Top Takeaways from the January 2017 CHN Committee Meetings

Blue KC Value Based Agreement – What Measures are Included for 2017 and What's It Worth!?

The Blue Cross of Kansas City (Blue KC) value based agreement is effective January 1st, 2017!

$625k annualized CHN incentive

- For the next 6 months, your practice will receive a standard monthly incentive payment. This standard payment, called a "Care Coordination Fee", is a risk adjusted per member per month payment for each patient attributed to your practice. *Ask your practice's CHN Committee member for the approximate CCF incentive for your practice.*

$2.5 million maximum CHN annual incentive

- Beginning in July, 2017, the standard CCF incentive will transition to a Performance Based Incentive (PBI) payment. This payment is also a risk adjusted per member per month payment BUT it is based upon your practice's quality and cost performance in calendar year 2016. *Ask your practice's CHN Committee member for your practice's estimated performance and incentive.*

Blue KC incentive payments are monthly prospective payments to support additional system infrastructure to achieve better outcomes and the physician/non-physician work that falls outside of face-to-face visits.

YOUR PRACTICE'S PERFORMANCE IN 2017 ON THE LISTED MEASURES DETERMINES YOUR PRACTICE'S INCENTIVE PAYMENT BEGINNING IN JULY, 2018.

Maximum PBI Multiplier	Estimated Maximum CHN Incentive	What Measures Are Included and What are they Worth?
		**** Ask your practice's CHN Committee member for your practice's current performance. **** [Measure goals are listed in brackets.]
1.2	$754k	**Clinical Quality Measures** • 15 Month Well-Child Visits (6+ visits by 15 months) [>84.0%] • 3-6 Year Old Well-Child Visits (1 well visit per year) [>79.6%] • Adolescent Well-Care Visits (1 well visit per year) [>47.6%] • Weight Assessment & Counseling (Annual BMI Percentile Screening - Ages 3-17) [>65%] • Inappropriate Treatment (i.e. dispensed an antibiotic) for URI [<10%] • HPV Vaccination (2 dose series at least 6 months apart by 13th birthday) [>14%]
0.8	$502k	**Patient-Centered Medical Home (PCMH) & Engagement Measures** • PCMH: Population & Care Planning Meetings and Action Plans [At least 3] • PCMH: Documented Care Plans for Chronic or High Risk Patients [At least 3] • PCMH: Patient Referral Tracking [Documented Process & 2 Examples] • Engagement: Participation in >75% of monthly Children's Health Network committee meetings
1.0	$628k	**Patient Experience** • Access: "I can get in to see my provider when I need to" [>70% of scale value] • Understand Care Plan: "I understand my care plan and my role in it"[>70% of scale value] • Recommend Practice: "I would recommend this practice to family and friends" [>70% of scale value] • Demonstrated follow up on all patient experience measures not meeting goal
~1.15	$722k	**Cost / Resource Utilization** $\frac{\text{[Blue KC PCMH Cohort Mean Risk Adjusted Total Cost PMPM]}}{\text{[Practice Risk Adjusted Total Cost PMPM}}$ **Practices with ratio of 0.80 or less will receive 0 multiplier points *Additional information on how to evaluate and improve this measure will be shared with CHN practices in the coming months.*
~4.15	$2.6 million	Please support efforts within your practice to improve performance on these measures. Also, please provide clinical support for implementing the Patient-Centered Medical Home care model and Patient Experience surveys within your practice.

Patient-Centered Medical Home (PCMH) Implementation Kicks Off in January 2017

In alignment with the Blue KC agreement, CHN Committees are committed to implement and integrate PCMH care model principles within all CHN practices by the end of 2017. To achieve this aggressive goal, we need your support!

Why is This Important?

- Across the county, research and evidence has demonstrated that the PCMH care model has helped to control costs, improve quality, and deliver more value to patients, providers, and payers.
- 40% of Blue KC Performance Based Incentive payments are based on PCMH measures! This is approximately $1.0 million annually across all CHN practices.

What to Expect Throughout 2017:

- Members of your staff will be leading the implementation and sustainment of the PCMH implementation plan (see below). To support your practice, CHN's Medical Home team will be meeting with your practice every 2 weeks to review and support progress and address any barriers and/or challenges.

What to Expect in Q1 2017:

- **PCMH Foundation Established** – The PCMH team will work with your practice to define the project team, review important PCMH and population management concepts, and develop a work plan for Q1.
- **Patient Experience Surveys will be Implemented in Q1 2017.** The PCMH team will be meeting with your practice to setup the patient experience survey technology. Please serve as a clinical champion by helping staff understand the importance of collecting this information, which includes improving quality, showing your practice cares about patient/family feedback, and obtaining financial incentives in value-based agreements such as the Blue KC CHN agreement.

CHN Patient Centered Medical Home Care Model Implementation Plan

Children's Health Network

	2017 Jan-March **Q1**	2017 April -June **Q2**	2017 July-Sept **Q3**	2017 Oct-Dec **Q4**
PCMH Concepts				
Develop Project Team				
Complete PCMH Training				
Identify Team Roles and Accountability				
Patient Centered Access				
Offer Same Day Appointments (Routine and Urgent)				
After-hours Appointments (Routine and Urgent)				
Quality Improvement (QI) for Improvement on Access				
Practice Team				
Implement Pre-Visit Planning/Huddles				
Develop Standing Orders				
Scheduled Care Coordination Meetings				
Population Management				
Preventive Ex: Adolescent well visit; 3-6 years well visits, 0-15mo well visits				
Immunizations Ex: Age 2 Immunizations, Gardasil, and Seasonal Influenza				
Chronic Conditions Ex: Asthma Timely Office Visits				
Identify Patients for Care Coordination				
Behavioral Health Condition				
High Cost/High Utilization				
Poorly Controlled or Complex Conditions				
Develop Care Plans for Identified Populations				
Identify Treatment Goals				
Assess and Address Potential Barriers				
Develop a Self-Management Plan				
Closed Loop Referral Tracking				
Keeps a Log on all Referrals				
Follows Referral until seen by Specialist				
Obtains Report from Specialist into Medical Record				
Plan and Coordinate Care Transitions				
Communicates with Facility Prior to Admission				
Obtain Discharge Summaries from Hospital/Facility				
Identify Patients with Unplanned Admissions and ED Visits Proactively Contacts Patients/Families for Follow-up Care				
Identify and Measure Population Data				
QI on CIN Measure/s				
Quality Incentive Measures Summary				
Measure Patient/Family Experience				

Initial Implementation

PCMH Concept Implemented and Maintained

Questions or Comments? Please ask your Children's Health Network committee member representative or contact Children's Health Network at ProviderRelations@cmpcn.org.