2024 CARE-BASED INCENTIVE

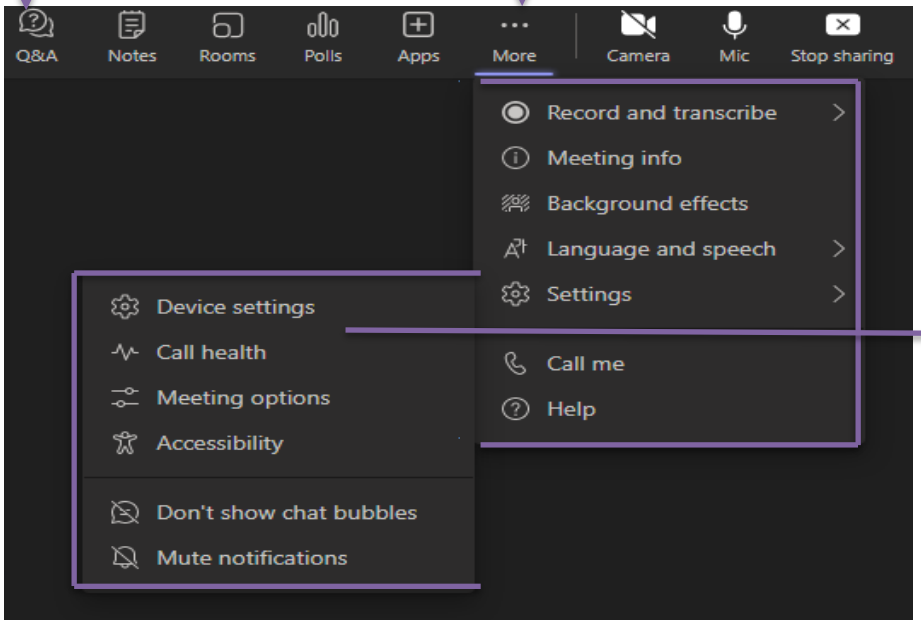
Georgia Gordon
Kristen Rohlf, MPH
Britta Vigurs
Alex Sanchez, MPH
Vera Eichenbaum, PharmD
Jo Pirie

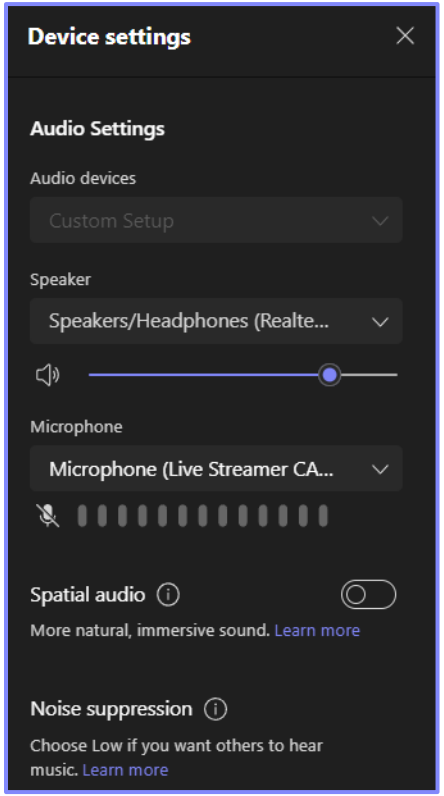
Provider Incentives

HOUSEKEEPING

Use Q&A to submit questions

For audio troubleshooting





TODAY'S HOST & PRESENTER

Georgia Gordon
Quality Improvement Project Specialist

Kristen Rohlf, MPH
Quality and Population Health Manager

Britta Vigurs, Quality Improvement Program Advisor II

TODAY'S HOST & PRESENTER

Vera Eichenbaum, PharmD, BCMAS, TTS
Clinical Pharmacist

Alex Sanchez, MPH
Quality Improvement Program Advisor III

Jo Pirie
Quality Improvement Program Advisor II

Agenda

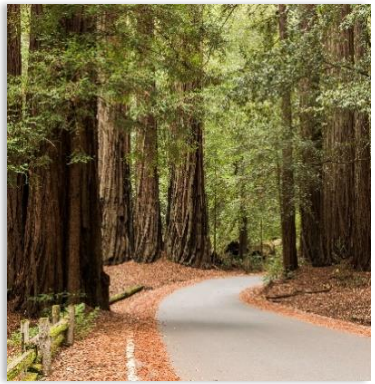
1. Program Overview
2. What's New?
3. Modified Measures
4. Exploratory Measures
5. Retired Measures
6. Resources

PROGRAM OVERVIEW

Established: 2010

Purpose:

- Encourage PCPs to promote and implement the Patient Centered Medical Home model
- Improve access to care
- Promote delivery of quality high-value care



FEE-FOR-SERVICE VS PROGRAMMATIC

Fee-for-Service

- A single payment incentive paid quarterly
- No rate calculation
- No minimum eligible member requirements

Programmatic

- Payment is based on:
  - ✓ Comparison Group Performance
  - ✓ CBI score
  - ✓ Eligible member months
  - ✓ Risk stratification score
- Payment occurs annually (end of Q4)
- Quarterly rates for the measures
- Rolling 12-month measurement period

Measure Type	Measure
Care Coordination Access	Adverse Childhood Experiences (ACEs) Screening in Children & Adolescents
	Application of Dental Fluoride Varnish
	Developmental Screening in the First Three Years
	Initial Health Appointment
	Post-Discharge Care
Care Coordination Hospital & Outpatient	Ambulatory Care Sensitive Admissions
	Plan All-Cause Readmissions
	Preventable Emergency Visits
Quality of Care	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits
	Depression Screening for Adolescents and Adults

Measure Type	Measure
Quality of Care Continued	Diabetic HbA1c Poor Control >9.0%
	Lead Screening in Children
	Immunization: Adolescents (Combo 2)
	Immunizations: Children (Combo 10)
	Well-Child Visits First 15 months of Life
Health Equity	Health Equity: Child and Adolescent Well-Care Visit
	Performance Improvement
	Member Reassignment Threshold
Exploratory	Chlamydia Screening in Women
	Controlling High Blood Pressure
	Colorectal Cancer Screening
	Well-Child Visits for Age 15 Months–30 Months

Measure Type	Measure	Payment
Fee-For-Service	Adverse Childhood Experience (ACEs) Training and Attestation	$200
	Behavioral Health Integration	$1,000
	Cognitive Health Assessment Training and Attestation	$200
	Diagnostic Accuracy and Completeness Training	$200
	Patient Centered Medical Home (PCMH) Recognition	$2,500
	Social Determinants of Health (SDOH) ICD-10 Z-Codes	$1,000
	Quality Performance Improvement Projects	$1,000

POLL QUESTION

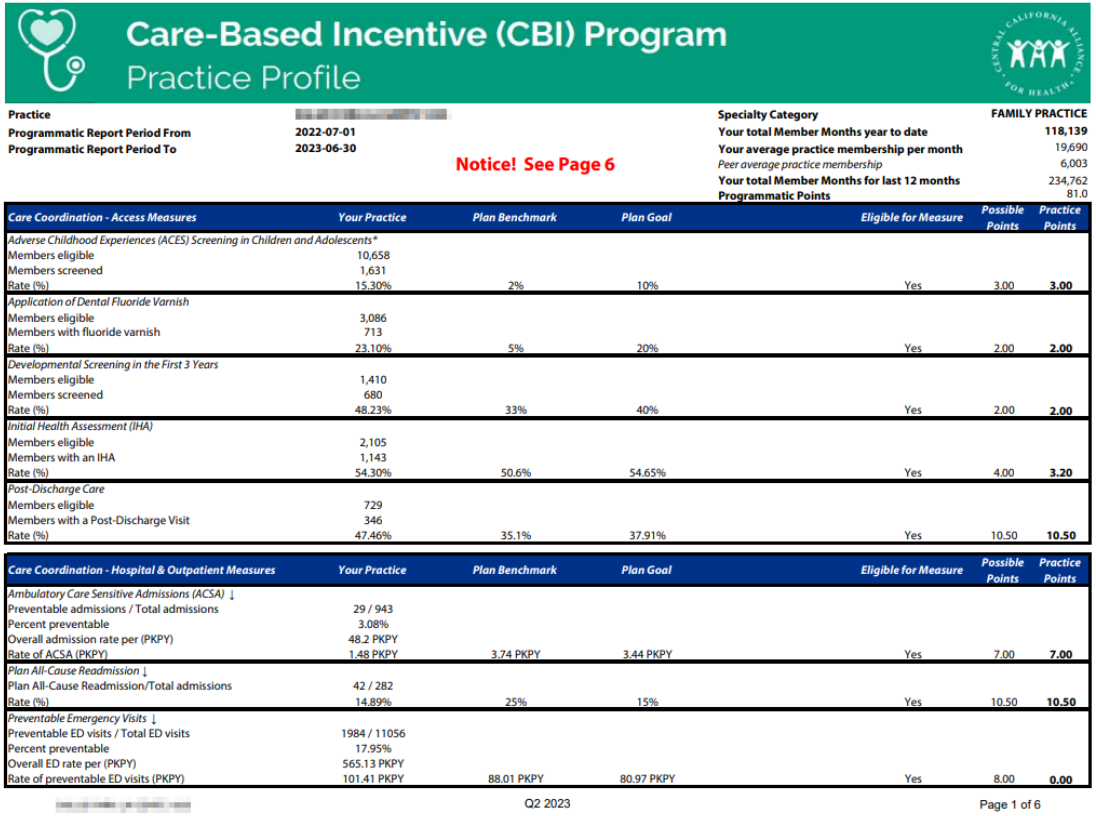
Does your clinic review the CBI Practice Profile reports when you receive it quarterly?

- Yes or No

Does your staff understand and utilize the results from the CBI Practice Profile?

- Yes or No

PROGRAM OVERVIEW



Care-Based Incentive (CBI) Program
Practice Profile

Practice	[redacted]	**Specialty Category**	**FAMILY PRACTICE**
Programmatic Report Period From	**2022-07-01**	**Your total Member Months year to date**	**118,139**
Programmatic Report Period To	**2023-06-30**	**Your average practice membership per month**	19,690
		Peer average practice membership	6,003
		Your total Member Months for last 12 months	234,762
		Programmatic Points	81.0

Notice! See Page 6

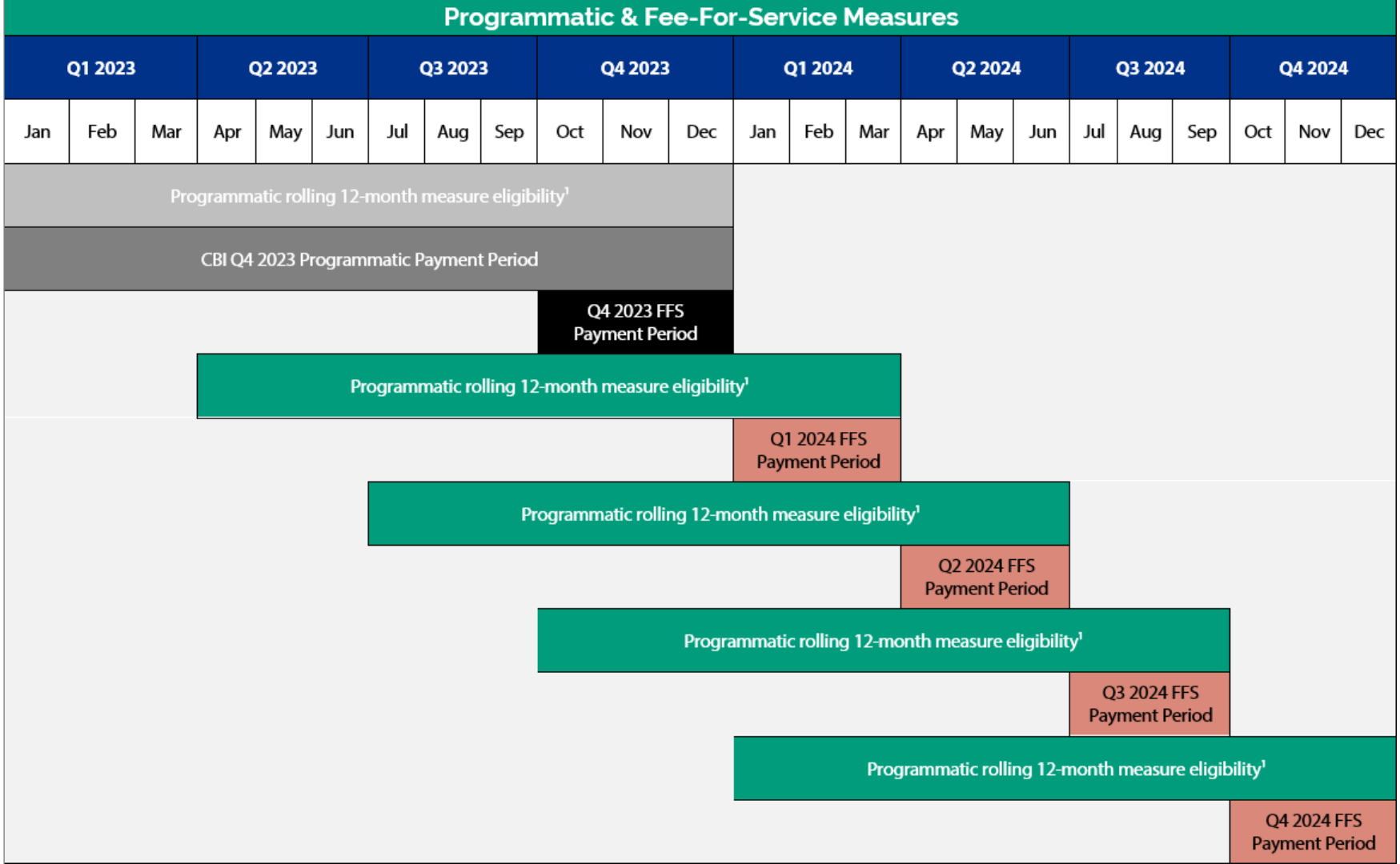
Care Coordination - Access Measures	Your Practice	Plan Benchmark	Plan Goal	Eligible for Measure	Possible Points	Practice Points
*Adverse Childhood Experiences (ACES) Screening in Children and Adolescents**						
Members eligible	10,658					
Members screened	1,631					
Rate (%)	15.30%	2%	10%	Yes	3.00	**3.00**
Application of Dental Fluoride Varnish						
Members eligible	3,086					
Members with fluoride varnish	713					
Rate (%)	23.10%	5%	20%	Yes	2.00	**2.00**
Developmental Screening in the First 3 Years						
Members eligible	1,410					
Members screened	680					
Rate (%)	48.23%	33%	40%	Yes	2.00	**2.00**
Initial Health Assessment (IHA)						
Members eligible	2,105					
Members with an IHA	1,143					
Rate (%)	54.30%	50.6%	54.65%	Yes	4.00	**3.20**
Post-Discharge Care						
Members eligible	729					
Members with a Post-Discharge Visit	346					
Rate (%)	47.46%	35.1%	37.91%	Yes	10.50	**10.50**

Care Coordination - Hospital & Outpatient Measures	Your Practice	Plan Benchmark	Plan Goal	Eligible for Measure	Possible Points	Practice Points
Ambulatory Care Sensitive Admissions (ACSA) ↓						
Preventable admissions / Total admissions	29 / 943					
Percent preventable	3.08%					
Overall admission rate per (PKPY)	48.2 PKPY					
Rate of ACSA (PKPY)	1.48 PKPY	3.74 PKPY	3.44 PKPY	Yes	7.00	**7.00**
Plan All-Cause Readmission ↓						
Plan All-Cause Readmission/Total admissions	42 / 282					
Rate (%)	14.89%	25%	15%	Yes	10.50	**10.50**
Preventable Emergency Visits ↓						
Preventable ED visits / Total ED visits	1984 / 11056					
Percent preventable	17.95%					
Overall ED rate per (PKPY)	565.13 PKPY					
Rate of preventable ED visits (PKPY)	101.41 PKPY	88.01 PKPY	80.97 PKPY	Yes	8.00	**0.00**

[redacted] Q2 2023 Page 1 of 6

CBI Practice Profiles

- Available Quarterly
- Distributed by your Provider Relations Representative
- Indicate any eligible FFS payment in the quarter

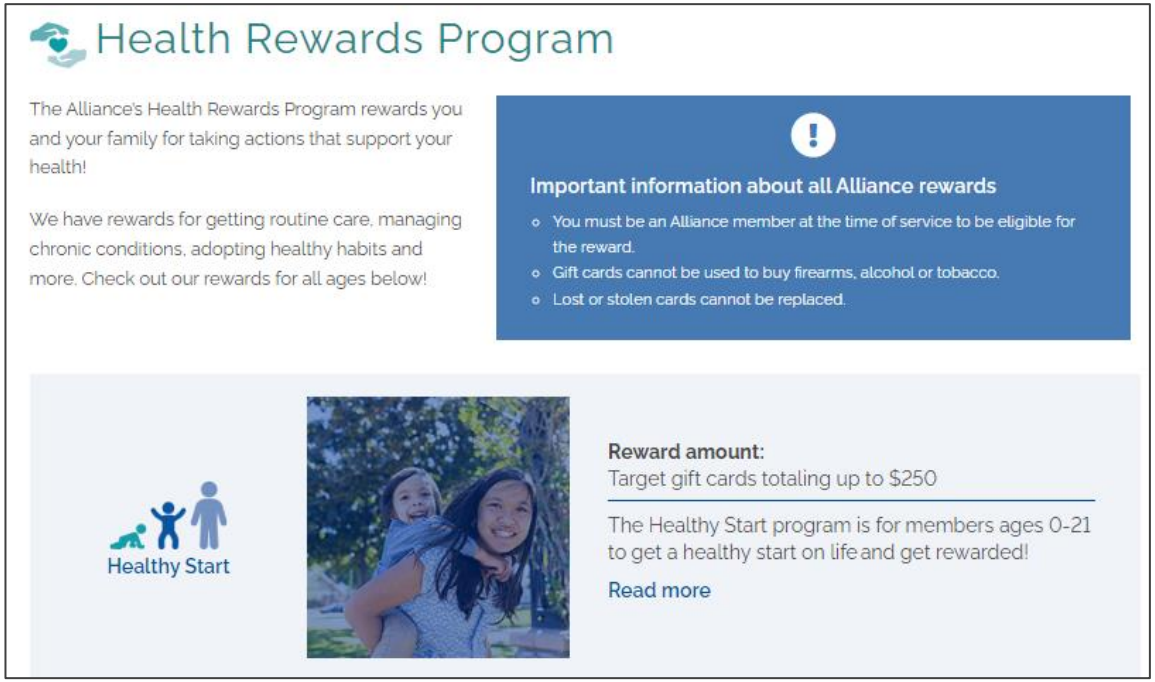

Programmatic & Fee-For-Service Measures
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Q1 2024
Q2 2024
Q3 2024
Q4 2024
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Programmatic rolling 12-month measure eligibility[1]
CBI Q4 2023 Programmatic Payment Period
Q4 2023 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q1 2024 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q2 2024 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q3 2024 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q4 2024 FFS Payment Period

POLL QUESTION

How many member rewards are available for our Alliance members?

- 5
- 10
- 16
- None

HEALTH REWARDS PROGRAM



- Healthy Start
- Baby Flu Vaccine
- Healthy Moms and Healthy Babies
- Healthy Weight for Life
- Healthier Living Program
- Nurse Advice Line

2022 CBI TOP PERFORMERS

Santa Cruz County

MARYLOU ROMO-GRITZEWSKY
PLAZITA MEDICAL CLINIC
SALUD PARA LA GENTE

Monterey County

SANTA LUCIA MEDICAL GROUP
TAYLOR FARMS FAMILY HEALTH AND WELLNESS CENTER
ST JUNIPERO CLINIC INC

Merced County

NEWMAN MEDICAL CLINIC
DIGNITY HEALTH MEDICAL FOUNDATION - MERCED
TIMOTHY S. JOHNSTON, M.D. PC

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POLL QUESTION

Which of the following are common sources of lead exposure?

- Paint in homes
- Soil
- Dust
- Pottery
- Home remedies, make-up and powders
- Candy
- Toys
- Jewelry
- All of the above

LEAD SCREENING IN CHILDREN

- One or more lead blood test for children 2 years of age
- Data collected from claims, laboratory data, and DHCS Fee-for-Service encounter claims
- CPT Code 83655

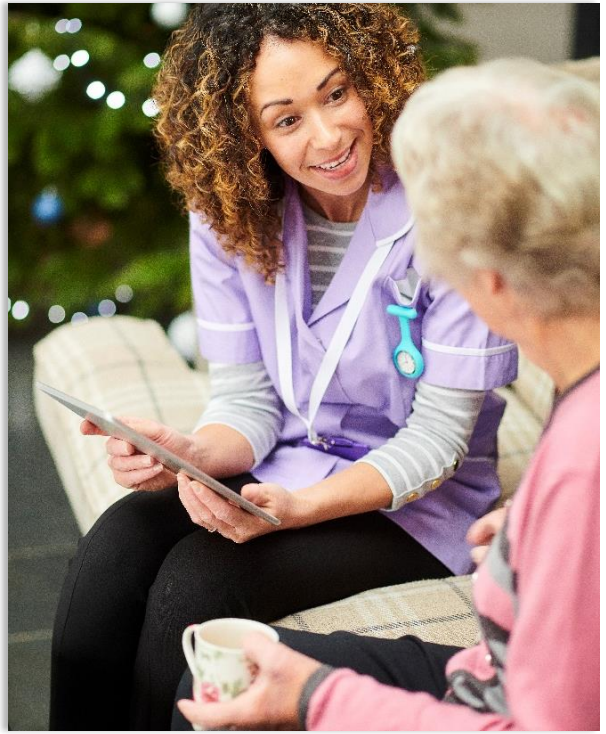
FEE-FOR-SERVICE: DIAGNOSTIC ACCURACY AND COMPLETENESS TRAINING

- Provide compensation for time spent in diagnostic accuracy training
- $200 for credentialed primary care providers
- Complete CMS training
- Submit completion certificate

CMS Medicare Learning Network Web training- Diagnosis Coding

FEE-FOR-SERVICE: COGNITIVE HEALTH ASSESSMENT TRAINING AND ATTESTATION

- State-wide program in California
- Medi-Cal members 65+ not on Medicare
- Warmline Services available
- Provider training and webinars
- Interactive Case Conferences
- Implementation guide, screening tools and resource information



DEMENTIA Care Aware

Dementia Care Aware Website:
https://www.dementiacareaware.org/

NEW MEASURE

Fee-For-Service: Cognitive Health Assessment Training and Attestation

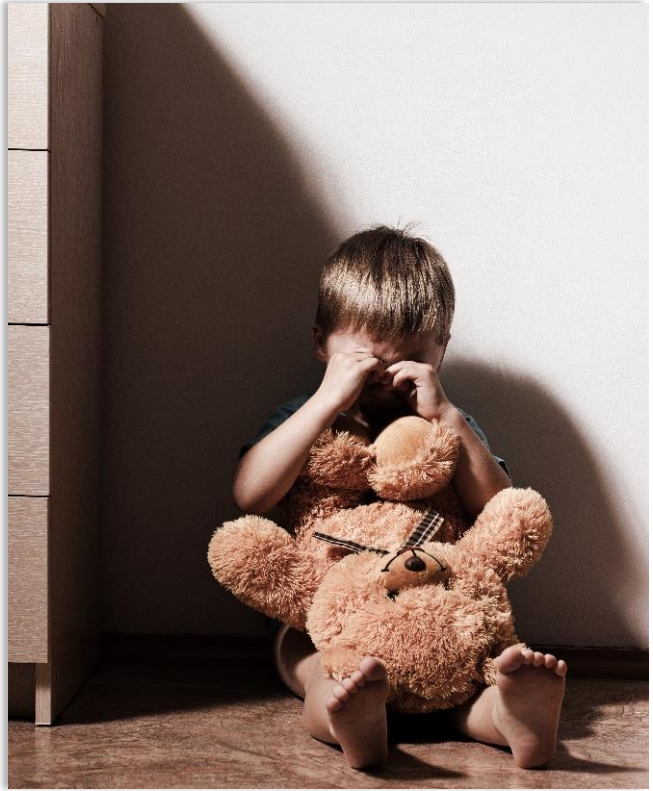
MEASURE: The plan shall pay providers, which includes mid-level providers, for completing the Cognitive Health Assessment (CHA) and attestation.

PAYMENT: $200 for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying licensed residents.

QUALIFICATION: Completed DHCS Dementia Care Aware Cognitive Health Assessment Training.

DATA COLLECTION: DHCS Monthly File.

FEE-FOR-SERVICE: SOCIAL DETERMINANTS OF HEALTH (SDOH) ICD-10 Z-CODES



- Use of DHCS priority SDOH codes
- Quarterly payments of $250, with a maximum of $1000
- Data collection through claims

APL 21-009: DHCS list of SDOH codes

POLL QUESTION

Are you integrating Social Determinates Of Health (SDOH) ICD-10 codes?

- Yes, currently
- No, not currently, plan to in 2023
- No, not currently, plan to in 2024
- No will not integrate SDOH codes

NEW MEASURE

Fee-For-Service: Quality Performance Improvement Projects

MEASURE: This measure is intended to provide compensation for the time spent in completing a Quality Performance Improvement Project with the Alliance.

QUALIFICATION: Practices with metrics that are below the minimum performance level, measured at the 50th percentile for the 2023 CBI programmatic payment.

PAYMENT: $1,000 for completion of approved Alliance Quality Performance Improvement Project.

Pharmacist-Led Academic Detailing Program: Diabetes

Vera Eichenbaum, PharmD, BCMAS, TTS

New Program Opportunity

Pharmacist-Led Academic Detailing (PLAD) Program

- Assist clinicians in managing Alliance members with uncontrolled diabetes (A1c > 9%) through tailored educational sessions around evidence-based pharmacologic clinical guidelines with Alliance pharmacists.

How does the program work?

FIVE 45-MINUTE WEEKLY, **INTERACTIVE**, VIRTUAL SESSIONS

SMALL GROUPS TO ENSURE **INDIVIDUALIZED APPROACH** (2-3 CLINICIANS)

Program Eligibility and Data Collection

Eligible members:

- Alliance members
- Adults 18–75 years old
- Has type 2 diabetes
- HbA1c score of >9% taken within 3 months prior to the start of the program. (The same members will be followed through the duration of the program)

Member exclusions:

- OHC
- Alliance members linked to the clinic who do not have a current A1c value (or measured within 3 month of the project start date).
- Pregnant members
- Pediatric members
- Members with Type 1 diabetes

What value does the program bring?

- American Diabetes Association (ADA) Standards of Care in Diabetes 2023
- Drug related clinical pearls and actionable takeaways
- Clinicians will have the opportunity to directly engage with an Alliance pharmacist
- Partner with clinicians to help our members

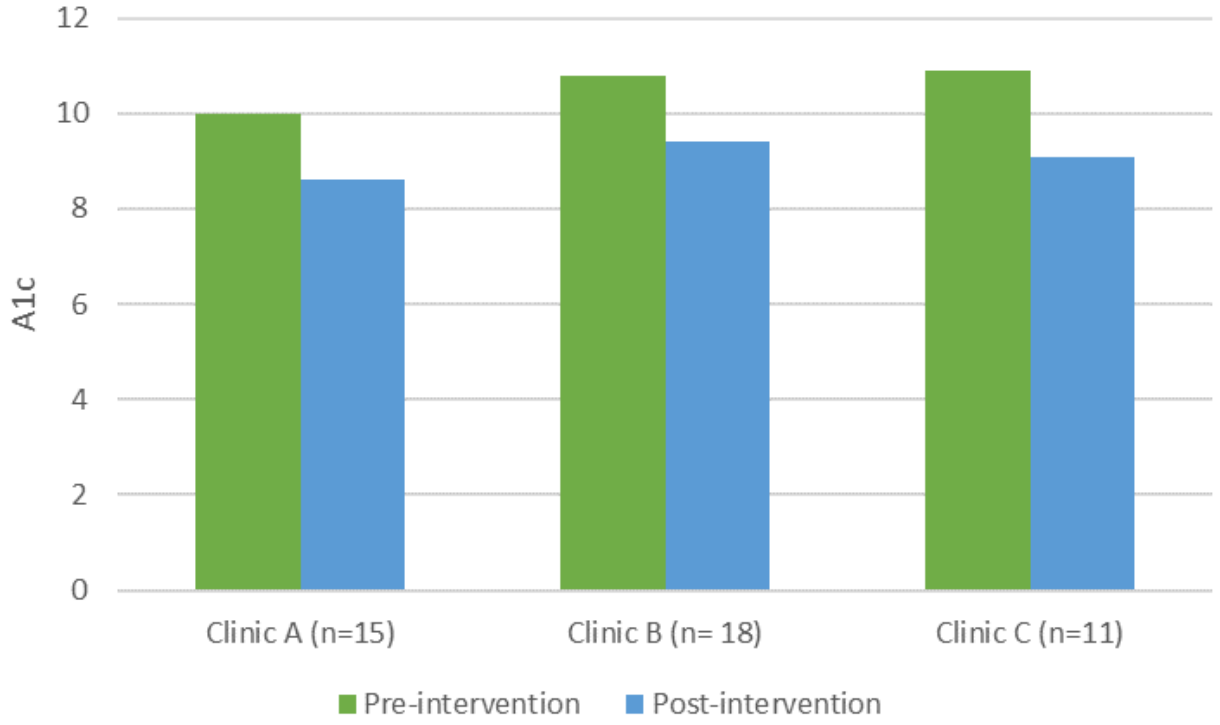
Program sessions (as of May 2023)

Completed: 1

In process: 4

Upcoming: ?

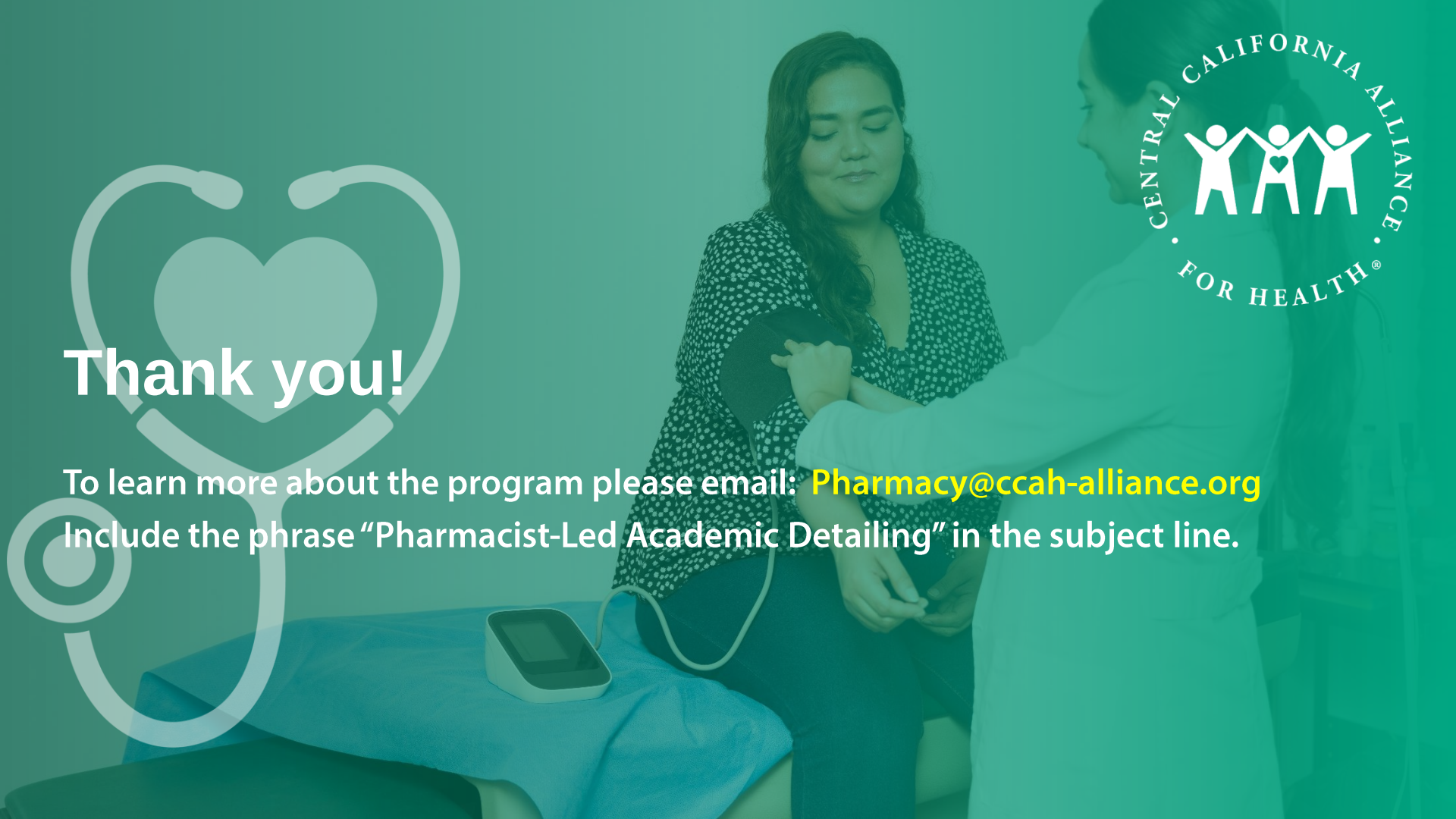
2021 Pilot Program Results
(9-month change in median A1c values)



Improve A1C by leveraging the multidisciplinary team

Reductions in A1C compared to usual care[8]:

-0.40% to -1.62%	-0.30% to -1.20%	-0.60% to -0.90%	-0.26% to -0.40%
			
Nurse- or Certified Diabetes Care & Education Specialist-led medication management	Care management & patient education interventions	Pharmacist-based interventions	Physician-based interventions



Thank you!

To learn more about the program please email: Pharmacy@ccah-alliance.org
Include the phrase "Pharmacist-Led Academic Detailing" in the subject line.

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MODIFIED MEASURES

Depression Screening for Adolescents and Adults

MEASURE DESCRIPTION: The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument.

ELIGIBLE CODES: LOINCs with result and screening code

DATA COLLECTION: Data Submission Tool

EXCLUSIONS:

- History of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.
- Depression that starts during the year prior to the measurement period.
- Members in hospice or using hospice services any time during the measurement period.

MODIFIED MEASURES

Health Equity Measure

Measure

This is a health plan performance measure, using the Child and Adolescent Well-Care Visit measure. Points will be distributed if well-child visit rates are improved for all ethnicities, with weighting to rates starting below the 50th percentile.

Metric: NCQA HEDIS Child and Adolescent Well-Care Visit.

Goal: 5 or 10% improvement.

Baseline: 2023 CBI programmatic rates.

Race/Ethnicity metric starting point	Points earned for 5% improvement for each race/ethnicity	Points earned for 10% improvement for each race/ethnicity
< 50th percentile	0.5	1
> 50th percentile	0.125	0.25

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WELL-CHILD VISITS
15 – 30 MONTHS

MEASURE

The percentage of members aged 30 months old who had 2 or more well-child visits with a PCP during 15-30 months of life.

TIPS!

- Schedule the next 6-month visits before the member leaves the exam room or clinic.
- Submit history of well-child visits via **Data Submission Tool**

EXPLORATORY MEASURES

Well-Child Visits for Age 15 – 30 Months

MEASURE: The percentage of members aged 30 months old who had 2 or more well-child visits with a PCP during the child's 15-month birthday plus 1 day and 30-month birthday.

ELIGIBLE CODES:

- **Well-visit CPT Codes:** 99382, 99392, 99461
- **Well-visit ICD-10 Codes:** Z00.121, Z00.129, Z00.2, Z02.5, Z76.1, Z76.2

DATA COLLECTION: Claims, DHCS Fee-For-Service encounter claims, Data Submission Tool

SERVICING PCP SITE REQUIREMENT: Credit is given to the linked PCP site on the day when the member turns 30 months old.

POLL QUESTION

If a 17-month-old patient presents for their 15-month well-care visit, at what age can they return for their next well-care exam, per Alliance frequency guidelines?

- 18 months
- 21 months
- 24 months
- 30 months

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RETIRED MEASURES

- Body Mass Index (BMI) Assessment: Children & Adolescent
- Immunizations: Adults

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THE ALLIANCE'S PRACTICE COACHING PROGRAM

GOAL To engage and support individual clinics in quality improvement work

BENEFITS

- Support in QI methods
- Technical assistance for Data
- Access to QI-related tools and assistance with building a process improvement plan
- Enhanced connections to Alliance resources

QUESTIONS? pc@ccah-alliance.org

Select to filter

Practice Transformation Academy ▼

Data and Measurement Part 1
December 21, 2022
Part 1 of 2

Data and Measurement Part 2
December 21, 2022
Part 2 of 2

Model for Improvement
December 21, 2022
PDSA Project Tracker PDSA Worksheet Data Collection Plan PDSA Cycle Example – All Washed Up! by VitalSmarts...

THE ABC'S OF QI **VIDEO SERIES**

- **Support clinic teams** with Quality Improvement efforts
- **Guide your QI project,** provides framework
- **Available videos**
  - SMART Aim Statements
  - Project Charters
  - Process Maps
  - Lean Wastes
  - Data

Link: https://thealliance.health/for-providers/resources/training/
Questions? Contact pc@ccah-alliance.org

POLL QUESTION

Does your clinic follow the American Academy of Pediatrics Periodicity Schedule?

- Yes
- No
- Unknown

https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

SWOTS IN PRACTICE PEDIATRIC PROJECT

Pediatric Best Practices Webinar

- Early childhood & adolescent well visits
- Immunizations
- Lead screening
- Fluoride application
- ACE screenings

Pediatrics Best Practices:
Central California Alliance for Health (thealliance.health)

SWOTS IN PRACTICE PREVENTATIVE SCREENINGS

Who needs a Breast Cancer screening:

Females 50 – 74 years old need a mammogram every 2 years

Who needs a Chlamydia screening:

Sexually active* females 16 to 24 years old

Focus: 16-17 years old

*Members are identified as sexually active through pharmacy claims, claims and encounter data

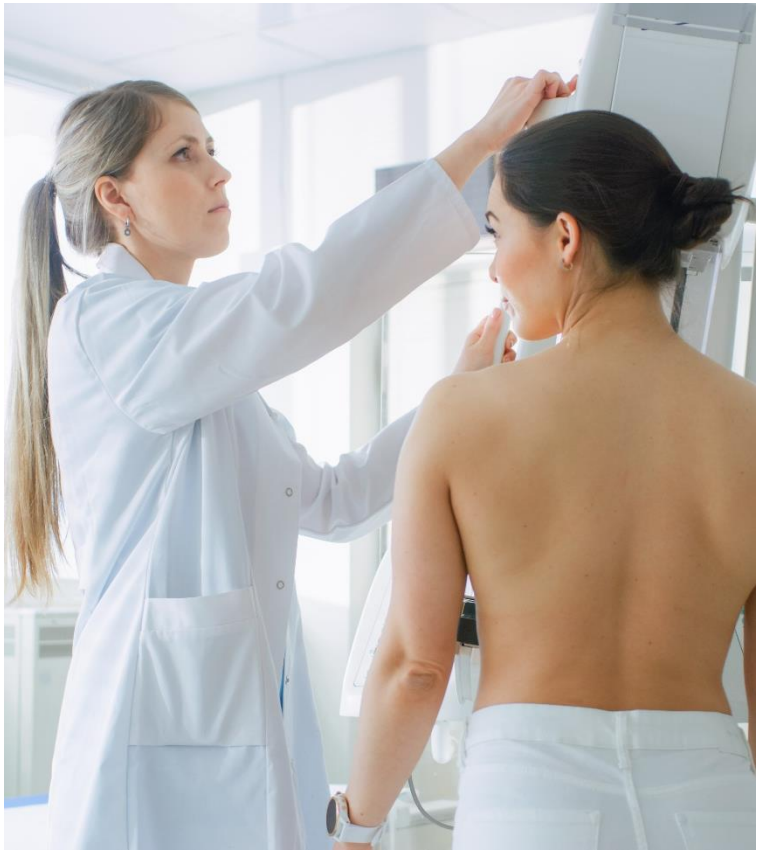
SWOTS IN PRACTICE PREVENTATIVE SCREENINGS

Utilize Provider Portal to identify members due for screenings

Submit history of mastectomy, mammograms & Chlamydia screenings via DST

Create standing orders

Use the opt-out approach



POLL QUESTION

How often do you submit your data to the Data Submission Tool?

- Monthly
- Quartley
- Yearly
- Not at all
- I don’t know

DATA SUBMISSION TIMELINE

Quarter	Supplemental Data **Due Date**
Q4 2023	**February 29, 2024**

Best Practice

Submit data **monthly** or **quarterly** to track progress

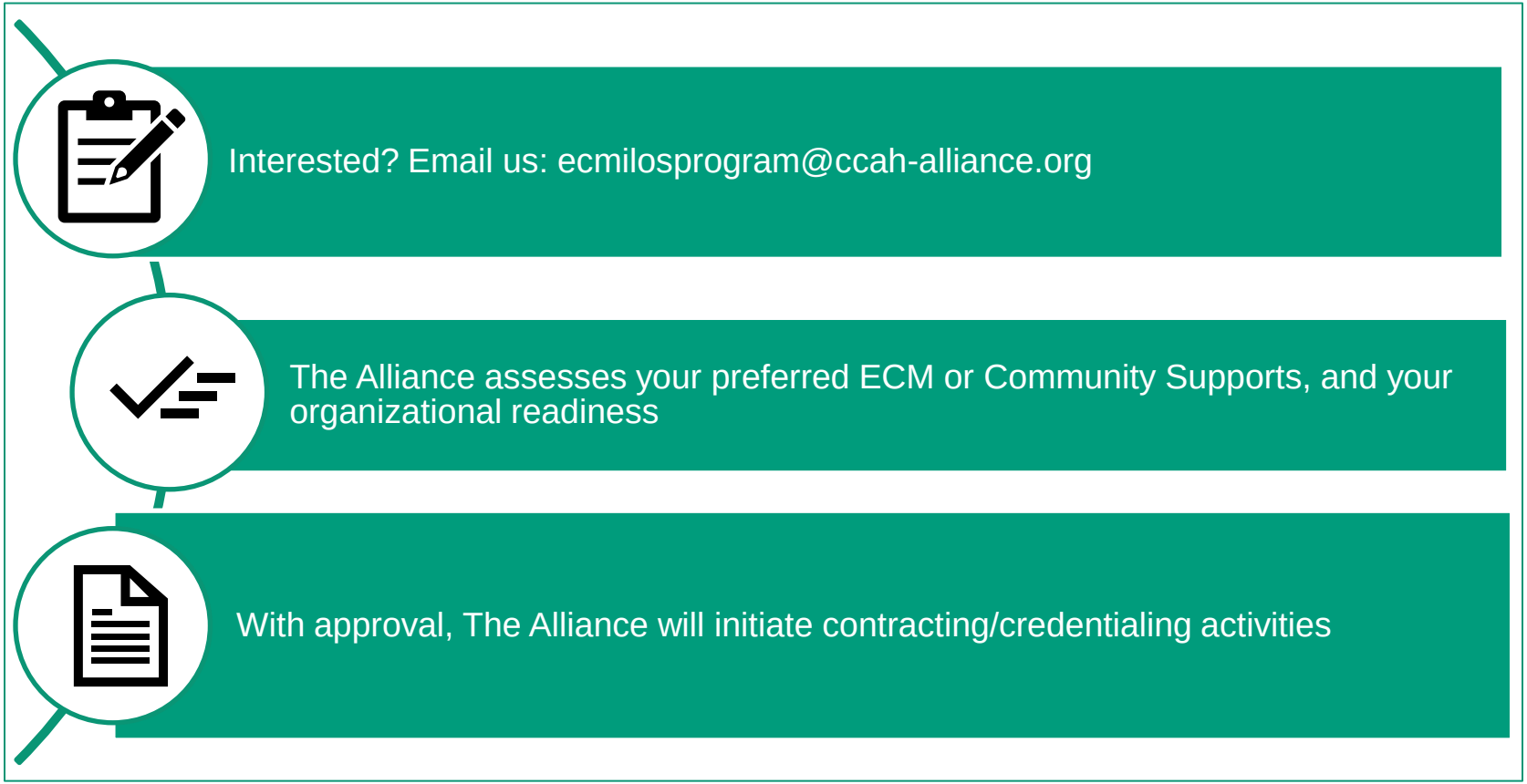
Set up your portal account or login here!

POLL QUESTION

Are you interested in becoming an ECM provider?

- Yes
- No
- We are already an ECM provider

Becoming an ECM/Community Supports Provider



EQUITY & PRACTICE TRANSFORMATION (EPT) PAYMENT
PROVIDER DIRECTED PAYMENT PROGRAM

- **GOAL:** To assist practice transformation to address health equity, population health, and move toward value-based care
- $650 million one-time funds
- Alliance weekly info sessions on Wednesdays!
  - 12 – 1:00p.m.
  - 5:15 – 6:15p.m.
  - RSVP via Doodle
- **Application due October 23, 2023**

Click here to get support applying for DHCS Equity and Practice Transformation grants

KEY POINTS & TAKEAWAYS

- Utilize the **CBI Incentive Summary** and **Tip Sheets**
- Keep track of **quarterly performance**
- Schedule virtual **CBI Forensics visit**
- View **Practice Transformation Academy Videos**
- Curious about **Practice Coaching**? Reach out to pc@ccah-alliance.org!
- Take advantage of available **fee-for-service** measures!


Questions?

CONTACT INFORMATION

CBI Team

cbi@ccah-alliance.org

Pharmacy

Pharmacy@ccah-alliance.org

Include the phrase “Pharmacist-Led Academic Detailing” in the subject line.

Provider Relations Representative

Main phone: 800-700-3874 ext. 5504

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

QUALITY IMPROVEMENT AND POPULATION HEALTH DEPARTMENT