## Measure Rationale and Source

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

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

## VIII. Unit of Service — 10% of Capitation

### Measure 2. Extended Office Hours

#### Description

This measure encourages the PCP to offer after-hours care may include any combination of in-person, video and telephone visits where the provider has live or real-time access to member's medical records and documents the encounter at the time of service for at least 8 hours/week beyond the normal business hours (defined below).

#### Thresholds

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

#### Measure Requirements

**Definition:**

Regular business hours: Defined as up to 9 hours between the hours of 8am and 6pm, Monday through Friday. Being open and not seeing patients during the lunch hour does not count toward the extended hours.

Larger groups (more than 4 PCP provider sites) are expected to be staffed for at least 40 hours per week during these regular business hours. Smaller groups are expected to be staffed at least 32 hours per week during these regular business hours.

Assuming these minimum hour requirements are met:

1. Any hours before 8am and after 6pm on weekdays, and any hours on weekends will count towards the 8 extended hours.
2. An office with scheduled visits from 8am to 6pm (10 hours) may count one of those hours towards the extended hours.

If a provider feels they are providing extended access, but their hours do not meet this definition, they may present their explanation in writing for consideration by the PHC administration.

#### Submission Process

All documentation must be submitted on the Extended Office Hour Quarterly Submission and Attestation template (Appendix IX) by January 31, 2022, and can be faxed to (707) 863-4316 or emailed to QIP@partnershiphp.org.

#### Exclusions

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

#### Measure Rationale and Source

Continuity of care is a central goal of primary care improvement efforts nationwide, because physician's offices with office hours during the weekends and evenings allow patients more opportunities to be seen, yielding opportunities for improved health outcomes, more patient satisfaction, and lower healthcare costs. Efforts in this area are not addressed in routine PCP contracts.

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

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

### Description

This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand (What is Patient-Centered Medical Home, n.d.).
Primary care provider sites with fewer than 50 assigned Partnership members.

### Thresholds

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

### Measure Requirements

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

### Submission Process

All documentation must be submitted on the Patient-Centered Medical Home Recognition template (Appendix I) by January 31, 2022, and can be faxed or emailed to QIP@partnershiphp.org.

### Exclusions

Submission received after the close of the “grace period” that ends on January 31 following the close of the measurement year.

### Measure Rationale and Source

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

## VI. UNIT OF SERVICE $10,000 Maximum per Parent Organization

### Measure 4. *Peer-Led Self-Management Support Groups*

#### Description

This measure encourages the PCP organization to host peer-led self-management groups for PHC member and non-PHC members focused a variety of conditions, or focused on specific diseases or conditions, such as Diabetes, Rheumatoid Arthritis, Chronic Pain, Hepatitis C, Cancer, Congestive Heart Failure, COPD, Asthma, Depression, Anxiety/Stress, and Substance use.

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

#### Thresholds

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

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

#### Measure Requirements

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

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

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

Proposed groups may submit elements 1-7 above prospectively for review and feedback at any time in the year, before groups start, to ensure program will be eligible for bonus.

#### Submission Process

All documentation must be submitted on the Peer-led Self-Management Support Group template (Appendix II) by January 31, 2022, and can be faxed or emailed to QIP@partnershiphp.org.

#### Exclusions

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

## Measure Rationale and Source

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

## VI. UNIT OF SERVICE — INCENTIVE AMOUNT VARIES BY SITE

### Measure 5. *Alcohol Misuse Screening and Counseling*

**Description**

This measure encourages the PCP sites to screen and counsel patients for alcohol misuse using standardized tools.

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

**Thresholds**

Minimum 5% of the sites assigned monthly assigned members must be screened for the additional $5.00 per screening billed to PHC.

**Measure Requirements**

PHC's claim system will validate and pay for up to two screenings for an individual every six months for the following codes:

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

PHC will extract claim data for G0442 and G0443 three months on March 31 following the close of the measurement year.

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

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

**Exclusions**

Claims denied for exceeding the frequency limits of two screenings per individual patient within a six month time frame.

**Measure Rationale and Source**

According to the Centers for Disease Control and Prevention January 2014 Vital Signs, it reports:

- At least 38 million adults in the US drink too much;
- Only 1 in 6 adults talk with their doctor, nurse, or other health professional about their drinking; and
- Alcohol screening and brief counseling can reduce the amount consumed on an occasion by 25% in those who drink too much. (CDC Vital Signs, 2014).

Drinking too much causes about 88,000 deaths in the US each year, and costs the economy about $224 billion (CDC Vital Signs, 2014). Talking with a patient about their drinking is the first step of screening and brief counseling, which involves:

- Using a set of questions to screen all patients for how much and how often they drink;

- Counseling patients about the health dangers of drinking too much, including women who are (or might be) pregnant; and
- Referring only those few patients who need specialized treatment for alcohol dependence.

The service is covered by most health insurance plans, including PHC.

## VI. UNIT OF SERVICE — $3,000 Maximum per Parent Organization

### Measure 6. *Health Information Exchange Participation*

**Description**

This measure encourages the PCP parent organizations to establish and maintain a continued linkage to a recognized community health information exchange (HIE) organizations.

**Thresholds**

The PCP parent organizations will be reimbursed for participating:

- Establishing first time linkage: During the measurement year, first year HIE connection is established are eligible to earn $3000.
- Continued utilization of the HIE: Year 2 and beyond of utilization of the HIE are eligible to earn $1500.

**Measure Requirements**

In order to qualify for the incentive PHC will validate the data exchange by working directly with the specified HIE to confirm the linkage with the HIE has to be established by confirming:

- Sending an HL7 Patient Visit Information to the HIE
  ***OR***
- Sending CCD document to the HIE
  ***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
- Jefferson HIE

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

**Submission Process**

All documentation must be submitted on the HIE Attestation template (Appendix III) by January 31, 2022 via email to qip@partnershiphp.org or fax to (707) 863-4316.

**Exclusions**

Unapproved HIE connections that do not meet the measure requirements.

**Measure Rationale and Source**

According to the Office of the National Coordinator for Health Information Technology (ONC), electronic exchange of clinical information is vital to improving health care quality, safety, and patient outcomes (Why is health information exchange important, n.d.). Health information exchange (HIE) can help your organization:

- Improve Health Care Quality: Improve health care quality and patient outcomes by reducing medication and medical error;
- Make Care More Efficient: Reduce unnecessary tests and services and improve the efficiency of care by ensuring everyone involved in a patient's care has access to the same information;
- Streamline Administrative Tasks: Reduce administrative costs by making many administrative tasks simpler and more efficient;
- Engage Patients: Increase patient involvement in their own health care and reduce the amount of time patients spend filling out paperwork and briefing providers on their medical histories; and
- Support Community Health: Coordinate with and support public health officials to improve the health of your community (Why is health information exchange important, n.d.).

Electronic exchange of clinical information allows doctors, nurses, pharmacists, other health care providers, and patients to access and securely share a patient's vital medical information electronically—improving the speed, quality, safety, coordination, and cost of patient care (Why is health information exchange important, n.d.).

## VI. Unit of Service $2,000 Maximum Per Parent Organization

### Measure 7. *Initial Health Assessment Improvement Plan*

**Description**

This measure encourages our PCP organizations to develop and submit an initial health assessment (IHA) improvement plan for ensuring newly assigned members are scheduled and seen within PHC's timeframe of within 90 days following the first month of PHC eligibility.

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

**Thresholds**

The PCP parent organization is eligible to earn an annual amount of $2000 for submitting IHA improvement plan.

- Documentation will be reviewed and approved by PHC's Manager of Clinical Quality and Patient Safety or other registered nurse (RN) designee.

**Measure Requirements**

In order to qualify PCP parent organizations need to submit IHA plans that address of all elements of the IHA template. Refer to Appendix IV for IHA template.

Our interpretation of the telehealth flexibilities is that an initial health assessment may be done through a video visit, if it includes all the elements of a comprehensive initial visit.

The IHA (Initial Health Assessment) includes the following criteria:

- Medical and Behavioral Health histories
- Identification of high-risk behaviors
- Assessment of need for preventative screenings or services, and health education
- Diagnosis and plan for treatment of any diseases
- A completed SHA (Staying Healthy Assessment)

**Submission Process**

All documentation must be submitted on the IHA template (Appendix IV) by January 31, 2022 via email to qip@partnershiphp.org or fax to (707) 863-4316.

**Exclusions**

Unapproved IHA plans that do not meet the measure requirements.

**Measure Rationale and Source**

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

DHCS requires the health plans to ensure that all new Medi-Cal beneficiaries have an initial health assessment (a first visit, including a health screening with the DHCS's Staying Healthy Assessment questionnaire. Normally this assessment includes an examination and must occur within 120 days of enrollment into Medi-Cal Managed care. Since a new Medi-Cal member has 1 month to select a PCP, the assigned PCP has about 90 days to complete this assessment. Most recent update, DHCS permitted to defer the completion of the IHA for these members until the COVID-19 emergency declaration is rescinded; however, DHCS will require the completion of the IHA for these members once the public health emergency is over (DHCS, 2020, page 9, para 4).

## VII. APPENDICES

### Appendix I. Patient-Centered Medical Home Documentation Template


4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31, 2022** and send to:

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

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

**Additional Notes/Comments:**

_____
_____
_____
_____
_____
_____

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31, 2022** and send to:

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

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure program will be eligible for the bonus paid to the parent organization, not the individual sites.

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

# Appendix III: Submission Template for HIE

If your organization is linked to an HIE during or prior to the 2021 Measurement year, you may qualify for an incentive for the 2021 PCP QIP. Please complete all of the following fields on this form and submit by **January 31, 2022** 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. The parent organization, not the individual sites, will qualify for an incentive based on **either** HIE linkage (as a first time user) or HIE maintenance (as a continuing user). Please refer to the Measure Specifications for details.

1. Name of practice linked to the HIE:_____

2. Type of linkage established (check at least one that applies):

☐ Sending HL7/ Patient Visit Information history to the HIE
☐ Sending CCD document to the HIE
☐ Retrieving clinical information such as labs from the HIE

3. Type of incentive
   - ☐ Linkage: First joined HIE *during* 2021 (list date)
     _____
   - ☐ Maintenance: First joined HIE *prior to* 2021 (list date)
     _____

4. Name of the HIE linked to (check the option that applies):

☐Sac Valley Med Share
☐North Coast Clinical Information Network
☐Redwood Med Net
☐Jefferson HIE
☐Other: _____

Submitted by: _____ Date: _____
Title: _____ Phone: _____
Email: _____

# Appendix IV: Initial Health Assessment (IHA) Improvement Plan Template

The parent organization will qualify for an incentive based on approved Initial Health Assessment Plan. Please refer to the Measure Specifications for details.

Please complete the form and follow instructions below. Submit material by **January 31, 2022** to:

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

Organization Name: _____
Practice Address: _____
Contact Name: _____ Contact Email: _____

## Improvement Plans should be a minimum of 400 words.

1. Attach a plan or report on how you are determining eligible patients. (How is your site running reports or retrieving information to determine the eligible population?)
2. Provide documentation of the process in which the site is reaching out to the newly assigned members (i.e. mailers/phone calls, etc.).
3. Provide a data collection plan to demonstrate how many members keep IHA appointments within the plan's timeframe AND the capture of the minimum necessary documentation. This includes:
    - A physical and mental history
    - Identification of high risk behavior
    - Assessment of need for preventative screenings or services, and health education
    - Diagnosis and plan for treatment of any disease
    - A completed Staying Health Assessment (SHA) form

4. Provide data collection plan for measuring any declinations to come in for an IHA appointment as well as completion of the SHA.

5. Has this been on a recent MRR CAP? If so, provide documentation/plan implementation of what you have done since the accepted CAP date to increase compliance with the IHA.

## Appendix V: 2021 PCP QIP Submission and Exclusion Timeline

| 2021 QIP Submissions | | |
|---|---|---|
| **DUE DATE** | **QIP MEASURE** | **REPORTING TEMPLATE** |
| **January 31, 2022** | All Clinical Domain Measures and Advanced Care Planning | Find on eReports |
| **January 31, 2022** | PCMH Recognition | Appendix I |
| **January 31, 2022** | Peer-led Self-Management Support Group | Appendix II |
| **January 31, 2022** | Health Information Exchange | Appendix III |
| **January 31, 2022** | Initial Health Assessment Improvement Plan | Appendix IV |
| **January 31, 2022** | Extended Office Hours | Appendix IX |

| 2021 QIP Exclusions | |
|---|---|
| **LAST DAY TO SUBMIT (ACCEPTED ALL YEAR)** | **APPLICABLE MEASURES** |
| **January 15, 2022** | A1C Good Control |
| **January 31, 2022** | All other measures from the Clinical Domain |

# Appendix VI: Data Source Table

| PCP QIP Core Measures | Practice Type | Data Source[22] | System Used for Data Monitoring | System Used for Data Submission |
|---|---|---|---|---|
| **Clinical Domain** | | | | |
| 1. Asthma Medication Ratio | Family, Internal, Pediatrics | PHC | eReports and Partnership Quality Dashboard (PQD) | Claims |
| 2. Breast Cancer Screening | Family and Internal | PHC and Providers | | eReports |
| 3. Cervical Cancer Screening | Family and Internal | | | |
| 4. Child and Adolescent Well Care Visits | Family and Pediatrics | | | |
| 5. Childhood Immunization Status, Combination 10 | Family and Pediatrics | | | |
| 6. Colorectal Cancer Screening | Family and Internal | | | |
| 7. Comprehensive Diabetic Care – HbA1c Control | Family and Internal | | | |
| 8. Controlling High Blood Pressure | Family and Internal | | | |
| 9. Immunization for Adolescents – Combination 2 | Family and Pediatrics | | | |
| 10. Well-Child Visits in the First 15 Months of Life | Family and Pediatrics | | | |
| 11. Counseling for Nutrition for Children/Adolescents | Pediatrics | | | |
| 12. Counseling for Physical Activity for Children/Adolescents | Pediatrics | | | |
| **Appropriate Use of Resources Domain** | | | | |
| 1. Ambulatory Care Sensitive Admissions | Family and Internal | PHC | PQD | Claims |
| 2. Risk Adjusted Readmissions | Family and Internal | | | |
| **Access/Operations Measures Domain** | | | | |
| 1. Avoidable ED Visits | Family, Internal, Pediatrics | PHC | PQD | Claims |
| **Patient Experience Domain** | | | | |

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

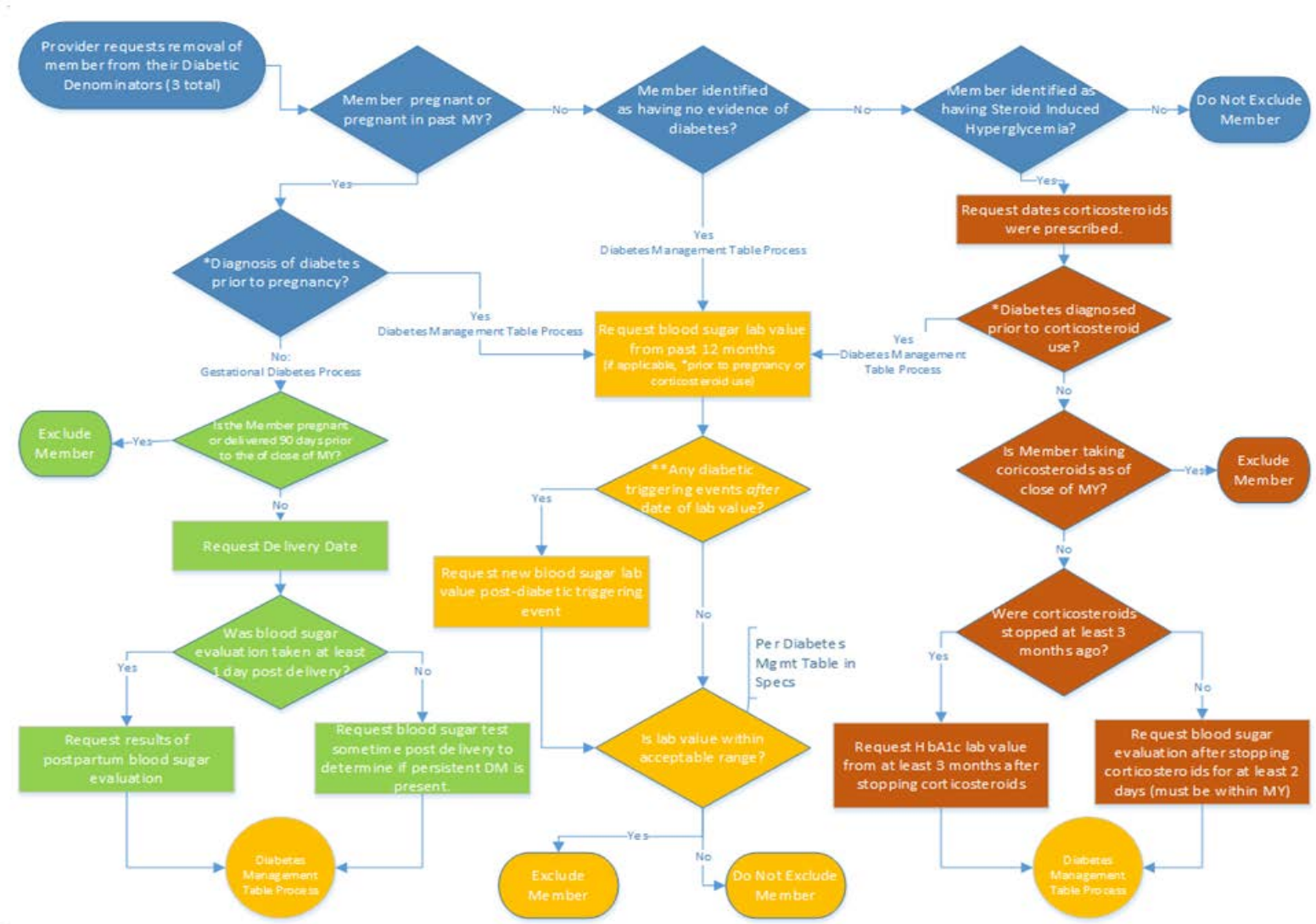
| | | | | |
|---|---|---|---|---|
| Survey Option (sites not qualified for CAHPS) | Family, Internal, Pediatrics | PHC and Provider | PQD | Submission Template |
| CAHPS Survey (for qualified sites) | Family, Internal, Pediatrics | PHC Vendor | | PHC Vendor |
| Mon**itoring Measures** | | | | |
| 1. Comprehensive Diabetic Care – Eye Exams (EYE) | N/A | PHC and Providers | eReports and PQD | eReports |
| 2. PCP Office Visits | N/A | PHC | | Claims |

# Appendix VII: Diabetes Management Table

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

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

## Appendix VIII: QIP Diabetes Exclusion Flow Chart



## Appendix IX: Extended Office Hour Quarterly Submission Attestation Form

### QUARTERLY SUBMISSION AND ATTESTATION FORM

*****Due Last Day of Each Quarter*****

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Please complete the form below and submit material by the **Last Day of Each Quarter** to: gip@partnershiphp.org .

Parent Organization: _____ PHC#_____

Site Name: _____

Address: _____ Date: _____

Submitted by & Title: _____ Phone: _____

Email: _____

**SELECT SUBMISSION QUARTER**

| QTR 1 ☐ | | | QTR 2 ☐ | | | QTR 3 ☐ | | | QTR 4 ☐ | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |

PCP sites must be open for the entire quarter an additional 8 hours per week or more beyond the regular business hours (defined as open for at least 9 hours between the hours of 8 am and 6 pm.) Note seeing patients during lunchtime hours does not count, and the site must be open to scheduled visits during the extended office time to receive credit.

☐ **CHECK THIS BOX IF YOU ARE A LARGE CLINIC** ☐ **CHECK THIS BOX IF YOU ARE A SMALL CLINIC**

**NOTE THE FOLLOWING:**

- Lunchtime hours do not count
- Tele/video visits are encouraged
- Only include "extended" hours below

WEEKLY EXTENDED HOURS – MONTH _____ MONTHLY TOTAL HOURS _____

| HOURS | MON | TUE | WED | THUR | FRI | SAT | SUN | WEEKLY HOURS |
|---|---|---|---|---|---|---|---|---|
| Start | | | | | | | | |
| End | | | | | | | | |
| Hours | | | | | | | | |

WEEKLY EXTENDED HOURS – MONTH _____ MONTHLY TOTAL HOURS _____

| HOURS | MON | TUE | WED | THUR | FRI | SAT | SUN | WEEKLY HOURS |
|---|---|---|---|---|---|---|---|---|
| Start | | | | | | | | |
| End | | | | | | | | |
| Hours | | | | | | | | |

WEEKLY EXTENDED HOURS – MONTH _____ MONTHLY TOTAL HOURS _____

| HOURS | MON | TUE | WED | THUR | FRI | SAT | SUN | WEEKLY HOURS |
|---|---|---|---|---|---|---|---|---|
| Start | | | | | | | | |
| End | | | | | | | | |
| Hours | | | | | | | | |

***SUBMIT TO QIP@PARTNERSHIPHP.ORG NO LATER THAN THE LAST DAY OF THE QUARTER AND NO EARLIER THAN THE FINAL WEEK OF THE QUARTER

## Appendix X: Patient Experience Survey Submission Template

4665 Business Center Dr.
Fairfield, CA 94534

# Quality Improvement Program – Patient Experience

Survey Submission Template and Example

Due Date for Part I Submission: July 31, 2021
Due Date for Part II Submission: January 31, 2022

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

## Survey: Part I Submission Template

(Due July 31, 2021)

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

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

## Survey: Part II Submission Template

(Due January 31, 2022)

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

2. Provide descriptions for the following for your re-measurement period:
   a. Population surveyed:

   b. How the survey was administered (via phone, point of care, web, mail, etc.):

   c. The time period for when the surveys were administered:

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

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

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

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

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

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

Dear Patient,

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

Please rank the following statements based on your visit today:

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

2. Provide descriptions for the following

   a. Population surveyed:

   b. How the survey was administered (via phone, point of care, web, mail, etc.):

   c. The time period for when the surveys were administered:

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

   Between March 1, 2021 and May 1, 2021, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2021. The first mailing was sent on March 1, followed by a second mailing on April 15. 500 surveys were mailed and 250 surveys were returned; yielding a 50% response rate.

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

   "I was given an appointment when I wanted it."

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

   80% of patients surveyed will select "strongly agree".

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

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

**Submitted by** Elizabeth Jones (QI Director) (Name & Title) **on** July 10, 2021 (Date)

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

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

   We had a consultant train our site over a two-month period (June- July 2021) on how to add same day appointments. The trainings included improvements to our scheduling system such as reducing the number of appointment types from 50 to 4. We developed and implemented scripts for the front desk staff so that they can educate our patients on the change in scheduling. We also collected data daily on our patient demand, supply and activity. This helped us determine where we can shift appointment slots based on our demand and corresponding supply. We also tried extending visit intervals for our well controlled patients with diabetes. Rather than bringing them in every 3 months, we now bring them in every 6 months.

2. Provide descriptions for the following for your re-measurement period:

   a. Population surveyed:

   b. How the survey was administered (via phone, point of care, web, mail, etc.):

   c. The time period for when the surveys were administered:

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

   Between October 15, 2021 and November 1, 2021, our site mailed a survey to all our adult patients who came in for an office visit between September 1 and October 1. We were only able to do one re-measurement cycle. The mailing was sent on October 15. Two hundred surveys were mailed and 110 surveys were returned; yielding a 55% response rate.

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

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

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

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

**Submitted by** Elizabeth Jones (QI Director) (Name & Title) **on** January 10, 2022 (Date)

## VII. Monitoring Measurement Set for the MY2021

**PHC wants to emphasize that the measures not included in the payment group remain clinically important.** Therefore, we are including this Monitoring Measurement Set.

The Monitoring Measurement Set is a separate and distinct measurement set that **does not have any points assigned to each measure**. The intent of this set is to provide visibility to your performance and access to the member gap-in-care list throughout the measurement year.

## VII. MONITORING MEASUREMENT SET MAXIMUM NUMBER OF POINTS: N/A

### Monitoring Measure 1. *Comprehensive Diabetes Management – Retinal Eye Exam*[23]

**Description**

The percentage of members 18-75 years of age who had a diagnosis of diabetes with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.

**Thresholds**

- Points Not Applicable

**Denominator**

The number of assigned members 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

**Numerator**

The number of assigned members in the eligible population who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:

- a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year **OR**
- a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year **OR**
- Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

For exams performed in the year prior to the measurement year, a result must be available.

**Exclusions**

Exclude assigned members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude 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 had a diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year.

PHC approved: have a current lab value indicating no diabetes that is less than 12 months old and more recent than the last diabetic triggering event (as visible on eReports). See Appendix VIII for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix IX for the Diabetes Exclusions Flow Chart.

**Measure Rationale and Source**

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

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

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

**VII. Monitoring Measurement Set**

## Monitoring Measure 2. *PCP Office Visits*

### Description

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

PHC will extract the total number of PHC office visits, telephone visits, and video visits from claims and encounter claims data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site.

### Thresholds

- Points Not Applicable

### Denominator

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

### Numerator

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

Calculation:

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

### Codes Used

- Codes to identify office visits location: OV Inclusion – Location Code on Code List
- Codes to identify office visits: OV Inclusion – Procedure Code on Code List
- Codes to identify void or denied claims in exclusions: OV Exclusion – Explain Code on Code List

### Exclusions

This measure excludes the following:

- Medicare-Medi-Cal dual capitated members

## References


(2001, October). Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions. Retrieved November 11, 2020 from: https://www.ahrq.gov/downloads/pub/ahrqqi/pqiguide.pdf

(2012) Getting Blood Pressure Under Control. Many missed opportunities to prevent heart disease and stroke. September 2012 CDC Vitalsigns®. Retrieved from November 11, 2020 from: https://www.cdc.gov/vitalsigns/hypertension/index.html#:~:text=Why%20is%20blood%20pressure%20control,to%20die%20from%20heart%20disease

(2014, January) Alcohol Screening and Counseling. CDC Vitalsigns®. Retrieved November 18, 2020 from: https://www.cdc.gov/vitalsigns/alcohol-screening-counseling/index.html#:~:text=It%20causes%20about%2088%2C000%20deaths,health%20professional%20about%20alcohol%20use.

2015). Measures of Care Coordination: Preventable Emergency Department Visits. Accessed at https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html

(2017, October). California Department of Health Care Services (DHCS). California Department of Health Care Services Medi-Cal Managed Care Quality Strategy Annual Assessment, October 2017. Retrieved November 10, 2020 from: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/2017_Medi-Cal_Managed_Care_Quality_Strategy_Annual_Assessment.pdf

(2020) National Diabetes Statistics Report. Estimates of Diabetes and Its Burden in the United States. Retrieved November 11, 2020 from: https://www.cdc.gov/diabetes/data/statistics-report/index.html

Dowd, B., M. Karmarker, T. Swenson, et al. (2014). Emergency department utilization as a measure of physician performance." American Journal of Medical Quality 29 (2), 135–43. Retrieved November 11, 2020 from: http://ajm.sagepub.com/content/29/2/135.long

Jerant, A., Moore-Hill, M., and Franks, P. (2009, July 7). Home-Based, Peer-Led Chronic Illness Self-Management Training: Findings From a 1-Year Randomized Controlled Trial. Retrieved November 18, 2020 from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2713168/#:~:text=PURPOSE%20Studies%20suggest%20peer%2Dled,follow%2Dup%20beyond%206%20months.

Jones 2011: Jones AL et al. Use of Advance Directives in Long-Term Care Populations. NCHS Data Brief, No 54. Hyattsville, MD: National Center for Health Statistics. 2011. Retrieved November 18, 2020 from: www.cdc.gov/nchs/data/databriefs/db54.pdf

Jin, J. (2014, December 17) Breast Cancer Screening: Benefits and Harms. Retrieved November 10, 2020 from: https://jamanetwork.com/journals/jama/fullarticle/2040228#:~:text=The%20goal%20of%20screening%20is,cancer%20is%20done%20by%20mammography.

Kass-Bartelmes 2003: Kass-Bartelmes BL. U.S. Agency for Healthcare Research and Quality. Advance Care Planning: Preferences for Care at the End of Life. Research in Action Issue 12. 2003. Retrieved November 18, 2020 from: www.ahrq.gov/research/endliferia/endria.htm

Li, R., Zhang, P., Barker, L., Chowdhury, F., and Zhang, X. (2010, August). Cost-effectiveness of interventions to prevent and control diabetes mellitus: a systematic review. Retrieved November 11, 2020 from https://pubmed.ncbi.nlm.nih.gov/20668156/

(n.d.). Advance Care Planning: Ensuring Your Wishes Are Known and Honored If You Are Unable to Speak for Yourself. Retrieved November 18, 2020 from: https://www.cdc.gov/aging/pdf/advanced-care-planning-critical-issue-brief.pdf

(n.d.). Agency for Healthcare Research and Quality (AHRQ). Improving Asthma Care Quality. Retrieved November 10, 2020 from: https://www.ahrq.gov/data/monahrq/myqi/asthma.html#why

(n.d.).American College of Obstetricians and Gynecology (ACOG) (n.d.) Cervical Cancer Screening. Retrieved November 10, 2020 from: https://www.acog.org/womens-health/faqs/cervical-cancer-screening

(n.d.). Colorectal Cancer Awareness. Retrieved November 11, 2020 from: https://www.cdc.gov/cancer/dcpc/resources/features/colorectalawareness/index.htm

(n.d.). FAQ Directoy: HEDIS Well-Child Visits in the First 30 Months of Life (W30) & Child and Adolescent Well-Care Visits (WCV). Retrieved November 11, 2020 from: https://www.ncqa.org/hedis/faq/?faq=000015734

(n.d.) Pediatric Quality Indicators Overview. Retrieved November 11, 2020 from: https://www.qualityindicators.ahrq.gov/Modules/pdi_resources.aspx

(n.d.) Plan All-Cause Readmission. Retrieved November 11, 2020 from: https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/

(n.d.). Promoting Healthy Nutrition. Retrieved November 11, 2020 from: https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_HealthyNutrition.pdf

(n.d.) Promoting Physical Activity. Retrieved November 11, 2020 from: https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_HealthyNutrition.pdf

(n.d.) Section 2: Why Improve Patient Experience. Retrieved November 12, 2020 from: https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/2-why-improve/index.html

(n.d.) What is the Patient-Centered Medical Home? Retrieved November 18, 2020 from: https://www.acponline.org/practice-resources/business-resources/payment/delivery-and-payment-models/patient-centered-medical-home/understanding-the-patient-centered-medical-home/what-is-the-patient-centered-medical-home#:~:text=The%20Patient%2DCentered%20Medical%20Home%20(PCMH)%20is%20a%20care,a%20manner%20they%20can%20understand.

(n.d.). Why are Childhood Vaccines So Important? Retrieved November 11, 2020 from: https://www.cdc.gov/vaccines/vac-gen/howvpd.htm

Pew 2006: Pew Research Center 2006: Pew Research Center for the People & the Press. Strong Public Support for Right to Die: More Americans Discussing — and Planning — End-of-Life Treatment. Telephone survey of 1,500 older adults conducted Nov. 9-27, 2005 under the direction of Princeton Survey Research Associates International. January 2006. Retrieved November 18, 2020 from: http://people-press.org/report/266/strongpublic-support-for-right-to-die

Schaffner, W., Brooks, D., Jenson, H., Juszczak, L., and Word, B. (2005) Adolescent Vaccination. Bridging from a Strong Childhood Foundation to a Healthy Adulthood. A report on strategies to increase adolescent immunization rates. Retrieved from https://www.aap.org/en-us/Documents/immunization_Adolescents_nfid.pdf

Sturgeon, M. (2015, December 15). American Academy of Pediatrics (AAP). Parent Plus: Importance of routine pediatrician visits. Retrieved from: https://www.aappublications.org/news/2015/12/15/WellChild121515