2022-2023 Practice Improvement Program (PIP) Orientation

San Francisco Health Plan

Practice Improvement Program (PIP)

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PIP
Practice Improvement Program
Partnering to prepare for the future

Agenda

ITEM
➢ Welcome ➢ Meeting Objectives and Agenda ➢ Introductions
➢ Program Overview
➢ Review Changes in 2022-23 PIP ➢ Program Changes ➢ Clinical Quality Domain ➢ Data Quality Domain ➢ Patient Experience Domain ➢ Systems Improvement Domain
➢ Measures with no changes in 2022-23

Housekeeping

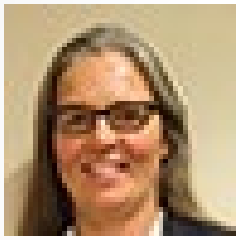
- Slides are attached to meeting invite
- Ask questions throughout and at Q&A
- No question is silly
- Please keep phones on mute unless you would like to ask a question

Introductions

- Name
- Organization

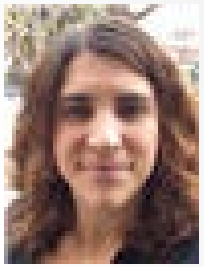
Program Overview

Practice Improvement Program (PIP) Leadership Team



Fiona Donald,
Chief Medical Officer

Hanan Obeidi
Vice President, Health Services Programs



Elizabeth Sekera
Manager, Population Health

Claire Hankins
Program Manager, Population Health

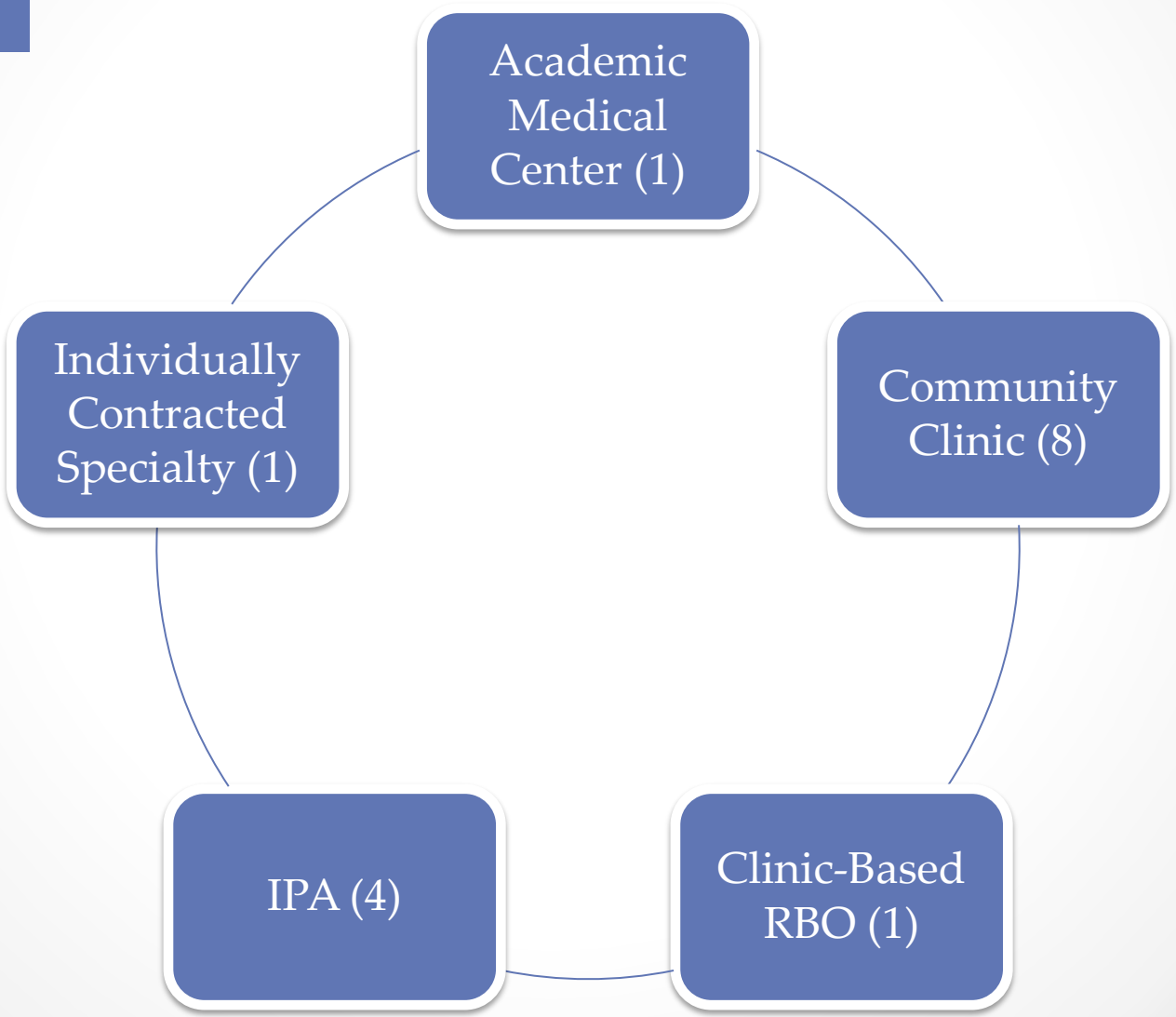
Susan Saleh
Specialist, Population Health

What is PIP?

Incentive program for SFHP Medi-Cal clinics and medical groups to achieve improvements in system and health outcomes.

Standardized

PIP Participant Types



PIP Reporting Timeline

Quarter	Quarter End Date	Materials Due to SFHP	Lookback Period
1	September 30, 2022	Monday, October 31, 2022	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.
2	December 31, 2022	Tuesday, January 31, 2023	
3	March 31, 2023	Friday, April 28, 2023	
4	June 30, 2023	Monday, July 31, 2023	

PIP Incentives

Maximum quarterly payments are allocated based on capitation and actual member months accrued during each month of the quarter.

- 20% of Medi-Cal capitation

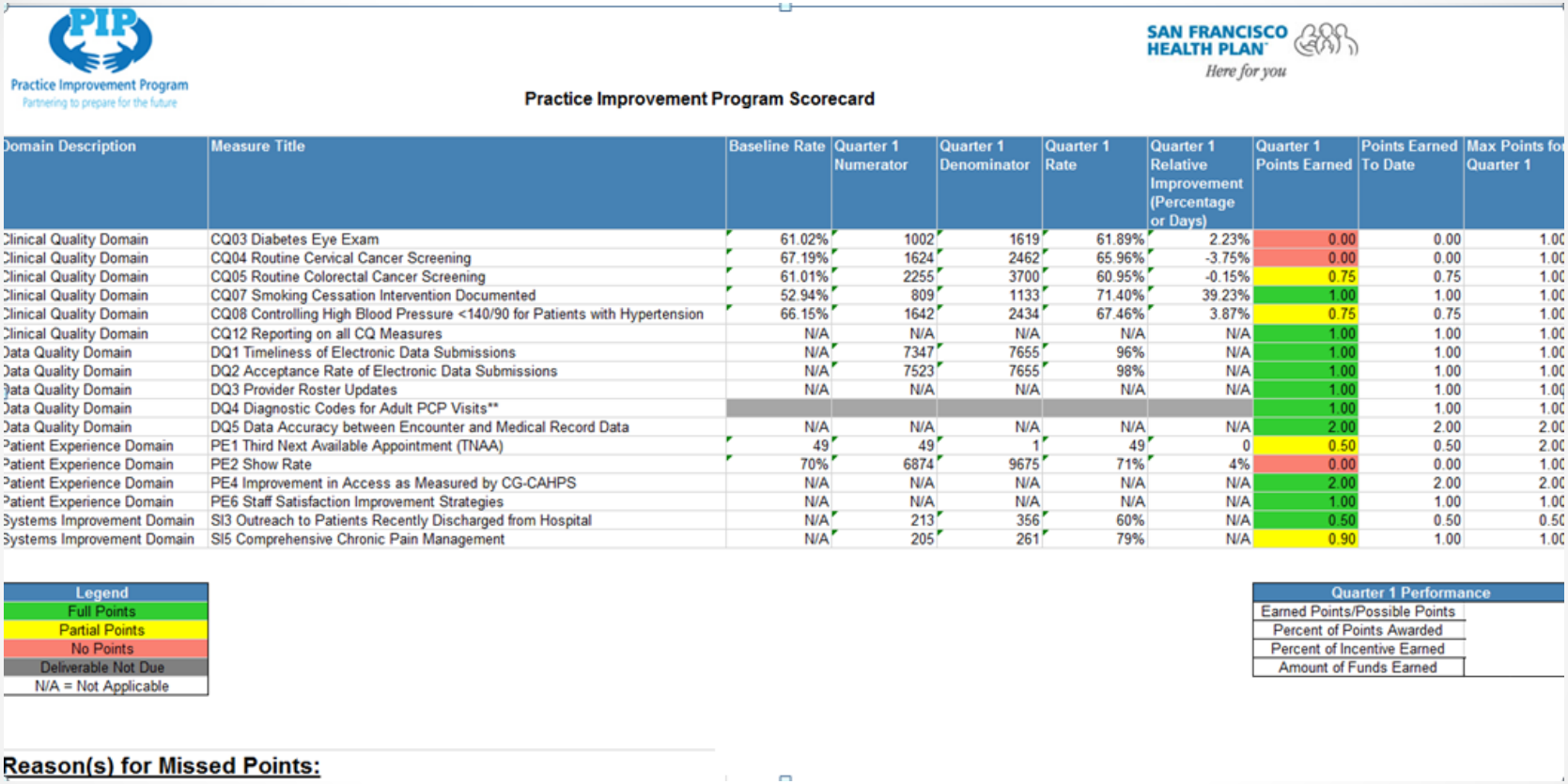
PIP Payment Methodology

- 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
- < 20% of points = no payment

Clinical Quality Domain: *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

Scorecard Review



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Practice Improvement Program Scorecard

Domain Description	Measure Title	Baseline Rate	Quarter 1 Numerator	Quarter 1 Denominator	Quarter 1 Rate	Quarter 1 Relative Improvement (Percentage or Days)	Quarter 1 Points Earned	Points Earned To Date	Max Points for Quarter 1
Clinical Quality Domain	CQ03 Diabetes Eye Exam	61.02%	1002	1619	61.89%	2.23%	0.00	0.00	1.00
Clinical Quality Domain	CQ04 Routine Cervical Cancer Screening	67.19%	1624	2462	65.96%	-3.75%	0.00	0.00	1.00
Clinical Quality Domain	CQ05 Routine Colorectal Cancer Screening	61.01%	2255	3700	60.95%	-0.15%	0.75	0.75	1.00
Clinical Quality Domain	CQ07 Smoking Cessation Intervention Documented	52.94%	809	1133	71.40%	39.23%	1.00	1.00	1.00
Clinical Quality Domain	CQ08 Controlling High Blood Pressure <140/90 for Patients with Hypertension	66.15%	1642	2434	67.46%	3.87%	0.75	0.75	1.00
Clinical Quality Domain	CQ12 Reporting on all CQ Measures	N/A	N/A	N/A	N/A	N/A	1.00	1.00	1.00
Data Quality Domain	DQ1 Timeliness of Electronic Data Submissions	N/A	7347	7655	96%	N/A	1.00	1.00	1.00
Data Quality Domain	DQ2 Acceptance Rate of Electronic Data Submissions	N/A	7523	7655	98%	N/A	1.00	1.00	1.00
Data Quality Domain	DQ3 Provider Roster Updates	N/A	N/A	N/A	N/A	N/A	1.00	1.00	1.00
Data Quality Domain	DQ4 Diagnostic Codes for Adult PCP Visits**						1.00	1.00	1.00
Data Quality Domain	DQ5 Data Accuracy between Encounter and Medical Record Data	N/A	N/A	N/A	N/A	N/A	2.00	2.00	2.00
Patient Experience Domain	PE1 Third Next Available Appointment (TNAA)	49	49	1	49	0	0.50	0.50	2.00
Patient Experience Domain	PE2 Show Rate	70%	6874	9675	71%	4%	0.00	0.00	1.00
Patient Experience Domain	PE4 Improvement in Access as Measured by CG-CAHPS	N/A	N/A	N/A	N/A	N/A	2.00	2.00	2.00
Patient Experience Domain	PE6 Staff Satisfaction Improvement Strategies	N/A	N/A	N/A	N/A	N/A	1.00	1.00	1.00
Systems Improvement Domain	SI3 Outreach to Patients Recently Discharged from Hospital	N/A	213	356	60%	N/A	0.50	0.50	0.50
Systems Improvement Domain	SI5 Comprehensive Chronic Pain Management	N/A	205	261	79%	N/A	0.90	1.00	1.00

Legend
Full Points
Partial Points
No Points
Deliverable Not Due
N/A = Not Applicable

Quarter 1 Performance	
Earned Points/Possible Points	
Percent of Points Awarded	
Percent of Incentive Earned	
Amount of Funds Earned	

Reason(s) for Missed Points:

Technical Assistance

PIP Website

http://www.sfhp.org/providers/practice-improvement-program-pip/

All 2022-23 measure resources will be available here

General Updates

- Continue with condensed measure set
- Quality Improvement Projects will continue to be an option in 22-23

2022-23 Measure Set

Clinical Quality Domain

CQ02	Diabetes HbA1c <8 (Good Control)	HEDIS
CQ04	Routine Cervical Cancer Screening	HEDIS
CQ05	Routine Colorectal Cancer Screening	
CQ06	Breast Cancer Screening	HEDIS
CQ08	Controlling High Blood Pressure (Hypertension)	HEDIS
CQ09	Adolescent Immunizations	HEDIS
CQ10	Childhood Immunizations	HEDIS
CQ11	Child and Adolescent Well-Care Visits	HEDIS
CQ12	Chlamydia Screening	HEDIS
CQ16	Well Child Visits in the First 15-Months of Life	HEDIS
CQ17	Well Child Visits in Children 15-30 Months of Age	HEDIS

CQ02 Diabetes HbA1c <8 (Good Control)

Measure	Numerator
CQ 02: Diabetes HbA1c <8 (Good Control)	**Numerator**: Number of patients in denominator whose most recent HbA1c level is < 8.0 in the last 12 months **Denominator**: Number of active patients with diabetes ages 18-75 years old

CQ04-CQ05: Cancer Screening

Measure	Numerator/Denominator
CQ04: Routine Cervical Cancer Screening	**Numerator:** Number of patients with cervices ages 24-64 who received one or more Pap tests during the past 3 years **OR** patients with cervices ages 30-64 who received cervical cytology and HPV co-testing during the past 5 years
	Denominator: Number of active patients with cervices ages 24-64 years old
CQ05: Routine 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
	Denominator: Number of active patients ages 51 - 75 years old
CQ06: Breast Cancer Screening	**Numerator:** Number of patients in denominator population who received a mammogram within the past 24 months
	Denominator: Number of active patients ages 52 - 75 years old

CQ08 Controlling High Blood Pressure (Hypertension)

Measure	Numerator/Denominator
CQ 08: Controlling High Blood Pressure	**Numerator:** 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.
	Denominator: Number of active patients with hypertension ages 18-85 years old

CQ09: Adolescent Immunizations

Measure	Numerator/Denominator
CQ09: Adolescent Immunizations	**Numerator:** Number of patients in the denominator population who received one meningococcal vaccine on or between the member's 11th and 13th birthday and one (Tdap) or (Td) vaccine on or between the member's 10th and 13th birthdays, and two HPV vaccines between the member's 9th and 13th birthday.
	Denominator: Number of active patients who turned 13 years old during the last year

CQ10 Childhood Immunizations

CQ 10: Childhood Immunizations

2021 - 2022 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2020

Added hepatitis A, rotavirus, and influenza vaccines to numerator.

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); four pneumococcal conjugate (PCV); one hepatitis A; two or three dose rotavirus; and two influenza 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)
- four pneumococcal conjugate (PCV)
- one hepatitis A (HepA)
- two two-dose **or** three three-dose rotavirus (RV); and
- two influenza

Denominator: Number of active patients who turned 2 years old during the last year

CQ11 Child and Adolescent Well-Care Visits

CQ 11: Child and Adolescent Well-Care Visits

2021 - 2022 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points on the rate of patients 3-21 years of age who had one or more Well-Care Visits with a PCP or an OB/GYN practitioner during the measurement year. The PCP does not have to be the practitioner assigned to the child.

$$\textbf{Well Care Visits} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who had at least one well-care visit with a PCP or an OB/GYN practitioner during the past year.}}{\textbf{Denominator:}\ \text{Number of active patients 3-21 years old}}$$

CQ12: Chlamydia Screening

Measure	Numerator/Denominator
CQ14: Chlamydia Screening	**Numerator:** Number of patients in the denominator population with at least one test for chlamydia in the last year
	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

CQ16 Well Child Visits in the First 15-Months of Life

CQ 16: Well Child Visits in the First 15 Months of Life

2021-2022 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the reporting of the rate of children 15 months of age who had six 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.

$$\textbf{Well Child Visits} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who had at least six well-child visits before the child's 15-month birthday.}}{\textbf{Denominator:}\ \text{Number of active patients who turned 15 months old during the last year}}$$

CQ17 Well Child Visits in Children 15-30 Months of Age

CQ 17: Well Child Visits in 15-30 Months

2021-2022 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Measure Description

Participants will receive points for the reporting of the rate of children 30 months of age who had two 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.

$$\textbf{Well Child Visits} = \frac{\textbf{Numerator:}\ \text{Number of patients in the denominator population who had at least two well-child visits between the child's 15-month plus 1 day and 30-month birthday.}}{\textbf{Denominator:}\ \text{Number of active patients who turned 30 months old during the last year}}$$

Data Quality Domain

DQ1	Provider Roster Updates

DQ1: Provider Roster Updates

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 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
	• Quarter 2
	• Quarter 4
		2.0 points

Systems Improvement Domain

SI1	Depression Screening and Follow-up
SI2	Follow-Up After Hospital Discharge
SI3	Opioid Safety
SI5	Percent of Members with a Primary Care Visit

SI1: Depression Screening and Follow-up

SI 1: Depression Screening and Follow-up

2021 - 2022 Practice Improvement Program Measure Specification

ALL PARTICIPANTS

Changes from 2020

Updated scoring methodology to reflect pay-for-performance.

Measure Description

Participants will receive points for reporting the rate of patients receiving depression screening and a follow-up to a positive screening, as described below.

$$\text{Depression Screening Rate} = \frac{\text{Numerator: Total number of patients with a negative depression screening AND total number of patients with a positive depression screening and documented follow-up plan during the measurement year}}{\text{Denominator: Total number of active patients at least 12 years of age during the measurement year.}}$$

Deliverables and Due Dates

Deliverable	Due Dates	PIP Network Threshold	Relative Improvement	Quarterly Scoring
Self-report the numerator and denominator as noted in the Measure Description, via the quantitative template.	• **Quarter1** • **Quarter 2** • **Quarter 3** • **Quarter 4**	75th Percentile 66.33%	10% or more	1.0 point
		60th Percentile 57.27%	5-9%	0.5 points

Systems Improvement Measures

Measure	Numerator/Denominator
SI2: Follow-Up Visit After Hospital Discharge	**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
SI3: Opioid Safety	**Deliverable a:** **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: Number of active patients ages 51 - 75 years old
	Deliverable b: Submit template with the names of 5 SFHP members with opioid safety risk reviewed during the quarter by the Controlled Substance Review Committee.
SI5: Percent of Member with a Primary Care Visit	**Numerator:** Number of SFHP members in the denominator population with at least one PCP visit in the last year
	Denominator: Total number of continuously enrolled SFHP Medi-Cal members assigned to your organization during the quarter.

Quality Improvement Projects

Question	Description
Please describe the focus of the quality improvement projects you will take on in the FY 2022-2023:	
Target population(s):	
Estimated number of SFHP members to be impacted by these efforts:	

By signing below, I am attesting that the organization will be engaging in the above quality improvement efforts in the 2022-2023 fiscal year from July 1, 2022 through June 30, 2023. If there are material changes to QIP efforts that may significantly impact the scope, implementation and/or outcome of the intended efforts from what is described above, I will contact SFHP to inform them of the specific changes and the impact to SFHP members.

PIP Participant Name:	
Medical/Executive Director Name (print):	
Medical/Executive Director Signature:	
Date:	

Questions?

Contact information:

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