

Quantifiable Patient Impact (QPI) Reporting: Companion Document

Table of Contents:

- Reporting on QPI2**
 - Semi-Annual Reporting (SAR) 2
 - Metric Achievement..... 2
 - Allowable Dates of Service..... 2
 - Multiple Metric Goals 3
- Determining QPI4**
 - Defining Individuals and Encounters 4
 - General Guidance 4
 - Project Area Level Guidance 5
 - Running the Numbers 8
 - What is QPI?..... 8
 - Moving from Cumulative to Annual QPI Numeric Goals 8
 - Determining the Pre-DSRIP Baseline 8
 - QPI Calculation..... 9
- QPI Reporting Template11**
 - Step-by-Step Instructions..... 11
 - Instructions tab:..... 12
 - Project Data Entry tab:..... 12
 - QPI Data Entry tab: 15
 - QPI Summary tab: 18
 - De-Identifying Personally Identifiable Information: 19
 - Submission of QPI Reporting Template 20
 - Progress Indicators: 20
 - Naming and Submitting QPI Reporting Template File: 20

While some of the content below repeats information from the *October DY3 Reporting Companion Document*, this document provides important details regarding QPI reporting that are not included elsewhere. Please read both documents carefully to ensure that QPI reporting is correctly completed.

Reporting on QPI

In order to properly document and calculate QPI achievement, starting in October DY3, the *QPI Reporting Template* will be required when reporting achievement for designated QPI metrics (marked "Yes" in the QPI Metric cell) and for Semi-Annual Reporting (SAR) in October.

Semi-Annual Reporting (SAR)

Every October, as part of the metric-level progress update required for Semi-Annual Reporting (SAR), HHSC will require all projects with a designated QPI metric in the demonstration year (DY) to submit the number of individuals served/ encounters provided in the DY due to the DSRIP project via their *QPI Reporting Template*.

While providers are required to submit a qualitative metric-level progress update in April, they are not required to submit their *QPI Reporting Template* in April unless they are reporting for metric achievement. However, providers who submit their QPI Reporting Template in April to report achievement of a QPI metric will still need to submit their *QPI Reporting Template* in October updated with data from the full DY. This annual information will be important for external communications regarding the impact of the DSRIP program.

Metric Achievement

While providers are required to submit Semi-Annual Reporting (SAR) in both April and October, they may report achievement of metrics for payment in either April or October of the demonstration year (DY). Alternately, in October, if the metric is not fully achieved by September 30, a provider may request to carry-forward the metric to the subsequent DY.

QPI metrics (like all Category 1 or 2 metrics and Category 3 milestones) should only be reported in April if the provider is confident that the metric was fully achieved during the allowable dates of service and can be clearly demonstrated.

Allowable Dates of Service

Only individuals served/ encounters provided during the demonstration year (DY) - or during the DY and subsequent DY, if reporting as carry-forward - may be counted as QPI.

While QPI metrics may be achieved in a subsequent demonstration year as carry-forward, they may not be achieved in an earlier demonstration year. For example, if a project includes a QPI-like metric in DY2 and serves more individuals or provides more encounters in DY2 than included in the DY2 goals, the additional individuals/encounters from DY2 cannot be included to meet DY3 QPI goals. Early achievement of QPI metrics is not allowed to ensure that each project's impact on patients continues to grow throughout the waiver demonstration period.

The allowable dates of service for QPI metrics are as follows:

DY Reporting	Not Reporting as Carry-forward	Reporting as Carry-forward
DY3	Oct. 1, 2013 – Sep. 30, 2014	Oct. 1, 2013 – Sep. 30, 2015
DY4	Oct. 1, 2014 – Sep. 30, 2015	Oct. 1, 2014 – Sep. 30, 2016
DY5	Oct. 1, 2015 – Sep. 30, 2016	Oct. 1, 2015 – Sep. 30, 2017

Please note that, if a QPI metric is carried forward for late achievement, the provider will need to demonstrate achievement of the carry-forward metric before the subsequent year's QPI metric is approvable.

Multiple Metric Goals

All goals in a metric must be achieved to be eligible for DSRIP payment (e.g. if a metric has two goals - expanding clinic hours and providing 200 visits - both the expanded hours and 200 visits would need to be completed). Providers should not report a metric as achieved until all goals are fully completed.

- For QPI metrics that include a QPI goal as well as another goal that is not a percentage (e.g. establishing a specialty care clinic), both goals must be completed to be eligible for metric payment.
- For QPI metrics that include a percentage goal (e.g. target population met, percentage increase in number served) as well as the numeric QPI goal, the numeric goal is the primary goal, while HHSC may accept variances in the percentage goal with explanation (e.g. lower than expected denominator size for target population).
- For QPI metrics that include a goal for establishing a DSRIP baseline (see the [Pre-DSRIP Baseline section below](#) for an explanation of DSRIP versus Pre-DSRIP baseline), the baseline must be determined and achievement of the QPI goal of number of individuals served or encounters provided must be demonstrated.
- For 4-Year projects with QPI metrics that require a Medicaid/ Low Income Uninsured (MLIU) QPI in addition to the total QPI (designated by a "Yes" in the Medicaid/ Low Income Uninsured cell), both the total QPI goal and the Medicaid/ Low Income Uninsured QPI numeric goal must be met.

Please note that while the QPI Reporting Template will serve as supporting documentation to demonstrate achievement of the QPI-related goal of a metric, providers will need to submit additional supporting documentation to support other non-QPI related goals included as part of QPI-designated metrics.

Determining QPI

Defining Individuals and Encounters

HHSC has received a variety of questions regarding the individuals and types of encounters that can be counted towards QPI. The [General Guidance section](#) includes broad information about defining individuals and encounters that applies to all or most projects and should be reviewed by all providers. HHSC has also attempted to address QPI as relates to certain project areas for which we received many questions. This information can be found in the [Project Area Level Guidance section](#).

Providers should base their QPI submission on the information included in these sections, as well as their metric language and project narrative. Keep in mind that changes requested through the current Plan Modification/ Technical Change process can apply only to DY4 and DY5 and do not apply to DY3 metrics.

General Guidance

Individuals:

- Individuals must have received a service consistent with the project during the demonstration year to be counted.
- For QPI individuals, all persons served through the project in the demonstration year should be included, even if those same individuals received services through the project in a prior year.
- Dual eligible patients (Medicare/Medicaid) can be counted towards MLIU QPI.
- Providers may base their MLIU QPI on an individual's payer status at the time of the first project encounter. So, if a client was served through the DSRIP project and was counted as MLIU, and their payer status changed during the waiver, they can continue to be counted.

Encounters:

- A provider may only count encounters if they are providing the visit. They cannot count the encounter if they are simply making a referral, unless this is specifically included as part of their metric language.
- Patient contacts can only be considered as unique QPI encounters wherein a unique service is delivered. Often this can be thought of as a unique billable event. For example, a registered nurse encounter typically is not a service distinct from "visit with physician", so it is considered part of the same visit/service/encounter and counted as one encounter for QPI purposes.
- Telephone calls (including outgoing) may only be counted as a separate QPI events if the call is clinical in nature, the call is specifically related to a project with a goal of telephone outreach, and the call was completed (e.g. the caller reached the intended person - not just their voicemail - and spoke with them about their care). Outgoing calls that would be appropriate would be a follow-up call to check on a patient's status with symptoms to determine if additional care is needed, a call completed through a nurse advice line created as part of the project, or a follow-up call with a patient who called into the urgent medical advice line. Administrative calls such as satisfaction with services or follow-up as to whether a patient went to the ED or PCP, would not be appropriate as

they are still part of the same initial encounter. Appointment reminder calls also would not count as QPI encounters.

- Text and email messages generally are not allowable QPI encounters, unless specifically mentioned in a project's metric language/ narrative.
- Group visits may be counted as multiple encounters equal to the number of individuals targeted by the project that attend the group visit.

Project Area Level Guidance

While not all project options are specifically addressed below, HHSC has attempted to include additional information on those for which we have received the most questions.

1.1: Expand primary care capacity

Recommended QPI metric: Primary care encounters provided.

- Encounters should, in general, only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.
- Visits may include prevention services such as screening for chronic disease, monitoring of disease state markers (e.g. cholesterol levels), and vaccinations.
- Encounters outside of the clinic as part of outreach may be counted towards QPI if they mirror the types and levels of encounters that would be allowable if conducted in the clinic.

1.2: Increase training of primary care workforce

Recommended QPI metric: Primary care encounters provided by residents, trainees, or additional staff (depending on project area option)

- See [1.1](#).

1.3: Implement a chronic disease management registry

Recommended QPI metric: Individuals managed in registry

- The registry should be designed to allow for the tracking of patient interactions and clinical studies (e.g. lab reports, patient histories) as necessary and pertinent to the DSRIP project. Individuals counted towards QPI should be in the registry and have received some level of interaction during the demonstration year.

1.6: Enhance urgent medical advice

Recommended QPI metric: Urgent care encounters provided

- See [1.1](#).

1.9: Expand specialty care capacity

Recommended QPI metric: Specialty care encounters provided.

- Encounters should, in general, only include office visits. They should not include pharmacy visits, lab visits, reminder or follow-up phone calls, etc. that result from or are related to the office visit.

1.10 Enhance performance improvement and reporting capacity

Recommended QPI metric: Individuals positively impacted by improvements

- QPI should equal the number of individuals who experience the improvement(s) in the demonstration year. Individuals must have received some level of service during the demonstration year to be counted.
- The QPI may be equivalent to the total number of individuals served during the demonstration year, or it may be limited to a subset of those served. If the project implemented improvements across the provider's entire system, the QPI would equal the number of patients served by the system in the demonstration year. If the project impacted only patients in one department, for example, the QPI would be limited to the patients served by that department.
- In addition to submitting the *QPI Reporting Template* showing the number of unique individuals impacted, the provider should also submit documentation that demonstrates that the proposed improvement was achieved.

1.12: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care

Recommended QPI metric: Individuals receiving community-based behavioral health/ substance abuse services

- For a QPI metric that has a goal of providing behavioral health and substance abuse services, a screening/assessment does not constitute a service. A diagnostic assessment and a diagnosis review would count as a service because the client is already in care. These would have to be updated at regular intervals for all consumers receiving services.

2.1: Enhance/ expand medical homes

Recommended QPI metric: Individuals receiving care under patient-centered medical home model

- Individuals must have received some level of service during the demonstration year to be counted towards QPI.

2.2: Expand chronic care management models

Recommended QPI metric: Individuals receiving care under chronic care model

- Individuals must have received some level of service during the demonstration year to be counted towards QPI.

2.3: Redesign primary care

Recommended QPI metric: Individuals positively impacted by improvements

- See [1.10](#).

2.4: Redesign to improve patient experience

Recommended QPI metric: Individuals positively impacted by improvements

- For a variety of reasons, it is often not possible to survey every patient seen in a demonstration year to determine whether their personal satisfaction increased. Provided a sampling method that is statistically sound (e.g., a sufficient number of individuals were sampled for the results to be statistically significant, the sampling was random, etc.) is used, individuals that were not surveyed can be counted as those impacted by improvements if they would be expected to also have experienced an improvement in satisfaction during the demonstration year (e.g., they were part of the group targeted by the improvements).
- Individuals must have received some level of service during the demonstration year to be counted.
- In addition to submitting the *QPI Reporting Template* showing the number of unique individuals impacted, the provider should also submit documentation that demonstrates that there was an improvement in patient satisfaction and an explanation of the sampling method if applicable

2.5: Redesign for cost containment

Recommended QPI metric: Individuals positively impacted by improvements

- See [1.10](#).

2.8: Apply process improvement methodology to improve quality/ efficiency (except 2.8.11)

Recommended QPI metric: Individuals positively impacted by improvements

- See [1.10](#).

2.10: Use of palliative care programs

Recommended QPI metric: Palliative care consults provided

- Consults, as well as additional visits (post consults), may be counted toward QPI if these are included in the project.

2.11: Conduct medication management

Recommended QPI metric: Number of unique individuals receiving medication management services

- Medication management activities may include providing and discussing written materials related to medications with patients to ensure that they understand the purpose of various medications, when they should be taken, consequences of drug omission, precautions related to over-the-counter drugs, toxic side effects, etc.

Running the Numbers

What is QPI?

HHSC understands that QPI continues to be confusing for some providers. In a nutshell, QPI metrics are intended to capture the additional individuals served or encounters provided in a given year as a result of the DSRIP project (compared to the service volumes that would have been provided had the DSRIP project not been implemented). QPI metrics are important to help show the impact of DSRIP on healthcare access and quality in Texas, particularly for Medicaid and low-income uninsured individuals.

Moving from Cumulative to Annual QPI Numeric Goals

One source of confusion for some providers has been the use of annual versus cumulative goals for QPI. Cumulative goals (which include QPI from the current demonstration year plus the QPIs from previous years) were implemented for reporting and payment purposes, since a QPI metric, if not achieved by the end of the demonstration year (DY) designated in the plan may be carried forward into a subsequent DY for late achievement.

To simplify QPI for providers, HHSC will no longer ask providers to reference or calculate cumulative QPI. Instead, moving forward only annual QPI (QPI specific to any single demonstration year) will be required. HHSC will remove references to cumulative QPI goals from DY4 and DY5 baseline/ goals and numeric QPI goals will be adjusted to reflect annual goals rather than cumulative goals.

The calculations needed by HHSC for payment of carry-forward QPI metrics will be automatically made by the *QPI Reporting Template*.

Determining the Pre-DSRIP Baseline

A general goal of DSRIP is to show increased capacity and enhanced services compared to what existed prior to DSRIP. To determine the level of service that existed prior to the implementation of the DSRIP project, the provider must determine the pre-DSRIP baseline. Every QPI metric should have one (and only one) pre-DSRIP baseline. While the QPI will change from one DY to the next, the pre-DSRIP baseline will not change.



The pre-DSRIP baseline should typically be calculated based on the number of individuals served or encounters provided in the year prior to the year the DSRIP project starts. Depending on when a DSRIP project started, the pre-DSRIP baseline year might be based DY2 or DY1 service volume.

For projects that provide a new program or service (e.g., the opening of a new primary care clinic), the pre-DSRIP baseline would be 0 individuals or encounters. For projects that expand an existing program or service (e.g., increasing hours and staff at an existing primary care clinic), there is a pre-DSRIP baseline greater than 0 that the project seeks to build on (e.g., the number of encounters provided at the clinic prior to the increase in hours and staff). By reporting a pre-DSRIP baseline, providers are able to show the impact of the project in serving additional individuals or providing additional encounters over the pre-DSRIP service volume.

The pre-DSRIP baseline should reflect the QPI metric:

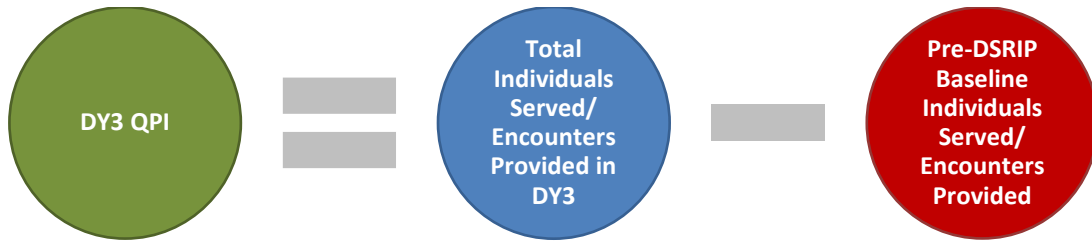
- If the project's QPI metric is individuals-based, the pre-DSRIP baseline will be based on the number of unique individuals served during the pre-baseline period. If the project's QPI is encounters-based, the pre-DSRIP baseline will be calculated based on the number of encounters provided during the pre-baseline time period.
- The pre-DSRIP baseline should also reflect the project's goal. If, for example, a provider already operates a primary care clinic that serves patients of all ages, and the goal of the project is to increase primary care capacity for the community by hiring an additional physician, the pre-DSRIP baseline would be the number of primary care clinic office visits provided in the year prior to the hiring of the new physician. If, however, the goal of the project is to increase primary care capacity for children by hiring a pediatrician, the provider may choose to base their pre-DSRIP baseline on the number of primary care clinic office visits provided to children in the year prior to the hiring of the new physician.

When discussing QPI, it's important to distinguish between a pre-DSRIP baseline and a DSRIP baseline. In contrast to pre-DSRIP baseline which measures service volume PRIOR to DSRIP project implementation, a DSRIP baseline measures service volume AFTER the project is implemented (typically during the first year of implementation). In their metrics, some providers refer to "establishing a baseline" in their first year of project implementation and increasing the number of individuals served or encounters provided by X% over the baseline in subsequent years. For example, a project may have a DY2 (non-QPI) metric to establish the first year's number of visits for a new primary care clinic (1000 visits), and then have QPI metrics in DY3-5 to increase that volume by 200 additional visits each year to 1200, 1400 and 1600 visits per year, respectively. In this case, since the 1000 visits in DY2 were provided as part of the DSRIP project, they are considered a DSRIP baseline, and are not the same as the pre-DSRIP baseline that HHSC is requesting when providers report on QPI metrics.

 <p>Pre-DSRIP Baseline</p> <p>Based on individuals served or encounters provided PRIOR TO implementation of DSRIP project</p> <p>Equals 0 if DSRIP project is not an expansion (i.e., provides a new program or service)</p>	 <p>DSRIP Baseline</p> <p>Based on individuals served or encounters provided AFTER implementation of DSRIP project</p> <p>Often reported as an "Establish a baseline" metric for DSRIP projects providing a new program or service</p>
---	---

QPI Calculation

To determine the number of individuals served or encounters provided in a given demonstration year (DY) that are a result of the DSRIP project (the QPI), you must subtract the Pre-DSRIP individuals served/ encounters provided from the total individuals served/ encounters provided in the DY.



HHSC has included some examples of how to calculate QPI below.

QPI Example 1 (New Project - Encounters): A provider is opening its first primary care clinic as part of their DSRIP project during DY2. Consequently, their pre-DSRIP baseline is 0 visits. The clinic provided 1,000 visits in DY2 (its first year of operation as a DSRIP project - so a DSRIP baseline), and the QPI goals are to provide an additional 400 visits over DY2 in DY3, 600 visits over DY2 in DY4 and 800 visits over DY2 in DY5, making the project's QPI 1,400 visits in DY3, 1,600 visits in DY4, and 1,800 visits in DY5. In order to meet their QPI metrics, the provider would need to provide 1,400 total visits in DY3, 1,600 in DY4, and 1,800 in DY5.

DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY3	0	1,400	1,400
DY4	0	1,600	1,600
DY5	0	1,800	1,800

QPI Example 2 (Expansion Project - Encounters): Through their DSRIP project, a provider will expand primary care capacity at an existing clinic by hiring new staff beginning in DY3. The provider provided 1,000 visits in DY2 (the year prior to the clinic expansion), which is the pre-DSRIP baseline. The provider's QPI goals are that the new staff will provide an additional 1,400 visits in DY3, and additional 1,600 visits in DY4, and an additional 1,800 visits in DY5. In order to meet their QPI metrics, the provider must provide a total of 2,400 visits at the clinic in DY3, 2,600 total visits in DY4, and 2,800 total visits in DY5.

DY	Pre-DSRIP Baseline	QPI Encounters	Total Encounters
DY3	1,000	1,400	2,400
DY4	1,000	1,600	2,600
DY5	1,000	1,800	2,800

QPI Example 3 (New Project - Individuals): A new diabetes care management program is being established through DSRIP, so the pre-DSRIP baseline is 0 individuals receiving care under the chronic care model. Through DSRIP, the project plans to serve 50 patients in DY2 (a non-QPI metric), and enroll 50 more patients in the program in each subsequent DY, making the QPI goals 100 individuals receiving care under the chronic care model in DY3, 150 individuals receiving care in DY4 and 200 individuals

receiving care in DY5. To meet their QPI metrics, they must provide care to 100 unique individuals in DY3, 150 in DY4, and 200 in DY5.

DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY3	0	100	100
DY4	0	150	150
DY5	0	200	200

QPI Example 4 (Expansion Project - Individuals): A diabetes care management program is being expanded through DSRIP. Prior to DSRIP, in DY2, a hospital had a care management program that served 50 individuals with diabetes each year (the pre-DSRIP baseline). Beginning in DY3, the hospital intends to enroll 50 additional patients to the program in each DY as part of their project, making the QPI goals 50 additional individuals served in DY3, 100 in DY4, and 150 in DY5. To meet the QPI metrics, the provider will have to serve a total of 100 individuals in DY3, 150 in DY4, and 200 in DY5.

DY	Pre-DSRIP Baseline	QPI Individuals	Total Individuals
DY3	50	50	100
DY4	50	100	150
DY5	50	150	200

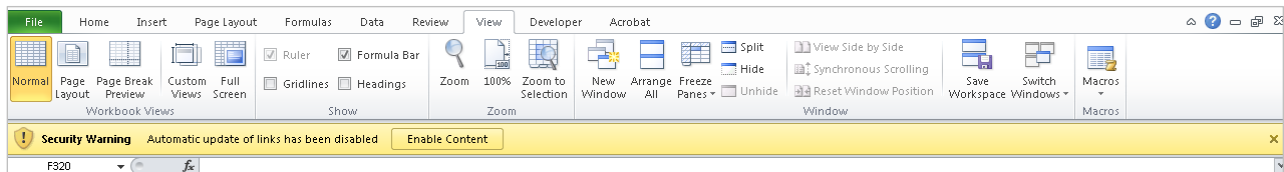
QPI Reporting Template

Step-by-Step Instructions

Providers should only submit one QPI Reporting Template per project. The template will serve to meet both metric achievement and SAR requirements for DY3, DY4, and DY5.

Provider entries are highlighted in yellow. Blue text indicates information that is auto-filled based on provider inputs.

To ensure the *QPI Reporting Template's* interactive features work properly, be sure to click the *Enable Macros* button if it pops up upon opening the file (see image below). Also, confirm that workbook calculations are set to *Automatic*. (Under the *File* tab in Excel, click *Options*, followed by *Formulas*. Under *Calculation Options*, select *Automatic* for *Workbook Calculation*.)



To ensure that identifying patient information is not transmitted to HHSC, providers will not be able to save the *QPI Reporting Template* until the last step (Step 9: De-Identifying Patient IDs) is completed for

the DY(s) for which the provider is reporting. As such, HHSC recommends providers complete the template in one sitting if possible. Providers should also consider running the client database query (see Step 6) prior to entering any information into the QPI template.

Instructions tab:

Step 1: Before entering any information in the *QPI Reporting Template*, carefully read the *QPI Reporting Companion Document*. The Instructions tab in the *QPI Reporting Template* also includes the Step-by-Step Instructions included in the *Companion Document* and may be used as a quick reference while

How to Submit:
The *QPI Reporting Template* should be uploaded to the online reporting system with all other applicable supporting documentation.

By checking this box, I confirm that I have read the QPI Reporting Companion Document and understand that QPI data must be de-identified before submission to HHSC.

completing the template. Check the box at the bottom of the Instructions tab (see image below) to confirm you have read the *Companion Document* and that you understand that QPI data must be de-identified prior to submission to HHSC.

Checking the box on the Instructions tab will change your progress for "Instructions" on the QPI Data Entry tab from a red Incomplete to a green Complete.

PROGRESS INDICATOR	
Step 1: Instructions	Complete
Step 2: Project Selection Inputs	Incomplete
Step 3: Metric Selection Inputs	Incomplete
Step 4: Data Entry & Summary Tabs	Incomplete

Project Data Entry tab:

Providers will enter general provider, Medicaid/ Low-Income Uninsured (MLIU), and QPI metric information on the Project Data Entry tab.

Step 2: Under Step 2 (see image below), providers will select their region (RHP) number, their TPI and the project's ID from the dropdown menus.

2 - PROJECT INFORMATION

Region:

TPI:

Provider:

Project ID:

Project Area:

% of Individuals Served that are Medicaid/ Low-Income Uninsured				
	% Medicaid	% Low-Income Uninsured	Total % MLIU	Description of MLIU (payer sources income levels etc.)
DY3 MLIU % Goal:			0.00%	
DY3 MLIU % Actual:			0.00%	
DY4 MLIU % Goal:			0.00%	
DY4 MLIU % Actual:			0.00%	
DY5 MLIU % Goal:			0.00%	
DY5 MLIU % Actual:			0.00%	

These selections will allow the auto-filled cells in the QPI Template to fill. (Please note that DY4 and DY5 information in the *QPI Reporting Templates* will be updated after review of Change Requests are completed and prior to April DY4 reporting.)

Enter the Medicaid and Low-Income Uninsured (MLIU) percentages for your project for the DY for which you are reporting. The combined MLIU percentage will be calculated for you based on your entries. Enter a description of the MLIU that includes payer sources that are included, income levels, and other information you think would be helpful to describe how these percentages were calculated. If your MLIU percentages vary greatly from the goals, please also include an explanation of why this is the case.

Note that, while supporting documentation does not need to be submitted during reporting to support the MLIU percentages you enter, this information is auditable by the compliance monitor.

The MLIU percentages should be updated each time you report (i.e., if you report for payment in April, and then report for SAR in October, you should enter the MLIU percentage for October 1 through March 31 of the DY in April and update the percentages for the full year in October.

Once you complete all inputs under Step 2, "Project Selection Inputs" under the Progress Indicator will change from a red Incomplete to a green Complete.

Step 3: The Template allows a provider to report up to three QPI metrics to accommodate projects with multiple QPI metrics in a DY. Step 3 (see image below) will show one, two or three sets of input boxes, depending upon the number of QPI metrics a project includes. Projects with more than one QPI metric should repeat the instructions below for each QPI metric.

3 - QPI METRIC SELECTION			
QPI Metric #1			
QPI Metric ID:	DY3	DY4	DY5
Metric Language:	P-6.1	1-11.1	1-11.1
	Baseline: 3 sites/zero patients Goal: 4 sites/ 10 patients served at new site. 10 individuals	Numerator: Number receiving counselling services from new center after expansion. Denominator: Number of people receiving counselling services in the previous year. Baseline: 10 patients receiving counselling services at new center. Goal: 250% over previous year (15 new patients receiving counselling services at new counseling site, for a total	Numerator: Number receiving counselling services from new center after expansion. Denominator: Number of people receiving counselling services in the previous year. Baseline: 25 patients receiving counselling services at new center. Goal: 100% over previous year (25 new patients receiving counselling services at new counseling site, for a total
Metric Grouping	Individuals		
Metric Achievement Reporting Status:			
Metric-Level SAR Reporting Status:			
QPI Goal:	10	25	48
QPI Actual:			
MLIU QPI required?	No	No	No
MLIU QPI Goal:			
MLIU QPI Actual:			
Revise the MLIU QPI description for this metric, if it differs from the project-level description inserted from your entry above:			

Select your Metric Achievement Reporting Status from the dropdown list for the applicable DY. If you do not have a QPI metric for a given DY, "NA - No QPI metric in DY#" will be selected. If you are submitting your template in April or October and are reporting for payment, select "Reporting DY# metric achievement in DY# reporting period". If you are not reporting your QPI metric for payment (e.g., you're submitting your template in October to report SAR and will be requesting carry-forward for your QPI metric), select "Not ready to report DY# metric achievement". If you are submitting your template in April or October of the subsequent DY to report your QPI metric as carry-forward, select "Reporting DY# metric achievement as carry-forward".

Once you have reported your QPI metric for payment, this dropdown should not be changed (e.g., if you submitted your template in April for payment and are re-submitting in the October of the same DY, your selection not be changed). The only exception to this rule will be for providers who reported a metric as achieved during April DY3 reporting. Because providers did not have access to the DY3 - DY5 QPI Reporting Template in April, providers should change their Metric Achievement Reporting Status to "Reporting DY3 metric achievement in DY3 reporting period", so it's clear metric achievement was reported for DY3.

Next, select your Metric-Level SAR Reporting Status from the dropdown list for the applicable DY. If you do not have a QPI metric for a given DY, "NA - No QPI metric in DY#" will be selected. If you are reporting for payment in April reporting, "Not reporting QPI for Oct DY# SAR purposes" should be selected. If you are reporting for any reason in October, "Reporting QPI for Oct DY# SAR purposes" should be selected. Like for the Metric Achievement Reporting Status, once you have reported for SAR for a DY, this dropdown should not be changed. So, if you are reporting as carry-forward, you should not change this dropdown when you report for payment, because you will already have submitted your SAR for this metric.

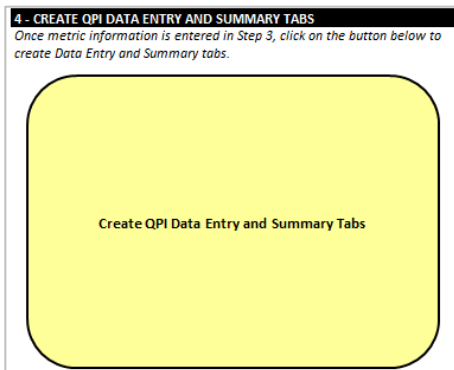
If you're reporting for payment and/ or for SAR for the metric listed, enter the QPI you have achieved to date for the related metric. Each time you submit the reporting template for the same DY, you will need to update this cell. So, for example, if you are reporting in April of a DY and have entered the QPI you achieved between October 1 and March 31, you will want to update this cell with the full year's QPI when you report for SAR in October. Similarly, if you report for SAR only in October and report as carry-forward in April or October of the next DY, you'll want to update the QPI with your carry-forward QPI when reporting for payment.

For some 4-year projects, providers are required to report a Medicaid, Low-Income Uninsured QPI in addition to the total QPI. For these providers, the MLIU QPI Required cell will be marked "Yes". (If the MLIU QPI Required cell is marked "No", this step can be skipped.) Providers who must report a MLIU QPI should enter the MLIU QPI goal as it is listed in the baseline/ goal statement and enter the MLIU QPI achieved. Please note that the MLIU QPI should be similar to the total QPI times the Total MLIU % reported for the DY in Step 2. For example, if the total QPI reported is 100 and the MLIU % reported in Step 2 is 75%, the MLIU QPI should be around 75.

The box below the MLIU QPI Actual will auto-fill with the MLIU description entered for the DY in Step 2. Generally, the description should be the same for overall MLIU % and MLIU QPI. If for some reason the descriptions differ, please update the cell under Step 3.

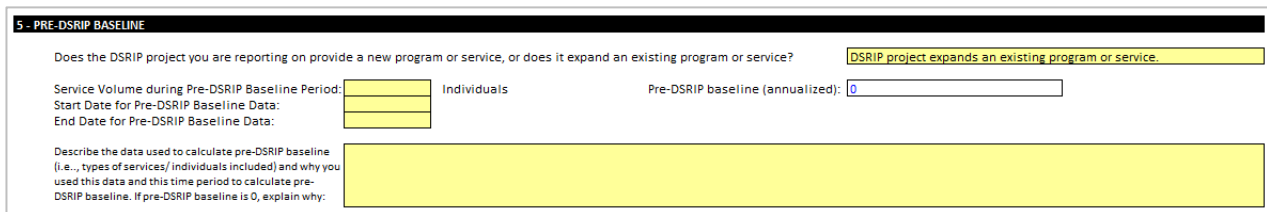
Once you complete all inputs under Step 3, "Metric Selection Inputs" under the Progress Indicator will change from a red Incomplete to a green Complete.

Step 4: Once steps 1 - 3 are complete, click on the "Create QPI Data and Summary Tabs" button (see image below). This action will create two new tabs for each QPI metric set. Proceed to the newly created QPI Data Entry tab.



QPI Data Entry tab:

Step 5: When completing the *QPI Reporting Template* for the first time for any metric, the provider will need to provide information regarding the Pre-DSRIP baseline in Step 5 (see image below) to demonstrate that the QPI in each DY is an increase over the previous service volume. Providers should carefully read the *QPI Reporting Companion Document* to confirm that they are correctly entering their pre-DSRIP information.

A screenshot of a form titled "5 - PRE-DSRIP BASELINE". The form contains several input fields and a text area. The first question is "Does the DSRIP project you are reporting on provide a new program or service, or does it expand an existing program or service?" with a dropdown menu set to "DSRIP project expands an existing program or service". Below this are three input fields for "Service Volume during Pre-DSRIP Baseline Period:", "Start Date for Pre-DSRIP Baseline Data:", and "End Date for Pre-DSRIP Baseline Data:". To the right of these is a label "Individuals" and a "Pre-DSRIP baseline (annualized):" input field with the value "0". At the bottom is a large text area for "Describe the data used to calculate pre-DSRIP baseline (i.e., types of services/ individuals included) and why you used this data and this time period to calculate pre-DSRIP baseline. If pre-DSRIP baseline is 0, explain why:".

Providers will need to indicate whether their "DSRIP project provides a new program or service" or their "DSRIP project expands an existing program or service". If the project provides a new program or service, the pre-DSRIP baseline service volume and dates will gray out and the annualized pre-DSRIP baseline will auto-fill to 0. If the project is an expansion, the provider will need to enter the pre-DSRIP baseline that they calculated for their project, as well as the dates used for the calculation.

Whenever possible, providers should use 12 months of data immediately preceding the implementation of the DSRIP project to calculate their pre-DSRIP baseline. If a project begins seeing patients on November 1, 2013, for example, the provider could base their pre-DSRIP baseline on the service volume

(encounters provided or individuals served depending on their QPI metric grouping) between November 1, 2012 and October 31, 2013. If the provider is not able to obtain dates exactly one year prior to the date of implantation, they may submit data from a time period close to these dates (e.g., their fiscal or calendar year data) that is more readily available. The pre-DSRIP baseline date range should not overlap the QPI date range the provider will provide in Step 5.

If a provider is unable to obtain 12 months of data on which to calculate the pre-DSRIP baseline, the template will calculate an annualized pre-DSRIP baseline based on the data entered.

In the space provided, all providers should provide a description of the data used to determine their pre-DSRIP baseline (including the target population, the types of encounters included, etc.) and the reason the date range for the calculation was used. If the provider did not use 12 months of data to calculate their pre-DSRIP baseline and/ or did not use 12 months immediately preceding the implementation of their project, they should provide justification here. If a provider's pre-DSRIP baseline is 0, they should clearly explain why they consider their project to be a new project and not an expansion. If the pre-DSRIP baseline entered in the *QPI Template* differs from what is included in the project narrative or in the baseline/ goal, providers should also include an explanation for this change in this box.

While HHSC is not asking providers to submit documentation to support the calculation of their project's pre-DSRIP baseline, this information is auditable by compliance monitor.

Step 6: In order to properly document and calculate QPI achievement, HHSC is asking providers to paste patient ID and encounter date data from their EHR system, client database, or spreadsheet into the related columns on the QPI Data Entry tab (see image below). Providers should enter both patient and encounter data regardless of their QPI metric grouping. (Note: To simplify reporting, unlike in the *PILOT April DY QPI Reporting Template*, HHSC is no longer requesting payer source data when reporting QPI.)

6 - QPI DATA ENTRY		
DY3		
Patient ID	Encounter Date	
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		
35		
36		
37		

DY4		
Patient ID	Encounter Date	
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		
35		
36		
37		

DY5		
Patient ID	Encounter Date	
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		
32		
33		
34		
35		
36		
37		

HHSC recognizes that each provider has their own unique way of collecting data, so we've kept flexibility in mind when designing the *QPI Reporting Template*.

- Patient IDs can include letters, numbers, or a combination of both. The only requirement is that unique individuals have unique IDs. Pasting confidential information like names or social security numbers into the Patient ID field is acceptable, because the template will de-identify the data before it's sent to HHSC.
- Encounter dates need to include month, day, and year.

In order to obtain the data you want to paste into the *QPI Reporting Template*, follow the steps below:

Run a query from provider's data source that includes patient ID and encounter date variables and reflects the QPI metric and pre-DSRIP baseline data the provider submitted:

- Providers will need to limit the query to the types of encounters and that are relevant to the DSRIP project based on the project option, metric ID, and metric language. A primary care (1.1) project, for example, should typically only include office visits (and not appointment reminder calls, lab visits, etc.) in their query. Please refer to the *QPI Reporting Companion Document*, as well as the QPI metric language when determining the patient contact types to include in your query.
- Providers will also need to limit the query to the types of individuals that are relevant to the DSRIP project. For example, if a provider's goal is to increase the number of women served, the query should be limited to women.
- Providers will also need to limit the query to the appropriate dates.
 - For April reporting of achievement, for example, encounters should be limited to those that occurred between October 1 and March 31 of the DY.
 - For October reporting, encounters should be limited to those that occurred between October 1 and September 30 of the DY.
 - For carry-forward reporting, encounters should be limited to October 1 of the DY and the date in the subsequent DY on which the provider provided the last encounter for carry-forward.

Once the provider has run a query limiting the data to the appropriate encounters, individuals, and date parameters, they should highlight and copy the data from the query, so it can be pasted into *the QPI Reporting Template*. If the query includes the Patient ID and Encounter Date fields side by side and in the same order as they are in *the QPI Reporting Template* (i.e., Patient ID in the first column, Encounter Date in the second column), the provider can highlight and copy all of the data in these two columns (minus the field names). If the query does not display the fields side-by-side and/ or does not display them in the same order as the template, the provider will need to copy and paste the data from each field one at a time.

Once the provider has highlighted and copied the data (minus the field names) from the query, return to the QPI Data Entry tab of the *QPI Reporting Template*. Right click on the first cell in the Patient ID column (or the column related to the data you copied if you're pasting fields one-by-one) in the QPI workbook and select Paste Values. If you have a large number of encounters to paste, it may some time

to paste all of the data. Please be patient and do not attempt to do any other actions in the template until the paste is complete.

Step 7: Once the appropriate Patient ID and Encounter Date data has been pasted into the template, providers will need to describe the data that was pasted into the spreadsheet in Step 7 (see image below).

7 - QPI DATA DETAILS

DY3

Describe the data entered below detailing the types of individuals (e.g. children attending a particular school, individuals with behavioral health issues, age groups, etc.) and patient contacts (e.g. office visits, phone calls, screenings, admissions, discharges, etc.) that are included.

Start Date for DY3 QPI Data: _____

End Date for DY3 QPI Data: _____

DY4

Describe the data entered below detailing the types of individuals (e.g. children attending a particular school, individuals with behavioral health issues, age groups, etc.) and patient contacts (e.g. office visits, phone calls, screenings, admissions, discharges, etc.) that are included.

Start Date for DY4 QPI Data: _____

End Date for DY4 QPI Data: _____

DY5

Describe the data entered below detailing the types of individuals (e.g. children attending a particular school, individuals with behavioral health issues, age groups, etc.) and patient contacts (e.g. office visits, phone calls, screenings, admissions, discharges, etc.) that are included.

Start Date for DY5 QPI Data: _____

End Date for DY5 QPI Data: _____

In the text box, specify:

- the types of encounters (e.g., office visits, nurse line calls completed, screenings, pharmacy consultations, etc.) that are included in the data; and
- the types of individuals (ages, diagnoses, discharges, etc.) that are included in the data.

Then, enter the date ranges for QPI encounters you included in Step 6.

QPI Summary tab:

Step 8: Once the provider enters their information on the QPI Data Entry page, but before they click the button to de-identify the information they entered, they should go to the QPI Summary tab to view the *QPI Template* calculations.

QPI calculations will be based on the project's QPI grouping. If the grouping is encounters, all encounters within the allowable date ranges will be counted. If the grouping is Individuals, the number of unique individuals with encounters within the allowable date ranges will be calculated. The QPI will equal the total eligible encounters provided or individuals served minus the pre-DSRIP baseline.

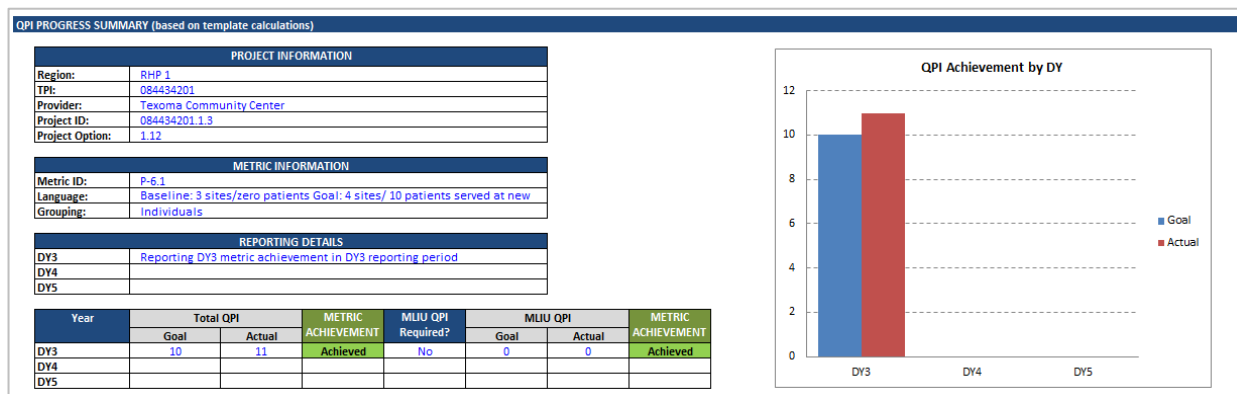
Data Calculation Match Indicator: The provider should view the Data Calculation Match Indicator (see image below) on the QPI Summary tab to confirm that the QPI Template calculation matches what the provider entered as their QPI actual on the Project Data Entry tab (the Provider Calculation).

DATA CALCULATION MATCH INDICATOR			
Year	Actual QPI Individuals		
	Provider Calculation	Template Calculation	Calculations Match
DY3	11	11	Yes
DY4			
DY5			

If the template calculation matches the provider entry, the Calculations Match column will indicate "Yes" in green. If there is a discrepancy between the template calculation and the provider entry, the provider will see a red "No" the Calculations Match column.

If template calculation and provider entry does not match according to the Data Match Indicator, the provider should carefully review the *QPI Reporting Companion Document* and the provider entries to confirm data was correctly entered. If after taking these steps, the provider is still unable to reconcile provider and template discrepancies, please go to the yellow Feedback box (Step 8) on the QPI Summary tab and provide a detailed explanation of how provider entries were calculated and provide supporting DE-IDENTIFIED information (see the *Companion Document* for more information) to support that calculation.

QPI Progress Summary: The Progress Summary table (see below) displays the QPI Goals and QPI Actuals side-by-side by demonstration year and indicates whether QPI goals (both total QPI and MLIU QPI, if applicable) were achieved according to template calculations. Providers are strongly encouraged NOT to submit a metric for payment if the Total QPI and the MLIU QPI (if applicable) show Not Achieved.



De-Identifying Personally Identifiable Information:

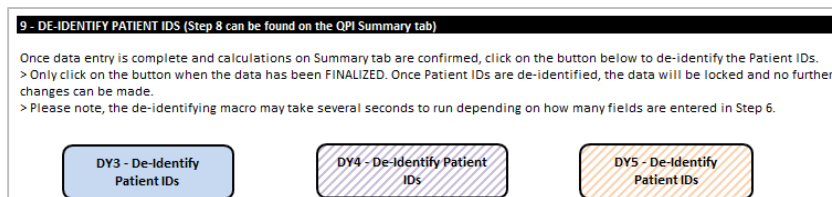
Once the provider verifies that all data has been correctly entered and they are ready to submit the data information entered for this metric, they will return to the Metric QPI Data Entry tab and de-identify the QPI data (patient IDs).

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable Patient Information. Providers are required to only submit De-identified information as evidence of meeting a metric. (De-Identified Information means health information, as defined in the [HIPAA privacy regulations](#) as not [Protected Health Information](#), regarding which there is no reasonable basis to believe that the information can be used to identify an [Individual](#). See the "WARNING NOTICE Regarding Submission of Supporting Documentation" in the *Companion Document* for more information on Protected and De-Identified Health Information.)

The QPI Reporting Template includes a step to de-identify any protect patient information (e.g., social security numbers) that may have been pasted into the template. During this process, Patient IDs entered by the provider will be replaced by randomly generated IDs unique to each patient.

Providers should be sure they have completed steps 1 - 8 and have no further changes to make before completing Step 9.

Step 9: To de-identify patient IDs, return to the QPI Data Entry tab and click on the applicable DY's De-Identify Patient IDs button. (See image below.) If a provider has entered a large number of patient IDs, this process may take a little time. Please do not attempt any other actions in the *QPI Reporting Template* until this step has been completed.



Once de-identifying is complete, Patient IDs will have been replaced by randomly generated IDs and the DY# - Patient IDs De-Identified progress indicator will show complete. DY data under Step 6 on the QPI Data Entry tab may also be greyed out and locked. This will occur once a provider has indicated they have reported for metric achievement for the DY and they have reported for SAR purposes for the DY.

Providers may now save the template (see Naming QPI Reporting Template File section below).

Submission of QPI Reporting Template

Progress Indicators:

Before submitting the *QPI Reporting Template*, please confirm that the Progress Indicators on the QPI Data Entry tab(s) show a green “Complete” for all sections (see image below).

PROGRESS INDICATOR	
Step 5: Pre DSRIP Baseline	Complete
Step 6: QPI Data Entry	Complete
Step 7: QPI Data Details	Complete
Step 8: QPI Calculation Check	Match
Step 9: De-Identify Patient IDs	
DY3 - Patient IDs De-Identified:	Complete
DY4 - Patient IDs De-Identified:	N/A
DY5 - Patient IDs De-Identified:	N/A

Naming and Submitting QPI Reporting Template File:

Providers should name their *QPI Reporting Template* as follows: RHPXX_ProjectID_QPI. Be sure to continue to save the file as a macro-enabled file [with an .xlsm (preferred) or .xlm file extension]. Remember, providers will not be able to save the *QPI Reporting Template* until the last step (Step 9: De-Identifying Patient IDs) is completed. The *QPI Reporting Template* should be uploaded to the online reporting system along with all other applicable supporting documentation.