| Demographic Information |
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| MCO Name: |
| Project Leader Name:       Title: |
| Telephone Number:       Email Address: |
| PIP Title: *<PIP Topic>* |
| Submission Date: |
| Resubmission Date (if applicable): |

| Step I: Select the PIP Topic.The topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve member health, functional status, and/or satisfaction. The topic may also be required by the State. |
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| PIP Topic:  Provide plan-specific data:  Describe how the PIP topic has the potential to improve member health, functional status, and/or satisfaction: |

| Step II: **Define the PIP Aim Statement(s).** Defining the aim statement(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.  The statement(s) should:   * Be structured in the recommended X/Y format: “Does doing X result in Y?” * The statement(s) must be documented in clear, concise, and measurable terms. * Be answerable based on the data collection methodology and indicator(s) of performance. |
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| Statement(s): |

| **Step III: Define the PIP Population.** The PIP population should be clearly defined to represent the population to which the PIP Aim statement(s) and indicator(s) apply.  **The population definition should:**   * Include the requirements for the length of enrollment, continuous enrollment, new enrollment, and allowable gap criteria. * Include the age range and the anchor dates used to identify age criteria, if applicable. * Include all inclusion, exclusion, and diagnosis criteria used to identify the eligible population. * Include a list of diagnosis/procedure/pharmacy/billing codes used to identify the eligible population, if applicable. Codes identifying numerator compliance should not be provided in Step III. * Capture all members to whom the statement(s) applies. * Include how race and ethnicity will be identified, if applicable. * If members with special healthcare needs were excluded, provide the rationale for the exclusion. |
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| Population definition:  Enrollment requirements (if applicable):  Member age criteria (if applicable):  Inclusion, exclusion, and diagnosis criteria:  Diagnosis/procedure/pharmacy/billing codes used to identify the eligible population (if applicable): |

| Step IV: Use Sound Sampling Methods. If sampling is used to select members of the population (denominator), proper sampling methods are necessary to ensure valid and reliable results. Sampling methods should be in accordance with generally accepted principles of research design and statistical analysis. If sampling was not used, please leave table blank and document that sampling was not used in the space provided below the table.  The description of the sampling methods should:   * Include components identified in the table below. * Be updated annually for each measurement period and for each indicator. * Include a detailed narrative description of the methods used to select the sample and ensure sampling methods support generalizable results. | | | | |
| --- | --- | --- | --- | --- |
| Measurement Period | Performance Indicator Title | Sampling Frame Size | Sample  Size | Margin of Error and Confidence Level |
| **MM/DD/YYYY–MM/DD/YYYY** |  |  |  |  |
|  |  |  |  |  |
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| **Describe in detail the methods used to select the sample:** | | | | |

| **Step V:** Select the Performance Indicator(s). A performance indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research.  **The description of the Indicator(s) should:**   * Include the complete title of each indicator. * Include the rationale for selecting the indicator(s). * Include a narrative description of each numerator and denominator. * If indicator(s) are based on nationally recognized measures (e.g., HEDIS, CMS Core Set), include the year of the technical specifications used for the applicable measurement year and update the year annually. * Include complete dates for all measurement periods (with the month, day, and year). * Include the mandated goal or target, if applicable. If no mandated goal or target enter “Not Applicable.” | |
| --- | --- |
| Indicator 1 | **[Enter Indicator title]** |
| **[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]** |
| Numerator Description: |  |
| Denominator Description: |  |
| Baseline Measurement Period | MM/DD/YYYY to MM/DD/YYYY |
| Remeasurement 1 Period | MM/DD/YYYY to MM/DD/YYYY |
| Remeasurement 2 Period | MM/DD/YYYY to MM/DD/YYYY |
| Mandated Goal/Target, if applicable |  |
| Indicator 2 | **[Enter Indicator title]** |
| **[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]** |
| Numerator Description: |  |
| Denominator Description: |  |
| Baseline Measurement Period | MM/DD/YYYY to MM/DD/YYYY |
| Remeasurement 1 Period | MM/DD/YYYY to MM/DD/YYYY |
| Remeasurement 2 Period | MM/DD/YYYY to MM/DD/YYYY |
| Mandated Goal/Target, if applicable |  |
| *Indicator 3* | **[Enter Indicator title]** |
| **[Insert a narrative description, and the rationale for selection, of the indicator. Describe the basis on which the indicator was developed, if internally developed.]** |
| Numerator Description: |  |
| Denominator Description: |  |
| Baseline Measurement Period | MM/DD/YYYY to MM/DD/YYYY |
| Remeasurement 1 Period | MM/DD/YYYY to MM/DD/YYYY |
| Remeasurement 2 Period | MM/DD/YYYY to MM/DD/YYYY |
| Mandated Goal/Target, if applicable |  |
| **Use this area to provide additional information.** | |

| Step VI: Valid and Reliable Data Collection. The data collection process must ensure that data collected for each indicator are valid and reliable.  **The data collection methodology should include the following:**   * Identification of data elements and data sources. * When and how data are collected. * How data are used to calculate the indicator percentage. * A copy of the manual data collection tool, if applicable. * An estimate of the reported administrative data completeness percentage and the process used to determine this percentage. | | |
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| **Data Sources (Select all that apply)** | | |
| [ ]Manual Data  Data Source  [ ] Paper medical record abstraction  [ ] Electronic health record abstraction  Record Type  [ ] Outpatient  [ ] Inpatient  [ ] Other, please explain in narrative section.    [ ] Data collection tool attached (required for manual record review) | [ ] Administrative Data  Data Source  [ ] Programmed pull from claims/encounters  [ ] Supplemental data  [ ] Electronic health record query  [ ] Complaint/appeal  [ ] Pharmacy data  [ ] Telephone service data/call center data  [ ] Appointment/access data  [ ] Delegated entity/vendor data \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Requirements  [ ] Codes used to identify data elements (e.g., ICD-10, CPT codes)- please attach separately  [ ] Data completeness assessment attached  [ ] Coding verification process attached  Estimated percentage of reported administrative data completeness at the time the data are generated: \_\_\_\_\_\_\_ % complete.  Description of the process used to calculate the reported administrative data completeness percentage. Include a narrative of how claims lag may have impacted the data reported: | [ ] Survey Data  Fielding Method  [ ] Personal interview  [ ] Mail  [ ] Phone with CATI script  [ ] Phone with IVR  [ ] Internet  [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Survey Requirements:  Number of waves: \_\_\_\_\_\_\_\_  Response rate: \_\_\_\_\_\_\_\_\_  Incentives used: \_\_\_\_\_\_\_ |

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| In the space below, describe the step-by-step data collection process used in the production of the indicator results: | | | | | | | | | |
|  | | | | | | | | | |
| Step VII: **Indicator** Results. Enter the results of the indicator(s) in the table below. For HEDIS-based/CMS Core Set PIPs, the data reported in the PIP Submission Form should match the validated performance measure rate(s).  Enter results for each indicator by completing the table below. *P* values should be reported to four decimal places (i.e., 0.1234). Additional remeasurement period rows can be added, if necessary. | | | | | | | | |
| Indicator 1 Title: [Enter title of indicator] | | | | | | | | |
| Measurement Period | | Indicator Measurement | Numerator | | Denominator | Percentage | Mandated Goal or Target, if applicable | Statistical Test Used, Statistical Significance,  and *p* Value |
| **1/1/2019 – 12/31/2019** | | Baseline |  | |  |  | N/A for baseline | N/A for baseline |
| **1/1/2020– 12/31/2020** | | Implementation Year |  | |  |  |  |  |
| **1/1/2021– 12/31/2021** | | Remeasurement 1 |  | |  |  |  |  |
| **1/1/2022– 12/31/2022** | | Remeasurement 2 |  | |  |  |  |  |
| Indicator 2 Title: [Enter title of indicator] | | | | | | | | |
| Time Period | Indicator Measurement | | | Numerator | Denominator | Percentage | Mandated Goal or Target, if applicable | Statistical Test, Statistical Significance,  and *p* Value |
| **1/1/2019 – 12/31/2019** | Baseline | | |  |  |  | N/A for baseline | N/A for baseline |
| **1/1/2020– 12/31/2020** | Implementation Year | | |  |  |  |  |  |
| **1/1/2021– 12/31/2021** | Remeasurement 1 | | |  |  |  |  |  |
| **1/1/2022– 12/31/2022** | Remeasurement 2 | | |  |  |  |  |  |
| Indicator 3 Title: [Enter title of indicator] | | | | | | | | |
| **Time Period** | Indicator Measurement | | | **Numerator** | **Denominator** | **Percentage** | **Mandated Goal or Target, if applicable** | **Statistical Test, Statistical Significance,  and *p* Value** |
| **1/1/2019 – 12/31/2019** | Baseline | | |  |  |  | N/A for baseline | N/A for baseline |
| **1/1/2020– 12/31/2020** | Implementation Year | | |  |  |  |  |  |
| **1/1/2021– 12/31/2021** | Remeasurement 1 | | |  |  |  |  |  |
| **1/1/2022– 12/31/2022** | Remeasurement 2 | | |  |  |  |  |  |

| Step VII: **Data Analysis and** Interpretation of Results. Clearly document the results for each indicator(s). Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation of the results.  **The data analysis and interpretation of indicator results should include the following for each measurement period:**   * Data presented clearly, accurately, and consistently in both table and narrative format. * A clear and comprehensive narrative description of the data analysis process, the percentage achieved for the measurement period for each indicator, and the type of two-tailed statistical test used. Statistical testing *p* value results should be calculated and reported to four decimal places (e.g., 0.1234). * Statistical testing should be conducted starting with Remeasurement 1 and comparing to the baseline. For example, Remeasurement 1 to the baseline and Remeasurement 2 to the baseline. For purposes of the validation, statistical testing does not need to be conducted between measurement periods (e.g., Remeasurement 1 to Remeasurement 2). * Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process. * A statement indicating whether or not factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods were identified. If there were no factors identified, this should be documented in Step VII. |
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| **Baseline Narrative:**  **Baseline to Remeasurement 1 Narrative:**  **Baseline to Remeasurement 2 Narrative:** |

| Step VIII: Improvement Strategies. Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis.  This step should be updated for each measurement period by adding to existing documentation. Include the following:   * Quality Improvement Team and Activities Narrative Description * Barriers/Interventions Table: Prioritized barriers and corresponding intervention descriptions. (Please note that the interventions documented in the Barriers/ Interventions table should be in accordance with AHCA’s requirements for the BH PIP intervention implementation dates and at least one of the interventions should focus on utilizing Florida’s Encounter Notification Service (ENS) to facilitate timely outreach to the member to schedule follow-up visits with eligible providers) * Intervention Evaluation Table: Evaluation of each intervention * Clinical and Programmatic Improvement Table: Discussion of any clinical or programmatic improvement achieved at any remeasurement during the PIP |
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| Quality Improvement Team and Activities Narrative Description: Under the measurement period placeholder below corresponding to the most recent completed measurement period, add a description of the quality improvement team members, the causal/barrier analysis process, and quality improvement tools used to identify and prioritize barriers for each measurement period below.  **Baseline Narrative:**  **Remeasurement 1 Narrative:**  **Remeasurement 2 Narrative:**  **Barriers/Interventions Table:** In the table below, report prioritized barriers, corresponding interventions, and intervention details (initiation date, current status, and type.   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Barrier Priority Ranking | Barrier Description | Intervention Initiation Date (MM/YY) | Intervention Description | Select Current Intervention Status | Select if Member, Provider, or System Intervention | |  |  |  |  | Click to select status | Click to select status | |  |  |  |  | Click to select status | Click to select status |   **Intervention Evaluation Table:** In the table below, list each intervention that was included in the Barriers/Interventions Table, above. For each intervention, document the processes and measures used to evaluate effectiveness, the evaluation results, and next steps taken in response to the evaluation results. Additional documentation of evaluation processes and results may be attached as separate documents. Attachments should be clearly labeled and referenced in the table below.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Measurement Period | Intervention Description | Evaluation Process | Evaluation Results | Next Steps | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   **Clinical and Programmatic Improvement Table:** In the table below, describe any clinical and/or programmatic improvement that was achieved at any remeasurement period during the PIP. Specify each remeasurement period when improvement was obtained and the intervention(s) that led to the improvement. Provide intervention evaluation results in the *Supporting Quantitative or Qualitative Data* column.   |  |  |  | | --- | --- | --- | | **Clinical Improvement** | | | | **Remeasurement Period** | **Narrative Summary of Clinical Improvement** | **Supporting Quantitative or Qualitative Data** | |  |  |  | |  |  |  | | **Programmatic Improvement** | | | | **Remeasurement Period** | **Narrative Summary of Programmatic Improvement** | **Supporting Quantitative or Qualitative Data** | |  |  |  | |  |  |  | |