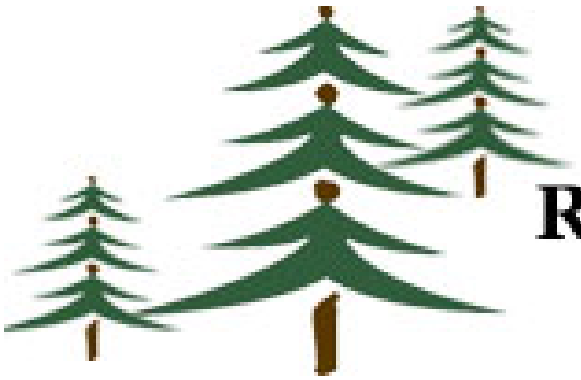

Redwood Community Health Network

Redwood Community Health Coalition

Performance Improvement Program

Program Year 2021 – updated December 18, 2020

Redwood Community Health Network
Performance Improvement Program 2021

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Program Overview:

The Redwood Community Health Network (RCHN) Performance Improvement Program (PIP) offers financial incentives to Sonoma County member health centers in order to improve clinical quality and outcomes, improve patient experience, build clinically integrated network infrastructure, and decrease total cost of care for the population that RCHN members serve. RCHN's PIP program is a risk-pool based performance incentive program.

Guiding Principles

1. All incentive measures chosen are anticipated to:
    a. Reduce unnecessary utilization of services and reduce patient costs
    b. Improve the quality of health center care delivered
    c. Improve patient experience
    d. Increase utilization of preventive services
2. Measures are based on community need
3. Measures are aligned with national standards

Eligibility:

Health center members of RCHN are eligible for PIP if they participate in joint contracting between RCHN and Partnership HealthPlan and if the health center reports results to RCHN. Health center members must maintain adequate access to care and primary care utilization. In order to monitor this, health centers will provide RCHN access to their information on Partnership Health Plan's Partnership Quality Dashboard (PQD).

RCHN Support for Quality Improvement:

Health centers receive support for quality improvement through Redwood Community Health Coalition (RCHC)'s Population Health Programs including RCHC's HRSA Health Center Controlled Network grant activities. These include:

- Medical Director/CMO peer meeting: the venue where standardized clinical guidelines are developed to improve clinical measures
- RCHC's shared clinical decision support tools to support standardized clinical guidelines within the electronic health record: templates, order sets, alerts, recalls, reports, etc.
- Analytics and reports to support health center reporting and RCHC evidence based clinical initiatives
- Documented best practices for health center outcome measures: published to the RCHC website
- Conferences and trainings: published to the RCHC calendar
- Quality Improvement Leads peer meeting: the venue where best practices are captured and shared
- Data Standards and Integrity Council (DSIC): The Council's mission is to improve data governance, standardization, and management across the PHCs, and identify priority RCHC standard reports.
- Data Analyst Leads peer meeting: the venue where health center data leads are trained on RCHC standard reports and data validation

- Clinical work groups are formed to address particular areas of health on an as needed basis. These groups are made up of RCHN staff, content experts from health centers and other stakeholder organizations, and make recommendations to the Medical Directors for standards in clinical practice.

Program timelines:

- The PIP program runs on an annual period beginning January 1 and ending December 31.
- Measurement periods for clinical quality measures are for the 12 months preceding the end of the reporting period unless otherwise noted in the measurement description.
- Health centers report all improvement measures electronically to RCHN quarterly by the end of the month following the quarter's close. For those health centers not using Relevant, reports will need to be submitted to RCHN and the source query and supporting data may also be requested.

Governance:

RCHN staff develop and administer the PIP program to be consistent with industry performance incentive programs, including selection of the outcomes measurement set with defined targets. In the development and administration of the PIP program, RCHN adheres to federal and state laws, and guidance. RCHN staff collaborates with internal and external stakeholders for program feedback including the following groups:

- RCHN Membership – CEOs of health centers
- RCHC Medical Directors/CMO of health centers
- RCHC Quality Improvement peer group – Quality leads of health centers
- Partnership HealthPlan of California

Code Sets and Reporting Instructions:

All clinical quality improvement measurements are based on standard code sets. If available, the measurement will be based on the CMS eMeasure code set which can be obtained through the National Library of Medicine at NLM Value Set Authority Center (VSAC) and are posted on the RCHN website. Measures not included in the eMeasure code set will be standardized using HEDIS specifications and code sets. All measures will be reviewed and standardized as needed by RCHC's Data Standards and Integrity Council.

RCHN publishes reporting instructions annually and posts them on RCHC's website.

Clinical Quality Measure Targets:

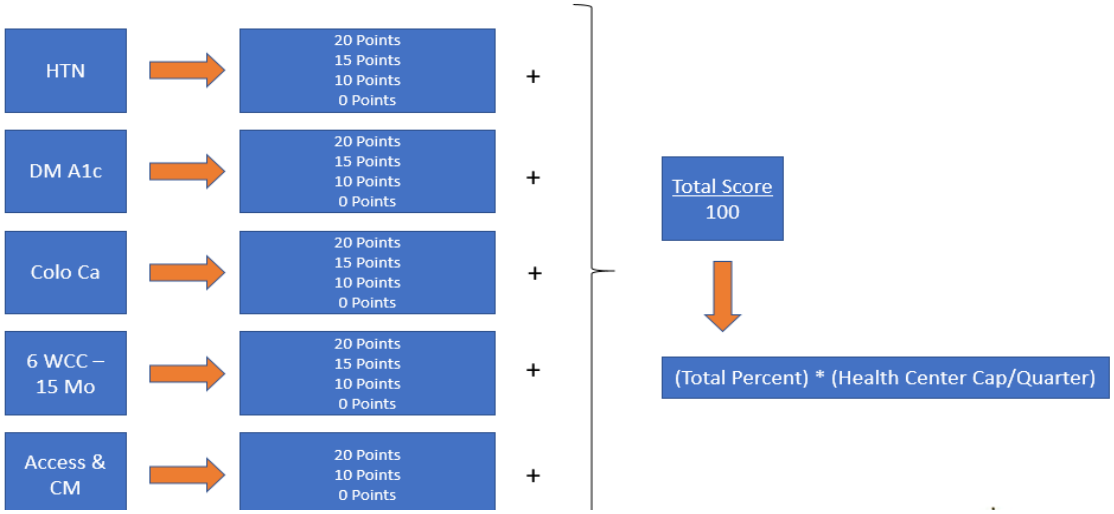
Measure/ Results	HTN – BP control	DM <9	Colon Cancer Screening	6 WCC by 15 months
TARGETS				
2016 Target	64%	71%		
2017 Target	65%	71%	40%	
2018 Targets	65% full points 62% ¾ points 59% half points	71% full points 63% ¾ points 55% half points	40% full points 36% ¾ points 32% half points	
2019 Targets	67% full points 64% ¾ points 61% half points	71% full points 63% ¾ points 55% half points	41% full points 37% ¾ points 34% half points	
2020 Targets	70% full points 67% ¾ points 64% half points	71% full points 65% ¾ points 60% half points	44% full points 40% ¾ points 37% half points	50% full points 45% ¾ points 40% half points
2020 Adjusted Targets (Q3,Q4-COVID)	**67% full points 64% ¾ points 61% half points**	**68% full points 62% ¾ points 57% half points**	**41% full points 37% ¾ points 34% half points**	**50% full points 45% ¾ points 40% half points**
2021 Targets	**67% full points 64% ¾ points 61% half points**	**68% full points 62% ¾ points 57% half points**	**41% full points 37% ¾ points 34% half points**	**55% full points 50% ¾ points 45% half points**
2019 PIP PERFORMANCE				
Q1- 2020 Average	69.8%	69.1%	45.6%	51.7%
Q2 - 2020 Average	n/a – alternate measure set adjusted for COVID pandemic			
Q3 – 2020 Average	63.9%	65.0%	41.1%	56.2%
Q4 – 2020 Average	TBD	TBD	TBD	TBD
BENCHMARK COMPARISONS				
QIP Targets 2020	61.04% (full pts) 50th percentile	50.97% (full pts) 50th percentile	32.24% (full pts) 25th percentile	65.83% (full pts) 50th percentile
UDS CA – 2019	66.23%	65.62%	46.24%	N/A

Payment:

1. Quarterly payment

RCHN will calculate a maximum payment (CAP) to each health center based on a measure of health center volume from the Uniform Data System from the prior calendar year. Payment amounts for the PIP program are calculated by adding the total points achieved for each quality measure. The individual points earned divided by 100 to calculate the percent of total funds available to each health center that will be paid.

Funds will be distributed quarterly to health centers no later than 45 days after the reporting period closes.



2. Relative improvement points

At the end of Q4, health centers ending the reporting year at 70 - 89% of points will be able to earn additional funds if the health center achieves >10% relative improvement in any one qualifying clinical measure. Qualifying measures are any of the four clinical measures that did not make full points in the 4th quarter. Qualified health centers that achieve the improvement threshold will receive 50% of the funds in reserve for that health center.
Calculation:

$$\frac{\text{(Current year performance) – (previous year performance)}}{\text{100 – (previous year performance)}}$$

3. Unearned funds

Unearned funds during the program year will roll over each quarter for an opportunity to earn the incentive when measures are met.
For unearned funds at the end of the program year:
Unearned funds following the determination of relative improvement, will roll over to the aggregate pool for the future year or will be utilized for projects and programs which will support quality improvement throughout the network.

Clinical Quality Improvement Measure Definitions

1. Hypertension Control

Rationale
Uncontrolled hypertension leads to coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. For every 20 mmHg systolic or 10 mmHg diastolic increase in blood pressure, there is a doubling of mortality from both ischemic heart disease and stroke (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

Heart disease and stroke accounted for more than 25% of deaths in Sonoma County in 2013 and continues to account for more than 25% from 2014-2017 (Sonoma County Department of Health Services 2019). Over the year 2013, the percentage of Heart Disease related deaths increased by nearly 6%. In Sonoma County 7% of adults were found to have heart disease which is higher than the state average and increased from 2012 – 2014 (Sonoma Health Action 2015).

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the control of hypertension and the long-term clinical outcomes is well established. In addition to preventing cardiovascular events and deaths, controlling hypertension would also result in cost savings to total cost of care for patients with hypertension (Moran 2015).

Measure alignment: CMS165, NCQA 0018, PHP QIP 2020, UDS 2020. Self-monitored blood pressure definition follows the QIP/HEDIS recommendations.

Measure description: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension and whose blood pressure was adequately controlled during the measurement period.

Program Performance Thresholds:

- Full points – 67%
- ¾ points – 64%
- Half points – 61%

Denominator definition: Patients 18–85 years of age at of the beginning of the reporting period, who had at least one medical visit, who had a diagnosis of essential hypertension during the measurement period or any time prior to the measurement period end.

Numerator definition

- Denominator patients whose most recent office blood pressure was <140/90 mm Hg. If no blood pressure is recorded during the measurement period, the patient's blood pressure is "not controlled". If there are multiple blood pressures taken on the same day, use the lowest systolic and diastolic values as the most recent blood pressure reading.
- The following blood pressure readings are acceptable:

  - Readings performed by a clinician or trained staff member as part of an office visit
  - Readings from a remote monitoring device transmitted to the health center electronically
  - Readings taken by the patient in the context of a telehealth visit where the reading is visualized (photo or video) or otherwise verified by the provider or trained staff member directly.
  - Self-reported blood pressure readings where the measurement cannot be independently verified by the provider or trained staff member.
- The following blood pressures should not be reported:
  - Those taken during an inpatient or ED visit

Exclusions

- Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period
- Patients who have been pregnant during the measurement period
- Patients who were in hospice at any time during the measurement year
- Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
- Patients aged 66 and older with advanced illness and frailty

2. Blood Sugar Control in Diabetes

Rationale

People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. Average medical expenditures for people with diabetes is 2.3 times higher than for people without diabetes. (CDC 2017).

The percent of people in Sonoma County living with diabetes has been increasing steadily from 2011-2015 especially amongst those over 65 years of age (Sonoma Health Action 2015). Sonoma County Health Centers average rate of control of diabetes (A1c≤9) in 2016 was 68% much lower than the Healthy People 2020 Goal of 83.9% (HRSA 2016).

Randomized clinical trials have demonstrated that improving control of A1c levels correlates with a reduction in microvascular complications (retinopathy, nephropathy and neuropathy) in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993). Improved diabetes control also results in decreased cardiovascular complications and potentially reduces the cost associated with them.

Measure alignment: CMS122, NQF0059, PHP QIP 2020, UDS 2020

Measure description: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c ≤ 9.0% during the measurement period.

Program Performance Thresholds:

- Full points – 68%
- ¾ points – 62%
- Half points – 57%

Denominator definition: Patients 18–74 years of age at of the beginning of the reporting period, with a diagnosis of diabetes (type 1 or type 2) and at least one medical visit during the measurement period. Patients with a diagnosis of secondary diabetes due to another condition should not be included.

Numerator definition: Patients with most recent HbA1c level (performed during the measurement period) is ≤ 9.0%.

Exclusions

- Patients who were in hospice at any time during the measurement year
- Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
- Patients aged 66 and older with advanced illness and frailty

3. Colon Cancer Screening

Rationale

Colorectal cancer is the third leading cause of cancer death in the United States (American Cancer Society 2019). If the disease is caught in its earliest stages, it has a five-year survival rate of 91%. Colorectal cancer screening of individuals with no symptoms can identify polyps whose removal can prevent more than 90% of colorectal cancers. Studies have shown that the cost-effectiveness of colorectal cancer screening is $40,000 per life year gained (American Cancer Society 2015).

The incidence of colon cancer for people over 50 years of age, in Sonoma County is higher than the state average (Healthy Communities Institute 2016). The average screening rate for Sonoma County health centers in 2019 was 46% which is below the Healthy People 2020 goal of 70.5% (HRSA 2016).

Measure alignment: CMS130, NQF0034, PHP QIP 2020, UDS 2020

Measure description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

Program Performance Thresholds:

- Full points – 41%
- ¾ points – 37%

- Half points – 34%

Numerator definition
Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- FIT-DNA (Cologuard) during the measurement period or the two years prior to the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period

Denominator definition: Patients 50–74 years of age at of the beginning of the reporting period and at least one medical visit during the measurement period

Exclusions

- Patients with a diagnosis or past history of total colectomy or colorectal cancer
- Patients who were in hospice for any part of the measurement period
- Patients aged 66 or older who were living long-term in an institution for more than 90 days during the measurement period
- Patients aged 66 and older with advanced illness and frailty

4. Six Well Child Checks by 15 months

Rationale
Assessing a child's physical, emotional and social development is important. Behaviors established during childhood such as eating habits and physical activity, often extend into adulthood. Well child visits provide an opportunity for health centers to provide prevention services such as immunizations screenings, and counseling to influence health and development. (NCQA 2019)

Measure alignment: HEDIS W15, PHP QIP 2020, CA Managed Care Accountability Set

Measure description: Percentage of children 15 months old who had 6 well-child visits with a primary care physician during the first fifteen months of life.

Program Performance Thresholds:

- Full points – 55%
- ¾ points – 50%
- Half points – 45%

Denominator definition: Children who have had at least one medical visit after 2 months of age and who turned 15 months old during the measurement year.

Numerator definition: Denominator patients who received six or more well-child visits with a PCP during their first 15 months of life. (Well-child visits are defined by CPT codes on claims)

Access and Care Management Measures

1. Telehealth and APM Readiness Reporting

Part A: Telehealth Reporting (2021 Quarters 1-2)

Rationale

Telehealth has the potential to improve access to and lower the cost of primary care. Because of regulatory restrictions until 2020 the use of telehealth to provide primary care has been restricted for use by health centers. The lifting of restrictions in response to the COVID pandemic has accelerated the use of telehealth to provide primary care. In response to the COVID pandemic health centers quickly established telehealth visits in order to maintain care to their patients. Many health centers have been able to implement phone-based services more quickly than video. Though phone-based care is effective for some situations video-based care may provide a higher quality experience for patients. We will collect data from network health centers in order to foster sharing of workflows and promising practices across the coalition.

Reporting

1. Health centers will report numbers of in-person, telephonic and video visits performed during the reporting quarter. Visit definitions align with UDS definitions for 2020.

   Template:

	In-Person	Telehealth Video	Telehealth Phone
Medical Visits			
Behavioral Health Visits			
Dental Visits			
Vision or Eye Care Visits			

2. Health centers will also participate in getting patient feedback about the experience of primary care delivered through telehealth through an initiative with California Primary Care Association (CPCA). Health centers will be able to choose between sending the survey link to their own patients who have experienced telehealth visits or having CPCA send the messages. The participation in this initiative will be reviewed in detail in the RCHC telehealth workgroup.

Program Performance Thresholds

Quarter 1:

- Full 10 points – Reported data for quarter 1 and either participated in the CPCA/PBGH patient feedback survey during quarter 1 or CEO signature committing to participate in Q2.
- Half 5 points – Either only reported data or only participated in the patient feedback survey.

Quarter 2:

- Full 10 points – Reported data for quarter 2 of 2021 and participation during either quarter in the CPCA patient feedback survey.
- Half 5 points – Either only reported data or only participated in the patient feedback survey.

Part B: Alternative Payment Model (APM) Readiness (Quarters 3-4)

Rationale

APMs incentivize lower cost and higher quality care. In order to prepare for APM opportunities for health centers in California RCHN's network health centers will complete a readiness template and have a facilitated discussion of results.

Reporting

- Quarter 3 – Health centers will complete the CPCA or other APM readiness template. The template is to be agreed upon by the RCHN membership by June 1, 2021.
- Quarter 4 – Health centers will share and discuss their results as part of an RCHN membership meeting during the 2021 year.

Program Performance Thresholds:

- Full 10 points – Completed data template, shared results and discussed as part of an RCHN membership meeting.
- Half 5 points – Either only completed the template or only participated in discussion.

2. Health Equity Reporting

Rationale

According to the CDC, Health Equity is when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (CDC 2020.) Health disparities are differences in outcomes by population. In order to improve quality of care, patient experience and utilization of preventive care services health centers will need to address health disparities in the populations they serve. For the 2021 PIP program health centers will examine their data,

choose to address a health disparity and then share their work with RCHC and their peers in order to advance the effort on improving health equity throughout the network.

Reporting

- Quarter 1: Health centers will examine their quality or utilization data for disparities and submit a brief narrative to RCHC: Describe the data that was examined and the disparity that was identified:
- Quarter 2: Health centers will formulate a plan to address the disparity identified in Quarter 1 and provide a brief narrative to RCHC: Describe the health center's plan to address the identified health disparity either in a short paragraph or by submitting a PDSA template:
- Quarter 3: Health centers will take action to address the identified disparity as planned in Quarter 2 and provide an update to RCHC. Health centers may provide the update in writing via a short paragraph or PDSA template or they may provide the update verbally at any RCHC quality improvement meeting.
- Quarter 4: Health centers will share the results, findings and ongoing activities related to the identified disparity with RCHC. Health centers may share the results by presenting in an RCHC peer group meeting, QI chatroom or completing an RCHC promising practice template.

Note: The choice of measure is not limited to those clinical measures in the PIP program.

Program Performance Thresholds:

- Full 10 points – Completed the activity listed by quarter above and reported results to RCHC.

Data Validation and Audit Procedures

RCHN will validate data against prior program performance for each quarter. RCHN will randomly audit health center values throughout the year. In cases when RCHN staff have direct access to health center data systems and electronic health record, RCHN staff will conduct the audit independent of the health center and notify the health center if there are any issues that need to be corrected. In cases when RCHN staff does not have direct access to the health center data, RCHN staff will request the source query and supporting data from the health center. RCHN may choose to contract with a third party to conduct data validation and audit functions. Health centers that fail to comply with validation and audit or who have open or unresolved validation or findings will not be eligible to receive funds from the PIP program until they are in compliance.

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Appendix A: Timeline for Data Submission

On or after the dates below, RCHN will pull the data for the clinical quality measures from Relevant. Any data not available through Relevant will need to be submitted by this date.

Due Date	Materials to be submitted
April 22, 2021	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) Access and Care Management: • Health Equity Reporting (Quarter 1) • Telehealth Reporting (Quarter 1)
July 22, 2021	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) Access and Care Management: • Health Equity Reporting (Quarter 2) • Telehealth Reporting (Quarter 2)
October 21, 2021	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) Access and Care Management: • Health Equity Reporting (Quarter 3) • APM readiness (Quarter 3)
January 20, 2022	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) Access and Care Management: • Health Equity Reporting (Quarter 4) • APM readiness (Quarter 4)