

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES**

Committee: Physician Advisory Committee
Date / Time: June 10, 2026 - 7:30 to 9:00 a.m.

Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

Members Present:	Angela Brennan, DO (FF) Betzabel Kunkel, MD (FF) Brian Montenegro, MD (FF) Matthew Zavod, MD (FF) Steven Gwiazdowski, MD (FF)	Teresa Shinder, MD (FF) Malia Honda, MD (E) Chester Austin, MD (C) John McDermott, FNP (C) Darrick Nelson, MD (R)	Karina Gookin, MD (AU) Christina Lasich, MD (SL) Mills Matheson, MD (OMM)	FF Fairfield SR Santa Rosa E Eureka R Redding C Chico AU Auburn	MCC Marin Community Clinics OMM Office of Dr. Matheson SL Sutter Health Lakeside
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Members Excused:	Vanessa Walker, DO Karen Sprague, MSN, CFNP	Derice Seid, MD (MCC)
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Members Absent:	Chris Myers, MD Danielle Oryn, DO	Candy Stockton, MD Michelle Herman, MD	Zoe Cappe, MD (FF)
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Partnership Staff:	Sonja Bjork, Chief Executive Officer Jennifer Lopez, Chief Financial Officer Wendi Davis, Chief Operating Officer Leigha Andrews, Region Director Vicky Klakken, Region Director Brigid Gast, RN, Sr. Dir., Care Management Aaron Brincko, Sr. Dir., Provider Relations Lisa O'Connell, Dir. Enhanced Health Services Doreen Crume, RN, Mgr. Care Coord. Stephanie Nakatani, Supervisor Provider Relations Representatives	Katherine Barresi, RN, Chief Health Services Officer Robert Moore, MD, Chief Medical Officer Kermit Jones, MD, Deputy Chief Medical Officer Colleen Townsend, MD, Region Medical Director Jeffrey Ribordy, MD, Region Medical Director Bradley Cox, MD, Region Medical Director R. Doug Matthews, MD, Region Medical Director Matthew Morris, MD, Region Medical Director Lisa Ward, MD, Region Medical Director Mark Netherda, MD, Medical Director for Quality Jeffrey DeVido, MD, Behavioral Health Clinical Dir. Stan Leung, Pharm.D., Director, Pharmacy Services Marshall Kubota, MD, Associate Medical Director	DeLorean Ruffin, DrPH, Director, Population Health Mohamed Jalloh, Pharm.D., Director, Health Equity Isaac Brown, Sr. Dir., Quality & Performance Improvement Vacant, Director, Quality Management Kristine Gual, Director, Quality Measurement Vacant, Manager of QI Programs Sue Quichocho, Mgr., Quality Measurement Megan Shelton, Project Manager, Quality Improvement Vacant, RN, Director, Utilization Mgmt. (UM) Kevin Jarret-Lee, RN, Assoc. Dir. of UM Robby Potter, RN, Supervisor of Inpatient UM David Lavine, Assoc. Dir. of Workforce Development
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AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	13/21 – PAC	Committee quorum requirements met (13).	06/10/26

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer (CEO) Report	Partnership’s Chief Executive Officer presented an administrative update. • State Budget / Medi-Cal Policy Outlook • Budget was due to the Governor by June 15 following intensive hearings in Sacramento among the Assembly, Senate, Administration, and stakeholders. • The May Revise proposed moving approximately 90,000 Partnership members with uncertain immigration status (UIS) out of Medi-Cal managed care and into state fee-for-service effective January 1, 2027. • California remains committed to providing Medi-Cal benefits to the UIS population beyond emergency and pregnancy-related care, but challenges may occur for affected members who are already assigned to doctors, may already be receiving specialty or ancillary care, and may experience major disruption if moved to a different network and lower state fee-for-service reimbursement structure. • Health plans proposed an alternative under which members would remain enrolled in their health plan while plans would use state-only dollars and separate funding from federal participation. support from California Medical Association (CMA), California Primary Care Association (CPCA), First 5, and many other groups. • The Assembly included the proposal in its version of the budget, but the Senate was less supportive because it was focused on achieving budget savings. • Constituents can still contact their Senator’s office or the Governor’s office to express support for keeping affected members in their health plans. • Operations • Operational concerns for Federally Qualified Health Centers (FQHC), tribal health centers, hospitals, and other providers, have been created by uncertainty of federal rules regarding immigration-status checks and pending litigation with an injunction. • Hospitals may bear a significant burden if members avoid primary care out of fear and later seek urgent or emergent care. • Hospitals are considering additional navigators, health care navigators, and community health workers to help members preserve eligibility and access appropriate care. • Member experience and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores have been topics of focus in efforts to improve members’ experience with the delivery system and mitigate the financial implications of low member-experience scores under state quality expectations. • County Eligibility and Work Requirement Implementation • Medicaid community engagement requirements, commonly referred to as work requirements, apply to Medi-Cal members ages 19–64 and require states to verify affected members meet 80 hours per week of work, volunteer activity, or school participation. • Native American members who identify that ethnicity on their Medi-Cal applications may be exempt from work requirements. The exemption does not discourage work, volunteering, or schooling, but may prevent additional bureaucracy for eligible members. • States are preparing eligibility systems and county processes to verify compliance after waiting for CMS instructions. • The proposed final rule does not include clear categorical exemptions for medically frail members, such as members with end-stage renal disease receiving dialysis several days per week. • The burden may shift to members and clinicians to complete paperwork documenting that a member’s medical condition prevents compliance and specifying the applicable duration. • The paperwork burden is similar to workers’ compensation and disability documentation but will affect medically vulnerable Medi-Cal members who may not know what steps are required to maintain eligibility. • Partnership and stakeholders who work with Medi-Cal members will need to help members understand and complete required documentation. • These new requirements will be added to the Keep Your Medi-Cal campaign and related member-facing and stakeholder-facing messaging. • Beginning January 2027, self-attestation may be permitted while states build eligibility systems and county workflows. Requirements for self-attestation are not yet available.

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I.B. Chief Medical Officer (CMO) Health Services Report	Partnership’s Chief Medical Officer presented the following Health Services report. • Partnership Clinic Leadership Academy • Partnership Clinic Leadership Academy kicked off the first week of June with a cohort of 35 providers. • The program is being delivered in collaboration with Healthforce UCSF and is designed to strengthen clinic leadership capacity across Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Centers, which serve 92% of Partnership members. • The program will include four in-person sessions along with asynchronous training during the year. • Public Health – Concerning Use of Kratom • Dr. Wu, Napa County Public Health Officer, in collaboration with the Napa Opioid Safety Coalition and the Napa-Solano Medical Society, provided a presentation on Kratom use and raised it as a public health concern. • Emergency physicians and clinicians involved in obstetric physician training have reported seeing kratom overdoses, including cases requiring higher doses of Narcan than typical opioid overdoses. • Dr. Moore noted concern about increasing teenage use, abuse, addiction risk, and overdose risk. • Kratom is an opioid-like substance, sometimes called “gas station heroin,” that can be purchased in some convenience store or gas station settings despite California restrictions. • It is illegal to sell and illegal to ingest in California, but not illegal to possess, creating a difficult enforcement environment. • Local law enforcement generally will not enforce the state restriction unless CDPH is involved, and enforcement may require a sting operation to catch an illegal sale. • Some states and counties have enacted additional ordinances that go beyond state law, including ordinances banning possession. • San Diego County was identified as having the strongest model ordinance. • Public Health Officers may face limitations in advocating for specific legislation because they work for counties, so medical societies and other organizations may need to advocate for additional local city and county regulations. • Partnership’s legislative team is following the topic closely. • Partnership Leadership • Partnership’s Regional Medical Director for Napa, Yolo, and Solano Counties has been selected to serve on California’s Rural Health Policy Council, which will advise the state on how to invest rural health transformation do. • Jayme Botke has been appointed Redding Region Director. • Irem Connery has been appointed Director of Member Experience.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	May 13, 2026, PAC minutes were presented for approval.	<u>MOTION:</u> Dr. Zavod moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Gwiazdowski. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried.
II.B.	Consent Calendar Review	<u>MOTION:</u> Dr. Gwiazdowski. moved to approve Agenda II.B.1, II.B.2, II.B.5, II.B.6, and II.B.7 as presented, seconded by Dr. Montenegro. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried.
II.B.1	• Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – May 20, 2026		
II.B.2	• Policies, Procedures, and Guidelines for Action Policy Summary May 13, 2026		
II.B.5	• Credentials Committee Meeting, April 8, 2026 Minutes Credentialed List		
II.B.6	• Pediatric Quality Committee Summary, May 5, 2026		
II.B.7	• Quality Improvement Health Equity Committee Summary, May 19, 2026		
II.C.1	Resignation from PAC, Dr. Vanessa Walker	<u>MOTION:</u> Dr. Montenegro moved to approve Agenda item II.C.1 as presented, seconded by Dr. Gwiazdowski. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried
II.C.2	Nomination to PAC, Dr. Leigh Vall-Spinosa	<u>MOTION:</u> Dr. Shinder moved to approve Agenda item II.C.2 as presented, seconded by Dr. Kunkel. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried
VI.A	Proposed 2027 Perinatal Quality Improvement Program (QIP) Measure Set	<u>MOTION:</u> Dr. Shinder moved to approve Agenda item VI.B as presented, seconded by Dr. Kunkel. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried

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III. A Committee Member Introduction	Dr. Leigh Vall-Spinosa is a family physician and Medical Director at the Dutton Clinic, part of Santa Rosa Community Health, located across the street from Partnership's Santa Rosa office. Dr. Vall-Spinosa began her medical career in Santa Rosa in 1996 through the Santa Rosa Family Medicine Residency, where Partnership Medical Director, Dr. Kubota served as her residency director. After completing residency, she and her husband, also a family physician, moved to Pueblo, Colorado where she worked as faculty in Southern Colorado Family Medicine and practiced in a busy faculty private practice for approximately five years. After having two sons, she and her family moved closer to family in New Mexico, where she is from. She worked at First Choice Community Health, an FQHC in Albuquerque, New Mexico. While at First Choice, she began prescribing Suboxone and became increasingly interested in addiction medicine. She and her family returned to Santa Rosa approximately ten years ago where her husband began working at Kaiser while she joined Santa Rosa Community Health. Partnership's Regional Medical Director for Sonoma and Marin County, Dr. Ward, was her then Medical Director when she started at Santa Rosa Community Health. Dr. Vall-Spinosa continued addiction medicine as part of her practice and became board certified in addiction medicine two years ago. She now also serves in a small faculty role for a new addiction medicine fellowship connected with the Santa Rosa residency program. Dr. Vall-Spinosa stated that she loves working in community health and FQHCs and is passionate about working with underserved populations. She looks forward to serving on PAC and working with other voting members to help patients receive the best possible care.
IV.A Status Update, Regional Medical	Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities. • Yolo County is recruiting for a Public Health Officer after Dr. Aimee Sisson's departure. • CommuniCare+OLE and Solano Family Health Services are recruiting to fill Chief Medical Officer roles. • Upcoming retirements will affect gastrointestinal (GI) and neurology specialty access in Yolo County. • General surgery, orthopedics, and oncology access remain open. • NorthBay Health acquisition of Providence Queen of the Valley continues to move forward. Meetings are being held in Napa to hear from the community.
IV.B. Status Update, Regional Medical	Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities. • Regional quality meeting was held on June 2 with approximately 35 people in attendance. Colorectal cancer screening was the primary topic. Alliance Medical Center and Petaluma Health Center presented best practices during the meeting. • Three leaders from Santa Rosa, Alexander Valley, and Marin City Health and Wellness are participating in the Partnership Clinical Leadership Program. • Partnership Santa Rosa hosted a Patient Information Session held at the Santa Rosa office, where Vanessa Hernandez, the new Member Engagement Specialist at the site, presented to 35 Spanish-speaking attendees and 35 English-speaking attendees. • Partnership helped connect RotaCare with Marin County, Marin Community Clinics, and a sister free clinic in Sonoma County for support in response to the possibility of more uninsured patients. • Met with Supervisor Rebecca Hermosillo in Sonoma County regarding Indigenous care and county capacity for eligibility and access. Partnership is working to stay closely connected with Supervisor Hermosillo because of shared purpose around these issues. • Quarterly meetings have been held with area providers to discuss recruitment challenges and innovations being developed by clinics, eligibility workers, and departments to respond to new workforce development demands. • The Hearts of Sonoma group is working again on local tobacco cessation strategies across Sonoma County. The group is attempting to encourage more local jurisdictions to adopt tobacco-related ordinances that make tobacco access more difficult. • Sonoma County Indian Health Project (SCIP) discussed new affiliations with UC Davis and Stanford for medical student rotations in addition to an affiliation with Kaiser for family medicine residency rotations as a long-term recruitment strategy and positive opportunity for clinicians to serve as mentors and preceptors. • Dr. Scott Holmes was named the new Chief Medical Officer at Alliance Medical Center. • Meetings are ongoing in work elevating billing issues from health centers and community-based organizations

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IV.C. Status Update, Regional Medical	Partnership’s Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities. • Del Norte County Department of Health and Human Services (DHHS) announced a ribbon cutting ceremony to be held on June 16, 2026, for a new emergency shelter and micro village offering 60 beds and 50 tiny homes to shelter unhoused individuals. Kitchen, bathroom, and laundry facilities will also be available. • Mendocino Community Health Centers (MCHC) recently opened a same-day clinic for existing members. MCHC optometry clinic will open in September. An urgent care facility is being planned, projected to open in 2028. • Mendocino Coast Clinics purchased a local pharmacy in order to preserve access for their members. • Dr. Jodi Parungao is working with both Long Valley Health and Round Valley Indian Health to support women’s health care needs.
IV.D. Status Update, Regional Medical	Partnership’s Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities. • Oroville Hospital recently declared bankruptcy and was presented at bidding auction for sale. Any sale must be approved by a judge no later than August 13, 2026. Partnership is closely monitoring the outcome. • Meeting to be held with Touro University to discuss options for Physician Assistant (PA) rotations and fellowships in the region. • Peach Tree Clinic is interested in expanding service for chiropractic care and potentially primary care in the Chico region. • Healthy Rural California Family Practice and Psychiatry residency welcomed a new class starting June 17, 2026.
IV.E Status Update, Regional Medical	Partnership’s Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities on behalf of Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties. • Jayme Botke has been appointed Partnership’s North Regional Director. • Obstetric (OB) and gynecology access has been constrained in the Red Bluff area due to the unexpected passing of a local OB/GYN. • CEO of Mercy Medical Center announced plans to retire in the fall. A replacement has not yet been selected. • Nourish and Flourish event in Redding was attended by an estimated 500 people. The event offered opportunities for wellness providing tests for diabetes screening, blood pressure, fluoride applications and offering education on CPR, asthma, and healthcare workforce.
IV.F Status Update, Regional Medical	Partnership’s Regional Medical Director for Plumas, Sierra, Nevada, Yuba, and Placer Counties presented a brief update on activities. • Operations meeting was held with Seneca Healthcare in Plumas County to discuss updates for the construction of a new hospital planned to open in 2027. Construction is on track and going well. Seneca’s CEO, Shawn McKenzie, announced plan to retire in November 2026. Chief Operations Officer (COO) Brady Haynes will succeed Mr. McKenzie as CEO. • Partnership’s Pharmacy Team met with Eastern Plumas Healthcare to focus on prescribing for improved management of diabetes and high blood pressure. • Nevada Memorial Hospital will be bringing in a surgical assist team to include a neurosurgeon trained in robotics. Future plans involve the addition of elastography (hydro scans), which is similar to an ultrasound and uses sound waves to determine how much scarring is in the liver. • Dr. Jarett Beaudoin has been appointed interim Public Health Officer for Yuba County. Yuba County is also recruiting for a Behavioral Health Director. • Placer County Health and Human Services in Auburn hosted Partnership’s ABCs of Quality event which was well attended by region healthcare providers. • Conducted a Perinatal Support Services webinar focused on childhood vaccinations attended by more than 100 participants.
IV. Introductions	<i>No additional introductions were presented.</i>
V. Old Business	<i>No old business was presented.</i>

AGENDA ITEM	DISCUSSION / CONCLUSIONS ACTION REQUIRED						
VI.A Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set	Partnership staff presented the 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set I. Summary of Current and Proposed Measures and/or Measure Changes (A) Gateway Measure – Measure 1 DataLink allows for data exchange from Provider Electronic Health Records to PARTNERSHIP to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems. (B) Clinical Measures – Measures 2-6 PHPS practices and select perinatal providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed for PCPs and OB/GYNs and includes the following clinical measures: Timely Immunization Status - Tdap and Influenza Vaccine, Timely Prenatal Care, Late Entry to Care with Depression Screening >14 weeks gestation, Timely Postpartum Care and Timely Assessments. Key: New Proposed Measures Change to Measure Design <table border="1" data-bbox="667 699 1677 1068"> <thead> <tr> <th data-bbox="667 699 1171 792">Current 2026 6-month Bridge Measures</th><th data-bbox="1178 699 1677 792">Proposed 2027 Measures</th></tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="667 792 1171 836" style="background-color: #d9ead3; text-align: center;">ECDS & Clinical Domains</td></tr> <tr> <td data-bbox="667 836 1171 1068"> Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive (Monitoring Only) </td><td data-bbox="1178 836 1677 1068"> Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments </td></tr> </tbody> </table> Proposed Changes for the PQIP 2027 Measure Set Programmatic Changes: Due to a new federal regulation that went into effect at the end of 2025, the Perinatal Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed 2027 Measurement Year covering the period of January 1, 2027, through December 31, 2027. In general, all the reporting timelines for any measures included in this set have been adjusted to correlate to a calendar year period. Those revisions are not presented here. What follows are the proposed measure changes with their rationales.	Current 2026 6-month Bridge Measures	Proposed 2027 Measures	ECDS & Clinical Domains		Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive (Monitoring Only)	Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments
Current 2026 6-month Bridge Measures	Proposed 2027 Measures						
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AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set, Continued	A. Gateway Measure 1: Electronic Clinical Data Systems (ECDS) – Datalink Implementation This measure supports the allowance of data exchange from provider Electronic Health Records to Partnership to capture clinical screenings, follow-up care and outcomes. ECDS participation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA is converting most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable for several ECDS measures. Partnership partnered with DataLink (a qualified HEDIS data aggregator) who can pull a much larger scope of measures than what is currently required for the Perinatal QIP. The DataLink process will continue to increase in emphasis and is now a gateway measure to the Perinatal QIP. Proposal: It is proposed that contracting and connection with DataLink remain a gateway measure for 2027. It is recommended that a June 30th deadline be set to give any new providers adequate time to complete the extraction process. Measure Requirements All providers with existing DataLink connectivity must maintain those connections and extractions throughout the measurement year to be eligible to receive their 2027 PQIP incentive payment. All participants new to the PQIP in 2027 must complete all Implementation Phases and Participation Requirement Steps by June 30, 2027, to be eligible to receive their 2027 PQIP incentive payment. B. Clinical Measures Measure 3. Timely Prenatal Care (<14 Weeks of Gestation) Measure Summary: Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization. Proposal: Since DataLink connections and extractions have occurred for PQIP providers during the previous year, it is proposed to add monthly DataLink extractions be the only option for submitting visit and depression screening data. The manual submission option would be removed, but Partnership would retain the right to request manual submissions as a means of data validation if needed. Below is the suggested language change for the reporting section of the measure. Reporting (Applies to Measures 3 & 4) Monthly DataLink Extractions Counts of qualifying prenatal visits will be gathered through the DataLink extraction process. Partnership reserves the right to periodically request manual submissions to validate extracted data. A timely prenatal visit is a comprehensive first prenatal visit with a clinical provider of obstetrics services (MD/DO/CNM/LM/NP/PA-c) that occurs in the first trimester of the pregnancy or within 42 days of Partnership enrollment. Note: New providers entering the PQIP in 2027 that are not yet connected to DataLink may provide manual submissions on the provided Excel template by the tenth of each month for January through June but must complete the implementation process by June 30, 2027, to be eligible to receive incentive payment. To request a template and instructions, email perinatalqip@partnershiphp.org.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set, Continued	II. Measure 4: Depression Screening at First Prenatal Visit with Late Entry to Care (>14 weeks Gestation) Measure Summary: Prenatal care visits to an OB/GYN or other perinatal care practitioner or PCP after the first trimester (equal to or greater than 14 weeks of gestation, as documented in the medical record) will be eligible for the incentive payment. A diagnosis of pregnancy must be present. Proposal: It is also proposed that Measure 4 have the same changes as noted in Measure 3. III. Measure 6: Timely Comprehensive Assessments Measure summary Providers will perform Comprehensive Health Assessments that included psychosocial, nutrition and health education assessments at the initiation of care, in each trimester and in the post-partum period. Proposal: It is proposed that this measure move from a monitoring measure to an incentivized measure as noted below. Measure Target Specifications Providers will earn a \$100 incentive for members who gave birth during the measurement year and received the following assessments: 1. Initial Assessment with code Z6500 or code Z6200 + Z6300 + Z6402 billed on claim(s) And 2. Three subsequent follow-up visits: one in the second trimester, one in third trimester and one postpartum. No incentive is earned if all visits are not completed. <i>A motion was taken for approval. Measure set passed without modification. No further questions were asked.</i>
VI.B Potentially Preventable Admissions	Partnership CMO Presented Potentially Preventable Admissions Partnership completed enough initial investigation to share findings with PAC to identify potential interventions that provider organizations could take within their own settings. The concept has been referred to by several names, including ambulatory care sensitive hospital admissions (ACSAs). The underlying principle is that certain hospital admissions are considered potentially preventable when strong primary care, outpatient care, and early treatment can prevent a member from becoming sick enough to require hospitalization. Measure definitions come from the Agency for Healthcare Research and Quality (AHRQ), which is part of the U.S. Department of Health and Human Services. • The AHRQ Quality Indicators (QIs) are standardized, evidence-based measures that assess health care quality, patient safety, and access using routinely collected hospital administrative data. • Most QIs are risk-adjusted to ensure fair comparisons across hospitals and regions. • Prevention Quality Indicators (PQIs) flag avoidable hospital admissions that may signal problems with access to outpatient or primary care. • Pediatric Quality Indicators (PDIs) focus on safety events and complications in hospitalized pediatric patients.

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VI.B Potentially Preventable Admissions, Continued	The adult heart failure measure is responsible for the largest number of preventable admissions in Partnership’s data. The importance of the principal diagnosis must be emphasized because the hospital’s coding decision determines whether an admission is counted as potentially preventable. If a different diagnosis is coded first and that diagnosis is not on the AHRQ list, the admission may no longer count as potentially preventable, even if heart failure is clinically relevant. The principal diagnosis assignment is usually determined by coders reviewing the medical record, based on coding rules and documentation. For the heart failure measure, certain exclusions apply, including cardiac procedures performed during the admission, such as cardiac catheterization, transplant, or valve procedures. • Transfers from another hospital are excluded. • Admissions from skilled nursing facilities are also excluded. • Hospice admissions are not specifically excluded, although some sicker skilled-nursing-facility patients may also be on hospice. • The heart failure diagnosis-code list includes a wide range of heart failure diagnoses, including right-sided failure, left-sided failure, reduced ejection fraction, and unspecified heart failure. Example Data Definition: Heart Failure • Included: • 18 years of age or older • Principal admission diagnosis: heart failure • Excluded: • Cardiac Procedures during admission • Transfers from hospital or SNF Heart failure diagnosis codes: (MRTCHFD) <table><tr><td>I0981</td><td>Rheumatic heart failure</td><td>I5041</td><td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td></tr><tr><td>I110</td><td>Hypertensive heart disease with heart failure</td><td>I5042</td><td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td></tr><tr><td>I130</td><td>Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td><td>I5043</td><td>Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td></tr><tr><td>I132</td><td>Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease</td><td>I50810</td><td>Right heart failure, unspecified</td></tr><tr><td>I501</td><td>Left ventricular failure, unspecified</td><td>I50811</td><td>Acute right heart failure</td></tr><tr><td>I5020</td><td>Unspecified systolic (congestive) heart failure</td><td>I50812</td><td>Chronic right heart failure</td></tr><tr><td>I5021</td><td>Acute systolic (congestive) heart failure</td><td>I50813</td><td>Acute on chronic right heart failure</td></tr><tr><td>I5022</td><td>Chronic systolic (congestive) heart failure</td><td>I50814</td><td>Right heart failure due to left heart failure</td></tr><tr><td>I5023</td><td>Acute on chronic systolic (congestive) heart failure</td><td>I5082</td><td>Biventricular heart failure</td></tr><tr><td>I5030</td><td>Unspecified diastolic (congestive) heart failure</td><td>I5083</td><td>High output heart failure</td></tr><tr><td>I5031</td><td>Acute diastolic (congestive) heart failure</td><td>I5084</td><td>End stage heart failure</td></tr><tr><td>I5032</td><td>Chronic diastolic (congestive) heart failure</td><td>I5089</td><td>Other heart failure</td></tr><tr><td>I5033</td><td>Acute on chronic diastolic (congestive) heart failure</td><td>I509</td><td>Heart failure, unspecified</td></tr><tr><td>I5040</td><td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td><td></td><td></td></tr></table> 	I0981	Rheumatic heart failure	I5041	Acute combined systolic (congestive) and diastolic (congestive) heart failure	I110	Hypertensive heart disease with heart failure	I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure	I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I5043	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	I132	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	I50810	Right heart failure, unspecified	I501	Left ventricular failure, unspecified	I50811	Acute right heart failure	I5020	Unspecified systolic (congestive) heart failure	I50812	Chronic right heart failure	I5021	Acute systolic (congestive) heart failure	I50813	Acute on chronic right heart failure	I5022	Chronic systolic (congestive) heart failure	I50814	Right heart failure due to left heart failure	I5023	Acute on chronic systolic (congestive) heart failure	I5082	Biventricular heart failure	I5030	Unspecified diastolic (congestive) heart failure	I5083	High output heart failure	I5031	Acute diastolic (congestive) heart failure	I5084	End stage heart failure	I5032	Chronic diastolic (congestive) heart failure	I5089	Other heart failure	I5033	Acute on chronic diastolic (congestive) heart failure	I509	Heart failure, unspecified	I5040	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure		
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AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Potentially Preventable Admissions	Background of ACSAs and Resulting Financial Consequences • Avoidable cost analysis – DHCS uses logic from AHRQ referencing PQIs and PDIs • Efficiency comparison – DHCS compares the plan’s rate of potentially preventable admissions (PPAs) against established regional or statewide efficiency benchmarks. If a county plan demonstrates higher-than-expected rates of admission for conditions that could have been managed in outpatient or primary care settings, it is flagged inefficient. • Capitation Reduction Calculation – The avoidable costs associated with these excess PPAs are calculated and trimmed from the plan’s inpatient base data. Because this directly impacts the PMPM capitation rate, removing these expenses lowers the final actuarially sound capitation rate paid to the plan. Partnership can see the quality measure definitions but does not receive the full methodology or detailed calculation showing how the dollar adjustment is derived. At the end of the process, Partnership receives a dollar amount that is not included in its capitation rate. The adjustment is functionally similar to a penalty, even though it is framed as an actuarial or efficiency adjustment. The quality rationale remains important: avoiding preventable hospitalizations is good for members, helps avoid unnecessary hospital stays, and supports better preventive and chronic care. What is the financial impact? • “Efficiency Factor” for ACSA is rebranded by DHCS as “Potentially Preventable Admissions”. • In 2024, the efficiency adjustment was approximately \$25 million. The other efficiency factors were below \$2 million each. • DHCS does not show its work, they just send the final amount of efficiency factor with our rates. Preventable admissions are a major utilization issue with both clinical and financial implications. • In 2024, the potentially preventable admissions efficiency adjustment was approximately \$25 million, larger than any other single quality measure impact discussed, with member experience being the next major area. • Other efficiency factors were each below approximately \$2 million. • Although Partnership does not receive the full methodology, it is estimated that the adjustment may reflect roughly one-quarter of the amount Partnership pays for those admissions. Care Continuum and Where Preventable Admissions Can Potentially be Influenced. • The first opportunity is preventing healthy members from developing chronic conditions, such as diabetes or heart failure, through effective primary care and prevention. • The second opportunity is preventing acute conditions through vaccination or treating them early before they become severe. • For members with chronic conditions, primary care can help stabilize conditions and prevent worsening exacerbations. • When members develop acute symptoms, strong primary care access and on-call systems may help them avoid unnecessary emergency department visits. • Examples such as urinary tract infections or gastroenteritis that might be managed earlier or differently if after-hours advice or rapid access were available. • Once a member reaches the emergency department, hospital practice patterns influence whether the patient is admitted or treated and discharged. • Partnership can identify hospitals with higher propensities to admit, although those hospitals will not be named publicly. • Once admitted, length of stay becomes another factor affecting cost and avoidable utilization. • Hospitalists’ attention to throughput and discharge planning can affect length of stay. • Some hospitalist groups move patients through care more efficiently, while others take longer, potentially due to culture or misaligned incentives. • After discharge, members may either enter a readmission cycle or return to stable chronic-condition management. • Readmission prevention is a shared responsibility among primary care providers, hospitals, and the health plan.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Potentially Preventable Admissions, Continued	Key Findings from Partnership’s 2025 data using AHRQ adult PQIs and pediatric PDIs Adult PQI admissions represented approximately 97% of all potentially preventable admissions in the 2025 data. 75% of admitted members were admitted more than once annually, many members were readmitted within seven days of discharge. For heart failure, 647 members were admitted once, 150 members were admitted twice, and 59 members were admitted three times during the year. The repeated admission distribution continued across higher admission counts. - Heart failure was the highest-volume category for total admissions, with approximately 1,500 admissions and approximately 908 unique patients. - The difference between total admissions and unique patients demonstrated that some members were being admitted repeatedly for the same condition during the year. - A total of more than 20,000 hospital days across the included admissions. - While heart failure had the highest total admissions, the admission rate for adult short-term diabetes complications was slightly higher than the heart failure admission rate. - Diabetes-related PQIs are a major contributor, including adult short-term diabetes complications, adult long-term diabetes complications, pediatric short-term diabetes complications, and uncontrolled diabetes. - For cardiac admissions, the key categories included heart failure and hypertension, with heart failure making up the major share. - Cardiac conditions accounted for approximately 38% of total hospital days in the adult category. - Diabetes-related conditions accounted for approximately 39% of total hospital days, making diabetes as important as cardiac conditions for intervention planning. One particularly concerning example was a member with adult long-term diabetes complications who was admitted 29 times in the calendar year. - Respiratory conditions included COPD, asthma in older adults, asthma in younger adults, and bacterial pneumonia. - Respiratory conditions accounted for approximately 16% of total hospital days. - Urinary tract infection accounted for approximately 4% of total hospital days. Pediatric PDI admissions represented approximately 3%, meaning adult admissions are the primary opportunity for impact. - PDI measures included short-term diabetes complications, asthma, gastroenteritis, and urinary tract infection. - Asthma was the largest pediatric PDI contributor, but pediatric preventable admissions remained small compared with adult admissions. - The top ten Primary Care Provider groups represented approximately the top 24% of admissions. - Total preventable admissions for 2025 were referenced at approximately 4,673. - One PCP group had approximately 1,605 admissions in the data view, and heart failure represented a significant share within high-volume groups. - Heart failure, adult short-term diabetes complications, and adult long-term diabetes complications were among the highest-volume categories across PCP groups. - Reviewing high-admission PCP groups and understanding case-by-case admission patterns may identify practical intervention opportunities. Preventable-admissions Data and PCP QIP Performance. - For controlling high blood pressure, hypertension and heart failure admissions may overlap with the PCPQIP measure population. - Although admissions represent a small portion of the overall denominator, a high percentage of admitted members appear to be in care gaps. - For hypertension admissions, approximately 88% of those admissions were associated with members in the care gap for controlling blood pressure measure. - For diabetes-related admissions, adult short-term complications, adult long-term complications, and uncontrolled diabetes were grouped, totaling approximately 829 patients. Among those members, approximately 91% were in the care gap for A1C control; 81% were in the care gap for retinal eye exams.

AGENDA ITEM	DISCUSSION / CONCLUSIONS																																																																																					
VI.B Potentially Preventable Admissions, Continued	Hospital Level Analysis One way to examine hospital influence is to look at preventable admissions by hospital, though raw numbers are affected by hospital size. Potentially preventable admissions may also be reviewed as a percentage of total hospital admissions but cautioned that those comparisons are affected by payer and patient mix, particularly whether a hospital provides obstetric and pediatric services. For example, if one regional medical center does not provide OB services, its denominator and comparisons are affected. Partnership plans to conduct additional analysis to break out those factors before drawing firm conclusions from hospital comparisons What can PCPs do now? • Ensure excellent follow-up on patients being discharged with CHF, DM, COPD/Asthma. • Strive for high rates of control of BP and DM: don't give up on anyone! • Ensure patients with COPD or asthma have an asthma control plan with rescue medications to handle exacerbations early. • Ensure good after-hours coverage for your patients' questions. • Strive for high rates of influenza, RSV, COVID vaccines in adults, especially those with other risk factors for admission. <i>The following slides were presented at the meeting illustrating key findings.</i> Factors impacting admission and length of stay <pre>graph LR HP([Healthy Patient]) -- "Some preventable with primary care" --> PC[Patient with Chronic Condition*] HP -- "Some acute conditions preventable (vaccines) or severity less (early UTI) with primary care" --> PAC[Patient with acute condition] PC -- "Some well controlled/stable with primary care" --> PAC PAC -- "Good on-call/triage system could lead to outpatient treatment" --> PED[Patient in ED] PAC -- "ER propensity to admit" --> PA[Patient Admitted] PED -- "ER propensity to admit" --> PA PA -- "Hospitalist attention to care impacts LOS" --> PD[Patient discharged] PD -- "Readmission Cycle" --> PC PD -- "Post-discharge case management and PCP care" --> PC</pre> *CHF, HTN, DM, COPD, Asthma Admissions Data <table><thead><tr><th>Admission Category</th><th>Total Admissions</th><th>Unique Patients</th><th>Sum of length of stay</th><th>Rate</th></tr></thead><tbody><tr><td>ASTHMA PED</td><td>145</td><td>135</td><td>269</td><td>1.07</td></tr><tr><td>ASTHMA IN YOUNG ADULTS</td><td>45</td><td>37</td><td>141</td><td>1.22</td></tr><tr><td>BACTERIAL PNEUMONIA</td><td>366</td><td>326</td><td>1441</td><td>1.12</td></tr><tr><td>COPD ASTHMA OLDER ADULT</td><td>416</td><td>298</td><td>1664</td><td>1.40</td></tr><tr><td>DIABETES LONG-T ADULT</td><td>505</td><td>351</td><td>3166</td><td>1.44</td></tr><tr><td>DIABETES SHORT-T ADULT</td><td>731</td><td>412</td><td>2033</td><td>1.77</td></tr><tr><td>DIABETES SHORT-T PED</td><td>51</td><td>42</td><td>119</td><td>1.21</td></tr><tr><td>GASTROENTERITIS PED</td><td>92</td><td>90</td><td>268</td><td>1.02</td></tr><tr><td>HEART FAILURE</td><td>1537</td><td>908</td><td>6947</td><td>1.69</td></tr><tr><td>HYPERTENSION</td><td>193</td><td>179</td><td>541</td><td>1.08</td></tr><tr><td>LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES</td><td>111</td><td>79</td><td>1226</td><td>1.41</td></tr><tr><td>LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES/ DIABETES LONG-T ADULT</td><td>111</td><td>71</td><td>935</td><td>1.56</td></tr><tr><td>UNCONTROLLED DIABETES</td><td>123</td><td>86</td><td>365</td><td>1.43</td></tr><tr><td>URINARY TRACT INFECTION PED</td><td>30</td><td>30</td><td>84</td><td>1.00</td></tr><tr><td>URINARY TRACT INFECTION ADULT</td><td>217</td><td>197</td><td>814</td><td>1.10</td></tr><tr><td>TOTALS</td><td>4673</td><td>3241</td><td>20013</td><td></td></tr></tbody></table>	Admission Category	Total Admissions	Unique Patients	Sum of length of stay	Rate	ASTHMA PED	145	135	269	1.07	ASTHMA IN YOUNG ADULTS	45	37	141	1.22	BACTERIAL PNEUMONIA	366	326	1441	1.12	COPD ASTHMA OLDER ADULT	416	298	1664	1.40	DIABETES LONG-T ADULT	505	351	3166	1.44	DIABETES SHORT-T ADULT	731	412	2033	1.77	DIABETES SHORT-T PED	51	42	119	1.21	GASTROENTERITIS PED	92	90	268	1.02	HEART FAILURE	1537	908	6947	1.69	HYPERTENSION	193	179	541	1.08	LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES	111	79	1226	1.41	LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES/ DIABETES LONG-T ADULT	111	71	935	1.56	UNCONTROLLED DIABETES	123	86	365	1.43	URINARY TRACT INFECTION PED	30	30	84	1.00	URINARY TRACT INFECTION ADULT	217	197	814	1.10	TOTALS	4673	3241	20013	
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AGENDA ITEM

VI.B

Potentially Preventable Admissions, Continued

2025 ACSAs: Adult Diagnosis Groups

Category	Diagnosis Groups	Number Partnership Members Admitted	Percent of all hospital days	Total hospital days in category
Cardiac	Heart Failure	1537 (33%)	35%	38%
	Hypertension	193 (4%)	3%	
Diabetes	Long term complications	505 (11%)	16%	39%
	Short term complications	731 (16%)	10%	
	Lower Extremity Amputation	222 (5%)	11%	
	Adult Uncontrolled DM	123 (3%)	2%	
Respiratory	COPD/Asthma (older adult)	416 (9%)	8%	16%
	Asthma younger adults	45 (1%)	1%	
	Bacterial Pneumonia	366 (8%)	7%	
Urinary	UTI	217 (5%)	4%	4%
Total Adult		4232 (93%)	97%	97%
Total Adult + Peds		4550 (100%)	100%	100%

2025 ACSAs: Child Diagnosis Groups

Category	Diagnosis Groups	Number Partnership Members Admitted	Percent of all hospital days
Diabetes	Short term complications	51 (1%)	1%
Respiratory	Asthma	145 (3%)	1%
GI	Gastroenteritis	92 (2%)	1%
Urinary	UTI	30 (1%)	0.4%
Total		318 (7%)	3%

Top 24% of admissions by PCP and PQI/PDI

	MA	ASTHMA IN YOUNGER ADULTS	BACTERIAL PNEUMONIA	COPD ASHMA OLD ADLT	DIABETES LONG-T ADULT	DIABETES SHORT-T ADULT	DIABETES SHORT-T PED	GASTROENTERITIS PED	HEART FAILURE	HYPERTENSION	LOWER-EXTREMITY AMPUT AMONG PAT W DIABETES	LOWER-EXTREMITY AMPUT AMONG PAT W DIABETES / LONG-T ADULT	UNCONTROLLED DIABETES	URINARY TRACT INFECTION PED	URINARY TRACT INFECTION ADULT	Grand Total
PCP 1	3		13	9	9	23			48		3	2	3	3	2	122
PCP 2	1	2	8	11	12	18			45		6	5	6	3	5	122
PCP 3		1	3	11	13	18			23	13				9	2	93
PCP 4		1		11	7	9	10		34		3	1	2	2	8	88
PCP 5			5	14	15	29			82		8	1		9	2	165
PCP 6	1		6	10	8	7		1	34		4	3	2		4	82
PCP 7	8	2	7	8	11	30	4		37		12	4	5	3	1	142
PCP 8		1	6	4	15	15			22		5	2	2	5	3	80
PCP 9	1		12	19	11	7	3		50		7	1	2	3	4	121
PCP 10	4		4	6	16	13	1		35		2	4	3	3	4	95
Grand Total	18	7	75	99	119	170	9		5	410	63	23	25	40	3	1110

4673 total admissions

AGENDA ITEM

DISCUSSION / CONCLUSIONS

VI.B

Potentially Preventable Admissions, Continued

Sum of Admissions Annually by Condition

Admission Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14-28	29+ admissions	Total
ASTHMA PED	125	10														135
ASTHMA IN YOUNG ADULTS	31	5	1													37
BACTERIAL PNEUMONIA	282	30	6	5		1	1		1							326
COPD ASTHMA ODER ADULT	233	87	35	24	18	8	3	8								416
DIABETES LONG-T ADULT	253	59	21	8	3	4		1					1		1	351
DIABETES SHORT-T ADULT	273	72	28	16	11	4	3	1		2	2					412
DIABETES SHORT-T PED	35	5	2													42
GASTROENTERITIS PED	88	2														90
HEART FAILURE	647	150	59	19	15	5	4	3	2	1	1		1			907
HYPERTENSION	153	14	5	3	1	1	1				1					179
LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES	55	17	6	1												79
LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES/ DIABETES LONG-T ADULT	53	12	4	1		1										71
UNCONTROLLED DIABETES	65	14	2	2	1		1					1				86
URINARY TRACT INFECTION PED	30															30
URINARY TRACT INFECTION ADULT	182	10	3		1	1										197
																3358

QIP data compared with ASCA (2025)

Measure	Numerator	Denominator	# of distinct members with ASA admit of related PQI in the denominator	% of ASA members in the care gap for QIP
Controlling High Blood Pressure	23744	35819	91 (PQI=hypertension)	88% (84% of this group were missing a BP reading)
			335 (PQI=heart failure)	88%
			829 (PQI=diabetes S-Term, L-Term and uncontrolled)	91%
HbA1C Good Control	22105	22920	407 (PQI=heart failure)	90%
Diabetes Retinal Eye Exam	18299	29920	829 (PQI=diabetes S-Term, L-Term and uncontrolled)	89%

AGENDA ITEM	DISCUSSION / CONCLUSIONS				
VI.B Potentially Preventable Admissions, Continued	<				

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on _____

Date


 Angela Brennan, D.O., Committee Chairperson

The foregoing minutes were APPROVED WITH MODIFICATION on _____

Date

Angela Brennan, D.O., Committee Chairperson