# Practice Improvement Program
# 2015 Program Guide

## Measure Set for IPA
## (BTMG, CCHCA and Hill)

**Application due: January 30, 2015**

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# Section I: 2015 Practice Improvement Program (PIP) Overview

| | |
|---|---|
| **Primary Objectives** | • Aligned with the Quadruple Aim:<br>1. Improving patient experience<br>2. Improving population health<br>3. Reducing the per capita cost of health care.<br>4. Improving staff satisfaction<br>• Financial incentives to reward improvement efforts in the provider network |
| **Eligibility Requirements** | • Contracted clinic or medical group with SFHP |
| **Funding Sources** | Two funding sources, as approved by SFHP's Governing Board:<br>• 18.5% of Medi-Cal capitation payments<br>• 5% of Healthy Kids capitation payment |
| **How surplus funds are managed** | • Participants' unearned funds roll over from one quarter to the next<br>• Unused funds are reserved for training and technical assistance to improve performance in PIP-related measures |
| **Measure Domains** | • Clinical Quality – Measures focused on improving clinical outcomes<br>• Data Quality – Measures focused on improving data quality<br>• Patient Experience – Measures focused on improving patient experience<br>• Systems Improvement – Measures focused on improving systems to enhance operations |

# Section II: PIP History

In 2010, San Francisco Health Plan's governing board approved the funding structure for the Practice Improvement Program (PIP), which launched in January 2011 with 26 participating provider organizations (clinics and medical groups). While the long-term objective of PIP is to reward performance-based outcome measures, PIP 2011 started with the basics of quality improvement infrastructure, focusing on reporting only to incentivize participants to build data and reporting capacity. PIP 2012 focused on improving systems in order to improve outcomes. PIP 2013 facilitated a stronger commitment to quality by establishing thresholds for clinical measures, incentivizing outreach to higher risk populations, and further developing the infrastructure and tools for quality improvement. In 2014, the Healthy San Francisco-funded initiative Strength in Numbers was fully integrated into PIP to streamline pay for performance programs. PIP 2015 continues this history, by narrowing the measure set to those most important and lowest performing measures, and continuing 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). This year we also plan to begin sharing unblinded data with PIP participants – please see the enrollment form for more information about this.

# Section III: Summary of Key Changes for 2015 PIP

*Changes in the 2015 PIP measure set were brought to the PIP Advisory Board for input on relevancy, implementation, and general feedback.*

- The total number of measures was reduced to help focus improvement efforts. Eliminated measures were either those in which majority of participants had sustained improvement or were no longer relevant to improvement efforts.
- Total possible points decreased as well. This means that each measure is worth more incentive funds.
- This year there are no bonus measures, however there is still the opportunity to earn back any incentive funds not earned in subsequent quarters.
- Clinical Quality scoring will now include points for improving on five priority measures. See Section VI for detailed information on this methodology.
- Incorporating existing member incentive programs sponsored by SFHP and Medi-Cal to help improve performance in aligned measures. See Appendix B for more information.

# 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 Wufoo[1] 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. Should a participant be exempt from a given measure (as described in the measures specifications), the total possible points allocated to that measure will not be included in the denominator when calculating the percent of total points received. Participants will receive a percent of the available incentive allocation based on the following algorithm:

[1] Wufoo is the online survey vendor PIP uses.

- 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
- 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 (particularly the PIP Advisory Board). See individual measure specifications for details.

## Sample Scoring

| Sample Scoring for 3 Participants | | | | |
|---|---|---|---|---|
| **Medical Home** | **Max Points** | **Points Received** | **% Points Awarded** | **% of Available Incentive Earned** |
| Participant A | 96 | 88 | 92% | 100% |
| Participant B (exempt from 1 measure) | 92 | 72 | 79% | 80% |
| Participant C (exempt from pediatric measures) | 80 | 67 | 84% | 90% |

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 July 2016 when HEDIS rates are deemed final. All payments will be announced by letter and email notification.

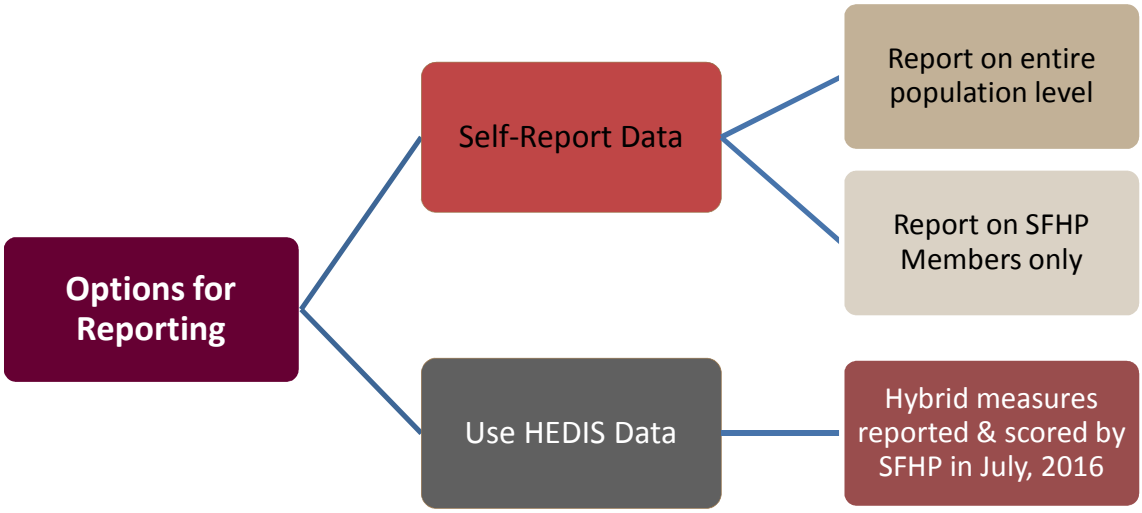
Timely submission of claim/encounter data is important for improving performance on quality measures, advocating for adequate rates from the state, and ensuring fair payments to providers. Participants will only be eligible for PIP incentive payments during quarters in which at least one encounter file 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.

# Section VI: 2015 Clinical Quality Domain

Due to its complexity, the following information is provided about the Clinical Quality Domain.

***Clinical Quality Reporting Methodology***

The reporting methodology for the clinical quality domain remains the same as in 2014, in that participants have the option to either self-report their own data or rely on SFHP-audited HEDIS data. SFHP encourages self-reporting of clinical data, as it is typically more current and thus more actionable than SFHP encounter data used for HEDIS. Below is a summary schematic of the reporting options:




Participants that choose to self-report data then have the option to either:

- Report on their entire clinic population, supporting payer-neutral population management, OR
- Report on their SFHP members only. Clinics and medical groups that have a small proportion of SFHP members must choose this option (e.g. Hill Physicians, Brown & Toland Physicians).

Participants that choose to use HEDIS data will have their administrative measures and hybrid measures (requiring chart review) reported and scored in July 2016 by SFHP, after HEDIS data collection is complete.

Note: PIP participants must choose a reporting methodology upon enrollment (self-reporting vs. SFHP reporting, population data vs. only SFHP member data) and maintain it for the entire program year. Inconsistency in method of reporting will create challenges in scoring and determining earned funds.

***Clinical Quality Scoring***

For 2015, the PIP clinical quality domain has fewer overall measures and is restructured to allow participants to focus on lower performing measures. Participants will receive points for demonstrating improvement over baseline on their five priority measures.

- Using relative difference methodology[2], the priority measures will be determined based on participants' lowest performing 2014 measures
- Points will be awarded for achieving thresholds, or attaining relative improvement over baseline
- Participants with one or more priority measures already performing at the top threshold will be awarded full points for staying within the threshold on those measures, rather than for improvement.

This methodology allows PIP participants to prioritize their improvement efforts, supports HEDIS priorities, enables SFHP to identify trends to provide focused technical assistance and training, and ensures robust data collection for both the participant and the SFHP.

***Clinical Quality Thresholds*** Points will be awarded for meeting the below thresholds:

*For measures with HEDIS thresholds:*

| Measure | 90th percentile | 75th percentile |
|---|---|---|
| CQ01 Diabetes HbA1c Test | 91.73% | 87.59% |
| CQ02 Diabetes HbA1c <8 | 59.37% | 52.89% |
| CQ03 Diabetes Eye Exam | 68.04% | 63.14% |
| CQ04 Cervical Cancer Screening | 76.64% | 71.96% |
| CQ08 Controlling High Blood Pressure | 69.79% | 63.76% |
| CQ09 Adolescent Immunizations | 86.46% | 80.90% |
| CQ10 Childhood Immunizations | 80.86% | 77.78% |
| CQ11 Well Child Visits | 82.69% | 77.26% |

*For measures without HEDIS thresholds a PIP network threshold will be used based on recent performance:*

| Measure | 90th percentile | 75th percentile | 60th percentile |
|---|---|---|---|
| CQ06 Labs for Patients on Persistent Meds | 90% | 83% | N/A |

To acknowledge success even if the top percentiles are not met, points will also be awarded if participants demonstrate relative improvement, defined as:

**Relative Improvement = (Current Rate – Baseline Rate) / (100 – Baseline Rate)**

For measure SI 1: Avoidable Emergency Department (ED) Visits where a lower rate is better, the following calculation will be used:

**Relative Improvement = (Current Rate – Baseline Rate) / (0 – Baseline Rate)**

[2] Like relative improvement, relative difference looks at each participant's performance as compared to the top percentile. The participant's performance will include Q1, Q2, and Q3 data. The resulting equation is:
**Relative Difference =** (Participant's 2014 performance – Top Percentile Rate) / (Top Percentile Rate)

In summary, clinical quality scoring will be determined as follows:

| Deliverable | Quarterly Scoring |
|---|---|
| Reporting on all Clinical Quality measures | 1 point |
| ***For each of the 5 priority measures:*** | |
| Achieving 90th HEDIS *or* 75th internal percentiles *or* 15% or more relative improvement over baseline* | 1 point |
| Achieving 75th HEDIS *or* 60th internal percentiles *or* 10-14% relative improvement over baseline** | 0.75 point |
| Achieving 5-9% relative improvement over baseline | 0.5 point |

***Exception: For CQ06 1 point will be awarded for reaching the 90th internal percentile or 15% or more relative improvement*

*** Exception: For CQ06 0.75 point will be awarded for reaching the 75th internal percentile or 10-14% relative improvement*

# CQ 01: Diabetes HbA1c Test

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes.

## Measure Description

Participants will receive points for improvement of the percentage of patients with diabetes in the eligible population who received an HbA1c test in the last 12 months.

**DM HbA1C Test** = **Numerator:** Number of patients in denominator population who received at least one HbA1c test within the last 12 months (see codes below) / **Denominator**: Number of patients with diabetes ages 18-75 in registry, EHR, or practice management system (see codes below)

## Measure Rationale

With support from health care providers and others, people with diabetes can reduce their risk of serious complications by controlling their levels of blood glucose, their blood pressure, and by receiving other preventive screenings in a timely manner. Studies have shown that reducing A1c blood test results by 1 percentage point (e.g., from 8.0 percent to 7.0 percent) reduces the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent (AHRQ, National Quality Measures Clearinghouse, 2014).

The Department of Health Care Services (DHCS) requires SFHP to report HbA1c testing as part of the annual HEDIS measure set. This measure is also part of the DHCS' auto-assignment program measure set. In the auto-assignment program, Medi-Cal Managed Care members are preferentially assigned to the health plan with the highest performance on each of six measures, of which HbA1c screening is one.

## Definitions

**Codes to Identify HbA1c Tests** (include in the numerator):

| CPT | CPT Category II | LOINC |
|---|---|---|
| 83036, 83037 | 3044F, 3045F, 3046F | 4548-4, 4549-2, 17856-6 |

**Codes to Identify Diabetes** (include in the denominator):

| Description | ICD-9-CM Diagnosis |
|---|---|
| Diabetes | 250, 357.2, 362.0, 366.41, 648.0 |

**Prescriptions to Identify Members with Diabetes** (include in the denominator):

alpha-glucosidase inhibitors, amylin analogs, anti-diabetic combinations, insulin, meglitinides, sulfonylureas, thiazolidinediones, nateglinide and repaglinide. **Metformin alone is not included as an indicator of diabetes.**

## Exclusions

• Patients with a diagnosis of polycystic ovaries (ICD-9-CM Code 256.4) are excluded from the measure.
• Patients with a diagnosis of gestational diabetes or steroid-induced diabetes during measurement year or the year prior may also be excluded from the measure.
• Participants with < 30 SFHP members in the eligible population are exempt from this measure.

## Resources

- See Appendix B for information on available $25 member incentive.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 02: Diabetes HbA1c <8 (Good Control)

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes.

## Measure Description

Participants will receive points for improvement on the percent of patients with diabetes in the eligible population whose most recent HbA1c results in the last 12 months were lower than 8.

$$\textbf{DM A1c<8} = \frac{\textbf{Numerator:}\ \text{Number of patients in denominator with evidence that the most recent HbA1c level is < 8.0 in the last 12 months (see codes below)}}{\textbf{Denominator:}\ \text{Number of patients with diabetes ages 18-75 in registry, EHR, or practice management system}}$$

## Measure Rationale

With support from health care providers and others, people with diabetes can reduce their risk of serious complications by controlling their levels of blood glucose, their blood pressure, and by receiving other preventive screenings in a timely manner. Studies have shown that reducing A1c blood test results by 1 percentage point (e.g., from 8.0 percent to 7.0 percent) reduces the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent (AHRQ, National Quality Measures Clearinghouse, 2014).

The Department of Health Care Services (DHCS) requires SFHP to report HbA1c control as part of the annual HEDIS measurement set.

## Definitions

Codes to Identify HbA1c Levels <8% (include in the numerator):

| Description | CPT Category II |
|---|---|
| Numerator compliant (HbA1c <8.0%) | 3044F |
| Not numerator compliant (HbA1c ≥8.0%) | 3045F, 3046F |

Please refer to CQ 1: page 10 for diabetes ICD-9 codes and exclusions.

## Exclusions

- Participants with < 30 SFHP members in the eligible population are exempt from this measure.

## Resources

- See Appendix B for information on available $25 member incentive.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 03: Diabetes Eye Exam

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes.

## Measure Description

Participants will receive points for improvement on the percent of patients with diabetes who received a retinal eye exam by an eye care professional in the last 12 months, OR a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the past 24 months.

**DM Eye Exam** = **Numerator:** Number of patients in denominator population with retinal exam or dilated eye exam performed by an eye care professional in the past 12 months **OR** a negative retinal or dilated eye exam performed by an eye care professional in last 24 months (see codes below)

**Denominator:** Number of patients with diabetes ages 18-75 years old in registry, EHR, or practice management system

## 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.

## Definitions

Codes to Identify Eye Exams (include in the numerator):

| CPT | CPT Category II | HCPCS |
|---|---|---|
| 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245. | 2022F, 2024F, 2026F, 3072F | S0620, S0621, S0625, S3000 |

Please refer to CQ 1: page 10 for diabetes ICD-9 codes and exclusions

## Exclusions

- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- *Blindness is **NOT** an exclusion for a diabetic eye exam because it is difficult to distinguish between individuals who are legally blind but require a retinal exam, and those who are completely blind and therefore do not require an exam.*

## Resources

- See Appendix B for information on available $25 member incentive.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 04: Routine Cervical Cancer Screening

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes.

## Measure Description

Participants will receive points for improvement on the percentage of patients with cervices 24–64 years of age who received one or more Pap tests in the last 3 years to screen for cervical cancer. Patients with cervices ages 30-64 with cytology/human papillomavirus (HPV) co-testing during the past 5 years can also be included in the numerator.

**Cervical Cancer Screening** = **Numerator:** Number of patients with cervices ages 24-64 who received one or more Pap tests during the past 3 years OR patients with cervices ages 30-64 who received cervical cytology and HPV co-testing during the past 5 years.

**Denominator:** Number of patients with cervices age **24-64 years** old who are considered an active patient in registry, EHR, or practice management system.

## Measure Rationale

Cervical Cancer can be detected in its early stages by regular screening using a Pap (cervical cytology) test. A number of organizations, including the American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA) and the American Cancer Society (ACS), recommend Pap testing every one to three years for all patients with cervices who have been sexually active or who are over 21 (ACOG, 2003; Hawkes et al., 1996; Saslow et al., 2002; AHRQ, National Quality Measures Clearinghouse, 2014)

The Department of Health Care Services (DHCS) requires SFHP to report Cervical Cancer Screening as part of the annual HEDIS report. This measure is also part of the DHCS auto-assignment program measure set. In the auto-assignment program, Medi-Cal Managed Care members are preferentially assigned to the health plan with the highest performance on each of six measures, of which Cervical Cancer Screening is one.

## Definitions

Codes to Identify Cervical Cancer Screening (include in the numerator):

| CPT | HCPCS | ICD-9-CM Procedure | UB Revenue | LOINC |
|---|---|---|---|---|
| 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175, 87620-87622 | G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 | 91.46 | 0923 | 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5, 59420-0, 30167-1, 49896-4, 21440-3, 38372-9 |

## Exclusions

- Participants with <30 SFHP members in the eligible population are exempt from this measure.
- Patients who had a hysterectomy with no residual cervix prior to the measurement period are excluded.
- Codes to identify exclusions:

| Description | CPT | ICD-9-CM Diagnosis | ICD-9-CM Procedure |
|---|---|---|---|
| Hysterectomy | 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135 | 618.5, 752.43, V88.01, V88.03 | 68.4-68.8 |

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 06: Labs for Patients on Persistent Medications

2015 Practice Improvement Program Measure Specification

## Changes from 2014

- Revised the numerator for the digoxin rate to add monitoring of serum digoxin level.
- In 2015, participants may choose to either self-report data or use SFHP's HEDIS data.

**Option 1: (new):** Participants may self-report numerators and denominators as described below. For baseline, the Quarter 1 rate would be used, eliminating relative improvement as an option in Quarter 1. If this option is chosen upon enrollment, SFHP will provide an eligible patient list in February 2015 based on 2014 pharmacy data to serve as the basis for the participant's denominator. If this option is chosen, participants should develop a way to ensure that this list is not the only source for their denominator; in other words, a Registry (or other tracking method) should be in place/created to monitor patients who require this monitoring.

**Option 2:** Participants will be scored on their 2015 HEDIS data only, thereby making all points available in Quarter 4 only. The participant's 2014 HEDIS rate would be used as baseline.

## Measure Description

Participants will receive points for demonstrating improvement on the rate of patients on ACE inhibitors and ARBs, digoxin or diuretics who have received at least one therapeutic monitoring agent in during the measurement year.

**Labs for Patients on Persistent Medications** =

**Numerator:** Number of patients in denominator population who received, in the last year:

- At least one serum potassium,
  **AND**
- A serum creatinine within the measurement year
  **AND (for members on digoxin)**
- A serum digoxin (just for members on digoxin)

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**Denominator:** SFHP members (for options 1 or 2) OR all patients (option 1 only), 18 years and older, on ACE inhibitor, ARBs, digoxin or diuretics for 180 days or more

## Measure Rationale

When patients use long-term medications, they are at risk of having an adverse drug event that results in increased use of both inpatient and outpatient resources. Continued monitoring for a medication's effectiveness and possible side effects reduces the likelihood of adverse drug events.

The Department of Health Care Services (DHCS) requires SFHP to report Labs for Patients on Persistent Medications as part of the annual HEDIS measure set.

## Data Source

- For option 1, SFHP will provide participants with a list of eligible patients based on SFHP pharmacy data in February 2015, and participants will self-report numerators and denominators quarterly.
- For option 2, SFHP lab data will be used to determine Quarter 4's score.

## Exclusions

- Participants with <30 SFHP members in the eligible population are exempt from this measure (according to SFHP's 2014 pharmacy data).

## Definitions

Commonly prescribed medications (see Appendix C and PIP website for complete list):
http://www.sfhp.org/providers/improving-quality/practice-improvement-program-pip/

| Diuretics | ACE Inhibitors | ARBs | Digoxin |
|---|---|---|---|
| HCTZ (hydrochlorothiazide) | Lisinopril | Losartan (Cozaar) | Digoxin |
| Spiro (Spironolactone) | Benazepril | Diovan | |
| Lasix/Furosemide | Enalapril | Benicar | |
| Chlorthalidone | | | |

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 08: Controlling High Blood Pressure (Hypertension)

2015 Practice Improvement Program Measure Specification

## Changes from 2014

In 2015, measure includes revision of definition of adequate control to include two different Blood Pressure (BP) thresholds based on age and diagnosis.

## Measure Description

Participants will receive points for reporting on the percentage of patients diagnosed with hypertension where appropriate BP control, for their risk group, was attained.

**Controlling High Blood Pressure <140/90** =

**Numerator:** Number of patients in the denominator population in which the most recent BP reading in the last year in an outpatient visit within the reporting period was documented as follows:

- 18-59 years of age whose BP was <140/90 mm Hg;
- 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg;
- 60-85 years of age without a diagnosis whose BP was <150/90 mm Hg.

**Denominator:** Number of patients with hypertension ages 18-85 years in the EHR, registry, or practice management system (see codes below)

## Measure Rationale

Controlling blood pressure has been proven to lower morbidity and mortality (AHRQ, National Quality Measures Clearinghouse, 2013). In addition, the Department of Health Care Services (DHCS) requires SFHP to report this as part of the annual HEDIS report and is included in the auto-assignment program measure set. In the auto-assignment program, Medi-Cal Managed Care members are preferentially assigned to the health plan with the highest performance on select measures, of which this is one.

## Definitions

Codes to Identify Hypertension (include in the denominator):

| Description | ICD-9-CM Diagnosis |
|---|---|
| Hypertension | 401 |

Codes to Identify Outpatient Visits:

| Description | CPT | HCPCS | UB Revenue |
|---|---|---|---|
| Outpatient Visits | 99201-99205, 99211-99215, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 | G0402, G0438, G0439, G0463 | 0510-0523, 0526-0529, 0982, 0983 |

## Exclusions

- Exempt from this measure are those patients with Hypertension who also:
  - have End Stage Renal Disease (ESRD),
  - have been pregnant during the measurement period, or
  - had an admission to a non-acute setting within the measurement period.
- Participants with <30 SFHP members in the eligible population are exempt from this measure.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 09: Adolescent Immunizations

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes.

## Measure Description

Participants will receive points for improvement on the rate of adolescents 13 years of age who had one dose of meningococcal vaccine and one (Tdap)/(Td) vaccine by their 13th birthday.

$$\textbf{Adolescent Immunizations} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who received one meningococcal vaccine on or between the member's 11th and 13th birthday and (Tdap) or (Td) on or between the member's 10th and 13th birthdays.}}{\textbf{Denominator:}\ \text{Number of patients who turned 13 years of age during the reporting period.}}$$

## Measure Rationale

Adolescent immunization rates have historically lagged behind early childhood immunization rates in the United States. Low immunization rates among adolescents have the potential to cause outbreaks of preventable diseases and to establish reservoirs of disease in adolescents that can affect other populations including infants, the elderly, and individuals with chronic conditions. Immunization recommendations for adolescents have changed in recent years.

In addition to assessing for immunizations that may have been missed, there are new vaccines targeted specifically to adolescents. This measure follows the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations (AHRQ, National Quality Measures Clearinghouse, 2014).

The Department of Health Care Services (DHCS) also requires SFHP to report this as part of the annual HEDIS report.

## Definitions

Codes to Identify Adolescent Immunizations (include in the numerator):

| Immunization | CPT | ICD-9-CM Procedure |
|---|---|---|
| Meningococcal | 90733, 90734 | |
| Tdap | 90715 | 99.39 |
| Td | 90714, 90718 | |
| Tetanus | 90703 | 99.38 |
| Diphtheria | 90719 | 99.36 |

## Exclusions:

- Participants with <30 SFHP members in the eligible population are exempt from this measure.
- Adolescents who had a contraindication for a specific vaccine.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 10: Childhood Immunizations

2015 Practice Improvement Program Measure Specification

## Changes from 2014

New Measure

## Measure Description

Participants will receive points for improvement on the rate of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. The measure calculates a rate for each vaccine and for the overall HEDIS Combo 3 rate.

**Childhood Immunizations** =

**Numerator:** Number of patients in the denominator population who received **all** of the following vaccines by their second birthday:

- four diphtheria, tetanus and acellular pertussis (DTaP);
- three polio (IPV); one measles, mumps and rubella (MMR);
- three haemophilus influenza type B (HiB);
- three hepatitis B (HepB),
- one chicken pox (VZV); and
- four pneumococcal conjugate (PCV)

**Denominator:** Number of patients who turned 2 years of age during the reporting period

## Measure Rationale

Childhood immunizations help prevent serious illnesses such as polio, tetanus and hepatitis. Vaccines are a proven way to help a child stay healthy and avoid the potentially harmful effects of childhood diseases, like mumps and measles. Even preventing "mild" diseases saves hundreds of lost school days and work days, and millions of dollars (AHRQ, National Quality Measures Clearinghouse, 2014).

This measure follows the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations (Kroger et al., 2006). In addition, the Department of Health Care Services (DHCS) requires SFHP to report this as part of the annual HEDIS report and is included in the auto-assignment program measure set. In the auto-assignment program, Medi-Cal Managed Care members are preferentially assigned to the health plan with the highest performance on select measures, of which this is one.

## Definitions

Please see Appendix D for required antigen dates. Codes to identify eligible immunizations:

| Immunization | CPT | HCPCS | ICD-9 Diagnosis | ICD-9-CM Procedure |
|---|---|---|---|---|
| DTaP | 90698, 90700, 90721, 90723 | | | 99.39 |
| IPV | 90698, 90713, 90723 | | | 99.41 |
| MMR | 90707, 90710 | | | 99.48 |
| HiB | 90645-90648, 90698, 90721, 90748 | | | |
| HepB | 90723, 90740, 90744, 90747, 90748 | G0010 | 070.2, 070.3, V02.61 | |
| VZV | 90710, 90716 | | 052-053 | |
| PCV | 90669, 90670 | | G0009 | |

## Exclusions:

- Participants with <30 SFHP members in the eligible population are exempt from this measure.
- Children who had a contraindication for a specific vaccine.

## Data Source/Resources

- See Appendix B for information on available $50 member incentive.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# CQ 11: Well Child Visits for Children 3-6 Years of Age

2015 Practice Improvement Program Measure Specification

## Changes from 2014

New Measure

## Measure Description

Participants will receive points on the rate of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

$$\textbf{Well Child Visits} = \frac{\textbf{Numerator:}\ \text{Number of patients from the denominator population who had at least one well-child visit with a PCP during the past year.}}{\textbf{Denominator:}\ \text{Number of patients 3-6 years of age.}}$$

## Measure Rationale

Well-child visits during the preschool and early school years are particularly important. A child can be helped through early detection of vision, speech and language problems. Intervention can improve communication skills and avoid or reduce language and learning problems. The American Academy of Pediatrics (AAP) recommends annual well-child visits for 2 to 6 year-olds (AHRQ, National Quality Measures Clearinghouse, 2014).

## Definitions

The definition of a Well Child Visit must include evidence of ***all*** of the following in the medical record:

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance
    - Note: The above components may occur over multiple visits as long as they occur during the measurement year

Codes to Identify Well Child Visits (include in the numerator):

| CPT | ICD-9-CM Diagnosis | HCPCS |
|---|---|---|
| 99381-99385, 99391-99395, 99461 | V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 | G0438, G0439 |

## Exclusions

- Participants with <30 SFHP members in the eligible population are exempt from this measure.

## Resources

- See Appendix B for information on available $25 member incentive.

## Deliverables and Scoring

*Please reference Section VI for information on all Clinical Quality deliverable and scoring information.*

# PE 4: Improvement in Access as Measured by CG-CAHPS

2015 Practice Improvement Program Measure Specification

## Changes from 2014

New measure

## Measure Description

This measure uses information collected directly from patients to assess perceived access to care. Using the CG-CAHPS' Getting Timely Appointments, Care and Information Composite, participants will be scored on improvement relative to their baseline scores rather than meeting a threshold score, due to bias from varying patient populations.

There are two predetermined methods for the administration of CG-CAHPS (please contact SFHP if you are uncertain what method your entity is participating in):

- **Method A:** Your organization administers its own CG-CAHPS survey. The Access composite baseline is submitted by January 30, 2015. Re-measurement is submitted by January 29, 2016.
- **Method B:** SFHP administers the 12-month PCMH version of the CG-CAHPS by mail to SFHP members.

For participants with more than 1 site and/or that serve both adult and children populations, the survey population chosen for improvement shall be determined through a conversation with SFHP. Please contact Vanessa Pratt at 415-615-4284 for more information.

## Measure Rationale

Patient Experience with access is largely connected to clinical outcomes (Annals of Family Medicine, Llanwarne, et al, 2013). SFHP Medi-Cal patients score their experience below the 25th percentile for the Patient Access composite, as measured by CAHPS. The CAHPS survey is rigorously developed to represent patients' top healthcare experience factors and is validated to ensure that results represent patients' true feelings. This measure supports participants in assessing patient access using input directly from patients.

## Definition

**CG-CAHPS:** The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey is a standardized tool to measure patients' perception of care provided by providers and teams in an office setting. The survey evaluates ease of access to care, provider communication with patients, and courtesy and helpfulness of office staff.

**CAHPS Getting Timely Appointments, Care and Information Composite:** Primarily includes questions on the following topics

a. Getting appointments for urgent care
b. Getting appointments for routine care
c. Getting an answer to a medical question during regular office hours
d. Getting an answer to a medical question after regular office hours
e. Wait time for appointment to start

## Data Source/Resources

- CG-CAHPS survey; specifically the Getting Timely Appointments, Care and Information Composite

## Exclusions

- Participants with less than 1500 SFHP members as of August 2014 are excluded from this measure.

## Deliverables and Scoring

| Deliverables | Due Dates | Scoring |
|---|---|---|
| Participate in CG-CAHPS baseline survey and submit score with enrollment form | January 30, 2015<br>(If participating in SFHP survey, no deliverable to SFHP required) | **1 point** (point to be reflected in Quarter 1 scorecard) |
| Submit an analysis of quantitative and qualitative results AND plan to improve results | April 30, 2015 | **1 point** will be awarded based on the completeness and quality of the deliverables |
| Submit report of activities implemented | October 30, 2015 | **1 point** |
| Participate in CG-CAHPS final survey | Complete and submit score by January 29, 2016 (If participating in SFHP survey, no deliverable to SFHP required) | **1 (full) point** for achieving 4.0% or more relative improvement[3] over baseline score in the Getting Timely Appointments, Care and Information Composite<br>**0.5 (partial) point** for achieving a 2.0-3.9% relative improvement over baseline in the Getting Timely Appointments, Care and Information Composite |

[3] Relative Improvement (RI) = (Current Rate – Baseline Rate) / (100 – Baseline Rate)

# PE 6: Staff Satisfaction Improvement Strategies

2015 Practice Improvement Program Measure Specification

## Changes from 2014

- In 2015, the measure omits including an improvement plan for addressing staff satisfaction.
- Participants that wish to use an internal survey will submit scores to SFHP.

## Measure Description

Participants will receive points for activities related to staff satisfaction. In order to guide these activities, an all staff satisfaction survey will be implemented. Participants will have the following two options:

- Option 1: SFHP will sponsor the Net Promoter Survey at no cost to participants
- Option 2: Participants may choose to use a different staff satisfaction survey with SFHP approval

*Please note:* In order for scores to be comparable and participants to be eligible for full points, the same survey must be used for both the baseline and re-survey.

## Measure Rationale

Staff satisfaction is directly tied to patient experience (British Medical Journal, Szecsenyi et al, 2011). The purpose of this measure is to make changes to improve staff satisfaction using the results of a staff survey. The Net Promoter staff survey is a national best practice evaluation tool for understanding staff loyalty and satisfaction.

## Data Source/Resources

- Net Promoter Survey or survey of your choice with SFHP approval.
- If participants wish to use the Net Promoter Survey, SFHP will sponsor this activity. Please see Appendix F for further details on this survey option.

## Deliverables and Due Dates

| Deliverables | Due Dates | Scoring |
|---|---|---|
| Submit the baseline score of a staff satisfaction survey, date, (completed during or after September 2014) AND 1-2 priority areas identified for improvement | Apr 30, 2015 | • **1 point** will be awarded for:<br>o Submitting the baseline score of an all-staff survey with a response rate of at least 65%,<br>o survey date, and<br>o the priority areas identified for improvement. |
| Submit a report of activities implemented specifically to address priority areas identified for improvement | Jan 29, 2016 | • **1 point** will be awarded for the report's completeness |
| Submit the final score of the staff satisfaction survey | Jan 29, 2016 | • **1 point** will be awarded for resurveying 65% of all staff and submitting final score<br>• **1 (full) point** for achieving 4.0% or more relative improvement over baseline<br>• **0.5 (partial) point** for achieving a 2.0-3.9% relative improvement over baseline |

# SI 1: Avoidable Emergency Department (ED) Visits

2015 Practice Improvement Program Measure Specification

## Changes from 2014

New measure replacing overall ED visit rate

## Measure Description

Participants will receive points for decreasing the average rate of assigned member's avoidable ED visits as compared to overall ED visits. Points will be awarded for improvement over the 2014 baseline, OR for meeting the PIP network threshold. The threshold is based on 2014 performance of PIP participating participants.

$$\textbf{Avoidable ED Visit Rate} = \frac{\textbf{Numerator:}\ \text{Total number of visits in the denominator categorized as avoidable}}{\textbf{Denominator:}\ \text{Total number of emergency department visits}}$$

## Measure Rationale

The goal of this measure is to decrease overutilization of ED visits. Reducing the number of frequent and inappropriate visits to the Emergency Department (ED) improves health outcomes and reduces overall healthcare costs (AHRQ, Agency for Healthcare Research and Quality, 2013). Examples of interventions to reduce ED utilization include:

1. Implement panel management improvement strategies;
2. Implement patient education efforts to re-direct care to the most appropriate setting;
3. Institute an extensive case management program to reduce inappropriate emergency department utilization by frequent users;
4. Offer prompt visits to primary care provider visits;
5. Implement narcotic guidelines that will discourage narcotic-seeking behavior;
6. Track data on patients prescribed controlled substances by widespread participation in the state's Prescription Monitoring Program (PMP).
7. Extended office hours.

## Resources

Online toolkits:
http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf
http://www.ahrq.gov/professionals/systems/hospital/toolkit/redtoolkit.pdf

For a list of primary diagnoses to identify an avoidable ED visit and information on additional interventions, please see Appendices G and H or visit the PIP website: http://www.sfhp.org/providers/improving-quality/practice-improvement-program-pip/

## Data Source

SFHP will provide a comparative report of rate of avoidable ED visits to total ED visits at the beginning of the PIP program year and each quarter thereafter.

| Participants to receive rates from SFHP | Timeframe of data included in rates |
|---|---|
| Baseline (sent after enrollment) | January 2014 – December 2014 |
| Quarter 1 Update (sent with Q1 scorecard) | April 2014 – March 2015 |

| | |
|---|---|
| Quarter 2 Update (sent with Q2 scorecard) | July 2014 – June 2015 |
| Quarter 3 Update (sent with Q3 scorecard) | October 2014 – September 2015 |
| Quarter 4 Update (sent with Q4 scorecard) | January 2014 – December 2015 |

## Deliverables and Scoring

| Deliverable | Due Date | Relative Improvement[4] | PIP Network Threshold | Q2 & Q3 Scoring | Q4 Scoring |
|---|---|---|---|---|---|
| **No deliverables are required for this measure.** Performance on this measure will be reported to participants by SFHP. | • Jul 31, 2015<br>• Oct 30, 2015<br>• Jan 29, 2016 | 9% or more RI | 75th percentile 11% or less[5] | 1 points | 2 points |
| | | 6%-8% RI | 50th percentile 12-13% | 0.75 points | 1.5 points |
| | | 3%-5% RI | *None* | 0.5 points | 1 points |

[4] Relative Improvement (RI) = (Current Rate – Baseline Rate) / (0 – Baseline Rate)
[5] Lower is better for this measure

# SI 2: After Hours

2015 Practice Improvement Program Measure Specification

## Changes from 2014

New Measure

## Measure Description

Participants will receive points for documenting that one or more medical home sites (serving a high volume of SFHP members) is open outside of traditional business hours as defined below. One-half point will be awarded per hour of services provided outside of traditional business hours, for up to four hours per week. After hours care must be in the primary care medical home and be available for all patients to count for this measure. A template shall be completed with the following information:

- Medical Home Site Name
- Days and times open after hours
- Patients eligible for after-hours appointments
- How many PCPs and/or teams working after hours
- Date of after-hours launch

## Measure Rationale

After hours care improves the convenience and continuity of primary care, and can lead to decreased utilization of Urgent Care Centers and Emergency Departments. This improves health outcomes and reduces overall healthcare costs (AHRQ, Agency for Healthcare Research and Quality, 2013).

## Definitions

After hours include:

- Weekdays 5:30pm and after
- Weekends anytime of the day

## Data Source

- Self-reported by participants.

## Deliverables and Scoring

| Deliverable | Due Dates | Scoring |
|---|---|---|
| Submit template with after-hours information for medical home site(s) serving a high volume of SFHP members. | • Jan 29, 2016 | • **0.5 points** will be awarded per hour the clinic has appointments available for all patients evenings after 5:30 PM and anytime of the day on weekends (up to 4 hours for a maximum of 2 points total). |

# SI 3: Outreach to Patients Recently Discharged from Hospital

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes

## Measure Description

Participants will receive points when practice staff contact patients within 7 days of inpatient discharge from the practice's assigned hospital.

$$\textbf{Outreach to patients recently discharged} = \frac{\textbf{Numerator:} \text{ \# of patients contacted within 7 days of discharge from the hospital}}{\textbf{Denominator}: \text{ Total number of hospitalizations}}$$

## Measure Rationale

Outreach to patients recently discharged from the hospital is an important step to reducing readmissions, which constitute a significant portion of healthcare costs. Studies have shown that in 2008, roughly 1 in 10 readmissions could have been prevented had there been proper management of acute conditions after discharge (Doug Melton, 2012). Additionally, SFHP found that 32% of readmissions for its patients occurred within the first 7 days.

## Definitions

Patient contact includes engaging with a patient via a phone call, home visit, primary care office visit, or specialist visit (if related to the hospitalization).

## Data Source

Discharge data is generated by participants. SFHP may request completed outreach lists for audit purposes and/or to inform future improvement program planning.

## Exclusions

- Members who are discharged from a psychiatric or maternity unit are excluded.
- Members who are unreachable after three or more attempts, or have a non-working or incorrect phone number, are excluded from the measure.

## Deliverables and Scoring

| Deliverable | Due Dates | Scoring |
|---|---|---|
| Submit total number of patients contacted (numerator) **and** total number of discharges (denominator) via online Wufoo form | • Apr 30, 2015<br>• Jul 31, 2015<br>• Oct 29, 2015<br>• Jan 30, 2016 | • **0.5 point** per quarter if **at least 50% of members** discharged are contacted within 7 calendar days<br>• **0.25 points** per quarter will be awarded if **25-49% of members** discharged are contacted within 7 calendar days |

# SI 4: Same-Day Pregnancy Testing & Referrals

2015 Practice Improvement Program Measure Specification

## Changes from 2014

- In 2014, measure was called "Increasing Timely Prenatal Care."
- In 2015, participants must have best practices (same day pregnancy testing and referrals) in place to qualify for points.

## Measure Description

Participants will receive points for having same-day pregnancy testing and referrals in place. This includes:

- Unlimited same-day capacity for pregnancy testing for all hours the clinic is open.
- Staff identified to perform same-day pregnancy testing.
- Documented policy of process for referring or scheduling pregnant patients to prenatal care.
- Documented policy of process for following up with referred patients to ensure they are connected to prenatal care.

## Measure Rationale

The purpose of this measure is to identify ways to increase the percentage of SFHP members whose pregnancies are identified early and receive timely prenatal care in the first trimester (within 13 weeks of last menstrual period).

## Definitions

**Timely Prenatal Care:** HEDIS defines the first prenatal visit as a prenatal visit occurring within the first 13 weeks of pregnancy, or within 42 days of Medi-Cal enrollment.

## Resources

- See Appendix B for information on available $25 member incentive.

## Deliverables and Scoring

| Deliverable | Due Date | Scoring |
|---|---|---|
| **Submit a descriptive summary addressing which of the following are in place:**<br>1. Unlimited same-day capacity for pregnancy testing for all hours the clinic is open<br>2. Staff identified to perform same-day pregnancy testing<br>3. Policy/Documented Procedure for referrals to prenatal care<br>4. Policy/Documented Procedure for following up with referred patients | **Jan 29, 2016** | **4 points**<br>(1 point for each deliverable) |

# SI 5: Comprehensive Chronic Pain Management

2015 Practice Improvement Program Measure Specification

## Changes from 2014

- Participants are required to submit the numerator and denominator of the patients meeting the Pain Management requirements, rather than just the overall rate.
- Requiring providers to review the CURES report has been excluded.
- Participants to review five SFHP members per quarter, rather than 20 per year.

## Measure Description

**Part A:** Participants will receive points based on the percent of Pain Registry (or equivalent) patients meeting the Pain Management requirements:

$$\textbf{Comprehensive Pain Management} = \frac{\textbf{Numerator:}\ \text{Total number of Pain Registry patients with Pain Management Requirements (one random drug urine screen and a signed pain management agreement)}}{\textbf{Denominator}:\ \text{Total number of patients in Pain Registry (or equivalent)}}$$

Participants may choose to report on just their SFHP members, or their entire patient population. For the data to be comparable, this choice should remain consistent from quarter to quarter.

**Part B:** Participants submit a list of the five SFHP members reviewed by the Controlled Substance Review Committee each quarter via secure email to PainManagement@sfhp.org, with brief documentation of committee recommendations.

## Definitions

**Chronic Pain:** Patients who are prescribed 20mg or more morphine equivalents per day for at least 60 days in the last 3 months.

**Pain Registry:** As one of the most effective panel management tools, SFHP highly encourages the use of a Pain Registry. A registry is a list of patients that meet a certain criteria, usually a diagnosis. Registries provide a tracking system with which to manage a group of patients, helping to ensure quality standards are met. If needed, SFHP can provide technical assistance with setting up a pain management registry. If a participant is unable to develop a pain registry, SFHP can provide a list of patients that meet the above criteria. Please note this need on your enrollment form.

**Pain Management Requirements:** Patients have each of the following documented in the last 12 months:

- One random drug urine screen performed (UTOX or Ameritox), and
- A signed pain management agreement on file.

**Controlled Substance Review Committee:** A committee providing independent review of charts for patients at risk of overdosing from opiates, typically patients with high doses, new patients, patients with suspicious urine drug screens, or patients with other concerning behaviors. Controlled Substance Review Committees help the provider stay accountable to clinic practice guidelines, and supports the clinic's ability to practice consistently and follow best practices. In clinics that have implemented peer review for all chronic opiate patients, providers often appreciate the ability to shift the burden of hard decisions to centralized decision makers. Ideally, this committee

is multi-disciplinary in order to allow for informed recommendations around continuing therapy, adding non-opiate therapy, referring to substance use or behavioral health, and weaning opiate therapy. Small clinics may need to implement medical director review if staffing is not sufficient for a committee.

## Data Source/Resources:

- Self-reported by participant. For participants without the ability to develop a pain registry, participants may use SFHP's working list of chronic pain patients which is based on pharmacy utilization data.
- Pain management resources are available online at http://www.sfhp.org/providers/improving-quality/pain-management/

## Exclusions

- Participants with < 15 SFHP/HSF members meeting the chronic pain criteria outlines above are exempt from this measure.
- Patients who have moved, changed clinics, were lost to follow up, or are deceased are excluded from the denominator.
- Patients who are physiologically unable to produce urine are excluded from the random drug urine screen requirement. They are not, however, excluded from the requirement to have a signed pain management agreement on file.

## Deliverables and Due Dates

| Deliverable | Due Date | Scoring |
|---|---|---|
| **PART A:** Self-report the numerator and denominator as noted in the Measure Description | Apr 30, 2015<br>Jul 31, 2015<br>Oct 30, 2015<br>Jan 29, 2016 | **0.5 point** will be awarded for meeting threshold of **60%** of patients that meet pain management requirements<br>**0.25 point** for **50-59%** meeting the criteria.<br>0 points for less than 50% meeting the criteria. |
| **PART B**: Submit the list of names of 5 SFHP members on high dose opiates or with concerning behavior, reviewed each quarter by controlled substance review committee, with brief documentation of committee recommendations. | Apr 30, 2015<br>Jul 31, 2015<br>Oct 30, 2015<br>Jan 29, 2016 | **0.5 point** will be awarded for submitting (via secure email)[6] the completed template listing the 5 SFHP members reviewed by the substance review committee to PainManagement@sfhp.org. |

[6] If participants do not have the ability to send secure email, please email PainManagement@sfhp.org to set-up an alternative arrangement.

# SI 6: Providers Open to New Members

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes

## Measure Description

Participants will receive points for increasing the percent of Primary Care Providers (PCPs) that accept new members.

$$\textbf{Providers Open to New Members} = \frac{\textbf{Numerator:} \text{ PCPs open to new members } \textbf{and} \text{ to auto-assigned members. Auto-assigned members are new members who do not choose a Primary Care Provider on enrollment with SFHP.}}{\textbf{Denominator}: \text{ Total number of PCPs reported on the Provider Roster}}$$

## Measure Rationale

Provider accessibility is a key requirement for primary health care (Access to Health Services, 2013). Since Medi-Cal expansion in 2014, it has become increasingly important that the influx of new members have adequate choice and access to providers. The purpose of this measure is to increase the percentage of PCPs accepting new members.

## Data Source

Quarterly Provider Roster Report Submission included in the 2015 Requirements and Reporting Responsibilities (R3) deliverables. This Roster Report indicates if PCPs are open to new members as well as if they are open or closed to "defaulted" members.

## Deliverables and Due Dates

| Deliverable | Relative Improvement[7] | Percent Providers Open to Default | Quarterly Scoring |
|---|---|---|---|
| **No deliverables required for this measure.** SFHP will utilize the R3 reporting to calculate the measure. | ≥15% | 60% or more | 2 points |
| | 10-14% | 45-59% | 1.5 points |
| | 5-9% | 30-44% | 1 point |

[7] Relative Improvement (RI) = (Current Rate – Baseline Rate) / (100 – Baseline Rate)

# 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.

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

## 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 fair payments to providers.

## Data Source

- SFHP-generated data based on participant's 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 **primary care 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 NOT in the 837P 5010 format are excluded from all data quality measures.

## Deliverables and Scoring

Points are awarded quarterly based on assessment by SFHP.

| Deliverable | % deliverables submitted within 90 days | Quarterly Scoring |
|---|---|---|
| Data submissions received within 90 days of date of service | >90% | 1 point |
| | 85-89% | 0.75 point |

# 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.

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

## 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 participants are 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 NOT in the 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 | Quarterly Scoring |
|---|---|---|
| Acceptance rate of fee-for-service claim and/or capitated encounter lines by SFHP upon submission | 80% | 1 point |
| | 70% to 79% | 0.75 point |
| | 60% to 69% | 0.5 point |

# DQ 4: Diagnostic Codes for Adult PCP Visits

2015 Practice Improvement Program Measure Specification

## Changes from 2014

No changes

## Measure Description

Participants will receive points for including 2 or more diagnostic codes on **outpatient PCP** encounter/claims for patients 45 or older.

$$\textbf{2 or more diagnostic codes} = \frac{\textbf{Numerator:} \text{ Total number of outpatient PCP encounter/claims with 2 or more diagnostic codes for patients ages 45 years or older for the quarter}}{\textbf{Denominator:} \text{ Total number of outpatient PCP encounter/claims submitted for patients ages 45 years or older for the quarter}}$$

## Measure Rationale

Due to the complexity of the patient population, a single diagnosis suggests that the coding or documentation may be incomplete and limits our ability to plan for effective case management and properly risk-stratify patients. More complete claim/encounter information also allows for more systematic population management, particularly for chronically ill members.

## Exclusions

- Encounters submitted electronically in files NOT in the 837P 5010 format are excluded from all data quality measures.

## Deliverables and Scoring

Points are awarded quarterly based on assessment by SFHP.

| Deliverable | Relative Improvement[8] | Percent of Visits | Quarterly Scoring |
|---|---|---|---|
| PCP outpatient encounter/claims with two or more diagnostic codes for patients 45 years or older (no deliverable due to SFHP.) | ≥15% | >65% | 1 point |
| | 10% – 14% | 60% - 64% | 0.75 point |
| | 5% – 9% | 55% - 59% | 0.5 point |

[8] Relative Improvement (RI) = (Current Rate – Baseline Rate) / (100 – Baseline Rate)

# DQ 5: Data Accuracy between Encounter and Medical Record Data

2015 Practice Improvement Program Measure Specification

## Changes from 2014

New measure

## Measure Description

In an effort to drive improvements in data quality, SFHP will compare the accuracy of data between the electronic encounter data submitted to SFHP for billing purposes and what is documented in providers' medical records. The number of encounters will be randomly selected by SFHP and be reviewed based on organizations' SFHP Medi-Cal membership size as of January 2015 (see table below). Then, organizations will either securely send copies to SFHP or provide SFHP staff with electronic access to the randomly selected charts. If an 80% accuracy threshold is not met, the organization will submit an improvement plan to SFHP to receive full points for this measure. Organizations attaining an accuracy score of 80% or more will be automatically awarded these points.

The following data elements will be compared between SFHP encounter/claim and medical record, and between medical record and SFHP encounter/claim. All data elements must match in order for the data to be deemed accurate. Partial accuracy (e.g. all below elements except for diagnoses matching) will be considered "inaccurate," and will count against the participant's overall accuracy score.

- Billing provider
- Beneficiary
- Date of service
- Rendering provider
- Diagnoses
- Procedures (both codes and modifiers)

## Definitions

**Data Accuracy:** Data is accurate when it correctly describes the real world event. Meaning, the electronic encounter data submitted is identical to the data in the medical chart.

## Measure Rationale

The purpose of this measure is to improve the completeness and accuracy of submitters' electronic data. More accurate and complete data will support clinical quality improvements as well as more appropriate pricing for services rendered. This measure mirrors the Department of Health Care Services' annual audit of Medi-Cal plans' electronic data. Health Plans will receive a financial penalty for low-performing audit results.

## Data Sources/Resources

- SFHP-generated data based on participant encounter submissions. Sample size based on organizations' SFHP Medi-Cal membership size as of January 2015:

| *SFHP Medi-Cal Membership Size* | *# Encounters Randomly Selected* |
|---|---|
| Less than 2,000 | 15 |
| 2,000 – 34,999 | 30 |
| 35,000 or more | 60 |

- Medical records (EMR or paper records) provided by participants

## Deliverables and Scoring

| Deliverable | Due Date | Scoring |
|---|---|---|
| Participation in SFHP assessment (either by sending copies of or providing electronic access to medical records). Results anticipated to participants by August 2015. | April 30, 2015 | 2 Points |
| Achieve 80% accuracy threshold,<br>**OR**<br>Submit an improvement plan if 80% accuracy threshold is not met. | October 30, 2015 | 2 Points |

*We acknowledge that the lag time between the deliverables and the dates of service upon which the assessed data is based is not ideal, as improvement efforts are often most successful when based on recent events. However, given multiple factors (e.g. the delay in encounter data, network-wide assessment lengths, allowing enough time for a meaningful performance improvement plan), this timeline represents the shortest possible option.*

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# APPENDIX

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

**IPAs Self-Report Option**

| 2015 Measure # | Title | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|---|
| | *Clinical Quality Domain* | | | | | |
| | Reporting on all CQ measures* | 1 | 1 | 1 | 1 | 4 |
| | Priority 1 | 1 | 1 | 1 | 1 | 4 |
| | Priority 2 | 1 | 1 | 1 | 1 | 4 |
| | Priority 3 | 1 | 1 | 1 | 1 | 4 |
| | Priority 4 | 1 | 1 | 1 | 1 | 4 |
| | Priority 5 | 1 | 1 | 1 | 1 | 4 |
| | **Total Points** | **6** | **6** | **6** | **6** | **24** |
| | *Patient Experience Domain* | | | | | |
| PE4 | Improvement in Access as Measured by CG CAHPS *(p. 21)* | 2 | | 1 | 1 | 4 |
| PE6 | Staff Satisfaction Improvement Strategies *(p. 23)* | 1 | | | 3 | 4 |
| | **Total Points** | **3** | **0** | **1** | **4** | **8** |
| | *Systems Improvement Domain* | | | | | |
| SI1 | Avoidable Emergency Department (ED) Visits *(p. 24)* | | 1 | 1 | 2 | 4 |
| SI2 | After Hours *(p. 26)* | | | | 2 | 2 |
| SI3 | Outreach to Patients Recently Discharged from Hospital *(p. 27)* | 0.5 | 0.5 | 0.5 | 0.5 | 2 |
| SI4 | Same Day Pregnancy Testing & Referrals *(p. 28)* | | | | 4 | 4 |
| SI5 | Comprehensive Chronic Pain Management *(p. 29)* | 1 | 1 | 1 | 1 | 4 |
| SI6 | Providers Open to New Members *(p. 31)* | 2 | 2 | 2 | 2 | 8 |
| | **Total Points** | **3.5** | **4.5** | **4.5** | **11.5** | **24** |
| | *Data Quality Domain* | | | | | |
| DQ1 | Timeliness of Electronic Data Submissions *(p. 32)* | 1 | 1 | 1 | 1 | 4 |
| DQ2 | Acceptance Rate of Electronic Data Submissions *(p. 33)* | 1 | 1 | 1 | 1 | 4 |
| DQ4 | Diagnostic Codes for Adult PCP Visits *(p. 34)* | 1 | 1 | 1 | 1 | 4 |
| DQ5 | Data Accuracy between Encounters and Medical Record Data *(p* | 2 | | 2 | | 4 |
| | **Total Points** | **5** | **3** | **5** | **3** | **16** |

| | Domain | Q1 | Q2 | Q3 | Q4 | TOTAL |
|---|---|---|---|---|---|---|
| | Clinical Quality | 6 | 6 | 6 | 6 | 24 |
| | Data Quality | 5 | 3 | 5 | 3 | 16 |
| | Patient Experience | 3 | 0 | 1 | 4 | 8 |
| | Systems Improvement | 3.5 | 4.5 | 4.5 | 11.5 | 24 |
| | **Total Points Across all Domains** | **17.5** | **13.5** | **16.5** | **24.5** | **72** |

| * Clinical Quality Measures: | | | |
|---|---|---|---|
| CQ01 | Diabetes HbA1c Test *(p. 10)* | CQ06 | Labs for Patients on Persistent Medications *(p. 14)* |
| CQ02 | Diabetes HbA1c <8 (Good Control) *(p. 11)* | CQ08 | Controlling High Blood Pressure (Hypertension) *(p.* |
| CQ03 | Diabetes Eye Exam *(p. 12)* | CQ09 | Adolescent Immunizations *(p. 17)* |
| CQ04 | Routine Cervical Cancer Screening *(p. 13)* | CQ10 | Childhood Immunizations *(p. 18)* |
| | | CQ11 | Well Child Visits for Children 3-6 Years of Age *(p. 20)* |

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## IPAs - SFHP Option (HEDIS reporting)

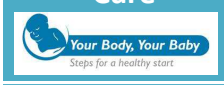
| 2015 Measure # | Title | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|---|
| | *Clinical Quality Domain* | | | | | |
| | Priority 1 | | | | 4 | 4 |
| | Priority 2 | | | | 4 | 4 |
| | Priority 3 | | | | 4 | 4 |
| | Priority 4 | | | | 4 | 4 |
| | Priority 5 | | | | 4 | 4 |
| | **Total Points** | **0** | **0** | **0** | **20** | **20** |
| | *Patient Experience Domain* | | | | | |
| PE4 | Improvement in Access as Measured by CG CAHPS *(p. 21)* | 2 | | 1 | 1 | 4 |
| PE6 | Staff Satisfaction Improvement Strategies *(p. 23)* | 1 | | | 3 | 4 |
| | **Total Points** | **3** | **0** | **1** | **4** | **8** |
| | *Systems Improvement Domain* | | | | | |
| SI1 | Avoidable Emergency Department (ED) Visits *(p. 24)* | | 1 | 1 | 2 | 4 |
| SI2 | After Hours *(p. 26)* | | | | 2 | 2 |
| SI3 | Outreach to Patients Recently Discharged from Hospital *(p. 27* | 0.5 | 0.5 | 0.5 | 0.5 | 2 |
| SI4 | Same Day Pregnancy Testing & Referrals *(p. 28)* | | | | 4 | 4 |
| SI5 | Comprehensive Chronic Pain Management *(p. 29)* | 1 | 1 | 1 | 1 | 4 |
| SI6 | Providers Open to New Members *(p. 31)* | 2 | 2 | 2 | 2 | 8 |
| | **Total Points** | **3.5** | **4.5** | **4.5** | **11.5** | **24** |
| | *Data Quality Domain* | | | | | |
| DQ1 | Timeliness of Electronic Data Submissions *(p. 32)* | 1 | 1 | 1 | 1 | 4 |
| DQ2 | Acceptance Rate of Electronic Data Submissions *(p. 33)* | 1 | 1 | 1 | 1 | 4 |
| DQ4 | Diagnostic Codes for Adult PCP Visits *(p. 34)* | 1 | 1 | 1 | 1 | 4 |
| DQ5 | Data Accuracy between Encounters and Medical Record Data ( | 2 | | 2 | | 4 |
| | **Total Points** | **5** | **3** | **5** | **3** | **16** |

| Domain | Q1 | Q2 | Q3 | Q4 | TOTAL |
|---|---|---|---|---|---|
| Clinical Quality | 0 | 0 | 0 | 20 | 20 |
| Data Quality | 5 | 3 | 5 | 3 | 16 |
| Patient Experience | 3 | 0 | 1 | 4 | 8 |
| Systems Improvement | 3.5 | 4.5 | 4.5 | 11.5 | **24** |
| **Total Points Across all Domains** | **11.5** | **7.5** | **10.5** | **38.5** | **68** |

| *** Clinical Quality Measures:** | | | |
|---|---|---|---|
| CQ01 | Diabetes HbA1c Test *(p. 10)* | CQ06 | Labs for Patients on Persistent Medications *(p. 14)* |
| CQ02 | Diabetes HbA1c <8 (Good Control) *(p. 11)* | CQ08 | Controlling High Blood Pressure (Hypertension) *(p.* |
| CQ03 | Diabetes Eye Exam *(p. 12)* | CQ09 | Adolescent Immunizations *(p. 17)* |
| CQ04 | Routine Cervical Cancer Screening *(p. 13)* | CQ10 | Childhood Immunizations *(p. 18)* |
| | | CQ11 | Well Child Visits for Children 3-6 Years of Age *(p. 20)* |

## ***Appendix B:*** Aligned Member Incentive Programs

Since operational improvement can only go so far, we are pleased to promote the following member incentive programs that are aligned with several PIP 2015 Measures. Materials available in most of the languages our members speak!

| Incentive Program | Description | Target Member Population | Gift Card | How to Obtain Submission Card |
|---|---|---|---|---|
| **Diabetes Care**   | Members with a diagnosis of diabetes (type 1 or type 2) who receive each of the following screening tests:<br>• Blood Pressure<br>• HbA1c<br>• LDL-C<br>• Micro Albumin<br>• Dilated Eye Exam<br>• Foot Exam | Ages 18-75 | $25 | Contact Annie George at ageorge@sfhp.org or 415-615-4291 |
| **Childhood Immunizations**  | Children who receive the following shots by age 2:<br>▪ 4 DTaP<br>▪ 3 Polio<br>▪ 4 Pneumococcal<br>▪ 3 HiB<br>▪ 3 Hep B<br>▪ VZV<br>▪ 2 Hep A<br>▪ 2 Flu<br>▪ MMR<br>• 2 Rotavirus | Age 2 and under | $50 | Contact Annie George at ageorge@sfhp.org or 415-615-4291 |
| **Well Child Visits**  | Children who receive a well-child visit during the calendar year | Ages 3 -6 | $25 | Contact Annie George at ageorge@sfhp.org or 415-615-4291 |
| **Prenatal Care**   | Pregnant members who receive a prenatal checkup within required timeframe (42 days for new members and 1st trimester for existing members). | Pregnant Members | $25 | Contact Annie George at ageorge@sfhp.org or 415-615-4291 |
| **Postpartum Care**   | Members who receive a maternal health visit at 3 weeks to 8 weeks postpartum | New mothers | $25 | Contact Annie George at ageorge@sfhp.org or 415-615-4291 |
| **Medi-Cal Incentives to Quit Smoking (MIQS)** | Members must have a valid Medi-Cal Beneficiary Identification Card number and complete the first counseling session | Medi-Cal members ages 18 and older who want to quit using/smoking tobacco | $20 | **Call 1-800-NO BUTTS to** enroll in Helpline counseling http://nobutts.org/miqs/ |

## Appendix C: *CQ06 List of Eligible Medications*

Patients on the following medications for 180 days or more are eligible for this measure:

ACE Inhibitors/ARBs

| Description | Prescription |
|---|---|
| Angiotensin converting enzyme inhibitors | • Benazepril • Captopril • Enalapril • Fosinopril • Lisinopril • Moexipril • Perindopril • Quinapril • Ramipril • Trandolapril |
| Angiotensin II inhibitors | • Azilsartan • Candesartan • Eprosartan • Irbesartan • Losartan • Olmesartan • Telmisartan • Valsartan |
| Antihypertensive combinations | • Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Trandolapril-verapamil |

Digoxin:

| Description | Prescription |
|---|---|
| Inotropic agents | Digoxin |

Diuretics:

| Description | Prescription |
|---|---|
| Antihypertensive combinations | • Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan |
| Loop diuretics | • Bumetanide • Ethacrynic acid • Furosemide • Torsemide |
| Potassium-sparing diuretics | • Amiloride • Eplerenone • Spironolactone • Triamterene |
| Thiazide diuretics | • Chlorothiazide • Chlorthalidone • Hydrochlorothiazide • Indapamide • Methyclothiazide • Metolazone |

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## **Appendix D:** *CQ10 Required Antigen Dates for Childhood Immunizations*

| *Overview:* Hepatitis B, MMR, VZV |
|---|
| For Hepatitis B, MMR, and VZV count any of the following:<br>• Evidence of the antigen or combination vaccine ***or***<br>• Documented history of the illness ***or***<br>• A seropositive test result for each antigen. |
| *Overview:* DTaP, HiB, IPV, pneumococcal conjugate |
| For DTaP, HiB, IPV, and pneumococcal conjugate, count *only*:<br>• Evidence of the antigen or combination vaccine |

*For combination vaccinations that require more than one antigen, the participant must find evidence of all the antigens*

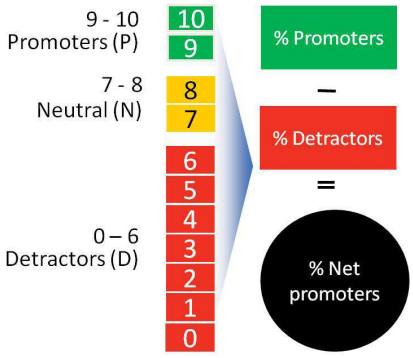
| *Individual Immunization Details* | |
|---|---|
| **DTaP** | At least four DTaP vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth |
| **Hepatitis B** | Either of the following on or before the child's second birthday meet criteria:<br>• At least three hepatitis B vaccinations, with different dates of service.<br>• History of hepatitis illness. |
| **HiB** | At least three HiB vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| **IPV** | At least three IPV vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| **MMR** | Any of the following with a date of service on or before the child's second birthday meet criteria:<br>• At least one MMR vaccination<br>• At least one measles and rubella vaccination ***and*** at least one mumps vaccination on the same date of service or on different dates of service<br>• At least one measles vaccination ***and*** at least one mumps vaccination ***and*** at least one rubella vaccination on the same date of service or on different dates of service.<br>• History of measles, mumps ***or*** rubella illness. |
| **Pneumococcal conjugate** | At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. |
| **VZV** | Either of the following on or before the child's second birthday meet criteria:<br>• At least one VZV vaccination, with a date of service on or before the child's second birthday.<br>• History of varicella zoster (e.g., chicken pox) illness. |

## Appendix F: *Net Promoter Survey Information*

The Net Promoter Survey Questions are:

1. On a scale from 0-10, how likely are you to recommend your organization as a place to work to a friend or relative?
    a) What would it take to rate your clinic a "10" or maintain the rating of "10"?
2. On a scale from 0-10, how likely are you to recommend your organization as a place to come for care to a friend or relative?
    a) What would it take to rate your clinic a "10" or maintain the rating of "10"?

The Net Promoter Score (NPS) is a measure of customer loyalty developed by Harvard Business School and Bain consulting. Their research demonstrated that the question most highly correlated to growth and customer likelihood to repurchase or return was: "On a scale of 0 -10, how willing would you be to recommend Company X to a friend or colleague?" To calculate the NPS based on this question, the percentage of "detractors" who gave a rating of 0-6 is subtracted from the percentage of "promoters" who responded 9 or 10 as follows:




The Net Promoter survey uses this question to measure employee engagement. The reason for this approach is that years of research have demonstrated the link between employee engagement and customer (patient) satisfaction and loyalty. Of note, employee responses to the NPS question can be substantially lower than customer scores as our teams often hold their company to even higher standards than do customers.

The Net Promoter Score for each of the above questions is calculated as follows:

| | | | | |
|---|---|---|---|---|
| **Net Promoter Score (NPS)** | = | **Promoters** (% of employees who responded with a 9-10 rating) | - | **Detractors** (% of employees who responded with a 0-6 rating) |

The qualitative responses from the survey will also be tabulated and can be used to design improvement projects.

## Appendix G: *SI1 Avoidable ED Visits diagnosis codes*

The following codes will be used to identify avoidable ED visits:

| Infectious and parasitic diseases | |
|---|---|
| 110.5 | DERMATOPHYTOSIS OF THE BODY |
| 112 | CANDIDIASIS |
| 112.0 | CANDIDIASIS OF MOUTH |
| 112.1 | CANDIDIASIS OF VULVA AND VAGINA |
| 112.2 | CANDIDIASIS OF OTHER UROGENITAL SITES |
| 112.3 | CANDIDIASIS OF SKIN AND NAILS |
| 112.8 | CANDIDIASIS OF OTHER SPECIFIED SITES |
| 112.82 | CANDIDAL OTITIS EXTERNA |
| 112.84 | CANDIDIASIS OF THE ESOPHAGUS |
| 112.85 | CANDIDIASIS OF THE INTESTINE |
| 112.89 | OTHER CANDIDIASIS OF OTHER SPECIFIED SITES |
| 112.9 | CANDIDIASIS OF UNSPECIFIED SITE |
| 133 | ACARIASIS |
| 133.0 | SCABIES |
| 133.8 | OTHER ACARIASIS |
| 133.9 | UNSPECIFIED ACARIASIS |

| Disorders of the eye | |
|---|---|
| 372 | DISORDERS OF CONJUNCTIVA |
| 372.0 | ACUTE CONJUNCTIVITIS |
| 372.00 | UNSPECIFIED ACUTE CONJUNCTIVITIS |
| 372.01 | SEROUS CONJUNCTIVITIS, EXCEPT VIRAL |
| 372.02 | ACUTE FOLLICULAR CONJUNCTIVITIS |
| 372.03 | OTHER MUCOPURULENT CONJUNCTIVITIS |
| 372.04 | PSEUDOMEMBRANOUS CONJUNCTIVITIS |
| 372.05 | ACUTE ATOPIC CONJUNCTIVITIS |
| 372.1 | CHRONIC CONJUNCTIVITIS |
| 372.10 | UNSPECIFIED CHRONIC CONJUNCTIVITIS |
| 372.11 | SIMPLE CHRONIC CONJUNCTIVITIS |
| 372.12 | CHRONIC FOLLICULAR CONJUNCTIVITIS |
| 372.13 | VERNAL CONJUNCTIVITIS |
| 372.14 | OTHER CHRONIC ALLERGIC CONJUNCTIVITIS |
| 372.15 | PARASITIC CONJUNCTIVITIS |
| 372.2 | BLEPHAROCONJUNCTIVITIS |
| 372.20 | UNSPECIFIED BLEPHAROCONJUNCTIVITIS |
| 372.21 | ANGULAR BLEPHAROCONJUNCTIVITIS |
| 372.22 | CONTACT BLEPHAROCONJUNCTIVITIS |
| 372.3 | OTHER AND UNSPECIFIED CONJUNCTIVITIS |
| 372.30 | UNSPECIFIED CONJUNCTIVITIS |
| 372.31 | ROSACEA CONJUNCTIVITIS |
| 372.39 | OTHER AND UNSPECIFIED CONJUNCTIVITIS |
| 373.33 | XERODERMA OF EYELID |

## **Appendix G:** *SI1 Avoidable ED Visits diagnosis codes continued*

| Disorders of the ear and mastoid process | |
|---|---|
| 382 | SUPPURATIVE AND UNSPECIFIED OTITIS MEDIA |
| 382.0 | ACUTE SUPPURATIVE OTITIS MEDIA |
| 382.00 | ACUT SUPPRATV OTITIS MEDIA W/O SPONT RUP EARDRUM |
| 382.01 | ACUT SUPPRATV OTITIS MEDIA W/SPONT RUP EARDRUM |
| 382.1 | CHRONIC TUBOTYMPANIC SUPPURATIVE OTITIS MEDIA |
| 382.2 | CHRONIC ATTICOANTRAL SUPPURATIVE OTITIS MEDIA |
| 382.3 | UNSPECIFIED CHRONIC SUPPURATIVE OTITIS MEDIA |
| 382.4 | UNSPECIFIED SUPPURATIVE OTITIS MEDIA |
| 382.9 | UNSPECIFIED OTITIS MEDIA |
| 383.02 | ACUTE MASTOIDITIS WITH OTHER COMPLICATIONS |

| Acute Respiratory Infections | |
|---|---|
| 460 | ACUTE NASOPHARYNGITIS |
| 462 | ACUTE PHARYNGITIS |
| 465 | ACUTE URIS OF MULTIPLE OR UNSPECIFIED SITES |
| 465.0 | ACUTE LARYNGOPHARYNGITIS |
| 465.8 | ACUTE URIS OF OTHER MULTIPLE SITES |
| 465.9 | ACUTE URIS OF UNSPECIFIED SITE |
| 466 | ACUTE BRONCHITIS AND BRONCHIOLITIS |
| 466.0 | ACUTE BRONCHITIS |

| Other Diseases of the Upper Respiratory Tract | |
|---|---|
| 472 | CHRONIC PHARYNGITIS AND NASOPHARYNGITIS |
| 472.0 | CHRONIC RHINITIS |
| 472.1 | CHRONIC PHARYNGITIS |
| 472.2 | CHRONIC NASOPHARYNGITIS |
| 473 | CHRONIC SINUSITIS |
| 473.0 | CHRONIC MAXILLARY SINUSITIS |
| 473.1 | CHRONIC FRONTAL SINUSITIS |
| 473.2 | CHRONIC ETHMOIDAL SINUSITIS |
| 473.3 | CHRONIC SPHENOIDAL SINUSITIS |
| 473.8 | OTHER CHRONIC SINUSITIS |
| 473.9 | UNSPECIFIED SINUSITIS |

| Diseases of Tonsils and Adenoids | |
|---|---|
| 474 | CHRONIC DISEASE OF TONSILS AND ADENOIDS |
| 474.0 | CHRONIC TONSILLITIS AND ADENOIDITIS |
| 474.00 | CHRONIC TONSILLITIS |
| 474.01 | CHRONIC ADENOIDITIS |
| 474.02 | CHRONIC TONSILLITIS AND ADENOIDITIS |
| 474.1 | HYPERTROPHY OF TONSILS AND ADENOIDS |
| 474.10 | HYPERTROPHY OF TONSIL WITH ADENOIDS |
| 474.11 | HYPERTROPHY OF TONSILS ALONE |
| 474.12 | HYPERTROPHY OF ADENOIDS ALONE |
| 474.2 | ADENOID VEGETATIONS |
| 474.8 | OTHER CHRONIC DISEASE OF TONSILS AND ADENOIDS |
| 474.9 | UNSPECIFIED CHRONIC DISEASE OF T&A |

## **Appendix G:** *SI1 Avoidable ED Visits diagnosis codes continued*

| Diseases of the Genitourinary System | |
|---|---|
| 595 | CYSTITIS |
| 595.0 | ACUTE CYSTITIS |
| 595.1 | CHRONIC INTERSTITIAL CYSTITIS |
| 595.2 | OTHER CHRONIC CYSTITIS |
| 595.3 | TRIGONITIS |
| 595.4 | CYSTITIS IN DISEASES CLASSIFIED ELSEWHERE |
| 595.8 | OTHER SPECIFIED TYPES OF CYSTITIS |
| 595.81 | CYSTITIS CYSTICA |
| 595.82 | IRRADIATION CYSTITIS |
| 595.89 | OTHER SPECIFIED TYPES OF CYSTITIS |
| 595.9 | UNSPECIFIED CYSTITIS |
| 599.0 | URINARY TRACT INFECTION SITE NOT SPECIFIED |
| 616 | INFLAMMATORY DISEASE OF CERVIX VAGINA AND VULVA |
| 616.0 | CERVICITIS AND ENDOCERVICITIS |
| 616.1 | VAGINITIS AND VULVOVAGINITIS |
| 628.8 | FEMALE INFERTILITY OF OTHER SPECIFIED ORIGIN |

| Diseases of the Skin and Subcutaneous System | |
|---|---|
| 698.8 | OTHER SPECIFIED PRURITIC CONDITIONS |
| 698.9 | UNSPECIFIED PRURITIC DISORDER |
| 705.1 | PRICKLY HEAT |

| Diseases of the Musculoskeletal System and Connective Tissue | |
|---|---|
| 724.2 | LUMBAGO |
| 724.5 | UNSPECIFIED BACKACHE |
| 724.7 | DISORDERS OF COCCYX |
| 724.8 | OTHER SYMPTOMS REFERABLE TO BACK |

| Symptoms, Signs and Ill-defined conditions | |
|---|---|
| 784.0 | HEADACHE |

| V Codes | |
|---|---|
| V67 | FOLLOW-UP EXAMINATION |
| V67.0 | SURGERY FOLLOW-UP EXAMINATION |
| V67.00 | FOLLOW-UP EXAMINATION FOLLOWING UNSPEC SURGERY |
| V67.01 | FOLLOWING SURGERY FOLLOW-UP VAGINAL PAP SMEAR |
| V67.09 | FOLLOW-UP EXAMINATION FOLLOWING OTHER SURGERY |
| V67.1 | RADIOTHERAPY FOLLOW-UP EXAMINATION |
| V67.2 | CHEMOTHERAPY FOLLOW-UP EXAMINATION |
| V67.3 | PSYCHOTHAPY&OTH TX MENTAL DISORDER F/U EXAM |
| V67.4 | TREATMENT HEALED FRACTURE FOLLOW-UP EXAMINATION |
| V67.5 | OTHER FOLLOW-UP EXAMINATION |
| V67.51 | F/U EXAM FOLLOW CMPL TX W/HIGH-RISK MED NEC |
| V67.59 | OTHER FOLLOW-UP EXAMINATION OTHER |
| V67.6 | COMBINED TREATMENT FOLLOW-UP EXAMINATION |
| V67.9 | UNSPECIFIED FOLLOW-UP EXAMINATION |
| V68 | ENCOUNTERS FOR ADMINISTRATIVE PURPOSES |

## Appendix G: *SI1 Avoidable ED Visits diagnosis codes continued*

| V Codes continued | |
|---|---|
| V68.0 | ISSUE OF MEDICAL CERTIFICATES |
| V68.01 | DISABILITY EXAMINATION |
| V68.09 | OTHER ISSUE OF MEDICAL CERTIFICATES |
| V68.1 | ISSUE OF REPEAT PRESCRIPTIONS |
| V68.2 | REQUEST FOR EXPERT EVIDENCE |
| V68.8 | ENCOUNTERS OTHER SPEC ADMINISTRATIVE PURPOSE |
| V68.81 | REFERRAL PATIENT WITHOUT EXAMINATION/TREATMENT |
| V68.89 | ENCOUNTERS OTHER SPEC ADMINISTRATIVE PURPOSE OTH |
| V68.9 | ENCOUNTERS UNSPECIFIED ADMINISTRATIVE PURPOSE |
| V70 | GENERAL MEDICAL EXAMINATION |
| V70.0 | ROUTINE GENERAL MEDICAL EXAM@HEALTH CARE FACL |
| V70.1 | GENERAL PSYC EXAMINATION REQUESTED AUTHORITY |
| V70.2 | OTHER&UNSPEC GENERAL PSYCHIATRIC EXAMINATION |
| V70.3 | OTH GENERAL MEDICAL EXAMINATION ADMIN PURPOSES |
| V70.4 | EXAMINATION FOR MEDICOLEGAL REASON |
| V70.5 | HEALTH EXAMINATION OF DEFINED SUBPOPULATION |
| V70.6 | HEALTH EXAMINATION IN POPULATION SURVEY |
| V70.7 | EXAMINATION OF PARTICIPANT IN CLINICAL TRIAL |
| V70.8 | OTHER SPECIFIED GENERAL MEDICAL EXAMINATION |
| V70.9 | UNSPECIFIED GENERAL MEDICAL EXAMINATION |
| V72 | SPECIAL INVESTIGATIONS AND EXAMINATIONS |
| V72.0 | EXAMINATION OF EYES AND VISION |
| V72.1 | EXAMINATION OF EARS AND HEARING |
| V72.11 | ENCOUNTER HEARING EXAM FOLLOW FAILED HEARING SCR |
| V72.12 | ENCOUNTER FOR HEARING CONSERVATION AND TREATMENT |
| V72.19 | OTHER EXAMINATION OF EARS AND HEARING |
| V72.2 | DENTAL EXAMINATION |
| V72.3 | GYNECOLOGICAL EXAMINATION |
| V72.31 | ROUTINE GYNECOLOGICAL EXAMINATION |
| V72.32 | ENCOUNTER PAP CERV SMER CONFIRM NL SMER FLW ABN |
| V72.4 | PREGNANCY EXAMINATION OR TEST |
| V72.40 | PREGNANCY EXAMINATION/TEST PREGNANCY UNCONFIRMED |
| V72.41 | PREGNANCY EXAMINATION OR TEST NEGATIVE RESULT |
| V72.42 | PREGNANCY EXAMINATION OR TEST POSITIVE RESULT |
| V72.5 | RADIOLOGICAL EXAMINATION NEC |
| V72.6 | LABORATORY EXAMINATION |
| V72.7 | DIAGNOSTIC SKIN AND SENSITIZATION TESTS |
| V72.8 | OTHER SPECIFIED EXAMINATIONS |
| V72.81 | PRE-OPERATIVE CARDIOVASCULAR EXAMINATION |
| V72.82 | PRE-OPERATIVE RESPIRATORY EXAMINATION |
| V72.83 | OTHER SPECIFIED PRE-OPERATIVE EXAMINATION |
| V72.84 | UNSPECIFIED PRE-OPERATIVE EXAMINATION |
| V72.85 | OTHER SPECIFIED EXAMINATION |
| V72.86 | ENCOUNTER FOR BLOOD TYPING |
| V72.9 | UNSPECIFIED EXAMINATION |

## **Appendix H:** *SI1 Avoidable ED Usage Intervention Ideas (Hill)*

The following are interventions that Hill Physicians Medical Group has conducted in the SF Region:

- Provide practices with a list of their HMO assigned members (this helps them identify who has not established a relationship with them yet)
- Provide a template letter to mail to patients. The template is a notification that the patient is assigned to the provider and what the provider's regular office hours are, and what to do in after-hours situations. The SF Urgent Care listing is also included in this mailing.
- Audit providers after-hours phone messages and/or answering services to ensure that they have the 911 emergency option stated, and ask that they also ensure there is either an on-call provider option OR state the nearest participating Urgent Care center as an option. *It has been proven that practices that state these options on their answering machine or through their answering service have lower ED rates.*
- Disseminate a member mailing to all SF Region members informing them that their PCP is their first point of contact, but Urgent Care is a better option over Emergency Room when appropriate. Included was an Urgent Care listing.
- Provide all SF Region PCPs with a report of Emergency Room utilization by patient, which includes an "avoidable" diagnosis column based on a list one of the ACO health plans has provided to Hill. The goal is to have the PCPs identify patients that have multiple ED visits for avoidable diagnosis services and educate them to contact the PCP or go to the Urgent Care.
- Identify practices that have a high ED utilization on certain days of the week and worked with those practices to change or extend their office hours on those days.
- Encourage group practices, in order to provider better access to patients. When that is not possible, Hill offers practices to consider a "Virtual" group practice. This means that solo PCP practices that are geographically near each other can take call for each other and see each other's patients. This has worked quite well and offers more options to patients.