

Practice Improvement Program 2015 Program Guide

Measure Set for UCSF Clinical Practice Group at SFGH (CPG)

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Section I: 2015 Practice Improvement Program (PIP) Overview

Primary Objectives	<ul style="list-style-type: none"> Aligned with the Quadruple Aim: <ol style="list-style-type: none"> Improving patient experience Improving population health Reducing the per capita cost of health care. Improving staff satisfaction Financial incentives to reward improvement efforts in the provider network
Eligibility Requirements	<ul style="list-style-type: none"> Contracted clinic or medical group with SFHP
Funding Sources	<p>Two funding sources, as approved by SFHP’s Governing Board:</p> <ul style="list-style-type: none"> 18.5% of Medi-Cal capitation payments 5% of Healthy Kids capitation payment
How surplus funds are managed	<ul style="list-style-type: none"> Participants’ unearned funds roll over from one quarter to the next Unused funds are reserved for training and technical assistance to improve performance in PIP-related measures
Measure Domains	<ul style="list-style-type: none"> Clinical Quality – Measures focused on improving clinical outcomes Patient Experience – Measures focused on improving patient experience Systems Improvement – Measures focused on improving systems to enhance operations Data Quality – Measures focused on improving data quality

Section II: PIP History

In 2010, San Francisco Health Plan’s governing board approved the funding structure for the Primary Care Practice Improvement Program (PIP), which launched in January 2011 with 26 participating provider organizations (clinics and medical groups). Specialty Care PIP was launched in 2013 with one participant (UCSF Clinical Practice Group at SFGH). While the long-term objective of both Primary Care and Specialty Care PIP is to reward performance-based outcome measures, each started with the basics of quality improvement infrastructure, focusing on reporting only to incentivize participants to build data and reporting capacity. Each year the measure sets have become more rigorous, moving from process measures (e.g. rewarding for development of a tracking plan) to outcome measures (e.g. rewarding for performance on a clinical indicator). Throughout the years, the program has aimed to align with other quality improvement initiatives, including: Aligning Quality Improvement in California Clinics (AQICC), the federal Meaningful Use of Health Information Technology measures (MU), Preventing Heart Attack and Strokes Everyday (PHASE), and the Healthcare Effectiveness Data and Information Set (HEDIS).

In 2015, PIP emphasizes access to care, as audits and surveys show that this remains the greatest area for improvement in San Francisco’s safety net.

Section III: Summary of Key Changes for 2015 PIP

Changes in the 2015 PIP measure set were brought to the PIP Specialty Care Advisory Board and the eReferral Program Manager for input on relevancy, implementation, and general feedback.

- The total number of measures and points available increased to spread the risk across more opportunities.
- The measure set is more aligned in collaboration with primary care.
- This year there are no bonus measures, however there is still the opportunity to earn back any incentive funds not earned in subsequent quarters.

Section IV: 2015 PIP Reporting Rules and Timeline

Reporting requirements vary based on the individual measure (see Section VII for detailed measure specifications). In addition to the enrollment deadline, there are four reporting deadlines and each falls on the last day of the month following the reporting quarter, as illustrated in the table below. All deliverables will be reported via an online Wufoo¹ form. Some measures will require baseline data (2014 performance data) to be included with enrollment.

Quarter	Quarter End Date	Materials Due to SFHP	Reporting Period
Enrollment	December 31, 2014	Friday, January 30, 2015	For all measures, the quarter's end date serves as the last day of the reporting period. Please see each measure's specifications for the first day of the reporting period.
1	March 31, 2015	Thursday, April 30, 2015	
2	June 30, 2015	Friday, July 31, 2015	
3	September 30, 2015	Friday, October 30, 2015	
4	December 31, 2015	Friday, January 29, 2016	

Once reports have been processed each quarter, participants will receive a summary report indicating the score used to calculate payment within 6-8 weeks after the quarterly deadline.

Section V: 2015 PIP Scoring Methodology and Payment Details

Incentive payments will be based on the percent of points achieved of the total points that a participant is eligible for in each quarter. For rate-based measures that require a baseline, points will be awarded if participants demonstrate relative improvement, defined as:

$$\text{Relative Improvement} = (\text{Current Rate} - \text{Baseline Rate}) / (100 - \text{Baseline Rate})$$

Participants will receive a percent of the available incentive allocation based on the following algorithm:

- 90-100% of points = 100% of payment
- 80-89% of points = 90% of payment
- 70-79% of points = 80% of payment
- 60-69% of points = 70% of payment

¹ Wufoo is the online survey vendor PIP uses.

- 50-59% of points = 60% of payment
- 40-49% of points= 50% of payment
- 30-39% of points= 40% of payment
- 20-29% of points = 30% of payment
- Less than 20% of points = no payment

The point allocation for each individual measure was determined based on the degree of alignment with overall program priorities, prioritization of the measure nationally, and input from participants. See individual measure specifications for details.

The 2015 measures were designed to be reasonably challenging. While SFHP wants to distribute the maximum funds possible, our primary goal is to drive improvement in patient care. Pairing high quality standards and a financial incentive is just one of our approaches in achieving this goal. As has been the case each year, any funds not earned in one quarter will be rolled over into the next quarter. Funds not earned by the end of the program year are reserved for training and technical assistance to improve performance in PIP-related measures.

For the 2015 program year, payments will be disbursed quarterly via electronic funds transfer. Participating organizations will receive their first PIP payment for Quarter 1 by May 2015, and their last payment for Quarter 4 by March 2016. All payments will be announced by letter and email notification.

Timely submission of claim/encounter data is important for improving performance on quality measures, advocating for adequate rates from the state, and ensuring fair payments to providers. Participants will only be eligible for PIP incentive payments during quarters in which at least one encounter file is received each month in the correct HIPAA 837 file format. **Failure to submit at least one data submission each month will result in disqualification from PIP payments for all domains for the relevant quarter. Those funds will NOT be rolled over into the next quarter.** All measures that are scored with claims/encounter data require data to be in the correct HIPAA 837 file format. SFHP provides a data clearinghouse (OfficeAlly) for submitters who do not have this ability; please contact Paul Luu at pluu@sfhp.org or 415-615-4427 for more information on this option.

CQ 1: Retinal Cameras

2015 Practice Improvement Program Measure Specification

Changes from 2014

New measure

Measure Description

Participants will receive points for:

Part A: Reporting the number of retinal cameras implemented in 3 additional primary care clinics between January and December 2015, including the clinic location names and implementation dates.

Part B: Reporting the number of eye exams performed in the above clinics using the retinal cameras.

Measure Rationale

Diabetic retinopathy is the leading cause of adult blindness in the U.S., and can be prevented with timely diagnosis (CDC, 2013). Additionally, the Department of Health Care Services (DHCS) includes Diabetic Eye Screening as a performance measure for all Medi-Cal Health Plans and the percent of diabetics that have an eye screening is an NCQA HEDIS measure. Each year, health plans submit their HEDIS rates to the state for public scoring.

Data Source

Self-reported by participant.

Exclusions

- Clinics with retinal cameras installed prior to January 2015 are excluded.
- Eye exams performed outside of the 3 primary care clinics (e.g. exams performed by mobile eye exam vans) should not be included in the rate reported.

Deliverables and Scoring

Deliverables	Due Dates	Scoring
Part A: Report the number of retinal cameras installed in primary care clinics between January and December 2015. Include the clinic location names and implementation dates.	January 29, 2016	0.5 points for each clinic reported, up to three clinics
Part B: Report the number of eye exams performed in the clinics reported in Part A.	January 29, 2016	0.5 points for each clinic reported
Total Points Available		3.0 Points

CQ 2: Auditing Retinal Screenings for Image Quality

2015 Practice Improvement Program Measure Specification

Changes from 2014

New measure

Measure Description

Participants will receive points for:

Part A: Developing and implementing a protocol to assess the image quality of retinal exams performed by primary care staff for all clinics in the San Francisco Health Network (SFHN). Protocol will include 1) description of auditing process, 2) staff responsible for auditing, 3) auditing schedule, 4) acceptable standards for image quality (e.g. minimum % of retinal exams meeting acceptable quality standards), and 5) action steps to be taken if performance with image quality needs improvement.

Part B: Reporting both the total number of eye exams performed in SFHN clinics and the number of eye exams that meet acceptable image quality standards.

Measure Rationale

Diabetic retinopathy is the leading cause of adult blindness in the U.S., and can be prevented with timely diagnosis (CDC, 2013). Additionally, the Department of Health Care Services (DHCS) includes Diabetic Eye Screening as a performance measure for all Medi-Cal Health Plans and the percent of diabetics that have an eye screening is an NCQA HEDIS measure. Each year, health plans submit their HEDIS rates to the state for public scoring.

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverables	Due Dates	Scoring
Part A: Provide protocols meeting the criteria outlined above.	<ul style="list-style-type: none"> Apr 30, 2015 	1 point
Part B: Report the total number of eye exams performed in SFHN clinics and the number of eye exams that meet acceptable image quality standards.	<ul style="list-style-type: none"> Apr 30, 2015 Jul 31, 2015 Oct 30, 2015 Jan 29, 2016 	0.5 point per quarter for reporting numerator and denominator
Total Points Available		3.0 Points

CQ 3: Follow-Up for Patients with Abnormal Retinal Screenings

2015 Practice Improvement Program Measure Specification

Changes from 2014

New measure

Measure Description

Participants will receive points for:

Part A: Developing and implementing a protocol for following up with patients that have an abnormal retinal screening from an SFHN exam. Protocol will include 1) process for identifying and following up on abnormal retinal screenings, 2) staff responsible for conducting the follow up, and 3) acceptable standards for patient follow up (e.g. minimum % of patients referred for an ophthalmology appointment after an abnormal retinal screening who are seen within the time period specified by the teleretinopathy abnormal exam criteria – see below.)

Part B: Reporting both the total number of patients referred for an ophthalmology appointment after receiving an abnormal retinal exam and those seen by an ophthalmologist within the pre-specified time frame.

Monthly Retinal Screening Follow- Up	=	<p>Numerator: Of those patients in the denominator, total number seen by an ophthalmologist within the pre-specified time period.</p> <p>Denominator: Total number of patients referred for an ophthalmology appointment after an abnormal screening</p>
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Part C: Achieving a timely follow-up rate of at least 50% for patients with an abnormal retinal screening in Quarter 4.

Abnormal retinopathy findings and associated recommended follow-up:

- Moderate nonproliferative diabetic retinopathy: clinic appointment within 6 months
- Severe nonproliferative diabetic retinopathy and/or diabetic macular edema: clinic appointment within 6 weeks
- Active proliferative diabetic retinopathy, suspected leukemic retinopathy, papilledema: clinic appointment within 30 days or sooner depending upon findings
- Cataracts, glaucoma suspects: clinic appointment within 3 months

Measure Rationale

Diabetic retinopathy is the leading cause of adult blindness in the U.S., and can be prevented with timely treatment (CDC, 2013). Furthermore, it is imperative to have reliable follow-up systems for legal and ethical reasons.

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverables	Due Dates	Scoring
Part A: Provide protocol(s) meeting the criteria outlined above.	<ul style="list-style-type: none"> • Apr 30, 2015 	1 point
Part B: For each month in the quarter, report the numerator and denominator as noted above.	<ul style="list-style-type: none"> • Apr 30, 2015 (Data Collection Period: Jan, Feb, Mar 2015) • Jul 31, 2015 (Data Collection Period: Apr, May, Jun 2015) • Oct 30, 2015 (Data Collection Period: Jul, Aug, Sept 2015) • Jan 29, 2016 (Data Collection Period: Nov, Oct Dec 2015) 	0.5 point per quarter
Part C: Achieving a follow-up rate of at least 50% for patients with an abnormal retinal screening in Quarter 4 (No additional deliverable required.)	<ul style="list-style-type: none"> • Jan 29, 2016 	1 point
Total Points Available		4.0 Points

CQ 4: Improving Teledermatology Coordination

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure

Measure Description

Participant will receive points for improving the process for teledermatology images and consult reports being uploaded to the electronic health record (EHR), as well as creating and executing the consultation in the EHR.

Part A: Develop and document a new process and procedure that improves efficiency and increases the utilization rate of the EHR. Process should address workflows for both on-site primary care clinic staff and dermatology staff. Revised process will address: directly uploading the teledermatology images, directly uploading the consult reports, and creating and executing the consult from the EHR.

PartB: Develop a training and implementation plan, and execute at Chinatown Public Health Center and Ocean Park Health Center.

Part C: Measure the rate for which the process is being followed. If performance is less than 75%, identify barriers and remediation steps.

$$\text{Quality Control Rate} = \frac{\text{Numerator: Number of referrals with 1) images directly uploaded, 2) consult reports directly uploaded, and 3) creating and executing consults from EHR.}}{\text{Denominator: Total number teledermatology referrals generated from OPHC and CPHC.}}$$

Part D: Achieve a 75% quality control rate. Partial points will be awarded if rate is 60-74%.

Measure Rationale

To improve efficiency and data sharing for existing teledermatology process.

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverable	Due Date	Scoring
Part A: Submit revised process map and protocol that meets the criteria identified above.	<ul style="list-style-type: none"> Apr 30, 2015 	1.0 Point if all criteria are represented. 0.5 Points if criteria are partially represented.
Part B: Submit training and implementation plan. Submit attestation that process was implemented at two clinics.	<ul style="list-style-type: none"> Jul 31, 2015 	0.5 Points for training and implementation plan. 0.25 Points for each clinic that process was implemented.

<p>Part C: Report numerator and denominator as noted above for Quarter 3. Submit barriers and remediation plan if rate is less than 75%</p>	<ul style="list-style-type: none"> Oct 30, 2015 (Data Collection Period: Jul, Aug, Sept 2015) 	<p>1.0 Point</p>
<p>Part D: Achieve a quality control of at least 75% in Quarter 4</p>	<ul style="list-style-type: none"> Jan 29, 2016 (Data Collection Period: Oct, Nov, Dec 2015) 	<p>1.0 Point if rate is at least 75% 0.5 Points if rate is 60-74%</p>
<p>Total Points Available</p>		<p>4.0 Points</p>

CQ 5: Improve Eye Van Technology

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure

Measure Description

Participant will receive points for developing and implementing a plan to provide electronic capture and transmission of screening eye examinations performed on the Eye Van.

Measure Rationale

Diabetic retinopathy is the leading cause of adult blindness in the U.S., and can be prevented with timely diagnosis (CDC, 2013). Additionally, the Department of Health Care Services (DHCS) includes Diabetic Eye Screening as a performance measure for all Medi-Cal Health Plans and the percent of diabetics that have an eye screening is an NCQA HEDIS measure. Each year, health plans submit their HEDIS rates to the state for public scoring.

Deliverables and Scoring

Deliverables will be submitted via a project plan template which will be available on the SFHP website.

[San Francisco Health Plan: Providers: Improving Quality: Practice Improvement Program \(PIP\)](#)

Deliverable	Due Date	Scoring
Submit project plan to provide electronic capture and transmission of screening eye examinations performed on the Eye Van. Plan should address training and implementation.	July 31, 2015	0.5 point
Submit implementation report to date, including successes, barriers, and lessons learned	January 29, 2016	1.0 points
Total Points Available		1.5 Points

PE 1: Provider Scheduling

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure

Measure Description

Participant will receive points for:

Part A: Achieving an 80% threshold for specialty clinics using a provider scheduling grid. Partial points will be awarded if rate is 70-79%

Part B: Implementing training(s) for front-line staff to use this tool.

Measure Rationale

Building physician schedules manually costs medical practices in staffing costs; a physician often builds out the schedules leading to an opportunity cost in that their physician's expertise is not being utilized seeing patients. Having a standardized tool for scheduling providers is important in order to meet demand and increase patient access. The scheduling software automatically balances clinical and facility needs and allows practices to know in real-time which staff are under or over hours.

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverable	Due Date	Scoring
Part A: Report percentage of clinics using provider scheduling grid.	<ul style="list-style-type: none"> Apr 30, 2015 (Data Collection Period: Jan, Feb, Mar 2015) Jul 31, 2015 (Data Collection Period: Apr, May, Jun 2015) Oct 30, 2015 (Data Collection Period: Jul, Aug, Sept 2015) Jan 29, 2016 (Data Collection Period: Nov, Oct Dec 2015) 	<p>0.5 point per quarter for achieving threshold of 80% or more.</p> <p>0.25 point per quarter for achieving threshold of 70-79%.</p>
Part B: Submit attestation that training(s) were conducted for front-line staff to use the tool	<ul style="list-style-type: none"> Jan 29, 2016 	0.5 point for conducting at least one training.
Total Points Available		2.5 Points

PE 2: Increase Productivity of Specialty Visits

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure

Measure Description

Participant will receive points for improving productivity in three clinics. Clinic productivity is defined as the number of encounters performed in the clinic each month by billable providers. Participant will choose 3 high-volume clinics with SFHP approval and improve productivity using existing provider resources. Points will be awarded based on relative improvement from baseline. Baseline data will be due during PIP enrollment and will cover October, November, and December 2014.

Measure Rationale

Improving patient access requires clinics to find the equilibrium of supply and demand. The equilibrium is typically met through a combination of curbing demand and increasing supply of appointments. This measure focuses on increasing supply using existing provider resources. Focusing on maximizing existing provider resources will allow participants to improve scheduling processes and increase clinic efficiency, as opposed to hiring additional providers to improve productivity.

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverable	Due Date	Scoring
Report total number of encounters for each of the three clinics for each month in the Quarter.	<ul style="list-style-type: none"> • Apr 30, 2015 (Data Collection Period: Jan, Feb, Mar 2015) • Jul 31, 2015 (Data Collection Period: Apr, May, Jun 2015) • Oct 30, 2015 (Data Collection Period: Jul, Aug, Sept 2015) • Jan 29, 2016 (Data Collection Period: Oct, Nov, Dec 2015) 	<p>1 point per clinic per quarter for >10% relative improvement</p> <p>0.5 points per clinic per quarter for 5-9% relative improvement</p>
Total Points Available		12.0 Points

PE 3: Third Next Available Appointment for New Patients

2015 Practice Improvement Program Measure Specification

Changes from 2014

- Changed threshold for full points to ≤ 30 days, to match CPG's internal goals.
- In 2015, TNAA will be measured for new patients only, instead of existing/all patients.
- Separate points at stake for each clinic reporting TNAA.
- To account for the fluctuation in TNAA that can produce extreme outliers, SFHP is requesting in 2015 that participant submit the median TNAA for each clinic. In prior years, participant was asked to report the mean, which is much more greatly influenced by outliers.

Measure Description

Participant will receive points for the three high volume clinics (per SFHP approval) improving or meeting thresholds for new patient TNAA. TNAA data should be collected at the same day and time of the week. Participant will submit data for the final 5 weeks of the reporting period each quarter.

How to calculate TNAA: Count the number of days between today and the third next available appointment for a new patient appointment. Report the median TNAA for all teams/providers sampled that week.

- Count calendar days (e.g. include weekends, holidays, and days off).
- Only count appointments saved for routine new patients. Do not count saved slots for urgent visits or other appointment types that have special scheduling rules (since they are "blocked" on the schedule).
- The data can be collected manually or electronically. Manual collection means looking in the schedule book and counting from today to the day of the third available appointment. Some electronic scheduling systems can be programmed to compute the number of days automatically.

Measure Rationale

As the industry standard for measuring access to appointments, the third next appointment best represents appointment access as it accounts for last minute cancellations. This measure is considered the overarching access measure, while the other access measures influence performance in Third Next Available Appointment (National Quality Measures Clearinghouse, 2013).

Data Source/Resources

- Self-reported by participant.
- EZ TNAA Calculator available on SFHP website:
http://www.sfhp.org/files/PDF/providers/JointIncentiveProgram/EZ_TNAA_Calculator.xls
- CA Dept of Managed Health Care for guidelines:
http://www.dmh.ca.gov/healthplans/gen/gen_timelyacc.aspx

Deliverables and Scoring

Deliverable	Due Dates	# of Days Reduced	Threshold	Scoring
Submit the three high volume clinics' median new patient TNAA for each of the final 5 weeks of the reporting period	<ul style="list-style-type: none"> • Apr 30, 2015 (Data Collection Period: Feb 24-Mar 28) • Jul 31, 2015 	≥ 10 days	30 calendar days or less	1 point per quarter per clinic
		5-9 days	31-37 calendar days	0.75 point per quarter per

via the online Wufoo form.	(Data Collection Period: May 26-Jun 27)			clinic
	<ul style="list-style-type: none"> • Oct 30, 2015 	3-5 days	NA	0.5 point per quarter per clinic
	(Data Collection Period: Aug 25-Sept 26)	NA	Participant reports data to SFHP quarterly	0.25 point per quarter per clinic
	<ul style="list-style-type: none"> • Jan 29, 2016 			
	(Data Collection Period: Nov 24-Dec 26)			
Total Points Available				12.0 Points

PE 4: No-Show Reduction Initiative

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure (replaces “Show Rate” measure from 2014)

Measure Description

Participant will receive points for developing and implementing a No-Show Reduction Initiative for at least one clinic with a high percent of no-shows. The no-show rate for the clinic chosen shall be submitted prior to beginning the initiative (to serve as the baseline) and in Quarter 4 (to determine the effectiveness of the initiative).

$$\text{Monthly No-Show Rate} = \frac{\text{Numerator: Of the appointments in the denominator, the total number of no-shows}}{\text{Denominator: Total number of pre-scheduled appointments during any given calendar month}}$$

Measure Rationale

The no-show rate directly impacts what is considered the overarching access measure: Third Next Available Appointment (The Journal of Laryngology & Otology, Cohen et al, 2007), (National Quality Measures Clearinghouse, 2013). In order to improve the no-show rate, determining the cause of no-shows is an important first step.

Data Source/Resources

- Self-reported by participant.
- Webinar on Access Measure reporting tips: http://www.sfhp.org/files/presentations/2013-09-17_13.01_Access_Webinar-JEdmondson.wmv

Deliverables and Scoring

Deliverable	Due Dates	Scoring
Submit No-Show numerator and denominator (as noted above) for Quarter 1 (January, February, and March 2015).	April 30 th , 2015	1 Point
Submit No-Show Initiative plan, including implementation timeline.	April 30 th , 2015	1 Point
Submit No-Show numerator and denominator (as noted above) for Quarter 4 (October, November, and December 2015).	January 29 th , 2016	1 Point for a relative improvement of 10% or more 0.5 Points for a relative improvement of 5-9%.
Total Points Available		3.0 Points

PE 5: Improvement in Patient-Provider Communication as Measured by CAHPS

2015 Practice Improvement Program Measure Specification

Changes from 2014

New measure

Measure Description

This measure supports sites in assessing and improving patient-provider communication. Participant will receive points for:

- Part A:** Submission of an analysis of quantitative and qualitative results and improvement plan for both the Diabetes clinic and Rheumatology clinic; and
- Part B:** Improving the scores in the CAHPS Patient-Provider Communication Composite over the baseline score for both the Diabetes clinic and Rheumatology clinic.

In order to account for well-documented biases from varying patient populations, participant will be scored on improvement relative to their baseline score, rather than meeting a threshold score.

Measure Rationale

Research shows effective communication is linked to many positive medical outcomes (American Psychological Association, Weir, 2012). Much of patient dissatisfaction and complaints are due to poor patient-provider relationships and many doctors overestimate their communication ability (The Oschner Journal, Ha et al, 2010). In previous surveys, SFHP and many clinics in its network have scored below the 25th percentile for the CAHPS Patient-Provider Communication composite.

Data Source/Resources

- CAHPS survey; specifically the Patient-Provider Communication Composite
- Online toolkit of Team Communication & Patient Safety strategies: <http://www.safecoms.org/>

Deliverables and Scoring

Deliverables	Due Dates	Scoring
Part A: Participate in CG-CAHPS baseline survey and submit baseline score for Diabetes and Rheumatology clinics with enrollment form	January 30, 2015	1 point (point to be reflected in Quarter 1 scorecard)
Part B: Submit an analysis of results and access improvement plan for both the Diabetes and Rheumatology clinics	April 30, 2015	2 points will be awarded based on the completeness and quality of the analyses and patient experience improvement plans (2 of each, one set for the Diabetes and another set for the Rheumatology clinic)
Part C: Participate in CAHPS final survey and submit re-measurement scores for Diabetes and Rheumatology clinics	January 29, 2016	1 point for achieving 4.0% or more relative improvement ² over baseline score in the Patient-Provider Communication Composite 0.5 points for achieving a 2.0-3.9% relative improvement over baseline in the Patient-Provider Communication Composite
Total Points Available		4.0 Points

² Relative Improvement (RI) = (Current Rate – Baseline Rate) / (100 – Baseline Rate)

PE 6: PCP Satisfaction with Electronic Specialty Care Consultation

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure

Measure Description

Participants will receive points for developing, implementing, and reporting the results of a survey to measure primary care providers' satisfaction with electronic specialty care consultation through the eReferral system for all specialty clinics. Additionally, points will be awarded for reporting three ways to improve satisfaction based on the results of the survey.

Measure Rationale

PCP satisfaction with the specialty communication improves referral completion (Archives of Pediatrics and Adolescent Medicine, Forrest et al, 2000), resulting in fewer no-shows. Determining ways to improve PCP satisfaction may also increase PCP ability to manage their patients without specialty appointments, resulting in fewer specialty appointments needed, thus increasing available appointments.

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverable	Due Date	Scoring
Submit survey tool and implementation plan	April 30 th , 2015	1 point
Submit survey results and three areas identified for improvement	January 29 th , 2016	1 point
Submit improvement plan	January 29 th , 2016	1 point
Total Points Available		3.0 Points

SI 1: CME Development to Promote Co-Management of Specialty Problems

2015 Practice Improvement Program Measure Specification

Changes from 2014

New measure

Measure Description

The purpose of this measure is to empower patient management in primary care by addressing PCP educational needs and gaps.

Participant will receive points for:

Part A: Identify at least 1 appropriate condition that would increase the ability of primary care physicians to manage cases that would have otherwise been referred to specialty care. Condition(s) should be based on the needs articulated by primary care providers and approved by the Chief Medical Officer of Primary Care.

Part B: Submitting documentation of CME implementation to support PCP co-management of the conditions identified.

Measure Rationale

The referral process has considerable implications for patients, the health care system and health care costs, and there is substantial evidence that referral processes can be improved. Active local educational interventions involving secondary care specialists are shown to impact referral rates (Cochrane Database Systemic Review, Grimshaw et al, 2005). One study found that almost half of all new referrals to a tertiary pediatric orthopedic clinic were for conditions considered to be manageable by primary care physicians (Journal of Pediatric Orthopedics, Hsu et al, 2012).

Deliverables and Scoring

Deliverable	Due Date	Scoring
Submit attestation listing condition identified in Part A with signature from Primary Care CMO	April 30, 2015	0.5 point
Submit attestation listing CME dates and list of attendees	January 29, 2016	1.5 points
Total Points Available		2.0 Points

SI 2: Timely Review of eReferrals

2015 Practice Improvement Program Measure Specification

Measure developed in consultation with eReferral Program Manager.

Changes from 2014

New measure

Measure Description

Participant will receive points for meeting thresholds on the number of clinics where at least 90% of eReferrals are reviewed in a timely fashion. Timely review is defined as within 3 business days, per the eReferral Program.

Measure Rationale

Wait times negatively impact satisfaction, productivity, and outcomes (Family Practice Management, O'Hare et al, 2004). Moreover, California law mandates that managed care Medi-Cal patients have timely access to care. Should an appointment be required, patients must legally be seen within 15 business days (California Department of Managed Health Care). Thus, timely review of eReferrals is a vital first step in meeting this mandate and enhancing overall functionality of the referral process.

Exclusions

Excluded from both the numerator and denominator are communications:

- To Diagnostic Services
- To Laguna Honda Hospital
- That arrive via eReferral system that do not require review, also known as "eScheduling."
- To Pediatrics
- To "Other Programs"

Deliverables and Scoring

Deliverable	Due Date	Threshold	Scoring
Report the total number of clinics where at least 90% of eReferrals are reviewed within 3 business days for each month in the reporting period.	<ul style="list-style-type: none"> • Apr 30, 2015 (Data Collection Period: Jan, Feb, Mar 2015) 	23 clinics	1 point per quarter
	<ul style="list-style-type: none"> • Jul 31, 2015 (Data Collection Period: Apr, May, Jun 2015) 	22 clinics	0.75 point per quarter
	<ul style="list-style-type: none"> • Oct 30, 2015 (Data Collection Period: Jul, Aug, Sept 2015) 	21 clinics	0.5 point per quarter
	<ul style="list-style-type: none"> • Jan 29, 2016 (Data Collection Period: Nov, Oct Dec 2015) 	20 clinics	0.25 point per quarter
Total Points Available			4.0 Points

SI 3: Population Management for Colorectal Cancer Screening

2015 Practice Improvement Program Measure Specification

Changes from 2014

New Measure

Measure Description

Participant will receive points for developing, implementing, and reporting results of a tracking system for patients with an abnormal colorectal cancer screening. Additionally, points will be awarded for determining a benchmark to be used in 2016.

**Monthly
Abnormal
Colorectal
Screening
Follow-
Up Rate**

$$= \frac{\text{Numerator: Number of patients in denominator receiving a colonoscopy within three months of referral to SFGH GI clinic.}}{\text{Denominator: Total number of patients 50-75 years of age with a positive FIT/FOBT referred for a colonoscopy in the first three quarters of the measurement year.}}$$

Measure Rationale

Colorectal cancer kills more Californians than any other cancer except for lung cancer, yet it is one of the most preventable cancers. Despite an effective screening test, racial and ethnic disparities exist in colorectal cancer rates. San Francisco's citywide dashboard, Community Vital Signs, tracks this measure and it is also a national HEDIS measure reported in Medicare and commercial health plans (Anderson, 2013).

Deliverables and Scoring

Deliverables will be submitted via a project plan template which will be available on the SFHP website.

[San Francisco Health Plan: Providers: Improving Quality: Practice Improvement Program \(PIP\)](#)

Deliverable	Due Date	Scoring
Submit project plan, including training and implementation	April 30 th , 2015	1 point
Submit implementation report, including successes, barriers, and lessons learned	January 29 th , 2016	1 point
Submit abnormal colorectal cancer screening follow up numerator and denominator as outlined above for the final 3 months of the measurement year: October, November, and December 2015.	January 29 th , 2016	1 point
Submit benchmark for abnormal colorectal cancer screening follow-up rate to be used in 2016	January 29 th , 2016	1 point
Total Points Available		4.0 points

DQ 1: Timeliness of Electronic Data Submissions

2015 Practice Improvement Program Measure Specification

Changes from 2014

No changes

Measure Description

Participants will receive points based on the percentage of fee-for-service claim and/or capitated encounter lines submitted within 90 days of the service date. This includes professional claims or encounters only. Claims or encounters submitted late due to pending Medi-Cal eligibility status are also included in this measure.

$$\text{Timeliness of Electronic Data Submissions} = \frac{\text{Numerator: Total number of claim/encounter lines with a date of service (DOS) equal to or less than 90 days from the date of the claim/encounter file of receipt (DOR) for the quarter}}{\text{Denominator: Total number of claim/encounter lines submitted for the quarter}}$$

Measure Rationale

Timely submission of claim/encounter data is important to improving performance on quality measures, advocating for adequate reimbursement rates from the state, and ensuring prompt payments to providers.

Data Source

- SFHP-generated data based on site claims and encounter submissions.

OR

- If a medical group is unable to achieve the 90% threshold due to a significant volume of out-of-network non-contracted services, SFHP will accept a supplemental report documenting that 90% of the in-MG professional services **data** for a given quarter was sent to SFHP within 90 days of the date of service.

Exclusions

- Facility charges are excluded.
- Dental, vision and mental health claims/encounters are excluded.
- Encounters submitted electronically in files other than 837P 5010 format are excluded from all data quality measures and will not receive points³.

Deliverables and Scoring

Points are awarded quarterly based on assessment by SFHP.

Deliverable	% deliverables submitted within 90 days	Scoring
Data submissions received within 90 days of date of service	>90%	1 point per quarter
	85-89%	0.5 point per quarter
Total Points Available		4.0 Points

³ SFHP provides a data clearinghouse for (OfficeAlly) for submitters who do not have the ability to produce 837P 5010 files on their own. This service qualifies for the PIP measure.

DQ 2: Acceptance Rate for Electronic Data Submissions

2015 Practice Improvement Program Measure Specification

Changes from 2014

- This measure will continue to support data remaining compliant with state regulations. At the time this measure set was published, ICD-9 codes were scheduled by the state to be retired by October 1, 2015. Should this state timeline be followed, for the final quarter of PIP 2015, participants will need to use ICD-10 codes for their claim/encounter lines to be accepted.

Measure Description

Participants will receive points based on the percentage of fee-for-service claim and/or capitated encounter lines accepted by SFHP upon submission. This measure includes professional claims and encounters only. Claims and encounters submitted late due to pending Medi-Cal eligibility status are also included in this measure.

$$\text{Acceptance Rate of Electronic Data Submissions} = \frac{\text{Numerator: Total number of claim/encounter lines accepted for the quarter}}{\text{Denominator: Total number of claim/encounter lines submitted for the quarter}}$$

Measure Rationale

Accurate submission of claims/encounter data is important for improving performance on quality measures, advocating for adequate rates from the state, and ensuring fair payments to providers.

Data Source

SFHP-generated data based on participant's claims and encounter submissions.

Resource

If participant is struggling with this measure (<50% score achieved), SFHP highly recommends immediate collaboration with PIP Data Quality contact, Paul Luu at pluu@sfhp.org or 415-615-4427.

Exclusions

- Facility charges are excluded.
- Dental, vision and mental health claims/encounters are excluded.
- Encounters submitted electronically in files other than 837P 5010 format are excluded from all data quality measures.

Deliverables and Scoring

Points are awarded quarterly based on assessment by SFHP.

Deliverable	% of claim/encounter lines accepted upon submission	Scoring
Acceptance rate of fee-for-service claim and/or capitated encounter lines by SFHP upon submission	80%	1 point per quarter
	70% to 79%	0.75 point per quarter
	60% to 69%	0.5 point per quarter
Total Points Available		4 Points

DQ 3: Provider Roster Updates

2015 Practice Improvement Program Measure Specification

Changes from 2014

No changes

Measure Description

Participant will receive points for submitting quarterly updates listing all providers at their site(s) with key information listed below.

Measure Rationale

Timely submission of updated provider rosters ensures SFHP maintains key compliance objectives and accurate member assignments. In the past, Provider Roster Updates have not occurred with regular frequency for all sites.

Data Source/Resources

Updated provider rosters must be submitted to provider.relations@sfhp.org or FTP folder. More detailed questions related to your provider roster can also be submitted to provider.relations@sfhp.org, or by calling (415) 547-7818 x7084.

For an example roster, see the template available on the PIP website

<http://www.sfhp.org/providers/improving-quality/practice-improvement-program-pip/>.

Deliverables and Scoring

Deliverable	Due Dates	Scoring
<p><u>Provider Roster Update</u> Roster must include for each site:</p> <ul style="list-style-type: none"> • Clinic hours • Clinic languages • Medical Director (name, phone, email) • Primary clinic contact (name, phone, e-mail) <p>Roster must include for each PCP:</p> <ul style="list-style-type: none"> • First and Last Name • Degree • License Number • Specialty • Date provider started at the clinic or terminated/left the clinic • Reason terminated (if applicable) • PCP email address • Practice address 	<ul style="list-style-type: none"> • Apr 30, 2015 • Jul 31, 2015 • Oct 30, 2015 • Jan 29, 2016 	0.5 point per quarter
Total Points Available		2.0 Points

DQ 4: Locked Encounters

2015 Practice Improvement Program Measure Specification

Changes from 2014

New measure

Measure Description

Participant will receive points for reporting the number of locked encounters within 72 hours of the patient visit over the total number of patient encounters, across all specialty clinics. In 2016, achieving a locked encounter rate threshold will be introduced for points.

$$\text{Locked Encounter Rate} = \frac{\text{Numerator: Total number of locked notes in eCW within 72 hours of patient visit}}{\text{Denominator: Total number of patient encounters}}$$

Clinics that are not set up on eCW at the start of the year should report 0 for both the numerator and denominator until eCW is set up.

Measure Rationale

Completed and closed notes are an indicator of quality care and are required before other providers can access the notes.

Definitions

- Locked Encounter: an electronic signature that identifies the author or responsible party who takes ownership of and attests to the information contained in the medical encounter (this may take the form of selecting the following functions in eCW: "locked", "review" or "co-sign").

Data Source

Self-reported by participant.

Deliverables and Scoring

Deliverables	Due Dates	Scoring
Report the numerator and denominator as noted above for each month in the quarter.	<ul style="list-style-type: none"> Apr 30, 2015 (Data Collection Period: Jan, Feb, Mar 2015) Jul 31, 2015 (Data Collection Period: Apr, May, Jun 2015) Oct 30, 2015 (Data Collection Period: Jul, Aug, Sept 2015) Jan 29, 2016 (Data Collection Period: Nov, Oct Dec 2015) 	0.5 point per quarter
Total Points Available		2.0 Points

APPENDIX

Appendix A: Overview of PIP Measures, Due Dates and Points

Domain	2015 Measure #	Title	Q1	Q2	Q3	Q4	Total
Clinical Quality	CQ1	Retinal Cameras (p. 6)				3	3
Clinical Quality	CQ2	Auditing Retinal Screenings for Image Quality (p. 7)	1.5	0.5	0.5	0.5	3
Clinical Quality	CQ3	Follow-Up for Patients with Abnormal Retinal Screenings (p. 8)	1.5	0.5	0.5	1.5	4
Clinical Quality	CQ4	Improving Teledermatology Coordination (p. 10)	1	1	1	1	4
Clinical Quality	CQ5	Improve Eye Van Technology (p. 12)		0.5		1	1.5
		Total Points	4	2.5	2	4	15.5
Patient Experience	PE1	Provider Scheduling (p. 13)	0.5	0.5	0.5	1	2.5
Patient Experience	PE2	Increase Productivity of Specialty Visits (p. 14)	3	3	3	3	12
Patient Experience	PE3	TNAA for New Patients (p. 15)	3	3	3	3	12
Patient Experience	PE4	No-Show Reduction Initiative (p. 17)	2			1	3
Patient Experience	PE5	Improvement in Patient-Provider Communication as Measured by CG-CAHPS (p. 18)	3			1	4
Patient Experience	PE6	PCP Satisfaction with Electronic Specialty Care Consultation (p. 19)	1			2	3
		Total Points	12.5	6.5	6.5	11	36.5
System Improvement	SI1	CME Development to Promote Co-Management of Specialty Problems (p. 20)	0.5			1.5	2
System Improvement	SI2	Timely Review of eReferrals (p. 21)	1	1	1	1	4
System Improvement	SI3	Population Management for Colorectal Cancer Screening (p. 22)	1			3	4
		Total Points	2.5	1	1	5.5	10
Data Quality	DQ1	Timeliness of Electronic Data Submissions (p. 23)	1	1	1	1	4
Data Quality	DQ2	Acceptance Rate for Electronic Data Submissions (p. 24)	1	1	1	1	4
Data Quality	DQ3	Provider Roster Updates (p. 25)	0.5	0.5	0.5	0.5	2
Data Quality	DQ4	Locked Encounters (p. 26)	0.5	0.5	0.5	0.5	2
		Total Points	3	3	3	3	12
		Domain	Q1	Q2	Q3	Q4	TOTAL
		Clinical Quality	4	2.5	2	4	15.5
		Patient Experience	12.5	6.5	6.5	11	36.5
		Systems Improvement	2.5	1	1	5.5	10
		Data Quality	3	3	3	3	12
		Total Points Across all Domains	22	13	12.5	23.5	74
		Total Number of Measures					18