QIP Manager
MONTHLY FORUM

Monday, January 27, 2020, 12-1PM

Play recording (57 min)

Agenda

Time	Topic	Lead(s)
7 min	**Welcome & Roll-Call** • **Announcements**	Kristina Mody
10 min	**Program & Reporting Updates**	David Lown
10 min	**QIP & PRIME Program Evolution**	David
30 min	**PY2 Data** • Member Sharing Round Robin	Dana Pong, Kristina
3 min	**Wrap-up**	Kristina

Roll-Call & Webinar Reminders

AHS	ARMC	CCRMC	KMC	LACDHS	NMC	RUHS	SCVMC	SFHN
Tanvir Hussain Annette Johnson Tangerine Brigham Holly Garcia Neha Gupta	Rolando Mantilla Lisa De La Cruz Staci McClane	Karin Stryker Nooshin Abtahi	Tyler Bangerter Kevin Jenson	Paul Giboney Irene Dyer	Jane Finney Anthony Leal	Corinne Matthews	Elena Tindall Vickie Wilson Bob Sheridan	Rachel Stern Jaime Martin Renata Ferreira

SJGH	SMMC	UCD	UCI	UCLA	UCSD	UCSF	VCMC	
Ahad Yousuf Farhan Fadoo Rajat Simhan	Brenda Macedo Kristen Gurley	Jeff Berg	Scott Thompson	Brandy Bryant	Heather Erwin Carlos Ramirez	Sara Coleman Clare Connors	Theresa Cho	

WEBINAR REMINDERS:

Chat Questions typed here will only be seen by CAPH/SNI Staff, who will repeat question and answer for group

Attendance Designate one person (QIP lead or project lead) to speak
Contact Abby if you want to add other team members

Recordings of the webinar and slide deck posted on SNI Link/QIP/Webinars

QIP/PRIME Contact List & Leads posted on SNI Link
Updates to leads? Additions/deletions to team?
Please contact Abby

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Health Plan Data Survey + Interviews

- Effective working relationships & data sharing processes for shared quality initiatives between DPHs and their Medi-Cal Managed Care health plan partners are increasingly essential for both organizations' success under an expanded future QIP

- To support these collaborations around quality SNI will
  - Survey DPHs on DPH-health plan data sharing for quality reporting (via SurveyMonkey)
  - Conduct DPH interviews focused on effective collaboration for successful quality initiatives, specifically QIP and HEDIS.

Timing

- By 1/31 – Survey tool and interview protocol sent to PRIME/QIP leads

- By 2/7 – Recommended interview leads sent to Kristina Mody

- By 2/18 – Data Sharing Survey due

- By 3/13 – Interviews conducted

QIP 3.0 Readiness Summit

- When: Thursday, April 2, 8:30am-3:00pm

- Where: Oakland Airport Hilton Hotel

- Who: PRIME/QIP Executive sponsors; program managers; reporting leads

- Participants will understand:
  - Current development status of QIP 3.0 and ways public health systems can prepare
  - Peer public health systems' initial plans for QIP 3.0 program and reporting improvements based on PRIME and QIP lessons learned

- Registration and agenda forthcoming by early February

eSNUG

eSNUG
Epic
Safety Net
User Group

- Who: reporting, analytics or clinical operations lead
- What: systems well-established on Epic sharing on how they are addressing technical and operational practices and lessons learned
- When: bimonthly meetings, Tuesday 1-2 starting February 18
    - First topic = predictive models with Santa Clara
- Contact Kristina Mody kmody@caph.org to be added to the listserv

Reporting & Program Updates

PY2 Reporting Reminders

- **Q-RU4 30-Day Unplanned Return to OR**- Data for QIP PY2 measurement period (7/1/18-6/30/19) is in Jan 2020 ACS NSQIP Semi-Annual Report. Due to DHCS by Feb 1, 2020. Ask DHCS to open portal.

*Page 309 of
PY2 Manual*

Report Dates and report sources:
- First data due to DHCS on 12/15/2019
  - This data is to be reported along with all other QIP PY2 measures.
  - This data should be sourced from the October 2018 ACS NSQIP Interim Semi-Annual Report (ISAR) representing the period April 1, 2018 through March 31, 2019.
- Second data due to DHCS on 2/1/2020
  - Data for this report should be sourced from the January 2020 ACS NSQIP Semi-Annual Report (SAR) representing the complete QIP PY2 measurement period: July 1, 2018 through June 30, 2019. This second report will provide the final data for the QIP PY2 measurement period.

PY3 Reporting Reminders

✓6/24/19:   Measure additions/removals released on DHCS QIP site

✓7/24/19:   Benchmarks v2 released

✓10/22/19: Q-RU-5 & Q-RU-6 NDC Codes & MMEs posted on SNI Link

✓11/22/19: Reporting Manual released on SNI Link

✓12/3/19:   Reporting Manual Walkthrough Webinar on SNI Link

✓12/10/19: PY3 Value Sets by Measure for MCPs on DHCS QIP site

• **12/15/20:** PY3 report due

Q-PC10 Childhood IZ Status Combo 10

- Forthcoming clarification via PCS:

- Q-PC10 adheres to native specs except "plan enrollment" → "DPH assignment".

- There is no "DPH engagement criteria". Hence, reference to encounter value sets in the "Value Sets for this Measure" section should not be there. The value sets are not listed in the logic, so this correction should not be having any impact on your rates

Page 66 of PY3 Manual

Value Sets for this Measure:

- HEDIS specs and value sets can also be obtained at the NCQA Store. Refer to the *Technical Specifications for Health Plans.*
- The most current HEDIS NDC list can be found on NCQA's NDC website.
- The following encounter value sets from Childhood Immunization Status eCQM 2020 117v8 will be used to establish the denominator DPH encounter for this measure and can be found at the National Library of Medicine Value Set Authority Center (VSAC). To access these value sets, users must obtain a free Unified Medical Language System Metathesaurus License.
- "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)"
- "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)"
- Only CPT 99394 from "Encounter, Performed: Preventive Care Services, Initial Office Visit, 0 to 17" using "Preventive Care Services, Initial Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1022)"
- Only CPT 99394 from "Encounter, Performed: Preventive Care, Established Office Visit, 0 to 17" using "Preventive Care, Established Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1024)"

Q-PC9 IZ for Adolescents Combo 2

- Forthcoming clarification via PCS:

- Typo in PY3 spec. Initial Office visit should be CPT 99384

*Page 63 of
PY3 Manual*

Data Criteria (QDM Data Elements)	• "Encounter, Performed: Home Healthcare Services" using "Home Healthcare Services (2.16.840.1.113883.3.464.1003.101.12.1016)" • "Encounter, Performed: Office Visit" using "Office Visit (2.16.840.1.113883.3.464.1003.101.12.1001)" • Only CPT 99394 from "Encounter, Performed: Preventive Care Services, Initial Office Visit, 0 to 17" using "Preventive Care Services, Initial Office Visit, 0 to • Only CPT 99394 from "Encounter, Performed: Preventive Care, Established Office Visit, 0 to 17" using "Preventive Care, Established Office Visit, 0 to 17 (2.16.840.1.113883.3.464.1003.101.12.1024)"

Q-RU6

- *RU6: Use of Opioids at High Dosage in Persons Without Cancer*
  - PY3 Manual has many native dates (i.e., based on calendar year). PCS will list correct PY3 dates as follows:

p.308   Guidance for Reporting: This measure applies to individuals age 18 and older. Age should be based on age as of July 1 of the measurement period.

p.309   Index Prescription Start Date (IPSD) - The earliest date of service for an opioid prescription during the measurement period. The IPSD must occur at least 90 days before the end of the measurement period (i.e. July 1 – April 2).

p.309   Eligible Population: Age: Age 18 and older as of July 1 of the measurement period.

p.310   June 30 of the measurement period.

p.310   Step 2: Identify individuals with an IPSD on July 1 through April 2 of the measurement period.

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PY3.5 Reporting Reminders

✓ 7/24/19: QIP PY3 Benchmarks v2 released on SNI Link to be used for PY3.5

✓ 11/15/19: PRIME DY15 Benchmarks v3 released on DHCS PRIMEone to be used for PY3.5

   (Controlling High BP released Dec 2019; *2.1.6 Postpartum to be updated after DY15 MY*)

✓ 10/22/19: Q-RU-5 & Q-RU-6 NDC Codes & MMEs posted on SNI Link

• January 2020: "QIP Metrics" PY3.5 Manual to be released on SNI Link (PY3 updated for CY2020)

• January 2020: PY3.5 Value Sets by Measure for MCPs on DHCS QIP site

   (Same as DY15/PY3 except Postpartum which uses HEDIS 2020 value sets)

• February 2020: "PRIME Transition Metrics" Manual for QIP PY3.5 (DY15 updated for CY2020)

• **3/31/21:** PY3.5 report due for "PRIME" measures

• **6/15/21:** PY3.5 report due for QIP measures

PY3.5 Benchmark for Influenza IZ (PRIME 1.3.3)

- As with the PRIME Mid-Year calendar year measurement period, the QIP PY3.5 measurement period only captures the first half of the flu season (Oct 1-Dec 31).

- Because the calendar year measurement period yield a lower performance rate, DHCS will adjust the DY15 benchmark for this measure for QIP PY3.5 to be:
  - Minimum Performance 55%, High Performance 80%

- DHCS email forthcoming.
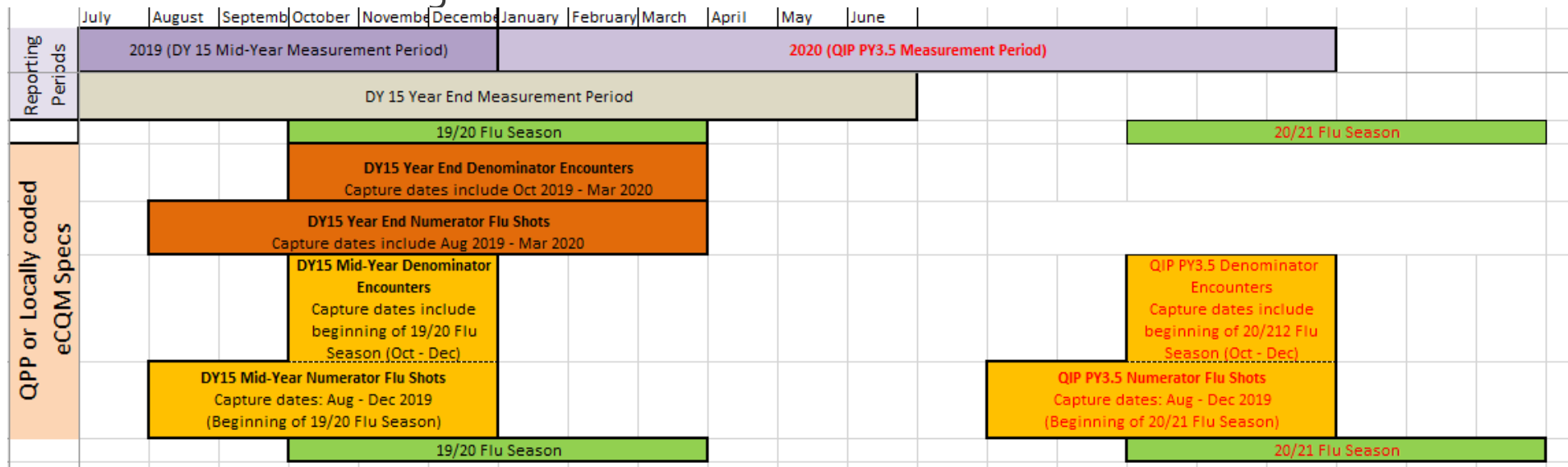
https://safetynetinstitute.org/wp-content/uploads/2020/01/1.3-flu-graphic_v4.xlsx

Reporting overview:

*PY 3.5 "PRIME Transition metrics" use DY15 Mid-Year as baseline, reported 3/31/20.
Report PY3.5 "QIP metrics" baselines (performance as of 12/31/19) at time of reporting PY3.5 performance (6/15/2021).

Can choose to report on <u>any</u> measure from PY3 Measure Set; does not have to be previously reported for QIP PY3 on 12/15/2020.

Denominator population for PRIME & QIP measures remain the same as they were under DY15 and PY3 respectfully.

Target Setting = 10% gap closure methodology for all metrics; regardless of PY3 gap closure methodology

<u>For QIP PY3.5 only</u>: QIP requirement of 1 MCMC individual in every reported denominator will only apply to the QIP PY3 measures. It DOES NOT apply to PRIME DY 15 measures in QIP PY3.5.
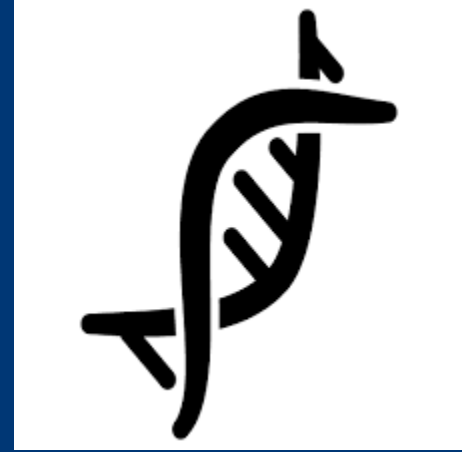
QIP
Evolution

Development Process & Timeline

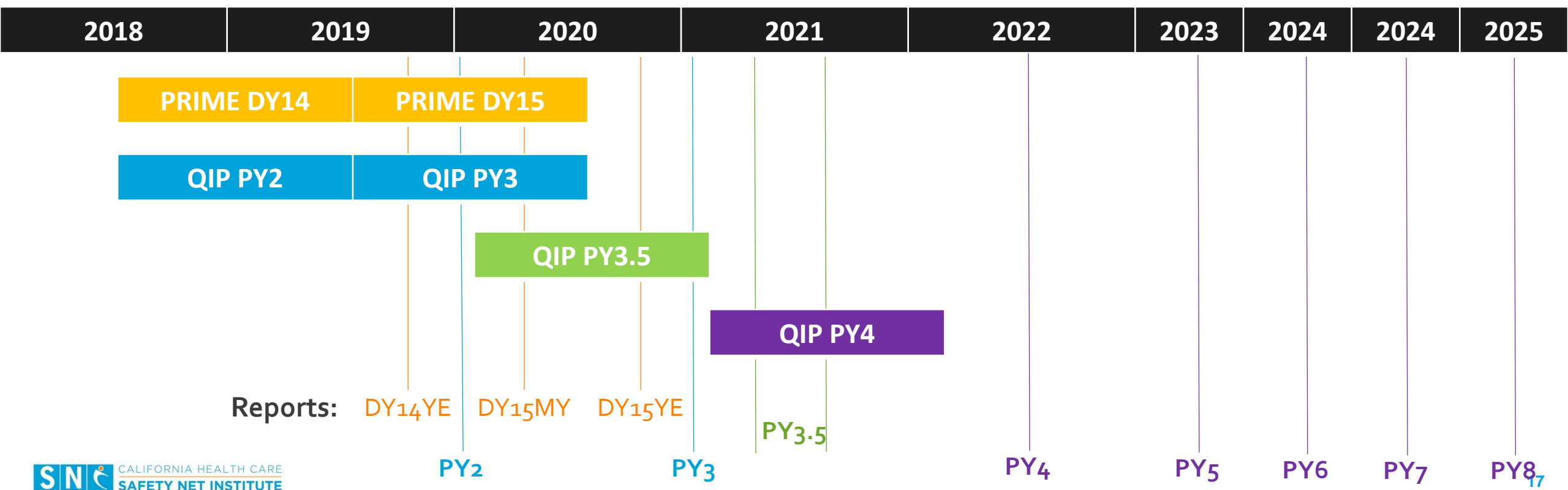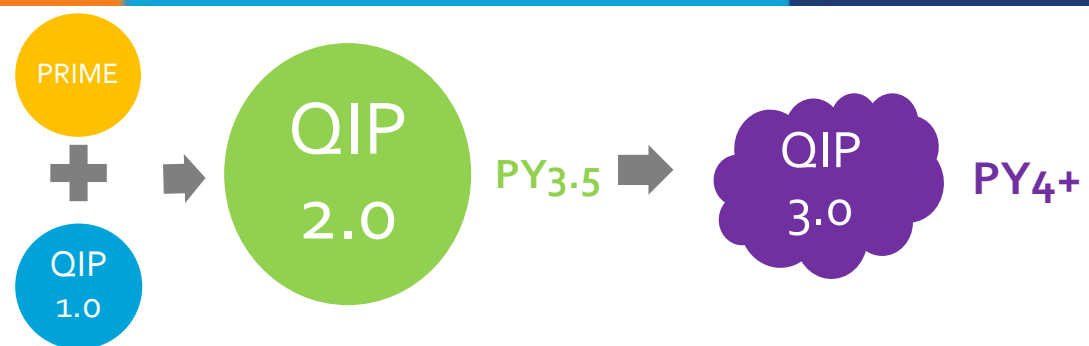| Date	Task
Sep 2019 – Jan 2020	SNI, DHLF, DHCS collaborates to identify a draft metric set (~80) • SNI engages CAPH & SNI Boards, CAC, MTAC for guidance
Jan 2020 Feb 2020 Mar 2020 Apr 2020	Draft metric set released for stakeholder input • DPH and DMPH input (via survey) • CAPH/SNI & DHLF internal committee and Board input • Managed Care Plan input via survey (as done with PY3 menu)
May 2020	QIP Quality Advisory Group recommendations
June 2020?	DHCS Approval of ~60 metric set for inclusion in Pre-Print to CMS
?	**DHCS submission of, and CMS approval, of Pre-Print**
Nov 2020	Reporting Manual completed
Dec 2020 (earlier if possible)	Benchmarks released
Jan 1, 2021	Program Year 4 begins

Reporting overview:

QIP 3.0 **PY4+**

Program Period	Measures	Report Due	Manual & Status	Benchmarks & Status
QIP PY4 1/1/21-12/31/21	*TBD - Measure Set and Minimum #	June 15, 2022	⮌ To be released before 12/31/20	⮌ To be released before 12/31/20

*TBD Measure Set/Minimum #
- We will know more in next few months.
- Feedback process will build on QIP 2.0, considering various factors (TBD).
- Measure set will likely be smaller than QIP 2.0/PY3.5.

Target Setting = 10% gap closure methodology for all metrics; regardless of PY3 gap closure methodology

Starting Jan 2021, the QIP requirement of 1 MCMC individual in every reported denominator will apply to all the QIP measures, including any PRIME measures included in QIP PY4+.

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Metrics for Consideration

Metric Type in order of Priority	# Metrics	Comments
Core Sub-Total	45	16 PRIME; 11 QIP
Non-Core HEDIS	21	2 PRIME; 3 QIP
Non-Core HRSA/UDS	7	2 PRIME
Remaining in PRIME/QIP metrics (exclusions applied)	31	18 PRIME/13 QIP
TOTAL	104	

PY2 Member Data

PY2 Reported Data

- Submitted to DHCS 12/15/19

- Data posted for CAPH member peer sharing on SNI Link:
  - https://safetynetinstitute.org/member-portal/programs/medicaid-managed-care/quality-incentive-program/reporting/
    Please do not share outside your system.
  - PY2 data not yet approved by DHCS. Data will be refreshed once SNI receives SCVMC's report.

- Improved bi-directional data sharing between managed care plans & PHS

- Performance variable across measures
  - Some PHS already above high performance benchmarks
  - Some PHS are under minimum performance thresholds, mainly for Pediatric Access to PCP

By System

Preliminary analysis shows that DPH met targets on 88% (283/320) of all reported metrics for PY2.
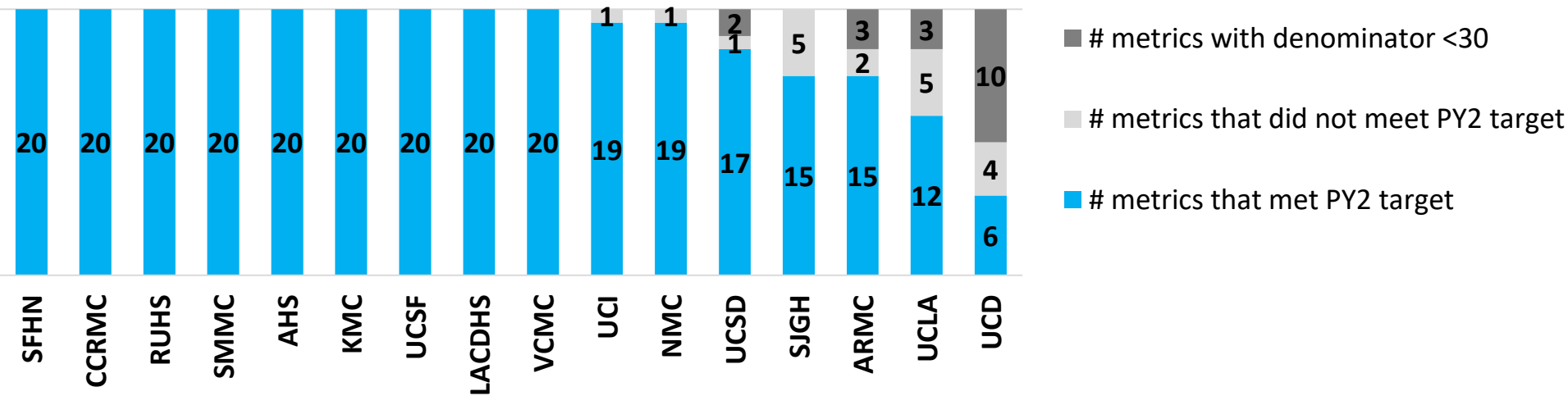
Legend:
- # metrics with denominator <30
- # metrics that did not meet PY2 target
- # metrics that met PY2 target

Data by system (# metrics that met PY2 target / did not meet / denominator <30):
- SFHN: 20
- CCRMC: 20
- RUHS: 20
- SMMC: 20
- AHS: 20
- KMC: 20
- UCSF: 20
- LACDHS: 20
- VCMC: 20
- UCI: 19, 1
- NMC: 19, 1
- UCSD: 17, 1, 2
- SJGH: 15, 5
- ARMC: 15, 2, 3
- UCLA: 12, 5, 3
- UCD: 6, 4, 10

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By Metric

PY2 data not yet approved by DHCS. SCVMC PY2 data not yet included or received by SNI.
Results contingent on 3 DPH updating their PY2 report to reflect reporting on 20 metrics instead of 21.

Minimum Denominator Criteria

PY1

PY2

Reported; met minimum denominator criteria

Reported; did not meet minimum denominator criteria

Did not report
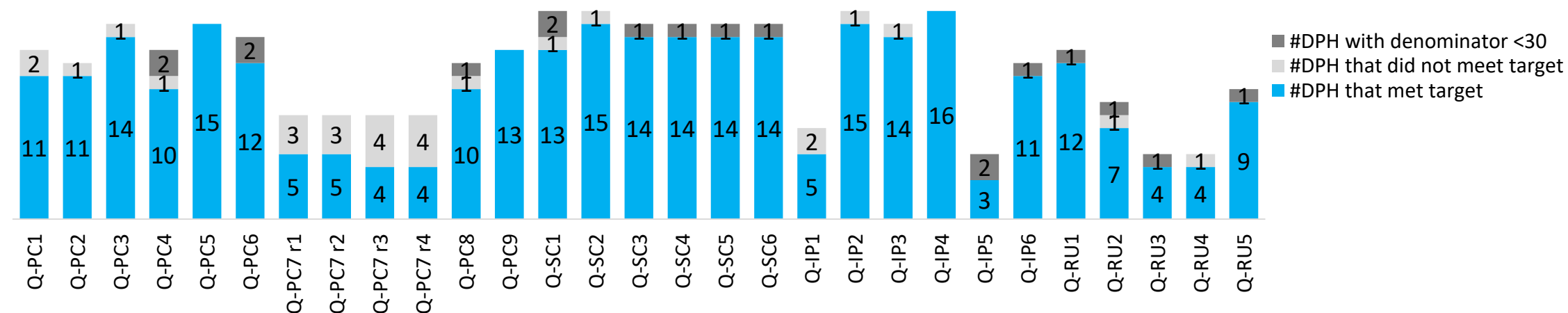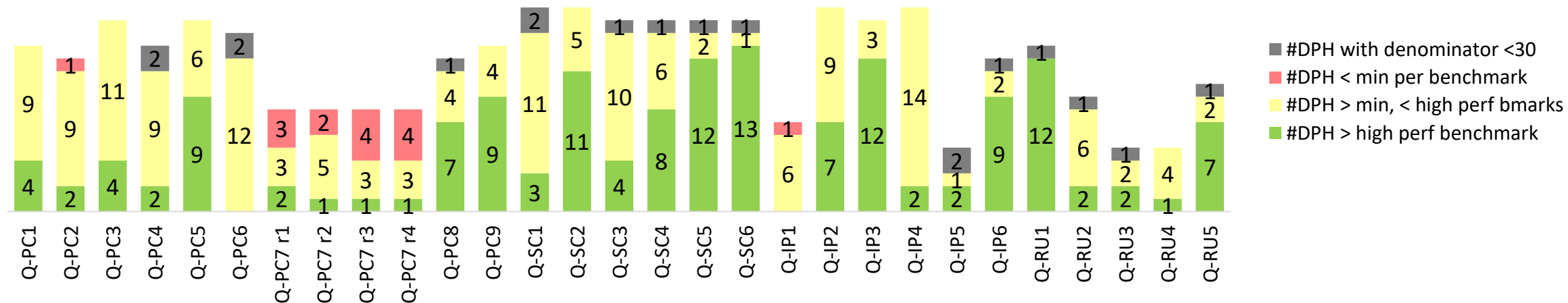
PY2 data not yet approved by DHCS.
SCVMC PY2 data not yet included or received by SNI.
Results contingent on 3 DPH updating their PY2 report
to reflect reporting on 20 metrics instead of 21.

PRIMARY CARE

Q-PC1 Diabetes Care: A1C Control (<8%)

High performance benchmark: 59%
Minimum performance benchmark: 42%

Site	Gray	Blue
SJGH	50%	53%
LACDHS	53%	53%
NMC	51%	54%
ARMC	54%	54%
UCLA	57%	56%
RUHS	52%	56%
KMC	55%	57%
UCSF	55%	58%
CCRMC	58%	58%
SFHN	62%	62%
SMMC	63%	62%
VCMC	60%	63%
UCSD	69%	65%

Q-PC2 Diabetes Care: Eye Exam
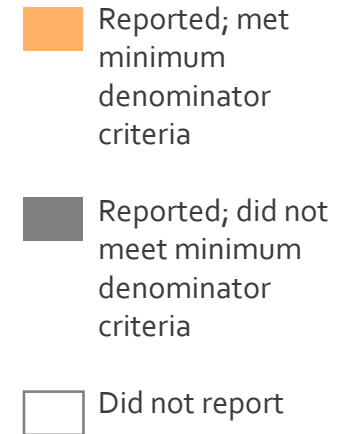
High performance benchmark: 68%
Minimum performance benchmark: 48%

Site	Gray	Blue
UCLA	36%	39%
RUHS	11%	48%
SJGH	47%	50%
ARMC	35%	51%
VCMC	43%	54%
AHS	51%	58%
CCRMC	56%	62%
UCSD	58%	65%
UCSF	66%	66%
SFHN	66%	68%
LACDHS	72%	71%
SMMC	98%	99%

Q-PC3 Diabetes Care: Blood Pressure Control

High performance benchmark: 76%
Minimum performance benchmark: 53%

Site	Gray	Blue
ARMC	37%	62%
UCI	65%	67%
SJGH	72%	68%
LACDHS	66%	70%
KMC	70%	71%
UCSF	66%	73%
NMC	74%	74%
UCSD	70%	75%
RUHS	60%	75%
AHS	73%	75%
VCMC	74%	76%
SMMC	74%	76%
SFHN	76%	77%
CCRMC	76%	77%
UCLA	74%	77%

Q-PC4 Asthma Medication Ratio

High performance benchmark: 72%
Minimum performance benchmark: 56%

Site	Gray	Blue
UCI	51%	56%
UCSF	52%	58%
CCRMC	53%	58%
AHS	59%	60%
UCSD	73%	61%
SMMC	61%	62%
VCMC	50%	66%
NMC	65%	67%
LACDHS	48%	71%
SJGH	72%	73%
KMC	7%	74%
UCD		
UCLA		

Q-PC5 Medication Reconciliation Post Discharge

High performance benchmark: 78%
Minimum performance benchmark: 39%

Site	Gray	Blue
SMMC	48%	57%
SFHN	56%	58%
VCMC	54%	59%
NMC	57%	61%
LACDHS	46%	65%
AHS	52%	76%
KMC	68%	84%
UCSD	62%	87%
RUHS	65%	98%
SJGH	44%	99%
UCI	54%	99%
UCSF	49%	99%
CCRMC	99%	100%
UCD	77%	100%
UCLA	70%	100%
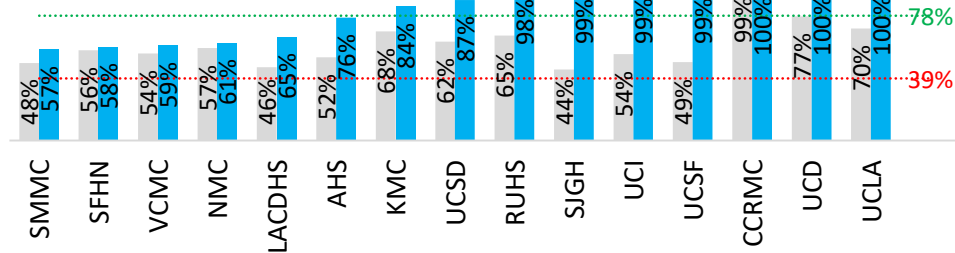
Q-PC6 7 Day Post-Discharge Follow-Up for High Risk Beneficiaries
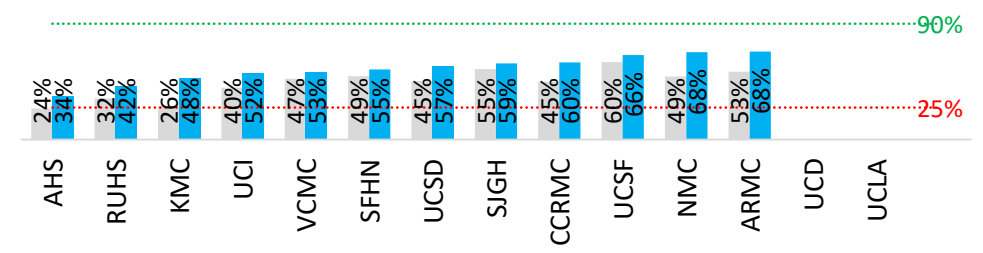
High performance benchmark: 90%
Minimum performance benchmark: 25%

Site	Gray	Blue
AHS	24%	34%
RUHS	33%	42%
KMC	26%	48%
UCI	40%	52%
VCMC	47%	53%
SFHN	49%	55%
UCSD	45%	57%
SJGH	55%	59%
CCRMC	45%	60%
UCSF	60%	66%
NMC	49%	68%
ARMC	53%	68%
UCD		
UCLA		

Minimum performance benchmark in red. High performance benchmark in green. DPH with denominator <30 are not shown. Better performance runs left to right. PY2 data not yet approved by DHCS. SCVMC PY2 data not yet included or received by SNI. Results contingent on 3 DPH updating their PY2 report to reflect reporting on 20 metrics instead of 21.
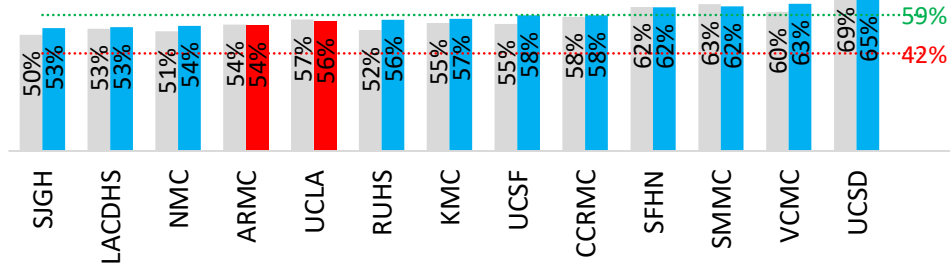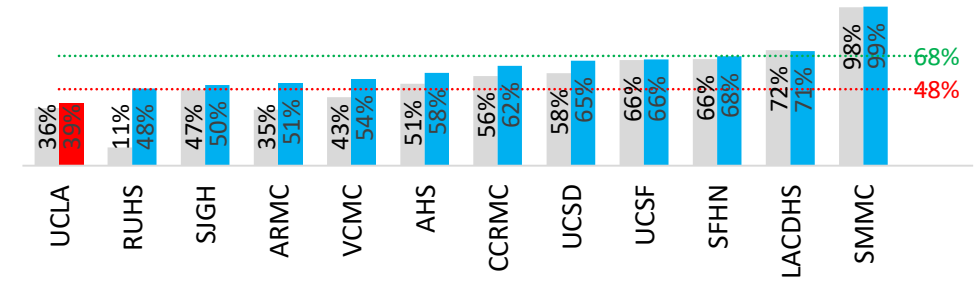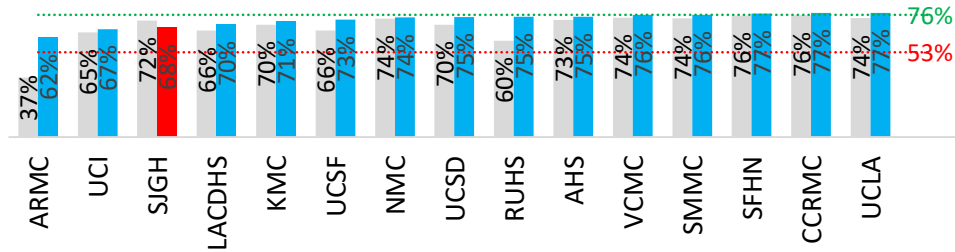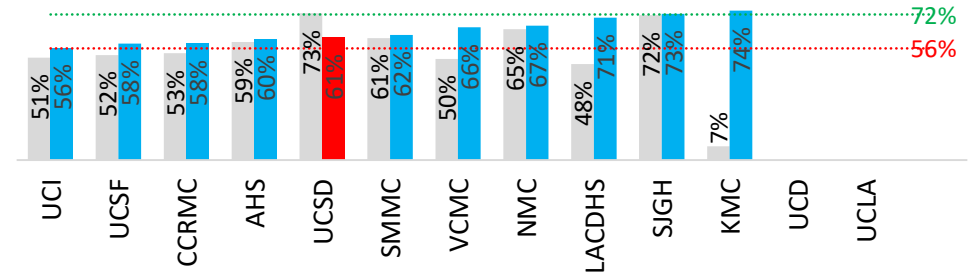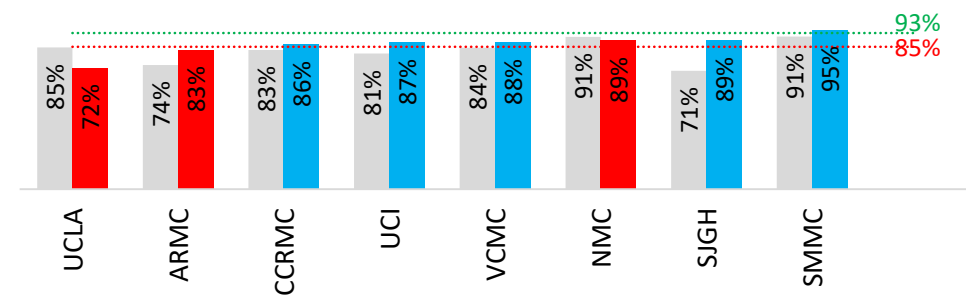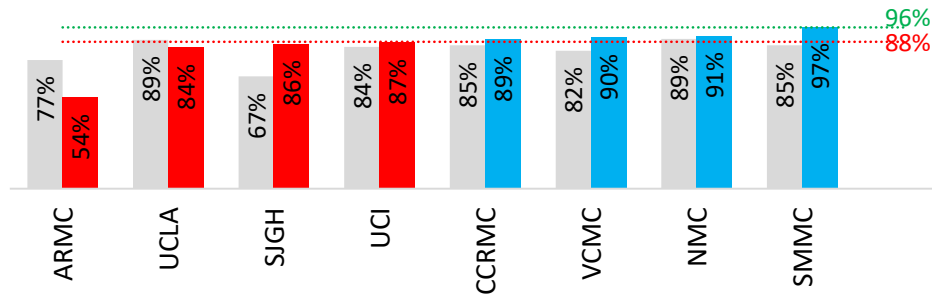
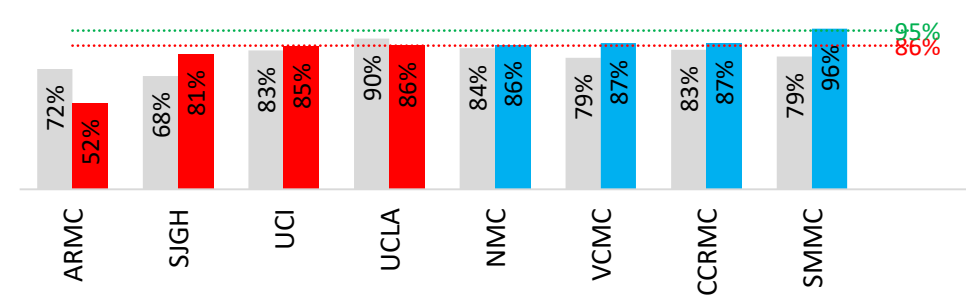26

Q-PC7 Children & Adolescent Access to PCP 12-24 mos.

ARMC 0%, 86% | UCLA 97%, 88% | SJGH 92%, 92% | NMC 95%, 95% | CCRMC 93%, 95% | VCMC 94%, 96% | UCI 97%, 99% | SMMC 100%, 100%

98% (green) / 93% (red)

Q-PC7 Children & Adolescent Access to PCP 25 mos - 6 Yrs

UCLA 85%, 72% | ARMC 74%, 83% | CCRMC 83%, 86% | UCI 81%, 87% | VCMC 84%, 88% | NMC 91%, 89% | SJGH 71%, 89% | SMMC 91%, 95%

93% (green) / 85% (red)

Q-PC7 Children & Adolescent Access to PCP 7-11 yrs

ARMC 77%, 54% | UCLA 89%, 84% | SJGH 67%, 86% | UCI 84%, 87% | CCRMC 85%, 89% | VCMC 82%, 90% | NMC 89%, 91% | SMMC 85%, 97%

96% (green) / 88% (red)

Q-PC7 Children & Adolescent Access to PCP 12-19 Years

ARMC 72%, 52% | SJGH 68%, 81% | UCI 83%, 85% | UCLA 90%, 86% | NMC 84%, 86% | VCMC 79%, 87% | CCRMC 83%, 87% | SMMC 79%, 96%

95% (green) / 86% (red)

Q-PC8 Childhood Immunization Status Combo 3

UCLA 67%, 68% | ARMC 48%, 70% | UCI 72%, 77% | SJGH 73%, 77% | LACDHS 86%, 83% | UCSF 81%, 84% | CCRMC 82%, 85% | NMC 88%, 86% | SFHN 90%, 87% | AHS 83%, 87% | SMMC 68%, 89% | UCD

79% (green) / 65% (red)
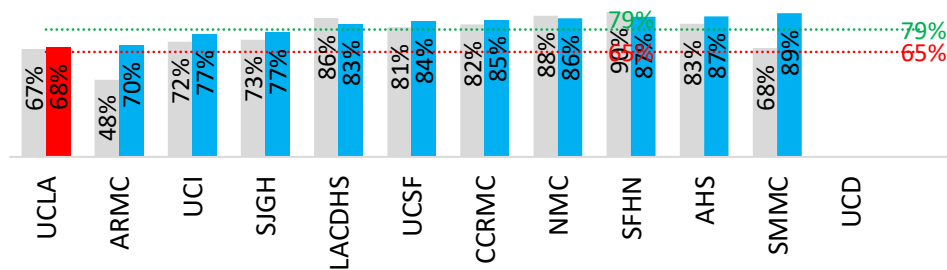
Q-PC9 Immunization for Adolescents Combo 2
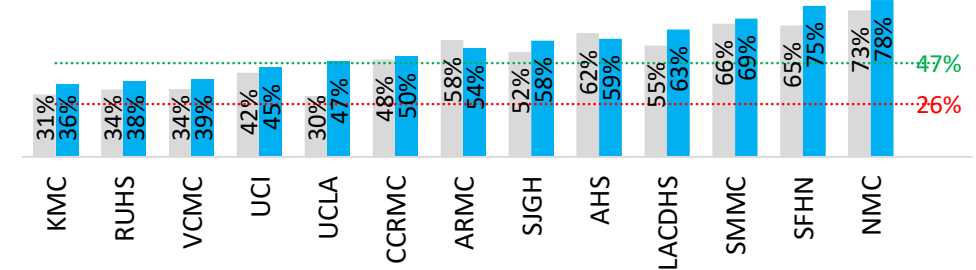
KMC 31%, 36% | RUHS 34%, 38% | VCMC 34%, 39% | UCI 42%, 45% | UCLA 30%, 47% | CCRMC 48%, 50% | ARMC 58%, 54% | SJGH 52%, 58% | AHS 62%, 59% | LACDHS 55%, 63% | SMMC 66%, 69% | SFHN 65%, 75% | NMC 73%, 78%
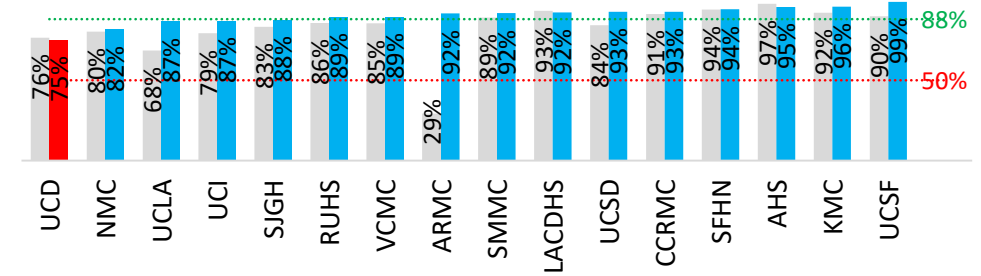
47% (green) / 26% (red)

Minimum performance benchmark in red. High performance benchmark in green. DPH with denominator <30 are not shown. Better performance runs left to right.
PY2 data not yet approved by DHCS. SCVMC PY2 data not yet included or received by SNI. Results contingent on 3 DPH updating their PY2 report to reflect reporting on 20 metrics instead of 21.
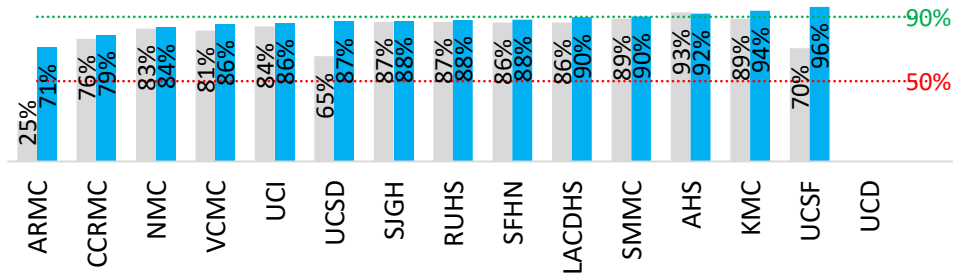
SPECIALTY CARE

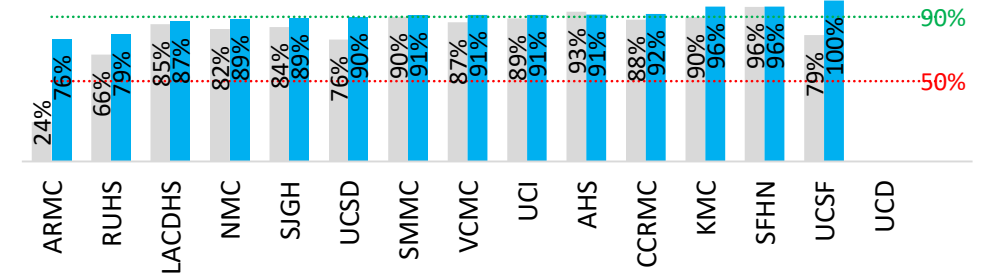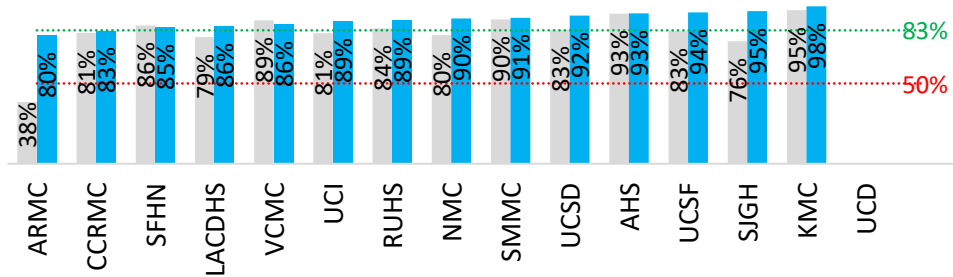## Q-SC1 AFib&AFlutter: Chronic Anticoagulation Tx

Bar chart (left to right): ARMC 15%/65%, SJGH 90%/78%, VCMC 75%/80%, SFHN 78%/80%, UCI 73%/81%, SMMC 76%/82%, CCRMC 76%/82%, AHS 79%/84%, RUHS 81%/86%, LACDHS 79%/86%, NMC 87%/88%, UCSD 94%/93%, KMC 93%/96%, UCSF 89%/97%, UCD, UCLA. High performance benchmark 90% (green), minimum performance benchmark 25% (red).
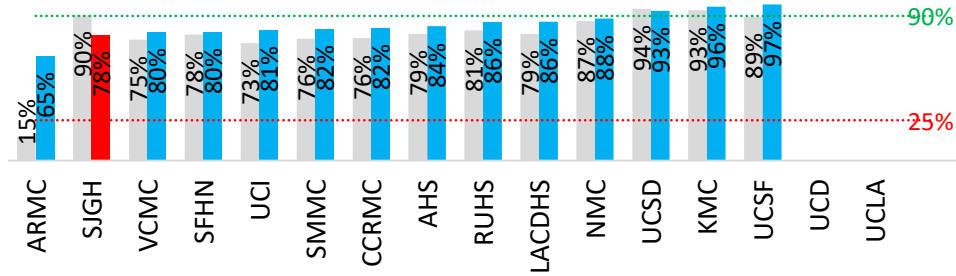
Q-SC2 CAD: Antiplatelet Tx

Bar chart (left to right): UCD 76%/75%, NMC 80%/82%, UCLA 68%/87%, UCI 79%/87%, SJGH 83%/88%, RUHS 86%/89%, VCMC 85%/89%, ARMC 29%/92%, SMMC 89%/92%, LACDHS 93%/92%, UCSD 84%/93%, CCRMC 91%/93%, SFHN 94%/94%, AHS 97%/95%, KMC 92%/96%, UCSF 90%/99%. High performance benchmark 88% (green), minimum performance benchmark 50% (red).

Q-SC3 CAD: ACE-I/ARB Tx - DM or LVEF < 40%

Bar chart (left to right): ARMC 25%/71%, CCRMC 76%/79%, NMC 83%/84%, VCMC 81%/86%, UCI 84%/86%, UCSD 65%/87%, SJGH 87%/88%, RUHS 87%/88%, SFHN 86%/88%, LACDHS 86%/90%, SMMC 89%/90%, AHS 93%/92%, KMC 89%/94%, UCSF 70%/96%, UCD. High performance benchmark 90% (green), minimum performance benchmark 50% (red).

Q-SC4 CAD: Prior MI or LVSD (LVEF <40%)

Bar chart (left to right): ARMC 24%/76%, RUHS 66%/79%, LACDHS 85%/87%, NMC 82%/89%, SJGH 84%/89%, UCSD 76%/90%, SMMC 90%/91%, VCMC 87%/91%, UCI 89%/91%, AHS 93%/91%, CCRMC 88%/92%, KMC 90%/96%, SFHN 96%/96%, UCSF 79%/100%, UCD. High performance benchmark 90% (green), minimum performance benchmark 50% (red).

Q-SC5 Heart Failure: ACE-I/ARB Tx - LVSD

Bar chart (left to right): ARMC 38%/80%, CCRMC 81%/83%, SFHN 86%/85%, LACDHS 79%/86%, VCMC 89%/86%, UCI 81%/89%, RUHS 84%/89%, NMC 80%/90%, SMMC 90%/91%, UCSD 83%/92%, AHS 93%/93%, UCSF 83%/94%, SJGH 76%/95%, KMC 95%/98%, UCD. High performance benchmark 83% (green), minimum performance benchmark 50% (red).

Q-SC6 Heart Failure: Beta-Blocker Tx for LVSD
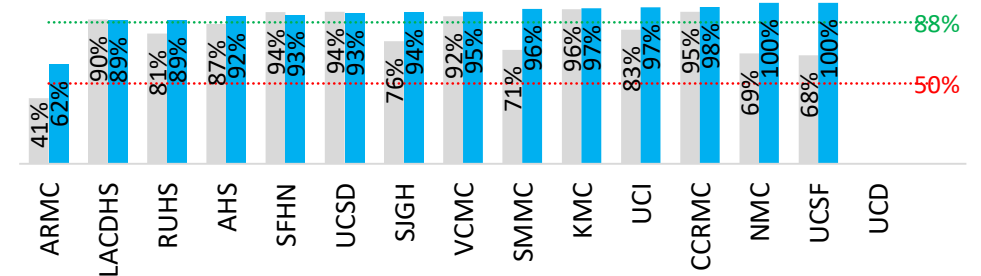
Bar chart (left to right): ARMC 41%/62%, LACDHS 90%/89%, RUHS 81%/89%, AHS 87%/92%, SFHN 94%/93%, UCSD 94%/93%, SJGH 76%/94%, VCMC 92%/95%, SMMC 71%/96%, KMC 96%/97%, UCI 83%/97%, CCRMC 95%/98%, NMC 69%/100%, UCSF 68%/100%, UCD. High performance benchmark 88% (green), minimum performance benchmark 50% (red).
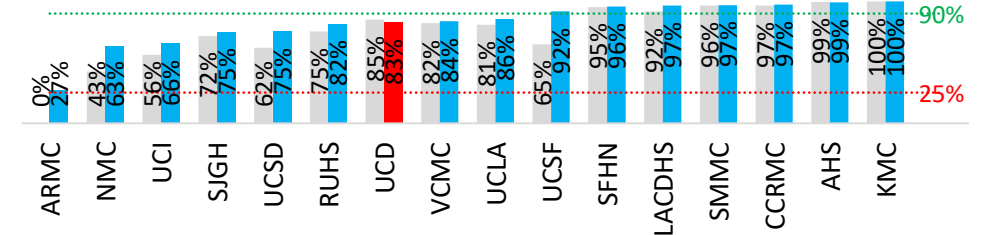
Minimum performance benchmark in red. High performance benchmark in green. DPH with denominator <30 are not shown. Better performance runs left to right.
PY2 data not yet approved by DHCS. SCVMC PY2 data not yet included or received by SNI. Results contingent on 3 DPH updating their PY2 report to reflect reporting on 20 metrics instead of 21.
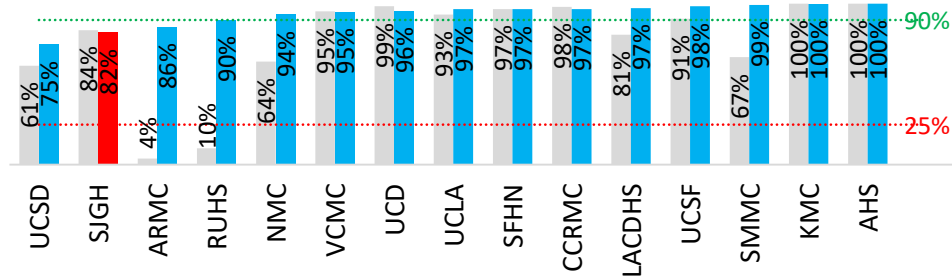
Q-IP1 Surgical Site Infection

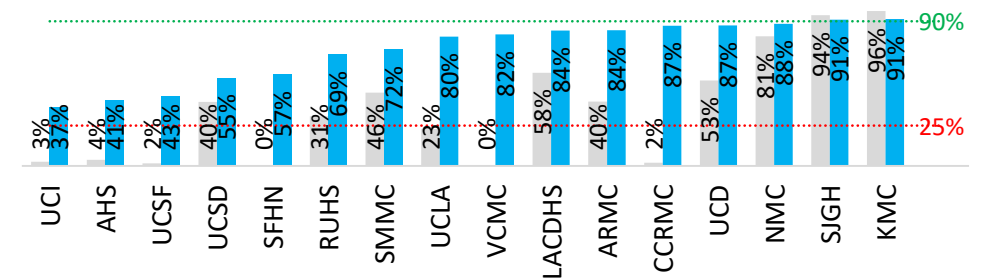SJGH 1.20 / 1.54; KMC 1.78 / 1.17; UCD 0.91 / 1.01; UCSF 0.88 / 0.84; UCLA 0.86 / 0.78; UCSD 1.46 / 0.62; RUHS 0.76 / 0.61. Benchmarks: 1.25 (red), 0.54 (green).
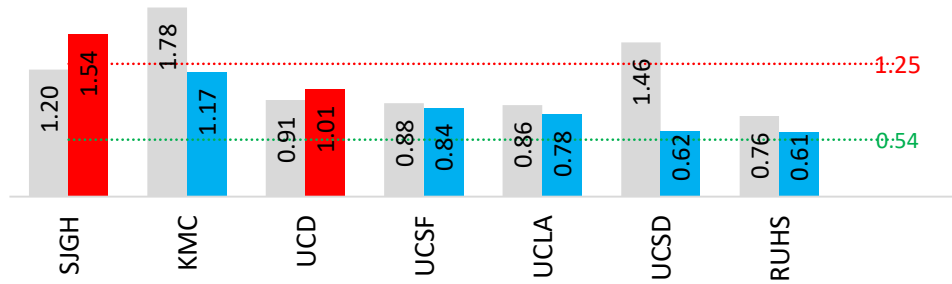
Q-IP2 Periop Care: Prophylactic Abx-1st/2nd Gen Cephalosporin

ARMC 0%/27%; NMC 43%/63%; UCI 56%/66%; SJGH 72%/75%; UCSD 62%/75%; RUHS 75%/82%; UCD 85%/83%; VCMC 82%/84%; UCLA 81%/86%; UCSF 65%/92%; SFHN 95%/96%; LACDHS 92%/97%; SMMC 96%/97%; CCRMC 97%/97%; AHS 99%/99%; KMC 100%/100%. Benchmarks: 90% (green), 25% (red).

Q-IP3 Periop Care: Venous Thromboembolism Prophylaxis

UCSD 61%/75%; SJGH 84%/82%; ARMC 4%/86%; RUHS 10%/90%; NMC 64%/94%; VCMC 95%/95%; UCD 99%/96%; UCLA 93%/97%; SFHN 97%/97%; CCRMC 98%/97%; LACDHS 81%/97%; UCSF 91%/98%; SMMC 67%/99%; KMC 100%/100%; AHS 100%/100%. Benchmarks: 90% (green), 25% (red).

Q-IP4 Prevention of Central Venous Catheter - Batermia

UCI 3%/37%; AHS 4%/41%; UCSF 2%/43%; UCSD 40%/55%; SFHN 0%/57%; RUHS 31%/69%; SMMC 46%/72%; UCLA 23%/80%; VCMC 0%/82%; LACDHS 58%/84%; ARMC 40%/84%; CCRMC 2%/87%; UCD 53%/87%; NMC 81%/88%; SJGH 94%/91%; KMC 96%/91%. Benchmarks: 90% (green), 25% (red).

Q-IP5 Appropriate Tx of MSSA Bactermia

AHS 83%/88%; LACDHS 98%/95%; SFHN 100%/100%; UCD; ARMC. Benchmarks: 90% (green), 25% (red).
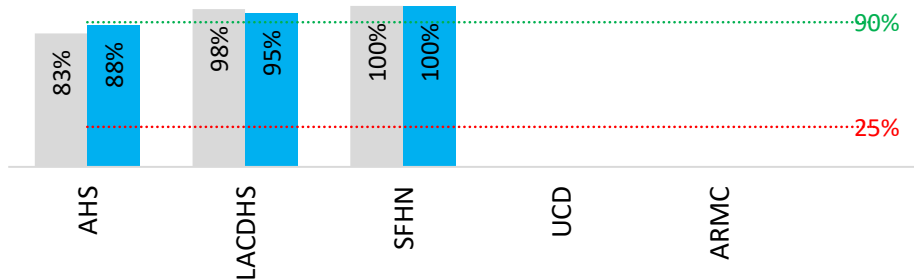
Q-IP6 Stroke: Discharged on Antithrombotic Therapy
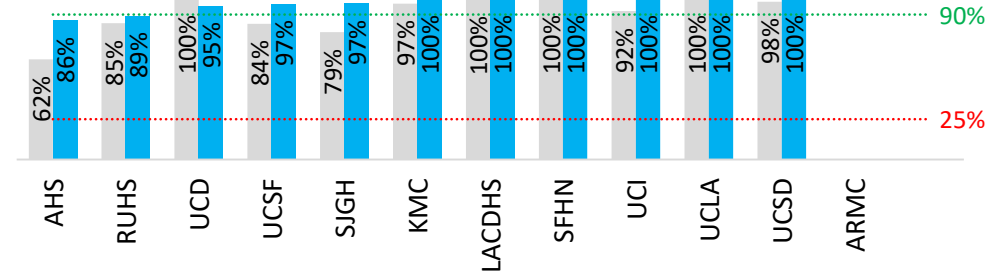
AHS 62%/86%; RUHS 85%/89%; UCD 100%/95%; UCSF 84%/97%; SJGH 79%/97%; KMC 97%/100%; LACDHS 100%/100%; SFHN 100%/100%; UCI 92%/100%; UCLA 100%/100%; UCSD 98%/100%; ARMC. Benchmarks: 90% (green), 25% (red).
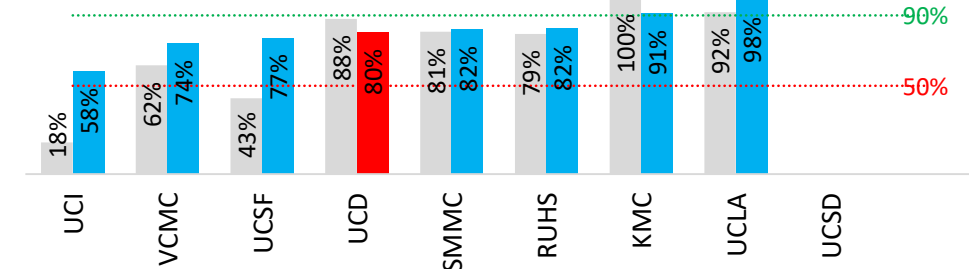
Minimum performance benchmark in red. High performance benchmark in green. DPH with denominator <30 are not shown. Better performance runs left to right.
PY2 data not yet approved by DHCS. SCVMC PY2 data not yet included or received by SNI. Results contingent on 3 DPH updating their PY2 report to reflect reporting on 20 metrics instead of 21.
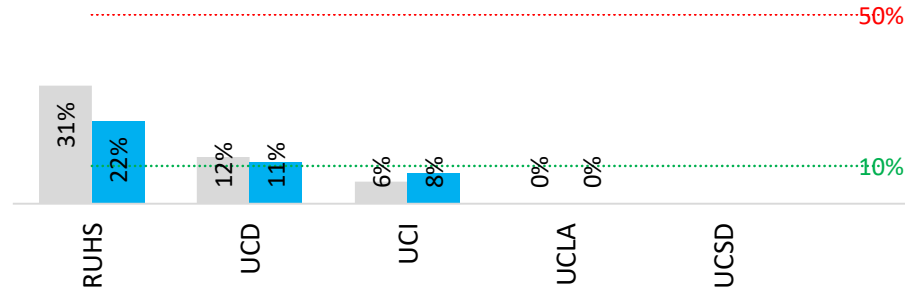
RESOURCE UTILIZATION
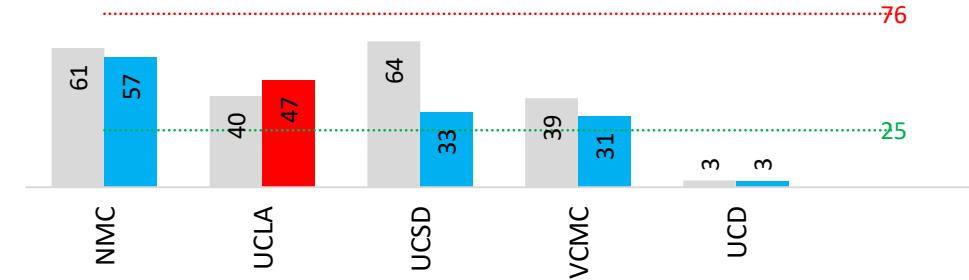

Q-RU1 Cardiac Stress Imaging: Low Risk Surgery Pts

UCI 2.59% / 6.67%; SFHN 2.58% / 3.51%; SMMC 1.31% / 2.93%; VCMC 1.71% / 2.40%; AHS 0.00% / 1.64%; ARMC 1.22% / 1.33%; LACDHS 1.33% / 0.31%; CCRMC 0.10% / 0.10%; KMC 0.00% / 0.00%; NMC 1.28% / 0.00%; RUHS 0.00% / 0.00%; UCSF 8.37% / 0.00%; UCD — ; benchmark 10%
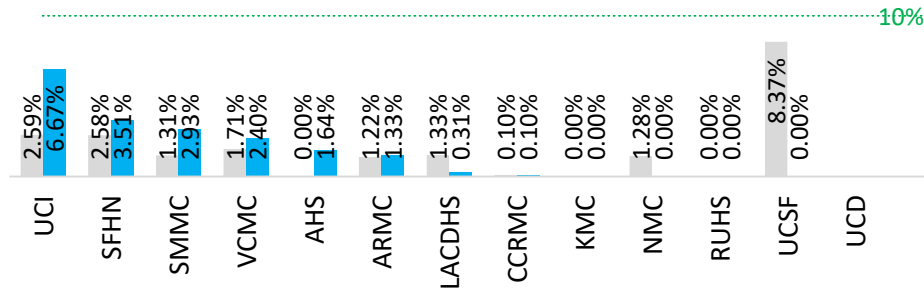
Q-RU2 ED CT for Minor Blunt Head Trauma - Adult

UCI 18% / 58%; VCMC 62% / 74%; UCSF 43% / 77%; UCD 88% / 80%; SMMC 81% / 82%; RUHS 79% / 82%; KMC 100% / 91%; UCLA 92% / 98%; UCSD — ; benchmarks 90%, 50%

Q-RU3 ED CT for Minor Blunt Head Trauma - Pediatric

RUHS 31% / 22%; UCD 12% / 11%; UCI 6% / 8%; UCLA 0% / 0%; UCSD — ; benchmarks 50%, 10%

Q-RU4 Unplanned Reoperation w/in the 30 Day Postop
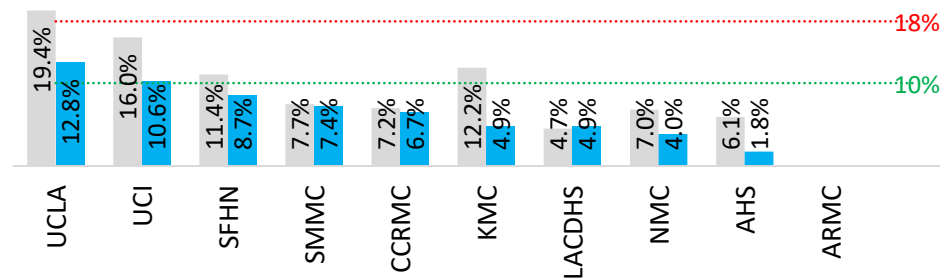
NMC 61 / 57; UCLA 40 / 47; UCSD 64 / 33; VCMC 39 / 31; UCD 3 / 3; benchmarks 76, 25

Q-RU5 Concurrent Use: Opioids & Benzodiazepines Rate 1

UCLA 19.4% / 12.8%; UCI 16.0% / 10.6%; SFHN 11.4% / 8.7%; SMMC 7.7% / 7.4%; CCRMC 7.2% / 6.7%; KMC 12.2% / 4.9%; LACDHS 4.7% / 4.9%; NMC 7.0% / 4.0%; AHS 6.1% / 1.8%; ARMC — ; benchmarks 18%, 10%

Q-RU5 Concurrent Use: Opioids & Benzodiazepines Rate 2

UCLA 12.9% / 12.5%; SFHN 11.4% / 9.4%; LACDHS 9.4% / 8.6%; UCI 11.1% / 8.3%; CCRMC 9.6% / 7.9%; NMC 9.1% / 7.6%; SMMC 8.4% / 7.4%; ARMC — / 7.0%; AHS 6.8% / 5.3%; KMC 11.1% / 3.3%
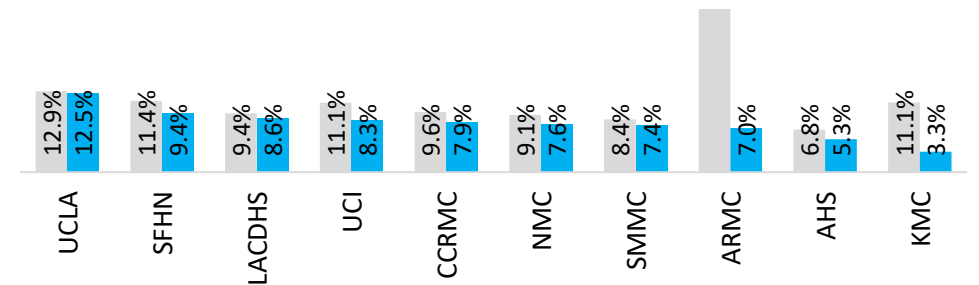
Minimum performance benchmark in red. High performance benchmark in green. DPH with denominator <30 are not shown. Better performance runs left to right.
PY2 data not yet approved by DHCS. SCVMC PY2 data not yet included or received by SNI. Results contingent on 3 DPH updating their PY2 report to reflect reporting on 20 metrics instead of 21.

Trends and examples from QIP narratives

Identify and address care gaps
- Integrated retinal screening data to help staff identify care gaps and perform same-day retinal exams (VCMC)

Improve data capture
- New HIM program can remove provider privileges if documentation not timely (ARMC)

Leverage integrated data
- Improved bi-directional data exchange with health plan, including flagging enrollment and assignment (RUHS)

Optimize and spread standard work
- Established Expected Practices for antibiotic use; redesigned Central Line Insertion Form embedded in EHR (LACDHS)

Trends and examples from QIP narratives *cont*

Aligning with other strategic initiatives

- Applying lessons learned from PRIME, e.g., around specialty care metrics (KMC)

Improving access to care

- Improved appointment access through pre-visit reminder calls, bundling of care services to reduce multiple appointments and trying innovative strategies for patient outreach (CCRMC)

Engaging patients

- Improved diabetic protocols to improve patient engagement, including screening and intensive pharmacist support (UCSD)

Provider and staff education

- Ongoing staff training for Health Coaching to support patients with and at risk for heart disease (SMMC)

Team and workforce development

- Re-orged amb cardiology to include pharmacists and NPs to leverage in-person and telephone visits (SFHN)
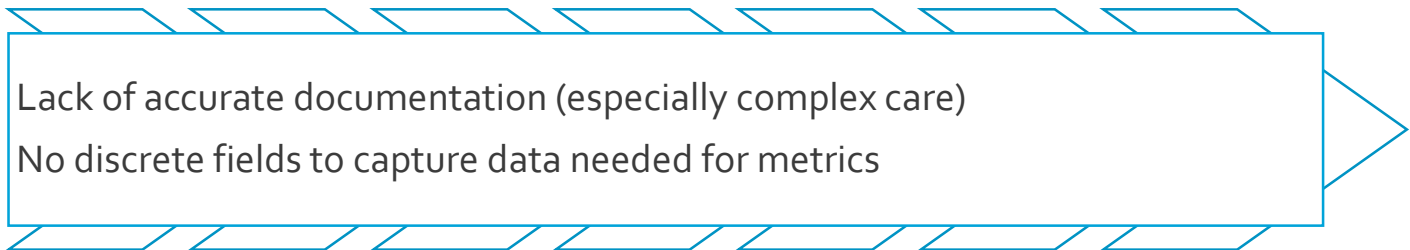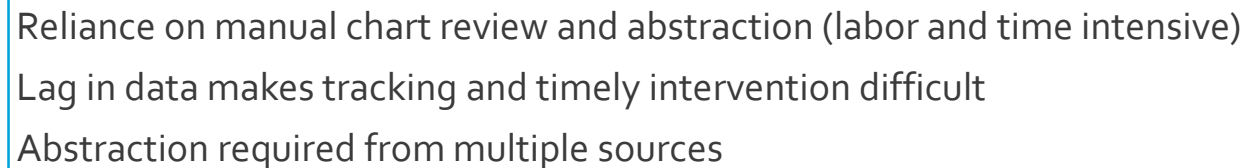
Challenges

Quality work

Difficult to sustain cross-department communication & collaboration

Documentation

Lack of accurate documentation (especially complex care)

No discrete fields to capture data needed for metrics

Reporting

Reliance on manual chart review and abstraction (labor and time intensive)

Lag in data makes tracking and timely intervention difficult

Abstraction required from multiple sources

Round Robin Sharing

1. What surprised you about PY2 performance?

2. Where are your priorities focus for PY3?
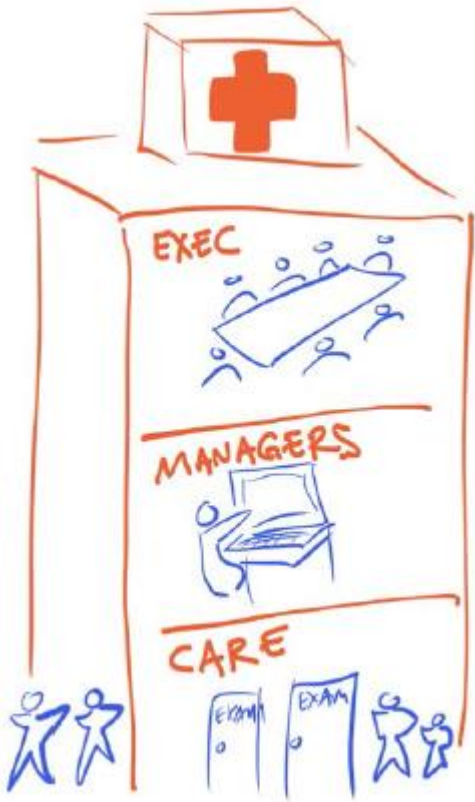
3. Do you have any questions for your peers?

WRAP UP

In Case You Missed It….

Anchoring PRIME Behavioral Health Integration in Practice

- VCMC's experience and learnings integrating BH over course of PRIME

Upcoming Dates

Feb 11 (12-1): PRIME/QIP OH

Feb 18 (1-2): eSNUG (Epic Safety Net User Group Meeting)

Feb 24 (11-1): QIP Leads

Mar 12 (12-1): PRIME/QIP OH

Mar 23 (11-1): QIP Leads

Apr 2 (Oakland): QIP 3.0 Readiness Summit

February				
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

March				
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27

April				
30	31	1	2	3