Aliados Health

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Aliados Health

Performance Improvement Program

Program Year 2023 – updated December 1, 2022

Aliados Health
Performance Improvement Program 2023

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Program Overview:

The Performance Improvement Program (PIP) offers financial incentives to health centers participating in the managed care contract with Partnership Health Plan through Aliados Health 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 these health centers serve. The 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 state and/or national standard and goals

Eligibility:

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

Support for Quality Improvement:

Health centers receive support for quality improvement through Aliados Health's quality improvement, population health, and informatics programs. These include:

- Medical Director/CMO peer meeting: the venue where standardized clinical guidelines are developed to improve clinical measures
- Consortium created 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 custom built in Relevant Aliados Health's population health management tool to support health center reporting and evidence-based clinical initiatives
- Documented promising practices for health center quality measures: published to the consortium website
- Consortium lead or sponsored conferences and trainings
- Quality improvement peer group meeting and the QI Chatroom Podcast: 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 standard reports

- Data Workgroup peer meeting: the venue where health center data leads are trained on standard reports and data validation
- Clinical work groups are formed to address areas of health on an as needed basis. These groups are made up of consortium staff, content experts from health centers and other stakeholder organizations, and make recommendations to the Medical Directors for changes or additions to 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 quarterly by the end of the month following the quarter's close. For health centers not using Relevant, report templates will need to be submitted via email. The source query and supporting data may also be requested.

Governance:

Aliados Health 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, Aliados Health adheres to federal and state laws, and guidance. Aliados Health staff collaborates with internal and external stakeholders for program feedback including the following groups:

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

Code Sets and Reporting Instructions:

All clinical quality improvement measures utilize standard code sets. If available, the measurement specifications align with 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 Aliados Health website. Measures not included in the eMeasure code set are standardized using HEDIS specifications and code sets. All measures are reviewed, standardized, and clarified as needed by Aliados Health's Data Standards and Integrity Council. A reporting manual is published annually and is available on the Aliados Health website.

Clinical Quality Measure Targets:

Measure/ Results	HTN – BP control	DM <9	Colon Cancer Screening (Expanded measure age range to 45-75 yo)	6 WCC by 15 months	Depression Screening and Follow-Up for Adolescents (12-17 yo)
TARGETS					
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	
2022 Targets	67% full points 64% ¾ points 61% half points	68% full points 62% ¾ points 57% half points	42% full points 38% ¾ points 35% half points	50% full points 45% ¾ points 40% half points	
2023 Targets	**70% full points 67% ¾-points 64% half points**	**71% full points 65% ¾ points 60% half points**	**42% full points 38% ¾ points 35% half points**	**60% full points 55% ¾ points 50% half points**	**55% full points 52% ¾ points 49% half points**
BENCHMARK COMPARISONS					
QIP Targets 2021	66.91% (full pts) 75th percentile	64.93%% (full pts) 75th percentile	41.84% (full pts) 50th percentile	69.83% (full pts) 75h percentile	N/A
UDS CA – 2021	56.92%	64.94%	39.94%	N/A	N/A
HEDIS 75th – 2021	62.53%	61.63%	61.25%	61.25%	

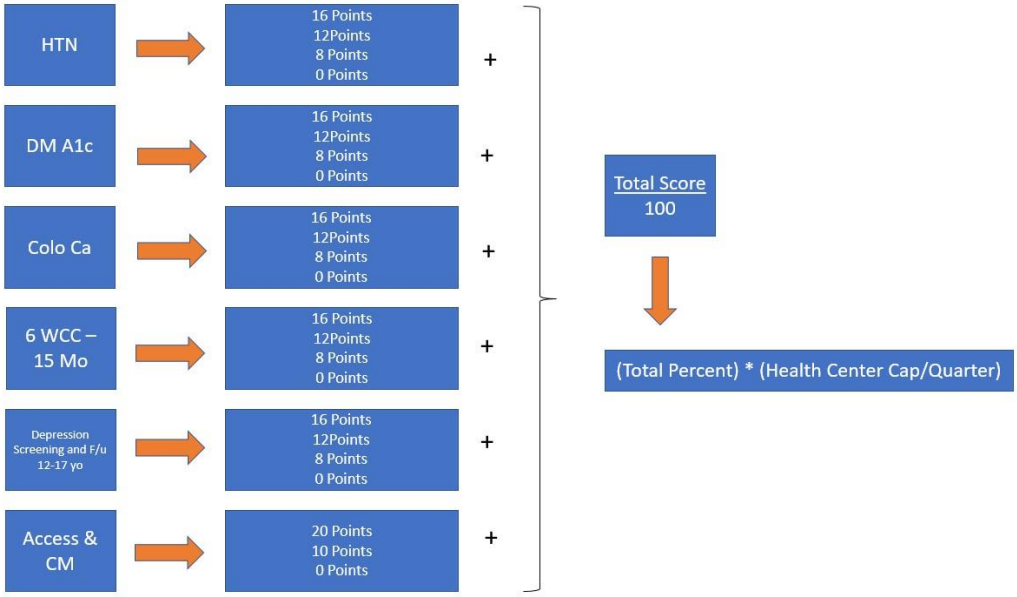
Payment:

1. Quarterly payment

Aliados Health will calculate a maximum payment (CAP) to each participating health center based on the health center volume reported on the Uniform Data System report 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 are 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 the fourth quarter, any participating health centers that end the reporting year at 70 - 89% of points are eligible to earn additional funds if the health center achieves >10% relative improvement in any one qualifying clinical measure. Qualifying measures are any of the five clinical measures that the health center did not achieve full points for in the fourth quarter. Qualified health centers that achieve the improvement threshold 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 roll over each quarter and are maintained for each individual health center to earn in each following quarter until the end of the calendar year. Unearned funds at the end of the program year are aggregated in a pool that is utilized for projects and programs which will support quality improvement related to the PIP program. Funds are used to address causes/challenges to meet the measure thresholds and be aligned with PIP program.

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 28% of deaths in Sonoma County in 2015-2017 (Sonoma County Department of Health Services 2019). Heart disease is the second leading cause of mortality in Sonoma County 2015-2017 (Sonoma County Department of Health Services 2019). 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: CMS165v11, NCQA 0018, PHP QIP 2023, UDS 2023.

Measure description: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Program Performance Thresholds:

- Full points – 70%
- ¾ points – 67%
- Half points – 64%

Denominator definition: Patients 18-85 years of age by the end of the measurement period who had a visit and diagnosis of essential hypertension starting before and continuing into or starting during the first six months of the measurement period.

Numerator definition

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

- 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 66-80 years old and older with advanced illness and frailty
- Patients aged 81 and older with 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 percentage 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: CMS122v11 (reversed), NQF0059, PHP QIP 2023, UDS 2023

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 – 71%
- ¾ points – 65%
- Half points – 60%

Denominator definition: Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period.

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 colon cancer screening rate for Sonoma County health centers in 2021 was 45%

Measure alignment: CMS130v11, NQF0034, PHP QIP 2023, UDS 2023

Measure description: Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer.

Program Performance Thresholds:

- Full points – 42%
- ¾ points – 38%
- Half points – 35%

Denominator definition: Patients 46-75 years of age by the end of the measurement period with a visit during the measurement period.

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

Exclusions

- Patients with a diagnosis or 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 health centers an opportunity to provide prevention services like immunization screenings and counseling to influence health and development. (NCQA 2019)

Measure alignment: HEDIS W15, PHP QIP 2023, CA Managed Care Accountability Set 2023

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 – 60%
- ¾ points – 55%
- Half points – 50%

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). There must be at least 14 days between each date of service. Well-child visits may be performed in-person, virtually by phone or video, or a combination of these, depending on the judgement of the clinician balancing the local public health implications of in-person visits and the individual needs of the patient.

5. Depression Screening and Follow-Up for Adolescents

Rationale:

Depression in adolescents has been linked to long term anxiety disorders, increased risk of substance use and increased risk of suicide attempt (Garber 2009). During the pandemic, more adolescents and young adults (ages 18- 24) reported symptoms of anxiety and/or depression (56%). Even prior to the pandemic, young adults were at higher risk of poor mental health (Sonoma County MSHA Plan 2022).

Suicide is the 10th leading cause of death for Americans overall and the second leading cause of death among young people aged 10–34. Suicide deaths per 100,000 population are higher in Sonoma County than US and California rates (CDC 2008)

USPSTF (United States Preventive Services Taskforce) recommends screening for depression in adolescents ages 12-18 (USPSTF 2022.) Participating health center screening rates for depression in 2021 for 12–17-year-old patients is 47% compared with 63%.

Measure alignment: CMS2v12, NQF 0418, UDS 2023, Managed Care Accountability Set 2023 (adjusted to age range 12 to 17).

Measure description: Percentage of patients aged 12 to 17 years of age screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Program Performance Thresholds:

- Full points – 55%
- ¾ points – 52%
- Half points – 49%

Denominator definition: All patients aged 12 to 17 years old at the beginning of the measurement period with at least one qualifying encounter during the measurement period

Numerator definition: Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.

Exclusions: N/A

Denominator Exceptions:
Patient refuses to participate
OR
Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)

Access and Care Management Measures

1. Value Based Care (Quarters 1-4)

Rationale
APMs (Alternative Payment Methodology) incentivize lower cost and higher quality care. To prepare for APM opportunities for health centers in California Aliados Health's network health centers will use a standardized risk score to identify a population for intervention. This builds on the network health centers preparation in 2022 implementation of a standardized risk score.

Reporting

- Quarter 1: Health centers will participate in the creation and review of a driver diagram with Aliados Health staff.
- Quarter 2: Health centers will submit a plan that includes work in any area outlined in the driver diagram.
- Quarter 3: Health centers will submit a brief report on activities in their work-plan. Provide a brief report on activities for this plan.
- Quarter 4: Health centers will share the results, findings, and any ongoing activities. Health centers may share results by presenting at an Aliados Health peer group meeting, QI chatroom or completing a promising practice template.

Program Performance Thresholds:

- Full 10 points - Completed the activity listed by quarter above

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. In order to identify disparities and monitor and improve equity health centers need to have high quality data collection of patient demographics. For the 2023 PIP program health centers will participate in development of a driver diagram, create a plan based on the co-developed driver diagram, report on activities, and share results and findings with Aliados Health members.

Reporting

- Quarter 1: Health centers will participate in the creation and review of a driver diagram with Aliados Health staff.
- Quarter 2: Health centers will submit a plan that includes work in any area outlined in the driver diagram.
- Quarter 3: Health centers will submit a brief report on activities in their work-plan. Provide a brief report on activities for this plan.
- Quarter 4: Health centers will share the results, findings, and any ongoing activities. Health centers may share results by presenting at an Aliados Health peer group meeting, QI chatroom or by completing a promising practice template.

Program Performance Thresholds:

- Full 10 points – Completed the activity listed by quarter above

Data Validation and Audit Procedures

Aliados Health will validate data against prior program performance for each quarter. Aliados Health will randomly audit health center values throughout the year. In cases when Aliados Health staff have direct access to health center data systems and electronic health record, Aliados Health 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 Aliados Health staff does not have direct access to the health center data, Aliados Health staff will request the source query and supporting data from the health center. Aliados Health 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.

Program Evaluation

Aliados Health will conduct a program evaluation following the end of the program year. The evaluation findings will be used by Aliados Health to inform the design of the following year's PIP program.

Aliados Health may change program deliverables during the program year when drastic circumstances prevent the ability of health centers or Aliados Health to be able to complete all or part of the PIP program. If this should occur Aliados Health staff along with the PIP oversight committee will put forth a reasonable alternative that is consistent with the PIP guiding principles above. Any changes will be documented as a program addendum and published to health center program staff, CMOs and CEOs. Changes will be published on the Aliados Health website prior to the end of the first affected quarter.

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Appendix A: Timeline for Data Submission

On or after the dates below, Aliados Health 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 20, 2023	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) • Depression Screen and Follow-Up for Adolescents (1 year) Access and Care Management: • Health Equity Reporting (Quarter 1) • Value-Based Care Reporting (Quarter 1) • Development/Review (Quarter 1)
July 20, 2023	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) • Depression Screen and Follow-Up for Adolescents (1 year) Access and Care Management: • Health Equity Reporting (Quarter 2) • Value-Based Care Reporting (Quarter 2)
October 19, 2023	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) • Depression Screen and Follow-Up for Adolescents (1 year) Access and Care Management:

	• Health Equity Reporting (Quarter 3) • Value-Based Care Reporting (Quarter 3)
January 18, 2024	Clinical Data: • Hypertension control (1 year) • 6 WCC – 15 months (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) • Depression Screen and Follow-Up for Adolescents (1 year) Access and Care Management: • Health Equity Reporting (Quarter 4) • Value-Based Care Reporting (Quarter 4)