Practice Improvement Program
2017 Program Guide
Primary Care

Community Clinic

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Section I: 2017 Practice Improvement Program (PIP) Overview

| Primary Objectives | • Aligned with the Quadruple Aim:  
|                   | 1. Improving patient experience  
|                   | 2. Improving population health  
|                   | 3. Reducing the per capita cost of health care  
|                   | 4. Improving staff satisfaction  
|                   | • Financial incentives to reward improvement efforts in the provider network  
| Eligibility Requirements | • Contracted clinic or medical group with SFHP  
|                        | • Assigned primary care medical home for 300+ SFHP members and/or HSF participants  
| Funding Sources | Two funding sources, as approved by SFHP’s Governing Board:  
| How Surplus Funds are Managed | • Participants’ unearned funds roll over from one quarter to the next for the duration of the year  
|                        | • At the end of the year, unused funds are reserved for training and technical assistance to improve performance in PIP-related measures  
| Measure Domains | • Clinical Quality – Measures aligned with external entities¹, such as NCQA/HEDIS. Selection criteria includes clinical relevance, opportunity for improvement, and self-reporting feasibility.  
|                    | • Data Quality – Measures derived from DHCS electronic data requirements and support comprehensiveness of coding.  
|                    | • Patient Experience – Measures intended to improve SFHP’s lowest performing HP-CAHPS composite, which remains Access to Care in 2017.  
|                    | • Systems Improvement – Measures supporting appropriate utilization of health care services.  

Section II: PIP History

In 2010, San Francisco Health Plan’s governing board approved the funding structure for the Practice

¹ Key External Healthcare Measurement Entities:  
Healthcare Effectiveness Data and Information Set (HEDIS)  
National Committee for Quality Assurance - Health Plan Accreditation (NCQA)  
National Quality Forum (NQF)  
Patient-centered medical home (PCMH)  
Uniform Data System (UDS)
Improvement Program (PIP), which launched in January 2011 with 26 participating provider organizations (clinics and medical groups). The long-term objective of PIP is to reward performance-based outcome measures, and has aimed to achieve this through the following stages:

- In the first two years of PIP in 2011-2012, participants were incentivized to build data and reporting capacities.
- In 2013, PIP introduced thresholds for clinical measures and began rewarding based on performance for the first time.
- In 2014, the Healthy San Francisco-funded initiative Strength in Numbers was fully integrated into PIP to streamline reporting requirements.
- In 2015, SFHP reduced the measure set to those most important and lowest performing measures.
- In 2016, Specialty Care access measures for medical groups because access remains the area for most opportunity with San Francisco’s Medi-Cal population.
- In 2017, new measures were added to the Clinical Quality domain to increase alignment with external entities.

Section III: Summary of Key Changes for PIP 2017

Changes in the PIP 2017 measure set were brought to the PIP Advisory Committee and other stakeholders for input on relevancy, implementation, and general feedback.

- The enrollment deadline has been moved up to allow more time between the enrollment period and Quarter 4 submissions.
- To reduce the occurrence of payment reconciliations, participants will have the opportunity to review their quarterly scorecard and notify SFHP of any needed data corrections before payments are wired; this review period will begin one-week from the date they receive their scorecard. Data corrections found after this one-week period will continue to follow the Data Correction Policy protocol.
- The following measure was retired:
  - Timeliness and Acceptance of Electronic Encounters, due to sustained improvements.
- For the first time since 2015, new clinical quality measures were added due to change in clinical guidelines and to align with external entities such as the Statewide Standardizing Medi-Cal Pay-for-Performance effort and the Public Hospital Redesign and Incentives in Medi-Cal (PRIME).
- The Systems Improvement domain is now focusing on appropriate utilization of health services to increase clarity of domain and measures. In addition, this will better support the quadruple aim by addressing more specifically the cost of care.
  - To support this change, Depression Screening has been added to PIP within the Systems Improvement domain. This is a first step to increasing utilization of mental health services, which is currently an improvement opportunity for SFHP.

Section IV: PIP 2017 Reporting Rules and Timeline

Reporting requirements and lookback periods vary based on the individual measure (see Section VII for detailed measure specifications). The four quarterly reporting deadlines fall on the last business day of the month following the reporting quarter, as illustrated in the table below.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Quarter End Date</th>
<th>Materials Due to SFHP</th>
<th>Lookback Period</th>
</tr>
</thead>
</table>


Lookback period: To determine the lookback period for each measure, please refer to the individual measure specification. For all measures, the final day of data to be included is the date listed under “Quarter End Date” above. The first day varies by measure based on lookback period. For example, measure SI 2 Follow-Up Visit After Hospital Discharge covers the three months of the quarter, whereas measure CQ 04 Routine Cervical Cancer Screening looks back either 3 or 5 years depending on the population.

Late Submissions Acceptance Policy and Procedure
Late submissions will be accepted up to two weeks after each quarter’s deadline. Participants may arrange for an extension, if negotiated prior to the deadline. When an extension has been granted, points and payment will not be affected. When an extension has not been granted, the late submission will not be accepted and the participant will forfeit the associated points.

Data Correction Policy
In order to more fully understand PIP’s impact and make informed decisions about measure development, SFHP relies on accurate data. In the event where the participant notices that incorrect data has been submitted, the participant should notify SFHP and re-submit their quantitative data template for that quarter with the reconciled data.

If the corrected data results in a change in incentive earned, a reconciled payment may be made in some cases. The following diagram illustrates this process:

For example, if a participant earned and was paid out for 80% of funds in Quarter 2 and then submitted corrected Quarter 2 data that should have earned them 90% of funds, a reconciled payment would depend on their Quarter 3 performance. If they earn 100% of funds in Quarter 3, then all unearned funds from Quarter 2 were recouped by Quarter 3’s 100% payment. In this case, a reconciled payment is not necessary. However, if the participant only earned 90% in Quarter 3, a reconciled payment would be made based on how much they should have earned in Quarter 2.
Once a participant has been paid for Quarter 4, reconciliation of funds is no longer possible due to program constraints. Regardless of ability to modify payment amounts, SFHP greatly appreciates corrected data whenever it is discovered to assist in program evaluation and decision making. For measures that use SFHP-produced data, the same process as above will be followed in the event that SFHP identifies a data accuracy issue.

**Data Validation Policy and Procedure**

To best understand program efficacy and standardize reporting, SFHP is invested in promoting activities that support data validation. If issues arise, SFHP is invested in working with participants to validate and improve data collection. To validate data, SFHP engages in the following activities:

- **Clinical Quality Domain:**
  - SFHP will compare self-reported data to SFHP-audited HEDIS data. Some variation is expected given the difference in denominator populations. Significant variation will be analyzed further in collaboration with participants.

- **PE 1 Third Next Available Appointment and PE3 Cycle Time:**
  - SFHP may audit the data collection process to ensure consistent methodology is being used.
  - In addition, SFHP will use grievance data as another mechanism for validation. As part of our normal grievance investigation process, we will conduct research to verify member experiences. Significant variation from PIP data will be analyzed further in collaboration with participants.

- During the course of the program year, SFHP may pursue additional validation activities as opportunities arise.

**Section V: 2017 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:

- 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 is determined based on the degree of alignment with overall program priorities and prioritization of the measure nationally. See individual measure specifications for details.
Measures are designed to be reasonably challenging. While SFHP wants to distribute the maximum funds possible, the 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.

To acknowledge success even if the top thresholds are not met, points are available for some measures when relative improvement tiers are met, defined as:

\[
\text{Relative Improvement} = \frac{\text{Current Rate} - \text{Baseline Rate}}{100 - \text{Baseline Rate}}
\]

Within 6-8 weeks after the quarterly deadline, participants will receive a scorecard indicating how payment was calculated. Participants will be given one week from the date they receive their quarterly scorecard to notify SFHP of any needed scoring corrections.

Payments will be disbursed quarterly via electronic funds transfer, within three weeks of the scorecard being sent. Participating organizations will receive their first PIP payment for Quarter 1 by June 2017, and their last payment for Quarter 4 by July 2018 when HEDIS rates are deemed final. All payments will be announced via 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 the PIP Team for more information on this option.

Measure Exemptions

Each measure has certain requirements for exemptions, see the specifications for details. Exemptions are determined once for the program year upon enrollment and communicated to participants via the annual measure grid. Thus, if a participant is determined to be exempt from a measure at the beginning of the year, they remain exempt from the measure for the remainder of the year. For those participants who are exempt from a measure, SFHP may have other resources for which to collaborate on improvement efforts. If interested, please contact the PIP team.

Section VI: 2017 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 2016, 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 more current and thus more actionable than SFHP encounter data used for HEDIS. Below is a summary schematic of the reporting options:

**Options for Reporting**

- **Self-Report Data**
- **Use HEDIS Data**

**Report on entire population level** (available to participants with a large proportion of SFHP members)

**Report on SFHP members only**

**Measures reported & scored by SFHP in July, 2018**

Participants that choose to self-report data on a quarterly basis have the option to either:

- Report on their entire clinic population if the vast majority of the population is represented in the clinic’s electronic system (Registry, EHR, etc.), supporting payer-neutral population management, OR
- Report on their SFHP members only.
  - Clinics and medical groups where the proportion of SFHP members to their overall population is small (generally < 10%) are required to choose this option. **To request an exemption from this, please speak with SFHP prior to enrollment.**
- For either option:
  - Eligibility will be determined via the baseline submission process. Participants will be exempt from all measures where the self-reported denominator is less than 30.
  - How to account for patient-reported data:
    - Compliant: include patient-reported data when the following criteria are met:
      - Verified by receiving results/notes or speaking with staff at the other facility
      - Test date, result, and facility recorded in the medical record
    - Not compliant: patient-reported data not meeting the above criteria

For participants that choose to use HEDIS data, the following will apply:

- Measures will be scored once in the program year, when data is finalized in July, 2018.
- Measure eligibility will be determined based on 2016 HEDIS data, available in July 2016. Participants will be exempt from all measures where the SFHP-reported HEDIS denominator is less than 30.
- HEDIS data is collected in two ways. SFHP reports each measure as determined by the National Committee for Quality Assurance (NCQA).
• Administrative: based only on electronic data sent to SFHP, primarily through claims and encounters. Data is collected for all eligible members. This methodology is used for the PIP measure CQ06.
• Hybrid: based on a random, much smaller sample of members. Data is collected via chart review for any member where administrative data is not available. This methodology is used for the following PIP measures: CQ01, CQ02, CQ03, CQ04, CQ08, CQ09, CQ10, and CQ11.
• The new 2017 measures being rewarded for reporting-only (CQ13-CQ17) are not eligible to use HEDIS data. Should a participant choose not to self-report on these measures, they will forfeit the associated points.
  - Measures CQ05 and CQ07, Colorectal Cancer Screening and Smoking Cessation Intervention, are not HEDIS measures for SFHP and thus participants must self-report these measures.

**Clinical Quality Scoring**

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Quarterly Scoring (Self-Report)</th>
<th>Yearly Scoring (HEDIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving 90th percentile HEDIS or 75th internal PIP percentiles or 15% or more relative improvement</td>
<td>1.25 points</td>
<td>5.0 points</td>
</tr>
<tr>
<td>Achieving 75th percentile HEDIS or 60th internal PIP percentiles or 10-14% relative improvement</td>
<td>1.0 point</td>
<td>4.0 points</td>
</tr>
<tr>
<td>Achieving 5-9% relative improvement over baseline</td>
<td>0.75 point</td>
<td>3.0 points</td>
</tr>
</tbody>
</table>

For each of the non-Priority Five measures:

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Quarterly Scoring (Self-Report)</th>
<th>Yearly Scoring (HEDIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reporting data quarterly</td>
<td>0.25 point</td>
<td>n/a</td>
</tr>
<tr>
<td>Maintaining performance relative to baseline*</td>
<td>0.25 point</td>
<td>1.0 point</td>
</tr>
</tbody>
</table>

For each of the new reporting-only measures (CQ12-CQ18):

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Quarterly Scoring (Self-Report)</th>
<th>Yearly Scoring (HEDIS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reporting data quarterly, beginning in Quarter 2</td>
<td>0.25 points</td>
<td>The HEDIS option is not available for reporting-only measures. If a participant chooses not to self-report, they will forfeit the points available for that measure.</td>
</tr>
</tbody>
</table>

*Maintaining performance relative to baseline = Maintaining baseline is defined as either maintaining/attaining the top threshold (found on page 11) or greater than -5.0% relative improvement. For example, relative improvement of -4.0% will be awarded points whereas -5.0% will not be awarded points.
In addition, participants will be eligible to earn **4.0 points** in Quarter 4 for submitting an analysis of disparities in one or more Priority Five measures. Please see Appendix C, CQ Disparities analysis for the template.

**Priority Five Determination:** Each participant’s Priority Five measures will be re-set in 2017 to allow new, lower performing measures to be targeted. Measures eligible for Priority Five inclusion are CQ01-CQ11. To determine Priority Five inclusion, Q4 2015-Q3 2016 self-reported data will be used if available. If not available, 2015 HEDIS data will be used. Participants will be notified in December 2016 their Priority Five measures for 2017. As before, participants will be allowed to swap up to one measure of their choosing, as long as the new measure is not currently at the top percentile.

**Clinical Quality Thresholds**

*For measures with NCQA HEDIS thresholds:*

<table>
<thead>
<tr>
<th>Measure</th>
<th>90&lt;sup&gt;th&lt;/sup&gt; percentile</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQ01 Diabetes HbA1c Test</td>
<td>92.88%</td>
<td>89.42%</td>
</tr>
<tr>
<td>CQ02 Diabetes HbA1c &lt;8</td>
<td>58.39%</td>
<td>52.55%</td>
</tr>
<tr>
<td>CQ03 Diabetes Eye Exam</td>
<td>68.11%</td>
<td>61.50%</td>
</tr>
<tr>
<td>CQ04 Cervical Cancer Screening</td>
<td>69.95%</td>
<td>63.88%</td>
</tr>
<tr>
<td>CQ06 Labs for Patients on Persistent Medications</td>
<td>91.84%</td>
<td>89.56%</td>
</tr>
<tr>
<td>CQ08 Controlling High Blood Pressure</td>
<td>70.69%</td>
<td>63.99%</td>
</tr>
<tr>
<td>CQ09 Adolescent Immunizations (without HPV)</td>
<td>86.57%</td>
<td>82.09%</td>
</tr>
<tr>
<td>CQ10 Childhood Immunizations</td>
<td>79.81%</td>
<td>75.60%</td>
</tr>
<tr>
<td>CQ11 Well Child Visits</td>
<td>82.97%</td>
<td>77.57%</td>
</tr>
</tbody>
</table>

*For measures without NCQA HEDIS thresholds, a PIP network threshold will be used based on Q4 2015-Q3 2016 performance:*

<table>
<thead>
<tr>
<th>Measure</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; percentile</th>
<th>60&lt;sup&gt;th&lt;/sup&gt; percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQ05 Colorectal Cancer Screening</td>
<td>67.25%</td>
<td>59.66%</td>
</tr>
<tr>
<td>CQ07 Smoking Cessation Intervention</td>
<td>93.08%</td>
<td>86.52%</td>
</tr>
</tbody>
</table>

**Section VII: 2017 PIP Resources**

Based on the amount of feedback received over the past few years, SFHP has consolidated all resource information online: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/). This information has been removed from each individual measure specification.

**Section VIII: 2017 Primary Care Measure Specifications**

The rest of this document consists of the individual specifications for each of the 2017 measures across all four domains: clinical quality, data quality, patient experience and systems improvement.
CQ 01: Diabetes HbA1c Test
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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

\[
\text{DM HbA1c Test} = \frac{\text{Numerator: Number of patients in denominator population who received at least one HbA1c test within the last 12 months}}{\text{Denominator: Number of active patients with diabetes ages 18-75 years old}}
\]

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 and 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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA Accreditation, HEDIS measure CDC: Comprehensive Diabetes Care, EAS, SWP4P, PCMH 6: Performance Measurement and Quality Improvement, and NQF (#0057).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: http://www.sfhp.org/providers/practice-improvement-program-pip/.
- 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 02: Diabetes HbA1c <8 (Good Control)

2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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

\[
\frac{\text{DM A1c<8}}{\text{Denominator: Number of active patients with diabetes ages 18-75 years old}} = \frac{\text{Numerator: Number of patients in denominator whose most recent HbA1c level is < 8.0 in the last 12 months}}{\text{Number of patients in denominator}}
\]

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 and 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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation¹, HEDIS measure CDC: Comprehensive Diabetes Care, EAS, SWP4P, and NQF( #0575).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: http://www.sfhp.org/providers/practice-improvement-program-pip/.
- 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.

¹ SFHP held accountable
CQ 03: Diabetes Eye Exam
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for improvement on the percentage 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.

\[
\text{DM Eye Exam} = \frac{\text{Numerator}}{\text{Denominator}}
\]

- **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.
- **Denominator**: Number of active patients with diabetes ages 18-75 years old

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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation, HEDIS measure CDC: Comprehensive Diabetes Care, EAS, SWP4P, and NQF( #0575).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- 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.**

Deliverables and Scoring
Please reference Section VI for information on all Clinical Quality deliverable and scoring information.
CQ 04: Routine Cervical Cancer Screening
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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

\[
\text{Cervical Cancer Screening} = \frac{\text{Numerator}}{\text{Denominator}}
\]

\[
\text{Numerator: Number of patients with cervixes ages 24-64 who received one or more Pap tests during the past 3 years OR patients with cervixes ages 30-64 who received cervical cytology and HPV co-testing during the past 5 years}
\]

\[
\text{Denominator: Number of active patients with cervixes ages 24-64 years old}
\]

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 cervixes 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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation\(^2\), HEDIS measure CCS: Cervical Cancer Screening, EAS, SWP4P, UDS reporting, and NQF(#0032).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/)
- Patients who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix prior to the measurement period are excluded.
- 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 05: Routine Colorectal Cancer Screening
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for improvement on the percentage of members 51–75 years of age screened for routine colorectal cancer during the eligible time period.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator: Number of active patients ages 51 - 75 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients in denominator population who received a FOBT or FIT test during the past year, OR Number of patients in denominator population who received a sigmoidoscopy during the past 5 years, OR Number of patients in denominator population who received a screening colonoscopy during the past 10 years</td>
<td></td>
</tr>
</tbody>
</table>

Measure Rationale
Colorectal cancer kills more Californians than any other cancer except for lung cancer, yet it is one of the most preventable cancers. Despite an effective screening test, racial and ethnic disparities exist in colorectal cancer rates. San Francisco’s citywide dashboard, Community Vital Signs, tracks this measure and it is also a national HEDIS measure reported in Medicare and commercial health plans (Anderson, 2013). The proportion of adults 50 years of age and older who report use of either a fecal occult blood test (FOBT) or a sigmoidoscopy or colonoscopy within recommended time intervals has not changed since 2008 (American Cancer Society, 2015).

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation, UDS reporting, and NQF(#0034).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- 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 06: Labs for Patients on Persistent Medications
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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 during the measurement year.

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 (applies only to members on digoxin)

Denominator: Number of active patients 18 years and older, on ACE inhibitor, ARBs, digoxin or diuretics for 180 days or more in the last year

Measure Rationale
When patients use long-term medications, they are at risk of adverse drug events that result in increased use of both inpatient and outpatient resources. Continued monitoring of 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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation, HEDIS measure MPM: Annual Monitoring for Patients on Persistent Medications, Diuretics, EAS, SWP4P, PCMH 3: Population Health Management, and NQF(#2371).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: http://www.sfhp.org/providers/practice-improvement-program-pip/.
- 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 07: Smoking Cessation Intervention
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for documenting that a smoking cessation intervention took place within the last two years for all patients who have a documented history of tobacco use and have been seen for an outpatient visit during that time. Include current patients with 1 visit in the past 12 months, and at least 2 visits ever.

\[
\text{Numerator: Number of patients in denominator population with a documented smoking cessation counseling intervention in the EHR or registry in the last 2 years}
\]

\[
\text{Smoking Cessation Intervention} = \text{Denominator: Number of active patients who are (must meet all of the following): a. 18 years or older; b. Have a documented history of tobacco use in the past 2 years; c. Seen for at least one outpatient visit within the past 2 years}
\]

Measure Rationale
Smoking and tobacco use is the leading preventable cause of death in the United States, causing more than 430,700 deaths each year. Despite the risks, over 47 million Americans smoke or use tobacco. Seventy percent of smokers are interested in stopping smoking completely; smokers report that they would be more likely to stop smoking if a doctor advised them to quit. A number of clinical trials have demonstrated the effectiveness of clinical quit-smoking programs. Simply getting brief advice to quit is associated with a 30 percent increase in the number of people who quit (AHRQ, National Quality Measures Clearinghouse, 2014). In addition, great disparities exist within this population. For example, when looking at education levels 22% of adults whose highest level of education is a high school diploma smoke. In comparison, 9% of those with an undergraduate degree smoke, and 5.6% of those with a graduate degree do so (American Cancer Society, 2015).

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation\(^1\), HEDIS measure MSC: Medical Assistance with Smoking and Tobacco Use Cessation, CAHPS, UDS reporting, and NQF(#0028).

Data Source/Resources
- Self-reported quarterly by clinics.

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: http://www.sfhp.org/providers/practice-improvement-program-pip/.
- 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 08: Controlling High Blood Pressure (Hypertension)
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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

\[
\text{Controlling High Blood Pressure } \left< \frac{140}{90} \right> = \frac{\text{Numerator}}{\text{Denominator}}
\]

- **Numerator:** Number of patients in the denominator population in which the most recent BP reading 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 of diabetes whose BP was <150/90 mm Hg.

- **Denominator:** Number of active patients with hypertension ages 18-85 years old

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 measure as part of the annual HEDIS report and it 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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation\(^7\), HEDIS measure CBP: Controlling High Blood Pressure, EAS, PRIME, Meaningful Use, UDS reporting, and NQF(#0018).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- 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
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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

\[
\text{Adolescent Immunizations} = \frac{\text{Numerator}}{\text{Denominator}}
\]

\text{Numerator: Number of patients in the denominator population who received one meningococcal vaccine on or between the member's 11th and 13th birthday and one (Tdap) or (Td) vaccine on or between the member's 10th and 13th birthdays}

\text{Denominator: Number of active patients who turned 13 years old during the last year}

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 establish reservoirs of disease in adolescents that can affect other populations including infants, the elderly, and individuals with chronic conditions.

In addition to the assessment of missed immunizations, SFHP is also taking steps to evaluate the immunization rate of new vaccines that are targeted specifically at 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).

Note: this measure will begin to phase-out in 2017 to make room for the new PIP measure CQ 12: Adolescent Immunizations (with HPV). You can read more information about this new measure on the CQ 12: Adolescent Immunizations (with HPV) PIP measure specification page.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation\(^2\), HEDIS measure IMA: Immunizations for Adolescents, EAS, and NQF(#1407).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: http://www.sfhp.org/providers/practice-improvement-program-pip/.
- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- Adolescents who had a contraindication for a specific vaccine are exempt from this measure.

Deliverables and Scoring
Please reference Section VI for information on all Clinical Quality deliverable and scoring information.
CQ 10: Childhood Immunizations
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for improvement on the rate of children 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.

\[
\text{Childhood Immunizations} = \frac{\text{Numerator}}{\text{Denominator}}
\]

**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 active patients who turned 2 years old during the last year

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. 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.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation, HEDIS measure CIS: Childhood Immunization Status, Meaningful Use, UDS reporting, and NQF(#0038).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- Children who had a contraindication for a specific vaccine are exempt from this measure.

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
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

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.

Well Child Visits = Numerator: Number of patients in the denominator population who had at least one well-child visit with a PCP during the past year.

Denominator: Number of active patients 3-6 years old

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).

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation, HEDIS measure W34: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, EAS, SWP4P, and NQF(#1516).

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- 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

Deliverables and Scoring
Please reference Section VI for information on all Clinical Quality deliverable and scoring information.
CQ 12: Adolescent Immunizations (with HPV)

2017 Practice Improvement Program Measure Specification

Changes from 2016
New measure.

Measure Description
Participants will receive points for reporting the rate of adolescents who had one dose of meningococcal vaccine, one (Tdap)/(Td) vaccine, and two HPV vaccines by their 13th birthday.

Numerator: Number of patients in the denominator population who received one meningococcal vaccine on or between the member’s 11th and 13th birthday, one (Tdap) or (Td) vaccine on or between the member’s 10th and 13th birthday, and two HPV vaccines between the member’s 9th and 13th birthday.

Denominator: Number of active patients who turned 13 years old during the last year

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 establish reservoirs of disease in adolescents that can affect other populations including infants, the elderly, and individuals with chronic conditions. In addition, the HPV vaccine is effective in the prevention of many types of cancers for people of all genders and is being recommended for inclusion in the vaccination schedule for adolescents by many entities, such as the State of California and the National Committee for Quality Assurance.

In addition to the assessment of missed immunizations, SFHP is also taking steps to evaluate the immunization rate of new vaccines that are targeted specifically at 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) requires SFHP to report this as part of the annual HEDIS report.

Measure Source
Inclusion of this measure is supported by alignment with external healthcare measurement entities including, NCQA accreditation and EAS.

As a new HEDIS measure in 2017, percentile thresholds for this measure have not yet been determined.

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: http://www.sfhp.org/providers/practice-improvement-program-pip/.
- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- Adolescents who had a contraindication for a specific vaccine are exempt from this measure.
Deliverables and Scoring
Please reference Section VI for information on all Clinical Quality deliverable and scoring information.

Resources
For guidance on how to treat patients who have already started the HPV vaccine with respect to the change in vaccine dosing guidelines, please see slide 34:
CQ 13: Adolescent Immunizations (HPV only)
2017 Practice Improvement Program Measure Specification

Changes from 2016
New measure.

Measure Description
Participants will receive points for reporting the rate of adolescents who had two doses of the HPV vaccine by their 13th birthday.

\[
\text{Adolescent Immunizations: } = \frac{\text{Numerator}}{\text{Denominator}}
\]

- **Numerator**: Number of patients in the denominator population who received at least two HPV vaccines on or between their 9th and 13th birthdays.
- **Denominator**: Number of active patients who turned 13 years old in the last year.

Measure Rationale
Adolescent immunization rates have historically lagged behind early childhood immunization rates in the United States. The HPV vaccine has been proven to be effective in the prevention of many types of cancers for people of all genders.

Measure Source
Inclusion of this measure is supported by recommendation of the PIP advisory committee, as emphasis on the HPV vaccine in 2017 PIP will support and drive participants’ improvement efforts for adolescent HPV immunizations.

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- Adolescents who had a contraindication for a specific vaccine are exempt from this measure.

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

Resources
For guidance on how to treat patients who have already started the HPV vaccine with respect to the change in vaccine dosing guidelines, please see slide 34: [https://www.cdc.gov/vaccines/ed/ciinc/downloads/2016-10-26/recommendations-hpv-2-doses-2016.pdf](https://www.cdc.gov/vaccines/ed/ciinc/downloads/2016-10-26/recommendations-hpv-2-doses-2016.pdf)
CQ 14: Chlamydia Screening
2017 Practice Improvement Program Measure Specification

Changes from 2016
New measure

Measure Description
Participants will receive points for reporting the rate of sexually active patients able to get pregnant who had at least one chlamydia test in the last year.

\[
\text{Chlamydia Screening} = \frac{\text{Numerator}}{\text{Denominator}}
\]

\[
\text{Numerator: Number of patients in the denominator population with at least one test for chlamydia in the last year}
\]

\[
\text{Denominator: Number of active patients who meet all of the following criteria:}
\]

- are sexually active
- have the ability to become pregnant
- between the ages of 16-24 years old

Clinical Quality Thresholds

<table>
<thead>
<tr>
<th>Measure</th>
<th>90th percentile</th>
<th>75th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQ14 Chlamydia Screening</td>
<td>68.92%</td>
<td>61.63%</td>
</tr>
</tbody>
</table>

Measure Rationale
Chlamydia is usually asymptomatic in people of all genders, and as a result infections often are undiagnosed. Approximately 3 million new infections are estimated to occur each year among sexually active people with the ability to get pregnant between the ages of 14-19. Chlamydial infections in patients with a cervix can cause cervicitis, which if untreated can cause Pelvic Inflammatory Disease (PID). The inflammatory and immune responses to PID can cause fallopian tube damage, scarring and blockage which can result in long-term adverse outcomes of infertility, ectopic pregnancy, and chronic pelvic pain. This measure follows the Centers for Disease Control and Prevention (CDC) Division of STD Prevention’s Guidelines, (Centers for Disease Control and Prevention, 2014).

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation, and EAS.

Definitions & Exclusions
- Please refer to the PIP webpage for numerator compliance and exclusion codes: [http://www.sfhp.org/providers/practice-improvement-program-pip/](http://www.sfhp.org/providers/practice-improvement-program-pip/).
- 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.
DQ 1: Provider Roster Updates
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for reviewing SFHP provider data on a quarterly basis and providing new information when applicable. The process will be as follows:

- *Within the first week after the quarter has ended:* SFHP will email SFHP-generated provider roster to designated PIP contact. Roster will include data regarding providers who were known to be active during the three months of the quarter. See Appendix A for an example.

- *During the month after the quarter has ended:* the designated PIP contact will review the SFHP-generated provider roster. The roster will contain information for each provider known to be active at any point during the three months of the quarter. Contractors, courtesy staff, fellows, and residents are excluded. The following elements are required (unless stated otherwise) to be included about each provider:

  a) First and last name (legal with preferred in parenthesis)
  b) Medical degree
  c) Type of Practitioner (PCP or Specialist)
  d) Primary Specialty
  e) Secondary Specialties (if applicable)
  f) Language(s) spoken other than English (if applicable)$^1$
  g) License number
  h) NPI
  i) Email address*
  j) For NPs, PAs, CNMs only: Name of MD/DO Supervisor* (if applicable)
  k) Site Name
  l) Language(s) spoken at site other than English (if applicable)$^2$
  m) Hours & Days Site is Open
  n) Date listed with SFHP
  o) Date terminated/left the organization* (if applicable)
  p) Open to new members (Y/N)* (For PCPs only)
  q) Open to auto-assignment (Y/N)** (For PCPs only)

*This information is for SFHP internal use only.
^Not applicable to the SFHN.

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$^1$ SFHP providers are not required to speak English, however the vast majority do. Therefore in an effort to save time when reporting for this measure we will not require you to specify if providers speak English.
• **By the Quarter’s Due Date:**
  - When changes need to be made:
    - Submit the Supporting Information Template
    - Return the SFHP-produced roster with changes noted in the first column
  - When no changes need to be made:
    - Submit a signed Provider Roster Attestation

• Complete a Provider Roster Attestation verifying that all information has been reviewed and (if applicable) updates provided. Attestation and supporting information template (if applicable) should be uploaded via Wufoo.

**Measure Rationale**
Timely submission of updated provider rosters ensures SFHP maintains key compliance objectives and that member assignments are accurate. Despite being a contractual requirement, SFHP does not routinely receive timely and accurate provider data from all clinics and medical groups. This has resulted in very poor scores on state audits; for example, a 2015 Department of Health Care Services Deliverables and Scoring

**Exclusions**
- The following providers should be excluded from the roster: contractors, courtesy staff, fellows, and residents.

**Data Source/Resources**
- Questions related to your provider roster can also be submitted to provider.relations@sfhp.org, or by calling (415) 547-7818 x7084.

**Deliverables and Scoring**

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Dates</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>If there are <strong>no changes</strong> that need to be made to the current quarter’s provider roster, please submit the Provider Roster Attestation.</td>
<td>Quarterly</td>
<td>2.0 points</td>
</tr>
<tr>
<td>If <strong>changes do need to be made</strong> to the current quarter’s provider roster, please submit the supporting information in one of the two approved ways. Deductions will be made in these cases:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 0.10 point deduction (up to a maximum of 0.50 point) for each piece of missing information noted in Measure Description.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 0.25 point deduction (up to a maximum of 1.0 point): Discrepancy between Medical Staff Office (MSO)/Profiles/Change Reports/Credentialing Packet and Provider Roster. Discrepancies that will affect scoring are:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Providers in one source and not the other.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Additions/terminations reported via PIP that should have been reported via entity’s contractual method > 1 month prior
DQ2: Accuracy between Encounter and Medical Record Data

2017 Practice Improvement Program Measure Specification

Changes from 2016

The re-measurement audit has been replaced with implementation of improvement plan from Q3 2016.

Measure Description

In an effort to drive improvements in data quality, participants will compare the accuracy of data between what is submitted electronically to SFHP for billing purposes and what is documented in participants’ medical records. For each self-audit, SFHP will provide a random sample of 5 primary care claims/encounters for participants to audit.

Two audit processes will be carried out: first a comparison of the billing information to the medical record, and then the medical record to the billing information. The following data elements will be compared in each of these processes:

<table>
<thead>
<tr>
<th>Data Element</th>
<th>Billing Information → Medical Record</th>
<th>Medical Record → Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Beneficiary (Member Name, Date of Birth)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2. Date of service</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. Rendering Provider</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4. Diagnoses</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Procedures (both codes and modifiers)</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

All audit checks (as represented by X’s in the grid above) must pass in order for the overall comparison to be deemed compliant (see definition below). In other words, if some (but not all) of the audit checks pass, the overall comparison will be considered non-compliant.

\[
\text{Data Accuracy Compliance Rate} = \frac{\text{Numerator}}{\text{Denominator}}
\]

**Numerator:** Total number of compliant comparisons (see definition below)

**Denominator:** Total number of medical records being compared

Definitions

- **Billing Information:** Obtained by claims/encounters submitted to SFHP on the most current and standard Center of Medicaid and Medicare Services (CMS) 1500 form in HIPAA 5010 837-compliant format.
- **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.
- **Compliant:** A medical record to encounter comparison is compliant if all 9 of the audit checks outlined above match.

---

* SFHP identifies PCP encounters using the following definition: rendering provider must be identified as a PCP with SFHP & the encounter must have an appropriate corresponding revenue code. Participants with fewer than 5 SFHP defined encounters in a quarter will not be eligible to complete a quarterly self-audit.
Measure Rationale
The purpose of this measure is to improve the completeness and accuracy of participants’ electronic data. More accurate and complete data will support clinical quality improvements as well as more appropriate pricing for services rendered. The randomly selected encounter data for this measure is based on the date of service (DOS), as it allows participants to see the effects of changes implemented in a timelier manner. This measure mirrors a portion of the Department of Health Care Services’ (DHCS) annual audit of Medi-Cal plans’ electronic data (DHCS QMED 2.3 & 3.1), wherein Health Plans will receive a financial penalty for low-performing audit results.

Measure Source
Inclusion of this measure is supported by alignment with external healthcare measurement entities including, the Department of Health Care Services (DHCS) Quality Measures for Encounter Data (QMED).

Data Sources/Resources
- Encounter Audit Tool is customized and will be sent to participants each quarter
  - This is an Excel report of 5 randomly selected encounters for your self-audit (measure Deliverables C & D).
- Encounter Audit Tool Companion Guide and Instructions is available online
  - This is a Word document that serves as a guide for the Encounter Audit Tool, outlining the fields included and directions for how to transfer results to your quantitative data template.
- Medical Record Audit Tool is available online
  - This is a Word document to assess the E/M code level (to use for visits that were billed with an E/M code)
- Medical Record Audit Tool Companion Guide is available online
  - This is a Word document outlining the fields included in the tool above and general medical record documentation guidelines.
- DHCS Quality Measures for Encounter Data (QMED) specifications:

Deliverables and Scoring

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Date</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deliverable A:</strong> Participants to conduct self-audit and submit results on quantitative data template.</td>
<td>Quarter 1, Quarter 2</td>
<td>0.50 points</td>
</tr>
<tr>
<td><strong>Deliverable B:</strong> Complete template detailing how improvement plan submitted Q3 2016 was implemented</td>
<td>Quarter 3</td>
<td>1.0 point</td>
</tr>
</tbody>
</table>
PE 1: Third Next Available Appointment
2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for improving or meeting thresholds for Third Next Available Appointment (TNAA). Participants will submit data for the final five weeks each quarter, and SFHP will score performance based on median of the five pieces of data.

How to calculate TNAA: TNAA data should be collected once a week, at the same day and time of the week. Count the number of days between today and the third next available appointment for regular return visit for each provider/team. Then, take the median of all providers/teams and report that value for each of the final five full weeks of the quarter.

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

Measure Rationale
As the industry standard for measuring access to appointments, the third next appointment best represents appointment access as it accounts for last minute cancellations. This measure is considered the overarching access measure, as it represents the impact of the combination of other access measures such as Show Rate and Cycle Time (National Quality Measures Clearinghouse, 2013).

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including the Department of Managed Health Care regulations.

Data Source
- Self-reported by participant.
- CA Department of Managed Health Care guidelines: http://www.dmhc.ca.gov/healthplans/gen/gen_timelyacc.aspx

Deliverables and Scoring

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Dates</th>
<th># of Days Reduced</th>
<th>Threshold</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit the median established patient follow-up visit TNAA for each of the final 5 full weeks of the reporting period. <strong>Note:</strong> SFHP will determine median of five pieces of data and use it to score performance.</td>
<td>Quarter 1</td>
<td>n/a</td>
<td>14 calendar days or less</td>
<td>2.0 points</td>
</tr>
<tr>
<td></td>
<td>Quarter 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarter 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarter 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥ 10 days</td>
<td>15-21 calendar days or less</td>
<td>1.5 points</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5-9 days</td>
<td>n/a</td>
<td>1.0 point</td>
<td></td>
</tr>
</tbody>
</table>
PE 2: Show Rate

2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points when one or more practice sites (serving a high volume of SFHP members) improves or attains high performance on PCP/PCP team appointment show rate. Data will be submitted for each of the three months of the quarter. SFHP will combine these three numerators and denominators, creating a quarterly show rate. Performance will be scored based on the quarterly show rate.

\[
\text{Monthly Show Rate} = \frac{\text{Numerator}}{\text{Denominator}}
\]

- **Numerator**: Of the total appointments in the denominator, the number of appointments which patients kept.
- **Denominator**: Total number of pre-scheduled appointments for a PCP/PCP team visit during any given calendar month.

Measure Rationale
Show Rate is an indicator of patient satisfaction, provider-patient relationship, and clinic efficiency. A high no-show rate often leads to appointment delays for all patients. Furthermore, an accurate count of no-shows is helpful for understanding what is impacting the third next available appointment rate.

Measure Source
Inclusion of this measure and PIP benchmark determination was informed by SFHP in conjunction with the PIP advisory committee, as well as supported by alignment with external healthcare measurement entities including the PCMH 1: Patient-Centered Access guidelines.

Data Source/Resources
- Self-reported by participant.

Exclusions
- Walk-ins and patient cancellations are excluded from the calculation. While very important, filling no-show appointment times with walk-in or urgent care patients does not change the show rate.
- Patients who cancel or reschedule their appointments do not count as no-shows.
### Deliverables and Scoring

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Dates</th>
<th>Relative Improvement&lt;sup&gt;5&lt;/sup&gt;</th>
<th>Threshold</th>
<th>Quarterly Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit monthly data each quarter via the quantitative template. <strong>Note:</strong> SFHP will determine quarterly show rate by combining numerators and denominators for each month in the quarter, and using it to determine performance.</td>
<td>• <strong>Quarter 1</strong>&lt;br&gt;(Timeframe: Jan, Feb, Mar)&lt;br&gt; • <strong>Quarter 2</strong>&lt;br&gt;(Timeframe: Apr, May, Jun)&lt;br&gt; • <strong>Quarter 3</strong>&lt;br&gt;(Timeframe: Jul, Aug, Sept)&lt;br&gt; • <strong>Quarter 4</strong>&lt;br&gt;(Timeframe: Oct, Nov, Dec)</td>
<td>n/a</td>
<td>85% or more</td>
<td>1.0 point</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10%</td>
<td>80-84%</td>
<td>0.75 point</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5-9%</td>
<td>n/a</td>
<td>0.5 point</td>
</tr>
</tbody>
</table>

<sup>5</sup> Relative Improvement (RI) = (Current Rate – Baseline Rate) / (100 – Baseline Rate)
PE 3: Office Visit Cycle Time

2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will self-report primary care cycle time data for at least one site serving a large volume of SFHP members to receive points for either meeting a threshold or for the number of minutes reduced each quarter. Cycle time can be collected in one of the following ways:

- **Option A**: Electronically capture cycle time by using an electronic health record or practice management system.
- **Option B**: Manually collect cycle time by sampling a minimum of 15 patients per month on a consistent day and time (e.g. appointments on Mondays from 2:00 to 4:00 pm). If participants choose this option, we recommend utilizing the IHI Patient Cycle Tool found on the SFHP PIP webpage.

Each quarter, participants will submit the median cycle time for each month in the given quarter. SFHP will score performance based on the most recent month’s median cycle time (Month 3). Please ensure the median in Month 3 on the quantitative data template represents the most recent month.

Measure Rationale
Cycle time is an important indicator of patient satisfaction, clinic efficiency, and ultimately patient access. The goal is not to reduce value-added time spent with members of the care team, but to decrease the amount of time a patient spends waiting.

Measure Source
Inclusion of this measure was informed by SFHP in conjunction with the PIP advisory committee.

Definition
The office visit cycle time is defined as the amount of time that a patient spends at an office visit, beginning at the time the patient is checked in and ending at the time the patient is checked out (i.e. finished with their appointment).

Data Source
- Self-reported.

Deliverables and Scoring

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Dates</th>
<th># Minutes Reduced</th>
<th>PIP Network Threshold</th>
<th>Quarterly Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter</td>
<td>Data Collection Period</td>
<td>10 or more minutes reduced</td>
<td>75th percentile 64 minutes or less</td>
<td>60th percentile 65-69 minutes</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>(Jan, Feb, Mar)</td>
<td></td>
<td>1.0 point</td>
<td></td>
</tr>
<tr>
<td>Quarter 2</td>
<td>(Apr, May, Jun)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td>(Jul, Aug, Sept)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td>(Oct, Nov, Dec)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Self-report the median cycle time for each month in the quarter.
PE 4: Staff Satisfaction Improvement Strategies

2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for activities related to staff satisfaction. In order to guide these activities, a satisfaction survey of all staff will be implemented. In 2017, participants will administer their own survey. Participants may choose to measure their Net Promoter Score, use the Gallup 12 staff satisfaction survey, or another method with SFHP approval. Technical assistance will be offered in Spring 2017 for participants seeking support with administering staff satisfaction surveys (including analysis and follow-through).

In order to ensure statistical significance, each survey administered must meet the following sample size thresholds in order to be eligible for the points awarded for performance in Quarter 4:

- Participants with 30-60 staff – 60% response rate
- Participants with 61-150 staff – 50% response rate
- Participants with more than 150 staff – 35% response rate

*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.

Tips for Increasing Staff Response Rate:

- Offer reward or recognition for completing survey (e.g. $5 coffee gift card, pizza party for reaching a specific response rate)
- Regularly communicate the current response rate and goal.
- Reinforce and restate the changes that have been made due to prior staff satisfaction surveys.

Measure Rationale
Staff satisfaction has been shown to be directly related to patient experience (British Medical Journal, Szecsenyi et al, 2011).

Measure Source
Inclusion of this measure is considered as reward for improvement, due to bias from varying patient populations.

Exclusions
- Participants with fewer than 30 staff are exempt from this measure.

Deliverables and Due Dates

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Due Dates</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliverable A: Submit template with the following included:</td>
<td>Quarter 1</td>
<td>0.5 point for completed template, if required</td>
</tr>
<tr>
<td>• Baseline score of a staff satisfaction survey</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1

2

0.5 point for completed template, if required

3
- If survey has multiple questions, only one score may be chosen. For participants using Net Promoter survey, chosen question must be “How likely are you to recommend organization as a place to work?”
  - Survey type (Gallup, Net Promoter, etc.)
  - Survey date (completed October 1, 2016-January 15, 2017)
  - Survey question
  - Response rate (numerator/denominator)
  - 1-2 priority areas identified for improvement

| Deliverable B: Submit template with a report of activities implemented specifically to address priority areas identified for improvement | Quarter 3 | 1.0 point for completed template |
| Deliverable C: Submit template with the following included: | Quarter 3 | 0.5 point for completed template, if required response rate met. |
| • Survey type (must be same as baseline) | 0 point if required response rate not met. |
| • Survey date (completed August 1, 2017-October 15, 2017) |  | |
| • Survey question (must be same as baseline) |  | |
| • Response rate (numerator/denominator) |  | |
| Deliverable D: Improvement on staff satisfaction survey score, submitted via the Quantitative Data Template. | Quarter 3 | If required response rate met: |
| • Score must represent question chosen for baseline. | 1.5 point for > 4.0% relative improvement |
| | 1.0 point for 2.0% - 3.9% relative improvement |
| | If required response rate not met: |
| | 0 point |
PE 5: Improvement in Patient Experience of Primary Care Access

2017 Practice Improvement Program Measure Specification

Changes from 2016

- The root cause analysis deliverable from 2015-2016 was replaced with an analysis of qualitative data collected directly from patients.
- Beginning in 2017, SFHP will not coordinate the administration of the CG-CAHPS survey to give participants maximum flexibility in survey administration.
- Added clarification that survey tool must be comparable from baseline to re-measurement.

Measure Description

This measure uses information collected directly from patients to assess perceived access to care. Using a validated survey, participants will be scored on improvement from their baseline score rather than meeting a threshold score, due to bias from varying patient populations.

SFHP encourages the use of the CG-CAHPS survey tool as it meets the following criteria. Participants may choose to use a different survey tool as long as it meets the same criteria. To use this option, please contact PIP staff upon program enrollment. Survey tool must be comparable from baseline to re-measurement.

Patient Experience Survey Tool Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Conducted and analyzed by or audited by third party</td>
<td>Supports consistent and unbiased survey methodology</td>
</tr>
<tr>
<td>2. Surveyed population is a random sample of all Medi-Cal patients</td>
<td>Results can be generalized across the population</td>
</tr>
<tr>
<td>3. Survey conducted at least twenty-four hours after visit concludes</td>
<td>Surveys conducted during or immediately after a visit can offer a limited view of the patient’s full experience, including follow-up services needed post visit</td>
</tr>
<tr>
<td>4. Tool has been validated</td>
<td>Validation ensures that the tool is reliable; meaning, that it yields results that reflect patient perception of the health care system</td>
</tr>
<tr>
<td>5. Includes access-related questions</td>
<td>Access to care represents the biggest opportunity for improvement for San Francisco’s Medi-Cal population, as it is the lowest ranking area on member surveys</td>
</tr>
<tr>
<td>6. Sampling methodology ensures that each question obtains at least thirty responses</td>
<td>Results can be considered statistically meaningful</td>
</tr>
</tbody>
</table>

Participants will also receive points for collecting and analyzing qualitative data from patients, as well as developing and implementing a plan to improve baseline performance. Qualitative data collection must come from at least 10 patients belonging to your clinic/group. Options include open-ended survey questions, focus groups, or key informant interviews.

Measure Rationale

Patient Experience with access is largely connected to clinical outcomes (Annals of Family Medicine, Llanwarne, et al, 2013). Historically this has been the lowest scoring composite for SFHP Medi-Cal
members, falling below the 25th percentile for Health Plan CAHPS. CAHPS and equivalent surveys are rigorously developed to represent patients’ top healthcare experience factors and are validated to ensure that results represent patients’ true feelings. This measure supports participants in assessing and improving patient access using input directly from patients.

**Measure Source**

Inclusion of this measure supported by alignment with external healthcare measurement entities including, the PCMH 1: Patient-Centered Access guidelines, and is considered as reward for improvement, due to bias from varying patient populations.

**Definitions**

**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.

**CG-CAHPS Access to Care Composite:**

1. Patient got appointment for urgent care as soon as needed
2. Patient got appointment for non-urgent care as soon as needed
3. Patient got answer to medical question the same day he/she contacted provider’s office

**Data Source**

- CG-CAHPS survey; specifically the Access to Care Composite.
  - Other survey may be substituted if it meets the criteria outlined on the prior page and is approved by SFHP upon enrollment.

**Exclusions**

- Participants with less than 1,500 SFHP members are excluded.

**Deliverables and Scoring**

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Due Dates</th>
<th>Scoring</th>
</tr>
</thead>
</table>
| **Deliverable A:** Submit template with:  
  - CG-CAHPS or equivalent baseline data  
  - A description of the qualitative data collection methodology (sampling methodology, questions asked, and number of patients participating)  
  - An analysis of themes found in qualitative data  
  - Plan to improve results, based on qualitative data | Quarter 2 | 3.0 points for completed template |
| **Deliverable B:** Submit template with report of activities implemented | Quarter 3 | 1.0 point for completed template |
| **Deliverable C:** Submit re-measurement score for CG-CAHPS or equivalent survey on Quantitative Data Template | Quarter 4 | 2.0 points for ≥3% absolute improvement  
  1.0 point for 2-2.99% absolute |
<table>
<thead>
<tr>
<th></th>
<th>improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>0.0 points</strong> for &lt;2% absolute improvement</td>
</tr>
</tbody>
</table>
PE 8: Expanding Access to Services

*2017 Practice Improvement Program Measure Specification*

**Changes from 2016**
- In 2015, measure was in Systems Improvement domain.
- Options one and two have been changed, per current need and participant feedback.
- Deliverable C (the attestation that service expansion has occurred) has been moved to Quarter 4 to allow more time for implementation.
- Mid-year change: a new option (Option 4) has been added to allow participants to complete their Corrective Action Plan (CAP) through PIP.

**Measure Description**
Participants will receive points for expanding access to services. For participants with multiple sites, this expansion may happen at one or more sites serving a large volume of SFHP members.

Participants will choose **one** of the following options. To be eligible, service must be *new or only available on a limited basis* for the organization (or specific site), and must be implemented in calendar year 2017.

1. **Option One:** Implement best practices to improve Hepatitis C screening and treatment, to include protocols that address screening workflow, treatment workflow, and registry management.

2. **Option Two:** Perform **one** of the following improvements in opioid safety:
   - Expand number of providers with X licenses by 25% in 2017
   - Conduct SBIRT screenings with at least 10% of the patient population in 2017
   - Prescribe Naloxone at least once in 2017 for at least 50% of patients who present a risk for opioid overdose

3. **Option Three:** Perform **one** of the following primary care services by staff other than PCPs during all hours that organization (or specific site) is open:
   - Ear lavage
   - Fluoride varnish application, for participants serving children
   - Diabetic Foot check exams (optional addition: Diabetes education and/or health coaching)
   - Toenail clippings for patients with Diabetes (optional addition: Diabetes education and/or health coaching)
   - Self-injection teaching
   - Wound care

4. **Option Four:** Complete a SFHP Corrective Action Plan (CAP), to address the access improvement activities identified by the SFHP CAP letter. See Appendix B: Corrective Action Plan (CAP) in PIP for additional details regarding timeline, deliverables, and scoring.
Measure Rationale
San Francisco Health Plan scores the lowest among California Medi-Cal plans in patient experience for access. Operational metrics reported by PIP participants such as TNAA validate these scores. Member focus groups conducted in 2016 cite member desire for more services available in their primary care medical home. This measure is intended to incentivize the interventions with high potential to improve access. In addition, some interventions may improve other PIP measures, such as clinical and patient experience measures.

Measure Source
Inclusion of this measure was informed by the SFHP compliance department.

Data Source
- Self-reported by participant.

Deliverables and Due Dates

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Due Dates</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deliverable A</strong>: Submit service expansion plan using required template</td>
<td>Quarter 2</td>
<td>2.0 points for completed template</td>
</tr>
<tr>
<td><strong>Deliverable A - CAP option</strong>: Approved CAP submission (as approved by SFHP’s Provider Relations Department)</td>
<td>Quarter 2</td>
<td>2.0 points for completed template</td>
</tr>
<tr>
<td><strong>Deliverable B</strong>: Submit example materials from service expansion</td>
<td>Quarter 3</td>
<td>2.0 points for example materials</td>
</tr>
<tr>
<td><strong>Deliverable B – CAP option</strong>: Approved supporting materials submission (as approved by SFHP’s Provider Relations Department)</td>
<td>Quarter 3</td>
<td>2.0 points for example materials</td>
</tr>
<tr>
<td><strong>Deliverable C</strong>: Attestation service expansion has occurred, signed by Medical Director or equivalent</td>
<td>Quarter 4</td>
<td>2.0 points for signed attestation</td>
</tr>
<tr>
<td><strong>Deliverable C – CAP option</strong>: Approved submission (as approved by SFHP’s Provider Relations Department)</td>
<td>Quarter 4</td>
<td>2.0 points for signed attestation</td>
</tr>
</tbody>
</table>
SI 1: Depression Screening

2017 Practice Improvement Program Measure Specification

Changes from 2016
New measure.

Measure Description
Participants will receive points for reporting the rate of patients receiving depression screening.

\[
\text{Depression Screening Rate} = \frac{\text{Numerator}}{\text{Denominator}}
\]

**Numerator**: Total number of patients in the denominator with a depression screening in the measurement year.

**Denominator**: Total number of active patients at least 12 years of age during the measurement year.

*Numerator Measurement Option #2*: Measure depression screening using other registry methods. Participants choosing this option must report their methodology for measuring depression screening.

Measure Rationale
Screening for depression is an important first step in increasing behavioral health utilization, which is low for SFHP members. Both PRIME and HEDIS have similar measures.

Measure Source
Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities including, NCQA accreditation\(^7\).

Data Source
- Self-reported by participant.

Deliverables and Due Dates

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Date</th>
<th>Quarterly Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-report the numerator and denominator as noted in the Measure Description.</td>
<td>Quarterly, beginning in Quarter 2</td>
<td>1.0 points per quarter</td>
</tr>
</tbody>
</table>
SI 2: Follow-Up Visit After Hospital Discharge

2017 Practice Improvement Program Measure Specification

Changes from 2016
No changes.

Measure Description
Participants will receive points for increasing the rate of follow-up office, home, or telephonic visits within 7 calendar days of hospital discharge from an in-network, contracted hospital. This is the hospital that members assigned to your organization through SFHP are expected to receive hospital services. For questions on this, please contact the PIP Team. Points will be awarded for meeting thresholds (see scoring section below).

Quarterly Office Visit Follow-Up After Hospital Discharge Rate

Numerator: Total number of discharges in the denominator with an eligible follow-up visit within 7 calendar days

Denominator: Total number of inpatient discharges during the quarter

Measure Rationale
Timely follow-up after hospital discharge has been shown to decrease mortality (Fidahussein et al., Risk Management Healthcare Policy, 2014) and increase patients’ access of supportive services, such as rehabilitation providers and behavioral health care (Sommers and Cunningham, National Institute for Health Care Reform Brief No. 6, 2011). All of the new models of care involve multiple steps that occur both pre- and post-discharge, and all involve multi-disciplinary health care teams. They differ in how and when they use various care team members, as well as in the emphasis placed on certain steps. However, all the models share the following core attributes: an accountable leader or manager, teamwork, medication reconciliation and clinical management of medications, patient and caregiver education, counseling and engagement, and follow-up. Medication management has been highlighted at the core of advanced discharge planning and transitional care (Improving Medical Adherence and Reducing Readmissions, NEHI, Oct 2012).

Measure Source
Inclusion of this measure and PIP benchmark determination was informed by SFHP in conjunction with the PIP advisory committee.

Definitions
- An eligible follow-up visit is any outpatient office, home, or telephonic visit that meets all of the following criteria:
  - With an MD, NP, PA, RN, behavioral health provider, or pharmacist.
  - Eligible follow-up visits may also be performed by other staff operating under a standardized procedure with escalation instructions to a provider type noted above when necessary. To use this option, please provide SFHP with the standardized procedure prior to submission.
  - Occurs within 7 calendar days of the discharge
Includes, at minimum, medication reconciliation and assessment of access to supportive services.

**Exclusions**
- Discharges from a psychiatric or maternity unit are excluded.
- Participants with fewer than 30 discharges during October-December 2016 as determined by SFHP are exempt from this measure for the 2017 program year.

**Data Source**
- Self-reported by participant.

**Deliverables and Scoring**

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Date</th>
<th>Threshold</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit quarterly numerator and denominator as noted above via quantitative data template.</td>
<td>Quarter 1</td>
<td>50%</td>
<td>1.0 point</td>
</tr>
<tr>
<td></td>
<td>Quarter 2</td>
<td>40%</td>
<td>0.5 point</td>
</tr>
<tr>
<td></td>
<td>Quarter 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarter 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

50% 1.0 point

40% 0.5 point
SI 3: Opioid Safety

2017 Practice Improvement Program Measure Specification

Changes from 2016

- The measure, deliverables, and components have been renamed **Opioid Safety** to better represent intention and scope. As such, deliverables may include any patient/member with opioid safety risk (see the “Definitions” section at the end of the specification).
  - Part A: At minimum, Part A’s denominator must still include all patients/members meeting the chronic opioid treatment for non-cancer pain criteria outlined in the definitions section. Beginning in 2017, Part A’s denominator may also include patients/members not meeting these criteria if they present opioid safety risk.
  - Part B: In 2017, Part B may include review of any SFHP member with opioid safety risk.
- Part A has been modified to include review of a CURES report within the last 12 months to support PIP participant success with potential changes in California prescribing protocol and national guidelines.
- Part A no longer requires a *random* urine drug screen; any urine drug screen performed one year prior to the quarter’s end date satisfies this requirement.

Measure Description

**Part A:** Participants will receive points based on the percentage of opioid registry patients who meet the opioid safety requirements:

\[
\text{Quarterly Opioid Safety Rate} = \frac{\text{Numerator}}{\text{Denominator}}
\]

**Numerator:** Total number of opioid registry patients who meet the opioid safety requirements: *all* of the following must be documented in the last 12 months:

- one drug urine screen (does not have to be random)
- a signed opioid treatment agreement
- CURES report reviewed

**Denominator:** Total number of patients in Opioid Registry on the last day of the Quarter

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

**Part B:** Participants submit a list of the five SFHP members reviewed by the Controlled Substance Review Committee during the months of the quarter via secure email to PainManagement@sfhp.org. Any member with opioid safety risk may be reviewed. Include brief documentation of committee recommendations and attestation that CURES report reviewed. CURES must be run no more than one month prior to review.

Measure Rationale

Information from the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain (http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm) indicates that opioid prescriptions have quadrupled and over 165,000 people have died from prescription opioids since 1999. SFHP has seen a decrease in the prevalence of members who have received opiate prescriptions from 2013 through
2016; this trend is likely due to a number of factors, including increased awareness, local, State and Federal efforts to reduce opiate prescribing. We consider this PIP measure as an important contributor to the positive trends we have seen. Thank you PIP participants! With that said, opioid prescribing still carries great risks. This measure intends to mitigate those risks by incentivizing best practices through panel management and interdisciplinary collaboration on treatment plans for patients receiving opioid prescriptions.

**Measure Source**
Inclusion of this measure and PIP benchmark determination was informed by SFHP in conjunction with the PIP advisory committee.

**Data Source**
- Self-reported by participant.

**Exemptions & Exclusions**
- Participants with < 15 SFHP/HSF members meeting the chronic opioid treatment criteria (as outlined in the definitions section) are exempt from Part A and Part B.
- Patients with a diagnosis of cancer, who have moved, changed clinics, were lost to follow up, or are deceased are excluded.
- Patients who are physiologically unable to produce urine are excluded from the random drug urine screen requirement in Part A’s numerator. They are not, however, excluded from the other opioid safety requirements (a signed pain management agreement and CURES report review).

**Deliverables and Due Dates**

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Due Date</th>
<th>Quarterly Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deliverable A:</strong> Self-report the numerator and denominator as noted in the Measure Description</td>
<td>• Quarter 1&lt;br&gt;• Quarter 2&lt;br&gt;• Quarter 3&lt;br&gt;• Quarter 4</td>
<td>0.5 point for ≥ 60%&lt;br&gt;0.25 point for 50-59%&lt;br&gt;0 points for 49% or less</td>
</tr>
<tr>
<td><strong>Part B:</strong> Submit template with the names of 5 SFHP members with opioid safety risk reviewed during the months of the quarter by the Controlled Substance Review Committee. Include brief documentation of committee recommendations and attestation that CURES report reviewed. CURES must be run no more than one month prior to review.</td>
<td>• Quarter 1&lt;br&gt;• Quarter 2&lt;br&gt;• Quarter 3&lt;br&gt;• Quarter 4</td>
<td>0.1 point/member, up to 0.5 point, will be awarded for submitting (via secure email)⁶ the completed template listing the 5 SFHP members reviewed by the Controlled Substance Review Committee to <a href="mailto:PainManagement@sfhp.org">PainManagement@sfhp.org</a>.</td>
</tr>
</tbody>
</table>

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

Chronic Opioid Treatment for Non-Cancer Pain: Patients who are prescribed 20mg or more morphine equivalents per day for at least 60 days in the last 3 months for non-cancer pain.

Opioid Safety Risk: As recent evidence and news reports have indicated, opioid prescriptions present inherent risk. With that said, there are some situations that present greater risk. Examples are provided below to assist participants in identifying instances where greater attention may be beneficial. Please note that these situations should not preclude patients from being eligible for opioid prescriptions; rather, they are provided to help participants organize and refine their efforts.

Per the CDC’s 2016 Guidelines, here are some examples of situations presenting greater opioid safety risk:
- Patients receiving concurrent opioid (of any dose/length) and benzodiazepine prescriptions
- Patients receiving Methadone prescriptions for the treatment of chronic pain
- Patients receiving Methadone for treatment as part of Opiate Treatment Program
- Patients over the age of 65 and receiving any opioid prescription (of any dose/length)
- Patients with renal or hepatic insufficiency receiving any opioid prescription (of any dose/length)
- Patients with current or a history (personal or family) of substance abuse and/or any prior non-fatal overdose requesting and/or receiving any opioid prescription (of any dose/length)
- Patients with mental health diagnoses receiving any opioid (of any dose/length)

Opioid Registry: As one of the most effective panel management tools, SFHP highly encourages the use of a registry to track patients receiving chronic opioids. It is optional to also include patients presenting opioid safety risk. 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. At any point during the PIP year, SFHP can provide a list of patients that meet the above criteria if a participant is unable to develop a registry or otherwise desires this information. Please request this from the program administrators.

Opioid Safety Requirements: Each of the following is documented in the last 12 months:
- One drug urine screen performed (UTOX) (does not have to be random),
- A signed opioid treatment agreement on file,
- CURES report reviewed

Controlled Substance Review Committee: A committee providing independent review of records for patients on chronic opioid treatment or those that present opioid safety risk. Reasons reviewed can include patients with high doses, new patients, patients with suspicious urine drug screens, or patients with other concerning behaviors. Controlled Substance Review Committees help providers stay accountable to clinic practice guidelines, and support the clinic’s ability to practice consistently and follow best practices. 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. At a minimum, the committee must contain two prescribers. Small clinics may implement medical director review if staffing is not sufficient for a committee.

CURES Department of Justice Report: Online state database containing information for all controlled substance prescriptions filled by every patient in California. Includes all payer sources including cash. Registration requires online sign-up the link below, then having a notary public certify the provider’s
signature and medical license. SFHP will provide a notary public to facilitate provider registration upon request. Reviewing the CURES report at least annually, and for all new patients, allows prescribers to better identify patients who are receiving medications from multiple sources and are at risk for addiction and diversion. https://pmp.doj.ca.gov/pdmp/index.do
### Clinic A Provider Roster

#### EXAMPLE

<table>
<thead>
<tr>
<th>First and Last Name (legal with preferred in parenthesis)</th>
<th>Medical Degree</th>
<th>Type of Practitioner (PCP or Specialist)</th>
<th>Primary Specialty</th>
<th>Secondary Specialties (if applicable)</th>
<th>Language(s)</th>
<th>License Number</th>
<th>Email Address</th>
<th>Name of MD/DO Supervisor (for NPs, PAs, CNMs only)</th>
<th>Site Name</th>
<th>Language(s) Spoken At Site</th>
<th>Hours &amp; Days Site is Open</th>
<th>Date listed with SFHP</th>
<th>Date terminated/left the organization (if applicable)</th>
<th>Open to new members (Y/N)</th>
<th>Open to Auto Assignment (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARROYO, ABIGAIL (ABBY)</td>
<td>MD</td>
<td>PCP</td>
<td>PEDIATRICS</td>
<td>ADOLESCENT MEDICINE</td>
<td>ARABIC, ENGLISH, SPANISH</td>
<td>XXXXXXXX</td>
<td><a href="mailto:aarryo@clinica.org">aarryo@clinica.org</a></td>
<td></td>
<td>CLINIC A</td>
<td>ARABIC, CANTONESE, ENGLISH, MANDARIN, PORTUGUESE, RUSSIAN, SPANISH</td>
<td>M-F 8AM-5PM, SAT 9AM-3PM</td>
<td>7/8/2011</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>OLIVERA, BLAKE</td>
<td>NP</td>
<td>SPECIALIST</td>
<td>PSYCHIATRY</td>
<td>PEDIATRIC MEDICINE</td>
<td>ENGLISH, PORTUGUESE</td>
<td>XXXXXXXX</td>
<td><a href="mailto:b.olivera@clinica.org">b.olivera@clinica.org</a></td>
<td>ABIGAIL ARROYO</td>
<td>CLINIC A</td>
<td>ARABIC, CANTONESE, ENGLISH, MANDARIN, PORTUGUESE, RUSSIAN, SPANISH</td>
<td>M-F 8AM-5PM, SAT 9AM-3PM</td>
<td>5/13/2009</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Corrective Action Plan (CAP) in PIP

PIP participants have the option to submit their Corrective Action Plan (CAP) to SFHP through PIP measure PE8: Expanding Access to Services. All submitted CAPs and supporting material will be evaluated and approved by SFHP Provider Relations; please submit all deliverables to the appropriate SFHP CAP representative. A description of the process is outlined below.

<table>
<thead>
<tr>
<th>Final Due Date</th>
<th>Deliverable</th>
<th>Deliverable Description</th>
<th>Available PIP points:</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 15, 2017</td>
<td>Initial CAP submission</td>
<td>CAPs must respond to all deficiencies identified by SFHP. Submitted CAPs will be evaluated by SFHP Provider Relations and returned to group or clinic for any revisions. Groups and clinics will receive CAP approval when all revisions are complete.</td>
<td>N/A</td>
</tr>
<tr>
<td>July 31, 2017</td>
<td>Deliverable A: Approved CAP submission</td>
<td>CAPs must be finalized in order to qualify for PIP points.</td>
<td>2 points</td>
</tr>
<tr>
<td>September 15, 2017</td>
<td>Initial submission of supporting materials</td>
<td>Supporting materials must demonstrate the process of an enacted CAP. Examples of supporting materials include training materials, communication plans, revised policies and procedures, or other materials that demonstrate the enacted CAP. Supporting materials will be evaluated by SFHP Provider Relations and returned to group or clinic for any revisions. Groups and clinics will receive approval when all revisions are complete.</td>
<td>N/A</td>
</tr>
<tr>
<td>October 31, 2017</td>
<td>Deliverable B: Approved supporting materials submission</td>
<td>Supporting materials for CAPs must be finalized to qualify for PIP points.</td>
<td>2 points</td>
</tr>
<tr>
<td>December 15, 2017</td>
<td>Initial submission of outcome report</td>
<td>Outcome reports must demonstrate the outcome of an enacted plan. Examples of outcome reports include an audit of appointment availability, survey of telephone triage availability, or other data collection that demonstrates the success of the enacted CAP. Outcome reports will be evaluated and returned to group or clinic for any revisions. Groups and clinics will receive approval when all revisions are complete.</td>
<td>N/A</td>
</tr>
<tr>
<td>January 31, 2018</td>
<td>Deliverable C: Approved submission</td>
<td>Evidence of outcome for CAP must be finalized by SFHP Provider Relations to be eligible for points.</td>
<td>2 points</td>
</tr>
</tbody>
</table>