SAN FRANCISCO HEALTH PLAN

Practice Improvement Program
Partnering to prepare for the future

Practice Improvement Program
2019 Program Guide
Primary Care

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Section I: 2019 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	As approved by SFHP's Governing Board: • 18.5% of Medi-Cal capitation payments
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	There are four measure domains including: • Clinical Quality • Data Quality • Patient Experience • Systems Improvement Measure inclusion criteria considered: • clinical relevance and alignment with external entities[1] • opportunity for improvement across SFHP's provider network • potential healthcare cost-savings • supports appropriate utilization of health care services • self-reporting feasibility

[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)

Section II: PIP History

In 2010, San Francisco Health Plan's governing board approved the funding structure for the Practice Improvement Program (PIP), which launched in January 2011 with 26 participating provider organizations (clinics and medical groups). 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 were added 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[1].
- In 2018, new measures were added to the Systems Improvement domain to support appropriate utilization of primary care visits and expansion of the palliative care Medi-Cal benefit.
- In 2019, the patient experience domain was assessed with the goal of strengthening the measure set to improve alignment with SFHP and participant improvement priorities, strengthen patient experience metrics (i.e. methodology and targets), and simplify reporting.

Section III: Summary of Key Changes for PIP 2019

Changes in the PIP 2018 measure set were brought to the PIP Advisory Committee and other stakeholders for input on relevancy, implementation, and general feedback.

1) The PIP program calendar will shift to follow the fiscal year, beginning in FY 2020/21. This change is in response to participant feedback and interest in aligning PIP with the fiscal year. To operationalize this change the 2019 program year will be extended by two quarters, "Quarter 5" and "Quarter 6". The 2019 program will end June 30, 2020.
2) CQ Domain:
    - Each participant's Priority Five CQ measures will be reset, determined by the last four quarters of data 2017 Q4-2018 Q3.
    - CQ03: Diabetes Eye Exam and CQ08: Controlling High Blood Pressure (Hypertension) measure specifications were updated to align with changes to the NCQA HEDIS measure specification.
    - Reporting on CQ 06: Labs for Patients on Persistent Medications is optional for all participants in in this reporting year. Participants who choose not to report will be exempt from reporting, and those who choose to report will report per regular submission guidelines. This is the last year of the measure, and it will be fully removed from PIP starting with the first quarter of the 2020/2021 program year.
3) PE Domain:

- Show Rate was retired due to sustained improvement across the PIP network. Great work!
- Deliverables for PIP survey measures (i.e. PE3: Staff Satisfaction & PE4: Patient Experience of Primary Care) were streamlined to reduce the number of deliverables due to SFHP.
- PE3: Staff Satisfaction improvement was removed from the IPA measure set.
- PE4: Improvement in Patient Experience of Primary Care Access was modified to include two additional from CG-CAHPS composites: *Customer Service* & *Provider Communication*; new composites will be reporting-only in 2019. A full list of composite questions can be found in Appendix C.
- PE7: The Expanding Access to Services measure (previously PE8 in 2018) will be the next iteration of the PIP Enhance Funding opportunity. The first deliverable for this measure will be due Q2 2019 and will be in the form of a proposal. Further information regarding this measure will be sent out in early July 2019.

Section IV: PIP 2019 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 quarter end date, as illustrated in the table below.

Quarter	Quarter End Date	Materials Due to SFHP	Lookback Period
Enrollment	December 31, 2018	Friday, January 18, 2019	For all measures, the quarter's end date serves as the last day of the lookback period. Please see each measure's specifications for the first day of the lookback period.
1	March 31, 2019	Tuesday, April 30, 2019	
2	June 30, 2019	Wednesday, July 31, 2019	
3	September 30, 2019	Thursday, October 31, 2019	
4	December 31, 2019	Friday, January 31, 2020	
5	March 31, 2020	Thursday, April 30, 2020	
6	June 30, 2020	Friday, July 31, 2020	

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

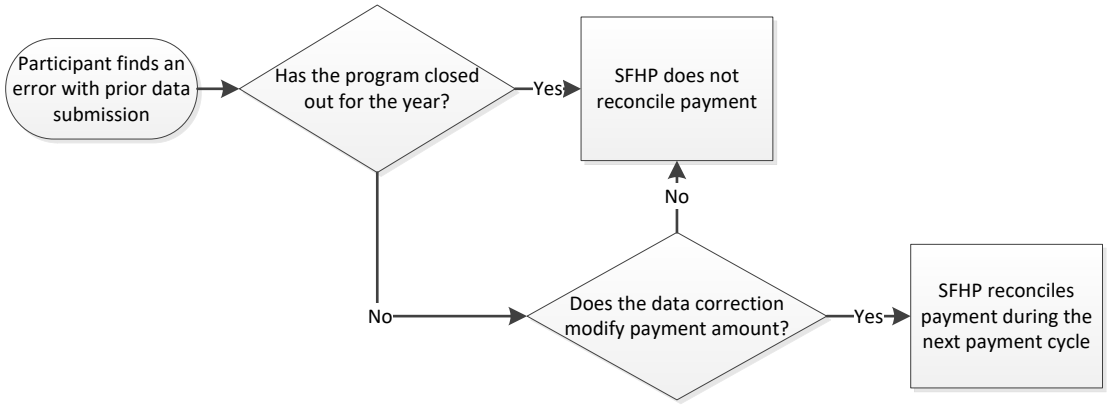
Late submissions will be accepted up to two weeks after each quarter's deadline. Participants may arrange for an extension, if negotiated prior to the deadline. When an extension has been granted, points and payment will not be affected. When an extension has not been granted, the late submission will 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 submit their corrected data as soon as

possible. If the data was originally submitted via the quantitative data template, SFHP may request that the quantitative data template be resubmitted.

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 the final quarter of the program year, 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:

- Quantitative Data Validation
  - With every quarterly submission, SFHP will compare the current quarter's quantitative data to the prior quarter's. If there is a difference that seems beyond what could be due to normal variation, SFHP will follow-up with the participant for more information.
- Clinical Quality Domain:
  - SFHP will compare self-reported data to SFHP-audited HEDIS data on an annual basis. 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 PE 2 Office Visit 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.

Mid-Year Measure Change Policy

Mid-year measure changes are discouraged; however there are cases that merit a measure change mid-year. The following cases are used to evaluate a measure change request:

- When a measure no longer represents both participant and SFHP priorities.
- When a measure is dictated by external agencies and the agency removes their support for the measure.
- When the relevancy/validity of the measure is undermined due to substantive interim changes in medical evidence and/or widely accepted clinical practice guidelines including, but not limited to, USPTF guideline changes.

Section V: 2019 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 approach 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:

Relative Improvement = (Current Rate – Baseline Rate) / (100 – 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 two weeks of the scorecard being sent. Participating organizations will receive their first PIP payment for Quarter 1 by June 2019, and their last payment for Quarter 6 by October 2020. 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

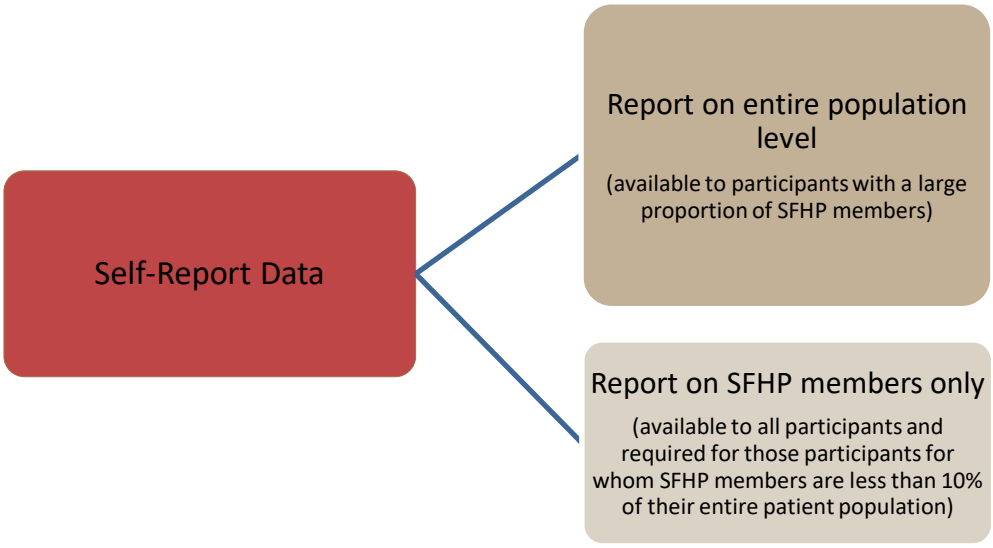
Each measure has certain requirements for exemptions, see the specifications for details. Exemptions are determined once for the program year upon enrollment and communicated to participants via the annual measure grid. Thus, if a participant is determined to be exempt from a measure at the beginning 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: 2019 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 is self-report only. Below is a summary schematic of the reporting options:



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 participant's electronic system (Registry, EHR, etc.), supporting payer-neutral population management, **OR**
- Report on their SFHP members only.
    - Participants 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

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

Clinical Quality Scoring

Deliverable	Quarterly Scoring (Self-Report)
For each of the Priority Five measures:	
Achieving HEDIS 90th percentile *or* 75th internal PIP percentile *or* 15% or more relative improvement	1.25 points

Achieving HEDIS 75th percentile *or* 60th internal PIP percentile *or* 10-14% relative improvement	1.0 point
Achieving 5-9% relative improvement =	0.75 point
For each of the non-Priority Five measures:	
Self-reporting data quarterly	0.25 point
Maintaining performance relative to baseline*	0.25 point

**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.*

CQ disparities analysis

In addition, participants will be eligible to earn **3.0 points** for submitting an analysis of disparities in one or more Priority Five measures. Please see Appendix D, CQ Disparities analysis for the template and quarter due.

Priority Five Measures Determination: Each participant's Priority Five measures will be re-set in 2019 to allow new, lower performing measures to be targeted for improvement. Measures eligible for Priority Five inclusion are CQ01-CQ15. To determine Priority Five inclusion, self-reported data from Q4 2017-Q3 2018 will be used. Participants will be notified in December 2018 their Priority Five measures. 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:

Measure	90th percentile	75th percentile
CQ01 Diabetes HbA1c Test	92.70	90.45
CQ02 Diabetes HbA1c <8	59.49	55.47
CQ03 Diabetes Eye Exam	68.61	64.23
CQ04 Cervical Cancer Screening	70.68	66.01
CQ06 Labs for Patients on Persistent Medications	92.76	90.67
CQ08 Controlling High Blood Pressure	71.04	65.78
CQ09 Adolescent Immunizations	46.72	37.71
CQ10 Childhood Immunizations	79.56	74.70
CQ11 Well Child Visits	83.70	79.33
CQ12 Chlamydia Screening	71.33	65.43
CQ13 Timely Access to Prenatal Care	90.75	87.06
CQ14 Postpartum Care	73.97	69.34
CQ15 Asthma Medication Ratio	71.93	67.03

For measures without HEDIS Medicaid thresholds, a PIP network threshold will be used based on prior year's PIP participant data:

Measure	75th percentile	60th percentile

CQ05 Colorectal Cancer Screening	86.79	60.38
CQ07 Smoking Cessation Intervention	89.48	84.27

Section VII: 2019 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/ . This information has been removed from each individual measure specification.

Section VIII: 2019 Primary Care Measure Specifications

The rest of this document consists of the individual specifications for each of the 2018 measures across all domains: clinical quality, patient experience, and systems improvement.

Please see *Appendix B: Measure Set by Participant-Type Grid* for details on the measures assigned by participant-type (i.e. Community Clinic, Clinic-Based RBO, IPA, or Academic Medical Center).

CQ 01: Diabetes HbA1c Test

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

No Changes.

Measure Description

Participants will receive points for improvement on the percentage of patients with diabetes (type 1 and type 2) in the eligible population who received an HbA1c test in the last 12 months.

$$\textbf{DM HbA1C Test} = \frac{\textbf{Numerator:}\ \text{Number of patients in denominator population who received at least one HbA1c test within the last 12 months}}{\textbf{Denominator}\text{: Number of active patients with diabetes ages 18-75 years old}}$$

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 (e.g. eye, kidney, and nerve diseases) by as much as 40 percent (AHRQ, National Quality Measures Clearinghouse, 2014). In addition, monitoring HbA1c levels is an important first step towards diabetes control with the potential to reduce health care costs associated to treatment for diabetic complications.

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)

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

No Changes.

Measure Description

Participants will receive points for improvement on the percentage of patients with diabetes (type 1 and type 2) in the eligible population whose most recent HbA1c results in the last 12 months was lower than 8%.

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

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% to 7%) reduces the risk of microvascular complications (e.g. eye, kidney, and nerve diseases) by as much as 40 percent (AHRQ, National Quality Measures Clearinghouse, 2014). In addition, improvements in HbA1c control is associated to decreased morbidity and mortality from diabetes and, thus, can reduce health care costs associated to treatment of diabetic complications.

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 accreditation[2], 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.

[2] SFHP held accountable

CQ 03: Diabetes Eye Exam

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Bilateral eye enucleation was added to the numerator.

Measure Description

Participants will receive points for improvement on the percentage of patients with diabetes (type 1 and type 2) 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 OR has had a bilateral eye enucleation

$$\textbf{DM Eye Exam} = \frac{\textbf{Numerator:}\ \text{Number of patients in denominator population with retinal exam or dilated eye exam performed by an eye care professional in the past 12 months } \textbf{OR} \text{ a negative retinal or dilated eye exam performed by an eye care professional in last 24 months } \textbf{OR} \text{ has had a bilateral eye enucleation}}{\textbf{Denominator:}\ \text{Number of active patients with diabetes ages 18-75 years old}}$$

Measure Rationale

Diabetic retinopathy is the leading cause of adult blindness in the U.S., and can be prevented with timely diagnosis (CDC, 2013). As such, 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 received an eye screening is an NCQA HEDIS measure. Studies indicate that diabetes eye exams, like retinal exams, can reduce health complications from diabetes and reduce health care costs for treatment of diabetic complications. One study found that screening and treatment for eye disease in patients with type II diabetes generates annual savings of $24.9 billion to the federal government (American Diabetes Association, 1994).

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 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.
- 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

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

No Changes.

Measure Description

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

$$\textbf{Cervical Cancer Screening} = \frac{\textbf{Numerator:}\ \text{Number of patients with cervices ages 24-64 who received one or more cervical cytology during the past 3 years OR patients with cervices ages 30-64 who received cervical cytology and HPV co-testing during the past 5 years}}{\textbf{Denominator:}\ \text{Number of active patients with cervices ages 24-64 years old}}$$

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 cervices who have been sexually active or who are over 21 (ACOG, 2003; Hawkes et al., 1996; Saslow et al., 2002; AHRQ, National Quality Measures Clearinghouse, 2014). Meeting and exceeding targets for cervical cancer screenings may ensure patients receive life-saving, preventive care. As such, screenings can identify cancer early and reduce health care costs associated to cancer treatments for advanced illness.

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, which includes Cervical Cancer Screening.

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/ .
- 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

2019 Practice Improvement Program Measure Specification

Clinic-Based RBO & Community Clinic

Changes from 2018

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.

Colorectal Cancer Screening =

Numerator:
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

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Denominator: Number of active patients ages 51 - 75 years old

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). Meeting and exceeding targets for colorectal cancer screenings can ensure that patients receive life-saving, preventive care. As such, screenings can identify cancer early and reduce health care costs associated to cancer treatments for advanced illness.

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/.
- 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

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Reporting on this measure is optional for all participants in in this reporting year. Participants who choose not to report will be exempt from reporting, and those who choose to report will report per regular submission guidelines. This is the last year of the measure, and it will be fully removed from PIP starting Quarter 1 of the 2020/2021 program year.

Measure Description

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

Labs for Patients on Persistent Medications =

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

- At least one serum potassium,
  AND
- A serum creatinine within the measurement year
  OPTIONAL:
  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 (optional) or diuretics for 180 days or more in the last year

Measure Rationale

When patients use long-term medications, they are at risk for adverse drug events. Studies indicate these adverse drug events cause more than 700,000 visits to the ER each year (CDC, 2012). As a result, increased use of both inpatient and outpatient resources contribute to increased health care costs. Continued monitoring of a medication's effectiveness and possible side effects reduces the likelihood of adverse drug events, increasing patient safety and decreasing associated costs.

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

2019 Practice Improvement Program Measure Specification

Clinic-Based RBO & Community Clinic

Changes from 2018

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.

Smoking Cessation Intervention	=	**Numerator**: Number of patients in denominator population with a documented smoking cessation counseling intervention in the EHR or registry in the last 2 years **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

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 known health risks, over 47 million Americans smoke or use tobacco. As a result, medical spending surveys estimate that 8.7% of all healthcare spending, or $170 billion a year, is used to treat tobacco-related illnesses, and public programs like Medicare and Medicaid paid for most of these costs (Reuters, 2014).

Seventy percent of smokers are interested in stopping smoking completely; furthermore, 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 receiving brief advice to quit is associated with a 30% increase in the number of people who quit (AHRQ, National Quality Measures Clearinghouse, 2014). In addition, lower education levels are associated with higher rates of smoking. For example, 22% of adults whose highest level of education is a high school diploma smoke, compared to 9% of adults with an undergraduate degree, and 5.6% of adults with a graduate degree (American Cancer Society, 2015).

Smoking cessation interventions may prompt smokers to initiate a quit attempt, which may not have otherwise occurred without an intervention. Patients who stop smoking often experience various health benefits from quitting and as such, quitting can reduce health costs associated with tobacco-related illness and treatment.

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 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)

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Removed different blood pressure targets for different age groups.
- Q1 data submissions will be reporting-only and will used to reset baseline data for the 2019 program year. Pay-for-performance will resume in Q2.

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.

$$\textbf{Controlling High Blood Pressure <140/90} = \frac{\textbf{Numerator:} \text{ Number of patients in the denominator population in which the most recent BP reading in an outpatient visit within the reporting period was<140/90 mmHG.}}{\textbf{Denominator:} \text{ Number of active patients with hypertension ages 18-85 years old}}$$

Measure Rationale

High blood pressure increases the risk of heart disease and stroke, the two leading causes of death in the United States (CDC, 2012). Controlling blood pressure has been proven to lower morbidity and mortality (AHRQ, National Quality Measures Clearinghouse, 2013). Some studies also indicate that failure to achieve blood pressure targets contribute to avoidable costs associated with a number of cardiovascular events (James, et al., 2014).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[2], 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/ .
- 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

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

No changes.

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.

$$\textbf{Adolescent Immunizations with HPV} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who received one meningococcal vaccine on or between the member's 11th and 13th birthday, one (Tdap) or (Td) vaccine on or between the member's 10th and 13th birthday, and two HPV vaccines between the member's 9th and 13th birthday.}}{\textbf{Denominator:}\ \text{Number of active patients who turned 13 years old during the last year}}$$

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 vulnerable populations including infants, the elderly, and individuals with chronic conditions. Meningococcal and (Tdap)/(Td) vaccines prevent illness and related outbreaks. In addition, the HPV vaccine is effective in preventing many types of cancers for people of all genders. Immunization research suggests disease prevention associated to immunizations saves hundreds of lost school days and work days, and millions of dollars associated with preventable illnesses (AHRQ, National Quality Measures Clearinghouse, 2014). As such, adolescent immunizations can save health care costs associated with preventable illnesses.

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 to adolescents. This measure follows the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations (AHRQ, National Quality Measures Clearinghouse, 2014).

The Department of Health Care Services (DHCS) 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[2], the 2019 HEDIS measure specification for Immunizations for Adolescents – Combo 2, 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/ .
- 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

CQ 10: Childhood Immunizations

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

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.

Childhood Immunizations =

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

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

Denominator: Number of 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. Immunization research suggests disease prevention associated to immunizations saves hundreds of lost school days and work days, and millions of dollars associated with preventable illnesses (AHRQ, National Quality Measures Clearinghouse, 2014). As such, childhood immunizations can save health care costs associated with preventable illnesses.

This measure follows the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immuniztion 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[2], HEDIS measure CIS: Childhood Immunization Status—Combo 3, 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/ .

- For MMR, hepatitis, VZV and hepatitis A, count any of the following :
    - Evidence of the antigen or the combination vaccine
    - Documented history of the illness
    - A seropositive test result
- 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

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

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.

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

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. In addition, well-child visits can establish habitual preventive care with the potential to reduce health care costs into adolescence and adulthood.

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/ .
- 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: Chlamydia Screening

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

No changes.

Measure Description

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

Chlamydia Screening =

Numerator: Number of patients in the denominator population with at least one test for chlamydia in the last year

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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

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 become pregnant between the ages of 14-19. Chlamydial infections in patients with a cervix can cause cervicitis, which can cause Pelvic Inflammatory Disease (PID) if left untreated. 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. Meeting and exceeding targets for chlamydia screenings supports health in patients with a cervix and can reduce health costs associated to complications from infection. 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[2] 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/ .
- 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 13: Timely Access to Prenatal Care

2019 Practice Improvement Program Measure Specification

Clinic-Based RBO & IPA Participants only

Changes from 2018

No changes.

Measure Description

Participants will receive points for reporting the rate of patients who received a prenatal care visit in the first trimester of their pregnancy or within 42 days of enrollment into Medi-Cal, whichever is later.

Timely Access to Prenatal Care	=	**Numerator:** Number of patients in the denominator population who received a prenatal in the first trimester of their pregnancy or within 42 days of enrollment into Medi-Cal, whichever is later. **Denominator:** Number of active patients who had a live birth in the last year.

Measure Rationale

Prenatal care visits inform patients about the important steps they can take to ensure a safe pregnancy and protect their infant. As such, timely access to prenatal care can reduce complications from pregnancy and the associated health care costs.

Measure Source

Inclusion of this measure and PIP determination is supported by alignment with external healthcare measurement entities, including NCQA accreditation[2], EAS, and PRIME.

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 14: Postpartum Care

2019 Practice Improvement Program Measure Specification

Clinic-Based RBO & IPA Participants only

Changes from 2018

No changes.

Measure Description

Participants will receive points for reporting the rate of patients that had a postpartum visit within 21-56 days OR 7-84 days* after childbirth.

$$\textbf{Postpartum Care} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who had a postpartum visit between 21-56 days OR 7-84 days after delivery.}}{\textbf{Denominator:}\ \text{Number of active patients who had a live birth in the last year.}}$$

Measure Rationale

Postpartum care provides important opportunities to assess the physical and psychosocial well-being of the parent, and for counseling on infant care. In addition, postpartum visits offer counseling on family planning, which can reduce the risk of unwanted pregnancies and save an estimated $7 billion in Medicaid spending for the cost of unplanned births (Cleland et al., 2011).

*NCQA has changed the 2020 postpartum measure specification from 21-56 days after delivery to 7-84 days. Participants will have the option to report on the old or new measure specification based on individual reporting needs.

Measure Source

Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA accreditation[2], EAS, and PRIME.

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 15: Asthma Medication Ratio

2019 Practice Improvement Program Measure Specification

Clinic-Based RBO & IPA Participants only

Changes from 2018

No changes.

Measure Description

Participants will receive points for reporting the rate of patients with persistent asthma who had a ratio of controller medication units to total asthma medication of 0.50 or greater.

Asthma Medication Ratio =

Numerator: Number of patients in the denominator population who have a ratio of 0.5 or greater of controller asthma medication units to total asthma medications in the measurement year.

Denominator: Number of active patients between the ages 5-64 with persistent asthma as defined as one or more of the following in the past two years:

- At least one ED visit with a primary diagnosis of asthma
- At least one inpatient encounter with a primary diagnosis of asthma
- At least four outpatient visits with a diagnosis of asthma **and** at least two asthma medication dispensing events
- At least four asthma medication dispensing events
    - If the patient was only dispensed short acting medications (leukotriene modifier or antibody inhibitor) they should also have a diagnosis of asthma in any setting

Measure Rationale

Asthma can be managed through the regular administration of asthma controller medications, which can control chronic symptoms and can prevent future exacerbation and progressive decline in lung function (or for children, reduced lung growth). The use of reliever or short acting medications will help ease acute symptoms but do not provide long-term asthma control and if used more than recommended, can cause long-term side effects. Asthma control strategies can reduce ED visits by as much as 68% and hospitalizations by as much as 85%, resulting in cost savings to inpatient care (CDC, 2015).

Measure Source

Inclusion of this measure and PIP benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA accreditation[2] 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/ .
- One controller medication unit is defined as an amount of medication lasting 30 days or less; one medication unit equals one inhaler canister, one injection, or a 30-day or less supply of an oral medication.
- Participants with < 30 SFHP members in the eligible population are exempt from this measure.
- Persistent asthma is defined as meeting at least one of the four denominator criteria.

Deliverables and Scoring

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

DQ 1: Provider Roster Updates

2019 Practice Improvement Program Measure Specification

IPA & ACADEMIC MEDICAL CENTER ONLY

Changes from 2018

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:

1. *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.
2. *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)*[3]
    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*)
    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.

[3] 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 that SFHP maintains key compliance objectives and accurate member assignments. 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 audit found 88% of randomly selected SFHP provider data to have errors. Moreover, CA Senate Bill 137 requires all Knox-Keene-licensed health plans in California to collect much more robust provider data, effective 7/1/2016. The revised process for this measure will support SB137.

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).

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

Deliverable	Due Dates	Scoring
• If there are ***no changes*** that need to be made to the current quarter's provider roster, please submit the Provider Roster Attestation. • If ***changes do need to be made*** 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: ○ 0.10 point deduction (up to a maximum of 0.50 point) for each piece of missing information noted in Measure Description. ○ 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	• Quarter 2 • Quarter 4 • Quarter 6	2.0 points

Roster. Discrepancies that will affect scoring are: • Providers in one source and not the other. • Additions/terminations reported via PIP that should have been reported via entity's contractual method > 1 month prior		

PE 1: Third Next Available Appointment

2019 Practice Improvement Program Measure Specification

CLINIC-BASED RB0 & COMMUNITY CLINIC ONLY

Changes from 2018

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). In addition, this measure supports operational efficiency of primary, preventative care. Timely access to preventive care can identify and treat health conditions early, potentially reducing health care costs from treatment due to health complications.

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

Deliverable	Due Dates	# of Days Reduced	Threshold	Scoring

Submit the median established patient follow-up visit TNAA for each of the final 5 full weeks of the reporting period, via the quantitative template. **Note:** SFHP will determine median of five pieces of data and use it to score performance.	• Quarter 1 • Quarter 2 • Quarter 3 • Quarter 4 • Quarter 5 • Quarter 6	n/a	14 calendar days or less	2.0 points
		≥ 10 days	15-21 calendar days or less	1.5 points
		5-9 days	n/a	1.0 point

PE 2: Office Visit Cycle Time

2019 Practice Improvement Program Measure Specification

ACADEMIC MEDICAL CENTER, CLINIC-BASED RBO, COMMUNITY CLINIC ONLY

Changes from 2018

PIP Network performance thresholds updated.

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. All primary care providers at the site, including per diem and part-time providers, should be included in cycle time. 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. Inclusion of this measure supports operational efficiency of primary preventive care. Timely access to preventive care can identify and treat health conditions early, potentially reducing health care costs from treatment due to health complications.

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

Deliverable	Due Dates	# Minutes Reduced	PIP Network Threshold	Quarterly Scoring

Self-report the median cycle time for each month in the quarter, via the quantitative template.	• **Quarter 1** (Data Collection Period: Jan, Feb, Mar) • **Quarter 2** (Data Collection Period: Apr, May, Jun) • **Quarter 3** (Data Collection Period: Jul, Aug, Sept) • **Quarter 4** (Data Collection Period: Oct, Nov, Dec) • **Quarter 5** (Data Collection Period: Jan, Feb, Mar) • **Quarter 6** (Data Collection Period: Apr, May, Jun)	10 or more minutes reduced	**75th percentile** 63 minutes or less	1.0 point
		5-9 minutes reduced	**60th percentile** 64-68 minutes	0.5 point

PE 3: Staff Satisfaction Improvement Strategies

2019 Practice Improvement Program Measure Specification

Community Clinics, Clinic-Based RBOs, and Academic Medical Centers

Changes from 2018

- This measure was removed from the IPA measure set.

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 2019, 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 2019 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, staff lunch, 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). In addition to improved patient experience, other benefits to improving staff satisfaction include reduced turnover and associated reductions in training costs. Improved staff satisfaction is also linked to empowered staff who will work to continuously identify process improvements that result in health care cost-saving opportunities (Powell, 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

Deliverables	Due Dates	Scoring
Deliverable A: Submit template with the following included:	Quarter 1	• 0.5 point for completed

• Baseline score of a staff satisfaction survey ○ 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, 2018-January 15, 2018) • Survey question • Response rate (numerator/denominator) • 1-2 priority areas identified for improvement		template, if required response rate met. • 0 point if required response rate not met.
Deliverable B: Submit template with: • Report of improvement activities implemented • Survey type (must be same as **baseline**) • Survey date (completed August 1, 2016-October 15, 2016) • Survey question (must be same as baseline) • Response rate (numerator/denominator)	Quarter 3	1.0 point for completed template, if response rate met.
Deliverable C: Improvement on staff satisfaction survey score, submitted via the Quantitative Data Template. ○ Score must represent question chosen for baseline.	Quarter 3	*If required response rate met:* • 1.0 point for ≥ 4.0% relative improvement • 0.5point for 2.0% - 3.9% relative improvement *If required response rate not met:* 0 point
Additional deliverable(s) TBD: Due to two extra quarters in the 2019 program, the PIP team will work with the advisory committee and participants to determine additional improvement activities and timing.	TBD	TBD

PE 4: Improvement in Patient Experience of Primary Care Access

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Addition of questions from CG-CAHPS composites: *Customer Service* & *Provider Communication.* See Appendix C for full list of composite questions.
- New composites will be reporting-only in 2019.
- Scoring: addition of CG-CAHPS improvement thresholds, in addition to absolute improvement thresholds.

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. Patient feedback can help providers capture the patient's voice, gain more understanding of the patient population, and target specific improvement areas to improve the overall quality of health service delivery. As such, this measure can incentivize providers to understand more about patients' needs and save future costs by identifying the right patient concerns and utilizing resources efficiently.

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

	Criteria	Rationale
1.	Conducted and analyzed by *or* audited by third party	Supports consistent and unbiased survey methodology
2.	Surveyed population is a random sample of all Medi-Cal patients	Results can be generalized across the population
3.	Survey conducted at least twenty-four hours after visit concludes	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
4.	Tool has been validated	Validation ensures that the tool is reliable; meaning, that it yields results that reflect patient perception of the health care system
5.	Includes access-related questions	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
6.	Sampling methodology ensures that each question obtains at least thirty responses	Results can be considered statistically meaningful

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. Timely access to preventive care can identify and treat health conditions early, potentially reducing health care costs from treatment due to health complications.

Measure Source

Inclusion of this measure is 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.

Data Source

- CG-CAHPS survey; please see Appendix C for full list of composite questions.
    - 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 optionally exempt.

Deliverables and Scoring

Deliverables	Due Dates	Scoring
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	Quarter 2	**2.0 points** for completed template

qualitative data		
Deliverable B: Submit template with: • Report of improvement activities implemented • Re-measurement data collection methodology	Quarter 4	**1.5 point** for completed template
Deliverable C: Submit re-measurement score for CG-CAHPS or equivalent survey on Quantitative Data Template.	Quarter 4	**Access to Care Composite ONLY:** **2.0 points** for achieving: CG-CAHPS 90th percentile (90.9%)* or ≥3% absolute improvement **1.0 point** for achieving: CG-CAHPS 60th percentile (88.7%)* or 2-2.99% absolute improvement **0.0 points** for <2% absolute improvement **All other composites:** **0.5 point** for reporting results
Additional deliverable(s) TBD: Due to two extra quarters in the 2019 program, the PIP team will work with the advisory committee and participants to determine additional improvement activities and timing.		
*Press-Ganey medical group percentile scores (State of California); 7/1/2018-9/30/2018		

PE 5: Primary Care Access as Measured by Appointment Availability Survey Compliance

2019 Practice Improvement Program Measure Specification

ACADEMIC MEDICAL CENTER & IPA ONLY

Changes from 2018
No changes.

Measure Description
This measure uses information collected directly from providers to assess access to care. Health Plans are required to monitor appointment availability for all providers. Using the California Department of Managed Health Care (DMHC) Provider Appointment Availability Survey, participants will be scored on their overall compliance rate. The survey addresses a variety of access measures, including access to routine primary care, urgent primary care, routine specialty care, urgent specialty care, non-physician mental health, psychiatry, prenatal care, and ancillary care. For the purposes of this measure, scoring will include access to routine primary care and urgent primary care.

DMHC Timely Access Regulations for Primary Care	
Non-Urgent Primary Care Appointments	Within 10 business days of patient request
Urgent Primary Care Appointments	Within 48 hours of patient request

To implement the survey, SFHP will collaborate with the Industry Collaborative Effort (ICE), a group of health plans that collaborate to decrease the administrative cost of measurement and decrease the burden on providers. SFHP will submit a contact list of randomly selected providers to ICE. ICE will administer the survey via phone through a qualified survey vendor.

Provider compliance with appointment availability can be met by two ways:

1. Meeting standards for appointment regulations (listed above) on their own
2. Meeting standards for appointment regulations via another available provider in the same location

Each participant's score will represent a combination of non-urgent and urgent compliance rates.

$$\textbf{Primary Care Appointment Availability} = \frac{\textbf{Numerator:}\ \text{Total number of primary care providers in compliance with DMHC Appointment Availability standards listed above (must be compliant in both categories)}}{\textbf{Denominator}:\ \text{Total number of primary care providers that respond to the Appointment Availability Survey}}$$

Measure Rationale
The Timely Access to Non-Emergency Health Care Services Regulation (Timely Access Regulation) requires health plans to meet timeliness standards for provision of health care services, including wait time standards for appointments, as well as for customer service and triage (Knox-Keene Health Care Service Plan Act of 1975; California Code of Regulations, title 281; Bill SP 964). The Provider Appointment Availability Survey is one component of the report submitted each March to DMHC. This measure supports participants in assessing patient access as well as operational efficiency of primary

preventive care. Timely access to preventive care has can identify and treat health conditions early, potentially reducing health care costs from treatment due to health complications.

Measure Source

Inclusion of this measure and PIP benchmark determination was informed by the SFHP compliance department.

Data Source

- No submission due from PIP Participants.
- DMHC Provider Appointment Availability Survey for Primary Care (administered in the summer/fall)

Deliverables and Scoring

Deliverable	Due Date	Scoring
Participate in provider appointment availability survey (via phone, online, or fax)	Quarter 4. No submission due from participants.	**8.0 points** for achieving a 80% compliance rate

PE 6: Improvement in Specialty Access

2019 Practice Improvement Program Measure Specification

CLINIC-BASED RBO & IPA ONLY

Changes from 2018

- The data source for this measure has changed from HP-CAHPS to a survey administered by the PIP participant. As such, the measure will be scored as pay-for-reporting for this year only.

Measure Description

This measure uses information collected directly from members to assess perceived access to specialty care. Both deliverables are due in Quarter 3 and are as follows:

Deliverable A

- Participants will be awarded points for submitting their survey name, version if applicable, specialty care access question, and specialty care access question score.

Deliverable B

- Participants will be awarded points for collecting and analyzing qualitative data from patients, as well as developing a plan to improve baseline performance. Qualitative data collection must come from at least 10 patients belonging to the participant's organization. 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). SFHP Medi-Cal members consistently report challenges with access, including access to specialty care. This measure supports participants in assessing member access using input directly from members. In addition, by assessing member experience and perception of access, this measure supports operational efficiency of preventive care. Improvements to timely access to preventive care can identify and treat health conditions early, potentially reducing health care costs from treatment due to health complications.

Measure Source

Inclusion of this measure supported by alignment with external healthcare measurement entities, including NQF #0006, and is considered as reward for improvement, due to bias from varying patient populations.

Data Source

- Quantitative and qualitative data collected directly from patients by the participant or participant's vendor.

Deliverables and Scoring

Deliverable	Due Date	Scoring
Deliverable A: Submit template with: • Survey name (and version if applicable) • Specialty care access question • Specialty care access question score	Quarter 3	**1.0** point for submitting survey name (and, if applicable, version). **1.0** point for submitting specialty care access survey question. **1.0** point for submitting specialist access survey response score.
Deliverable B: Submit template with: • An analysis of themes found in qualitative data • Plan to improve results, based on qualitative data	Quarter 3	**1.0** point for reporting an analysis of themes found in qualitative data. **1.0** point for a reporting a plan to improve results, based on qualitative data.

SI 1: Depression Screening and Follow-up

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Part B: Follow-up Data Assessment was added.

Measure Description

Participants will receive points for reporting the rate of patients receiving depression screening and creating a system/clinic-wide protocol with pathways for each appropriate follow-up to a positive screening, as described below.

Part A: Rate of patients receiving depression screening

$$\textbf{Depression Screening Rate} = \frac{\textbf{Numerator:}\ \text{Total number of patients in the denominator with a depression screening in the measurement year.}}{\textbf{Denominator}:\ \text{Total number of active patients at least 12 years of age during the measurement year.}}$$

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

Part B: Follow-up Data Assessment
Participants will submit template describing how follow-up to a positive screening data is captured.

Measure Rationale

Screening for depression is an important first step in increasing behavioral health utilization, which is low for SFHP members. In addition, depression has a large effect on health care costs and on productivity. It is estimated that monthly depression-related worker productivity losses had human capital costs of nearly $2 billion while adults with depression or depressive symptoms have significantly higher health care costs, even after adjusting for chronic medical conditions (Katon et al., 2003). Inclusion of this measure supports early detection with potential for cost savings from treatments associated to health complications from depression. 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[2], PQRS, PRIME, and UDS.

Definitions

Appropriate Follow-up to a positive screening, on or within 30 days of screen includes:

1. **Additional evaluation for depression**
    - Follow-up with a case manager, with documented assessment of depression symptoms.
    - Telephone visit with diagnosis of depression or other behavioral health condition.
    - Assessment on the same-day as the positive screen, including additional depression assessment indicating no depression or no symptoms that require follow-up.

    OR
2. **Referral to a practitioner who is qualified to diagnose and treat depression**

- Follow-up behavioral health encounter, including assessment, therapy, collaborative care, medication management, acute care, and telehealth encounters.
- Follow-up outpatient visit, with a diagnosis of depression or other behavioral health condition.

OR

3. **Pharmacological Intervention**
   - Dispensed anti-depressant medication

Data Source

- Self-reported by participant.

Resources

- See PIP website for resources including a list of common and vetted depression screening tools for both adolescents and adults.

Deliverables and Due Dates

Deliverable	Due Dates	PIP Network Threshold	Quarterly Scoring
Deliverable A: Self-report the numerator and denominator as noted in the Measure Description.	• **Quarter1** • **Quarter 2** • **Quarter 3** • **Quarter 4** • **Quarter 5** • **Quarter 6**	**75th Percentile** 76.38%	1.0 point
		60th Percentile 52.22%	0.5 point
Deliverable B: Submit template specifying how follow-up to a positive screening data is collected	• **Quarter 2**	N/A	1.0 points

SI 2: Follow-Up Visit After Hospital Discharge

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Numerator definition was updated to support clinical best practice that a follow-up visit post discharge should not occur on the same-day as discharge. This change aligns with similar measures administered by external entities.

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 1-7 calendar days post discharge / **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). In addition, timely follow-up after hospital discharge can reduce unplanned readmissions and the associated health care costs (Boutwell, et al., 2009). 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 2018 as determined by SFHP are exempt from this measure for the 2018 program year.

Data Source

- Self-reported by participant.

Deliverables and Scoring

Deliverable	Due Date	Threshold	Scoring
Submit quarterly numerator and denominator as noted above via quantitative data template.	• **Quarter 1** • **Quarter 2** • **Quarter 3** • **Quarter 4** • **Quarter 5** • **Quarter 6**	50%	1.0 point
		40%	0.5 point

SI 3: Opioid Safety

2019 Practice Improvement Program Measure Specification

COMMUNITY CLINIC, CLINIC-BASED RBO, & ACADEMIC MEDICAL CENTER ONLY

Changes from 2018

No changes.

Measure Description

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

Quarterly Opioid Safety Rate =

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 (https://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. In addition, it is estimated that the financial toll of opioid overuse, including direct health care costs, lost productivity, and costs to the criminal justice system totals $78.5 billion. 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 and 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! However, 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. By supporting best practices for opioid prescribing, there is potential to reduce costs to the health care system associated to the opioid epidemic.

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

Deliverable	Due Date	Thresholds	Quarterly Scoring
Deliverable A: Self-report the numerator and denominator as noted in the Measure Description, via quantitative template.	• **Quarter 1** • **Quarter 2** • **Quarter 3** • **Quarter 4** • **Quarter 5** • **Quarter 6**	≥ 60% 50-59% 49% or less	**0.5 point** **0.25 point** **0 point**
Deliverable B: 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.	• **Quarter 1** • **Quarter 2** • **Quarter 3** • **Quarter 4** • **Quarter 5** • **Quarter 6**		**0.1 point/member, up to 0.5 point,** will be awarded for submitting (via secure email)[4] the completed template listing the 5 SFHP members reviewed by the Controlled Substance Review Committee to PainManagement@sfhp.org.

Definitions

Chronic Opioid Treatment for Non-Cancer Pain: Patients who are prescribed 20mg or more morphine equivalents per day for at least 72 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

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

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) any 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 on 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

SI 4: Providers Open to New Members

2019 Practice Improvement Program Measure Specification

IPAs ONLY

Changes from 2018

No changes.

Measure Description

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

$$\textbf{Quarterly Rate of Providers Open to New Members} = \frac{\textbf{Numerator:} \text{ PCPs in the denominator open to new members } \textbf{and} \text{ to auto-assigned members. Auto-assigned members are new members who do not choose a Primary Care Provider on enrollment with SFHP.}}{\textbf{Denominator}: \text{ Total number of PCPs affiliated with SFHP as of the last week of the Quarter.}}$$

Measure Rationale

Provider accessibility is a key requirement for primary health care (Access to Health Services, 2013). Since Medi-Cal expansion in 2014, it has become increasingly important that the influx of new members have adequate choice and access to providers. The purpose of this measure is to increase the percentage of PCPs accepting new members. This measure can help curb healthcare costs by increasing opportunity for new members to establish strong preventive health practices.

Measure Source

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

Data Source

Provider data submitted to SFHP by medical groups.

Deliverables and Due Dates

Deliverable	Due Date	Relative Improvement	Threshold	Quarterly Scoring
No deliverables required for this measure.	• **Quarter 1** • **Quarter 2** • **Quarter 3** • **Quarter 4** • **Quarter 5** • **Quarter 6**	≥ 15%	80% or more	**2.0** points
		10-14%	70-79%	**1.5** points
		5-9%	60-69%	**1.0** point

SI 5: Percent of Members with a Primary Care Visit

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018
No changes.

Measure Description
This measure uses SFHP claims/encounter data to determine the percentage of SFHP Medi-Cal members assigned to your organization with at least one primary care visit in the last year. Participants will earn points for improvement of the primary care visit rate.

$$\textbf{Quarterly Primary Care Visit Rate} = \frac{\textbf{Numerator}: \text{Number of SFHP members in the denominator population with at least one PCP visit in the last year}}{\textbf{Denominator:} \text{ Total number of continuously enrolled SFHP Medi-Cal members assigned to your organization during the quarter.}}$$

Measure Rationale
Establishing routine PCP visits can identify and treat health conditions early, potentially reducing health care costs from treatment due to health complications. SFHP has found overall primary care utilization is low among its members and disparities exist between medical groups. There is room for improvement across the network. This measure supports appropriate outreach to members who would most benefit from routine primary care visits.

Outreach may be conducted in various ways. SFHP recommends participants consider member age and visit history when identifying the appropriate outreach population. Upon request SFHP can provide your organization with a list of assigned members who had an ED visit but no primary care visit in 2018.

Measure Source
Inclusion of this measure is supported by alignment with the SFHP fiscal year 17/18 organizational goal.

Definitions
- Primary Care Provider (PCP): Rendering provider identified as a PCP according to SFHP provider data.
- PCP Visit: A PCP visit occurs when a member receives primary care services. Beyond a member's assigned PCP, this includes visits by other PCPs and urgent care providers.

Data Source
- SFHP claims/encounter data.

Deliverable Schedule

SFHP will send participants PCP visit rate.

Deliverable	Due Date	Scoring
Deliverable A: Receive PCP visit rate. No submission required.	SFHP to provide in: Quarter 1, Quarter 2, Quarter 3, Quarter 4, Quarter 5, Quarter 6	*To be scored Q4.* **1.0 points** for achieving 5% or more absolute improvement over baseline* or achieving SFHP average PCP visit rate. **0.5 points** for achieving 3% absolute improvement over baseline.* **0.25 points** for achieving 1% absolute improvement over baseline.*
Deliverable B: Submit improvement plan template (for participants not meeting SFHP average PC visit rate in Q1 2019)	Quarter 2	**1.0 points**
^ Due to two extra quarters in the 2019 program, the PIP team will work with the advisory committee and participants to determine appropriate timing. **Baseline will be determined by Q4 2019 PCP visit rate*		

SI 6: Palliative Care

2019 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2018

- Develop palliative care referral processes for an eligible population not included in your 2018 PIP activities: COPD or CHF.
- *If COPD and CHF were both chosen as the eligible population of focus in 2018, please choose another disease-specific eligible population for identification and review, per Medi-Cal guidelines, see definitions below.

Measure Description

Participants will receive points for identifying the palliative care resources available within their network and building capacity to identify members who may be eligible for referral to palliative care services.

Part A (All Participants): Identify members who may be eligible for referral to palliative care services by completing the following:

- Identify patients who are potentially eligible for palliative care by using an SFHP list of members who are potentially eligible for palliative care, or creating your own list of potentially eligible patients.

- For potentially eligible members:
  - Complete chart review to determine eligibility for referral to palliative care services as defined by DHCS' minimum eligibility criteria (see Appendix D).
  - For patients found eligible, make appropriate referrals to care

- Attestation by medical director (or equivalent) verifying chart review of members eligible for palliative care and appropriate referrals were made.

Measure Rationale

Palliative care is specialized medical care for people with terminal diagnoses or serious illness, focused on providing relief from the symptoms and stress of serious illness and improving quality of life for both patients and families. For SFHP members close to end-of-life, palliative care can deliver care that is important to patients and often lacking from traditional medical services. Palliative care services help assess patients' and families' goals of care and match treatments to goals. Subsequently, potential cost savings may be associated to a reduction of mismatch between medical treatments and patient preferences.

Measure Source

Inclusion of this measure supports the new palliative care benefit for SFHP members and is supported by alignment with external healthcare entities, including the Department of Managed Health Care regulations.

Data Source

- Self-reported by participant.
- Upon request, SFHP will provide participant with a list of their assigned SFHP members diagnosed with COPD or CHF.

Resources

See PIP website for resources for COPD and CHF diagnosis codes and DHCS Palliative Care Eligibility Criteria.

Exclusions

- Participants with fewer than 30 SFHP members diagnosed with COPD and CHF are exempt from this measure for the 2019 program year, as determined by SFHP's palliative care member roster run January 2019.

Deliverable Schedule

Deliverable	Due Date	Scoring
Deliverable A: Submit attestation signed by a medical director (or equivalent), verifying that chart review was performed for patients with COPD or CHF potentially eligible for palliative care and appropriate referrals were made.	Quarter 4	4.0 points
Additional Deliverable(s) TBD: Due to two extra quarters in the 2019 program, the PIP team will work with the advisory committee and participants to determine additional improvement activities and timing.	TBD	TBD

Definitions

If COPD and CHF were chosen as the focus in 2018, then one of the two other groups below must be the focus in 2019:

- Advanced Cancer: Must meet (a) and (b)

a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia
b. The member has a Karnofsky Performance Scale score less than or equal to 70 or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

- Liver Disease: Must meet (a) and (b) combined or (c) alone

a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, and international normalized ratio greater than 1.3
b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices
c. The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score greater than 19.

Section VIII: Appendix

Appendix A: DQ 1 Sample Report

SFHP-produced, participant to update

Clinic A Provider Roster

EXAMPLE

First and Last Name *(legal with preferred in parenthesis)*	Medical Degree	Type of Practitioner *(PCP or Specialist)*	Primary Specialty	Secondary Specialties *(if applicable)*	Language(s)	License Number	Email Address	Name of MD/DO Supervisor *(For NPs, PAs, CNMs only)*	Site Name	Language(s) Spoken At Site	Hours & Days Site is Open	Date listed with SFHP	Date terminated/left the organization *(if applicable)*	Open to new members (Y/N) *(For non-SFHN PCPs only)*	Open to Auto Assignment (Y/N) *(For non-SFHN PCPs only)*
ARROYO, ABIGAIL (ABBY)	MD	PCP	PEDIATRICS	ADOLESCENT MEDICINE	ARABIC, ENGLISH, SPANISH	XXXXXXX	a.arroyo@clinica.org		CLINIC A	ARABIC, CANTONESE, ENGLISH, MANDARIN, PORTUGEUSE, RUSSIAN, SPANISH	M-F 8AM-5PM, SAT 9AM-3PM	7/8/2011		Y	Y
OLIVERA, BLAKE	NP	SPECIALIST	PSYCHIATRY	PEDIATRIC MEDICINE	ENGLISH, PORTUGEUSE	XXXXXXX	b.olivera@clinica.org	ABIGAIL ARROYO	CLINIC A	ARABIC, CANTONESE, ENGLISH, MANDARIN, PORTUGEUSE, RUSSIAN, SPANISH	M-F 8AM-5PM, SAT 9AM-3PM	5/13/2009			

SAN FRANCISCO HEALTH PLAN

Practice Improvement Program
Partnering to prepare for the future

Appendix B: Measure Set by Participant-Type Grid

NOTE: An "X" indicates the measure is included in the participant-type's measure set.

Measure	Community Clinic	Clinic-Based RBO	IPA	Academic Medical Center
Clinical Quality Domain				
CQ01 Diabetes HbA1c Test	X	X	X	X
CQ02 Diabetes HbA1c <8 (Good Control)	X	X	X	X
CQ03 Diabetes Eye Exam	X	X	X	X
CQ04 Routine Cervical Cancer Screening	X	X	X	X
CQ05 Routine Colorectal Cancer Screening	X	X		
CQ06 Labs for Patients on Persistent Medications	X	X	X	X
CQ07 Smoking Cessation Intervention Documented	X	X		
CQ08 Controlling High Blood Pressure (Hypertension)	X	X	X	X
CQ09 Adolescent Immunizations	X	X	X	X
CQ10 Childhood Immunizations	X	X	X	X
CQ11 Well Child Visits for Children 3-6 Years of Age	X	X	X	X
CQ12 Chlamydia Screening	X	X	X	X
CQ13 Timely access to Prenatal Care		X	X	
CQ14 Postpartum Care		X	X	
CQ15 Asthma Medication Ratio		X	X	
Data Quality Domain				
DQ1 Provider Roster Updates			X	X
Patient Experience Domain				
PE1 Third Next Available Appointment (TNAA)	X	X		
PE2 Office Visit Cycle Time	X	X		X
PE3 Staff Satisfaction Improvement Strategies	X	X		X
PE4 Improvement in Patient Experience of Primary Care Access (CG-CAHPS)	X	X	X	X
PE5 Appointment Availability Survey Compliance (Primary Care)			X	X
PE6 Improvement in Specialty Access (HP-CAHPS)		X	X	
Systems Improvement Domain				
SI1 Depression Screening and Follow-up	X	X	X	X
SI2 Follow-Up Visit After Hospital Discharge	X	X	X	X
SI3 Opioid Safety	X	X		X
SI4 Providers Open to New Members			X	
SI5 Percent of Members with a Primary Care Visit	X	X	X	X
SI6 Palliative Care	X	X	X	X

Appendix C: CG-CAHPS Composite Questions

Composite	Question	Response Options
Access to Care	In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that needed care right away?	Yes/No If no, the respondent skips to next question in the composite
	In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?	Never Sometimes Usually Always
	In the last 6 months, did you make any appointments for a check-up or routine care with this provider?	Yes/No If no, the respondent skips to next question in the composite
	In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?	Never Sometimes Usually Always
	In the last 6 months, did you contact this provider's office with a medical question during regular office hours?	Yes/No If no, the respondent skips to next question in the composite
	In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?	Never Sometimes Usually Always
Customer Service (reporting-only)	In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?	Never Sometimes Usually Always
	In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?	Never Sometimes Usually Always
How Well Providers Communicate with Patients (reporting-only)	In the last 6 months, how often did this provider explain things in a way that was easy to understand?	Never Sometimes Usually Always
	In the last 6 months, how often did this provider listen carefully to you?	Never Sometimes Usually Always
	In the last 6 months, how often did this provider show respect for what you had to say?	Never Sometimes Usually Always
	In the last 6 months, how often did this provider spend enough time with you?	Never Sometimes Usually Always

Appendix D: Palliative Care Diagnosis Codes and DHCS Eligibility Criteria

Diagnosis codes used to identify patients with CHF and COPD (source: Partnership Health Plan)

Class	Diagnosis	ICD9	ICD10
CHF	Cardiomyopathy	425	I50.1 - I50.9
	Heart Failure	428	I11.0, I13.0, I13.2
COPD	Asbestosis	501	J61
	Bronchiectasis	494	J47
	Chronic bronchitis	491	J41, J42,
	COPD	496	J44.0, J44.1, J44.9
	Emphysema	492	J43.1, J43.2, J43.9

SB 1004 Palliative Care Eligibility Criteria for Patients with CHF or COPD (Source: DHCS APL)

DHCS' minimum eligibility criteria requires a beneficiary to meet all requirements for the general eligibility criteria and at least one of the four disease-specific eligibility requirements.

A. General Eligibility Criteria:

1. The beneficiary is likely to or has started to use the hospital or emergency department as a means to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
2. The beneficiary has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The beneficiary's death within a year would not be unexpected based on clinical status.
4. The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.
5. The beneficiary and, if applicable, the family/patient-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and
    b. Participate in Advance Care Planning discussions.

B. Disease-Specific Eligibility Criteria:

1. Congestive Heart Failure (CHF): Must meet (a) and (b)

   a. The beneficiary is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher[5]; AND
   b. The beneficiary has an Ejection Fraction of less than 30 percent for systolic failure OR significant co-morbidities.
2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
   a. The Beneficiary has a Forced Expiratory Volume (FEV)1 less than 35 percent of predicted AND a 24-hour oxygen requirement of less than three liters per minute; OR
   b. The beneficiary has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

If a beneficiary continues to meet the above minimum eligibility criteria, he or she may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death. Medi-Cal managed health plans (MCPs) should periodically assess the beneficiary for changes in his/her condition or palliative care needs. MCPs may discontinue palliative care that is no longer medically necessary or reasonable.

[5] NYHA classifications are available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-HeartFailure_UCM_306328_Article.jsp#.WefN7rpFxxo

Appendix E: Templates

2019 PIP Clinical Quality Disparities Improvement Template

Quarter 6

(Due: 7/31/2020)

Develop a disparities reduction plan and implement activities for any disparity findings/trends in your 2017 or 2018 PIP disparities analysis.

Complete the table below and resize table as needed:

Which measure and demographic variables did you select for disparities analysis?	
Briefly summarize the disparity findings you will address.	
What is the goal for your disparities reduction plan?	
Provide a high-level timeline of planned activities	
Summarize the activities implemented and results.	

PE 3: Staff Satisfaction Improvement Strategies

Quarter 1 Template

(Due: April 30, 2019)

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1. Staff Satisfaction Survey Measurement Information:

Baseline Score: *If survey has multiple questions, only one score may be chosen.*	
Survey Type: *e.g. Gallup, Net Promoter*	
Date of Survey:	
Survey Question: *For participants using Net Promoter survey, chosen question must be "How likely are you to recommend organization as a place to work?"*	
Response Rate:	Numerator:
	Denominator:

2. Please list 1-2 priority areas identified for improvement:

PE 3: Staff Satisfaction Improvement Strategies

Quarter 3 Template

(Due: October 31, 2019)

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1. Please fill out the table below describing the activities implemented to improve your staff satisfaction score. Feel free to add additional rows/columns as needed.

Improvement Activity	Relationship to Staff Satisfaction	Staff Responsible	Date Implemented

2. Staff Satisfaction Survey Re-measurement Information:

Survey Type: *must be same as baseline*	
Date of Survey:	
Survey Question: *must be same as baseline*	
Response Rate:	Numerator:
	Denominator:

PE 4: Improvement in Patient Experience of Primary Care Access

Quarter 2 Template

(Due: July 31, 2019)

- **Step One: Identify baseline (Access to Care Composite only)**

#	Questions asked	# Responses	Question Score
1.			
2.			
3.			

Baseline Score: *Access Composite Score (average of each question's scores):* _____

Population Represented: (check one)

Adults		*Children*		*Both*	

- **Step Two: Data Collection Methodology (For all composites)**
  Please fill out the table below describing your survey methodology. 2019 surveys should now include questions from all three composites (see Appendix C for details):

Survey Type: *e.g. CG-CAHPS or other* *(If other, please specify)*	
Date of Survey:	
Sampling Methodology:	
Response Rate:	Numerator (*total number of respondents)*: Denominator (*total number of patients who survey was sent to*):
Third-Party Responsible for Conducting and Analyzing Survey:	
Which populations (if any) were included outside of Medi-Cal? *e.g. children or adults*	

If CG-CAHPS was used, which version was used?	
Do you plan to make changes to any of the methodology described above?	

- **Step Three: Analysis of Themes Found in Qualitative Data**
  Please fill out the table below detailing the themes found in your qualitative data. Please add rows/columns as needed.

Theme Identified	Data analysis that supports this theme
Theme 1:	
Theme 2:	

- **Step Four: Improvement Plan**
  Please submit plan for improving the patient experience of access**.** Please note regardless of your improvement plan focus, the score upon which you will be measured is the overall Access Composite score.

Root cause of performance	Proposed improvement activities	Date to be completed
• ***Example****: Long wait times-phone*	• ***Example****:* ○ *Create a new phone tree* ○ *Flex staff schedules* ○ *Collect data on phone demand*	• ***Example****: October 1st, 2019*

Focus: Improvement plan is targeting (please check one):

☐ The entire organization (recommended)
☐ Specific sites (please indicate which sites) _____

PE 4: Deliverable B

PE 4: Improvement in Patient Experience of Primary Care Access

Quarter 4 Template

(Due: January 31, 2020)

---

1. Improvement Plan

Please fill out the table below describing the activities implemented to improve patient experience of access. Feel free to add additional rows/columns as needed.

Improvement Activity	How Activity is Related to Patient Experience of Access	Staff Responsible	Date Implemented

2. Re-measurement Data Collection Methodology

Please fill out the table below describing your survey methodology for re-measurement:

Survey Type: *e.g. CG-CAHPS or other* *(If other, please specify)*	
Date of Survey:	
Sampling Methodology:	
Response Rate:	Numerator (*total number of respondents)*:

	Denominator (*total number of patients who survey was sent to*):
Third-Party Responsible for Conducting and Analyzing Survey:	
Which populations (if any) were included outside of Medi-Cal? *e.g. children or adults*	
If CG-CAHPS was used, which version was used?	
Do you plan to make changes to any of the methodology described above?	

PE 6: Improvement in Specialty Access
Quarter 4 Template
(Due: January 31, 2020)

Step One: Identify your baseline:

Score for HP-CAHPS specialist access question as reported by SFHP: _____

HP-CAHPS specialist access question asks members the following:

In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

Step Two: Analysis of Themes Found in Qualitative Data

Please fill out the table below detailing the themes found in your qualitative data. Please add rows/columns as needed.

Themes Identified	Data analysis that supports this theme
Theme 1:	
Theme 2:	

Step Three: Improvement Plan

Based on the findings from the analysis, please submit an improvement plan for the HP-CAHPS specialist access question score**.**

Root cause of performance	Proposed improvement activities	Date to be completed
• **Example**: Not enough cardiologists open to SFHP members	• **Example**: ○ Conduct focus group to determine barriers for recruitment and retention ○ Create program to recruit	• **Example**: December 1st, 2016

	and retain cardiologists open to SFHP members	

Focus: Improvement plan is targeting (please check one):

	The entire group (recommended)
	Specific sites (please indicate which sites) _____

SI 3: Opioid Safety

Due: Quarterly

Number	Member Name	Date of Birth	SFHP ID #	Run Date of CURES Reviewed by Committee (must be within 1 month of review)	Date Reviewed	Reason Reviewed	Brief Recommendations
1							
2							
3							
4							
5							

Note: If patient is not covered by SFHP or HSF, then do not give name or ID # information in order to be HIPPA compliant. Also please securely email this list to PainManagement@sfhp.org. If unable to send secure email, send an email to that address to initiate secure email exchange.

SI 5: Percent of Members with a Primary Care Visit

Quarter 2 Template

(Due: July 31, 2019)

Improvement Plan

Please submit an improvement plan detailing the activities that will be implemented to improve the Quarterly Primary Care Visit Rate. (Please add rows as needed.)

Proposed improvement activities	Staff Responsible	Date to be completed
1.		
2.		

SI 6: Palliative Care

Quarter 4 Template

(Due: January 31, 2020)

Attestation

Please have your Medical Director (or equivalent) sign below verifying chart review of members with COPD eligible for palliative care and appropriate referrals were made.

PIP Participant Name:	
(if applicable) Site(s) Chosen:	
Medical/Executive Director Name (print):	
Medical/Executive Director Signature:	
Date:	