Care-Based Quality Improvement Program

PROVIDER INCENTIVES

Program Overview

Program Objective

The aim of the Care-Based Quality Improvement Program (CB QIP) is to provide financial investment for practices to make quality improvement interventions. This endeavor will assist practices who are performing below minimum performance levels (MPL) for prioritized CBI measures to make sustained improvements in staffing, processes, and technology. This program is process oriented and should support practices in reaching CBI 2023 benchmarks.

This is a one-time program with funding contingent on validation of 2022 CBI quarter four data in April 2023. In order to apply, providers must complete the application and submit it through the application portal. Program applications will be accepted for formal review by The Alliance's Quality Improvement and Population Health team during the month of April. Once your application is approved, Letters of Agreement will need to be signed and finalized for participation and receipt of funds.

The program will prioritize the following measures for selection by participating CBI practices:

- Well-Child Visits in the First 15 Months
- Immunizations for Children (Combo 10)
- Child and Adolescent Well Care Visits (3-21 years)
- Immunizations for Adolescents
- Diabetic HbA1c Poor Control (>9%)
- Cervical Cancer Screening
- Breast Cancer Screening
- Chlamydia Screening for Women

For each measure selected by your practice, the application must document the specific best practices you will implement in your improvement strategies. A detailed list of best practices can be found below under the **Program Resources** section.

Finally, we ask that a SMART (Specific, Measurable, Achievable, Relevant, Time-bound) Aim Statement is created for each measure selected for performance improvement. This statement will allow your team to articulate a clear, specific goal you wish to achieve during this CB QIP timeframe.

The SMART acronym is explained below:

- **Specific** – What is the goal of the project? What is to be accomplished? Who will be involved or affected? Where will it take place?
- **Measurable** - The indicator to measure the goal. What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **Achievable** - Is the goal attainable (not too low or too high)? The achievement you want to attain based on a best practice/average score/benchmark.
- **Relevant** – The goal addressed the problem to be improved.

- **Time-bound** – The timeline for achieving the goal is within the project timeframe.

For more information on how to create a SMART AIM statement, please refer to the Practice Transformation Academy Video 1: SMART Aim Statements and How to write a SMART Aim Statement Worksheet.

General Instructions

Thank you for your interest in the Care-Based Quality Improvement Program. In order to apply, applicants must complete the application through the online application portal by **5 p.m. PST on May 19, 2023**. In order for this application to be considered complete for the purposes of submission, all components of the application must be completed including practice contact information, measure(s) selection, best practice(s), and SMART Aim statement. The Letters of Agreement must be signed by **5 p.m. PST on June 28, 2023**.

Program Implementation Timeline

Steps	Timeline
CCAH CB QIP Request for Applications	March 14, 2023
2022 CBI Q4 Practice Profiles shared by Provider Relations Representatives to CBI groups	April 14, 2023
CB QIP Applications due to CCAH	May 19, 2023
CCAH reviews applications based on a standardized scoring tool. Medical Directors outreach to applicants not meeting application criteria.	May 22, 2023-June 5, 2023
Providers return requested application updates	By June 8, 2023
CCAH provides eligible CBI Providers final determination letters, and Letters of Agreement for signature	By June 13, 2023
Participating CB QIP providers submit signed LOA to CCAH	June 28, 2023
CB QIP start date	June 29, 2023
CB QIP operations duration	June 29, 2023-December 31, 2023

Criteria for Eligibility

All practices receiving a 25%-100% CBI payment reduction in 2022 CBI Q4 Payments will be eligible to participate in the CB QIP. We recommend CBI practices to first take note of how many of their CBI Quality of Care measures fall below the 50th percentile to then determine which measures they wish to focus their efforts on. Additionally, we advise practices to keep in mind current resource limitations, expectations for involvement, and the overall timeframe of the project when making their selection of measures. Project design should also focus on elements that are sustainable beyond the program timeline. To participate, the practice must select at least one measure to qualify for the program.

Tier	Quality of Care Performance < 50th Percentile	CBI Programmatic Payment Adjustment
1	1-3 measures between 25th and 49th and no metrics < 25%	25% payment reduction
2	4 or more measures between 25th and 49th and no metrics <25th	50% payment reduction
3	1-3 measures ≤24th	75% payment reduction
4	4 or more measures ≤24th	No CBI payment

Payment and Project Criteria

Funding will be based on:

- Linked member months.
- Effort required to complete measure for a member.
- Gap between current performance and 50th percentile.

Practices will be notified of the amount they are eligible for once program eligibility is confirmed and the 2022 CBI Q4 data validation is completed. 80% of the funds will be paid once the Letters of Agreement is finalized. The final 20% of funding will be paid based on program participation in the initial and mid-point cohort meetings in June and August 2023, with each meeting equating to 10% of the remaining payment.

How funding can be used:

- ✓ EMR Improvements
- ✓ Consultant Assistance
- ✓ Process redesign (standing orders, etc.)
- ✓ Data submission improvements
- ✓ Engagement projects
- ✓ FNP/PA recruitment
- ✓ Other Staff recruitment

Expectations for Involvement

Mid-Project Performance Review:
Following the first three months of program implementation, a meeting will be scheduled for August 2023 for CBI practices to have report on the status of their implementation plan and hear best practice strategies and lessons learned from their peers. For providers unable to participate in the cohort meetings, a supplemental narrative of project implementation will be required for submission prior to the cohort meeting.

Program Resources

Best Practices for Implementation:

Early Scheduling: Schedule the next visit before the member leaves the exam room or clinic to ensure that members stay on schedule with the Bright Futures Periodicity Schedule or maintain follow-up on key care plan needs. Examples include routine HbA1c testing and ensuring that all children receive developmental screenings at minimum occurring at 9 months, 18 months, 24 or 30 months of age. For other members, this may mean a patient portal reminder before screening is due, such as a prompt 1 month before cervical cancer screening is due.

Telehealth Visits: For patients/families that do not feel comfortable coming into the clinic, telehealth visits are an option that can capture routine and preventive information. This is a recommended strategy in some cases but less than ideal for children who require vision and hearing screening with each well child visit.

Leverage Missed Opportunities: Utilize episodic and sick visits to increase preventive services such as immunizations, as well as convert acute visits into well-visits (sports physicals). Similarly, a well visit or acute care visit for an adult can have a screening for cervical cancer or chlamydia added to it with staff training and change in work instructions.

Group Well-Care Visits: Implement the option for group well-visits, proven to be effective for multi-child families and for chronic conditions like diabetes.

Standing Orders: Review standing orders to ensure that vaccinations are available during all visits, including sick or well-visits, regular hours, or weekend clinics. For implementation guidelines, reference the Standing Order Templates for Administering Vaccines. Perform A1C test every 3 months in patients whose therapy has changed or who are not meeting glycemic goals (≥9.0 HbA1c). Standing orders can also be created for routine screenings like mammography, pap and hrHPV. Example standing orders include diabetes and mammograms from the UCSF Center for Excellence in Primary Care.

EHR Prompts: Create flags or pop-ups in the EHR to alert care teams for when members are due for preventative health screenings or vaccines during chart prep or when the member presents in your health center. Ensure prompts do not turn off until results are received rather than when the test is ordered.

Prep For Success: Empower staff to chart review and place standing orders for care they are due for, such as immunizations and pap smears. Reviewing the schedule of immunizations can help in avoiding any missed opportunities to maintain vaccine compliance, and most vaccines can be given even with mild illness. As part of the prep for immunizations, always screen for contraindications. The Centers for Disease Control and Prevention offers a number of tools practices can employ including the Child & Adolescent Immunization Schedule, Adult Immunization Schedule, as well as guidance on formulating catch-up immunization schedules. Immunization Action Coalition includes example checklists for screening contraindications, and a check list for suggestions to improve your immunization services. Example Pre-Visit Planning toolkits like the American Medical Association's STEPS Forward program offers workflows, planning tools and templates.

Utilize Immunization Registries: Ensure staff has current accounts with your local immunization registry, and staff are trained to enter both administered vaccines and historical vaccines from health records into the registry. Normalize checking the registries prior to administering any vaccines.

Monitor the Provider Portal: Review compliance by utilizing the Quality and CBI reports as a tool to identify members that are due for their well-visits, childhood immunizations, or key preventative health screenings (breast cancer, cervical cancer, and STI prevention).

Routine Recalls and Outreach Strategies: Institute routine call-backs, utilizing the Provider Portal to generate member lists. Remind parents via phone, text, email, or postcard of upcoming visits, screenings, and vaccines they are due for. Reconcile portal report data with your clinics records before beginning outreach.

Assist in Scheduling: Help members schedule appointments with imaging centers while they are in the office or provide members with a list of nearby contracted imaging/mammography centers.

Utilize EHR Reports: Run population health management reports out of your EHR, including either active and inactive patients or another time-bound filter. Many practices make patients inactive after 18, 24 or 36

months, which may miss women due for their cervical cancer screening.

Create EHR Templates: Use age-specific standardized templates in your EHR to maximize documentation of Bright Futures requirements and trigger reminders for the next well visits.

Reassess Declinations: A patient may choose to decline screening even if strongly encouraged by the health care team. A patient should be periodically re-assessed and supported to complete screenings as per current guidelines. Utilizing EHR prompts can assist in creating a reassessment strategy.

Patient/Family Education: Promote healthy behaviors and assess for risky behaviors to detect conditions that may interfere with physical, social, and emotional development. Utilize lay health volunteers or healthcare staff to conduct individual education sessions to help people overcome barriers to screenings. Share reliable sources of immunization information with parents such as Reliable Sources of Immunization Information: Where Parents Can Go to Find Answers! Point-of-care testing for A1C provides the opportunity for more timely treatment changes. Enroll members into Alliance Health Education and Disease Management Programs using the Health Education and Disease Management Program Referral Form.

Pharmacist-Led Academic Detailing Diabetes Program Participation: The Alliance Pharmacy Team will be using academic detailing to educate clinicians on optimal guideline-based pharmacotherapy. Academic detailing has been proven to improve outcomes for patients with chronic conditions such as diabetes. It involves direct engagement with clinicians to assess their needs, identifying areas for change in practice, education on the latest clinical guidelines, and equipping them with specific tools to implement the changes. The program involves ten 45-minute interactive virtual sessions with a small group of 2-3 clinicians over ten weeks. Each session will be dedicated to reviewing the latest standards on pharmacologic approaches to glycemic control and reviewing case studies to show how to incorporate these recommendations into practice.

Champion Prevention: Confident recommendations and education by a health care professional is the main reason parents decide to vaccinate. Using a champion within your clinic can ensure staff are trained and up to date on procedures, recommendations, and workflows. They can support monitoring quality performance and other activities.

Utilize Resources for High Risk: Refer Alliance members to Care Management services, including Complex Case Management and Care Coordination, by calling Case Management at 800-700-3874, ext. 5512. Refer Alliance members to Enhanced Care Management (ECM) Services and Community Supports through the Alliance Provider Portal, email (listecmteam@ccah-alliance.org), mail or fax, or by phone at 831-430-5512.

Other Activities to Support your Success:

Staff Education: Keep clinical staff up to date with current recommendations and communication tools for key preventative health items, such as the CDC's Provider Resources for Vaccine Conversations with Parents. Consult the "Chlamydia Screening Starter Guide" for more strategies and guidelines. Refer to the CDC's A Guide to Taking a Sexual History for a sample of discussion points and questions that may be asked. Refer to CDC Sexually Transmitted Infections Treatment Guidelines, 2021 for up-to-date clinical guidelines.

Community Partnerships: Partner with community stakeholders, such as school-based clinics.

Population Specific Centered Care: Incorporate adolescent-friendly materials and ensure confidentiality through private consultation time with adolescent members during well-care visits to foster trusted and reliable relationships. For members in poor HbA1c control, set appropriate individualized A1C goals based on relevant comorbidities, demographic factors, and other considerations. Point-of-care testing for A1C provides the opportunity for more timely treatment changes.

Assess Health Literacy: A lack of understanding and/or language differences may create barriers in following a recommended care plan. Utilize the Alliance's telephonic and face-to-face interpreting services.

Culturally Appropriate Care: Display culturally appropriate posters and brochures at an appropriate literacy level in patient areas to encourage patients to talk to providers about preventative services. Hire clinicians and staff to accommodate language needs, gender preferences, and LGBT sensitivity of patients served. Remember, cultural competence is not just limited to race, ethnicity and culture. Perceptions, values, beliefs, and trust can also be influenced by factors such as religion, age, sexual orientation, gender identity and socioeconomic status.
Standardize Processes and Protocols: Utilize an immunization checklist to improve your clinic's vaccine compliance, such as the Immunization Action Coalition (IAC's) Suggestions to Improve Immunization Services. Have written policies and protocols in place for key prevention services, such as Chlamydia and other STI screening. The United States Preventive Services Task Force (USPSTF) recommends screening adolescents and young adults < 25 years: Annual chlamydia and gonorrhea screenings should be performed for women < 25 years of age and older women at risk. Syphilis, HIV, chlamydia, and hepatitis B screenings should be given to all pregnant women. gonorrhea screenings should be given to pregnant women at risk. HIV screening should be performed for everyone ages 15-65 (USPSTF). Younger adolescents and older adults who are at increased risk of infection should also be screened.

Practice Coaching: For practices with 5,000 or more linked members, practice coaching will be available upon request and formal review of such request. You will have the option to detail your interest in this resource on your application form. This level of engagement requires leadership commitment and engagement. It also requires assigning improvement champions at your site, ensuring protected time has been allocated for key staff to engage in improvement work, and requires your site to engage on a routine basis with your assigned coach to track and make continued changes for process improvement. The goal of initiating the Practice Coaching (PC) Program is to support PHCCs in overcoming some of these barriers, and to provide mentorship as they work toward the Quadruple Aim of improving population health, improving the patient experience, reducing healthcare expenditures, and improving the professional environment of healthcare personnel (Bodenheimer et al., 2014; Sikka et al., 2015).

Practice coaches are mentors from organizations, like the Alliance, who support primary health care centers (PHCCs) in improving delivery of care. They provide a wide range of skills and resources such as helping to define actionable goals, modeling best practices, building organizational capacity for change, utilizing project management tools, and running small tests of change (Grumbach et al., 2012).

Existing Alliance Resources:

- The Care-Based Incentive Resources page on the Alliance website. There practices will find details on incentives, programmatic measure benchmarks, CBI Tip Sheets, and CBI Technical Specifications.
- Webinars & Trainings.
- The Alliance Provider Portal and Provider Portal User Guide.

References

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med, 12(6), 573-576. doi:10.1370/afm.1713

Sikka, R., Morath, J. M., & Leape, L. (2015). The Quadruple Aim: care, health, cost and meaning in work. In BMJ Qual Saf (Vol. 24, pp. 608-610). England.

Grumbach, K., Bainbridge, E., & Bodenheimer, T. (2012). Facilitating improvement in primary care: the promise of practice coaching. Issue Brief (Commonw Fund), 15, 1-14.