Summary of Approved Measure Set for Measurement Year 2025

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key:

New Measure || Change to Measure Design || ~~Measure removed~~

2024 Measures	2025 Recommendations
Clinical Domain	
Family Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Care: HbA1c Control 7. Diabetes Management: Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children	**Family Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Child and Adolescent Well Care Visits 5. Childhood Immunization Status: Combo 10 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: HbA1c Control 8. Diabetes Management: Eye Exams 9. Controlling High Blood Pressure 10. Immunizations for Adolescents – Combo 2 11. Well-Child Visits in the First 15 Months of Life 12. Lead Screening in Children 13. Chlamydia Screening in Women (both age groups: 16-24yo) – **Monitoring** 14. Well-Child Visits in the first 15-30 months of life – **Monitoring** 15. Topical fluoride in Children – **Monitoring** 16. **Reduction of Inequity Adjustment (Participation is Optional)**
Clinical Domain	
Internal Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Comprehensive Diabetes Care: HbA1c Control	**Internal Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Colorectal Cancer Screening

5. Controlling High Blood Pressure 6. Diabetes Management: Eye Exams	5. Comprehensive Diabetes Care: HbA1c Control 6. Controlling High Blood Pressure 7. Diabetes Management: Eye Exams 8. Chlamydia Screening in Women (21-24yo) - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**
Clinical Domain	
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children	**Pediatric Medicine:** 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children 6. Chlamydia Screening in Women (16-20yo) 7. Well-Child Visits in the first 15-30 months of life 8. Topical fluoride in Children - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**

Appropriate Use of Resources	
Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)	**Family Medicine & Internal Medicine:** 1. Ambulatory Care Sensitive Admissions 2. ~~Risk Adjusted Readmission Rate (RAR~~) 3. Follow-up within 7 days after Hospital Discharge
Access and Operations	
All Practice Types: 1. Avoidable ED Visits 2. PCP Office Visits	**All Practice Types:** 1. Avoidable ED Visits 2. PCP Office Visits
Patient Experience	
All Sites: 1. Patient Experience	**All Sites:** 1. Patient Experience

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Unit of Service	
All Sites: 1. Advance Care Planning Attestations 2. Extended Office Hours	**All Sites:** 1. Advance Care Planning Attestations 2. Extended Office Hours

3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity 7. Blood Lead Screening 8. Dental Fluoride Varnish Use 9. Tobacco Use Screening 10. Electronic Clinical Data Systems (ECDS)	3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity ~~7. Dental Fluoride Varnish Use~~ 8. Tobacco Use Screening 9. Electronic Clinical Data Systems (ECDS) 10. Early Administration of the 1st HPV Dose 11. Early Administration of Flu Initiation and Booster Doses 12. Academic Detailing

Programmatic Changes:

I. Descriptions of Potential 2025 Measure Changes for Core Measurement Set

A. Change(s) to Existing Measures – Core Measurement Set

i. Retire Risk Adjusted Readmission Rate (RAR) and replace with Follow-up within 7 days after Hospital Discharge. See rational in section I.B.

B. Potential Additions as New Measures – Core Measurement Set

i. Breast Cancer Screening (Family Practice & Internal Medicine: ***Monitoring*** for age group: 40-49yo) – In April 2024, the US Preventive Services Task Force (USPSTF) published updated guidance on screening for breast cancer. The new recommendation is that all persons assigned as female at birth should be screened for breast cancer every other year beginning at age 40 and continuing through 74 years of age. (The previous recommendation was to begin screening at age 50 years). According to the USPTF report, more women in their 40s are getting breast cancer, with rates increasing by about 2% per year. Initiating screening at age 40 years could save about 20% more lives from breast cancer overall. Additional data suggests that this change could have an even greater effect on the Black population, saving up to 40% more lives in this demographic (USPSTF Bulletin April 30, 2024).

Because members and providers are used to the recommendation to start at age 50 years, an adjustment period is indicated to allow member and provider to "get caught up" on screening of eligible members aged 40-49 years. For this reason, this new measure will be a monitoring measure only for 2025. All Primary Care Providers seeing members from the eligible population (all persons assigned as female at birth aged 40-74 years) should initiate screening now, in accordance with the guidelines. As the screenings are recommended for every other year, any

screening done in 2025 will count for numerator compliance when the measure moves to an active measure in 2026 (anticipated).

ii. Chlamydia Screening in Women (Family Practice: ***Monitoring*** for age groups: 16-24yo, Internal Medicine: ***Monitoring*** for age group: 21-24yo, Pediatrics: **Active** for age group: 16-20yo) – The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: "Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV". Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women)

iii. Well-Child Visits in the first 15-30 months of life (Family Practice: ***Monitoring*** & Pediatrics: **Active**) – Members who turned 15 months and 1 day - 30 months old during the MY and had two or more well child visits. This measure will be separate from the W15. According to the American Academy of Pediatrics (AAP), well-child visits at 18 and 24 months are important because they allow for developmental and behavioral screening, including specific autism-spectrum disorder (ASD) screening. These visits also support timely vaccination, laboratory testing and opportunities for parents to ask questions, receive guidance, and support their child's healthy habits.

iv. Topical fluoride in Children (Family Practice & Pediatrics: ***Monitoring***) – Age range will mirror HEDIS, 1-4yo, with a minimum of 2 applications per MY. This will be a 2025 monitoring measure for Family Medicine & Pediatrics. Topical fluoride varnish (TFV) application is recognized as one of the most effective strategies for preventing dental caries and improvement of oral health in all children (8). In addition to prevention, TFV has the potential to re-mineralize existing caries and halt the progression from caries to cavities. According to the CDC, the prevalence of untreated cavities (tooth decay) in the primary teeth of children (aged 2 to 5) from low-income households is about three times higher than that of children from higher income households. Young children are seen in primary care settings earlier and more frequently than in dental offices, making well child visits an ideal opportunity for early detection of caries and varnish application.

v. Reduction of Inequity Adjustment – Participation is optional. Partnership HealthPlan of California (PHC) is actively engaged in HE initiatives that bring

equitable awareness and result in improved quality performance within the 24 counties we serve. We highly encourage provider organizations to partner with us in these efforts and together, we can help move our communities toward equitable access to healthcare. In reviewing the performance of our clinical measures, we recognize there are underlying disparities among our member populations based on location, access and Social Determinants of Health (SDOH). To help our provider organizations with identifying and addressing disparities in their member populations, we have created the Disparity Analysis dashboard housed within eReports which promotes the identification of disparities across all PCP QIP clinical measures based on race/ethnicity groups. This new clinical measure will incentivizing participating sites with set dollar amount if they improve performance in a specific priority group within an identified measure of focus (Child and Adolescent Well Care Visits being the main focus, followed by Childhood Immunization Status Combo 10, Immunization in Adolescents, Breast Cancer Screening & Colorectal Cancer Screening). The sites selected priority group must be performing below the 25th percentile in a particular measure of focus with the goal to improve performance by at least 20% or reaching the 50th percentile at the end of the measurement year.

vi. Follow-up within 7 days after Hospital Discharge (Family Practice & Internal Medicine) – A readmission occurs when a patient is discharged from a hospital and then admitted back into a hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. 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 in alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768). A follow up with a hospitalist, a primary care clinician or a specialist within a week after discharge from the hospital can help reduce readmissions back to the hospital. While this can be a struggle, a good strategy to attain this goal is to have a proper discharge summary which can be communicated with the follow-up provider.

II. Descriptions of Potential 2025 Measure Changes for Unit of Service Measurement Set

A. Change(s) to Existing Measures – Unit of Service

i. Peer Led and Pediatric Group Visits – Expanding the qualifying pediatric well child group visit from exclusively Well-Child Visits in the First 15 Months to both Well-Child Visits in the First 15 Months and Well-Child Visits in the First 15-30 months of Life

ii. Retire Dental Fluoride Varnish Use and replace with Topical Fluoride in Children. See rational in section I.B.

B. Potential Additions as New Measures – Unit of Service

i. Academic Detailing - Medication management is an important component of disease state management, such as diabetes, hypertension, and asthma. Effective medication management requires the clinician and care team to have complete, accurate, and current data on pharmacy claims. PHC Pharmacy Academic Detailing partners clinicians with the PHC clinical staff to provide a review of actionable pharmacy claims data to address gaps in care such as medication non-adherence, suboptimal asthma medication therapy, and gap in statin therapy for people with diabetes and/or cardiovascular disease. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The purpose of this new unit of service measure is to incentivize provider organizations for hosting a two-part academic detailing meeting with PHC Pharmacy Team/Medical Director.