DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

# Quality Incentive Pool (QIP) Program Evaluation Report

## Program Year (PY) 4
## January 1, 2021, to December 31, 2021

May 2023

## Background

Beginning with the July 1, 2017, rating period (state fiscal year 2017-18), the Department of Health Care Services (DHCS) implemented a managed care directed payment program, the Quality Incentive Pool (QIP) program, for Designated Public Hospitals (DPH). The Department directed Medi-Cal managed care plans (MCPs) to make performance-based quality incentive payments to 17 participating DPH systems based on their performance on specified quality measures. QIP payments are linked to delivery of services under MCP contracts and increase the amount of funding tied to quality outcomes. To receive QIP payments, participating entities must achieve specified improvement targets, measured for all Medi-Cal beneficiaries utilizing services at the entity, which grow more difficult through year-over-year improvement or sustained high performance requirements. The total funding available for QIP payments is limited to a predetermined amount, or pool.

The six-month QIP PY3.5 functioned as a transition period to a new calendar year rating period, which took effect January 1, 2021 (QIP PY4). Starting with PY3.5, the QIP program incorporated the District and Municipal Public Hospitals (DMPHs) as participating entities and added Public Hospital Redesign and Incentives in Medi-Cal (PRIME) measures and funding into QIP. With the Medi-Cal 2020 1115 Demonstration (which authorized PRIME) ending, PRIME measures and funding were added to QIP to maintain and continue the momentum achieved with DPHs and DMPHs on improvements in the quality of care delivered to Medi-Cal beneficiaries. For Program Year (PY) 4, from January 1, 2021, to December 31, 2021, the Centers for Medicaid and Medicare (CMS) approved a budget of $ 1.989 billion.

QIP advances the state's managed care quality strategy goal of enhancing quality in DHCS programs by supporting DPHs and DMPHs to deliver effective, efficient, and affordable care. This program also promotes access and value-based payment, increasing the amount of funding tied to quality outcomes, while at the same time further aligning state, MCP, and hospital system targets. It integrates historical supplemental payments to come into compliance with the managed care final rule [42 Code of Federal Regulations (CFR) 438.6(c)], by linking payments to utilization and delivery of services under MCP contracts. Previous annual QIP Evaluations are posted on DHCS' QIP website and were shared with CMS.

The QIP program is authorized by Welfare and Institutions Code section 14197.4(c) and CMS-approved DPH and DMPH preprints, currently approved for PYs 4-6. On December 31, 2020, DHCS submitted the DPH and DMPH QIP preprints for PY4 to CMS for approval. Subsequently, DHCS updated the preprints in response to the COVID-19 Public Health Emergency (PHE). The DMPH preprint was approved on January 20, 2022 and the DPH preprint was approved on February 2, 2022.

The following reporting requirements, performance targets, and payment policies were updated for PY4 due to the COVID-19 PHE.

DPHs
Each DPH's maximum allowable payment amount was paid according to the following distribution:

- 50% of payment: based on achievement of five COVID-19 related measures (see "Addition of COVID-19 PHE and DMPH Infrastructure Measures" below). Reporting any available quantitative data along with a summary of how the measure and relevant activities were implemented was considered full achievement for these measures.

- 40% of payment: based on achievement of 10 pay-for-performance measures chosen by the DPH from priority or elective measures. Pay-for-performance (P4P), also known as value-based purchasing, is a payment model that offers financial incentives for meeting pre-defined targets or benchmarks on performance measures.
- 10% of payment: based on reporting the remaining 30 measures chosen by the DPH for MY 2021. Reporting the measures, including the required data and narratives, was considered full achievement for meeting these measures' PY4 targets.

DMPHs
Each DMPH's maximum allowable payment amount was paid according to the following distribution:
- 50% of payment: based on achievement of five COVID-19 related measures. Reporting any available quantitative data along with a summary of how the measure and relevant activities were implemented was considered full achievement for these measures.
- 20% of payment: DMPHs reported 5 or more measures (excluding the COVID-19 measures) and reported 20% of their measures (rounded to the nearest whole number) on a pay-for-performance basis. DMPHs that reported 4 or fewer measures (excluding the COVID-19 measures) did not have to report on a pay-for-performance basis and instead reported on the 2 infrastructure measures listed below (see "Addition of COVID-19 PHE and DMPH Infrastructure Measures" below).
- 30% of payment: based on reporting their remaining measures for measurement year 2021. Reporting the measures, including the required data and narratives, was considered full achievement for meeting these measures' PY4 targets.

In PY4, QIP entities were required to report a minimum number of measures (40 measures for DPHs, variable for DMPHs depending on their specific number of committed measures). Per the approved PY 4-6 preprints, 50% of reported measures had to be priority measures. The Priority Measure sub-set represents measures, which are of high priority to the state and to Medi-Cal MCPs. The sub-set is composed of measures from the Managed Care Accountability Set for which MCPs have Minimum Performance Levels plus several additional measures representing conditions with high priority, high prevalence, or high mortality in California.

- For any required priority measure, if the entity was unable to report due to not providing the relevant clinical services, a denominator less than 30, or not receiving sufficient assigned lives data from Medi-Cal Managed Care plans that resulted in a denominator less than 30, the entity could substitute an alternative measure from the PY4 QIP Measure List.
- For measures for reporting only, denominators of at least 30 were not required. Pay-for-reporting (P4R) is reporting any available quantitative data along with a summary of how the measure and relevant activities were implemented was considered full achievement for these measures and will receive payment. However, entities could not report measures for which they did not provide the relevant clinical services.

Addition of COVID-19 PHE and DMPH Infrastructure Measures:
For PY4 only, all QIP entities reported on the following five COVID-19 PHE measures:

a) Implementation of employee COVID-19 testing in 2021 [1]

[1] When reporting the employee testing, provision of tests to Medi-Cal beneficiaries and the community, and provision of vaccines to Medi-Cal beneficiaries and the community measures (a, c and d above), QIP entities were required to report the total number of tests or vaccines provided for each of the measures.

b) Implementation of employee COVID-19 vaccination in 2021 [2]
c) Implementation of infrastructure and partnerships for the provision of COVID-19 tests to Medi-Cal beneficiaries and community members in 2021 [1]
d) Implementation of infrastructure and partnerships for the provision of COVID-19 vaccines to Medi-Cal beneficiaries and community members in 2021 [1]
e) Implementation of hospital surge planning and/or response in 2021

For PY4 only, DMPHs that reported 4 or fewer measures (excluding the COVID-19 measures) did not have to report on a pay-for-performance basis and could instead report on the following infrastructure measures:

- Identification of QIP staffing needs for quality improvement and reporting
- Identification of QIP data needs for tracking and reporting

In PY4, the minimum performance benchmark was defined as the measure-specific 25th percentile benchmark. This definition was also used for PY3 and PY3.5. It should be noted that achievement was defined differently in the PY1 and PY2 reports. QIP entities were not required to report baseline data for PY4 because the minimum performance benchmark was the 25th percentile and therefore not tied to improvement from a baseline. For PY4 only, due to the COVID-19 PHE, QIP entities with a performance rate exceeding this minimum performance benchmark were considered to have fully achieved on that measure, and were assigned an Achievement Value (AV) for each pay-for-performance measure as follows:

- If the PY4 performance rate was less than the minimum performance benchmark, then the entity did not achieve on that measure and was assigned an Achievement Value (AV) of 0
- If PY4 performance was equal to or better than the minimum performance benchmark, then the and the entity achieved fully on that measure and was assigned an AV of 1.

Improving Health Equity (IHE) measures:
Two new measures were introduced into QIP for PY4 – Q-IHE1[3] and Q-IHE2. Both measures were designed to improve health equity for select populations in select metrics in QIP.

For PY4, all entities reporting on Q-IHE1 were required to use *Q-CDC-H9 Diabetes Poor Control* as the Equity Measure. If reporting Q-IHE1, entities were required to report sub-rates for <u>all</u> Q-CDC-H9 race/ethnicity groups. Two sub-rates, Diabetes Poor Control for African American/Black and Hispanic/Latino populations, were tied to payment upon meeting the Q-CDC-H9 performance benchmark. These accountable sub-rates needed to have denominators greater than 30. For example, if the Black/African American sub-rate had a denominator of less than 30, then payment was based on the performance rate of the Hispanic/Latino population, assuming that the Hispanic/Latino population had a denominator greater than 30. If both sub-rates had denominators less than 30 then the entity had to choose another priority measure and a priority population – a race

[2] QIP entities had to provide a brief summary of how the QIP entity implemented its employee vaccination/ vaccination verification program. At a minimum, entities must report the number and percentage of employees (i.e., numerator, denominator and rate) for whom the entity 1) verified as vaccinated and boosted, in accordance with verification standards outlined by the California Department of Public Health (CDPH), and 2) verified as having an approved religious or medical exemption in accordance with all CDPH guidance and State Public Health Officer orders. Entities were also required to report the number and percentage of employees that the entity vaccinated during PY4 (entities may report 0 if applicable).
[3] Priority measure

or ethnicity population identified as having statewide disparities[4] in that specific measure – from the DHCS-specified Eligible Equity Measure list as substitution.

For Q-IHE2, an entity could choose the measure and any of its priority populations from the QIP Eligible Equity Measures listed in the QIP Reporting Manual. An entity could choose a priority population for a QIP Eligible Equity measure, subject to the following requirements:

- The priority population had to be ***less than 50%*** of the parent measure's total population. *This requirement ensured efforts in IHE measures did not duplicate efforts in the parent measure.*
- The priority population baseline rate had to have ***3 percentage point or greater disparity*** compared to total population baseline rate of the parent measure. Should that gap decrease to less than 3 percentage points by the end of the program year, the entity was required to choose a ***new Priority Population*** and/or Eligible Equity Measure ***two Program Years later.***
- The priority population baseline rate could not be at or above the measure's 90th percentile benchmark. If an entity achieved ≥90th percentile in any one Program Year, the entity had to choose a ***new*** measure and/or a **different** Priority Population ***two Program Years later*** even if the performance on the Priority Population dropped below the 90th percentile in subsequent years (regardless of whether the entity reported on it or not).

Stratification of Reported Data by Race and Ethnicity:
DHCS required informational reporting of race and ethnicity stratifications for five measures in PY4. The required stratifications and protocols are outlined in QIP Policy Letter QPL 21-006. The specific measures stratified were:
• Q-BCS: Breast Cancer Screening.
• Q-CMS130: Colorectal Cancer Screening.
• Q-CBP: Controlling High Blood Pressure.
• Q-CMS147: Preventive Care and Screening: Influenza Immunization
• Q-CMS2: Preventive Care and Screening: Screening for Depression and Follow-Up Plan.

DMPH Community Partners:
The PY4 DMPH preprint included a provision allowing DMPHs to use managed care data from contracted community clinics ("community partners") in QIP data reporting, if approved to do so by DHCS. For a select group of measures, DMPHs could use data from DHCS-approved contracted community partners' patients in their QIP reports. Only specific QIP measures where the DMPH had a demonstrated role in the coordination of care and achievement of the measure were considered for this allowance. These measures generally included patients who had an emergency room or inpatient encounter at the DMPH and measured quality improvement activities that could be undertaken by the DMPH. In PY4, four hospitals had approved community partners: El Camino, Marin General, Palomar, and Tri-City. For more information regarding community partners, including which QIP measures were eligible for community partner data inclusion, please see the DMPH pre-print.

In PY4, there were 17 DPHs and 31 DMPHs (including one newly joined) that participated in QIP. Two DMPHs could not participate due to not having assigned lives or managed care members to qualify for reporting the QIP measures. Bear Valley Community Hospital and Palo Verde Hospital did not have assigned lives or the minimum required denominator (denominator of 30) in the QIP measures they planned to report. One DMPH discontinued participation because they became a privately owned hospital.

[4] DHCS Health Disparities Report, Preventive Services Report, Behavioral Risk Factor Surveillance System - BRFSS Survey 2018, and CA HIV/AIDS Health Disparities 2019

For more details, please see QIP Policy Letter 22-002 and Attachment 1 of the QIP PY4 DPH preprint and DMPH preprint available on the DHCS QIP webpage.

## Evaluation Purpose

The purpose of this and future program evaluations is to determine if QIP directed payments made through DHCS contracts with Medi-Cal MCPs to contracted DPHs and DMPHs result in improvement in the quality of inpatient and outpatient services for Medi-Cal members assigned to or seen by DPHs and DMPHs.

## Evaluation Questions

This evaluation was designed to determine:

- For each DPH or DMPH, the percentage of measures for which they met their quality performance targets

- For each measure, of DPHs or DMPHs reporting on that measure, what percentage met their quality performance targets

## Evaluation Design and Methods

The state used aggregate data reported by DPHs and DMPHs to DHCS pertaining to the performance measures listed in Attachment 1 of the DMPH and DPH preprints.

### QIP PY4 Data Audit

To support data integrity and ensure accountability for the QIP funds, DHCS partnered with the Health Services Advisory Group (HSAG) to assess QIP reports as part of the DHCS review and oversight process. For PY4, DHCS limited the audit to all data submitted for measures that were also part of the Measurement Year 2021 Medi-Cal Managed Care Accountability Set (MCAS). More information on the QIP PY4 Data Audit can be found in QPL 22-002 and QPL 22-003.

DPHs and DMPHs submitted encrypted aggregated data collected in accordance with the QIP PY4 Reporting Manual to DHCS, using a secure online reporting system. DHCS staff and the HSAG auditor reviewed the reported data for accuracy, asking questions of the entities and/or requesting corrected data when necessary, and then deemed the data final. DHCS conducted its analysis on 100 percent of the data.

The achievement rate for each measure was calculated by dividing the numerator by the denominator, except for risk-adjusted measures, as reported by the DPH/DMPH. Rates were suppressed to protect confidentiality because of small numbers and when the denominator was less

than 30 (except for risk-adjusted measures), which would resulting in a statistically unstable rate. For each hospital system, measure performance was assessed by comparing each measure's PY4 achievement rate to the measure's minimum performance benchmark and assigning an Achievement Value (AV) as specified in the QIP COVID-19 PHE Amended Preprint, Attachment 1. An AV would be zero if the DPH/DMPH did not achieve the minimum performance benchmark. During their audit, HSAG identified inaccuracies in target population on some pay-for-reporting measures reported by Antelope Valley Hospital and San Gorgonio Memorial Hospital. Reporting the measure, including the required data and narratives, was normally considered full achievement of the measure's target but because there were data inaccuracies for these hospitals, the affected measures were assigned an achievement value of 0.5.

A draft of this report was shared with stakeholders (DPHs, DMPHs, California Association of Public Hospitals/California Health Care Safety Net Institute, the District Hospital Leadership Forum, California Association of Health Plans, Local Health Plans of California, and MCPs) in May 2023, and the final report incorporated stakeholder input.

## Results

### DPHs

In PY4, aggregated data submitted by 17 DPHs to DHCS was used to determine the number of measures reported by each hospital. Numerators, denominators, achievement rates, and achievement values for each measure are posted on the Open Data Portal. Sixteen DPHs reported on at least 10 pay-for-performance and 30 pay-for-reporting measures (see table 1). Arrowhead Regional Medical Center did not receive all of its allotted funding, because it only reported 17 of the required 20 priority measures. UC Davis Medical Center reported and met its target for 11 pay-for-performance measures and Contra Costa Regional Medical Center reported 31 pay-for-reporting measures; however, this had no impact on funding.

Table 1 shows the number of pay-for-reporting and pay-for-performance measures, and the percentage of measures for which each DPH met the target. All DPHs reported meeting their target for measures regardless of whether the DPHs reported the measure as pay-for-performance or pay-for-reporting. However, for the 20 required priority measures all but one DPH (Arrowhead Regional Medical Center) reported on all 20 measures.

Table 2 shows for each measure how many DPHs met their target. For all measures reported, DPHs met their target regardless of whether the measure was reported as pay-for-performance or pay-for-reporting. DPHs were required to report the 20 priority measures, so these measures had higher numbers of DPHs reporting compared to the elective measures. However, there were four measures that DPHs were more likely to report as pay-for-performance: Colorectal Cancer Screening, Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%), Preventive Care and Screening: Influenza Immunization, and HIV Screening. Arrowhead Regional Medical Center did not report the following priority measures: Asthma Medication Ratio, Preventive Care and Screening: Influenza Immunization, and Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. All 17 DPHs reported on the following elective measures: Coronary Artery Disease: Antiplatelet Therapy, and HIV Screening. Of the rest of the elective measures, DPHs were least likely to report on Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (4 DPHs) and

Pharmacotherapy Management of COPD Exacerbation (3 DPHs). Also included in this table are the COVID-19 measures on which all 17 DPHs reported.

Information about both Improving Health Equity Measures (IHE1 and IHE2) is also included in Table 2. For IHE1, 16 DPHs reported on Comprehensive Diabetes: HbA1c Poor Control (>9.0%) for both the African American/Black and Hispanic/Latino populations. UCLA Medical Center had a denominator of less than 30 for both African American/Black and Hispanic/Latino populations for this measure; therefore, they were allowed to replace it with Colorectal Cancer Screening for the Native Hawaiian/Pacific Islander population. For IHE2, DPHs chose different measures and priority populations. Three DPHs reported on Controlling Blood Pressure (Arrowhead Regional Medical Center, San Francisco General Hospital, and UC San Francisco Medical Center, with SFGH and UCSF reporting on the African American/Black population, and Arrowhead on the Hispanic/Latino population). Contra Costa reported on the African American/Black population for the Child and Adolescent Well Visits measure while San Mateo reported on the African American/Black population for the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure. The full datasets for QIP PY4 are on the California Health and Human Services (CHHS) open data portal.

Table 3 shows the PY4 aggregate rates for the six measures that were stratified by race/ethnicity by all the DPHs. The six measures stratified were Controlling High Blood Pressure, Improving Health Equity 1, Breast Cancer Screening, Colorectal Cancer Screening, Preventive Care and Screening: Screening for Depression and Follow-Up Plan, and Preventive Care and Screening: Influenza Immunization. All 17 DPHs stratified four of the measures while 16 DPHs stratified the Preventive Care and Screening: Influenza Immunization measure (Arrowhead Regional Medical Center did not report this measure). Sixteen DPHs stratified the Improving Health Equity 1 (Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) measure) – UCLA had denominators less than 30 for both the African American/Black and Hispanic/Latino populations, so it switched its measure to Colorectal Cancer Screening for the Native Hawaiian/Pacific Islander population.

The aggregate rates varied for the measures by race and ethnicity for DPHs. For the Controlling High Blood Pressure and Colorectal Cancer Screening measures, Asians and Hispanics/Latinos had the highest rates, while African Americans/Blacks had the lowest rates. Asians and Hispanics/Latinos also had the highest rates for the Breast Cancer Screening and Preventive Care and Screening: Screening for Depression measures; however, the population with the lowest rate varied for these two measures. Whites had the lowest rate for Breast Cancer Screening and American Indians/Alaska Natives had the lowest rate for Preventive Care and Screening: Screening for Depression. Whites also had the lowest rate for the Preventive Care and Screening: Influenza Immunization measure, while Asians and American Indians/Alaskan Natives had the highest rates. For the Improving Health Equity 1 measure (lower rates are better), the Asian and African American/Black populations had the lowest and best rates, while the Native Hawaiian/Other Pacific Islander population had the highest/worst rate.

In Table 4, the aggregate rates were further stratified by ethnicity and then by race within each ethnicity group. The population sizes for the Unknown Ethnicity group were low so aggregate rates tended to be suppressed and when combined with the non-Hispanic/Latino group the rates for the racial groups did not change. Therefore, for both DPHs and DMPHs the non-Hispanic/Latino group was combined with the Unknown Ethnicity group. First in the table are the aggregate rates for those

that reported being non-Hispanic/Latino or of Unknown Ethnicity, then in the table are the rates for those who reported being Hispanic/Latino with stratification by identified race. There were low numbers of individuals identifying as both Hispanic or Latino and as an identifiable race; therefore, many of the dis-aggregated Asian and Native Hawaiian/Other Pacific Islander sub-populations rates were suppressed because of low numbers.

Populations with the best performance varied by measure as shown in table 4. For the Improving Health Equity 1 measure lower rates meant better performance. Table 4 also shows that there was considerable variability between entities' performance in different Asian groups. However, overall, the non-Hispanic/Latino Asian population had the most favorable rates. The populations with the best rates varied by measure. For the Controlling High Blood Pressure measure, the worst rates were among the non-Hispanic/Latino African American/Black and Hispanic/Latino African American/Black populations. For the Improving Health Equity 1 measure, both the non-Hispanic/Latino Native Hawaiian/Other Pacific Islander and the Hispanic/Latino Native Hawaiian/Other Pacific Islander populations had the worst rates. For the Colorectal Cancer Screening and Preventive Care and Screening: Influenza Immunization measures both the non-Hispanic/Latino Whites and non-Hispanic/Latino American Indian/Alaska Native populations had the lowest rates. For the Preventive Care and Screening: Screening for Depression measure the group with the lowest rates was the non-Hispanic/Latino American Indian/Alaska Native population. For the Breast Cancer Screening measure, the Hispanic/Latino American Indian/Alaska Native population had the highest rate while the non-Hispanic/Latino American Indian/Alaska Native and non-Hispanic/Latino Whites populations had the lowest rates.

When the non-Hispanic/Latino Asian group was dis-aggregated, the rates for measures also varied when focusing on those who reported at least one of these sub-group populations. The Laotian population had the highest aggregate rates for four of the measures (Controlling Blood Pressure, Breast Cancer Screening, and both Preventive Care and Screening: measures), as well as the lowest rate for IHE1, a measure where lower rates indicate better care. In contrast, the Japanese population had the lowest rate on the Breast Cancer Screening, Colorectal Cancer Screening measure, and one of the least favorable rates on the Improving Health Equity 1 measure, all indicating poorer than average care. For other groups, there was variation. For the Controlling High Blood Pressure measure the Cambodian population had the lowest rate. For the Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure, the Korean group had the lowest rate. For the Preventive Care and Screening: Influenza Immunization measure, the Asian Indian group had the lowest rate.

## DMPHs

In PY4, aggregated data submitted by 31 DMPHs to DHCS was used to determine the number of measures reported by each hospital. Numerators, denominators, achievement rates, and achievement values for each measure are posted on the Open Data Portal. Two DMPHs (Bear Valley Community Hospital and Palo Verde Hospital) did not participate in PY4 due to not having assigned lives or minimum required denominators for the QIP measures and one (Mendocino Coast District Hospital) discontinued participation because they became a privately owned hospital. Lastly, one new DMPH (Surprise Valley) joined the QIP program in PY4. All but two of the 31 DMPHs (Antelope Valley Hospital and San Gorgonio Memorial Hospital) met their targets for all of the pay-for-performance and pay-for-reporting measures (see table 5) they reported. Antelope Valley Hospital and San Gorgonio Memorial Hospital received 79.17% and 82.5% of the allotted funding respectively

due to data issues that could not be remediated during the hospital report review by DHCS and its data auditor.

Table 5 shows the number and percentage of pay-for-performance and pay-for-reporting measures each DMPH reported and for how many measures they met their target. Unlike the DPHs, DMPHs were not required to report the 20 priority measures, but they were still more likely to report measures from that list than the measures from the elective list. The number of pay-for-performance measures reported by DMPHs ranged from zero to four, while the number of pay-for-reporting measures ranged from two to sixteen.

Table 6 also shows for each measure how many DMPHs met their target. For almost all measures, DMPHs met their target regardless of whether the measure was reported as pay-for-performance or pay-for-reporting. Because of Antelope Valley Hospital and San Gorgonio Memorial Hospital not meeting their targets for all of their measures, the following measures had less than 100% for target being met: Prenatal and Postpartum Care (Postpartum Care) (83%), Appropriate Treatment for Upper Respiratory Infection (0%), Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (0%), Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (67%), Medication Reconciliation Post-discharge (60%), Pharmacotherapy Management of COPD Exacerbation (33%), Plan All Cause Readmission (33%), and Use of Imaging Studies for Low Back Pain (50%). DMPHs were more likely to report on measures from the priority list (ranged from 4 to 15) than those from the elective list (ranged from zero to eleven). The four measures reported by the most DMPHs were Breast Cancer Screening (15 DMPHs), Colorectal Cancer Screening (14 DMPHs), Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (13 DMPHs), and Preventive Care and Screening: Screening for Depression and Follow-Up Plan (14 DMPHs). No DMPHs reported on the following four measures: HIV Viral Load Suppression, Contraceptive Care – All Women, Depression Remission or Response for Adolescents and Adults, and Use of Opioids at High Dosage in Persons Without Cancer. Also included in this table are the COVID-19 measures that all 31 DMPHs reported. Lastly, seven DMPHs reported the Infrastructure Measures.

Also in Table 6 is information about both Health Equity Measures (IHE1 and IHE2). For IHE1, six DMPHs reported on the Comprehensive Diabetes: HbA1c Poor Control (>9.0%) for both the African American/Black and Hispanic/Latino populations. Tri City Medical Center did not have sufficient numbers to report on this measure and was allowed to replace it with Breast Cancer Screening for the African American/Black and White populations. Only Tri City Medical Center reported Prenatal and Postpartum Care: Timeliness of Prenatal Care measure for the African American/Black population as its IHE2 measure. The full datasets for QIP PY4 can be located on the California Health and Human Services (CHHS) open data portal.

Table 7 shows the PY4 aggregate rates for the same six measures that were stratified by race/ethnicity by the DMPHs that reported stratification for those measures. More DMPHs reported stratifications for the Breast Cancer Screening (15 DMPHs), Colorectal Cancer Screening (14 DMPHs) and Preventive Care and Screening: Screening for Depression and Follow-Up Plan (14 DMPHs) measures, than for the Improving Health Equity 1 (6 DMPHs), Preventive Care and Screening: Influenza Immunization (9 DMPHs) and Controlling Blood Pressure (10 DMPHs) measures. The aggregate rates varied for the measures by race and ethnicity for DMPHs. American Indians/Alaska Natives had the lowest rates for three of the measures (Breast Cancer Screening,

Colorectal Cancer Screening, and Preventive Care and Screening: Influenza Immunization); however, the population with the highest rate varied for each measure. For the Breast Cancer Screening measure, Hispanics and Asians had the highest rates, while the Native Hawaiian/Other Pacific Islanders and Asians had the highest rates for the Colorectal Cancer Screening and for the Preventive Care and Screening: Influenza Immunization measures. African Americans/Blacks had the worst rates for two of the measures (Controlling Blood Pressure and Improving Health Equity 1) while American Indians/Alaska Natives and Hispanics had the most favorable rates, respectively. Lastly, for the Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure the populations with the highest rate were the Hispanics and American Indian/Alaska Natives, while Native Hawaiians/Other Pacific Islanders had the lowest rate.

Table 8 shows the PY4 aggregate rates for the six measures that were stratified by race/ethnicity by the DMPHs that reported stratification for those measures. As with the DPH table, first are the aggregate rates for those that reported being non-Hispanic/Latino or of Unknown Ethnicity, followed by rates for those who reported being Hispanic/Latino, with both groups further stratified by identified race. Compared with DPHs, DMPHs had fewer patients who were both Hispanic/Latino and any identified race; therefore, many rates were suppressed because of low numbers. In particular, the rates for dis-aggregated Asian and Native Hawaiian/Other Pacific Islanders were suppressed for both those who were Hispanic/Latino, and for those who were not Hispanic/Latino or did not report their ethnicity.

The aggregate rates varied greatly by race and ethnicity at DMPHs. Non-Hispanic/Latino Whites and non-Hispanic/Latino African American/Blacks had the lowest aggregate rates for Controlling High Blood Pressure and the worst rates (highest) for the IHE1 (Comprehensive Diabetes Control) measure. While Hispanic/Latino Asians had the most favorable rate for the Controlling Blood Pressure measure and non-Hispanic/Latino Asians had the best rate for the IHE1 measure. For both the Breast Cancer Screening and Colorectal Screening measures, the non-Hispanic/Latino AI/AN group had the lowest rates. Hispanic/Latino Whites had the highest rate for Breast Cancer Screening and non-Hispanic/Latino Native Hawaiian/Other Pacific Islanders had the highest rate for Colorectal Cancer Screening. For the Preventive Care and Screening: Screening for Depression and Follow-Up Plan measure, the non-Hispanic/Latino AI/AN population had the highest rate, and the Hispanic/Latino African American/Black population had the lowest was rate. For the Follow-Up Plan and Preventive Care and Screening: Influenza Immunization measure the Hispanic/Latino Asian population had the highest rates, while the non-Hispanic/Latino White population has the lowest rate. Lastly, rates on these measures varied widely for the Asian subpopulations where aggregate reporting was possible – for example, non-Hispanic/Latino Filipino population had Breast Cancer Screening rates that were the lowest of all populations.

## Conclusion

This report provides information regarding the quality of services provided to Medi-Cal members at DPHs and DMPHs during calendar year 2021, a year marked by the influence of the COVID-19 pandemic on the health care delivery system. In this evaluation report, DHCS was not able to compare achievement rates for specific measures to achievement rates in previous years since there were no baseline data collected for these measures in PY4. All but one DPH (Arrowhead Regional Medical Center) reported on the 20 required priority measures. All but two of the 31 DMPHs (Antelope Valley Hospital and San Gorgonio Memorial Hospital) met their targets for all of the

reported pay-for-performance and pay-for-reporting measures. DMPHs reported a range of pay-for-performance (0 to 4 measures) and pay-for-reporting (2 to 16) measures.

In PY4, both DMPHs and DPHs reported measures for the QIP program, so both were evaluated in this report. For the priority measures that DPHs were required to report, 16 DPHs met their payment target on 100 percent of measures reported; however, one DPH only reported 17 out of the 20 required priority measures. The number of measures chosen by DMPHs also varied and 29 out of 31 (94%) met their payment target on 100% of measures reported. All DPHs and DMPHs reported on the five QIP COVID-19 PHE measures, while seven DMPHs reported the QIP Infrastructure Measures.

For both DPHs and DMPHs, the aggregate rates for the six measures stratified by race/ethnicity varied by population. Racial-ethnic differences in these rates showed where DPHs and DMPHs could focus their quality improvement efforts. For example, disparities for African Americans/Blacks on chronic disease care (diabetes and high blood pressure) persisted in both DPHs and DMPHs and narrowing these disparities should be an area of continued emphasis. In addition, preventive screenings (breast cancer, colorectal cancer, and influenza immunization) were consistently below-average for American Indian/Alaska Native patients in DMPHs and White patients in DPHs. There were a relatively small number of patients in racial groups that also reported being Hispanic/Latino; therefore, those rates tended to be suppressed. Disaggregating the non-Hispanic/Latino Asian group showed which groups would benefit from quality health programs targeting certain measures. For example, in DPHs the Laotian group had the best rates for five of the six measures while Japanese patients had worst rates for three of the six measures. This report and subsequent annual evaluation reports will be posted on the DHCS QIP website and shared with CMS, while the data itself is posted on the CHHS open data portal.

**Table 1: Number and Percentage of Pay for Performance and Pay-for-Reporting Measures with Targets Met for Each DPHs for PY4**

| DPH | No. Of Measures With Target Met | Percentage of Measures With Target Met |
|---|---|---|
| | | |
| Alameda Health System | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| Arrowhead Regional Medical Center* | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 33** | 100% |
| Contra Costa Regional Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 31** | 100% |
| Kern Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| Los Angeles County Health System | | |
| Pay-for- Performance Measures | 10 | 100% |
| Pay-for- Reporting Measures | 30 | 100% |
| Natividad Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| Riverside University Health System | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| San Francisco General Hospital | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| San Joaquin General Hospital | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |

| DPH | No. Of Measures With Target Met | Percentage of Measures With Target Met |
|---|---|---|
| | | |
| San Mateo Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| Santa Clara Valley Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| UC Davis Medical Center | | |
| Pay-for-Performance Measures | 11** | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| UC Irvine Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| UC Los Angeles Medical Center*** | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| UC San Diego Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| UC San Francisco Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |
| Ventura County Medical Center | | |
| Pay-for-Performance Measures | 10 | 100% |
| Pay-for-Reporting Measures | 30 | 100% |

*Arrowhead Regional Medical Center report only 17 of the 20 required priority measures.
**DPH reported more measures than required
***UCLA substituted Colorectal Cancer as their Improving Health Equity 1 Measure for the Native Hawaiian/Pacific Islander population because this DPH had denominator less than 30 for both African American/Black and Hispanic/Latino populations.

## Table 2: Percentage of DPHs Meeting Quality Improvement Targets for PY4

| Measures | Number of DPHs Meeting Target | | Number of DPHs Reporting | | Percentage of DPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| QIP Priority Performance Measures | | | | | | |
| Improving Health Equity 1* | 2 | 15 | 2 | 15 | 100% | 100% |
| (Comprehensive Diabetes: HbA1c Poor Control (>9.0%)↓ | 2 | 14 | 2 | 14 | 100% | 100% |
| African Americans/Blacks | 2 | 14 | 2 | 14 | 100% | 100% |
| Hispanics/Latinos | 2 | 14 | 2 | 14 | 100% | 100% |
| Colorectal Cancer Screening | ---- | 1 | ---- | 1 | ---- | 100% |
| Native Hawaiians/Pacific Islanders | ---- | 1 | ---- | 1 | ---- | 100% |
| Asthma Medication Ratio | 1 | 15 | 1 | 15 | 100% | 100% |
| Breast Cancer Screening | 6 | 11 | 6 | 11 | 100% | 100% |
| Cervical Cancer Screening | 2 | 15 | 2 | 15 | 100% | 100% |
| Child and Adolescent Well Care Visits | 5 | 12 | 5 | 12 | 100% | 100% |
| Childhood Immunization Status (CIS 10) | 3 | 14 | 3 | 14 | 100% | 100% |
| Chlamydia Screening in Women | 4 | 13 | 4 | 13 | 100% | 100% |
| Colorectal Cancer Screening | 11 | 6 | 11 | 6 | 100% | 100% |
| Comprehensive Diabetes Care: Eye Exam | 5 | 12 | 5 | 12 | 100% | 100% |
| Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓ | 10 | 7 | 10 | 7 | 100% | 100% |
| Controlling High Blood Pressure | 6 | 11 | 6 | 11 | 100% | 100% |
| Developmental Screening in the First Three Years of Life | 3 | 14 | 3 | 14 | 100% | 100% |
| HIV Viral Load Suppression | 6 | 11 | 6 | 11 | 100% | 100% |
| Immunizations for Adolescents | 4 | 13 | 4 | 13 | 100% | 100% |
| Prenatal and Postpartum Care (Postpartum Care) | 2 | 15 | 2 | 15 | 100% | 100% |
| Prenatal and Postpartum Care (Timeliness of Prenatal Care) | 1 | 16 | 1 | 16 | 100% | 100% |
| Preventive Care and Screening: Influenza Immunization | 10 | 6 | 10 | 6 | 100% | 100% |
| Preventive Care and Screening: Screening for Depression and Follow-Up Plan | 2 | 15 | 2 | 15 | 100% | 100% |

| Measures | Number of DPHs Meeting Target | | Number of DPHs Reporting | | Percentage of DPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | 4 | 12 | 4 | 12 | 100% | 100% |
| Rate 2** | 4 | 12 | 4 | 12 | 100% | 100% |
| Rate 3** | 4 | 12 | 4 | 12 | 100% | 100% |
| Well-Child Visits in the First 30 Months of Life | 1 | 16 | 1 | 16 | 100% | 100% |
| First 15 Months | 1 | 16 | 1 | 16 | 100% | 100% |
| 15 Months – 30 Months | 1 | 16 | 1 | 16 | 100% | 100% |
| Elective QIP Performance Measures | | | | | | |
| Advance Care Plan | 1 | 11 | 1 | 11 | 100% | 100% |
| Appropriate Treatment for Upper Respiratory Infection | 4 | 8 | 4 | 8 | 100% | 100% |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis | 2 | 6 | 2 | 6 | 100% | 100% |
| Cesarean Birth (PC-02)↓ | 6 | 8 | 6 | 8 | 100% | 100% |
| Comprehensive Diabetes Control: Medical Attention for Nephropathy | 2 | 9 | 2 | 9 | 100% | 100% |
| Concurrent Use of Opioids and Benzodiazepines↓ | 3 | 10 | 3 | 10 | 100% | 100% |
| Contraceptive Care – All Women | 1 | 8 | 1 | 8 | 100% | 100% |
| Coronary Artery Disease: Antiplatelet Therapy | 7 | 10 | 7 | 10 | 100% | 100% |
| Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%) | 4 | 11 | 4 | 11 | 100% | 100% |
| Depression Remission or Response for Adolescents and Adults | 2 | 11 | 2 | 11 | 100% | 100% |
| Follow-up PHQ-9 (Adults) | 2 | 11 | 2 | 11 | 100% | 100% |
| Depression Remission (Adults) | 2 | 11 | 2 | 11 | 100% | 100% |
| Depression Response (Adults) | 2 | 11 | 2 | 11 | 100% | 100% |
| Discharged on Antithrombotic Therapy (STK-2) | 2 | 8 | 2 | 8 | 100% | 100% |
| Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older | 2 | 9 | 2 | 9 | 100% | 100% |
| Exclusive Breast Milk Feeding (PC-05) | 5 | 10 | 5 | 10 | 100% | 100% |
| Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence | ----- | 4 | ----- | 4 | ----- | 100% |
| 7 Days | ----- | 4 | ----- | 4 | ----- | 100% |
| 30 Days | ----- | 4 | ----- | 4 | ----- | 100% |

| Measures | Number of DPHs Meeting Target | | Number of DPHs Reporting | | Percentage of DPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | 4 | 12 | 4 | 12 | 100% | 100% |
| HIV Screening | 10 | 7 | 10 | 7 | 100% | 100% |
| Improving Health Equity 2 | ----- | 5 | ----- | 5 | ----- | 100% |
| Control Blood Pressure | ----- | 3 | ----- | 3 | ----- | 100% |
| African Americans/Blacks | ----- | 2 | ----- | 2 | ----- | 100% |
| Hispanics/Latinos | ----- | 1 | ----- | 1 | ----- | 100% |
| Child & Adolescent Well Being | ----- | 1 | ----- | 1 | ----- | 100% |
| African Americans/Blacks | ----- | 1 | ----- | 1 | ----- | 100% |
| Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | ----- | 1 | ----- | 1 | ----- | 100% |
| African Americans/Blacks | ----- | 1 | ----- | 1 | ----- | 100% |
| Rate 2** | ----- | 1 | ----- | 1 | ----- | 100% |
| Rate 3** | ----- | 1 | ----- | 1 | ----- | 100% |
| Lead Screening in Children | ----- | 14 | ----- | 14 | ---- | 100% |
| Medication Reconciliation Post-discharge | 6 | 9 | 6 | 9 | 100% | 100% |
| Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) | 4 | 12 | 4 | 12 | 100% | 100% |
| Pharmacotherapy Management of COPD Exacerbation | 0 | 3 | 0 | 3 | 0% | 100% |
| Systematic Corticosteroid | 0 | 3 | 0 | 3 | 0% | 100% |
| Bronchodilator | 0 | 3 | 0 | 3 | 0% | 100% |
| Plan All-Cause Readmissions↓ | 1 | 5 | 1 | 5 | 100% | 100% |
| Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections | 5 | 9 | 5 | 9 | 100% | 100% |
| Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | 1 | 8 | 1 | 8 | 100% | 100% |
| Reduction in Hospital Acquired Clostridium Difficile Infections↓ | 1 | 11 | 1 | 11 | 100% | 100% |
| Statin Therapy For The Prevention And Treatment Of Cardiovascular Disease | 1 | 12 | 1 | 12 | 100% | 100% |
| Surgical Site Infection (SSI) Reported as SIR↓*** | 2 | 9 | 2 | 9 | 100% | 100% |
| Use of Imaging Studies for Low Back Pain | 4 | 7 | 4 | 7 | 100% | 100% |

| Measures | Number of DPHs Meeting Target | | Number of DPHs Reporting | | Percentage of DPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| Use of Opioids at High Dosage in Persons Without Cancer↓ | 2 | 7 | 2 | 7 | 100% | 100% |
| Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents | 1 | 9 | 1 | 9 | 100% | 100% |
| BMI | 1 | 9 | 1 | 9 | 100% | 100% |
| Counseling for Nutrition | 1 | 9 | 1 | 9 | 100% | 100% |
| Counseling for Physical Activity | 1 | 9 | 1 | 9 | 100% | 100% |
| QIP COVID-19 PHE Measures | | | | | | |
| Implementation of employee COVID-19 testing in 2021 | ----- | 17 | ----- | 17 | ----- | 100% |
| Implementation of employee COVID-19 vaccination in 2021 | ----- | 17 | ----- | 17 | ----- | 100% |
| Implementation of infrastructure and partnerships for the provision of COVID-19 tests to Medi-Cal beneficiaries and community members in 2021 | ----- | 17 | ----- | 17 | ----- | 100% |
| Implementation of infrastructure and partnerships for the provision of COVID-19 vaccines to Medi-Cal beneficiaries and community members in 2021 | ----- | 17 | ----- | 17 | ----- | 100% |
| Implementation of hospital surge planning and/or response in 2021 | ----- | 17 | ----- | 17 | ----- | 100% |

↓For these measures lower achievement rates indicate better care

*For the Improving health equity 1 measure, all DPHs were required to report data on Comprehensive Diabetes: HbA1c Poor Control (>9.0%); however, UCLA did not because for the African American/Black and Hispanic/Latino populations the denominators were less than 30. Therefore, UCLA reported on the Native Hawaiian/Pacific Islander population for Colorectal Cancer Screening instead

**For the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure rate 2 is the percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention, while rate 3 is the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user

***Composite SIR is the sum of the observed number of SSIs across all 6 procedure categories divided by the sum of the expected number of SSIs across the 6 procedure categories. Observed and expected data from all 6 procedure categories are included.

----numerator and denominator were zero

### Table 3: Aggregate Rate for the QIP Measures Stratified by Race-Ethnicity for DPHs

| Race/Ethnicity | Controlling High Blood Pressure | Improving Health Equity 1 (Comprehensive Diabetes Control)↓ | Breast Cancer Screening | Colorectal Cancer Screening | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Preventive Care and Screening: Influenza Immunization |
|---|---|---|---|---|---|---|
| Hispanic/Latino | 0.5750 | 0.3700 | 0.6419 | 0.5867 | 0.6517 | 0.5965 |
| White | 0.5572 | 0.3658 | 0.5037 | 0.5070 | 0.5445 | 0.5106 |
| African American/Black | 0.5004 | 0.3589 | 0.5303 | 0.4707 | 0.5989 | 0.5524 |
| American Indian/Alaska Native | 0.5712 | 0.3820 | 0.5095 | 0.5116 | 0.5395 | 0.6023 |
| Asian | 0.5861 | 0.2251 | 0.5987 | 0.6492 | 0.6369 | 0.6972 |
| Native Hawaiian/Other Pacific Islander | 0.5449 | 0.4180 | 0.5524 | 0.4996 | 0.5572 | 0.5982 |
| Other/Unknown/Declined | 0.5648 | 0.3704 | 0.5627 | 0.5680 | 0.6105 | 0.5896 |

Note –All rates are based on at least a numerator of 11 and a denominator of 30; Racial/ethnicity groups in the table are not mutually exclusive see QIP Policy Letter QPL 21-006 for details; UCLA had no data for IHE1;
↓For this measure lower achievement rates indicate better care

## Table 4: Aggregate Rate for the QIP Measures Stratified by Detailed Race and Ethnicity for DPHs

| Race/Ethnicity | Controlling High Blood Pressure | Improving Health Equity 1 (Comprehensive Diabetes Control)↓ | Breast Cancer Screening | Colorectal Cancer Screening | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Preventive Care and Screening: Influenza Immunization |
|---|---|---|---|---|---|---|
| **Non-Hispanic/Latino/Unknown Ethnicity** | | | | | | |
| **White** | 0.5435 | 0.3640 | 0.4301 | 0.4771 | 0.5162 | 0.5032 |
| **African American/Black** | 0.5001 | 0.3593 | 0.5289 | 0.5025 | 0.6004 | 0.5249 |
| **American Indian/Alaska Native** | 0.5699 | 0.3726 | 0.4198 | 0.4585 | 0.4957 | 0.5234 |
| **Asian** | 0.5868 | 0.2249 | 0.5984 | 0.6503 | 0.6376 | 0.6983 |
| Asian Indian | 0.5464 | 0.2281 | 0.6220 | 0.5760 | 0.6422 | 0.5553 |
| Cambodian | 0.5000 | 0.2632 | 0.6525 | 0.6505 | 0.6979 | 0.6530 |
| Chinese | 0.5930 | 0.1781 | 0.5608 | 0.7162 | 0.6212 | 0.7111 |
| Filipino | 0.6023 | 0.2208 | 0.6706 | 0.6304 | 0.7006 | 0.7361 |
| Japanese | 0.5091 | 0.2800 | 0.5534 | 0.5553 | 0.6647 | 0.6209 |
| Korean | 0.6222 | 0.2533 | 0.6279 | 0.6233 | 0.5983 | 0.6358 |
| Laotian | 0.6408 | 0.1759 | 0.7750 | 0.7143 | 0.7013 | 0.7860 |
| Vietnamese | 0.6148 | 0.1766 | 0.7091 | 0.6966 | 0.6154 | 0.6833 |
| Two or More Asian Races | 0.6359 | 0.3072 | 0.5773 | 0.6240 | 0.6363 | 0.7083 |
| Some Other or unknown Asian | 0.5864 | 0.2640 | 0.4827 | 0.5756 | 0.5728 | 0.6457 |
| **Native Hawaiian (NH)/Other PI** | 0.5436 | 0.4051 | 0.5476 | 0.4972 | 0.5612 | 0.6038 |
| Guamanian | * | * | * | a | 0.5000 | 0.5106 |
| Hawaiian | 0.5517 | 0.5211 | 0.5385 | 0.4626 | 0.5273 | 0.7393 |
| Samoan | a | * | * | 0.4000 | 0.5563 | 0.5489 |
| Two or More NH/Other PI | 0.5088 | * | * | * | 0.5714 | 0.6061 |
| Some Other/Unknown PI Race | 0.5445 | 0.3567 | 0.5385 | 0.4845 | 0.6124 | 0.5798 |
| **Other/Unknown/Declined** | 0.4922 | 0.3883 | 0.2734 | 0.4460 | 0.4232 | 0.4936 |

| Race/Ethnicity | Controlling High Blood Pressure | Improving Health Equity 1 (Comprehensive Diabetes Control)↓ | Breast Cancer Screening | Colorectal Cancer Screening | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Preventive Care and Screening: Influenza Immunization |
|---|---|---|---|---|---|---|
| **Hispanic/Latino** | | | | | | |
| **White** | 0.5729 | 0.3677 | 0.6105 | 0.5278 | 0.5692 | 0.5490 |
| **African American/Black** | 0.5172 | 0.3379 | 0.6290 | 0.5336 | 0.5541 | 0.5387 |
| **American Indian/Alaska Native** | 0.5725 | 0.3904 | 0.6538 | 0.5576 | 0.5793 | 0.6749 |
| **Asian** | 0.5407 | 0.2370 | 0.6226 | 0.6195 | 0.6017 | 0.6567 |
| Asian Indian | * | * | * | 0.5313 | 0.6667 | 0.6749 |
| Cambodian | * | * | ----- | * | [a] | * |
| Chinese | * | * | * | 0.6316 | 0.4854 | 0.6392 |
| Filipino | 0.5476 | 0.2295 | 0.7805 | 0.5696 | 0.5842 | 0.6788 |
| Japanese | * | * | * | * | 0.5385 | 0.5200 |
| Korean | * | * | * | * | * | 0.6667 |
| Laotian | * | * | * | [a] | 0.7800 | 0.6667 |
| Vietnamese | * | * | * | 0.7647 | 0.5238 | 0.6557 |
| Two or More Asian Races | * | * | * | * | 0.4250 | 0.6750 |
| Some Other/Unknown Asian | 0.5556 | * | * | 0.5977 | 0.5643 | 0.5942 |
| **Native Hawaiian (NH)/Other PI** | 0.5667 | 0.4518 | [a] | 0.5541 | 0.5161 | 0.5559 |
| Guamanian | ----- | ----- | ----- | * | * | [a] |
| Hawaiian | * | * | * | * | * | 0.4211 |
| Samoan | ----- | ----- | ----- | ----- | * | * |
| Two or More NH/Other PI | * | * | * | ----- | * | * |
| Some Other/Unknown PI Race | * | * | * | 0.5000 | 0.5227 | 0.5490 |
| **Other/Unknown/Declined** | 0.5784 | 0.3680 | 0.6638 | 0.6030 | 0.6912 | 0.6261 |

Note –All rates are based on at least a numerator of 11 and a denominator of 30; Totals are not a sum of subsequent rows see QIP Policy Letter QPL 21-006 for details; UCLA had no data for IHE1; ↓For this measure lower achievement rates indicate better care; *Rate suppressed to protect confidentiality because of small numbers; [a] Rate suppressed because the denominator was less than 30, resulting in a statistically unstable rate; ----numerator and denominator were zero

**Table 5: Number and Percentage of Pay for Performance and Pay-For Reporting Measures with Targets Met for PY4 for DMPHs**

| DMPHs | No. Of Measures With Target Met | Percentage of Measures With Target Met |
|---|---|---|
| Antelope Valley Hospital | | |
| Pay-for-Performance Measures | 1 | 33% |
| Pay-for-Reporting Measures | 6 | 50% |
| Eastern Plumas Health Care | | |
| Pay-for-Performance Measures* | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| El Camino Hospital | | |
| Pay-for-Performance Measures | 3 | 100% |
| Pay-for-Reporting Measures | 7 | 100% |
| El Centro Regional Medical Center | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 16 | 100% |
| Hazel Hawkins Memorial Hospital | | |
| Pay-for-Performance Measures | 2 | 100% |
| Pay-for-Reporting Measures | 7 | 100% |
| Jerold Phelps Community Hospital | | |
| Pay-for-Performance Measures | 1 | 100% |
| Pay-for-Reporting Measures | 5 | 100% |
| John C. Fremont Healthcare District | | |
| Pay-for-Performance Measures | 1 | 100% |
| Pay-for-Reporting Measures | 5 | 100% |
| Kaweah Delta Health Care District | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 16 | 100% |
| Kern Valley Healthcare District | | |
| Pay-for-Performance Measures | 1 | 100% |
| Pay-for-Reporting Measures | 5 | 100% |
| Lompoc Valley Medical Center | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 17 | 100% |

| DMPHs | No. Of Measures With Target Met | Percentage of Measures With Target Met |
|---|---|---|
| Mammoth Hospital | | |
| Pay-for-Performance Measures | 2 | 100% |
| Pay-for-Reporting Measures | 10 | 100% |
| Marin General Hospital | | |
| Pay-for-Performance Measures | 2 | 100% |
| Pay-for-Reporting Measures | 8 | 100% |
| Mayers Memorial Hospital District | | |
| Pay-for-Performance Measures | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Modoc Medical Center | | |
| Pay-for-Performance Measures | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Northern Inyo Hospital | | |
| Pay-for-Performance Measures | ----- | ----- |
| Pay-for-Reporting Measures | 4 | 100% |
| Oak Valley Hospital District | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 16 | 100% |
| Palomar Medical Center | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 14 | 100% |
| Pioneers Memorial Healthcare District | | |
| Pay-for-Performance Measures | 3 | 100% |
| Pay-for-Reporting Measures | 9 | 100% |
| Plumas District Hospital, Quincy | | |
| Pay-for-Performance Measures* | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Salinas Valley Memorial Healthcare System | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 16 | 100% |
| San Bernardino Mountains Community Hospital | | |
| Pay-for-Performance Measures | 2 | 100% |
| Pay-for-Reporting Measures | 6 | 100% |

| DMPHs | No. Of Measures With Target Met | Percentage of Measures With Target Met |
|---|---|---|
| San Gorgonio Memorial Hospital | | |
| Pay-for-Performance Measures | 1 | 50% |
| Pay-for-Reporting Measures | 4 | 50% |
| Seneca Healthcare District | | |
| Pay-for-Performance Measures* | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Sierra View District Hospital | | |
| Pay-for-Performance Measures | 2 | 100% |
| Pay-for-Reporting Measures | 8 | 100% |
| Sonoma Valley Hospital | | |
| Pay-for-Performance Measures* | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Southern Inyo Hospital | | |
| Pay-for-Performance Measures* | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Surprise Valley | | |
| Pay-for-Performance Measures* | ----- | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Tahoe Forest Hospital District | | |
| Pay-for-Performance Measures | 2 | 100% |
| Pay-for-Reporting Measures | 8 | 100% |
| Tri-City Medical Center*** | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 16 | 100% |
| Trinity Hospital | | |
| Pay-for-Performance Measures* | ------ | ----- |
| Pay-for-Reporting Measures | 2 | 100% |
| Washington Hospital Healthcare System | | |
| Pay-for-Performance Measures | 4 | 100% |
| Pay-for-Reporting Measures | 16 | 100% |

* DMPHs reporting 4 or less measures reported the two infrastructure measures instead of pay-for-performance measures
**First time this DMPH participated in the QIP program
***Tri City Medical Center substituted Breast Cancer for Improving Health Equity 1 Measure for the African American/Black and White populations
----numerator and denominator were zero

## Table 6: Percentage of DMPHs Meeting Quality Improvement Targets in PY4

| Measures* | Number of DMPHs Meeting Target | | Number of DMPHs Reporting | | Percentage of DMPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| QIP Priority Performance Measures | | | | | | |
| Improving Health Equity 1 | ----- | 7 | ----- | 7 | ----- | 100% |
| Comprehensive Diabetes: HbA1c Poor Control (>9.0%)↓ | ----- | 6 | ----- | 6 | ----- | 100% |
| African Americans/Blacks | ---- | 6 | ----- | 6 | ----- | 100% |
| Hispanics/Latinos | ----- | 6 | ----- | 6 | ----- | 100% |
| Breast Cancer Screening | ----- | 1 | ----- | 1 | ----- | 100% |
| African Americans/Blacks | ----- | 1 | ----- | 1 | ----- | 100% |
| Whites | ----- | 1 | ----- | 1 | ----- | 100% |
| Asthma Medication Ratio | ----- | 2 | ----- | 2 | ----- | 100% |
| Breast Cancer Screening | 5 | 10 | 5 | 10 | 100% | 100% |
| Cervical Cancer Screening | 5 | 7 | 5 | 7 | 100% | 100% |
| Child and Adolescent Well Care Visits | 5 | 4 | 5 | 4 | 100% | 100% |
| Childhood Immunization Status (CIS 10) | 1 | 9 | 1 | 9 | 100% | 100% |
| Chlamydia Screening in Women | 2 | 7 | 2 | 7 | 100% | 100% |
| Colorectal Cancer Screening | 6 | 8 | 6 | 8 | 100% | 100% |
| Comprehensive Diabetes Care: Eye Exam | ----- | 5 | ----- | 5 | ----- | 100% |
| Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)↓ | 3 | 10 | 3 | 10 | 100% | 100% |
| Controlling High Blood Pressure | 2 | 9 | 2 | 9 | 100% | 100% |
| Developmental Screening in the First Three Years of Life | ----- | 4 | ----- | 4 | ----- | 100% |
| HIV Viral Load Suppression | ----- | ----- | ----- | ----- | ----- | ----- |
| Immunizations for Adolescents | ----- | 5 | ----- | 5 | ----- | 100% |
| Prenatal and Postpartum Care (Postpartum Care) | 1 | 5 | 1 | 6 | 100% | 83% |
| Prenatal and Postpartum Care (Timeliness of Prenatal Care) | 1 | 5 | 1 | 5 | 100% | 100% |
| Preventive Care and Screening: Influenza Immunization | ----- | 9 | ----- | 9 | ----- | 100% |
| Preventive Care and Screening: Screening for Depression and Follow-Up Plan | 1 | 13 | 1 | 13 | 100% | 100% |

| Measures* | Number of DMPHs Meeting Target | | Number of DMPHs Reporting | | Percentage of DMPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | ----- | 11 | ----- | 11 | ----- | 100% |
| Rate 2** | ----- | 11 | ----- | 11 | ----- | 100% |
| Rate 3** | ----- | 11 | ----- | 11 | ----- | 100% |
| Well-Child Visits in the First 30 Months of Life | ----- | 7 | ----- | 7 | ----- | 100% |
| First 15 Months | ----- | 7 | ----- | 7 | ----- | 100% |
| 15 Months-30 Months | ----- | 7 | ----- | 7 | ----- | 100% |
| Elective QIP Performance Measures | | | | | | |
| Advance Care Plan | 1 | 5 | 1 | 5 | 100% | 100% |
| Appropriate Treatment for Upper Respiratory Infection | 0 | 1 | 2 | 1 | 0% | 100% |
| Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis | 0 | ----- | 1 | ----- | 0% | ----- |
| Cesarean Birth (PC-02)↓ | 3 | 6 | 3 | 6 | 100% | 100% |
| Comprehensive Diabetes Control: Medical Attention for Nephropathy | 1 | 3 | 1 | 3 | 100% | 100% |
| Concurrent Use of Opioids and Benzodiazepines↓ | ----- | 1 | ----- | 1 | ----- | 100% |
| Contraceptive Care – All Women | ----- | ----- | ----- | ----- | ----- | ----- |
| Coronary Artery Disease: Antiplatelet Therapy | 1 | 4 | 1 | 4 | 100% | 100% |
| Coronary Artery Disease: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%) | ----- | 2 | ----- | 2 | ----- | 100% |
| Depression Remission or Response for Adolescents and Adults | ----- | ----- | ----- | ----- | ----- | ----- |
| Follow-up PHQ-9 (Adults) | ----- | ----- | ----- | ----- | ----- | ----- |
| Depression Remission (Adults) | ----- | ----- | ----- | ----- | ----- | ----- |
| Depression Response (Adults) | ----- | ----- | ----- | ----- | ----- | ----- |
| Discharged on Antithrombotic Therapy (STK-2) | 1 | 7 | 1 | 7 | 100% | 100% |
| Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older | 2 | 4 | 2 | 4 | 100% | 100% |
| Exclusive Breast Milk Feeding (PC-05) | 2 | 9 | 2 | 9 | 100% | 100% |
| Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence | ----- | 2 | ----- | 3 | ----- | 67% |
| 7 Days | ----- | 2 | ----- | 3 | ----- | 67% |
| 30 Days | ----- | 2 | ----- | 3 | ----- | 67% |

| Measures | Number of DMPHs Meeting Target | | Number of DMPHs Reporting | | Percentage of DMPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | ----- | 1 | ----- | 1 | ----- | 100% |
| HIV Screening | 2 | ----- | 2 | ----- | 100% | ----- |
| Improving Health Equity 2 | ----- | 1 | ----- | 1 | ----- | 100% |
| Prenatal and Postpartum Care (Postpartum Care): African American/Black | ----- | 1 | ----- | 1 | ----- | 100% |
| Lead Screening in Children | ----- | 4 | ----- | 4 | ----- | 100% |
| Medication Reconciliation Post-discharge | 1 | 3 | 1 | 5 | 100% | 60% |
| Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) | 3 | 4 | 3 | 4 | 100% | 100% |
| Pharmacotherapy Management of COPD Exacerbation | ----- | 1 | ----- | 3 | ----- | 33% |
| Systematic Corticosteroid | ----- | 1 | ----- | 3 | ----- | 33% |
| Bronchodilator | ----- | 1 | ----- | 3 | ----- | 33% |
| Plan All-Cause Readmissions↓ | ----- | 1 | ----- | 3 | ----- | 33% |
| Prevention of Central Venous Catheter (CVC) Related Bloodstream Infections | 1 | 8 | 1 | 8 | 100% | 100% |
| Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan | 1 | 8 | 1 | 8 | 100% | 100% |
| Reduction in Hospital Acquired Clostridium Difficile Infections↓ | 2 | 9 | 2 | 9 | 100% | 100% |
| Statin Therapy For The Prevention And Treatment Of Cardiovascular Disease | 1 | 3 | 1 | 3 | 100% | 100% |
| Surgical Site Infection (SSI) *Reported as SIR*↓*** | 1 | 3 | 1 | 3 | 100% | 100% |
| Use of Imaging Studies for Low Back Pain | ----- | 2 | ----- | 4 | ----- | 50% |
| Use of Opioids at High Dosage in Persons Without Cancer↓ | ----- | ----- | ----- | ----- | ----- | ----- |
| Weight Assessment & Counseling for Nutrition and Physical Activity for Children & Adolescents | ----- | 8 | ----- | 8 | ----- | 100% |
| BMI | ----- | 8 | ----- | 8 | ----- | 100% |
| Counseling for Nutrition | ----- | 8 | ----- | 8 | ----- | 100% |
| Counseling for Physical Activity | ----- | 8 | ----- | 8 | ----- | 100% |

| Measures | Number of DMPHs Meeting Target | | Number of DMPHs Reporting | | Percentage of DMPHs Meeting Target | |
|---|---|---|---|---|---|---|
| | P4P | P4R | P4P | P4R | P4P | P4R |
| QIP COVID-19 PHE Measures | | | | | | |
| Implementation of employee COVID-19 testing in 2021 | ----- | 31 | ----- | 31 | ----- | 100% |
| Implementation of employee COVID-19 vaccination in 2021 | ----- | 31 | ----- | 31 | ----- | 100% |
| Implementation of infrastructure and partnerships for the provision of COVID-19 tests to Medi-Cal beneficiaries and community members in 2021 | ----- | 31 | ----- | 31 | ----- | 100% |
| Implementation of infrastructure and partnerships for the provision of COVID-19 vaccines to Medi-Cal beneficiaries and community members in 2021 | ----- | 31 | ----- | 31 | ----- | 100% |
| Implementation of hospital surge planning and/or response in 2021 | ----- | 31 | ----- | 31 | ----- | 100% |
| QIP Infrastructure Measures | | | | | | |
| Identification of QIP staffing needs for quality improvement and reporting | ----- | 7 | ----- | 7 | ----- | 100% |
| Identification of QIP data needs for tracking and reporting | ----- | 7 | ----- | 7 | ----- | 100% |

↓For these measures lower achievement rates indicate better care

*For the Improving health equity 1 measure, all DMPHs were required to report data on Comprehensive Diabetes: HbA1c Poor Control (>9.0%); however, Tri-City did not because for the African American/Black and Hispanic/Latino populations the denominators were less than 30 for that measure. Therefore, Tri-City reported on the African American/Black and White populations for the Breast Cancer Screening measure instead

**For the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure rate 2 is the percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention, while rate 3 is the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user

***Composite SIR is the sum of the observed number of SSIs across all 6 procedure categories divided by the sum of the expected number of SSIs across the 6 procedure categories. Observed and expected data from all 6 procedure categories are included.

## Table 7: Aggregate Rate for the QIP Measures Stratified by Race-Ethnicity for DMPHs

| Race/Ethnicity | Controlling High Blood Pressure | Improving Health Equity 1 (Comprehensive Diabetes Control)↓ | Breast Cancer Screening | Colorectal Cancer Screening | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Preventive Care and Screening: Influenza Immunization |
|---|---|---|---|---|---|---|
| Hispanic/Latino | 0.6291 | 0.1710 | 0.6510 | 0.3602 | 0.3895 | 0.3233 |
| White | 0.6131 | 0.3166 | 0.5024 | 0.3412 | 0.2964 | 0.3062 |
| African American/Black | 0.5828 | 0.3651 | 0.5211 | 0.3719 | 0.2183 | 0.2750 |
| American Indian/Alaska Native | 0.7143 | * | 0.4091 | 0.3223 | 0.3255 | 0.2727 |
| Asian | 0.6388 | 0.1918 | 0.5434 | 0.4261 | 0.1957 | 0.4323 |
| Native Hawaiian (NH)/Other PI | * | * | [a] | 0.4898 | 0.1759 | 0.4194 |
| Other/Unknown/Declined | 0.5658 | 0.2824 | 0.5799 | 0.3315 | 0.2391 | 0.3216 |

Note –All rates are based on at least a numerator of 11 and a denominator of 30
Racial/ethnicity groups in the table are not mutually exclusive see QIP Policy Letter QPL 21-006 for details
Tri-City had no data for IHE1
↓For these measures lower achievement rates indicate better care;
*Rate suppressed to protect confidentiality because of small numbers
[a] – Rate suppressed because the denominator was less than 30, resulting in a statistically invalid rate

## Table 8: Aggregate Rate for the QIP Measures Stratified by Detailed Race and Ethnicity for DMPHs

| Race/Ethnicity | Controlling High Blood Pressure | Improving Health Equity 1 (Comprehensive Diabetes Control) ↓ | Breast Cancer Screening | Colorectal Cancer Screening | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Preventive Care and Screening: Influenza Immunization |
|---|---|---|---|---|---|---|
| **Non-Hispanic/Latino/Unknown Ethnicity** | | | | | | |
| **White** | 0.6245 | 0.2913 | 0.4538 | 0.3436 | 0.3376 | 0.2571 |
| **African American/Black** | 0.6058 | 0.3390 | 0.5108 | 0.3849 | 0.2228 | 0.2712 |
| **American Indian/Alaska Native** | a | * | 0.4286 | 0.3118 | 0.3444 | 0.2873 |
| **Asian** | 0.6358 | 0.1944 | 0.5313 | 0.4255 | 0.1965 | 0.4254 |
| Asian Indian | * | * | * | * | 0.3286 | * |
| Cambodian | * | ----- | * | * | * | * |
| Chinese | * | * | * | * | 0.4571 | * |
| Filipino | 0.6029 | * | 0.3514 | 0.4063 | 0.1776 | 0.3300 |
| Japanese | ----- | * | * | * | * | * |
| Korean | * | * | * | * | * | * |
| Laotian | * | * | * | * | * | ----- |
| Vietnamese | * | ----- | * | * | * | * |
| Two or More Asian | 0.5429 | ----- | 0.5577 | 0.4823 | 0.1077 | 0.4475 |
| Some Other/Unknown Asian | a | * | a | 0.2683 | 0.1622 | 0.9213 |
| **Native Hawaiian (NH)/Other PI** | * | * | a | 0.5500 | 0.1844 | 0.4276 |
| Guamanian | * | ----- | * | * | * | * |
| Hawaiian | ----- | ----- | * | * | * | * |
| Samoan | * | ----- | * | * | * | * |
| Two or More NH/Other PI | * | ----- | ----- | ----- | * | * |
| Some Other/Unknown PI | 0.0000 | ----- | * | * | * | * |
| **Other/Unknown/Declined** | 0.6289 | 0.3333 | 0.3597 | 0.2050 | 0.1176 | 0.2332 |

| Race/Ethnicity | Controlling High Blood Pressure | Improving Health Equity 1 (Comprehensive Diabetes Control) | Breast Cancer Screening | Colorectal Cancer Screening | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Preventive Care and Screening: Influenza Immunization |
|---|---|---|---|---|---|---|
| **Hispanic/Latino** | | | | | | |
| **White** | 0.6051 | 0.3388 | 0.6364 | 0.3343 | 0.2394 | 0.4063 |
| **African American/Black** | * | * | * | * | 0.1869 | 0.2977 |
| **American Indian/Alaska Native** | * | * | * | * | 0.2807 | 0.2326 |
| **Asian** | 0.6667 | * | [a] | 0.4337 | 0.1909 | 0.4912 |
| Asian Indian | * | ----- | ----- | * | * | * |
| Cambodian | ----- | ----- | ----- | ----- | ----- | ----- |
| Chinese | ----- | ----- | ----- | ----- | * | ----- |
| Filipino | [a] | * | [a] | 0.4265 | 0.1751 | 0.4840 |
| Japanese | ----- | * | ----- | * | * | * |
| Korean | ----- | ----- | ----- | * | * | * |
| Laotian | ----- | ----- | ----- | ----- | * | ----- |
| Vietnamese | ----- | ----- | ----- | ----- | ----- | ----- |
| Two or More Asian Races | * | ----- | * | * | * | * |
| Some Other/Unknown Asian | * | ----- | * | * | * | * |
| **Native Hawaiian (NH)/Other PI** | * | ----- | * | * | * | 0.3824 |
| Guamanian | ----- | ----- | ----- | ----- | * | * |
| Hawaiian | * | * | * | * | * | ----- |
| Samoan | ----- | ----- | ----- | ----- | * | ----- |
| Two or More NH/Other PI | * | ----- | ----- | ----- | ----- | * |
| Some Other/Unknown PI Race | ----- | ----- | ----- | * | * | ----- |
| **Other/Unknown/Declined** | 0.5474 | 0.2966 | 0.6629 | 0.3965 | 0.3027 | 0.3587 |

Note –All rates are based on at least a numerator of 11 and a denominator of 30; Totals are not a sum of subsequent rows see QIP Policy Letter QPL 21-006 for details; Tri-City had no data for HE1; ↓For these measures lower achievement rates indicate better care; *Rate suppressed to protect confidentiality because of small numbers; [a] – Rate suppressed because the denominator was less than 30, resulting in a statistically invalid rate