

Peds PCP Quality Improvement Collaborative Session #2: 12/2/25

Disclosure: There are no relevant financial relationships, sponsorships, or other disclosures from anyone in control of content associated with this activity. This program is designed to provide educational information and does not involve the promotion of any specific product or service.

Targeted Investment Team

ASU TIPQIC

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- Matthew Martin, PhD
- Kailey Love, MBA, MS
- Taylor Vaughan, MPH
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- Francisca Dibarrart, PhD
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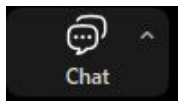
Agenda

| Time | Topic | Presenter |
|----------------------|---|---|
| 12:00 PM to 12:03 PM | Opening | William Riley, PhD |
| 12:03 PM to 12:10 PM | Measure Overview & Network Performance | William Riley, PhD |
| 12:10 PM to 12:30 PM | Measure Details: Definition, Coding, Targets, Attribution | George Runger, PhD Taylor Vaughan, MPH |
| 12:30 PM to 12:40 PM | Common Barriers & Best Practices | Matthew Martin, PhD |
| 12:40 PM to 12:58 PM | Discussion | Matthew Martin, PhD |
| 12:58 PM to 1:00 PM | Closing | Kailey Love, MBA, MS |

Learning Objectives

1. Describe strategies to facilitate population health management improvement.
2. Critically analyze the application of improvement methods and techniques to improve HEDIS quality metrics.
3. Evaluate strategies to identify and address upstream drivers of health for high risk populations
4. Explore process improvement strategies for population health management

Guidelines



Do not enter your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.



At least one representative from each TI organization must have registered and attend the QIC session using that registration link for the required QIC sessions.



Participants will automatically be muted and videos off as they join.



When interested in participating in the discussion, please raise your hand and unmute yourself.

To: Everyone v

Type message here...

Please drop your questions into the Chat. If we do not have time to address your question, we will compile all questions into a FAQ document and distribute post-event.

Disclosure

This is a CME activity



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Credit Statement: Arizona State University designates this live activity for a maximum of 1-credit from the following:

- ***AMA PRA Category 1 Credit™ – CME – 1 credit hour per session***
- ***Nursing Continuing Professional Development – NCPD – 1 credit hour per session***
- ***Psychology – CEP – 1 credit hour per session***
- ***Social Work – ACE – 1 credit hour per session***
- ***Interprofessional Continuing Education – IPCE – 1 credit hour per session***

**Providers should only claim credit commensurate with the extent of their participation in the activity.*



Measure Overview & Network Performance

Peds PCP QIC Curriculum Overview

| Peds PCP AOC Measures | TI Year 4: 10/1/2025 - 9/30/2026 | | | | | | | | | | | |
|--------------------------|---|---|-----|---|-----|---|-----|---|-----|---|-----|---|
| | O | N | D | J | F | M | A | M | J | J | A | S |
| W30 - Part 2 | QIC | | | | | | QIC | | | | | |
| WCV | | | QIC | | | | | | QIC | | | |
| W30 - Part 1 | | | | | QIC | | | | | | QIC | |
| Optional Resources | Ongoing Performance Improvement Project (PIP) | | | | | | | | | | | |
| | Ongoing Technical Assistance & Consultation | | | | | | | | | | | |

- **QIC's** in October, December, and February are **required**
 - Each QIC will focus on the a HEDIS measure as indicated in the above table
- **QIC's** in April, June, and August are **optional**
 - The focus of these sessions may shift based on performance and other priorities

Table 1
Targeted Investments (TI) 2.0
Year 4 Milestones and Incentive Percentages

| MILESTONES | PEDS PCP | | |
|--|--------------------------------------|------------|-----|
| | INCENTIVE % OF ANNUAL PAYMENT | | |
| M1. Performance Measures | 50 | | |
| | W30 - Part 1 | W30-Part 2 | WCV |
| | 15 | 20 | 15 |
| M2. Screening and Referral Systems for Nonmedical Drivers of Health | 25 | | |
| M3. Closed Loop Referral System (CLRS) | 15 | | |
| M4. Quality Improvement Collaboratives (QICs) | 10 | | |

Peds PCP

| Performance Measure | Measure Description | TI AOC Performance * | All AHCCCS Performance * | 2023 AZ Medicaid Average ¹ | 2023 HEDIS National Average ² |
|---|---|----------------------|--------------------------|---------------------------------------|--|
| * = Proposed 2026 ACOM306 Measure; * = MAC 2024 Scorecard Measure; ♡ = 2025 CMS Core Set Measure; * = 2024 UDS Quality of Care Measure; + = 2024 SAMHSA CCBHC Quality Measure; ⚙ = NCQA HEDIS Stratified Measure; * = MAC QRS Measure | | | | | |
| Well Child Visits (W30) - Part 2 * * ♡ ⚙ * | Percentage of child beneficiaries that had two well-child visits with a PCP between ages 15 months and 30 months | 65.9% | 64.7% | 59.2% | 69.2% |
| Child and Adolescent Well Care Visits (WCV) * * ♡ * | Patient(s) 3 - 21 years that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner in the last 12 reported months | 51.5% | 47.3% | 45% | 52.1% |
| Well Child Visits (W30) - Part 1 * * ♡ * | The percentage of child beneficiaries who had the 6 or more well-child visits with PCP in the first 15 months of age. | 57.8% | 58.5% | 56.8% | 59.0% |

*Report period ending June 30, 2025

1. <https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D>

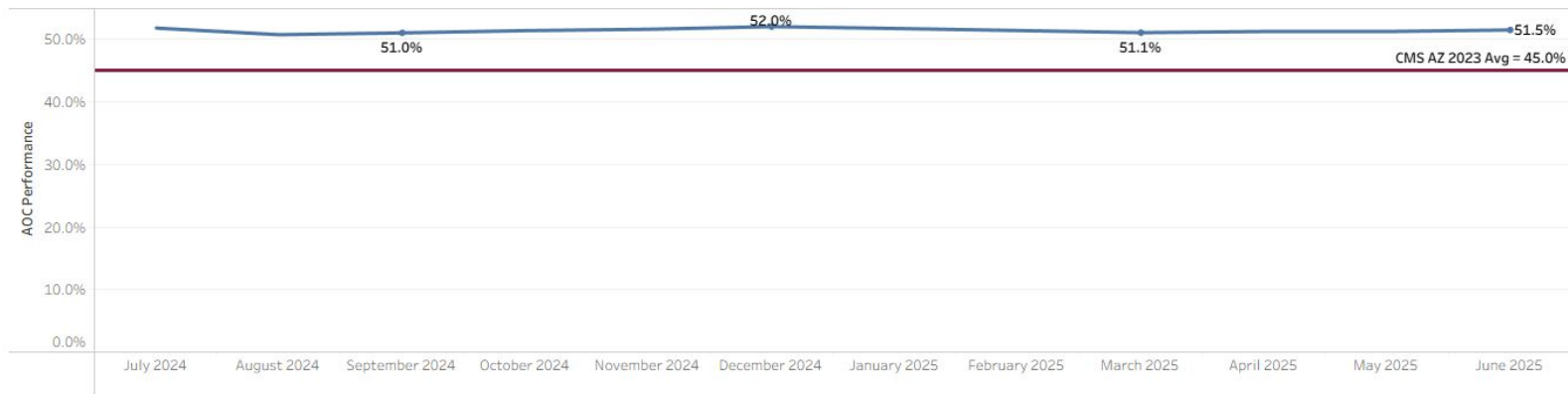
2. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/>

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

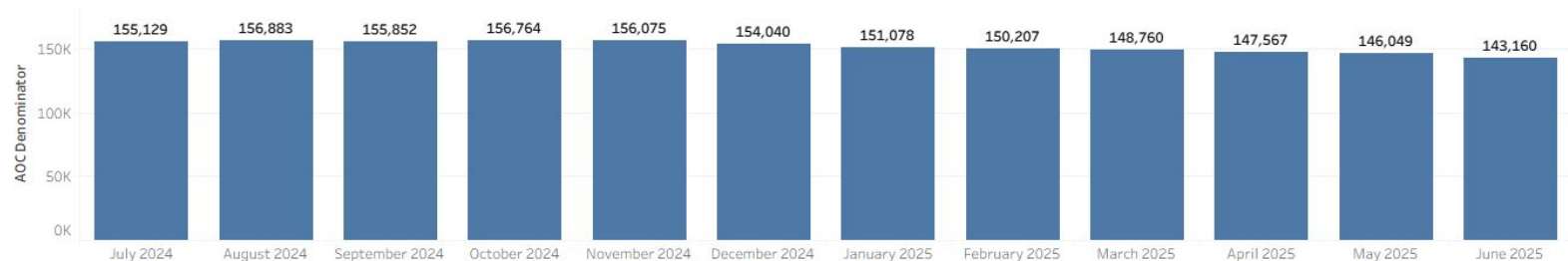
WCV Network Performance

Measure Performance (each month is a 12-month report period)

PEDS PCP



Measure Denominator





Measure Details

Child and Adolescent Well Care Visits

Definition

WCV: The percentage of persons 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement period.



Quality Alignment

| Peds PCP | | | | | | | | | |
|---|---|----------------------|-----------------------|----------------------------|---------------------------|----------------------------------|-----------------------------------|-------------------------------|-----------------|
| Performance Measure | Measure Description | TI AOC Performance * | Quality Alignment | | | | | | |
| | | | 2026 ACOM 306 Measure | MAC 2024 Scorecard Measure | 2025 CMS Core Set Measure | 2024 UDS Quality of Care Measure | 2024 SAMHSA CCBHC Quality Measure | NCQA HEDIS Stratified Measure | MAC QRS Measure |
| Child and Adolescent Well Care Visits (WCV) | The percentage of children and adolescents 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. | 51.5% | ✱ | ✱ | | | | ✱ | ✱ |

*Report period ending June 30, 2025

1. <https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D>

2. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/>

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

WCV Importance

Promotes early detection and prevention

Supports healthy growth and development

Improves long-term health outcomes

Encourages adolescent engagement

Reduces disparities

Indicator of system quality



Child and Adolescent Well Care Visits

Your performance is reported as a percentage calculated as the = numerator/denominator

| TI Area of Concentration | Measure | Denominator Definition | Numerator Definition |
|--------------------------|---|---|--|
| Peds PCP | Child and Adolescent Well-Care Visits (WCV) | Members aged 3 to 21 years old at the report period end date. | Members in the denominator who had at least one comprehensive well-care visit with a PCP or an OB/GYN. |

Note: WCV requires members to be continuously enrolled in medical benefits without a break greater than 45 days.

What is the Reporting Period?

- A HEDIS® measure's reporting period is a continuous 12-month window.
- TIP Provider Dashboards show your organization's performance on the selected measure for 12 consecutive, overlapping report periods, where each report period is a 12-month period ending in the month and year shown on the X-axis.
- Your performance levels for 12 report periods are provided so you can track how your performance changes across time. TI incentive payments are based on your performance for the Federal Fiscal Years (October 1st to September 30th).

Which Members Are in My Denominator?

To understand the members that you are accountable for and who are attributed to you (i.e., in your denominator) for this measure, you need to know the denominator definition (previous slide), as well as the AHCCCS member population assessed, and the attribution method used.

Member Population Assessed

- Members enrolled in one of the seven AHCCCS Complete Care (ACC) health plans

Member Population Exclusions

- ACC members who utilized hospice services or died

What Services Qualify for the Numerator?

Billing Codes

- TI 2.0 Year 4 use HEDIS® Measurement Year 2023 measure definitions.
- Due to licensing agreements, we are not able to publish a list of all qualifying services codes. However, we can direct you to resources containing the billing codes.
 - Please see these Arizona Health Plan Measure Guides. You do not have to be contracted with the plan to access these resources.
 - United Healthcare - [HEDIS® MY 2023 Reference Guide](#)
 - Definitions Only - Banner University Family Care - [HEDIS® Guide](#)
 - For more information on HEDIS measures or to get your own license, see the [NCQA HEDIS® site](#).
 - Value sets and codes used in HEDIS 2024 (Measurement Year 2023) measure calculations are available at no cost. Download the 2023 Quality Rating System (QRS) HEDIS Value Set Directory from the [NCQA store](#).

Attribution

- PCP attribution is based on claims and PCP-member assignments.
- Members are attributed to the PCP with whom they have the strongest relationship, as documented by claims, considering the frequency of visits, MCO PCP assignment, and the member's most recent PCP visit if multiple relationships exist. If no established relationship is documented, members are attributed to their MCO-assigned PCP. The most recent member assignments at the report period end.
- These assignments are provided monthly by health plans and AHCCCS. Milestone performance is calculated based on member-level attribution aggregated to the Organizational (Tax ID) level for participating sites.
- Interested providers can work with the ASU TIPQIC team to examine AHCCCS members who are eligible for each measure and attributed to their organization through a member list comparison (Data Harmonization).

Target Setting

Username

Enter your username

Password

[Sign In](#)
[Forgot your password?](#)

- Three tiers were set for the WCV measure
 - AHCCCS emailed each provider organization with individual target setting information
- For your organization's specific target, please see your dashboard or the email received from the AHCCCS TI team.
- TI Peds PCP providers need to exceed their target to achieve the incentives associated with this performance measure.

To log in to your dashboards, please visit data.tipqic.org.

If you would like to make any changes to your log-in or password, please email support@tipqic.org



Common Barriers & Best Practices

WCV Common Barriers

1. Patient & Family-Level Barriers

- Low awareness that annual well visits are needed
- Work, school, or childcare conflicts
- Limited or unreliable transportation
- Language or cultural communication barriers
- Competing priorities (housing, finances, etc.)
- Adolescent privacy or confidentiality concerns

2. Provider & Practice-Level Barriers

- Limited appointment availability for preventive care
- Missed chances to convert sick visits to well visits
- EHRs lack prompts or accurate documentation tools
- Staff turnover or limited HEDIS training
- Competing clinical demands
- Low provider awareness or buy-in



WCV Common Barriers

3. System & Data-Level Barriers

- Delayed claims cause underreporting
- Fragmented care across clinics/systems
- Insurance churn disrupts continuity
- Limited data tools in smaller practices
- Gaps in patient tracking or real-time data



WCV Barriers Cont.

4. Equity & Access Barriers

- Long travel distances for rural families
- Competing basic needs (housing, food, transport)
- Few bilingual or culturally competent providers
- Limited access to telehealth or digital tools
- Structural inequities drive care disparities

5. Adolescent-Specific Barriers

- Poor transition from pediatric to adult care
- Low perceived need for preventive visits
- Confidentiality concerns limit participation
- Few youth-friendly engagement strategies



WCV Best Practices

1. Outreach & Engagement

- Auto-schedule annual visits (e.g., birthday month)
- Send multi-channel reminders in preferred languages
- Offer evening/weekend or walk-in appointments
- Partner with schools and youth programs
- Provide transportation support (rideshares, bus passes)

2. Provider Engagement & Workflows

- Use EMR prompts and standing orders
- Convert sick visits to well visits when possible
- Run monthly “due for visit” lists
- Share performance dashboards and recognize progress



WCV Best Practices Cont.

3. Parent/Caregiver Education

- Reinforce value of annual well visits beyond vaccines
- Share culturally tailored materials (handouts, videos, portal)
- Address myths and stress early detection and milestones

4. Parent/Caregiver Education

- Use correct ICD-10/CPT codes meeting HEDIS criteria
- Include full preventive components in telehealth visits
- Reconcile EMR and claims data to find missing encounters



WCV Best Practices Cont.


5. Partnerships with Managed Care & Quality Teams

- Align pay-for-performance incentives with WCV goals
- Coordinate outreach or incentive programs with health plans
- Use plan registries and HEDIS gap reports for outreach

6. Equity-Focused Improvements

- Stratify WCV rates by race, ZIP code, and plan type
- Deploy mobile or school-based clinics in low-access areas
- Ensure culturally and linguistically competent care





WCV Non-Medical Drivers and Closed Loop Referral Systems

Non-Medical Drivers of Health (NMDOH) G/Z Codes

- Between May 2024 and June 2025, TI providers screened 28,328 unique patients for non-medical drivers of health, submitting 33,350 G codes via claims.
 - 81 TINs submitted at least one G code during this time period.
- The most commonly identified needs were employment, housing, and larger economic conditions. Over 4,500 NMDOH referrals were given to help patients meet these needs.
- **Year 4 Milestone 2B: ATTEST** to documenting NMDOH screening and referral results via consistent submission of claims using G procedure codes (G9919 and G9920), V4 modifier, and Z diagnosis codes as appropriate.

Advantages of Providers Screening for Non-Medical Drivers of Health for WCV

Advantages of Screening

- Reveals barriers to well-care (e.g., transportation, work, housing)
- Enables tailored care coordination and supports (e.g., flexible scheduling, transport)
- Builds trust and strengthens family engagement
- Prioritizes outreach to high-risk children
- Reduces no-shows by addressing barriers early
- Advances health equity by targeting resources
- Closes the loop on social needs through referrals



Advantages of Providers Screening for Non-Medical Drivers of Health for WCV

How Screening Improves WCV Measure Performance

- Increases the number of completed well-care visits by removing modifiable barriers.
- Enhances outreach success through accurate, preference-based communication.
- Prevents avoidable gaps in care by addressing needs early during any encounter.
- Generates actionable data to guide targeted quality improvement strategies.



Closed Loop Referral Systems and WCV

What Closed-Loop Referrals Achieve

- Confirm whether families actually connect with referred social services (transportation, housing, food support).
- Ensure identified social needs are **resolved**, not just documented.
- Provide real-time visibility into referral status for care teams.
- Strengthen collaboration between clinical teams and community-based organizations.
- Reduce patient drop-off by following up on incomplete or unsuccessful referrals.



Closed Loop Referral Systems and WCV

How This Improves WCV Measure Performance

- Removes barriers (transportation, childcare, communication)
- Reduces no-shows and boosts visit completion
- Enables quick re-engagement when referrals fail
- Supports targeted, personalized outreach
- Promotes equity through closed-loop support
- Strengthens engagement with preventive care and the medical home





Provider Discussant & Respondent

Provider Discussant & Respondent

- Provider Discussant
 - Callie Pediatrics, Mary Beth Callie
- Provider Respondent
 - Children's Medical Center, Kolleen Weber



Provider Discussant Questions

- What is your current process for the WCV measure?
- What factors seem to impact the success of your process performance on the WCV measure?
- What QI methods or techniques have you used to improve your process (if any)?
- What is your plan to improve your performance on the WCV measure?
- What is your process for non-medical drivers in relation to the WCV?





Peds PCP Discussion

Discussion Questions

1. What factors do you think most influence your organization's performance on the WCV measure?
2. How are you currently identifying and outreaching to patients who are due for a WCV, and what changes could make this process more reliable or efficient?
3. How confident are you in the accuracy of your HEDIS data and attribution lists? What strategies could improve data reconciliation?

Discussion Questions

- 4 What, if any, disparities in WCV rates have you observed (e.g., location, language, SES)?
- 5 What opportunities exist to strengthen coordination with other organizations (e.g., managed care, schools, CBOs)?
- 6 Based on what you've learned today, what's one improvement strategy you plan to implement in your practice?



Closing

Closing & Next Steps

- For those interested in CME, an evaluation survey will be distributed following this event and CME certificates will be distributed to those who complete this survey at the end of the month.
- Register for the February QIC session(s)





Questions?

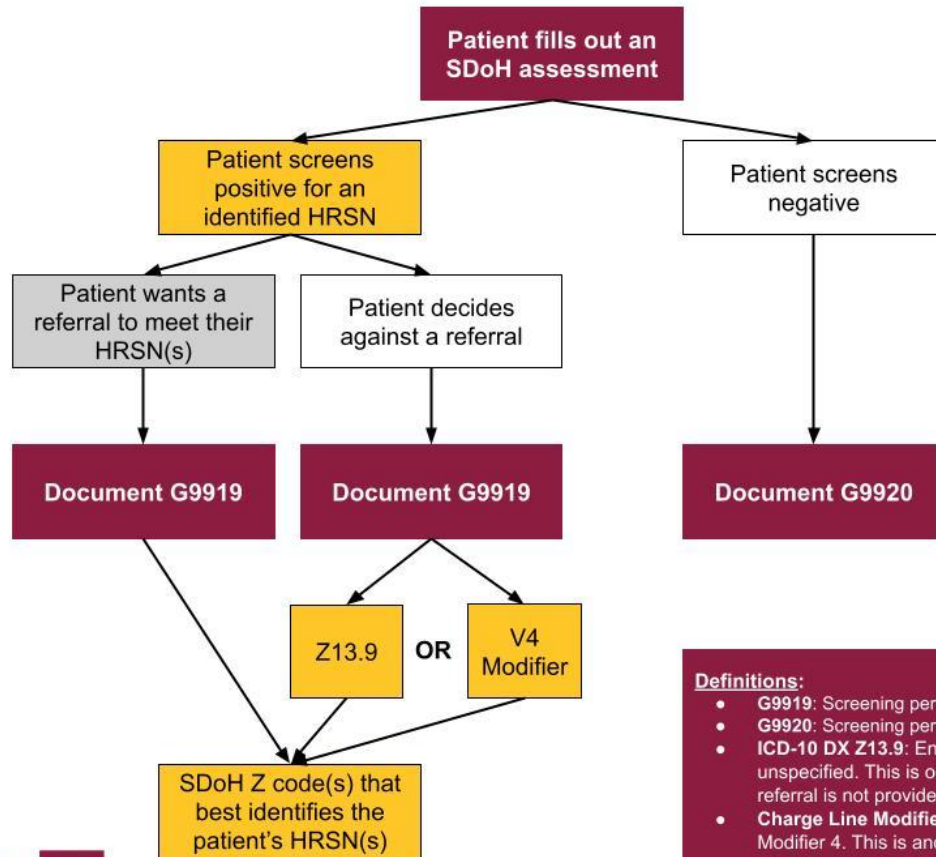
AHCCCS Questions: targetedinvestments@azahcccs.gov

ASU TIPQIC General Inquiries: TIPQIC@asu.edu

Support Tickets: support@TIPQIC.org

Relevant Websites:

- AHCCCS TI: <https://www.azahcccs.gov/PlansProviders/TargetedInvestments/>
- ASU TIPQIC: tipqic.org
- Dashboards: data.tipqic.org



Definitions:

- **G9919:** Screening performed and positive.
- **G9920:** Screening performed and negative.
- **ICD-10 DX Z13.9:** Encounter for screening, unspecified. This is one option to use when a referral is not provided.
- **Charge Line Modifier V4:** Demonstration Modifier 4. This is another option to use when a referral is not provided.
- **SDoH ICD-10 DX Z codes:** Z55x-Z65x.