

Redwood Community Health Network

Redwood Community Health Coalition

Performance Improvement Program

Program Year 2019

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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. Measures will reflect both preventive care and chronic disease management
2. Where possible measures should both improve quality and appropriate utilization of services
3. Measures are based on community need
4. 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 Health Plan and if the health center reports results to RCHN.

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 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.
- All improvement measures: Health centers report to RCHN quarterly by the end of the month following the quarter's close.
- Annual measures: Health centers report to RCHN quarterly by the end of the month following the year's close.
- Payment: RCHN distributes payment to health centers within 45 days after the reporting period closes.

Governance:

RCHN staff developed and administers the PIP program to be consistent with industry performance incentive programs, including selection of the outcomes measurement set with defined targets. 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

Code Sets and Reporting Instructions:

All clinical quality improvement measurements are 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.

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

Clinical Quality Measure Targets:

Measure/Results	Cervical Cancer Screening	HTN – BP control	DM <9	Colon Cancer Screening
TARGETS				
2014 Target	n/a	55%	65%	
2015 Target	55%	61%	71%	
2016 Target	65%	64%	71%	
2017 Target	68%	65%	71%	40%
2018 Targets	68% full points	65% full points	71% full points	40% full points

	64% ¾ points 60% half points	62% ¾ points 59% half points	63% ¾ points 55% half points	36% ¾ points 32% half points
2019 Targets	69% full points 65% ¾ points 61% half points	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
CURRENT PIP PERFORMANCE				
Q1- 2018 Average	72.3%	71.6%	66.0%	41.5%
Q2 - 2018 Average	71.8%	71.6%	66.9%	41.4%
Q3 – 2018 Average	72.2%	71.5%	66.7%	44.1%
Q4 – 2018 Average	73.0%	70.2%	68.5%	45.1%
BENCHMARK COMPARISONS				
HP 2020	93%	61.2%	83.9%	70.5%
QIP Targets 2018	70.8 (full pts) HEDIS 90 th percentile 65.9 (partial pts) HEDIS 75 th percentile	71.7% (full pts) HEDIS 90 th percentile 64.8% (partial pts) HEDIS 75 th percentile	70.9% (full pts) HEDIS 90 th percentile 64.5% (partial pts) HEDIS 75 th percentile	56.8% (full pts) 45.0% (partial pts) HEDIS 50 th Percentile
UDS CA – 2017	59.2%	64.8%	66.3%	44.9%

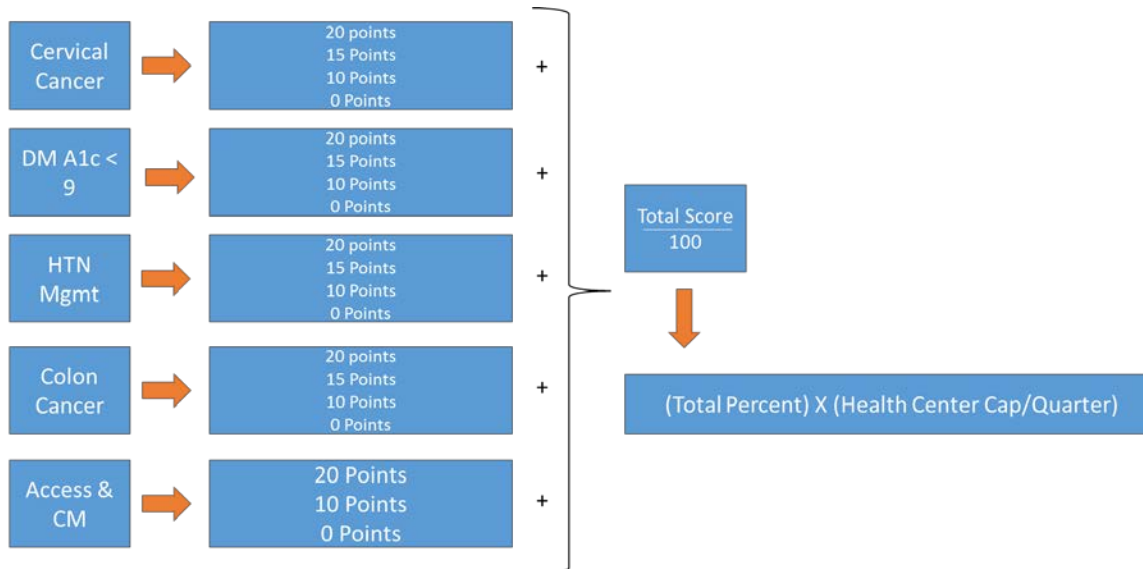
Payment:

1. Quarterly payment

RCHN will calculate a maximum payment (CAP) to each health center based on a measure of health center volume from the 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. Annual payments

Additional annual payments will be made for meeting the thresholds for electronic reporting, coding training participation and participation in the quality improvement workgroup. These payments will be made to health centers no later than 45 days after the program year ends.

- Electronic reporting - \$10,000

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. 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 2018, UDS 2018

Measure description

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

Program Performance Thresholds:

- Full points – 67%
- $\frac{3}{4}$ points – 64%
- Half points – 61%

Numerator definition

- Patients 18–59 years of age as of the end of the reporting period or those who are 60-85 years of age as of the end of the reporting period, with a diagnosis of diabetes, whose BP was <140/90 mm Hg.
- Patients 60–85 years of age as of the end of the reporting period and who do not have a diagnosis of diabetes whose BP was <150/90 mm Hg.

Denominator definition

Patients 18-85 years of age, who had at least one medical visit, who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

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

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 \leq 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 2018, UDS 2018

Measure description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c \leq 9.0% during the measurement period.

Program Performance Thresholds:

- Full points – 71%
- $\frac{3}{4}$ points – 63%
- Half points – 55%

Numerator definition

Patients with most recent HbA1c level (performed during the measurement period) is \leq 9.0%

Denominator definition

Patients 18-75 years of age with diabetes with at least one medical visit during the measurement period.

Exclusions

Patients who have been pregnant during the measurement period

3. Cervical Cancer Screening

Rationale

Cervical cancer has a high survival rate when detected early, yet it is the second most common cancer among women worldwide (Myers et al. 2008). If pre-cancerous lesions are detected early by Pap tests and treated, the likelihood of survival is nearly 100 percent (American Cancer Society 2015). In addition to decreasing morbidity and mortality screening for cervical cancer has the potential to decrease costs associated with the treatment of cervical cancer.

In 2013, in the United States, women with no health insurance and recent immigrants (populations frequently served at RHCN health centers) were least likely to have a Pap test (American Cancer Society

2015). The rate of late diagnosis of cervical cancer has risen in Sonoma County from 2011 – 2013. Sonoma County health centers' screening rate in 2016 was 64% which is below the Healthy People 2020 goal of 93% (HRSA 2016).

Measure alignment: CMS124, NQF0032, PHP QIP 2018, UDS 2018

Measure description

Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21-64 who had cervical cytology performed every 3 years
- Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Program Performance Thresholds:

- Full points – 69%
- $\frac{3}{4}$ points – 65%
- Half points – 61%

Numerator definition

Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:

- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test
- Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test

Denominator definition

Women 23-64 years of age with a visit during the measurement period

Exclusions

Women who have had a hysterectomy with no residual cervix

4. Colon Cancer Screening

Rationale

Colorectal cancer is the third leading cause of cancer death in the United States (American Cancer Society 2015). 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 2016 was 46% which is below the Healthy People 2020 goal of 70.5% (HRSA 2016).

Measure alignment: CMS130, NQF0034, PHP QIP 2018, UDS 2018

Measure description

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

Program Performance Thresholds:

- Full points – 41%
- $\frac{3}{4}$ 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 below:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years preceding the measurement period
- Colonoscopy during the measurement period or the nine years preceding the measurement period

Denominator definition

Patients 50-75 years of age with a visit during the measurement period

Exclusions

Patients with a diagnosis or past history of total colectomy or colorectal cancer

Access and Care Management Measures

1. Access Measurement

Health centers will create a report to reflect new patient wait times which will be collected monthly on the first Tuesday of each month at any time of day. This report will reflect the 1st available appointment for a new patient. This data will be collected for each licensed site and shared with the RCHN Board

quarterly. Health centers using Relevant may opt to report electronically to RCHC by notifying RCHC of what report to use. This data will be collected by RCHC staff without health center involvement. For those health centers that RCHC is unable to access the data, full points can be gained by reporting to RCHC monthly on the 1st Tuesday of each month.

New patient wait time will is the number of days until the first available appointment for a new patient with no current urgent problems.

Program Performance Thresholds:

- Full 10 points – 100% reported each quarter using the table below

Site Name	Measurement Month	Number of Days for New Patient Appointment
	Month 1 in quarter	
	Month 2 in quarter	
	Month 3 in quarter	

2. Care Management

Health Centers will demonstrate implementation and use of care planning elements by reporting the total active FTE caseload for care management as of the end of quarter in the table below. Because of overlapping caseloads the total may be not equal the sum of each role’s caseload.

- Caseload will be defined as patients in any care management program such as IOPCM, complex care management, health homes program, whole person care or any similar complex care program. Caseload should not include patients in only PHASE, or other population health programs.
- For CEC caseload do not include patients who are seen only for screenings and enrollment.
- FTE should be reported as approximate amount of FTE in each category spent on care management.

Program Performance Thresholds:

- Full 10 points – 100% reported each quarter using the table below.

Case Manager Role	FTE	Total active caseload	Medicare or Dual	Medicaid only	No insurance	Other
Nurses (RN/LVN)						
Licensed Social Workers (MSW, LCSW)						
Community Health Workers/Navigators						

(CEC, Navigator, CHW)						
Total unique patients in care management						

Annual Measures

1. Electronic reporting of results

In order to build network capacity to continue to do quality improvement work together and also to insure data quality, health centers are encouraged to implement electronic reporting of results through the RCHC Relevant system.

Program Performance Thresholds:

- Full points = The health center is sharing validated results from all clinical measures for all 4 quarters through the RCHC aggregate. Or for health centers that did not implement in 2018, a signed contract is on file for implementation in 2019.
- Half points = The health center is sharing validated results for at least one quarter of the 2019 reporting period.

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.

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Appendix A Timeline for Data Submission

Due Date	Materials to be submitted
<p>April 15, 2019</p> <p>April 24, 2019</p>	<p>Notify RCHC PIP project manager if ready to report electronically for clinical measures (using RCHC Relevant aggregate).</p> <p>Clinical Data:</p> <ul style="list-style-type: none"> • Hypertension control (1 year) • Cervical cancer screening (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • New patient wait time report (1 Quarter) • Case Management caseload report (1 Quarter)
<p>July 24, 2019</p>	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Hypertension control (1 year) • Cervical cancer screening (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • New patient wait time report (1 Quarter) • Case Management caseload report (1 Quarter)
<p>October 24, 2019</p>	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Hypertension control (1 year) • Cervical cancer screening (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • New patient wait time report (1 Quarter) • Case Management caseload report (1 Quarter)
<p>January 24, 2020</p>	<p>Clinical Data:</p> <ul style="list-style-type: none"> • Hypertension control (1 year) • Cervical cancer screening (1 year) • Diabetes A1c control (1 year) • Colon Cancer Screening (1 year) <p>Access and Care Management:</p> <ul style="list-style-type: none"> • New patient wait time report (1 Quarter) • Case Management caseload report (1 Quarter) <p>Annual Measures (By April 15, 2019 for Q1, or by 15th of any reporting month for half points)</p> <ul style="list-style-type: none"> • Relevant documentation