Program	Texas Incentives for Physician and Professional Services (TIPPS)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and possibly STAR Kids

Intended Quality Outcomes

1. Support access and improve outpatient care for Medicaid managed care members.
2. Expand successful innovations from DSRIP to a broader base of physician practice groups across the state to improve primary care, chronic care, maternal health, behavioral health, and social drivers of health (SDOH).

Program Overview

- The TIPPS program is a new value-based directed payment program (DPP). The program is intended to span 3 years. In Year 1, the program would include the three components described below.
- Three classes of physician practice groups are eligible to participate: 1) physician groups affiliated with a health-related institution (HRI) as defined by Section 63.002 of the Texas Education Code; 2) physician groups affiliated with a hospital receiving the indirect medical education add-on (IME); and 3) other physician practice groups that are not HRI or IME (Other).
- Component 1: Paid as a per-member-per-month (PMPM) payment, triggered by implementation of quality improvement activities. HRIs and IMEs are eligible for Component 1.
- Component 2: Serves as a performance incentive payment based on achievement of quality metrics focused on primary care and chronic care. HRIs and IMEs are eligible for Component 2.
- Component 3: Serves as a rate enhancement for certain outpatient services based on achievement of quality metrics focused on maternal health, chronic care, behavioral health, and SDOH. All physician practice groups are eligible for Component 3.
- Physician practice groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 60 percent of the quality metrics in CY2019 or CY2020 in each Component 2 and 3 to be eligible to participate in the Component.

Reporting Requirements

- Component 1 includes structure measures and requires semi-annual reporting of status/progress for all Component 1 measures.
- Components 2 and 3 include Improvement Over Self (IOS) and benchmark measures and require semi-annual reporting.
- Reporting is tentatively planned to take place during Quarter 1 (Sep-Nov 2021) and Quarter 3 (Mar-May 2022).
    - Quarter 1: report data for all Component 2 and 3 measures for January to June 2021.
    - Quarter 3: report data for all Component 2 and 3 measures for January to December 2021.
- Physician practice groups must report Medicaid managed care stratified by program population (i.e. STAR, STAR+PLUS, STAR Kids,) as well as Other Medicaid, Uninsured, and Other payer types.

Achievement Requirements

- All measures must be reported for a provider to be eligible for payment. If a measure does not have a minimum denominator volume of 30, then the measure is not included in calculating achievement.
- For Year 1, IOS measures are reporting CY2021 as baseline as a condition of participation in the program. IOS measures will be pay-for-performance in later years.
- Year 1 goals for benchmark measures for reported CY2021 are meeting or exceeding the:
    - 50th percentile of national HEDIS benchmarks for Component 2
    - 25th percentile of national HEDIS benchmarks for Component 3.
- Component 2:
    - 100% payment based on achieving at least 4 benchmark measures;
    - 75% payment for achieving 3 measures; OR
    - 50% payment for achieving 2 measures.
- Component 3: 100% payment based on achieving at least 1 benchmark measure.

Component 3 rate enhancements will be applied to the following 10 CPT codes that align with the measures.

99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
T1 - PMPM	T1-101	Patient-Centered Medical Home (PCMH) Certification Status	Structure	NA	NA
	T1-102	CG-CAHPS PCMH Item Set	Structure	NA	NA
	T1-103	Same-day, walk-in, or after-hours appointments in the outpatient setting	Structure	NA	NA
	T1-104	Care team includes personnel in a care coordination role not requiring clinical licensure	Structure	NA	NA
	T1-105	Pre-visit planning and/or standing order protocols	Structure	NA	NA
	T1-106	Patient education focused on disease self-management	Structure	NA	NA
	T1-107	SDOH Data Infrastructure: Screening for SDOH, e.g. food insecurity	Structure	NA	NA
	T1-108	Identification of pregnant women at-risk for Hypertension, Preeclampsia, or Eclampsia; treatment based and follow-up	Structure	NA	NA
	T1-109	Providers demonstrate connectivity to/participation in local HIE	Structure	NA	NA
	T1-110	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist/psychologist	Structure	NA	NA
T2 - P4P	T2-111	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	0028e	PCPI
	T2-112	Cervical Cancer Screening	Process	0032	NCQA
	T2-113	Childhood Immunization Status	Process	0038	NCQA
	T2-114	Immunization for Adolescents	Process	1407	NCQA
	T2-115	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process	0418e	CMS
	T2-116	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Process	0057	NCQA
	T2-117	Preventive Care and Screening: Influenza Immunization	Process	0041	AMA-PCPI
	T2-118	Tobacco Use and Help with Quitting Among Adolescents	Process	2803	NCQA
	T2-119	Chlamydia Screening in Women	Process	0018	NCQA
	T2-120	Controlling High Blood Pressure	Outcome	0033	NCQA
T3 - P4P	T3-121	Food Insecurity Screening	Process	NA	Texas HHSC
	T3-122	Maternity Care: Post-Partum Follow-Up and Care Coordination	Process	NA	CMS
	T3-123	Behavioral Health Risk Assessment for Pregnant Women	Process	NA	CMS
	T3-124	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<9.0%)	Outcome	0575	NCQA
	T3-125	Depression Response at Twelve Months	Outcome	1885	MN CM
	T3-126	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Process	2801	NCQA

Program measures and rationales

Measure ID	Measure Name	Rationale
T1-101	Patient-Centered Medical Home (PCMH) Accreditation and Recognition Status	PCMH accreditation is associated with a number of improved clinical outcomes and reduced hospital and emergency visits.[i] The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management.[ii]
T1-102	CG-CAHPS Patient-Centered Medical Home (PCMH) Item Set -	The Patient-Centered Medical Home (PCMH) Item Set is a set of supplemental questions that can be added to the adult and child versions of the CAHPS Clinician & Group Survey (CG-CAHPS) to gather more information on patient experience with the domains of primary care that define a medical home. The medical home concepts are applicable to primary care no matter how the physician practice is organized. The PCMH Item Set provides a valuable evaluation tool for all practices whether or not they are categorized as medical homes.[iii]
T1-103	Same-day, walk-in, or after-hours appointments in the outpatient setting	As part of the DSRIP Transition, the Best Practices Workgroup members were surveyed to prioritize practices from DSRIP that have been key for driving improvements in the health status of clients within focus areas and populations for continued delivery system reform and quality improvement. This practice was among the top 10 prioritized key practices for driving improvements in the health status of clients. The External Quality Review Organization (EQRO) for Texas also found that very few weekend and after-hours appointments were available to members. Lack of weekend and after-hours appointments limits member access to vital services for prenatal, preventive, and behavioral health care.[iv] Most Americans report having a usual source of medical care, but many also report significant barriers to timely access to such care. This can lead patients to use the emergency department (ED) as a ready alternative to their usual source of medical care, even when such care could be provided more cost-effectively in a primary care setting.[v] Access to after-hours care coordinated with one's usual primary care provider (PCP) is poor in the U.S. compared to other Western industrialized nations. "After-hours care" refers to care for medical problems arising between 5 p.m. and 8 a.m., and on weekends and holidays, that could be appropriately managed by the patient's primary care physician/team.[vi] Yet, continuity of primary care, including care received outside usual business hours, is associated with improved patient outcomes and lower ED use for non-urgent problems. The high rates of ED use for non-urgent, after-hours care contributes to fragmentation of patients' care, inefficient use of resources and higher spending since ED visits cost more than primary care visits. Health problems developing outside of normal business hours are a leading cause of ED visits, with almost 65 % of all ED visits (regardless of severity) occurring between 5 p.m. and 8 a.m. or on weekends.[vii]
T1-104	Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical	Care teams are groups of primary care staff members who collectively take responsibility for a set of patients. Care teams blend multidisciplinary skills, focusing several people's insights, rather than a single physician's, on each patient's problems. Care teams involve the efficient delegation of responsibilities such that no team members perform duties that do not require their skills.[viii] There is evidence that community health workers as part of team based care improved health-related

	social worker, community health worker, medical assistant, etc.)	outcomes, including disease understanding and self-management and chronic disease-related health outcomes, mainly in clinics, but also in a community-level setting.[ix] As part of the DSRIP Transition, the Best Practices Workgroup members were surveyed to prioritize practices from DSRIP that have been key for driving improvements in the health status of clients within focus areas and populations for continued delivery system reform and quality improvement. This practice was among the top 10 prioritized key practices for driving improvements in the health status of clients.
T1-105	Pre-visit planning and/or standing order protocols (e.g. for screenings/assessments, immunization status, tests/results, prescription changes/refills, scheduling follow-up visits, evidence-based practices, etc.)	Care teams involve the efficient delegation of responsibilities such that no team members perform duties that do not require their skills. A number of practices have demonstrated that many primary care visits, especially for chronic disease, involve relatively simple matters that could be handled by nonphysician team members via protocols or standing orders (Bodenheimer, 2007).[x] Pre-visit planning by non-physician members can reduce the time a physician needs to spend on tasks during the appointment. [xi] As part of the DSRIP Transition, the Best Practices Workgroup members were surveyed to prioritize practices from DSRIP that have been key for driving improvements in the health status of clients within focus areas and populations for continued delivery system reform and quality improvement. This practice was among the top 10 prioritized key practices for driving improvements in the health status of clients.
T1-106	Patient education focused on disease self-management (e.g. lifestyle changes, symptom recognition, clinical triage guidance, etc.)	Using self-management support in primary care can have a positive effect on the care and health outcomes of people with chronic conditions, as well as provider and patient satisfaction.[xii] Self-management education (SME) programs teach strategies to help adults manage chronic conditions and live a healthier life. Not all SME programs are the same, but they all can help patients develop strategies to manage their health. Research studies have shown that SME programs help reduce symptoms and improve quality of life.[xiii]
T1-107	SDOH Data Infrastructure: Screening for SDOH, e.g. food insecurity	Health systems are increasingly interested in addressing the social determinants of health in their patient populations. The National Academy of Medicine has identified this as a vital direction for US health care. Social needs screening and navigation programs help identify patients with basic social needs (such as food insecurity, housing insecurity, and inability to afford other basic needs) in order to connect those patients with services to resolve those needs.[xiv] The American Academy of Family Physicians recommends screening every patient for SDOH.[xv]
T1-108	Identification of pregnant women at-risk for Hypertension, Preeclampsia, or Eclampsia; treatment based on best practices; and follow-up with postpartum women diagnosed with Hypertension, Preeclampsia, or Eclampsia	Hypertensive disorders of pregnancy remain a major health issue for women and their infants in the United States. Preeclampsia, either alone or superimposed on preexisting (chronic) hypertension, presents the major risk. Optimal management requires close observation for signs and premonitory findings and, after establishing the diagnosis, delivery at the optimal time for both maternal and fetal well-being. Chronic hypertension is associated with fetal morbidity in the form of growth restriction and maternal morbidity manifested as severely increased blood pressure (BP). However, maternal and fetal morbidity increase dramatically with the superimposition of preeclampsia.[xvi]
T1-109	Providers demonstrate connectivity to/participation in local HIE	The Texas Health IT Strategic Plan seeks to connect local HIEs with ambulatory care providers and hospitals. This strategy will build the critical mass of connected providers needed to create meaningful exchange of clinical data across Texas.[xvii] Lack of interoperability and care coordination have resulted in duplication of care, increased error rates, adverse drug-drug interactions, reduced safety, and increased costs. It has been argued that investments in health information technologies will radically transform the healthcare sector by increasing efficiencies, decreasing expenditures and increasing quality. Prevalence of chronic diseases, and the need for improved quality of care and patient outcomes necessitates the application of Health Information Technology (HIT) and Health Information Exchange (HIE) to streamline patient care, eliminate waste, and improve care coordination, with the goal of ultimately improving

		patient health outcomes. A study found that those institutions with the highest HIT scores for specific measures of clinical decision support, continuity of care documentation and clinical discharge and summary care documentation showed modest and statistically significant levels of improvement in health care quality outcomes for the 3 key outcome metrics of over the study period. Overall, more intensive use of HIT/HIE in the long run could help providers achieve better quality outcomes.[xviii]
T1-110	Telehealth to provide virtual medical appointments and/or consultations with a psychiatrist or a psychologist	Video-based telepsychiatry helps meet patients' needs for convenient, affordable and readily-accessible mental health services. It can benefit patients in a number of ways, such as: • Improve access to mental health specialty care that might not otherwise be available (e.g., in rural areas) • Bring care to the patient's location • Help integrate behavioral health care and primary care, leading to better outcomes • Reduce the need for trips to the emergency room • Reduce delays in care • Improve continuity of care and follow-up • Reduce the need for time off work, childcare services, etc. to access appointments far away • Reduce potential transportation barriers, such as lack of transportation or the need for long drives • Reduce the barrier of stigma There is substantial evidence of the effectiveness of telepsychiatry and research has found satisfaction to be high among patients, psychiatrists and other professionals. Telepsychiatry is equivalent to in-person care in diagnostic accuracy, treatment effectiveness, quality of care and patient satisfaction. [xix]
T2-111	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.[xx]
T2-112	Cervical Cancer Screening	This measure assesses appropriate cervical cancer screening by seeking to ensure that women 21-64 years of age are screened for cervical cancer using the appropriate criteria for their age. Each year, approximately 12,000 women are diagnosed with cervical cancer in the U.S. (U.S. Cancer Statistics Working Group, 2015). Research suggests that cervical cancer is preventable with regular screening and follow-up and is curable if found and treated early. Adherence to this measure could lead to early treatment in affected women, which is associated with long survival and good quality of life (CDC 2015). [xxi]
T2-113	Childhood Immunization Status (CIS)	Vaccines are critical tools for avoiding preventable illnesses in both the child and general population. By encouraging vaccination of children, the measure protects these most vulnerable individuals from avoidable morbidity and mortality while building important herd immunity and reducing medical costs.[xxii]
T2-114	Immunization for Adolescents	This measure assesses the provision of critical immunizations in adolescents by their 13th birthday per clinical guidelines. The intent of the measure is to improve primary prevention of vaccine-preventable diseases including meningococcal meningitis, tetanus, diphtheria and pertussis (whooping cough).[xxiii]
T2-115	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	This measure aligns with the U.S. Preventive Services Task Force's (USPSTF) guidelines recommending routine screening for depression as a part of primary care for both children and adults, seeking to increase detection and treatment of depression and reduce the associated economic burden. The measure is an important contribution to the quality domain of community and population health. The World Health Organization describes major depression as the leading cause of disability worldwide (Pratt & Brody, 2008). According to the Center for Behavioral Health Statistics and Quality (2015), in 2014, 11.7 percent of adolescents aged 12 to 17 and 6.6 percent of adults 18 years and older in the United States received a diagnosis of major depressive disorder. A study by Borner et al. (2010) found that 20 percent of adolescents are likely to have experienced depression by the time they are 18 years old. In adults, depression is the leading cause of disability in high-income countries and is associated with increased mortality due to suicide and impaired ability to manage other health-related issues (Siu, 2016). The effects of depression in adults can include difficulties in functioning at home, in the workplace, and in social situations (Pratt & Brody, 2008). For example, 35

		percent of men and 22 percent of women with depression reported that their depressive symptoms make it difficult for them to work, accomplish tasks at home, or get along with other people (Pratt & Brody, 2008). Effects of depression in adolescents are similar to those in adults; however, Siu (2016) noted depression has a negative effect on developmental trajectories in children and adolescents younger than 18 years old. Also, major depressive disorder in the adolescent population is especially problematic because it is linked with higher possibility of suicide attempt, death by suicide, and recurrence of the disorder in young adulthood. Evidence strongly recommends screening for depression in adolescent and adult patients. Specifically, the USPSTF found convincing evidence that screening in primary care settings improves accurate identification of adolescent and adult patients with depression (Siu, 2016). Yet Borner et al. (2010) cite evidence that physicians are identifying and treating depression among adolescents even less than among adults, and that more than 70 percent of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated (Borner, 2010, p. 948). Additionally, according to the 2016 USPSTF guideline for screening for depression in children and adolescents, only 36 to 44 percent of children and adolescents with depression receive treatment, further evidence that the majority of depressed children and adolescents go untreated. Although primary care providers (PCPs) are the first line of defense in detecting depression, studies show that PCPs fail to identify up to 50 percent of depressed patients, due to both lack of time and a lack of brief, sensitive, and easy-to-administer psychiatric screening tools (Borner, 2010). Finally, according to the 2016 USPSTF guideline for screening depression among adults, the United States spent about $22.8 billion on depression treatment in 2009, and an additional estimated $23 billion on lost productivity (Siu, 2016). This substantial economic burden warrants regular screening for depression, as screening is the first step in identifying those at risk for developing major depressive disorder and closing the performance gap.[xxiv]
T2-116	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.[xxv]
T2-117	Preventive Care and Screening: Influenza Immunization	Influenza may lead to serious complications including hospitalization or death (1). Influenza vaccination is the most effective protection against influenza virus infection (1). However, data indicate that less than half of all eligible individuals receive an influenza vaccination (2). This measure promotes annual influenza vaccination for all persons aged >= 6 months. [xxvi]
T2-118	Tobacco Use and Help with Quitting Among Adolescents	Tobacco use can have both immediate and long-term serious health consequences, yet data show that, despite some successes, many adolescents continue to begin or use tobacco products. Research has shown that health care providers can play an important role in promoting tobacco-use abstinence and cessation. Thus, this measure encourages standardized documentation of tobacco use status among adolescents and appropriate follow-up for those who are users.[xxvii]
T2-119	Chlamydia Screening in Women	This measure assesses the percentage women 16-24 years of age who were identified as sexually active and who received a test for chlamydia. The improvement in quality envisioned by the use of this measure is increased identification of untreated chlamydia infections in women that can lead to serious and irreversible complications and can be unknowingly transmitted to sexual partners. Despite the availability of effective treatments, a large proportion of sexually active individuals continue to go undiagnosed due to the disease s asymptomatic nature. Early detection, screening, and treatment have proven to be effective in managing and preventing chlamydia. [xxviii]
T2-120	Controlling High Blood Pressure	One out of every three Americans have hypertension, or high blood pressure (Fields, 2004). Even with the availability of effective treatment options, more than half of Americans with hypertension are untreated or do not have optimal levels of blood pressure while under treatment (AHA, 2010). Improvements in quality or better control of blood pressure as related to this measure would help significantly reduce the probability of serious and costly complications, including coronary artery disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease and retinopathy. [xxix]

T3-121	Food Insecurity Screening	The Hunger Vital Sign™ (HVS) is a validated 2-question food insecurity screening tool that allows clinicians to accurately identify households at risk of food insecurity and address patient needs appropriately. Endorsed by the American Academy of Pediatrics, the tool is being used by hundreds of clinicians in the US and is being incorporated into electronic health record systems.[xxx]
T3-122	Maternity Care: Post-Partum Follow-Up and Care Coordination	Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions (such as diabetes and hypertension), mental health status (including postpartum depression), and family planning (including contraception and inter-conception counseling).[xxxi] Managing and ensuring concrete post-partum follow-up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. Post-partum follow-up for depression screening, breast feeding evaluation, family planning, and glucose screening are important risk factors to evaluate after childbirth. [xxxii] Maternal depression is one of the most common perinatal complications; however, the disorder remains unrecognized, undiagnosed, and untreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that three to 25 percent of women experience major depression during the year following childbirth. Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcome, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6-12 weeks postpartum and managed appropriately. This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have post-partum visits are excluded from this measure.[xxxiii]
T3-123	Behavioral Health Risk Assessment for Pregnant Women	According to American College of Obstetricians and Gynecologists (ACOG), screening and intervention for alcohol and other drug use are recommended for all pregnant women. Because smoking continuation during pregnancy is associated with the likelihood of other substance use, screening for alcohol and other substance use is an important component of care.[xxxiv] The Texas Maternal Mortality and Morbidity Review Committee (MMMRC) recommends that providers use validated screening tools to screen all pregnant and postpartum women for perinatal mood and anxiety disorders and for substance use disorder (SUD). The MMMRC also found that violence and intimate partner violence were leading community level factors contributing to death and recommends routine screening for intimate partner violence, as does ACOG.[xxxv]
T3-124	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life. With support from health care providers, patients can manage their diabetes with self-care, taking medications as instructed, eating a healthy diet, being physically active and quitting smoking.[xxxvi]
T3-125	Depression Response at Twelve Months	Use of rating scales to measure outcomes of depression treatment is thought to improve both treatment process and outcomes and eventually might be required for accreditation and payment. Recommendations for specific measures have focused on response (≥50% improvement) and remission (symptoms in normal range). [xxxvii] Response is preferable for comparing treatment outcomes, because it does not favor more or less baseline symptom severity, indicates clinically meaningful improvement, and is transparent and easy to calculate.[xxxviii]
T3-126	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Studies report contrasting results regarding the efficacy and safety of pharmacological, psychological, and combined interventions in psychosis and schizophrenia in children, adolescents and young adults. For children, adolescents and young adults, the balance of risk and benefit of antipsychotics appears less favourable than in adults.[xxxix]

[i] https://www.ncqa.org/wp-content/uploads/2019/09/20190926_PCMH_Evidence_Report.pdf
[ii] https://pcmh.ahrq.gov/page/defining-pcmh
[iii] https://www.ahrq.gov/cahps/surveys-guidance/item-sets/PCMH/index.html
[iv] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/eqro-summary-of-activites-report-contract-yr-2018.pdf

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[xxiii] https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1605
[xxiv] https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=3417
[xxv] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
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[xxvii] https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2274
[xxviii] https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2513
[xxix] https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1246
[xxx] https://sirenetwork.ucsf.edu/tools-resources/resources/hunger-vital-sign-best-practices-screening-and-intervening-alleviate-food
[xxxi] https://www.medicaid.gov/medicaid/quality-of-care/downloads/2020-maternity-chart-pack.pdf
[xxxii] https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1958
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