AHARO Payment Reform Model

Submitted by the

Accountable Healthcare Alliance of Rural Oahu

Revised October 3, 2013

(Includes Updated Appendix C)

AHARO PAYMENT REFORM MODEL
Updated October 3, 2013
(Updated Appendix C)

I. Background

The Accountable Health Care Alliance of Rural Oahu (AHARO) is a "virtual accountable care organization" responsible to the community elected governing boards of the three Federally Qualified Community Health Centers (FQHCs) of Rural Oahu: Koolauloa Community Health and Wellness Center, Waimanalo Health Center, and Waianae Coast Comprehensive Health Center.

These three Health Centers serve a total of approximately 40,000 patients through over 200,000 clinical visits annually. Approximately 50% of these patients (20,000) are enrolled in the Hawaii QUEST (Medicaid) program.

In November 2010 AHARO was established through an interagency agreement as a patient-based response to health care transformation. AHARO activity has included the development of supplemental health care home standards, population-specific performance-based reimbursement systems, and shared savings partnerships based on transparency and relative contribution to outcomes. AHARO seeks trust-based partnerships both with a vertical network of providers, valued by our patients, and with selected Medicaid managed care organizations.

It is the intent of AHARO to assure that performance-based health care is fair to safety net providers and results are accountable to the patients served as well as to payers.

II. Innovations

While AHARO supports compliance with NCQA Patient Centered Medical Home Standards its members also believe that these standards do not go far enough in measuring the full value that community health centers provide their patients or Medicaid payers. The following initiatives are being developed to provide a more comprehensive system of evaluating these contributions.

- Supplemental *Health Care Home* Standards
- 360 Health Care Home Plan Performance Standards
- Cooperative Pay for Performance Metrics/Real Time Dashboards
- Partnership Investment in Health Information Technology (HIT) / Care Coordination and Training
- Shared Savings and Transparent Risk Pools

A description of each of these initiatives is provided in the following sections.

III. Supplemental *Health Care Home* Standards

Prior to the establishment of AHARO, its member health centers conducted numerous conferences and workshops dating back to 2008 with the intent to respond to draft NCQA Patient-Centered Medical Home Standards. Four areas of additional standards were developed through this process that specifically addressed the needs of medically underserved areas and populations (MUAs/MUPs) that are characteristic of FQHCs. These supplemental standards expand the NCQA Medical Home model to what AHARO has termed the "Health Care Home"

because it addresses areas that impact wellness that go beyond medical issues. These four areas of competency were recently adopted by the Consumer Board Committee of the National Association of Community Health Centers (NACHC) and include:

A. Care Enabling Services: designed to reduce access barriers in medically underserved areas.

B. Cultural Proficiency: designed to trigger supplemental services when the shared values and practices of the patient population are different from the dominant State population.

C. Patient/Community Involvement: designed to measure levels of participation of the patient population and community when such involvement is essential to population outcomes.

D. Workforce/Employment Referral Services: designed to support services essential to maintaining a viable and meaningful means of employment essential to well-being.

Scoring templates for supplemental health care home standards are shown in Appendix A. Enabling services codes and related documentation is found in Appendix B.

IV. 360 Health Care Home Plan Performance Standards

AHARO recognizes that the ability to create shared savings in health care risk pools and achieve successful compliance with performance metrics requires not only the systems and actions of health care providers; success is also linked to the system and performance of Managed Care Organizations and other Medicaid payers. AHARO has developed a set of performance standards for Medicaid payers that focus on the following capabilities:

A. Primary Care and Specialty Network Capability: designed to measure a plan's ability to provide vertical networks of providers under contract and accessible to patients.

B. Claims Processing Capability: designed to measure the technical capabilities of a Plan's claims adjudication effectiveness.

C. Care Coordination and Health Information Systems: designed to measured collaborative efforts in managing patient care and targeting improved quality and shared savings.

D. Health Care Home Model and Value Added Support: designed to measure the flexibility and support offered by the Plan to the MUA based health care home that is responding to supplemental health care home standards identified in Section III of this document.

E. Aligned Incentives and Shared Savings: designed to assess the Pay For Performance and shared savings model with emphasis on transparent assessment of the relative value provided by health care home/payer partners.

E. Effectiveness and Efficiency Initiatives: designed to assess levels of cooperation in paperwork reduction and automation of processes while improving reporting quality.

Draft Scoring Templates for the 360 evaluation processes are shown in Appendix C.

V. Cooperative Pay for Performance Metrics/Real Time Dashboards

AHARO projects are based on the cooperative development of performance metrics between payers and health care homes. AHARO asserts that population characteristics are important factors in the level of performance healthcare homes achieve on process-related measures.

AHARO health centers have been using metrics developed as a part of the Pacific Innovation Collaborative (PIC) project. These metrics were negotiated with two health plan partners and include measures with subsets of patients demonstrating co-morbidities to psychosocial conditions as well as metrics that measure access to primary care. For more information on PIC, visit the following links at the AAPCHO website:

http://www.aapcho.org/site/aapcho/section.php?id=11276

http://www.aapcho.org/site/aapcho/section.php?id=11412

AHARO and PIC have created a Hawaii and US based data exchange and data repository that combines information from electronic health records at participating health centers and those of the two health plans. Dashboards created are real-time and reflect the status of performance by heath care homes updated within 24 hours. Drill downs are currently available specific to health care home, primary care sites and individual providers. Incentives are proposed linked to improved performance on selected metrics by each individual health care home.

Dashboards are also being developed for accruals within health plan risk pools and for use by patient and AHARO consumer Board members. Performance metrics and dashboards are shown in Appendix D.

VI. Partnership Investment in HIT/Care Coordination and Training

The ability of any health care system to contain cost and improve quality is linked to the development and use of emerging technology. Innovations include the use of technology to prove value, the development and monitoring of best practices protocols through use of electronic health records, and the use of tele-health (including telemetry) to efficiently monitor and provide care to patients remotely. AHARO members also have pilot projects underway using remote technology for outstationed eligibility assistance and for dispensing medications.

AHARO is proposing partnerships with health plans that invest in new technology through matching funds. Current models proposed under AHARO include a $5 matching fund established by Medicaid managed care organizations to build both HIT and care coordination activity.

Care coordination will focus on preventable costs. For AHARO, key target groups for care coordination include patients defined as complex, newly diagnosed chronic disease patients and patients identified by both health plan and health care home based predictive software. The later is under development by AHARO health centers.

Care coordination in the AHARO model shifts from health plan based care coordination to health care home based care coordination. There are specific programs in graduated competencies at the Waianae Coast Comprehensive Health Center to train a workforce in community based facilitators of both HIT and care coordination functions with the latter including training on safety issues (see Appendix E). These capabilities also fit well into the supplemental health care home standards proposed for low income (MUA/MUP) communities.

VII. Shared Savings and Transparent Risk Pools

There is a demonstrated utility derived from building and applying trust within health care networks. More will get done in terms of saving dollars and producing better outcomes if a network is based on common values and there is trust between the provider network and Medicaid health plans. Specialists are more likely to see Medicaid patients, health care homes are more likely to pursue incentives, and health plans and health care homes are more likely to pursue joint care coordination if there is a strong element of trust.

While the development of a "satisfaction" dashboard that measures the relationship between payer, health care home, and State Medicaid agency may be useful; the more definitive relationship can be defined through a contract based on aligned incentives and shared savings. These incentives must be aligned horizontally. The beneficiaries of savings created within risk pools of Medicaid patients should be partially determined by performance on 360 dashboards. Who provides the relative utility in producing outcomes is a key question to be asked. The subjective nature of this assessment can be somewhat diminished if 360 objectives are prospectively defined.

In AHARO member contracts, specific financial performance metrics are proposed in areas of reduced hospital readmissions and appropriate after-hours utilization. Performance on these measures should relate to prospective investments of risk pool dollars in future years. These measures proposed for 2012 are attached as Appendix F.

VIII. Conclusions

The model of payment reform summarized above is not being proposed for the larger health care delivery system in Hawaii or beyond. Rather it reflects a modification of various initiatives already underway in those venues. This model meets the value criteria community health center board members have set specifically for the Medicaid program as it serves patients in low income and Medically Underserved Areas in Hawaii.

Serving patients in Hawaii's medically underserved communities, where there is a concentration of poverty, lack of employment opportunities, unique access barriers to care, and medical complexity that often includes psycho-social influences, requires population specific performance based systems and services. For MUA populations we must move well beyond medical models and integrate job training and behavioral health functions into accessible integrated networks of care. Health care homes must be defined by the scope of services required to produce both quality outcomes and return on investment of Medicaid dollars. AHARO believes the system and standards summarized in this document is the beginning in designing a model that can meet these goals.

The consumer board constituency driving AHARO seeks inclusion of these concepts within the greater mission of reengineering Hawaii's health care delivery system. Ultimately it is believed that improved transparency will determine the ultimate effectiveness of this model.

IX. Appendices

A. Templates for Supplemental Health Care Home Standards *(revised 2-29-12)*
B. Enabling Services Codes and Related Documentation
C. Draft Scoring Templates for 360 Evaluation of Health Plans *(updated scoring 10-3-13)*
D. Performance Metrics and Dashboards
E. Graduated Competencies Training Criteria – Health Care Reform *(revised 1-4-12)*
F. 2012 Financial Performance Measures

APPENDIX A

Templates for Supplemental Health Care Home Standards

Supplemental Patient-Centered Medical Home Standards

Copper Level
32 Points
Your score effective January 1, 2012 Shown below:

PCMH 7: For MUA/MUP Community Based Initiatives to help facilitate access to care in higher poverty level or culturally unique communities.

Element A: Care Enabling Services — 8 Points

The practice evaluates patients' abilities to receive services and has systems in place to overcome potential access barriers by:		YES	NO	N/A
1.	Assessing on an ongoing basis the self-reported and actual access barriers experienced by patients in the PCMH.			
2.	Offering patients the eight basic enabling services identified by AAPCHO and NACHC (attached).			
3.	Having appropriate programs, staffing, and resources to provide these care enabling services.			
4.	Coding and tracking these enabling services on charge tags or electronic records.			
5.	Measuring the impact of enabling services on performance metrics.			
6.	Developing and utilizing enabling protocols on electronic health record templates.			
7.	Having an established patient and family feedback system for appropriateness, effectiveness and improvement of care enabling services			

	8	6	4	2	0
	The practice meets all 7 factors	The practice meets 5 factors, including factor 3	The practice meets 3 factors including factor 3	The practice meets only factor 3	The practice meets less than 3 factors

TOTAL POINTS ELEMENT A

Element B: Cultural Proficiency — 8 Points

The practice addresses the cultural background of consumers in its policies, procedures and practices through the following:		YES	NO	N/A
1.	Assesses the diversity of consumers and trains staff, providers, and others about the diversity.			
2.	Has a panel of cultural advisors engaged in developing and evaluating cultural practices.			
3.	Has an established plan for cultural sensitivity training and professional development for staff.			
4.	Providers follow culturally specific protocols based on patient background and demographics.			
5.	Buildings and facilities that reflect the patient population's culture and background (e.g. male family planning clinic design to make men feel welcome).			
6.	Provides and/or promotes complementary and/or alternative healing practices in alignment with primary and preventive health services.			

	8	6	4	2	0
	The practice meets all 6 factors	The practice meets 4 factors, including factor 1	The practice meets 3 factors including factor 1	The practice meets factor 1	The practice meets no factors or does not meet factor 1

TOTAL POINTS ELEMENT B

Element C: Community Involvement — 8 Points

The practice is an integrated part of the community, encouraging participation and elevating the level of health education and organization through the following:		YES	NO	N/A
1.	Has a panel of patients or Consumer Board that reviews and approves an annual plan that identifies health care needs and disparities within the community; establishes an action plan to address these issues.			
2.	Reviews adequate data to measure performance to promote access, quality, cost effectiveness and makes recommendations for consideration.			
3.	Has a systematic process in place to measure patient satisfaction and performs any remedial actions deemed necessary.			
4.	Has a volunteer program that involves community members and various activities to promote a healthier community.			
5.	Conducts outreach with community participation through health fairs, etc.			
6.	Engages in Community Based Participatory Research with patients trained as the investigator (PI).			
7.	Has patients sitting on internal committees, (for example, Quality Improvement Committee or Cultural Competency Committee.)			

	8	6	4	2	0
	The practice meets all 7 factors	The practice meets 5 factors, including factor 1	The practice meets 3 factors including factor 1	The practice meets only factor 1	The practice meets no factors or does not meet factor 1

TOTAL POINTS ELEMENT C

Element D: Workforce and Economic Development — 8 Points

The practice is a center of economic opportunity for the community by offering the following:		YES	NO	N/A
1.	A protocol in place to refer unemployed patients to job training activities within the service area.			
2.	An "on the job" training program for workers to improve job competencies that are aligned with healthcare transformation needs.			
3.	A plan in place to promote a continuum of job training activities for service area residents that ranges from entry level careers to professional education with preparatory or "pipeline" services identified.			
4.	Programs to support staff development activities, e.g. tuition reimbursement, flexible scheduling, job-sharing, telecommuting, and other training programs.			
5.	Programs to attract workers from other industries with transferable skills to work at a healthcare home.			
6.	Programs to share training/workforce development resources with other healthcare homes as needed.			
7.	Acting as a training site for at least 3 different health care disciplines, ex. medical assistants, nurses, nurse practitioners, physician's assistants, social workers, medical students, psychology interns, or medical or dental residents.			

	8	6	4	2	0
	The practice meets all 7 factors	The practice meets 5 factors, including factor 1	The practice meets 3 factors including factor 1	The practice meets only factor 1	The practice meets no factors or does not meet factor 1

TOTAL POINTS ELEMENT D

TOTAL POINTS ELEMENTS A - D

APPENDIX B

Enabling Services Codes and Related Documentation

AAPCHO
Association Of Asian Pacific Community Health Organizations

The Role of Enabling Services in Patient-Centered Medical Homes

Community health centers, including AAPCHO members, have long served as patient-centered medical homes for nearly 600,000 medically underserved Asian Americans, Native Hawaiians, and other Pacific Islanders (AA&NHOPIs) or 1 in 9 low-income AA&NHOPI. The Patient-Centered Medical Home (PCMH) is a model of team-based primary health care delivery that emphasizes timely access to services, coordination and continuity of care, enhanced communications between patients and providers, and a systems-based focus to quality and safety improvements. Moreover, this paradigm stresses an ongoing patient-physician relationship, holistic and preventive care, and optimal integration and utilization of health information technology.

1. Background on the Patient-Centered Medical Home (PCMH)

To strengthen the primary health care safety net, four physician membership organizations jointly issued seven principles that comprise the primary care PCMH:[i]

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Coordinated and/or integrated care
- Quality and safety
- Enhanced access
- Payment

Evidence suggests that PCMHs improve care for racial and ethnic minorities, and potentially eliminates health disparities.[ii] PCMHs are also increasingly acknowledged today for sustaining chronic care management and improving health outcomes. Therefore, many private and public health plans are incentivizing primary care practices that meet National Committee for Quality Assurance (NCQA) PCMH standards in access and communication, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications.

2. Importance to AA&NHOPIs

AAPCHO community health centers serve a predominantly AA&NHOPI population with distinctive health needs. The AA&NHOPI population in the United States is burgeoning and represents many nationalities and more than 100 different languages and dialects. With higher levels of poverty, uninsured, and limited English proficiency than non-Hispanic whites, AA&NHOPI subgroups continue to experience difficulties in accessing health care and significant health disparities despite aggregate data that obscures these distinctions.[iii] Additionally, cultural differences magnify the challenges AA&NHOPIs face in obtaining appropriate health services, and demonstrate an increased need for a PCMH model uniquely adapted to fit diverse patients' needs.

3. Enabling Services – A Critical Factor in Building PCMH

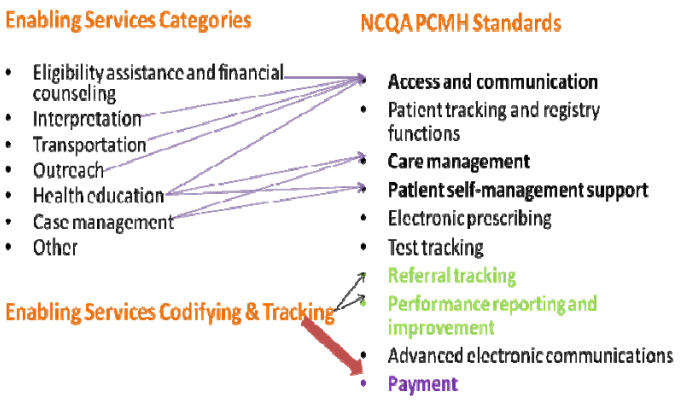
Community health centers offer comprehensive, quality, affordable primary and preventive care and are well positioned to meet the NCQA's PCMH criteria in patient assistance, quality improvement, enhanced access, and electronic health records. A critical factor in community health centers' success at improving care and reducing health disparities for medically underserved populations lies in their consistent utilization of **enabling services** – non-clinical services provided to patients to support care delivery, enhance health literacy, and facilitate access to care. Enabling services include a variety of supportive services such as case management and health education and are incorporated with medical care to eliminate quality chasms in care delivery and reduce health disparities.

Conservative estimates from the federal health center data show that nationally Federally Qualified Health Centers (FQHCs) provided over 4,500,000 enabling services to almost 1,700,000 patients in 2008.[iv] With

For further information, please contact Hui Song at 510-272-9536x119 or hsong@aapcho.org

AAPCHO
Association Of Asian Pacific Community Health Organizations

its staff working as part of the multi-disciplinary team, such as that prescribed by PCMH, **enabling services strengthen a community's medical home**.



Enabling services are critical in providing seamless care to medically underserved populations, including AA&NHOPI communities. Focusing on the holistic health of patients, enabling services integrate multiple components of care to improve the well-being of an individual. As seen in the figure, enabling services directly correlate to NCQA PCMH standards. However, enabling services are often jeopardized by political and financial pressures. Enabling services are generally not reimbursed nor have continuous funding. This is of particular concern because community health centers have limited resources. Although costs of enabling services increased from 2000-2008, FQHCs spent less than 8% of their total expenditures on enabling services in 2008.[iv] With inadequate funding, enabling services are only available to some of the neediest patients. Due to the lack of data on enabling services, it is challenging to advocate for more funds to sustain these critical services. As shown in the figure, enabling services codifying and tracking support a strong documentation and reporting system for PCMH and result in more accurate payments to fully recognize community health centers' effort in providing culturally competent health care.

4. Recommendations

With the passage of the Affordable Care Act (ACA) and plans to double the number of health centers and thereby expand coverage to millions of low-income adults, community health centers are well positioned to continue serving as the model of PCMH. Community health centers have the capacity to integrate and coordinate services provided by a network of specialists, health care organizations, and community organizations. Although the PCMH better aligns patient and provider priorities, improves health outcomes, and reforms payment systems to better reflect services utilized, AAPCHO believes that **the medical home model must also recognize enabling services as an indispensable feature that helps address the geographic, language, cultural/social, and health literacy challenges of this population**. As the national discussion on PCMH continues, we urge consideration of the following:

- Adoption of NCQA measure standards for PCMH, including those in the Joint Principles of the Medical Home
- Adoption of AAPCHO's standards for enabling services delivery, codification, and tracking
- Implementation of the Agency for Healthcare Research and Quality (AHRQ)'s medical home definition, such that services are patient-centered, comprehensive, coordinated, accessible, and focused on improvements to quality and safety.
- Development of complementary PCMH standards for federally designated Medically Underserved Areas to recognize cultural proficiency, training and workforce development, community involvement, and enabling services

References

[i] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the patient-centered medical home. 2007.
[ii] Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care: Results from the Commonwealth Fund 2006 Health Care Quality Survey. New York, NY: The Commonwealth Fund; 2007.
[iii] US Census Bureau. 2006-2008 American Community Survey 3-Year Estimates. Washington, DC: US Census Bureau; 2009.
[iv] Bureau of Primary Health Care Uniform Data System. Rockville, MD: Bureau of Primary Health Care; 2008.

Enabling Services at Community Health Centers - A Critical Component in Building Sustainable Health Care Homes

The Enabling Services Accountability Project: Demonstrating health centers' added value through enabling services data collection and analysis

September 2010

Rosy Chang Weir, PhD
Hui Song, MS, MPH
Association of Asian Pacific Community Health Organizations

Made possible by grants from the Office of Minority Health
and the California Wellness Foundation

Name	Definition
Case Management Assessment	Non-medical assessment that includes the use of an acceptable instrument measuring socio-economic, wellness, or other non-medical health status.
Case Management Treatment	An encounter with a center-registered patient or the patient's family member in which the patient's treatment plan is developed or facilitated by a case manager. The plan must incorporate the referral to services of multiple providers or health care disciplines.
Case Management Referral	Facilitation of a health-related visit for a registered patient of the center to a health care or social service provider.
Eligibility Assistance/ Financial Counseling	Counseling of a patient with financial limitations that results in a submission of a completed application to a sliding fee scale or health insurance program including Medicaid, Medicare, or pharmaceutical benefits program, or development of a payment plan.
Health Education/ Supportive Counseling	Provision of health education or supportive counseling in which wellness, preventive disease management or other improved health outcomes are attempted through behavior change methodology.
Interpretation	The provision of interpreter services by a third party (other than the primary care giver) intended to reduce barriers for a limited English-proficient patient or a patient with documented limitations in writing or speaking skills that are sufficient to affect the outcome of a medical visit or procedure.
Outreach	Patient services that result in the acceptance of a new patient into a provider's panel who was formerly without a primary care provider at the health center.
Transportation	Providing direct assistance to a patient by an employee or contractor of a health center to provide transportation for registered patients to receive necessary medical care.
Other	All other services that reduce access barriers to health care for a registered patient and that do not fall into the above eight categories and are provided by an employee or contractor at the health center.

Figure 1: Enabling Services Definitions

AAPCHO and partnering health centers successfully implemented enabling services data collection protocols within a span of three months to a year based on health center staff and systems availability. Health center partners have since positioned themselves as mentors, sharing their experiences and templates with new health centers interested in enabling services data collection. Particularly notable, one health center was able to use their data to negotiate a better reimbursement rate for the provision of enabling services from their Medicaid managed care payer. Additionally, analysis of collected data find that enabling services users, despite being minority and publicly insured or un-insured, have better diabetes outcomes and childhood immunizations when compared to other health center patients.

Currently, AAPCHO's enabling services project is ready to expand and implement at new sites. In addition to the four pilot sites, we have implemented our enabling services data collection protocol at three other sites in California and Hawaii. Along with refining our training curriculum and templates, AAPCHO provided refresher sessions to current staff. We further identified best practices in data collection from our pilot study health centers, in order to replicate and implement such practices at

ENABLING SERVICES DATA COLLECTION IMPLEMENTATION PACKET

Enabling Services Accountability Project

Updated October 2010

MISSION

To implement a standardized data collection system that improves the collection of enabling services data at health centers, and advocate for adequate reimbursement of these services so health centers can improve the health of medically underserved communities of color.

Accounts of Participating Health Centers

"The data from the project shows that our health center provides a great many services to patients and the community"

"The project was a good way to get national input"

"The project demonstrates that enabling services are the core of what makes quality care for our patients"

"We enjoyed meeting and joining forces with other health centers to show that enabling services are valuable to our vulnerable populations"

"The project was beneficial in terms of the possibility that we might incorporate enabling services data into federal reports for funding and to get an assessment of the enabling services activities provided by our health center to patients and to the community"

"The data will allow our managers to better assign staff and evaluate those activities which staff participate in. We will look at the outcome of sessions like nutritional counseling and the impact on patient health status"

ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

NEW YORK ACADEMY OF MEDICINE

Made possible with funding from:
Agency for Healthcare Research and Quality; The California Wellness Foundation; The MetLife Foundation; The Office of Minority Health

Enabling Service Data Collection

Implementation Packet Description of Contents

Tool	Useful for	Purpose
Enabling Services Info Sheet	Management, Project coordinator	To provide information about the project purpose and goals.
Enabling Services Policy Brief	Management, Project coordinator	To highlight how AAPCHO is utilizing enabling services data collection to influence public policy.
Enabling Services Accountability Project FAQs	Management, Enabling service staff	To provide answers to commonly asked questions.
Enabling Services Needs Assessment Tool	Enabling service staff	To provide an assessment that helps organizations better understand its capacity and needs in collecting and reporting enabling services data.
Handbook for Enabling Services Data Collection	Enabling service staff	To provide detailed guidelines on how to collect enabling services data that is valid and useful.
Sample Encounter Forms	Project coordinator	To provide sample encounter forms that have already proved useful to community health centers.
Handbook Quick Reference Card	Enabling service staff	To provide an at-a-glance look at key enabling service definitions. This tool can be laminated and placed on a provider's ID tag or other suitable area.
Implementation Training Curriculum	Project coordinator	To provide a curriculum that helps train staff on enabling services data collection and implementation.
File Layout Manual	Data analyst	To provide a data layout that helps users organize data before it is entered. The tool includes instructions to import data from other databases, such as practice management systems.
Sample Enabling Service Database	Data analyst	To provide a sample database in which to enter data.
Data Evaluation Tool	Project coordinator	To provide a tool for evaluating data entry (by crosschecking data entry with completed encounter forms to detect rate of error) and recognize and resolving errors.
Data Collection Evaluation Tool	Project coordinator	To provide a tool that enables users to measure and monitor the progression of staff's data collection efforts.
Project Benefits and Challenges	Management, Project coordinator	To provide information about the project benefits and challenges.
Project Timeline	Management, Project coordinator	To provide a tool that enables users to create a timeline and monitor the progression of their project.
Enabling Services Accountability Project Fact Sheets	Management, Project Coordinator	To provide project outcomes from the Enabling Services Accountability Project.
Enabling Services Project Introduction	Management, Enabling service staff	To provide a sample introductory presentation, that includes an overview of the Enabling Services Accountability Project, the data collection process, the implications and importance of data collection, and the study findings.
Enabling Services References	Management, Project coordinator	To provide additional references on enabling services.

APPENDIX C

Draft Scoring Templates for 360 Evaluation of Health Plans

(Updated Scoring 10-3-13)

Supplemental Patient-Centered Medical Home Standards for Health Care Plans
(Copper Level - 64 Points)

Element A: Specialty Network Accessibility		**7 Points**		
		YES	**NO**	**N/A**
1.	Plan has a comprehensive network of specialists, with open panels, accepting new patients, and Plan's list of specialists is accurate, specific to QUEST, QEXa, & Dual SNP patients, and updated monthly.			
2.	Plan provides access to a dashboard/database of next (or 3rd next) available appointments with specialists, based on the Medicaid timely access metrics.			
3.	Plans assist in the implementation of HIT technology; specifically Direct Messaging Technology for Care Continuity Documents containing progress notes, medications, & prescribed treatment plans. Tracking must also be in place to ensure timeliness & compliance.			
4.	Plan provides/supports enabling services that assist patients in keeping their specialty appointments, e.g. reminder calls, transportation to appointments. Codes are established for these enabling services and the process is tracked in database.			
5.	Plan assumes ultimate responsibility of finding specialty care for patients when such is deemed necessary by their PCP and has a system in place for addressing remedial action when indicated by data from the dashboard or audits.			
6.	Plan strives to support integration of primary care and behavioral health by providing crisis services in the ER for SPMI populations & by making available behavioral health services within 10 miles of the primary care provider's office and within 24 hours from time of referral.			
7.	The effectiveness of plan-coordinated behavioral health services is clearly monitored. Specific plan capabilities in addressing problems of substance abuse and pain management are measured and coded to adequately fund community health centers that are better able to deliver these services.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 7 factors	The plan meets 5 factors	The plan meets 3 factors	The plan meets 2 or fewer factors	The plan meets no factors

Element B: Claims Processing Capability	**9 Points**

		YES	NO	N/A
1.	Provides eligibility data through online lookup and 270/271 format.			
2.	Accepts 837P & 837I electronic claims at no cost to provider.			
3.	Accepts claim attachment such as EPSDT forms and progress notes electronically.			
4.	Provides 835 electronic remittance (no more than 1 per day) and image of paper remittance advice electronically.			
5.	Accepts crossover claims directly from traditional Medicare. Provider does not need to submit secondary claim, paper or electronic.			
6.	Coordinates benefit when a member is enrolled to multiple lines of business within Health Plan. Provider does not need to submit secondary claim, paper or electronic.			
7.	Establishes coordination of benefit arrangement (similar to #5 above) with other payer(s) serving Hawaii market.			
8.	Provides electronic tool (and designated staff when appeals exceed 20 per month) for denial appeal with tracking and timely response (within 30 days).			
9.	Collaborates with the community health center to ensure that coding is accurate and reflects the services provided.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 9 factors	The plan meets 6 factors	The plan meets 4 factors	The plan meets 2 or fewer factors	The plan meets no factors

Element C: HIT and Care Coordination	**9 Points**

		YES	NO	N/A
1.	Support the implementation of electronic, near real-time and if appropriate, secure, bidirectional, information exchange between providers and the health plan for enrollment, eligibility, and clinical data, in addition to claims.			
2.	Support a collaborative effort in development and implementation of an electronic care management system, including advanced registry tools to identify and track patient populations, patients with specific or co-morbid conditions, not recently seen, missed appointments, recently discharged, medications, identification of patient cohorts by providers or care teams, and predictive analytics.			
3.	Use modern interface standards (HL7, CCR, and CCD) for exchanging data and real-time transmission of data.			
4.	Provide online access to risk-pool data (capitation, PPS, and other financial data) for tracking purposes.			
5.	Implement electronic, near real-time, submission of prior authorizations and bidirectional referral information, supporting interface standards for integrating with EHR.			
6.	Support a collaborative effort in improving transmission of electronic EHR data to health plan for EPSDT reporting.			
7.	Support for implementation and investment in personal health records, secure electronic messaging, mobile care management technologies, and home health monitoring devices.			
8.	Makes provider-based investments in the advancement of tools to support remote tele-health visits.			
9.	Provides patient portal for health plan and health education related information.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 9 factors	The plan meets 7 factors	The plan meets 5 factors	The plan meets 3 or fewer factors	The plan meets no factors

Element D: Value Added Services Support – Health Care Home Model		**8 Points**		
		YES	**NO**	**N/A**
1.	Provide financial reimbursement/consideration for advanced care enabling services as defined by the Association of Asian Pacific Community Health Organizations (AAPCHO).			
2.	Provide financial reimbursement/consideration for medical nutrition therapy for patients at risk for hypertension, diabetes, and related conditions.			
3.	Provide eligibility assistance through 1) notification reminders for renewal enrollment deadlines and 2) notification when a condition makes them eligible for disability benefits. This will support eligibility assistance and other financial counseling useful to the patient in maintaining QUEST eligibility.			
4.	Provide financial reimbursement/consideration for services to CSAC certified substance abuse counselors for patients diagnosed with substance abuse.			
5.	Provide wellness programs for patients at risk or with any chronic disease conditions.			
6.	Provide recognition and support for traditional (non-western) practitioners certified under a recognized Board/ Council.			
7.	Community involvement in health care home and efforts with community to facilitate behavior change at a population level.			
8.	Support compliance with NCQA PCMH in addition to supplemental PCMH standards for MUA/MUP populations.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 8 factors	The plan meets 6 factors	The plan meets 4 factors	The plan meets 2 or fewer factors	The plan meets no factors

Element E: Aligned Incentives and Shared Savings		**9 Points**		
		YES	**NO**	**N/A**
1.	The shared savings formulas from margins created in annual provider-based risk pools are based on attributes of healthcare home and health plan.			
2.	One incentives mechanism shows alignment from Medicaid agency to plan to provider to patient. For example, incentives are aligned with cost, care and engagement.			
3.	Plan assists healthcare home in complying with NCQA PCMH and Meaningful Use Standards.			
4.	Plan supports bi-directional HIE and/or direct information exchange through additional funding to support care transitions			
5.	Plan supports and reimburses for process outcomes and tools to continuously track and measure performance through pay-for-performance incentives.			
6.	Reimbursement incentives include a measure related to goals established between healthcare home and health plan, including improved patient access via same day appointment, online care, and expanded hours of operations (i.e., evening and weekend clinic hours).			
7.	Performance metrics are risk adjusted and include sub-population measurements of psycho-social co-morbidities			
8.	Performance metrics are negotiated with primary care providers and are flexible to target goals established between primary care providers and health plan.			
9.	Performance measures are based on baseline performance improvement by Medicaid healthcare home over baseline rather than comparing Medicaid healthcare home to another provider group.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 9 factors	The plan meets 7 factors	The plan meets 5 factors	The plan meets 3 or fewer factors	The plan meets no factors

Element F: Effectiveness & Efficiency Initiatives (Other/Miscellaneous)		**4 Points**		
		YES	**NO**	**N/A**
1.	Paperwork reduction initiatives are planned annually in joint effort with providers.			
2.	Plan supports unified statewide and integrated credentialing service and takes concrete actions to promote this in the state.			
3.	Plan sets objectives and supports population health. Determines needs of the community – supporting expanded patient satisfaction and remediation.			
4.	Plan provides ombudsmen service to address patient complaints and concerns.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 4 factors	The plan meets 3 factors	The plan meets 2 factors	The plan meets 1 or fewer factors	The plan meets no factors

Element G: Inpatient Management and Care Transition Management		**8 Points**		
		YES	**NO**	**N/A**
1.	Plans have a benchmarking tool to evaluate opportunity days by APDRG to identify specific hospital conditions where Length of Stay is excessive, where readmissions are inappropriate and avoidable admissions.			
2.	Plans hold Joint Operating Committees with their largest volume hospitals to discuss ways of improving efficiency and quality. They evidence this by minutes and specific action plans and reduction goals.			
3.	Plans perform clinical rounds and onsite and telephonic reviews using Milliman or Interqual guidelines.			
4.	Plans have formal discharge plans for high-risk patients and conduct a formal risk discharge assessment.			
5.	Plans have formal care transitions to the next level of care including hard hand-offs to Accountable Care Community practices which include medication review & reconciliation, face-to-face functional assessment for selected risk, and confirmed appointment scheduling with the Primary Care physician within 7 working-days of discharge.			
6.	Plans have formal Care Transition technology to support an automated workflow and notifications to the primary care provider/practice and patient for both admission and discharge.			
7.	Plans have a formalized program with hospitalists to avoid admissions (or covert observation in the ER with influence over admitting).			
8.	Plans provide real time ADT data from inpatient stays electronically to Accountable Care Practices to enable them to schedule a visit within 7 working-days of discharge.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 8 factors	The plan meets 6 factors	The plan meets 4 factors	The plan meets 2 or fewer factors	The plan meets no factors

Element H: Non-Emergent ER Reduction		**5 Points**		
		YES	**NO**	**N/A**
1.	Plans receive real time ADT data from hospitals to effect real-time interventions with the hospital, primary care, and behavioral health.			
2.	Plans provide analytics and intervention strategies to assess reasons and actions to reduce inappropriate ER. Proactively engage different elements of the network to implement these strategies. Provide such information to hospitals to effect these strategies and can evidence interventions.			
3.	Plans proactively reach out to frequent ER users to implement case management interventions.			
4.	Plans provide Accountable Care Community practices with real time notification data to practices electronically to ensure 7 working-days follow-up with the patient through an outreach call or a visit.			
5.	Plans present their intervention strategies to Accountable Care Community practices on a monthly basis.			

Scoring

100%	75%	50%	25%	0%
The plan meets all 5 factors	The plan meets 4 factors	The plan meets 3 factors	The plan meets 2 or fewer factors	The plan meets no factors

APPENDIX D

Performance Metrics and Dashboards

AAPCHO
Association Of Asian Pacific Community Health Organizations

2010 FACT SHEET

The Pacific Innovation Collaborative (PIC)

The Pacific Innovation Collaborative Health Information Technology Project is a Department of Health & Human Services Health Resources and Services Administration funded network of eight community health centers and two health plans in Hawaii and Washington. The intent of the network is to design and develop an electronic infrastructure for community health centers in separate states to exchange patient information based on performance measures important to the network. The overall aim is to utilize electronic medical record systems to reduce health disparities by improving the safety, quality, efficiency and effectiveness of health care delivery.

Project Partners

Federally Qualified Health Centers

- Community Health Centers of King County (CHCKC)
- Healthpoint
- Family Health Centers (FHC)
- International Community Health Services (ICHS)
- Kalihi-Palama Health Center (KPHC)
- PTSO of Washington
- NeighborCare Health
- Waianae Coast Comprehensive Health Center (WCCHC)
- Waimanalo Health Center (WHC)

Health Plans

- AlohaCare
- Community Health Plan of Washington (CHPW)

Project Years

The project is comprised of four phases:

- Phase 1: Planning/Testing (2007-08)
- Phase 2: Expansion of Infrastructure (2008-09)
- Phase 3: Implementation (2008-10)
- Phase 4: Final Evaluation & Review (2010-11)

Health Information Technology (HIT) and Health Information Exchange (HIE)

Health Information Technology (HIT) refers to a wide variety of computer applications, which includes electronic medical, health, and dental record systems, patient portals, personal health records, chronic disease management systems, data warehouse/reporting systems, and digital imaging systems, to name a few. Through the PIC project, AAPCHO has created a Health Information Exchange, in which project members share data and provide technical assistance and facilitation of shared care management (team-based care). This HIE helps improve communication between providers and their patients and is believed to improve individual health center performance.

Performance Measures and the PIC Repository

With improving health center performance in mind, project members carefully chose measures to track through a combination of claims, practice management system, and electronic health record data [Table 1]. From a health center perspective, these measures, both clinical and process-based, were selected to have an impact on the timeliness; effectiveness; efficiency; and the safety, risk management, and quality of care provided to patients.

PIC Measures
1. Patients with 4 DTaP, 3 OPV/IPV, 1 MMR, 3 HepB, 3Hib, and Varicella vaccinations by age two
2a. Patients with either Type 1 or Type 2 Diabetes whose HbA1c is >9
2b. Diabetic patients with a behavioral health (mental health or substance) diagnosis whose HbA1c is >9
3a. Patients less than seven years old who have had a primary care visit within the last 12 months
3b. Patients greater than six years old who have had a primary care visit within the last 24 months
3c. Third next available appointment
4a. Patients seen in the ER with low complexity problems
4b. Patients seen in the ER who follow up with primary care
5. Patients with well-child visits: (a) in the first 15 months, (b) at 3-6 years old, (c) at 12-21 years old
6. Patients for whom early notification of pregnancy was made to the health plan

Table 1

Tracking the six measures outlined in Table 1 would allow project sites to improve on overall health center performance and provision of care. For example, capturing data for patients with Type 1 or Type 2 Diabetes whose hemoglobin levels are greater than 9% (Measure 2a) would allow a health center to better track the progress of these patients over time, and tailor its diabetes management strategies to improve its patients' health outcomes.

300 Frank H. Ogawa Plaza, Suite 620 Oakland, CA 94612
p 510.272.9536 f 510.272.0817
www.aapcho.org

2010 FACT SHEET

The Pacific Innovation Collaborative (PIC) (continued)

Once collected, process measure data from all sites are sent to regional database repositories in Oahu, Hawaii and Seattle, Washington. AAPCHO serves as the project's central repository, electronically collecting data from the regional databases [Figure 1]. The central repository aggregates clinical information and provides reports for all project sites to view and share.

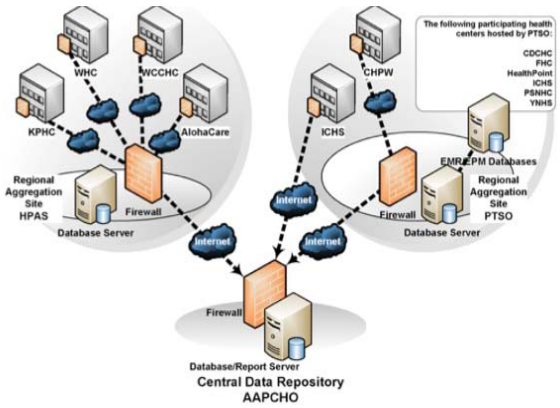


Figure 1

PIC Dashboard

A PIC comparative dashboard [Figure 2] was created as a user-friendly summary report of aggregate data for the measures listed in Table 1. The dashboard was developed as a model for project health centers to view this data across multiple health centers. It enables users to view trend analysis and is beneficial for the future development of HIT activities, such as AAPCHO's Pay-for-Performance and Enabling Services HIT projects.

		M5 HEDIS Well Child Visits					
Practice	Report Month	M5a Den	M5a WC	M5b Den	M5b WC	M5c Den	M5c WC
Health Center 1		194	92%	306	66%	244	34%
Health Center 2		100	89%	207	57%	343	49%
Health Center 3		1127	87%	2099	51%	2601	35%
Health Center 4		242	81%	423	65%	811	45%
Health Center 5		466	93%	1005	64%	1543	38%

Figure 2 - A sample clip of the dashboard outlines HEDIS well child visits for patients in (a) the first 15 months, (b) at 3 to 6 years, and (c) at 12 to 21 years from January to June 2008. *(Data downloaded 10-11-10)*

Project Impact

The PIC HIE network is a Health Center Controlled Network. The creation of this network has provided the opportunity for project health centers to optimize limited resources to share HIT models and practices. The hope is that by building infrastructure to share and exchange HIT, project health centers can utilize this technology to provide better quality care for their patient populations.

References

- For information about utilizing and opitmizing HIT at health centers, reference Moore, R., Rachman, F.D., Lardiere, M.R. (2010). Using health information technology to improve quality. *Health Center Controlled Network Series Information Bulletin*, 15, 14.
- For more information and opportunities for implementing and utilizing HIT, visit the following websites:
  1. Office of the National Coordinator for Health Information Technology website at http://healthit.hhs.gov.
  2. Agency for Healthcare Research and Quality National Resource Center HIT website at http://healthit.ahrq.gov
  3. Health Resources and Services Administration Health Information Technology website at http://www.hrsa.gov/healthit/
  4. National Association of Community Health Centers HIT web page at http://www.nachc.com/Health Information Technologies (HIT).cfm

For more information about the PIC Project, please contact, Research Associate Heather Law, MA at hlaw@aapcho.org. You may also visit the PIC web page at http://research.aapcho.org.

APPENDIX E

Graduated Competencies Training Criteria – Health Care Reform

COMMUNITY BASED TRAINING RELATED TO HEALTHCARE TRANSFORMATION IN HAWAII – 2012				
The overall goal is to seek compliance through workforce training and development with standards for health care homes and in particular, supplemental standards for MUA communities. This grant will focus specifically on developing a sustainable community-based workforce targeted at HIT support and care coordination at the health care home level.				
Competencies	**Medical Assistants**	**Team Managers**	**Care Coordinators**	**Information Technology**
Minimum Entry Level Qualifications	Graduated from Medical Assistant Program.	Graduated from LPN or RN program; licensed in the State of Hawaii as a RN or LPN.	Minimum Bachelor's prepared as a registered nurse, registered dietitian, or social worker.	
Core Annual Competency Review	1. Immunizations/EMR 2. Vital Signs 3. Injections (ID, SQ, IM) 4. Documentation/Abstraction 5. Medication Administration	1. Scope of Practice/Team Care/ Customer Service/ Patient Complaints 2. QI/Understanding Panel Management/ Value Based Care/ Informatics 3. Enabling Services & Technical Skill Set (vital signs, injections) 4. Leadership/Boundaries/ Evidence-Based Care 5. Documentation/Abstraction/ Immunizations	1. Use of decision support, database and/or tracking systems to provide clinical care. 2. Motivational interviewing 3. Referral tracking 4. Health education/ community events 5. Self-management care plan 6. Specific intervention training	
NCQA PCHCH Standards	**(1) PCHCH LEVEL COMPETENCY by POSITION related to HIT SUPPORT AND CARE COORDINATION**			
PCMH 1. Enhance Access and Continuity	1. Anticipates the needs of the patient (ex: provides interpretation services, clinical summaries, self-management support, referral for care coordination, test results, etc.). 2. Support patients & families in self-management, self-efficacy and behavior change. 3. Document the patient's choice of PCP. 4. Adhere to standing orders.	1. Monitor practice no show, productivity, and 3rd next available appt. 2. Ensure staff actively assist with panel management 3. Involve care team in the evaluation of the practice's performance and quality improvement activities.	1. Engaging in team meetings with the care team. 2. Establish communication and obtain information from hospital facilities to seamlessly transition patients to primary care. 3. Coordinate care for individual high-risk patients.	1. 10% of patients have electronic access to their health information. 2. Secured electronic two-way communication between patients/families and their practice.
PCMH 2. Patient Populations	1. 100% EMR documentation 2. Offers patients Advanced Directive services. 3. Heights, weights, BP and status of tobacco use on more than 50% of patients in a practice. 4. Allergies for more than 80% of patients.	1. Clinical data and evidence based guidelines are used to generate lists of patients to remind of services needed for at least a) 3 different preventive services, b) 3 different chronic care services, c) pts not seen recently by the practice.	1. 100% EMR documentation 2. Depression screening using a standardized tool. 3. Remind patients receiving care coordination of preventive and chronic care services needed.	1. Patient registries related to specific chronic and/or preventive condition.

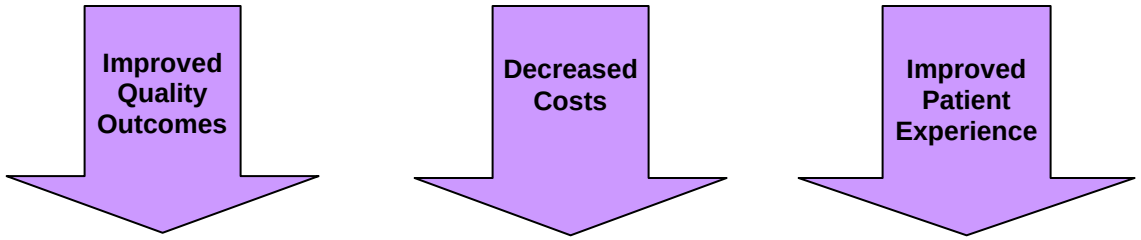
PCMH 3. Plan and Manage Care	1. Conducts pre-visit preparations. 2. Follows up with patients who have not kept their appointments. 3. Assist with prescription refills. 4. Assist with medication reconciliation with patients/families for more than 50% of care transitions.	1. Support electronic prescribing in practice.	1. Collaborates with patient/family to establish an individual care plan (self-management plan). 2. Addresses barriers when patient has not met identified plan goals.	1. Systematic electronic process to identify high risk or complex patients.
PCMH 4. Self Care Support and Community Resources	1. Access to key community resources of importance to the patient population.	1. Access to key community resources of importance to the patient population. 2. Offer opportunities for health education and peer support (ex: group visits).	1. Access to key community resources of importance to the patient population. 2. Provide health education and peer support (ex: participation in group visits, facilitates health education classes, etc.). 3. Documents self-management plans and goals, utilizes tools to record self-care results for patients/families receiving care coordination.	
PCMH 5. Track and Coordinate Care	1. Provide an electronic summary of care record for 50% of referrals to the referred specialist. 2. Followup to obtain a specialist's report. 3. Tracks lab tests, follow up on overdue results.	1. Facilitate ease of communication and scheduling care transition appts requested by care coordinators with practice.	1. Coordinate with facilities care transitions, obtains patient admission and discharge dates and discharge summaries from hospitals, ERs, skilled nursing facilities, etc.	1. Capability for electronic exchange of key clinical information between clinicians and facilities.
PCMH 6. Measure and Improve Performance	1. Support and assist with obtaining feedback from patients/families on their experiences with the practice and their care. 2. Improves performance on at least 3 preventive or chronic care measures and 1 patient experience measure (access, communication, coordination, whole-person care).	1. Generate and review reports on at least 3 preventive measures and 3 chronic care clinical measures. 2. Support and assist with obtaining feedback from patients/families on their experiences with the practice and their care. 3. Sets goals and acts to improve performance on at least 3 preventive or chronic care measures and 1 patient experience measure (access, communication, coordination, whole-person care).	1. Support and assist with obtaining feedback from patients/families on their experiences with the practice and their care. 2. Improves performance on at least 3 preventive or chronic care measures and 1 patient experience measure (access, communication, coordination, whole-person care).	1. Develop electronic version of the PCMH CAHPS survey tool and capability of sending and/or providing patients with a weblink to access the survey tool. 2. Collates results of survey tool. 3. WCCHC Performance Report Card/Dashboard available electronically for the public.

PCMH 7. **Supplemental PCHCH Standards** for MUA/MUP communities				
Element A. Enabling Services		1. Support tracking of enabling services for intake coordinators.	1. Code and track enabling services provided through care coordination. 2. Assist with measuring the impact of enabling services on performance metrics. 3. Document enabling services in EMR.	
Element B. Cultural Proficiency	1. Complete cultural sensitivity training.	1. Complete cultural sensitivity training. 2. Ensure facilities/space reflect the patient population's culture and background. 3. Supports complementary and/or alternative healing practices in alignment with primary and preventive services.	1. Complete cultural sensitivity training. 2. Ensure facilities/space reflect the patient population's culture and background. 3. Supports complementary and/or alternative healing practices in alignment with primary and preventive services. 4. Incorporate cultural considerations into patient self-management plans.	
Element C. Community Involvement	1. Supports community engagement and involvement of patients in specific health center processes.	1. Engages patients as an active member of their care team. 2. Supports patients serving on internal committees of the Health Center.	1. Engages patients as an active member of their care team. 2. Supports patients serving on internal committees of the Health Center.	
Element D. Workforce and Economic Development	1. Complete program leading towards LPN, RN, SW, or RD.	1. If LPN, complete program leading towards RN, SW, or RD, OR 2. Complete a clinical informatics recognized certificate program related to information technology and clinical care or support, OR 3. Any other recognized certificate program related to information technology, care coordination, self-management, quality & performance.	1. Complete a clinical informatics recognized certificate program related to information technology and clinical care or support, OR 2. Any other recognized certificate program related to information technology, care coordination, self-management, quality & performance, OR 3. Complete a program leading to a Master's degree in a related area.	

NCQA PCHCH Standards	(2) ORGANIZATIONAL COMPETENCIES
PCMH 1. Access and Continuity	1. Ensure capacity to accommodate assigned patients in primary care. 2. IT support for development of a patient portal and secured electronic communication between patients/families and their care team.
PCMH 2. Patient Populations	1. IT support for developing patient disease registries.
PCMH 3. Plan and Manage Care	1. Support of care coordination resources at the minimum entry level qualifications. 2. Support for development of a personal health record (PHR).
PCMH 4. Self Care Support and Community Resources	
PCMH 5. Track and Coordinate Care	1. Establish relationships with other facilities – hospitals, ERs, skilled nursing facilities to obtain information on admissions & discharges, create consistent communication linkages for seamless patient transitions.
PCMH 6. Measure and Improve Performance	1. Develop a culture that values improvement of patient experience, patient-centeredness, or whole-person care. a. Kiosks or computer pods for patients to complete patient experience survey tool. 2. Develop a culture that values, empowers, and implements staff ideas for improved performance.
PCMH 7. **Supplemental PCHCH Standards** for MUA/MUP communities	
Element A. Enabling Services	1. Support for enabling services as an essential component of every care team.
Element B. Cultural Proficiency	1. Availability and accessibility of routine cultural sensitivity training from internal resources.
Element C. Community Involvement	1. Develop a culture that supports consumer involvement on internal committees of the Health Center: a. Meetings via conference call, webex, skype, etc. b. Meetings during the off-hours (evenings, weekends, etc.) c. Recruitment of consumers (non-board members) or representatives of patient advocate organizations d. Training of consumers to serve on internal committees and understand their role/responsibilities e. Identify benefits to consumers who serve on internal committees of the health center. Facilitate community efforts to create behavior change at a population level.
Element D. Workforce and Economic Development	1. Establish long-term relationships and MOAs with specific schools/universities (in or out of state) to provide community based placement for MA, RN, LPN, SW, and RDs. 2. Cultivate school/university relationships to involve commitments related to placement/acceptance of qualified staff to their MA, RN, LPN, SW, or RD programs. 3. Cultivate school/university relationships to involve commitments related to delivering distance education to the Waianae community through WCCHC. 4. Cultivate school/university relationships to involve commitments related to community service and investment back to the Waianae community and/or WCCHC. 5. Re-develop a plan to provide for tuition subsidies for staff interested in completing a program leading towards MA, LPN, RN, RD, SW.

NCQA PCMH 2011 Standards; Supplemental PCMH Standards.

(3) COMPLETED COMPETENCIES LEAD TO OUTCOMES:



Improved Quality Patient Outcomes

Decreased No Shows

Decreased hospitalizations and re-admissions

Decreased inappropriate use of ER

Competent Staff

Improved Productivity & Panel Management

Improved Patient Experience

Decreased 3rd Next Available Appointment

(1) PCHCH LEVEL COMPETENCY – First level bonuses for staff.
(2) ORGANIZATIONAL COMPETENCIES – Second level bonuses for specific staff to complete organizational competencies
(3) OUTCOME LEVEL COMPETENCY – Third level bonuses for demonstrated improvement by staff on performance indicators

APPENDIX F

Financial Performance Measures
Potential Target Cost Saving Areas for
Health Plan – WCCHC Contract

POTENTIAL TARGET COST SAVING AREAS FOR
Health Plan – WCCHC Contract

Definition of members: Health Plan QUEST and Medicare members continuously enrolled with Health Plan and assigned to WCCHC for at least 3 months unless otherwise stated in the individual metric. (Health Plan will identify which metrics 3 months should not apply to.)

Facility Costs:

1. ***Decrease hospitalizations***

   Numerator: Number of all members in the denominator who were hospitalized at least once in the measurement period (excluding OB, newborns).

   Denominator: Number of all adult members diagnosed with cardiovascular disease or diabetes.

   Source of Data: Health Plan

2. ***Decrease hospital days***

   Numerator: Total acute hospital days for Health Plan members (excluding OB, Newborns)

   Denominator: Total member-months with Health Plan for members divided by 1000 times 12 (to annualize the measure)

   Source of Data: Health Plan

3. ***Decrease 30-day hospital re-admissions***

   Need to consider whether ***risk adjustments*** are necessary for this measure (age, gender, pre-existing co-morbidities, etc.) or to specify measure by diagnosis and age. This does not include admission to a long term care facility, skilled nursing, care home, or rehabilitation center.

   Numerator: Number of Health Plan members in the denominator who were re-admitted to an acute hospital within 30 days of being discharged from an acute hospital.

   Denominator: Total number of Health Plan members, excluding neonates and pregnant women who were hospitalized (30 days prior).

   Source of Data: Health Plan

4. ***Decreased ER use***

   4a. Reduce high utilization of emergency services
   "High utilization" is defined to mean patients with ***6 or more*** emergency visits in a 12 month period.

   Numerator: Number of Health Plan members with 6 or more emergency visits in a 12 month period.

Denominator: Total number of Health Plan members with at least 1 visit to the emergency room, excluding WCCHC emergency services.

4b. Reduce inappropriate use of emergency services
"Inappropriate" use of emergency services are those emergency visits considered to be ***low complexity*** and coded as 99281 or 99282.

Numerator: Number of low complexity (99281 or 99282) encounters of Health Plan members.

Denominator: Total number of emergency room encounters by Health Plan members, excluding WCCHC emergency services.

4c. Reduce the overall rate of ED use (ED visits /1000 members)

Numerator: Total ED visits by Health Plan members

Denominator: Total member-months with Health Plan for members divided by 1000 times 12 (to annualize the measure)

Source of Data: Health Plan

Drug Costs:

5. ***Increased generic dispensing ratio (GDR)***

   Need to verify how to calculate GDR and consider focusing metric on particular providers or diagnoses. Exclude brand name medications for which there is no generic equivalent from the denominator.

   Numerator: Number of prescriptions in which generic medications were dispensed for Health Plan Medicare members.

   Denominator: Total number of prescriptions for Health Plan Medicare members.

   Source of Data: Health Plan

6. ***Improve medication adherence (Diabetes Mellitus and medication possession ratio (MPR) for chronic medications)***

   Measures obtained from the National Quality Forum, "National Voluntary Consensus Standards for Medication Management: A Consensus Report."
   http://www.qualityforum.org/Publications/2010/05/National_Voluntary_Consensus_Standards_for_Medication_Management.aspx

   Numerator A Statement: The sum of the days' supply that falls within the measurement window for each antidiabetic class for each patient in Denominator A.

   Numerator B Statement: The sum of the days' supply that falls within the measurement window for a statin fill for each patient in Denominator B.

Numerator C Statement: The sum of the days' supply that falls within the measurement window for an ACEI and/or ARB fill for each patient in Denominator C.

Time Window: Any time during the measurement period (12 consecutive months).

MPR Numerator:

1. New users: For patients with no prescriptions in the 180 days prior to the measurement period, sum of:
    - Days' supply of all medications from the first prescription until the end of the measurement period.
    - Remove the days' supply that extends past the end of the measurement period.

2. Continuous users: For patients with 1 or more prescriptions in the 180 days prior to the measurement period, sum of:
    - Days' supply of all medications in the measurement period.
    - Remove the days' supply that extends past the end of the measurement period and add days' supply from the previous period that applies to the current period.
    - During the measurement period, the beneficiary may not have more than a one-month gap in coverage.

Denominator A Statement: Health Plan QUEST members assigned to WCCHC,18 and over with diabetes mellitus who have at least one claim for a single oral hypoglycemic agent or multiple agents within an antidiabetic class. A separate denominator is calculated for each antidiabetic class (e.g.,biguanides).

Denominator B Statement: Health Plan QUEST members assigned to WCCHC,18 and over with diabetes mellitus who have at least one claim for statins.

Denominator C Statement: Health Plan QUEST members assigned to WCCHC,18 and over with diabetes mellitus who have at least one claim for ACEIs and/or ARBs.

Time Window: Any time during the measurement period (12 consecutive months).

MPR Denominator:

1. New users: Number of days from the first prescription to the end of measurement period.

2. Continuous users: Number of days from the beginning to the end of the measurement period.

Exclusion Criteria:

- Patients who died during the measurement period
- Patients who are actively enrolled in multiple plans concurrently as of the end of the measurement period

- Patients with two or more prescriptions within the same class on the same date of service
- Patients with a diagnosis of polycystic ovaries who do not have a face-to-face visit with a diagnosis of diabetes in any setting during the measurement period
- Patients with a diagnosis of gestational diabetes or steroid-induced diabetes who do not have a face-to-face visit with a diagnosis of diabetes in any setting during the measurement period.

Source of Data: Health Plan

Other:

7. ***Increase advanced directives on file***
   Numerator: Number of adults in the denominator with an indication of an advanced directive entered in the WCCHC electronic medical record.

   Denominator: Total number Health Plan members 50 years and older.

   Recommended change by Health Plan: Total Health Plan adults (age 50+) assigned to WCCHC.

   Source of Data: WCCHC EMR