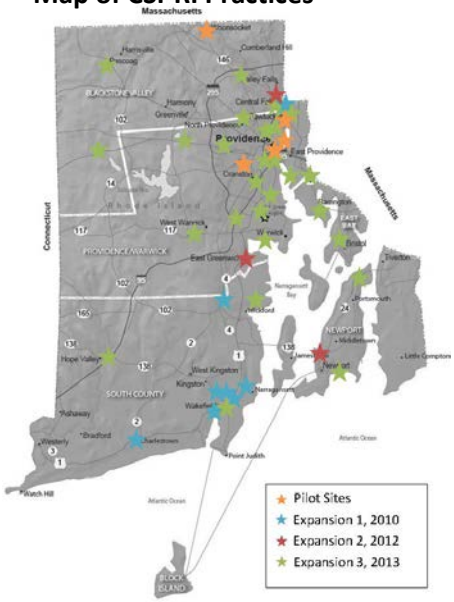
CSI-RI Orientation Binder – August 2013

Tab 7: Transformation Resources

The Rhode Island Chronic Care Sustainability Initiative (CSI-RI)

Map of CSI-RI Practices



CSI-RI's mission is to lead the transformation of primary care in Rhode Island. CSI-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care.

History

Launched in 2008 by the Office of the Health Insurance Commissioner, the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) brings together key health care stakeholders to promote care for patients with chronic illnesses through the patient-centered medical home (PCMH) model.

CSI-RI began with five pilot sites in 2008 and has grown to 36 practices. Currently, over 260,000 Rhode Islanders receive their care from CSI-RI practices. **Over the next four years, up to 20 practices will be added each year, with the goal of providing over 500,000 Rhode Islanders with access to a PCMH.**

Results

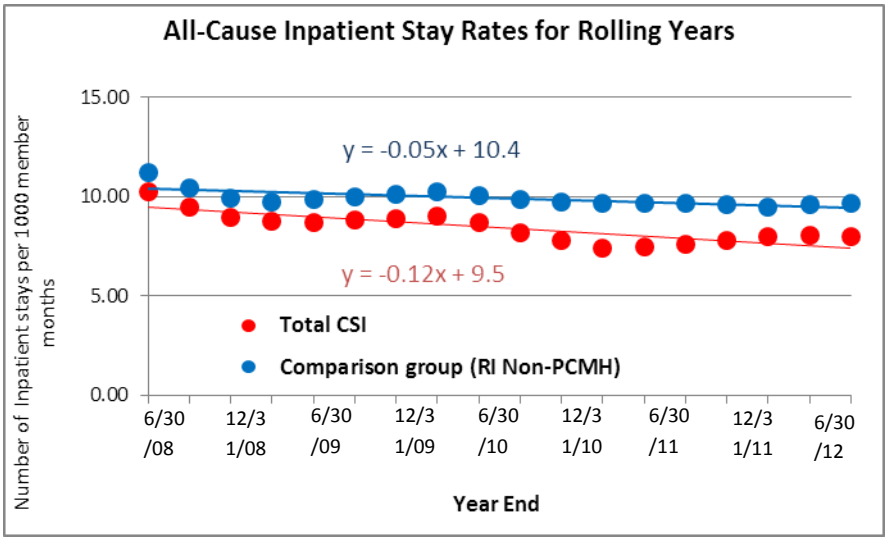
PCMHs improve health outcomes, help patients have better care experiences and reduce expensive, unnecessary hospital and emergency department visits. Here in Rhode Island, CSI-RI practices are showing that effective PCMHs truly make a difference for patients, providers and payers, as well as the entire health care system.

Clinical quality

- CSI-RI rewards practices for performance and improvement on clinical quality measures related to diabetes, high blood pressure and depression. To qualify for payments, practices must either demonstrate a 50% improvement from their baseline or meet a specified benchmark level for four of the seven quality measures. They have done so for the last three years.

Utilization

- By the second quarter of 2012, participating practices have seen an overall reduction in hospital admissions and emergency department visits from the start of the program.



Patient experience

- According to 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, patients are realizing the immediate benefits of PCMHs. All five pilot sites received positive ratings from patients on different aspects of their experience, including access, communication, office staff, shared decision-making, self-management, support and behavioral support.

National recognition

- CSI-RI practices were among the first in the country to be recognized as medical homes of the highest quality. Twenty-one of the 36 participating practices have Level 3 recognition by the National Committee on Quality Assurance (NCQA), the highest obtainable recognition awarded to patient-centered medical homes.

External evaluation

- Meredith Rosenthal, Ph.D. of the Harvard School of Public Health, with support from the Commonwealth Fund, conducted an evaluation of the early years of CSI-RI (2008-2010). Dr. Rosenthal found that at the end of two years, CSI-RI practices had higher NCQA scores, greater provider job satisfaction and improvements on a number of quality measures, particularly those related to diabetes.

Table: Staff Surveys of Pilot Sites in Year 1 and Year 2 of CSI-RI

Standard	Baseline	Post-Intervention
Access & communication	70.6%	88.9%
Patient tracking & registry functions	60.0%	95.2%
Care management	30.0%	96.8%
Patient self-support management	6.7%	83.3%
Electronic prescribing	18.8%	70.0%
Test tracking	40.8%	100.0%
Referral tracking	60.0%	100.0%
Performance reporting & improvement	48.0%	97.0%
Advanced electronic communication	6.3%	11.3%

Leadership and Funding

The administration of the project is supported through the Rhode Island Foundation and led by a team from the University of Massachusetts Medical School.

Support for the practices comes through the developmental contract, an agreement negotiated between the health plans and the participating primary care practices under the auspices of the Office of the Health Insurance Commissioner. The contract calls for payments to supplement the traditional fee-for-service structure, providing practices with per member per month payments designed to drive practice transformation and quality improvement. These supplemental payments allow the practices to make structural enhancements, including the addition of a Nurse Care Manager, who oversees care coordination efforts, as well as an analytical structure to use electronic medical records to track patient data.

Funding Sources	
Blue Cross Blue Shield RI (BCBSRI)	Medicare
Neighborhood Health Plan (NHP)	Medicaid
Tufts Health Plan	Office of Health Insurance Commissioner (OHIC)
United Health Plan (UHP)	Lifespan

CSI-RI is supported by funding from public and private payers in Rhode Island, along with grant funding from government and non-governmental sources.

Participating Practices

- Anchor Medical Associates (Lincoln, Providence, and Warwick)
- Aquidneck Medical Associates (Newport and Portsmouth)
- Associates in Primary Care (Warwick)
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- Coastal Medical (Narragansett, Pawtucket, Providence, and Wakefield)
- Comprehensive Community Action Program (Cranston, Coventry, and Warwick)
- East Bay Community Action Program (East Providence and Newport)
- Family Health and Sports Medicine (Cranston)
- Family Medicine at Women's Care (Pawtucket)
- Internal Medicine Center (Pawtucket)
- Internal Medicine Partners (North Providence)
- Kristine Cunniff, MD (Narragansett)
- Medical Associates of RI (Bristol and Barrington)
- Memorial Hospital Family Care Center (Pawtucket)
- Nardone Medical Associates (Pawtucket)
- Ocean State Medical (Johnston)
- Richard Del Sesto (East Greenwich)
- South County Hospital Family Medicine (East Greenwich)
- South County Internal Medicine (Wakefield)
- South County Walk-In and Primary Care (Narragansett)
- Stuart Demirs, MD (Charlestown)
- Thundermist Health Center (Wakefield, West Warwick, and Woonsocket)
- Tri-Town Community Action Program (Johnston)
- University Family Medicine (East Greenwich)
- University Internal Medicine (Pawtucket)
- University Medicine (6 sites – East Providence, Providence and Warwick)
- WellOne Primary Medical and Dental Care (Foster, North Kingston, and Pascoag)
- Women's Primary Care, Women's Medical Collaborative (Providence)
- Wood River Health Services (Hope Valley)

CSI – RI Management Team

Providence Office:

RI Foundation
One Union Station
Providence, RI 02903

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Co-Project Director, CSI-RI
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Practice	EHR	Practice Facilitator	REC Relationship Manager
Pilot Sites (participating since October 2008):			
Coastal Medical, Inc. – Greenville 10 Davol Square, Suite 400, Providence, RI Physician Champion: Dr. John Gaines (drsgaines@cox.net)	**E Clinical Works**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Coastal Medical, Inc. - Hillside Avenue Family & Community Medicine 727 East Avenue, Pawtucket, RI Physician Champion: Dr. Chris Campanile (chris.campanile@cox.net)	**E Clinical Works**	**Aimee Schayer** Aimee.Schayer@bcbsri.org 401-459-5602	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Family Health and Sports Medicine 725 Reservoir Avenue, Cranston, RI Physician Champion: Dr. Albert Puerini, Jr. (apuerini@ripcpc.com)	**Epichart**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Thundermist Health Center – Woonsocket 450 Clinton Street, Woonsocket, RI Physician Champion: Dr. David Bourassa (DavidB@thundermisthealth.org)	**E Clinical Works**	**Anne Pushee** Anne_Pushee@Brownpcmh.org	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
University Medicine – Governor Street Primary Care Center 285 Governor Street, Providence, RI Physician Champion: Dr. Thomas Bledsoe (Thomas_Bledsoe@brown.edu)	**E Clinical Works**	**Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Expansion Sites (participating since April 2010)			
Coastal Medical, Inc. – Narragansett 360 Kingstown Rd, Suite 200, Narragansett, RI Physician Champion: Dr. Dariusz Kostrzewa (dkostrzewa@hotmail.com)	**E Clinical Works**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262

Practice	EHR	Practice Facilitator	REC Relationship Manager
Expansion Sites (participating since April 2010)			
Coastal Medical, Inc. – Wakefield 70 Kenyon Ave, Suite 215, Wakefield, RI Physician Champion: Dr. J. Russell Corcoran (rcorcoran@pol.net)	**E Clinical Works**	**Aimee Schayer** Aimee.Schayer@bcbsri.org 401-459-5602	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Kristine Cunniff, MD 350 Kingstown Rd, Narragansett, RI Physician Champion: Kristine Cunniff (kcunniff@cox.net)	**Epichart**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Memorial Hospital Family Care Center 111 Brewster Street, Pawtucket, RI Physician Champion: Dr. David Ashley (david_ashley_md@brown.edu)	**GE Centricity**	**Scott Hewitt** Scott_Hewitt@brown.edu 401-729-2818	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236
South County Hospital Family Medicine 3461 South County Trail, East Greenwich, RI Physician Champion: Dr. Laura Henseler (lhenseler@schospital.com)	**Greenway**	**Lauren Morton** Lauren.Morton@bcbsri.org 401-459-5531	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236
South County Internal Medicine 481 Kingstown Rd, Wakefield, RI Physician Champion: Dr. Paul Barratt (pbarratt@scim.necoxmail.com)	**AllScripts**	**Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Stuart Demirs, MD 4099 Old Post Rd, Charlestown, RI Physician Champion: Dr. Stuart Demirs (sdemirs@cox.net)	**Epichart**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Thundermist Health Center of South County 1 River Street, Wakefield, RI Physician Champion: Dr. David Bourassa (DavidB@thundermisthealth.org)	**E Clinical Works**	**Anne Pushee** Anne_Pushee@Brownpcmh.org	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262

Practice	EHR	Practice Facilitator	REC Relationship Manager
Expansion Second Wave (participating since October 2012)			
Blackstone Valley Community Health Center 42 Park Place, Pawtucket, RI Physician Champion: Dr. Jerald Fingerut (jfingerut@bvchc.org)	**NexGen**	**N/A**	**Sue Dettling** SDettling@RIQI.org 401-276-9141 x 236
East Bay Community Action Program - Newport 19 Broadway, Newport, RI Physician Champion: Dr. Eileen Gonzalez (drg@ebcap.org)	**NexGen**	**Suzanne Herzberg** Suzanne_Herzberg@brownpcmh.org	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
University Family Medicine 1351 South County Trail, Suite 301 East Greenwich, RI Physician Champion: Dr. Karen Blackmer (karenblackmer@verizon.net)	**Epichart**	**Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Expansion Third Wave (participating since October 2013)			
Anchor Medical Associates 1 Commerce Street, 2nd Floor, Lincoln, RI 1 Hoppin Street, 3rd Floor, Providence, RI 400 Bald Hill Road, Suite 520, Warwick, RI Physician Champion: Dr. Diane Siedlecki (dsiedlecki@lifespan.org)	**Athena health**	**Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Aquidneck Medical Associates 50 Memorial Boulevard, Newport, RI 02840 77 Turnpike Avenue, Portsmouth, RI 02871 Physician Champion: Dr. David Gorelick (d-gorelick-09@aquidneckmed.com)	**E Clinical Works**	**Aimee Schayer** Aimee.Schayer@bcbsri.org 401-459-5602	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262

Practice	EHR	Practice Facilitator	REC Relationship Manager
Expansion Third Wave (participating since October 2013)			
Associates in Primary Care 857 Post Road, Warwick, RI 02888 Physician Champion: Dr. Martin Kerzer (martin_kerzer@brown.edu)	**Athena health**	**Aimee Schayer** Aimee.Schayer@bcbsri.org 401-459-5602	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Comprehensive Community Action Program 311 Doric Avenue, Cranston, RI 02910 191 MacArthur Boulevard, Coventry, RI 02816 226 Buttonwoods Avenue, Warwick, RI 02886 Physician Champion: Dr. Elena Kwetkowski (ekwetkowski@comcap.org)	**NexGen**	**Anne Pushee** Anne_Pushee@Brownpcmh.org	**Sue Dettling** SDettling@RIQI.org 401-276-9141 x 236
East Bay Community Action Program 100 Bullocks Point Avenue, East Providence, RI 02915 Physician Champion: Dr. Sarah Fessler (sfessler@ebcap.org)	**NexGen**	**Suzanne Herzberg** Suzanne_Herzberg@brownpcmh.org **Scott Hewitt** Scott_Hewitt@brown.edu 401-729-2818 **Joanna Brown** Joanna_Brown@brown.edu	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Family Medicine at Women's Care 407 East Avenue, Suite 150, Pawtucket, RI 02860 Physician Champion: Dr. Emily Harrison (eharrison@women-care.com)	**Ingenix Care Tracker**	**Joanna Brown** Joanna_Brown@brown.edu	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Internal Medicine Center 111 Brewster Street, Pawtucket, RI 02860 Physician Champion: Dr. Joseph Diaz (joseph_diaz@brown.edu)	**GE Centricity**	**Joanna Brown** Joanna_Brown@brown.edu	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236

Practice	EHR	Practice Facilitator	REC Relationship Manager
Expansion Third Wave (participating since October 2013)			
Internal Medicine Partners 1635 Mineral Spring Avenue, Suite 200, North providence, RI 02904 Physician Champion: Dr. Puneet Sud (psud91@hotmail.com)	**Athena health**	**Lauren Morton** Lauren.Morton@bcbsri.org 401-459-5531	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236
Medical Associates of RI 1180 Hope Street, Bristol, RI 02809 286 Maple Avenue, Barrington, RI 02806 Physician Champion: Dr. Pamela Harrop (pharrop@lifespan.org)	**E Clinical Works**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236
Nardone Medical Associates 333 School Street, Suite 112, Pawtucket, RI 02860 Physician Champion: Dr. Ahmad Al-Raqqad (kasebmed@yahoo.com)	**Med Net Solutions**	**Suzanne Herzberg** Suzanne_Herzberg@brownpcmh.org **Scott Hewitt** Scott_Hewitt@brown.edu 401-729-2818	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Ocean State Medical 1539 Atwood Avenue, Suite 101, Johnston, RI 02919 Physician Champion: Dr. Frank Savoretti (lawyerdoc@cox.net)	**E Clinical Works**	**Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
Richard Del Sesto 3461 South County Trail, Suite 203, East Greenwich, RI 02818 Physician Champion: Dr. Richard Del Sesto (rmdelsesto@verizon.net)	**Epichart**	**Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235
South County Walk-In and Primary Care 360 Kingstown Road, Suite 104, Narragansett, RI 02882 Physician Champion: Dr. Monica Gross (mgross@southcountywalkin.com)	**Soapware**	**Lauren Morton** Lauren.Morton@bcbsri.org 401-459-5531	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236

Practice	EHR	Practice Facilitator	REC Relationship Manager
Expansion Third Wave (participating since October 2013)			
Thundermist Health Center 186 Providence St, West Warwick, RI 02893 Physician Champion: Dr. Michael Poshkus (michaelpo@thundermisthealth.org)	**E Clinical Works**	**Anne Pushee** Anne_Pushee@Brownpcmh.org	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
Tri-Town Community Action Program 1126 Hartford Avenue, Johnston, RI 02857 Physician Champion: Dr. Amato Polselli (apolselli@tri-town.org)	**NexGen**	**Anne Pushee** Anne_Pushee@Brownpcmh.org	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236
University Internal Medicine 407 East Ave, Suite 120, Pawtucket, RI 02860 Physician Champion: Dr. David Marcoux (dmarcoux@lifespan.org)	**Intergy by Vitera**	**Aimee Schayer** Aimee.Schayer@bcbsri.org 401-459-5602	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
University Medicine 1275 Wampanoag Trail, Suite 200, East Providence, RI 02915 1035 Post Road, Warwick, RI 02888 111 Plain Street, 3rd Floor, Providence, RI 02905 909 North Main Street, Suite 300, Providence, RI 02904 407 East Avenue, Suite 110, Pawtucket, RI 02860 Physician Champion: Dr. Francis Basile (fbasile@lifespan.org)	**E Clinical Works**	*909 North Main and Plain St-* **Megan Nolan** Megan.Nolan@bcbsri.org 401-459-2063 *East Ave-* **Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092 *Barrington-* **Aimee Schayer** Aimee.Schayer@bcbsri.org 401-459-5602 *Warwick-* **Lauren Morton** Lauren.Morton@bcbsri.org 401-459-5531	**Kerri Costa** KCosta@RIQI.org 401-276-9141 x 235

Practice	EHR	Practice Facilitator	REC Relationship Manager
Expansion Third Wave (participating since October 2013)			
WellOne Primary Medicine 36 Bridge Way, Pascoag, RI 02859 308 Callahan Road, North Kingstown, RI 02852 142A Danielson Pike, Foster, RI 02825 Physician Champion: Dr. Andrea Marcote (amarcote@welloneri.org)	**NexGen**	**Suzanne Herzberg** Suzanne_Herzberg@brownpcmh.org	**Sue Dettling** sdettling@riqi.org 401-276-9141 x 236
Women's Primary Care, Women's Medical Collaborative 146 West River Street, Providence, RI 02904 Physician Champion: Dr. Iris Tong (itong@lifespan.org)	**E Clinical Works**	**Jackie Lefebvre** Jacqueline.lefebvre@bcbsri.org 401-459-2092	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262
WoodRiver Health Services 823 Main Street, Hope Valley, RI 02832 Physician Champion: Dr. Christopher Campagnari (ccampagnari@wrhsri.org)	**Inpriva**	**Scott Hewitt** Scott_Hewitt@brown.edu 401-729-2818	**Andrea Levesque** ALevesque@RIQI.org 401-276-9141 x 262

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CSI-RI 2014 Committee Meeting Schedule

CSI Executive Committee

Charge: Make recommendations to the Steering Committee regarding the strategic direction and overall governance of the project.

Meeting Date: 4th Friday, 7:30-9AM
Location: BVCHC, 38 East Ave, Pawtucket, RI
Chair: Tom Bledsoe (Thomas_Bledsoe@brown.edu)

Data and Evaluation Committee

Charge: Lead performance improvement, measure selection and harmonization; develop goals and benchmarks, evaluation, research, and liaison with the APCD. Serve as liaison to other committees.

Meeting Date: 1st Tuesday, 7:30-9AM
Location: Memorial Hospital Center for Primary Care Conference Room, 111 Brewster Street, Pawtucket
Co-Chairs: Peter Hollmann (Peter.Hollmann@bcbsri.com) and Liz Fortin (ElizabethF@thundermisthealth.org)

Practice Reporting Committee (required)

Charge: Review practice data quarterly, perform data validation, public reporting via CSI-RI web portal, support quarterly performance improvement and data sharing meetings with practice staff, and assist with EMR/IT issues where possible. Serve as liaison to other committees.

Meeting Date: 4th Tuesday, 8-9:30AM
Location: 1150 New London Ave, Cranston
Co-Chairs: Christine Grey (CGrey@bvchc.com) and Rob Mencunas (RMencunas@polarismedical.com)

Steering Committee (open)

Charge: Responsible for strategic direction and overall governance of the project.

Meeting Date: 2nd Friday, 7:30-9AM
Location: RIQI, 50 Holden Street, Providence
Co-Chairs: Tom Bledsoe (Thomas_Bledsoe@brown.edu), Kathleen Hittner (Kathleen.Hittner@ohic.ri.gov), and Deidre Gifford (DGifford@ohhs.ri.gov)

Practice Transformation Committee (open)

Charge: Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice-based coaching and technical assistance; and support workforce development for PCMH. Committee is tasked with deploying resources to practices for items such as practice coaching, NCM training and NCQA application assistance. Serve as liaison to other committees and external organizations.

Meeting Date: 3rd Thursday, 7:30-9AM
Location: RIQI, 50 Holden Street, Providence
Co-Chairs: Andrea Galgay (Andrea.Galgay@bcbsri.org) and Joanna Brown (Joanna_Brown@brown.edu)

Contracting Committee

Charge: Responsible for contract development, attribution, and looking at alternate payment models and PCMH as part of a delivery system. Serve as liaison to other committees.

Meeting Date: 4th Thursday, 7:30-9AM
Location: RIQI, 50 Holden Street, Providence
Facilitators: Deb Hurwitz (Debra.Hurwitz@umassmed.edu) and Pano Yeracaris

Nurse Care Manger Best Practice Sharing Collaborative (open)

Meeting Date: 2nd Tuesday of every month 8-9:30AM
Location: RIQI, 50 Holden Street, Providence
Facilitator: Deb Hurwitz (Debra.Hurwitz@umassmed.edu) and Susanne Campbell (Susanne.Campbell@umassmed.edu)

Provider Best Practice Sharing Collaborative (open)

Meeting Date: Ad-Hoc Meeting
Location: RIQI, 50 Holden Street, Providence
Facilitator: TBD

Community Health Team Planning Committee

Charge: Develop a plan for implementation and evaluation of a community health team in South County and Pawtucket.

Meeting Date: 2nd and 4th Friday, 9:30-11 AM
Location: (2nd Friday) RIQI, 50 Holden St, Providence
(4th Friday) BVCHC, 38 East Ave, Pawtucket, RI
Facilitator: Deb Hurwitz (Debra.Hurwitz@umassmed.edu

Integrate Behavioral Health Planning Workgroup

Charge: Establish a workgroup to lead the transformation of primary care in RI in the context of an integrated health care system

Meeting Date: 3rd Thursday, 3:3-5 PM
Location: RIQI, 50 Holden St, Providence
Facilitator: Deb Hurwitz (Debra.Hurwitz@umassmed.edu

RHODE ISLAND CHRONIC CARE SUSTAINABILITY INITIATIVE AGREEMENT

This Rhode Island Chronic Care Sustainability Initiative Agreement (the "Agreement") is entered into this _____ day of _____ 2013, by and between [Plan], (hereinafter "Plan"), and _____ (hereinafter referred to interchangeably as the "Provider" or "Practice").

W I T N E S S E T H:

WHEREAS, the Plan and the Provider desire to enter into an agreement for the funding toward the Rhode Island Chronic Care Sustainability Initiative ("CSI-RI") on the terms and conditions set forth herein; and

WHEREAS, the Provider is a group of primary care providers (practitioners) or a solo practitioner in the Plan's network pursuant to a Medical Group Participation Agreement or other substantially similar provider network participation agreement with Plan (hereinafter "Group Agreement") and

WHEREAS, CSI-RI, a Multi-Payer Demonstration of the Patient-Centered Medical Home ("PCMH"), a model of primary care that will improve the care of chronic disease and lead to better overall health outcomes for Rhode Islanders.

NOW, THEREFORE, in consideration of the mutual covenants, promises and undertakings hereinafter set forth and for other good and sufficient consideration, the receipt of which is hereby acknowledged, the parties hereto agree as follows:

I. DEFINITIONS

A. A "Practice Site " shall mean the physical location where an individual primary care provider or group of primary care providers who are (i) under a Group Agreement with the Plan and considered "in-network" ; and (ii) credentialed by the Plan with a specialty in Internal Medicine or Family Practice (or any midlevel practitioners employed by the Internal medicine or Family Practice providing primary care services) shall provide services as described under this Agreement

II. PRACTICE SITE PARTICIPATION

A. The Provider's Practice Site(s) for purposes of participation under this Agreement and its individual Practitioners located at such Practice Site(s) as of the date of this Agreement include:

[Insert Expansion Provider or Group Name and Practice Site Location]

Provider Name(s)	Practitioner Type (physician or physician extenders)	NPI number

B. The other Practice Sites and their respective Practitioners participating in CSI-RI and covered under terms identical to or substantially similar to this Agreement (each group has executed its own separate contract) and who will be measured collectively with Provider, and will collectively be defined as "CSI-RI Practices" include all Practice Sites referenced in Attachment A: CSI-RI Practices.

C. The Plan reserves the right to limit PMPM payments as described in Section VIII. Compensation herein to the number of physicians and physician extenders ("Practitioners") listed in Section II.A. In the event that the Practice employs a new Practitioner at the Practice Site, the new Practitioner shall be included in

PMPM calculations if he or she is replacing one of the Practitioners identified in Section I.A. If the new Practitioner is being added to the Practice Site and is not replacing an existing Practitioner, the new Practitioner shall be included in PMPM calculations subject to the limitations set forth herein. If the Practice patient attribution increases more than 25% from its original attribution as described in Section II B as a result of the Practice Site adding one or more Practitioners that are not replacing existing Practitioners, then the additional PMPM payment will be paid at the discretion of the Plan. Notwithstanding above, the parties agree that any physician Practitioner added to a Practice Site must first be added to the underlying Group Agreement between the parties. Practices serving Neighborhood Health Plan members will have their PMPM calculations based upon NHP members assigned to said Practice.

1. Should the Practitioners identified in this Section II A change, the Provider will notify CSI-RI and the Plan with the Practitioner name, NPI number (if applicable), and the effective date of the change at least 30 days prior to each quarterly payment date. If the providers to not submit timely updates and, as a result, do not get paid for a newly added Practitioner, Plan is not responsible for and Provider shall not be entitled to any retroactive payments for any quarters in which the notice obligation described herein was not met for the Practitioner at issue. However, notwithstanding the foregoing, if, Plan makes overpayments to Provider due to Provider's failure to provide appropriate notice of the change in a Practitioner's status, Plan shall be entitled to recover such monies through offsets to future PMPM payments and, upon termination of the Agreement, through reimbursement within sixty (60) days of notice to Provider by Plan of such overpayment.

D. On a quarterly basis, CSI-RI management will request an update to the Practitioner list.

E. Unless otherwise authorized by Plan, if Provider participates in another physician incentive program administered by Plan for commercial benefit plans, then the Provider agrees to terminate the other incentive program in order to participate under this Agreement.

III. LEVELS OF PRACTICE TRANSFORMATION

A. A practice shall begin under this Agreement at one of the following four (4)levels of practice transformation, defined below, as determined by CSI-RI Project management and the CSI-RI Executive Committee. A practice may not exceed one (1) year per each level of practice transformation. Movement to the next level shall be confirmed by CSI-RI Project management and the CSI-RI Executive Committee at the end the one year period at a given level of transformation. If Practice fails to advance to next level of transformation within the 12 month period, continued participation in the CSI-RI project shall be reviewed and determined by voting members of the CSI-RI Executive Committee.

B. Start-up Year

The Practice must meet the following structural elements in order to receive compensation as outlined in Section VIII. Compensation:

1. Element #1: Electronic Medical Record: The Practice must have an electronic medical record in place meeting meaningful use standards, Stage 1.
2. Element #2: Nurse Care Managers (NCMs) Hired and Trained. The Practice must have hired and trained Nurse Care Managers per the Nurse Care Manager Role and Responsibilities outlined in Attachment B: Nurse Care Manager Role and Responsibilities.
3. Element #3: NCQA Patient-Centered Medical Home Recognition: The Practice shall demonstrate substantial efforts to achieve and maintain level 1 recognition as defined by the NCQA-Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of the Start-Up Year in order to receive the compensation as outlined in Section VIII. Compensation. If level 1 recognition is not achieved, the Practice will work with CSI-RI Project Management to make a plan for resubmission in six (6) months. If after the second submission, the Practice fails to achieve level 1 recognition,

continued participation in the CSI-RI project shall be reviewed and determined by voting members of the CSI-RI Executive Committee. Upon completion of the evaluation, the Provider shall disclose to CSI-RI Management all content and scoring related to the evaluation.

C. Transition Year: NCQA Patient-Centered Medical Home Recognition:

The Practice shall demonstrate substantial efforts to achieve and maintain Level 2 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of the Transition Year in order to receive the compensation as outlined in Section VIII. Compensation. If level 2 recognition is not achieved, the Practice will work with CSI-RI Project Management to make a plan for resubmission in six (6) months. If after the second submission, the Practice fails to achieve level 2 recognition, continued participation in the CSI-RI Project shall be reviewed and determined by voting members of the CSI-RI Executive Committee. Upon completion of the evaluation, the Provider shall disclose to CSI-RI Management all content and scoring related to the evaluation.

D. Performance Year I: NCQA Patient-Centered Medical Home Recognition:

The Practice shall document a plan and achieve Level 3 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of Performance Year I in order to receive the compensation as outlined in Section VIII. Compensation. If level 3 recognition is not achieved, the Practice will work with CSI-RI Project Management to make a plan for resubmission in six (6) months. This will result in a PMPM reduction, as defined in attachment H, until level 3 recognition is regained. If after the second submission, the Practice fails to regain level 3 recognition, continued participation in the CSI-RI Project shall be reviewed and determined by voting members of the CSI-RI Executive Committee. Upon completion of the evaluation, the Provider shall disclose to CSI-RI Management all content and scoring related to the evaluation.

E. Performance Year II: NCQA Patient-Centered Medical Home Recognition:

The Practice shall demonstrate substantial efforts to achieve and maintain Level 3 recognition as defined by the NCQA – Patient-Centered Medical Home version Standards ("NCQA-PCMH standards"), by the end of Performance Year II in order to receive the compensation as outlined in Section VIII.

. Compensation. If level 3 recognition is not achieved, the Practice will work with CSI-RI Project Management to make a plan for resubmission in six (6) months. If after the second submission, the Practice fails to achieve level 3 recognition, continued participation in the CSI-RI Project shall be reviewed and determined by voting members of the CSI-RI Executive Committee. Upon completion of the evaluation, the Provider shall disclose to CSI-RI Management all content and scoring related to the evaluation. For plans who are re-submitting for their level 3 recognition, if level 3 recognition is not achieved, the Practice will work with CSI-RI Project Management to make a plan for resubmission in six (6) months. This will result in a reduction in the PMPM until level 3 recognition is regained. If after the second submission, the Practice fails to regain level 3 recognition, continued participation in the CSI-RI Project shall be reviewed and determined by voting members of the CSI-RI Executive Committee. Upon completion of the evaluation, the Provider shall disclose to CSI-RI Management all content and scoring related to the evaluation.

IV. PERFORMANCE METRICS

A. "Target" refers to the three (3) measures outlined in Section II.F.1. – F.3 below; specifics related to the definitions of the metrics and how performance will be measured are outlined in this Agreement. Targets #1 and #2 will be measured based on the Practice's sole performance; Target #3 1a) Inpatient admission and 1b) ED visits will be measured based on the aggregate performance of CSI-RI Practice sites as described under Section I A. and B. of this Agreement. (See Section VI a. for procedures to be used in case of disputes in the calculation of Target results). Practices will agree to un-blinded, public reporting of approved performance metrics on the PCMHRI website, amongst the CSI-RI community.

1. Target # 1: Process Improvement (Practice Metric): Practice will demonstrate to the Plan's satisfaction successful implementation and maintenance of the following Process Improvement metrics:

a. After Hours: The Practice will submit to CSI-RI Management the After Hours Protocol and Plan for Monitoring Performance. The protocol for the Practice will include: the strategy for accessing weekends, holidays & extended hours of care, location, hour of operations, and protocols outlining how the Practice's Eligible Subscribers can access care from these sites as an alternative to emergency room care. CSI-RI Management will submit the protocols and plans to the CSI-RI Executive Committee for review and approval. The approved After Hours Program must be in operation no later than (insert date 6 months after start of contract).

b. Hospital – Outpatient transition best practices: compliant with the Quality Partners of Rhode Island, "HOSPITAL & COMMUNITY PHYSICIAN BEST PRACTICES" (see Attachment F: Quality Partners of Rhode Island). Practice will attest to compliance with policy by the end of Start Up year.

c. Compacts with high volume specialists: Practice will establish compacts consistent with Attachment G: "Colorado Primary Care - Specialty Care Compact" and "American College of Physicians Council of Subspecialty Societies (CSS) Patient-Centered Medical Home (PCMH) Workgroup" such that one (1) compact is established and approved by the Plan by (insert date = 3 months after start of transitions year) Two (2) additional compacts are established by the Practice and approved by the Plan by (insert 6 months after start of transition year) and a total of no less than four (4) compacts with four (4) different specialties shall be established by (insert date 9 months after start of transition year) and maintained for the term of this Agreement. One of the compacts must be with a hospitalist or hospitalist group unless the Practice provides inpatient care for all of the Practice's Eligible Subscribers at the Practice's primary hospital. Eligible Subscribers receive inpatient services.

d. Practice must also meet the NCM quarterly reporting requirements to CSI-RI Management as defined by CSI-RI management.

e. If structural items (IV, A, 1, a-d) are not achieved or maintained, during any level of practice transformation, the Practice will work with CSI-RI Project Management to make a plan for completion within six (6) months. If not completed within six (6) months, continued participation in the CSI-RI Project shall be reviewed and determined by voting members of the CSI-RI Executive Committee.

2. **Target # 2: Quality and Patient Experience (Provider Metrics):** Reporting and Measurement for Target #2 will be reviewed annually by the CSI-RI Data and Evaluation Committee with recommendations to the CSI-RI Executive Committee to modify the specific benchmarks.

    a. Quality: Practice will achieve the CSI-RI clinical quality measures as defined in Attachment C: Reporting and Measurement for Target #2. If the benchmark is not achieved, the target will also be considered as met if the Practice achieves half the distance between the baseline rate and the target, as long as half the distance equals at least a 2.5 % point improvement. The quality measures are based on industry- standards metrics. See Attachment C: Reporting and Measurement for Target #2.

    b. Patient Experience: Practice will allow the conduct of the CAHPS-PCMH survey and present findings to the RI CSI-RI Executive Committee by the end of the transition year, along with a plan for the incorporation of these findings into their practice redesign. See Attachment C: Reporting and Measurement for Target #2.

3. **Target #3: Utilization Metric (CSI-RI Provider Metric):** Reporting and Measurement for Target # 3 will be reviewed annually by the CSI-RI Data and Evaluation Committee with recommendations to the CSI-RI Executive Committee to modify the specific benchmarks.

a. Practice will achieve the CSI-RI Utilization measures as defined in Attachment D: Reporting and Measurement for Target #3.

b. Plan shall provide to the data aggregator and evaluation vendor identified by CSI-RI Project Management sufficient claims detail by product to support the reporting for the Inpatient and ER metrics as identified in Target #3. As of February 28, 2012, the data aggregator is the Rhode Island Quality Institute and evaluator is RTI.
c. Plan shall provide the claims data to the data aggregator and evaluation vendor, within fifteen (15) days of the end of each quarter.
d. CSI-RI Project Management designated vendor will aggregate and report the results within thirty (30) days of receipt of all of the Plans' data.
e. Plan will then make the necessary retroactive payment adjustment (if any) and pay the revised PMPM consistent with the earned amount for Targets #1 -3 with Contract Quarter six (6) payment.

B. If at any time during this Agreement a Practice does not meet the minimum requirements as outlined by this Agreement, the Plan has the right to adjust the funding accordingly and /or terminate the funding associated with the Practice's participation in the program. Partial payments will not be made for partial achievement unless otherwise defined in this Agreement.

C. If this Agreement is terminated for cause, or as the result of a dispute or grievance in accordance with Section VI herein, PMPM compensation payments will be paid until the date of termination. If the Plan has made or makes any prospective payments to a Practice for services beyond the termination date, such payments shall be returned to the Plan by the Practice within thirty (30) days of the termination of this Agreement.

V. OTHER PERFORMANCE REQUIREMENTS

A. The Practice shall refer/coordinate Eligible Subscribers' care to providers contracted with the Plan at all times except when it is medically necessary to use a non-participating Plan provider (cases requiring emergency level of care), unless the Eligible Subscriber has elected to use the non-participating provider and assumes all or some of the costs of the service. In all cases, the Practice should provide necessary clinical information to coordinate the care of Eligible Subscribers, whether or not the Plan or the Eligible Subscriber is responsible for some or all of the cost of care. Contracted providers include physicians and hospitals as well as ancillary providers such as: clinical and pathology laboratories, durable medical equipment and behavioral health providers.

VI. TRAINING AND REPORTING

A. The Practice shall participate in training as established by a training and support entity selected by the voting members of the CSI-RI Executive Committee. If at any time the Practice fails to meet the training requirements, PMPM payments as defined in Section VIII. Compensation herein shall be eliminated until such time as training requirements are completed. Completion status will be determined by the voting members of the CSI-RI Executive Committee.
B. The Practice shall participate in any learning collaborative developed by the Practice Transformation Support and Training Committee.
C. The Practice shall participate in the Practice Reporting Subgroup. Integrity of quality data submitted by the practice will be reviewed by said subgroup on a monthly basis. The performance of a practice on quality metrics, as defined in section III, F, 2, will be based upon results approved by said committee.

D. The Practice shall endeavor to engage its patients in the CSI-RI program. Patient Engagement is defined as communication from the Practice to an Eligible Subscriber about the PCMH initiative and the additional

services that are made available. Patient Engagement shall be documented in the Subscriber's medical record.

E. The Practice, and at the Plan's discretion, the Plan, will participate in evaluations of CSI-RI conducted by a reviewer mutually agreed upon by the parties hereto and the CSI-RI Executive Committee, and provide data or other information requested as part of the evaluation. The Plan agrees to comply with reasonable requests.

F. The Plan agrees to provide - to the Practice and to CSI-RI management - the following reports (except as noted) related to the Plan's Eligible Subscriber population:
    1. Subscriber Panels – Quarterly (practice only);
    2. Subscriber Inpatient and ED Utilization – Weekly (practice only);
    3. Attribution List – Quarterly.
    4. Other reports as agreed to by the Plan

G. CSI-RI aggregator shall provide to the Practice reports on items described in attachment D.

H. The Practice agrees to provide the following reporting consistent with Attachment E: Quarterly Reporting Due Dates unless specified otherwise in this Agreement:

    1. Target #2 Quality and Patient Experience Metrics
    2. Process Measures for the following:
        a. After Hours Care
        b. Participation in Hospital – PCP transition best practices
        c. Compacts established with four (4) specialty groups (including one compact with a hospitalist)
        d. Patient Experience Survey
        e. Nurse Care Manager Activities

I. Plan will provide to CSI-RI project management updates on attribution counts for covered lives in each CSI-RI practice (quarterly).

J. Reporting values will be rounded to the nearest tenth of a digit for measurement purposes related to the Targets.

K. Plan will contribute sufficient claims detail to calculate the agreed upon CSI-RI utilization metrics outlined in this Agreement.

L. Plan will report to Practices three (3) additional measures selected through statewide "harmonization" which for purposes of this Agreement shall mean selecting measures that are consistent with the standard measures being used in various statewide initiatives related to primary care. Measures will be determined by mutual agreement between the various plans in PCMH, the Practice and the CSI-RI Executive Committee through the harmonization process. Such measure(S) shall be agreed upon by CSI-RI management, the CSI-RI executive committee and the Plans.

Notwithstanding the above, in the event Plan is unable to operationalize or administer any of the selected additional measures, it shall not be responsible for implementing such measures(s)

M. The committee structure and responsibilities are defined in Attachment I.

VII. USE OF DATA

A. Plan shall have the right to publish the clinical outcome data derived from this PCMH program in an aggregate fashion.

B. Should data from this PCMH program indicate a practitioner is operating at a level which would be an imminent threat to patients, this data can be used in individual practitioner termination proceedings and any required regulatory reporting.

VIII. COMPENSATION

A. The Practice shall be paid per member per month ("PMPM") payments based on the table in Attachment H: Per-Member-Per-Month payments, provided that all of the conditions of this Agreement are met including Section V: Other Performance Requirements, and achieving "Targets" as defined in section, V: Performance Requirements.

B. Payments made per member per month ("PMPM") will be made for Eligible Subscribers subject to the following definitions and requirements.

1. Eligible Subscribers means commercial subscribers, RItecare subscribers, and Medicare Advantage subscribers who receive coverage on a fully-insured basis or self-insured basis and who are entitled to receive covered health services as described in their respective subscriber agreements pursuant to the benefit programs underwritten or marketed by the Plan; Eligible RIteCare Subscriber payments will only be made for those products with two hundred (200) or more Eligible Subscribers.

2. Only Eligible Subscribers that either through self-selection or, in the absence of self-selection, through assignation to a Practitioner through an attribution methodology to a Practitioner listed in Section I.A, shall qualify as counting for purposes of the PMPM payments hereunder. Practices serving NHP members will have their PMPM calculations based upon the number of NHP members assigned to said practice.

3. The CSI-RI attribution methodology for Plan's Eligible Subscribers will be defined as:

   a. Eligible Subscribers with the most recent PCP Visit rendered by the Practitioner/Provider. "PCP Visit" is defined as an evaluation & management ("E/M") visit rendered by a Primary Care Physician as credentialed by the Plan with a specialty in Internal Medicine or Family Practice (or any midlevel practitioners employed by the practice providing primary care services). E/M visits are defined as CPT® codes 99201-99215 and 99381-99397. The Plan will calculate the number of Eligible Subscribers each quarter based on twenty-seven (27) months of claims data. Eligible Subscribers must be active Plan Subscriber as of the date indicated below in the payment schedule table (see Section IV d.2 for reporting requirements regarding Eligible Subscribers).

A PCP is defined as a primary care physician as credentialed by the Plan with a specialty in Internal Medicine or Family Practice (or any midlevel practitioners employed by the Internal Medicine or Family Practice providing primary care services).

CSI-RI Management will track quarterly attribution by the Practice and by the Plan with a report submitted to the Executive Committee.

D. PMPM payments for Eligible Subscribers (as defined in Sections A –B above) shall be made to Practice prospectively on a quarterly basis and no later than the 15th of the first month of each quarter. The schedule of payments follows:

PMPM Payment Schedule

	Contract Quarter:	Paid Claims Ending:	Active with Plan
1	April 1 – June, 30 2013	February 28, 2013	April 1, 2013
2	July 1 – September, 30 2013	May 31, 2013	July 1, 2013
3	October 1 – December 31, 2013	August 31, 2013	October 1, 2013
4	January 1 – March 31, 2014	November 30, 2013	January 1, 2014
5	April 1 – June 30, 2014	February 28, 2014	April 1, 2014
6	July 1 – September 30, 2014	May 31, 2014	July 1, 2014
7	October 1 – December 31, 2014	August 31, 2014	October 1, 2014
8	January 1 – March 31, 2014	November 30, 2014	January 1, 2015

PMPM Payment Due Dates

Contract Period		PMPM Payment Due Date
April 1 – June, 30 2013	Quarter 1	April 21, 2013
July 1 – September, 30 2013	Quarter 2	July 21, 2013
October 1 – December 31, 2013	Quarter 3	October 20, 2013
January 1 – March 31, 2014	Quarter 4	January19, 2014
April 1 – June 30, 2014	Quarter 5	April 20, 2014
July 1 – September 30, 2014	Quarter 6	July 20, 2014
October 1 – December 31, 2014	Quarter 7	October 20, 2014
January 1 – March 31, 2015	Quarter 8	January19, 2015

C. PMPM payments are subject to Practice adherence to NCQA PCMH Standards and the terms of this Agreement, and shall be paid in accordance with Section VIII herein.

D.

Adjustments to PMPM Payment. If Plan determines that the number of Eligible Subscribers used to calculate the PMPM payment for a prior Payment Quarter was inaccurate, then Plan reserves the right to determine the overpayment or underpayment resulting from the inaccuracy and to correct such overpayment or underpayment and resolve it by way of offsetting the overpayment or paying the appropriate amount for an underpayment through future quarterly PCMH Payments. If Plan makes a determination of an overpayment or underpayment after the final PMPM payment following the termination of this Agreement, then Plan will pay any underpayment within 60 days of its determination or Provider will pay to Plan the overpayment within 60 days after Plan notifies Provider of the overpayment. Notwithstanding the foregoing, Provider shall not be entitled to reimbursement for underpayment in circumstances where such underpayment resulted due to the failure of Provider to meet its notice requirements as set forth in Article II, Section (C)(1) hereunder relating to updating its Practitioner listing.

E. Nurse Care Managers ("NCM"). NCMs will be hired by the Practice to support the implementation and maintenance of the PCMH elements including but not limited to the coordination of care. Compensation for the NCM is included in the PMPM payments outlined in Section VIII.A. It is the expectation that the Practice will have a dedicated NCM retained to support the type of functions listed in Attachment B: Nurse Care Manager Role and Responsibilities. If at any time the Practice reasonably expects to be without a NCM for a period of thirty (30) days or more, the Practice will notify the CSI-RI Executive

Committee and the Plan. If more than thirty (30) days passes and the Practice has not been able to replace the NCM, the parties will attempt to reach a mutually agreeable alternative arrangement to replace the services provided by the NCM. However, if a mutually agreeable alternative is not agreed upon, the Plan will have the unilateral right to reduce the PMPM by an amount of no more than $2.50 or terminate this Agreement with the Practice.

IX. TERM AND TERMINATION

This Agreement shall commence on (insert date) and shall continue for (insert number of years) thereafter until (insert date), unless this Agreement is earlier terminated as set forth in this Section IX.

A. The Practice and the Plan hereto encourage the prompt and equitable settlement of all disputes or grievances arising from or related to this Agreement except for items specified under the section on cause for termination of contract. The parties agree to negotiate their differences directly and in good faith. If resolution is not possible, the issue will be referred to the voting members of the CSI-RI Executive Committee for review and comment, which review and comment shall be rendered within thirty (30) days. If the dispute or grievance is deemed irreconcilable following review by the CSI-RI Executive Committee, either party hereto may terminate this Agreement by providing the other party with not less than ninety (90) days' prior written notice of termination. Notwithstanding the above, this section is intended to apply only to disputes related to subject matters governed under this Agreement related to the PCMH program. Any other disputes between the parties shall be resolved pursuant to the dispute resolution terms contained in the underlying Group Agreement between the parties.

B. Either party hereto may terminate this Agreement immediately for cause as set forth below:
   1. material breach by the other party of any of the terms or conditions of this Agreement which is not cured within thirty (30) days following receipt by the breaching party of a notice of deficiency specifying the nature of the breach; or
   2. fraud committed by either party upon written notice; or
   3. failure to comply with applicable state and federal rules and regulations upon written notice; or
   4. loss or suspension of licenses/certifications necessary to fulfill this Agreement upon written notice; or
   5. the other party hereto commits an act of bankruptcy within the meaning of the federal bankruptcy laws, or bankruptcy, receivership, insolvency, reorganization, liquidation or other similar proceedings.

C. Additionally the Plan may terminate this Agreement for cause as set forth below:
   1. if the Practice becomes a non-participating Plan practice at any time during this Agreement; or
   2. if the Practice is expelled or suspended from the Medicare or Medicaid programs; or
   3. lack of need of Plan to continue with this Agreement as a result of economic considerations upon no less than ninety days (90) prior written notice.

Notwithstanding the above, the parties agree that, in the event Plan terminates an individual practitioner subject to this Agreement from the underlying Group Agreement with Practice pursuant to Plan's rights there under, this Agreement will remain valid with regard to the remaining practitioners.

D. Any notice of termination hereunder shall set forth the reason(s) for such termination. Upon termination of this Agreement, for whatever reason, the rights and obligations of the parties hereunder shall terminate. Termination of this Agreement shall not release Practice or each physician from providing services in accordance with the terms of such individual's Participating Agreement or Provider's Participating Provider Agreement and such Participating Agreement or Participating Provider Agreement shall remain in full force and effect until terminated in accordance with its terms.

X. MISCELLANEOUS

A. The Practice hereby expressly acknowledges such Practice understands that this Agreement constitutes a contract between the Practice and the Plan and that the Plan is an independent corporation operating under a license from [Plan]. The Practice further acknowledges and agrees that it has not entered into this agreement based upon representations by any person or entity other than Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the Practice for any of the obligations of Plan to the Practice created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of this Agreement and all other rights available by law.

B. The Practice shall comply with all rules, regulations, policies and amendments thereto which are communicated to the Practice.

C. In support of this Patient-Centered Medical Home Initiative, should the RI CSI-RI Executive Committee vote for specific activities, such voting will override these contractual terms, so long as they are not disputed by the Plan.

D. The parties hereto explicitly acknowledge and agree that the CSI-RI is not a party to this Agreement and that any deliveries or actions on CSI-RI's part described in this Agreement represent the current mutual understanding and expectation of the parties hereto with regard to future CSI-RI activity. However, no failure on the part of CSI-RI to act in accordance with the descriptions provided under this Agreement shall be deemed a breach of this Agreement by either party hereto.

E. All notices, authorizations or other communications required to be given pursuant to the terms and provisions of this Agreement shall be in writing and personally delivered or sent by overnight delivery, or by certified mail, return receipt requested, and shall be deemed to be duly delivered upon receipt at the following address:

If to: Insert Plan Contact information

If to the Provider: _____insert_____
_____
_____
_____

This Agreement constitutes the entire agreement of the parties relative to CSI-RI. The parties agree that the terms and conditions set forth in the underlying participating provider Group Agreement remain enforceable and take precedence over the terms of this Agreement with regard to the subject matter thereof and shall govern in the event of a direct conflict. This Agreement shall be construed under and governed by the laws of the State of Rhode Island. The invalidity or unenforceability of any provision hereof shall in no way affect the validity and enforceability of any other provisions. The waiver by either party of a breach or violation of any provision hereof shall not operate or be construed as a waiver of any other breach or violation hereof. Neither this Agreement nor any interest herein shall be assigned by the Practice without the express prior written consent of Plan, which consent may be withheld in the sole and absolute discretion of Plan.

F. The parties hereto are independent entities and neither of them nor any of their respective employees shall be construed to be the agent, employer or representative of the other, nor shall either party have any expressed or implied right or authority to assume or create any obligation on behalf of or in the name of the other party. Neither party shall be liable to the other for any act or omission of the other party hereto.

IN WITNESS WHEREOF, the parties have executed this Agreement in duplicate originals on the day and year set forth below.

[Provider]	[Plan]
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
Title:_____	Title: _____

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Contract Attachments

Attachment A: CSI-RI Practices

- Anchor Medical Associates (Lincoln, Providence, and Warwick)
- Aquidneck Medical Associates (Newport and Portsmouth)
- Associates in Primary Care (Warwick)
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- Coastal Medical (Narragansett, Pawtucket, Providence, and Wakefield)
- Comprehensive Community Action Program (Cranston, Coventry, and Warwick)
- East Bay Community Action Program (East Providence and Newport)
- Family Health and Sports Medicine (Cranston)
- Family Medicine at Women's Care (Pawtucket)
- Internal Medicine Center (Pawtucket)
- Internal Medicine Partners (North Providence)
- Kristine Cunniff, MD (Narragansett)
- Medical Associates of RI (Bristol and Barrington)
- Memorial Hospital Family Care Center (Pawtucket)
- Nardone Medical Associates (Pawtucket)
- Ocean State Medical (Johnston)
- Richard Del Sesto (East Greenwich)
- South County Hospital Family Medicine (East Greenwich)
- South County Internal Medicine (Wakefield)
- South County Walk-In and Primary Care (Narragansett)
- Stuart Demirs, MD (Charlestown)
- Thundermist Health Center (Wakefield, West Warwick, and Woonsocket)
- Tri-Town Community Action Program (Johnston)
- University Family Medicine (East Greenwich)
- University Internal Medicine (Pawtucket)
- University Medicine (6 sites – East Providence, Providence and Warwick)
- WellOne Primary Medical and Dental Care (Foster, North Kingston, and Pascoag)
- Women's Primary Care, Women's Medical Collaborative (Providence)
- Wood River Health Services (Hope Valley)

Attachment B: Nurse Care Manager Role and Responsibilities

- Completes initial patient assessment, including a comprehensive medical, psychosocial, and functional assessment of the patient, including in office or the home setting as needed; review with provider and clinical team members
- Provides detailed education about patient's specific chronic illness, including the pathology, signs and symptoms, complications, and medications used in treatment.
- Assures that screening tests, immunizations and urgent referrals are up to date; perform outreach when additional action is needed.
- Utilizes a interdisciplinary team approach to address opportunities to plan and coordinate care; acts in a supportive capacity to other team members (i.e. medical assistants, receptionist , office manager, provider, behavioral health provider) in supporting patient and the and treatment plan.
- Helps to arrange contact with other resources needed to support the treatment plan.
- Develops care management plans, interventions, and treatment goals in collaboration with patient/family; utilizes motivational interviewing techniques to assist patients with establishing self-management goals, and action plans with timeframes.
  - Promotes success with chronic care plan.
  - Coordinates care and communicates with multiple providers, with particular attention to transitions of care; acts as a liaison to hospital, long term care, specialists and home care.
  - Reviews test results and tracks outcomes.
  - Reviews medications and work with provider/pharmacist as needed to assist with medication management
  - Reviews patient risk issues and work with patient/family/team to reduce risk.
  - Works one-on-one with patients.
  - Arranges group visits.
- Leverages EMR / chronic disease registry/Current Care reporting to prioritize patient follow-up.
- Identifies and utilizes cultural and community resources.
- Generates quarterly reports on service volume, distribution of patients by plan, and types of services provided; analyze data and develop and implement performance improvement strategies to meet /exceed quality of care expectations.
- Ensures open communication, regarding patient status, with physicians and office staff.
- Provides training to non-RN Quality Assistant and other practice staff as needed.
- Attends required training and collaboration sessions [i.e., learning sessions (3), outcomes congress (1), care management collaboration meetings (up to 2 hours every 2 weeks), and practice team meetings] as scheduled.

Attachment C: Reporting and Measurement for Target #2: Quality and Patient Experience (Provider Metrics)

Reporting and Measurement of Target #2 will be reviewed annually by the CSI-RI Data and Evaluation Committee with recommendations to the CSI-RI Executive Committee to modify the specific benchmarks.

In order to successfully achieve Target #2, Practices must:

1. Achieve the below Clinical Quality benchmarks for 4 out of 7 clinical quality measures at the end of the measurement year; AND

2. Achieve the Patient Experience Survey benchmarks according to the following:
    a. Use "top box" (Always) for three composite domain scores of CAHPS PCMH: Access, Communication and Office Staff
    b. This is a Practice Level Performance measure
    c. Benchmarks, defined as 2012 medians, are as follows: Access (53%), Communication (80%), Office Staff (72%)
    d. Success in a domain is defined as 2013 result being at or above the 2012 median OR the practice improves from 2012 to 2013 so that the improvement achieves half the distance between the baseline rate and the 2012 median ("target"), as long as half the distance equals at least a 2.5 % point improvement. If there was no 2012 measurement, then the 2012 median must be attained.
    e. Success for this contractual measure is success in the Access Domain and at least one of the other two domains. If the Access domain target/improvement threshold is not achieved, it does not matter (for contractual success) what the scores were in the other domains.
    f. All questions of the domains are included.

If there are significant changes in CAHPS PCMH for 2013 in these domains, Data and Evaluation will propose a revision as needed.

Achieving Clinical Quality Benchmarks:

Practices can meet the Clinical Quality Benchmark in one of two ways. They will meet the benchmark if they:

1. Achieve the CSI-RI benchmark value (see below) for Performance Year I. For example, a practice would meet the CSI-RI benchmark for April 2012 through March 2013 if their clinical quality report to CSI-RI for that time frame meets or exceeds the CSI-RI benchmark. If a practice exceeds the target for a rolling year prior to the March, 2013 date, but does not achieve the benchmark during the April

2012 – March 2013 time frame, they will not be considered to have met the target; or,

2. Improve their performance on a particular measure by at least 50% of the distance between their baseline performance and the CSI-RI benchmark, as long as the difference between the practice's baseline and the CSI-RI benchmark is greater than or equal to 5%. If the difference between a practice's baseline measure and the CSI-RI benchmark is less than 5%, then the practice can only meet the benchmark by achieving the actual CSI-RI benchmark value. Baseline performance will be established in the Transition Year.
    g. Improving their performance from 50% to 64% during the measurement year, thereby meeting the CSI-RI benchmark value; or
    h. Improving their performance from 50% to 57% (half the distance between baseline and CSI-RI benchmark value).

    If a practice's baseline performance on the same measure is 60% in the baseline year, then the practice can only meet the benchmark by improving their performance from 60% to 64%, because the distance between 60% and 64% is less than 5%.

3. Practices can meet four of the seven benchmarks by either one of these methods, or any combination of the two methods.

CSI-RI Benchmark Values

The Data and Evaluation Committee established the benchmarks for the harmonized measures detailed below. These benchmarks were approved by the CSI-RI Executive Committee on August 24, 2012. Practices must meet the benchmark on four (4) out of the seven (7) measures to meet Target #2. Practices will continue to measure and report on all 15 measures. Only the indicated seven (7) will be used to meet the requirements of target #2.

Measure	Used for Payment	Threshold
Adult BMI (18-64)	✓	50%
Adult BMI (65+)	✓	50%
Depression Screen		90%
DM A1c Good Control (<8)	✓	67%
DM A1c Poor Control (>9)		23%
DM BP Control (<140/90)	✓	75%
DM BP Good Control (<130/80)		40%
DM LDL Good Control	✓	50%
Hypertension BP Control (<140/90)	✓	68%
Hypertension BP Measurement		99%
Tobacco Assessment		95%
Tobacco Cessation	✓	85%
DM LDL patients w/ Result		
DM HbA1c patients w/ Result		
DM BP patients w/Measurement		
Total # active patients 18+		

Description and Details for all CSI-RI Harmonized Measures

Diabetes Mellitus – HbA1c Poor Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with poorly controlled disease (having an A1c value greater than 9.0%)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator with the most recent HbA1c >9.0% in the measurement period or whose HbA1c reading was not taken or is missing.
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	Based on NQF 0059
Measure Domain/ Type	Outcome

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Diabetes Mellitus – Blood Pressure Good Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with well controlled blood pressure (having a blood pressure value less than 130/80)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure test result value during the measurement period is less than 130/80*
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	HEDIS 2011 and NQF 0061
Measure Domain/ Type	Outcome

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

*If multiple BP measurements occur on the same date or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled." Controlling High Blood Pressure (CBP)HEDIS 2011

Blood pressure is viewed as two separate values: systolic and diastolic. The lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record may be used. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on the date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

NQF MEASURE DETAILS -0061
http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=1235#k=diabetes&e=1&st=&sd=&mt=&cs=&s=n&so=a&p=1

Diabetes Mellitus – Blood Pressure Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 who had a blood pressure value less than 140/90)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure test result value during the measurement period is less than 140/90*
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0, PCOS 256.4 Gestational diabetes: 648.8
Measure source	Based on NQF 0061
Measure Domain/ Type	Outcome

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

*If multiple BP measurements occur on the same date or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled." ***Controlling High Blood Pressure (CBP)HEDIS 2011***

Blood pressure is viewed as two separate values: systolic and diastolic. The lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record may be used. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on the date as the representative BP. The systolic and diastolic results do not need to be from the same reading ***NQF MEASURE DETAILS -0061***

http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=1235#k=diabetes&e=1&st=&sd=&mt=&cs=&s=n&so=a&p=1

Diabetes Mellitus – LDL-C Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with well controlled LDL cholesterol (having LDL-C value less than 100 mg/dL)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent LDL value in the measurement period is less than 100mg/dL .
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	Based on NQF 0064
Measure Domain/ Type	Outcome

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Tobacco Cessation Intervention

Definition	The percentage of tobacco users in the total Active Patient population, given tobacco cessation advice including one or more of the following: advice to quit, counseling, referral for counseling, and/or pharmacologic therapy during the measurement period
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the last 24 months. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	Patients in the denominator who were given tobacco cessation intervention at least one time during any face-to-face encounter, including one with a nurse care manager, during the measurement period. Tobacco cessation intervention includes advice to quit, counseling, referral for counseling, and/or pharmacologic therapy (smoking cessation agent), active or ordered.
Denominator	Active patients age 18 and older who were seen two or more times or for 1 preventive visit, by a primary care clinician of the PCMH within the last 24 months and were identified as tobacco users in the most recent tobacco use assessment.
Exclusions	None
Measure source	Based on NQF 0028b
Measure Domain/ Type	Process

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Depression Screening

Definition	The percentage of patients age 18 and older screened one or more times for depression during the measurement period, using a standardized screening tool (PHQ-2 or other validated tool)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	Patients in the denominator who received a depression screen one or more times within the measurement period using the PHQ-2 or other validated tool. Include patients who have documented diagnoses with the following codes in the numerator. 296, 300.4, 311, 293.83, 298.0, 309.0, 309.1, 309.28
Denominator	Active patients age 18 and older who were seen two or more times **or for one preventive visit** by a primary care clinician of the PCMH within the last 24 months
Exclusions	Patients diagnosed with the following ICD-9 codes: 290,294,318
Measure source	Based on: Veterans' Health Administration measure http://www.qualitymeasures.ahrq.gov/content.aspx?id=16177
Measure Domain/ Type	Process

Tobacco Use Assessment

Definition	The percentage of patients age 18 and older who were queried one or more times about tobacco use during the measurement period
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the last 24 months. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	Patients in the denominator who were queried, with a documented response, one or more times about tobacco use within the measurement period
Denominator	Active patients age 18 and older who were seen two or more times or for 1 preventive visit, by a primary care clinician of the PCMH within the last 24 months
Exclusions	None
Measure source	Based on NQF 0028a
Measure Domain/ Type	Process

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Diabetes Mellitus – HbA1c Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with controlled disease (having an A1c value less than 8.0%)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator with the most recent HbA1c <8.0% in the measurement period
Denominator	Active patients between the ages of 18-75 years at any time during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	Based on NQF 0575
Measure Domain/ Type	Outcome

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Adult Body Mass Index – Age 18-64

<table>
<tr><td>Definition</td><td>Percentage of patients age 18-64 whose calculated BMI is either in the normal range or is above or below the normal range and have a documented follow up plan within the measurement year.</td></tr>
<tr><td>Active Patient</td><td>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:
Patients who have left the practice by the end of the measurement year, as determined by:
• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice
• Patient has passed away
• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person
• Patient has been discharged</td></tr>
<tr><td>Measurement Period</td><td>12 months</td></tr>
<tr><td>Numerator</td><td>Patients in the denominator who meet the following criteria:
1. Patients whose calculated BMI is in normal range:
2. Patients whose calculated BMI is ABOVE or BELOW normal range AND have a documented care plan

<table><tr><th>BMI Range</th><th>Age 18- 64 years</th></tr><tr><td>ABOVE Normal</td><td>≥25 kg/m^2</td></tr><tr><td>NORMAL</td><td>greater than 18.5 kg/m^2 but less than 25 kg/m^2</td></tr><tr><td>BELOW Normal</td><td>≤18.5 kg/m^2</td></tr></table></td></tr>
<tr><td>Denominator</td><td>Active patients age 18-64 years who were seen by a primary care clinician of the PCMH during the measurement year</td></tr>
<tr><td>Exclusions</td><td>Optionally, these exclusions may be applied:
• Patients diagnosed with a terminal illness in the measurement year
• Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28)
• Patients for whom the exam was not done for patient reason
• Patients for whom the exam was not done for medical reason
• Patients for whom the exam was not done for system reason</td></tr>
<tr><td>Measure source</td><td>Based on NQF 0421</td></tr>
<tr><td>Measure Domain/ Type</td><td>Process</td></tr>
</table>

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Adult Body Mass Index – Age 65 and Older

<table>
<tr><td>Definition</td><td>Percentage of patients age 65 years and older whose calculated BMI is either in the normal range or is above or below the normal range and have a documented follow up plan within the measurement year.</td></tr>
<tr><td>Active Patient</td><td>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:
Patients who have left the practice by the end of the measurement year, as determined by:
• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice
• Patient has passed away
• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person
• Patient has been discharged</td></tr>
<tr><td>Measurement Period</td><td>12 months</td></tr>
<tr><td>Numerator</td><td>Patients in the denominator who meet the following criteria:
1. Patients whose calculated BMI is in normal range:
2. Patients whose calculated BMI is ABOVE or BELOW normal range AND have a documented care plan

<table><tr><th>BMI Range</th><th>Age 65 years and older</th></tr><tr><td>ABOVE Normal</td><td>≥30 kg/m^2</td></tr><tr><td>NORMAL</td><td>greater than 22 kg/m^2 but less than 30 kg/m^2</td></tr><tr><td>BELOW Normal</td><td>≤22 kg/m^2</td></tr></table></td></tr>
<tr><td>Denominator</td><td>Active patients age 65 years and older who were seen by a primary care clinician of the PCMH during the measurement year</td></tr>
<tr><td>Exclusions</td><td>Optionally, these exclusions may be applied:
• Patients diagnosed with a terminal illness in the measurement year
• Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28)
• Patients for whom the exam was not done for patient reason
• Patients for whom the exam was not done for medical reason
• Patients for whom the exam was not done for system reason</td></tr>
<tr><td>Measure source</td><td>Based on NQF 0421</td></tr>
<tr><td>Measure Domain/ Type</td><td>Process</td></tr>
</table>

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Hypertension: Blood Pressure Measurement

Definition	The percentage of patient visits for patients age 18 and older with a diagnosis of hypertension who have been seen for at least 2 office visits in the last 12 months, with blood pressure recorded
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator who have had a blood pressure recorded in the measurement period
Denominator	Active patients age 18 and older with a diagnosis of hypertension who have been seen at least 2 times by a primary care clinician of the PCMH during the last 12 months. The ICD-9 codes for hypertension: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93
Exclusions	None
Measure source	NQF 0013
Measure Domain/ Type	Process

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

Hypertension: Blood Pressure Control

Definition	The percentage of patients age 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year (having a BP value of <140/90)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure is adequately controlled (having a blood pressure value <140/90) in the measurement period*
Denominator	Active patients age 18-85 with an active diagnosis of hypertension for more than 6 months before the end of the reporting period who have been seen by a primary care clinician of the PCMH. Use the following ICD-9 codes: 401, 401.0, 401.1, 401.9
Exclusions	• Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28) • Patients who are diagnosed with ESRD (ICD code 585.6)
Measure source	Based on NQF 0018 and HEDIS 2011 Controlling High Blood Pressure (CBP)
Measure Domain/ Type	Process

NOTE: This measure definition is based on the NQF measure definition but does not include all of the detail found in the programming instructions for the electronic specification. If your EHR provides a Meaningful Use certified automated report for the measure which accurately reflects the CSI/Beacon reporting period, the report may be used to calculate the measure. If you are reporting at the practice level, be sure not to count patients more than once.

* If multiple BP measurements occur on the same date or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled." ***Controlling High Blood Pressure (CBP)HEDIS 2011***

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Begin reporting 1Q2014

Definition	The percentage of visits with a diagnosis of acute bronchitis for patients 18–64 years of age on the date of visit, who were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Visits in the denominator where an antibiotic medication (Table A) was prescribed by a primary care clinician of the PCMH on the date of visit.
Denominator	Outpatient visits during the reporting period to the primary care clinician by active patients age 18-64 on the date of the visit with a diagnosis of acute bronchitis. ICD-9 code for Acute Bronchitis: 466.0 CPT Codes for visit type: - 99201-99205, 99211-99215
Exclusions	None
Measure source	Based on HEDIS 2013
Measure Domain/ Type	Process

Table A: Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Kanamycin • Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Antipseudomonal penicillins	• Piperacillin	• Ticarcillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	• Ticarcillin-clavulanate
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Erythromycin-sulfisoxazole • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gatifloxacin • Gemifloxacin	• Levofloxacin • Lomefloxacin • Moxifloxacin	• Norfloxacin • Ofloxacin • Sparfloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime • Loracarbef
Sulfonamides	• Sulfadiazine • Sulfamethoxazole-trimethoprim	• Sulfisoxazole	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Chlamydia Screening – Obtaining Sexual History
Begin reporting 1Q2014

Definition	The percentage of women 18–24 years of age on the date of visit who were screened for sexual history during the measurement year.
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	The number of patients in the denominator who were screened for sexual history during the measurement year.
Denominator	Active female patients age 18-24 on the date of visit who were seen for a preventive visit by a primary care clinician of the PCMH within the 12 month reporting period. **CPT Codes to identify preventive visit:** 99201 – 99215 with preventive diagnosis code (v20.x, v22.x, v23.x, v70.x, v72.31) or preventive visit 99385, 99395
Exclusions	None
Measure source	Based on HEDIS 2010
Measure Domain/ Type	Process

Chlamydia Screening – Testing
Begin reporting 1Q2014

<table>
<tr><td>Definition</td><td>The percentage of women 18–24 years of age on the date of visit who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.</td></tr>
<tr><td>Active Patient</td><td>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:
Patients who have left the practice by the end of the measurement year, as determined by:
Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice
Patient has passed away
Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person
Patient has been discharged</td></tr>
<tr><td>Measurement Period</td><td>12 months</td></tr>
<tr><td>Numerator</td><td>The number of patients in the denominator with documentation of at least one test for Chlamydia during the measurement year.

Codes to Identify Chlamydia Screening (NCQA CHL-C 2013)

<table><tr><th>CPT</th><th>LOINC</th></tr><tr><td>87110, 87270, 87320, 87490, 87491, 87492, 87810</td><td>557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2</td></tr></table>
NOTE: These codes are not the only form of test documentation. Data from other structured fields may also be included.</td></tr>
<tr><td>Denominator</td><td>Active female patients age 18-24 on the date of visit who were seen for a preventive visit and documented as sexually active, during the measurement.

CPT Codes to identify preventive visit:

99201- 99215 with preventive diagnosis code (V20.X, V22.X, V23.X, V70.X, V72.31) or Preventive Visit: 99385, 99395</td></tr>
<tr><td>Exclusions</td><td>None</td></tr>
</table>

Measure source	Based on HEDIS 2013
Measure Domain/ Type	Process

Fall Risk Management
Begin reporting 1Q2014

Definition	The percentage of patients age 66 and older on the date of visit who were screened for fall risk during the measurement period.
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator who were screened for fall risk during the measurement year. At a minimum, the following questions must be asked: • Have you fallen two or more times in the past year • Have you fallen once with injury in the past year
Denominator	Active patients age 66 and older on the date of visit who were seen by a primary care clinician of the PCMH within the 12 month reporting period. CPT codes: 99201-99205, 99212-99215,99387,99397 G codes: G0402, G0438, G0439
Exclusions	None
Measure source	Based NQF 0101 Part A
Measure Domain/ Type	Process

Reporting Requirements:

1. Definition of Active Patient: Active Patients - Patients are active if they have been seen for an office visit in the past 2 years and are currently a patient in the practice. Patients who have transferred, passed away, and/or are no longer able to be reached meaning the patient's contact information results in no phone, no emergency contact person, and mail sent to the patient is returned to the sender (3 separate contact attempts must be made in order to satisfy this requirement if no longer able to be reached.)

1. Baseline performance will be the calendar year just prior to contract initiation (insert dates).
2. Data is based on a rolling year:

This table shows the specified timeframes that should be used for each report.

Report	Active Patients	Measurement Year
Report 12	1/1/10-12/31/11	1/1/11-12/31/11
Report 13	4/1/10-3/31/12	4/1/11-3/31/12
Report 14	7/1/10-6/30/12	7/1/11-6/30/12
Report 15	10/1/10-9/30/12	10/1/11-9/30/12
Report 16	1/1/11-12/31/12	1/1/12-12/31/12
Report 17	4/1/11-3/31/13	4/1/12-3/31/13
Report 18	7/1/11-6/30/13	7/1/12-6/30/13
Report 19	10/1/11-9/30/13	10/1/12-9/30/13
Report 20	1/1/12-12/31/13	1/1/13-12/31/13

Attachment D: Reporting and Measurement for Target #3 (Utilization Metrics)

1. CSI aggregator shall provide to the Practice reports on items described in attachment D:
    a) Hospital Emergency Department (ED) visits / 1000 – Quarterly; claims data to CSI management for aggregator;
    b) Hospital admissions / 1000 – Quarterly,
    c) Ambulatory Care Sensitive Admissions / 1000
    d) Thirty (30) day hospital re-admissions/ 1000
    e) Ambulatory Care Sensitive ED visits
2. In order to meet contractual requirements for the corresponding PMPM rate, CSI-RI practices must achieve the following benchmarks:
    a. CSI-RI Practices will achieve a five percent (5%) relative reduction in hospital admissions per thousand as compared to similar, non –PCMH providers during the same measurement period. "Non-PCMH practices" will be defined by the Data and Evaluation Committee and approved agreed to Executive Committee and voting members of the by the CSI-RI Steering Committee. `

       For example, if the comparison non- PCMH practices have decreased their rate of hospitalization from 50 hospital admission / 1000 to 49 hospital admissions / 1000 (2% reduction) , CSI-RI Practices will achieve a rate deduction of 7 % to meet target: i.e. 75 hospital admissions / 1000 to (75– [75 X .07]) = 69.75 hospital admissions / 1000).

    b. CSI-RI Practices will achieve ten percent (7.5%) relative reduction in ED visits per thousand as compared to similar, non –PCMH practices during the same measurement period.

       For example, if the comparison non- PCMH practices decreased their rate of ED visits from 300 ED visits / 1000 to 270 ED visits / 1000 (10 % reduction), CSI-RI Practice will achieve a reduction of 20% to meet target: 250 visits / 1000 to (250 – [250 X .20] = 200 ER visits /1000).

3. Target #3 is an annual measure and will be based on comparison utilization activity for the (insert date of calendar year which ends 3 months before the start of the transition year) "Base Year" as compared to the (insert date of calendar which ends 3 months before start of performance year I) "Performance Year".

4. ED visits and Hospital admissions are defined and measured as follows

   Emergency Department visits: All Cause

Measure Set ID	#1	**Version Number**	3
Version Effective Date	April 2, 2012	**Date Endorsed**	
Care Setting	Emergency Department	**Unit of Measurement**	1,000 member months
Measurement Duration	Quarterly	**Measurement Period**	April 1, 2009– March 31, 2013
Measure Type	Outcome	**Measure Scoring**	Rate/1,000 member months
Payer source	Commercial claims initially	**Improvement notation**	Higher rates indicate poorer quality

Origin of Measure	National Committee for Quality Assurance (NCQA). HEDIS® 2011: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2010. Various pages. Modifications done in accordance with the Beacon-CSI-RI working group consensus
Measure description	The number of ED visits per 1,000 member months, excluding visits that lead to admissions or observation stays and any visits for pregnancy, mental health, or chemical dependency services, in adults ages 18 years and older.
References	National Committee for Quality Assurance (NCQA). HEDIS® 2011: Healthcare Effectiveness Data and Information Set. Vol. 1, narrative. Washington (DC): National Committee for Quality Assurance (NCQA); 2010. Various pages. RAND working paper: "Developing an Efficiency Measurement Approach to Assess Hospital Readmissions, Ambulatory Care Sensitive Admissions, and Preventable Emergency Department Visits: A Resource Guide for Beacon Communities and Other Community Collaboratives." http://qualitymeasures.ahrq.gov/content.aspx?id=34130&search=emergency+department https://www.bluecrossma.com/staticcontent/npi_docs/UB_04FormLocatorAppendices.pdf Coffey RM, Barrett ML, Steiner S. Final Report Observation Status Related to Hospital Records. 2002. HCUP Methods Series Report #2002-3. ONLINE September 27, 2002. Agency for Healthcare Research and Quality. Available: http://www.hcup-us.ahrq.gov.
Release Notes/ Summary of Changes	V2: Clarified that exclusion for mental health purposes or the visit is related to chemical dependency is based upon principal diagnosis. Added exclusion for dental related visits. V3: Removed text "except where the end date of coverage in the quarter is the date of death" for denominator exclusions.

Technical Specifications	
Target Population	Adults ages 18 years and older with an ED visit.
Denominator	
Denominator Statement	1,000 member months for adults ages 18 years and older.
Denominator Details	1,000 member months for adults ages 18 years and older. Include all patients who were covered for the full quarter.
Denominator Exceptions and Exclusions	Exclude patients if not covered for the full quarter. Exclude patients who are attributed to out-of-state providers.
Denominator Exceptions Details	None
Numerator	
Numerator Statement	The number of ED visits, excluding visits that lead to admissions or observation stays and any visits for pregnancy, dental health, mental health, or chemical dependency services, in adults ages 18 years and older.
Numerator Details	Number of ED visits for adults ages 18 years and older. Count each ED visit not leading to an admission or observation stay as one visit.

	Multiple visits on same date count as only one visit. ED visits are identified by at least one of the following[1]: • CPT codes 99281–99285 with UB revenue codes 045x, 0981 • CPT codes 10040–69979 with POS 23. • HCPCS codes G0380–G0385.[2] Exclude ED visits occurring on the same day as an admission or the day before an admission.[3] Exclude ED visits occurring on the same day as an observation stay or the day before an observation stay.[4] Observational stays are identified as • UB revenue code 0760 (general classification category) or 0762 (observation room); and • HCPCS code G0378 (hospital observation service, per hour) or G0379 (direct admission of patient for hospital observation care).[5] Exclude visits where the principal diagnosis is any of the following pregnancy related ICD-9 codes[6]: • Complications of Pregnancy, Childbirth, and the Puerperium (630.xx–679.xx) • Newborn (Perinatal) Guidelines (760.xx–779.xx) • V20.xx Health supervision of infant or child • V22.xx Normal pregnancy • V23.xx Supervision of high-risk pregnancy • V24.xx Postpartum care and evaluation • V27.xx Outcome of delivery • V28.xx Antenatal screening • V29.xx Observation and evaluation of newborns for suspected condition not found • V30.xx–V39.xx Liveborn infant according to type of birth

[1] Specifications for Beacon-CSI-RI use has items grouped differently (The codes are there, but the grouping may make a difference):
- CPT codes 99281–99285 and POS = 23
- CPT codes 10040–69979 and POS = 23
- UB rev codes 0450, 0451, 0452, 0459, 0981 and POS = 23

[2] These are not included in the specifications for Beacon-CSI-RI use.
[3] Specifications for Beacon-CSI-RI use are inconsistent on this point. In one place it indicates same day or day before, but in another place it says just the same day. Same goes for observation stay.
[4] Specifications for Beacon-CSI-RI use define observation stays as revenue codes of 760, 761, 762, 769. Specifications for Beacon-CSI-RI use also indicates, "Exclude claims with a day bed code" with no specific codes listed.
[5] We currently are not counting revenue codes 0761 and 0769 as observation stays because they may be treatment rooms and not true observation stays. Claims with CPT codes 99217–99220 are also not counted as observation stays.
[6] Specifications for Beacon-CSI-RI use do not have these exclusions.

	Exclude visits where the principal diagnosis is for mental health purposes or the visit is related to chemical dependency, as defined by[7] • CPT codes 90801–90899 • principal ICD-9-CM diagnosis codes 290.xx–326.xx • ICD-9-CM procedure code 94.26, 94.27, or 94.6 • principal ICD-9-CM diagnosis codes 960.xx–979.xx with secondary ICD-9-CM diagnosis codes 291.xx–292.xx or 303.xx–305.xx. Exclude visits where the principal diagnosis is dental related (ICD-9 codes 520.xx–525.xx).[8]
Risk Adjustment	
Risk adjustment strategy to be determined and incorporated into Round 2.	
Sampling	
No sampling; patients assigned to practices according to the Beacon-CSI-RI attribution methodology.	

Hospital Admissions: All Cause

Measure Set ID	#4	**Version Number**	3
Version Effective Date	April 2, 2012	**Date Endorsed**	
Care Setting	Hospital	**Unit of Measurement**	1,000 member months
Measurement Duration	Quarterly	**Measurement Period**	April 1, 2009– March 31, 2013
Measure Type	Outcome	**Measure Scoring**	Rate/1,000 member months
Payer source	Commercial claims initially	**Improvement notation**	Higher rates indicate poorer quality
Origin of Measure	Beacon-CSI-RI Modifications done in accordance with the Beacon-CSI-RI working group consensus.		
Measure description	Number of hospital admissions per 1,000 member months, excluding any admissions for pregnancy, mental health, or chemical dependency services in adults ages 18 years and older.		
References	https://www.bluecrossma.com/staticcontent/npi_docs/UB_04FormLocator Appendices.pdf Beacon-CSI-RI Phase 1 Utilization and Cost Metrics—Proposed Health Plan Reporting Specifications		
Release Notes/ Summary of Changes	V2: Clarified that exclusion for mental health purposes or the visit is related to chemical dependency is based upon principal diagnosis. Added exclusion for dental-related visits. V3: Removed text “except where the end date of coverage in the quarter is the date of death” for denominator exclusions.		

[7] Specifications for Beacon-CSI-RI use do not have these exclusions.
[8] Specifications for Beacon-CSI-RI use do not have these exclusions.

Attachment E: Reporting Due Dates

Reports are due 15 days following the close of the reporting period.

Report	Report Due Date
Report 13	4/15/2012
Report 14	7/15/2012
Report 15	10/15/2012
Report 16	1/15/2013
Report 17	4/15/2013
Report 18	7/15/2013
Report 19	10/15/2013
Report 20	1/15/2014

Attachment F: Quality Partners of Rhode Island: "Hospital & Community Physician Best Practices"

Safe Transitions Project

COMMUNITY PHYSICIAN OFFICE BEST PRACTICES MEASURES[1]

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
1. Provide the Emergency Department (ED) with clinical information when referring patients for evaluation	ED	ED provided with clinical information at the time of patient referral	Medical record or electronic audit trail	Yes: Documentation of provision of clinical information by the referring physician's office either: • At the time of patient referral for ED evaluation, or • Within 1 hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician. No: No documentation of above	Inclusions: All patients referred for ED evaluation by their community physician Exclusions: Patients who are cared for by their community physician's office while in the ED	• Clinical information: Verbal or written information that includes the main reason for referral to the ED, expectation, problem list, medication list, and applicable labs or studies • Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • Patients referred for ED evaluation: Patients sent to the ED by their community physician or another clinician in their physician's office for further evaluation of a clinical problem that may or may not lead to inpatient admission. This can occur either from the office or following a phone call during which the physician office directed the patient to the ED. • Patients cared for by their community physician: Patients whose care is supervised/directed by their community physician while in the ED • Referring physician's office: A staff member or clinician at the community physician's office • Supported by community discussions, e.g., with the PCP Advisory Council at HEALTH

[1] Endorsements: Blue Cross & Blue Shield of Rhode Island; Leading Age Rhode Island; the Primary Care Physician Advisory Council, and the Rhode Island Health Center Association's Clinical Leadership Committee (pending RIHCA Board approval). Also included in the Chronic Care Sustainability Initiative (CSI) physician contracts.

This material was prepared by Quality Partners of Rhode Island (10SOW-RI—7.2-122011 - 796), the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Last update: 12/1/2011

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
2. Respond to time-sensitive ED and hospital clinical questions verbally, if needed	ED and Hospital	Outpatient staff member spoke to ED or hospital clinician about time-sensitive clinical questions, if needed	Medical record or electronic audit trail	Yes: Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred: • A direct call between the ED or hospital clinician and an outpatient staff member, or • A return phone call from an outpatient staff member within 1 hour of the ED or hospital clinician's phone call to the community physician's office. No: No documentation of above	Inclusions: All ED or hospital patients whose care requires ED or hospital clinician phone calls to the community physician's office for time-sensitive clinical conversations Exclusions: Patients: • Without a known PCP, or • Who are followed by their community physician's office while in the ED or hospital.	• Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting and is contacted by the ED or hospital • Direct call: A phone call during which the ED or hospital clinician is connected with an outpatient clinician who can answer clinical questions about the patient's care • Documentation: Included in the data source(s) • ED or hospital clinician: Physician, NP, PA, or nurse who care for the patient • Outpatient staff member: Clinical or clerical staff who can address the ED or hospital clinician's specific question • Return phone call: A phone response to a message from the ED or hospital clinician from an outpatient staff member who can answer clinical questions about the patient's care • Time-sensitive clinical question: Whether or not a patient's care "requires" a conversation and in what timeframe is a subjective determination left to the ED or inpatient clinician's discretion, with the understanding that outreach is intended to be limited to situations where information is needed to inform the patient's care. All patients whose ED or hospital clinician phones the community physician office are included in the metric. • May alert community physicians to "serious" decision-making (e.g., EOL discussions, significant status changes) and afford them the opportunity to go on-site to participate in discussions with their patient or patient's family, if desired by the physician and patient/family. • Supported by community discussions, e.g., with the PCP Advisory Council at HEALTH

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
3. Provide ED and hospital clinicians with access to outpatient clinical information, if needed	ED and Hospital	Community physician office provided ED or hospital clinician with clinical information, if needed	Medical record or electronic audit trail	Yes: Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request No: No documentation of above	Inclusions: All ED or hospital patients whose care requires ED or hospital clinician outreach to obtain outpatient clinical information. Exclusions: Patients: • Without a known PCP, or • Who are followed by their community physician's office while in the ED or hospital.	• Clinical information: Verbal or written information that includes the information requested by the ED/hospital and may include clinical complaint/problem, main reason for referral to the ED, expectation, problem list, medication list, and applicable labs or studies • Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • ED or hospital clinician: Physician, NP, PA, or nurse who care for the patient • Provision of clinical information: Provision of requested clinical information via email, phone, fax, or through remote access to medical record (e.g., ED or hospital clinician read-access to the community physician office's electronic medical record)

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
4. Confirm outpatient receipt of discharge information from the hospital (may be optional)	Community Physician	Community physician office confirmed receipt of hospital discharge information	Medical record or electronic audit trail	Yes: Documentation of the community physician office's confirmation of receipt of hospital discharge information No: No documentation of above	Inclusions: All hospital patients Exclusions: Patients who: • Are followed by their community physician while in the ED or hospital, or • Are discharged to acute care, long-term care, or skilled nursing.	• Confirmed receipt: Written documentation in the medical record or electronic audit trail that the community physician office has confirmed its receipt of the discharge information • Discharge information: In accordance with the Hospital Discharge Best Practices, the hospital is required to provide of one of the following within one business day of hospital discharge: ○ A Continuity of Care Form that includes a brief narrative of the hospital visit in the "clinician comments" section, ○ A Continuity of Care Form, plus a verbal hand-off, or ○ A draft Discharge Summary or final Discharge Summary, if completed within two days of discharge For the purpose of this measure, physician offices should confirm the receipt of the Continuity of Care Form or Discharge Summary (draft or final). • Documentation: Included in the data source(s) • Evidence base includes Project BOOST and NQF-endorsed Safe Practice (SP-15). Note that both of which are written from the hospital perspective, not the community physician office's perspective.

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
5. Outreach to high-risk patients via phone after ED or hospital discharge	Patient	High-risk patients contacted via phone after ED or hospital discharge	Medical record or electronic audit trail	Yes: Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital No: No documentation of above	Inclusions: All ED or hospital patients who are characterized as high-risk Exclusions: Patients who: • Are followed by their community physician's office while in the ED or hospital, • Are discharged to acute care, long-term care, or skilled nursing, • Refuse a follow-up phone call, or • Have an outpatient follow-up appointment within 72 hours of ED or hospital discharge	• Documentation: Included in the data source(s) • Follow-up phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up • High-risk patients: Patients with one or more of the following: ○ Age 80 years or older, ○ A diagnosis of cancer, chronic obstructive pulmonary disease, or congestive heart failure, ○ Polypharmacy (8+ medications), or ○ A hospitalization in the previous 6 months. • Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office • Evidence base includes Project BOOST; also supported by community discussions, e.g., with the PCP Advisory Council at HEALTH. There was no consensus from community physicians on whether or not this should occur with 100% of ED visits (e.g., education for improper ED use as well as appropriate follow-up).

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
6. Conduct follow-up visit with patients discharged from the hospital to the community	Patient	Follow-up visit conducted after patient discharge from the ED or hospital	Medical record or electronic audit trail	Yes: Documentation of one of the following: • An outpatient clinician phone call to the patient, family, or caregiver within 3 business days of discharge, or • A follow-up appointment scheduled within 14 days of discharge, unless otherwise documented in the medical record. No: No documentation of above	Inclusions: All hospital patients Exclusions: Patients who: • Are followed by their community physician's office while in the hospital, • Are discharged to acute care, long-term care, or skilled nursing, or • Refuse a follow-up phone call and appointment.	• Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • Follow-up appointment scheduled: A community physician office visit scheduled either by the ED/hospital or the community physician's office • Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office • Outpatient follow-up: A phone call or office visit with an outpatient clinician from the community physician's office • Phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up • Evidence base includes the Care Transitions Intervention (CTI) Model, Project BOOST, RED Education, NQF-endorsed Safe Practice (SP-15), and the Commonwealth Fund's "Health Care Leader Action Guide to Reduce Avoidable Readmissions"

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
7. Perform outpatient medication reconciliation for patients discharged from the ED or hospital to the community	Patient	Medication reconciliation performed after ED or hospital discharge	Medical record or electronic audit trail	Yes: Documentation of an outpatient clinician performing medication reconciliation within 14 days of ED or hospital discharge, either: • In-person at the community physician's office, or • Via phone by an outpatient clinician or CNA. And providing a copy to the patient, family, or caregiver. No: No documentation of above	Inclusions: All ED or hospital patients Exclusions: Patients who are discharged to acute care, long-term care, or skilled nursing	• Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • Medication reconciliation: The process of the community physician's office reviewing the patient's complete discharge medication regimen and comparing it with previous medications to ensure there are no inadvertent inconsistencies • Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office • Evidence base includes the Care Transitions Intervention (CTI) Model, RED Education, and NQF-endorsed Safe Practice (SP-15)

Attachment G: Colorado Primary Care - Specialty Care Compact & "American College of Physicians Council of Subspecialty Societies (CSS) Patient-Centered Medical Home (PCMH)

Colorado Primary Care - Specialty Care Compact

I. Purpose

- *To provide optimal health care for our patients.*
- *To provide a framework for better communication and safe transition of care between primary care and specialty care providers.*

II. Principles

- *Safe, effective and timely patient care is our central goal.*
- *Effective communication between primary care and specialty care is key to providing optimal patient care.*
- *Mutual respect is essential to building and sustaining a professional relationship and working collaboration.*
- *A high functioning medical system of care provides patients with access to the right care at the right time in the right place.*

III. Definitions

- *Generalist – a primary care physician (PCP) whose broad medical knowledge provides first contact, comprehensive and continuous medical care to patients across a lifetime.*
- *Specialist – a physician with advanced, focused knowledge and skills who provides care for patients with complex problems in a specific organ system, class of diseases or type of patient.*
- *Prepared Patient – an informed and activated patient who has an adequate understanding of their present health condition in order to participate in medical decision making and self-management.*
- *Transition of Care – an event that occurs when the medical care of a patient is assumed by another medical provider or facility such as a consultation or hospitalization.*

- *Technical Procedure – transfer of care to obtain a clinical procedure for diagnostic, therapeutic, or palliative purposes.*

- *Patient-Centered Medical Home –a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.*

- *Medical Neighborhood – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.*

Types of Care Management Transition

- *Pre-consultation exchange – communication between the generalist and specialist to:*

    1. *Answer a clinical question and/or determine the necessity of a formal consultation.*

    2. *Facilitate timely access and determine the urgency of referral to specialty care.*

    3. *Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.*

- *Formal Consultation (Advice) – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the generalist after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.*

- *Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network) – due to the complex nature of the disorder or consuming illness that affects*

multiple aspects of the patient's health and social function, the specialist assumes the total care of the patient and provides first contact, ready access, continuous care, comprehensive and coordinated medical services with links to community resources as outlined by the "Joint Principles" and meeting the requirements of NCQA PPC-PCMH recognition.

- *Co-management – where both primary care and specialty care providers actively contribute to the patient care for a medical condition and define their responsibilities including first contact for the patient, drug therapy, referral management, diagnostic testing, patient education, care teams, patient follow-up, monitoring, as well as, management of other medical disorders.*
  - *Co-management with Shared management for the disease -- the specialist shares long-term management with the primary care physician for a patient's referred condition and provides expert advice, guidance and periodic follow-up for one specific condition. Both the PCMH and specialty practice are responsible to define and agree on mutual responsibilities regarding the care of the patient. In general, the specialist will provide expert advice, but will not manage the condition day to day.*
  - *Co-management with Principal care for the disease (Referral) – the specialist assumes responsibility for the long-term, comprehensive management of a patient's referred medical/surgical condition. The PCMH continues to receive consultation reports and provides input on secondary referrals and quality of life/treatment decision issues. The generalist continues to care for all other aspects of patient care and new or other unrelated health problems and remains the first contact for the patient.*
    - *Consuming illness – this is a subset of referral when for a limited time due to the nature and impact of the disease, the specialist practice becomes first contact for care until the crisis or*

treatment has stabilized or completed. The PCMH remains active in bi-directional information, providing input on secondary referrals and other defined areas of care.

- *Emergency care – medical or surgical care obtained on an urgent or emergent basis.*

IV. Mutual Agreement for Care Management

- Review tables and determine which services you can provide.
- The *Mutual Agreement* section of the tables reflect the core elements of the PCMH and Medical Neighborhood and outline expectations from both primary care and specialty care providers.
- The *Expectations* section of the tables provide flexibility to choose what services can be provided depending in the nature of your practice and working arrangement with PCP or specialist.
- The *Additional Agreements/Edits* section provides an area to add, delete or modify expectations.
- After appropriate discussion, the representative provider checks each box that applies to the commitment of their practice.
- When patients self-refer to specialty care, processes should be in place to determine the patient's overall needs and reintegrate further care with the PCMH, as appropriate.
- The agreement is waived during emergency care or other circumstances that preclude following these elements in order to provide timely and necessary medical care to the patient.
- Upon signing this agreement, each provider should agree to an open dialogue to discuss and correct real or perceived breaches of this agreement, as well as, the format and venue of this discussion.
- This agreement is effective for 2 years and then should be renewed.

Colorado Primary Care - Specialty Care Compact

Transition of Care	
Mutual Agreement	
• Maintain accurate and up-to-date clinical record. • Agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD] • Ensure safe and timely transfer of care of a prepared patient	
Expectations	
Primary Care	Specialty Care
☐ PCP maintains complete and up-to-date clinical record including demographics. ☐ Transfers information as outlined in Patient Transition Record. ☐ Orders appropriate studies that would facilitate the specialty visit. ☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit ☐ Provides patient with specialist contact information and expected timeframe for appointment.	☐ Determines and/or confirms insurance eligibility ☐ Provides single source referral contact person ☐ When needed, be ready to communicate with the PCP prior to the appointment to assist in the preparation of patient and appropriate pre-referral work-up

Additional agreements/edits: _____

_____

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Colorado Primary Care - Specialty Care Compact

Access	
Mutual Agreement	
• Be readily available for urgent help to both the physician and patient via phone or e-mail. • Provide visit availability according to patient needs. • Be prepared to respond to urgencies. • Offer reasonably convenient office facilities and hours of operation. • Provide alternate back-up when unavailable for urgent matters.	
Expectations	
Primary Care	Specialty Care
☐ Communicate with patients who "no-show" to specialists. ☐ Determines reasonable time frame for specialist appointment. ☐ Provide a secure email option for communication with patient and specialist.	☐ Notifies PCP of 'no-shows' ☐ Provides visit availability according to patient needs. ☐ Be available to the patient for questions to discuss the consultation. ☐ Schedule first patient appointment with physician. ☐ Be available to PCP for pre-consultation exchange by phone and/or secure email. ☐ Provide a secure email option for communication with patient and provider. ☐ Provides PCP with list of practice physicians who agree to compact principles.

Additional agreements/edits: _____

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Colorado Primary Care - Specialty Care Compact

Collaborative Care Management

Mutual Agreement

- Define responsibilities between PCP, specialist and patient.
- Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up).
- Maintain competency and skills within scope of work and standard of care.
- Give and accept respectful feedback when expectations, guidelines or standard of care are not met
- Agree on type of specialty care that best fits the patient's needs.

Expectations

Primary Care	Specialty Care
☐ Follows the principles of the Patient Centered Medical Home or Medical Home Index. ☐ Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills. ☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. ☐ Reviews and acts on care plan developed by specialist. ☐ Resumes care of patient when patient returns from specialist care. ☐ Explains and clarifies results of consultation, as needed, with the patient. Makes agreement with patient on long-term treatment plan and follow-up.	☐ Reviews information sent by PCP ☐ Addresses referring provider and patient concerns. ☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. ☐ Confers with PCP or establishes other protocol before refers to secondary or tertiary specialists. Obtains proper prior authorization. ☐ Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions. ☐ Notifies the PCP of major interventions, emergency care or hospitalizations. ☐ Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs. ☐ Provides useful and necessary education/guidelines/protocols to PCP, as needed

Additional agreements/edits: _____

_____

Colorado Primary Care - Specialty Care Compact

Patient Communication	
Mutual Agreement	
• Engage and utilize a secure electronic communications platform for high risk patients such as ReachMyDoctor or CORHIO. • Prepare the patient for transition of care. • Consider patient/family choices in care management, diagnostic testing and treatment plan. • Provide to and obtain informed consent from patient according to community standards. • Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team.	
Expectations	
Primary Care	Specialty Care
☐ Informs patient of the reason for care transfer and expectations. ☐ Determines appropriate time frame for visit to specialist. ☐ Provides specialist name and contact information. ☐ Explains specialist results and treatment plan to patient, as necessary. ☐ Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team.	☐ Informs patient of diagnosis, prognosis and follow-up recommendations. ☐ Provides educational material and resources to patient. ☐ Recommends appropriate follow-up with PCP. ☐ Will be accountable to address patient phone calls/concerns regarding their management. ☐ Participates with patient care team.

Additional agreements/edits: _____

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Colorado Primary Care - Specialty Care Compact

V. Appendix

- **PCP Patient Transition Record**

1. **Practice details – PCP, PCMH level, contact numbers (regular, emergency)**
2. **Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation and contact information.**
3. **Communication preference – phone, letter, fax or e-mail**
4. **Diagnosis -- ICD-9 code**
5. **Query/Request – a clear clinical reason for patient transfer and anticipated goals of care and interventions.**
6. **Clinical Data --**
   - **problem list**
   - **medical and surgical history**
   - **current medication**
   - **immunizations**
   - **allergy/contraindication list**
   - **care plan**
   - **relevant notes**
   - **pertinent labs and diagnostics tests**
   - **patient cognitive status**
   - **caregiver status**
   - **advanced directives**
   - **list of other providers**
7. **Type of transition of care.**
8. **Visit status -- routine, urgent, emergent (specify time frame).**
9. **Follow-up request**

PCP	Date	Date	Initial	Date	Initial
Specialist	Date	Date	Initial	Date	Initial

Colorado Primary Care - Specialty Care Compact

- **Specialist Patient Transition Record**

1. Practice details – Specialist name, contact numbers (regular, emergency)
2. Patient demographics -- Patient name, identifying and contact information, insurance information, PCP designation.
3. Communication preference – phone, letter, fax or e-mail
4. Diagnoses (ICD-9 codes)
5. Clinical Data – problem list, medical/surgical history, current medication, labs and diagnostic tests, list of other providers.
6. Recommendations – communicate opinion and recommendations for further diagnostic testing/imaging, additional referrals and/or treatment. Develop an evidence-based care plan with responsibilities and expectations of the specialist and primary care physician that clearly outline:
    1. new or changed diagnoses
    2. medication or medical equipment changes, refill and monitoring responsibility.
    3. recommended timeline of future tests, procedures or secondary referrals and who is responsible to institute, coordinate, follow-up and manage the information.
    4. secondary diagnoses.
    5. patient goals, input and education provided on disease state and management .
    6. care teams and community resources.
7. Technical Procedure – summarize the need for procedure, risks/benefits, the informed consent and procedure details with timely communication of findings and recommendations.
8. Follow-up status – Specify time frame for next appointment to PCP and specialist. Define collaborative relationship and individual responsibilities.
    1. Consultation
    2. Co-management
        - Principal care
        - Shared care
    3. Specialty Medical Home Network (complete transition of care to specialist practice)
    4. Technical procedure

PCP	Date	Date	Initial	Date	Initial
Specialist	Date	Date	Initial	Date	Initial

Colorado Primary Care - Specialty Care Compact

References

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- Primary Care – Specialty Care Master Service Agreement CPMG - Kaiser Permanente. June 2008
- Care Coordination and Care Collaboration between PCP and Specialty Care template from TransforMed Delta Exchange
- Coordination Model: PCP to Specialist process map– from Johns Hopkins Bloomberg School of Medicine. The development and testing of EHR-based care coordination performance measures in ambulatory care (current study).
- Direct Referrals Model - Quality Health Network communication
- Principles of Service Agreements for PCMH and PCMH-N, American College of Physicians internal document 10-09.
- Dropping the Baton: Exploring what can go wrong during patient handoffs and reducing the risk. COPIC Insurance Company. Sept 2009 (151)

Attachment H: Per-Member-Per-Month Payment Grid

	Developmental Stage	PMPM Rates by contract year	Requirements
Stage 1 (max 1 yr)	Start up	$3.00 base $2.50 NCM **Max: $5.50**	Target 1: Practice must Hire NCM; establish compacts (4); create and implement an afterhours plan; achieve NCQA level 1 and engage in practice transformation Target 2: Establish quality data reporting for harmonized measures Target 3: Practice implements interventions to reduce ED visits and IP admissions
Stage 2 (max 1 yr)	Transition	$3.00 Base $2.50 NCM $0.50 to measure **Max:$6.00**	Target 1: All structural components in place and achieve NCQA level 2 Target 2: Quality data is stable; baseline established; practice is working to achieve quality benchmarks; Target 3: Focus interventions to reduce ED visits and IP admissions.
Stage 3	Performance I	$3.00 base $2.50 NCM $0.50 $0.50 $0.50 $0.50 **Max: $7.50**	**Target 1:** all structural requirements in place and achieve NCQA level 3 (if not achieved base is reduced by $0.50) **Target 2a:** Achieve 4 out of 7 quality benchmarks; **Target 2b**: Achieve top box score of 53% on "Access" and either 80% on "Communication" or 72% "Office Staff" **PCMH CAHPS** **Target 3a:** All-Cause Inpatient admissions **Target 3b:** All-Cause ED
Stage 4	Performance II	$3.00 base $2.50 NCM $0.50 $0.25 $0.50 $1.25 $0.75 **Max: $8.75**	**Target 1:** structure in place and maintain NCQA level 3 if not maintained base is reduced by $0.50) **Target 2a:** Achieve 4 out of 7 If achieve 6 out of 7 quality benchmarks **Target 2b:** Achieve top box score of 53% on "Access" and either 80% on "Communication" or 72% "Office Staff" **PCMH CAHPS** **Target 3a:** All-Cause Inpatient Admissions (5%) **Target 3b:** All-Cause ED (7.5%)

Attachment I: CSI-RI Committee Structure

CSI-RI Project Management maintains a list of chairpersons for and is ultimately accountable for the maintenance and continued operation of each committee.

Steering Committee
Charge: Responsible for strategic direction and overall governance of the project
Membership: Open to all interested in PCMH practice transformation in Rhode Island

Executive Committee
Charge: Make recommendations to the Steering Committee regarding the strategic direction and overall governance of the project.
Membership: Committee members only

Practice Transformation Committee
Charge: Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice based coaching and technical assistance. Serve as liaison to other committees and external organizations; and supports workforce development for PCMH. Committee is tasked with deploying resources to practices for items such as practice coaching, NCM training and NCQA application assistance.
Membership: Open to all practices interested in PCMH transformation

Data and Evaluation Committee
Charge: lead performance improvement, measure selection and harmonization, develop goals and benchmarks, evaluation, research, liaison with the APCD, and serve as liaison between committees
Members: CSI-RI practice representatives and committee members only

Practice Reporting Committee
Charge: Review practice data quarterly, perform data validation, public reporting via CSI-RI web portal, support quarterly performance improvement and data sharing meetings with practice staff, assist with EMR/IT issues where possible, and serve as liaison to other CSI-RI committees.
Members: CSI-RI practice representatives and committee members only

Contracting Committee
Charge: Contracting Development, attribution, alternate payment models, PCMH as part of a delivery system. Serve as liaison to other committees.
Membership: Committee members only

Service Expansion Committee
Charge: Lead, partner, or participate with appropriate stakeholders and organizations to develop additional service capabilities for CSI-RI PCMHs, include special populations, behavioral health, hospital transitions, CSI-RI Kids, oral health, alignment with other programs. Serve as liaison to other committees.
Membership: TBD

Marketing and Communications Subcommittee
Charge: Increase awareness and demand for PCM, support patient advisory group, increase patient awareness and participation in PCMH practices, serve as liaison to other committees.
Membership: TBD

Patient Advisory Subcommittee
Charge: Serve as the voice of the patient and family in PCMH; advise Steering committee and inform Executive Committee in program development.
Membership: TBD

Contract Scenarios

		Start-up 10/01/13 – Start-up 04/01/14	Start-up 10/01/13 – Transition 04/01/14	Transition 10/01/13 – Transition 4/1/14	Transition 10/01/13 -- Performance 1 04/01/14	Notes
Contract Terms		Start-Up 10/1/13 – 3/31/15 Transition 4/1/15 – 3/31/16 Performance I 4/1/16 – 3/31/17 Performance II 4/1/17 – 3/31/18	Start-Up 10/1/13 – 3/31/14 Transition 4/1/14 – 3/31/15 Performance I 04/1/15 – 3/31/16 Performance II 4/1/16 – 3/31/17	Transition 10/1/13 – 3/31/15 Performance I 4/1/15 – 3/31/16 Performance II 4/1/16 – 3/31/17	Transition 10/1/13 – 3/31/14 Performance I 4/1/14 – 3/31/15 Performance II 4/1/15 – 3/31/16	
First decision on movement between contract levels		02/28/15	02/28/14	2/28/15	02/28/14	
Target 1: Structural	Nurse Care Manager hired/retained	12/31/13	12/31/13	12/31/13	12/31/13	Please notify Michael.Mobilio@umassmed.edu
	NCQA recognition[1]	Level 2 or higher by 02/28/15	Level 2 or higher by 02/28/14	Level 3 by 02/28/15	Level 3 by 02/28/14	
	Compacts with Specialists[2]	1compact due 12/31/13 3 (total) due 03/31/14 4 (total) due 06/30/14	1 compact due 12/31/13 4 (total) due 02/28/14	1 compact due 12/31/13 4 (total) due 03/31/14	1 compact due 12/31/13 4 (total) due 02/28/14	Please send to Michael.Mobilio@umassmed.edu
	After-hours protocol in place[3]	03/31/14	02/28/14	03/31/14	02/28/14	Please send to Michael.Mobilio@umassmed.edu
	Attest to compliance with outpatient transitions best practice policy[4]	02/28/15	02/28/14	11/30/13	11/30/13	Please send to Michael.Mobilio@umassmed.edu
Target 2: Quality	First Required Quarterly Submission of Clinical Quality Measures (minimal look back period)[5]	**Due 4/15/14** Q1 '14: (10/1/13 – 3/31/14)	**Due 01/15/14** Q4 '13: (1/1/13-12/31/13)	**Due 01/15/14** Q3 '13: (10/1/12- 9/30/13) Q4 '13: (1/1/13-12/31/13)	**Due 01/15/14** Q1 '13: (4/1/12-03/31/13) Q2 '13: (7/1/12-06/30/13) Q3 '13: (10/1/12- 9/30/13) Q4 '13: (1/1/13-12/31/13)	Template for reporting will be sent to practices. Complete and return to Marie Sarrasin (MSarrasin@riqi.org)

Contract Scenarios

		Start-up 10/01/13 – Start-up 04/01/14	Start-up 10/01/13 – Transition 04/01/14	Transition 10/01/13 – Transition 4/1/14	Transition 10/01/13 -- Performance 1 04/01/14	Notes
	Baseline Period for Clinical Quality Measures in Performance Year I	Q1 2015 (4/1/14-03/31/15)	Q1 2014 (4/1/13-03/31/14)	Q1 2014 (4/1/13-03/31/14)	Q1 2013 (4/1/12-03/31/13)	
	Earliest eligibility for transition year Incentive of $0.50 PMPM for stable data report	Q2 2015	Q2 2014	Q1 2014 (if data submittal 1/15/14 deemed stable)	Q1 2014 (if data submittal 1/15/14 deemed stable)	
	CAHPS-PCMH Patient Experience Survey	Patient List pulled Dec 2013 Survey administered Jan 2014	Patient List pulled Dec 2013 Survey administered Jan 2014	Patient List pulled Dec 2013 Survey administered Jan 2014	Patient List pulled Dec 2013 Survey administered Jan 2014	Practices to be contacted by vendor prior to due date to pull list.
Target 3: Utilization	First Opportunity for Incentive Payment on Utilization Benchmark	Performance 1 Q2 2016	Performance 1 Q2 2015	Performance 1 Q2 2015	Performance 1 Q2 2014	All utilization data derived from CSI Claims Database
	Cohort	TBD	TBD	TBD	TBD	Utilization metric performance adjudicated on aggregate groupings
"Rules" related to Developmental Contract		Payment rate $5.50 PMPM Q2 2014 minimal reporting look back period from 10/1/13 – 6/30/14	Payment rate $5.50 PMPM for Start-up and Transition. Up to $6.00 in Transition if data deemed stable by Q2 2014.	Payment rate $5.50 PMPM and goes up to $6.00 if data deemed stable by Q1 2014.	Payment rate $5.50 PMPM and goes up to $6.00 if data deemed stable by Q1 2014. Eligible for Performance 1 incentives by 4/1/14 based on performance as reported Q1 2014 (4/1/13-3/31/14)	All prerequisites must be met prior to enactment of contract

1. In order for a practice to meet Transition Level, the practice must attain Level 2 NCQA. In order for a practice to meet Performance 1, the practice must attain NCQA Level 3.
2. One of the four compacts must be with a hospitalists or hospitalist group unless practice provides inpatient care
3. Must be in place prior to moving to Transition or Performance 1 or within six months of the contract start date, whichever is sooner.
4. Must be in place prior to moving to Transition or at the end of one contract year, whichever is sooner. Practices entering at Transition must meet within 60 days of contract start date.
5. In order for a practice to move from Start-up to Transition, the practice must have 1 data submittal of 12 months of data. In order for a practice in Transition to get the $0.50 PMPM incentive, they must report two consecutive quarters of data. In order for the practice to move to Performance 1, the practice must have 2 consecutive submittals of 12 months of data that are deemed data stable/valid by Practice Reporting/CSI. Practice may submit earlier than the first required submittal. Practices will begin reporting on new measures in Q1 2014 (report due 4/15/14).

2013 CSI-RI PMPM Rate Sheet

	Developmental Stage	PMPM Rates by contract year	Requirements
Stage 1 (max 1 yr)	Start up	$3.00 base $2.50 NCM **Max: $5.50**	Target 1: Practice must Hire NCM; establish compacts (4); create and implement an afterhours plan; achieve NCQA level 1 and engage in practice transformation Target 2: Establish quality data reporting for harmonized measures Target 3: Practice implements interventions to reduce ED visits and IP admissions
Stage 2 (max 1 yr)	Transition	$3.00 Base $2.50 NCM $0.50 **Max:$6.00**	Target 1: All structural components in place and achieve NCQA level 2 Target 2: Quality data is stable; baseline established; practice is working to achieve quality benchmarks; Target 3: Focus interventions to reduce ED visits and IP admissions.
Stage 3	Performance I	$3.00 base $2.50 NCM i. $0.50 ii. $0.50 iii. $0.50 iv. $0.50 **Max: $7.50**	**Target 1:** all structural requirements in place and achieve NCQA level 3 (if not achieved base is reduced by $0.50) i. **Target 2a:** Achieve 4 out of 7 quality benchmarks; ii. **Target 2b**: Achieve top box score of 53% on "Access" and either 80% on "Communication" or 72% "Office Staff" **PCMH CAHPS** iii. **Target 3a:** All-Cause Inpatient admissions iv. **Target 3b:** All-Cause ED
Stage 4	Performance II	$3.00 base $2.50 NCM i. $0.50 ii. $0.25 iii. $0.50 iv. $1.25 v. $0.75 **Max: $8.75**	**Target 1:** structure in place and maintain NCQA level 3 if not maintained base is reduced by $0.50) i. **Target 2a:** Achieve 4 out of 7 quality benchmarks ii. **Target 2a:** Achieve 6 out of 7 quality benchmarks iii. **Target 2b:** Achieve top box score of 53% on "Access" and either 80% on "Communication" or 72% "Office Staff" **PCMH CAHPS** iv. **Target 3a:** All-Cause Inpatient Admissions (5%) v. **Target 3b:** All-Cause ED (7.5%)

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Summary of Target 1 of the Developmental Contract

Practices will agree to un-blinded, public reporting of approved performance metrics on the PCMHRI website, amongst the CSI-RI community.

Target #1 Process Improvement (Practice Metric): Practice will demonstrate to the Plan's satisfaction successful implementation and maintenance of the following Process Improvement metrics:

a. After Hours Policy: Practice will submit to CSI-RI Management the After Hours Protocol and Plan for Monitoring Performance. The protocol for the Practice will include: the strategy for accessing weekends, holidays & extended hours of care, location, hour of operations, and protocols outlining how the Practice's Eligible Subscribers can access care from these sites as an alternative to emergency room care. CSI-RI Management will submit the protocols and plans to the CSI-RI Executive Committee for review and approval. The approved After Hours Program must be in operation no later than March 31, 2014. Sample After Hour's Policy provided.

b. Hospital Outpatient Transition Best Practices Policy: Practice will attest to compliance with transitions to care policy by the end of Start-Up Year. Healthcentric Advisor's "Community Physician Office Best Practice Measures" provided.

c. Compacts with High Volume Specialists: Practice will establish compacts such that one (1) compact is established and approved by the Plan by Dec 31, 2013. Two (2) additional compacts are established by the Practice and approved by the Plan March 31, 2014 and a total of no less than four (4) compacts with four (4) different specialties shall be established by June 30, 2014 and maintained for the term of the Developmental Contract. One of the compacts must be with a hospitalist or hospitalist group unless the Practice provides inpatient care for all of the Practice's Eligible Subscribers at the Practice's primary hospital. Eligible Subscribers receive inpatient services.

d. If structural items (a-c) are not achieved or maintained, during any level of practice transformation, the Practice will work with CSI-RI Management to make a plan for completion within six (6) months. If not completed within six (6) months, continued participation in the CSI-RI Project shall be reviewed and determined by voting members of the CSI-RI Executive Committee.

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Sample After Hours Care Policy

Policy A: After Hours Phone Calls
If a patient calls outside of office hours, they will be directed to the answering service for the on-call physician. On-call coverage will be scheduled by the PCPs and communicated to the answering service. This schedule will provide availability 24 hours per day, 7 days per week. The on-call physician will return phone calls within 1 hour.

Policy B: Office Closed
All Calls received after hours are answered by the practice answering service.

1. Non-Emergency calls:
   The answering service will page the on-call physician to recite or text page the patient message. If the physician does not reply to the answer service within the hour, the answering service will page th physician every 30 minutes until the physician returns the call to the answering service. After the on-call physician retrieves the message from the answering service, the physician will return the call to the patient service in a timely fashion according to the patient's medical need
2. The answering service must refer the patients to 911 and page the on call physician

Policy C:
Practice C provides care; treatment and services to patients based on the patient's identified needs as chartered by our identified scope of services.
Practice C maintains extended office hours during weeknights and weekends, both for our call center and clinical care. Patients have 24 hour access to telephone triage either through clinical staff assigned to work during those hours or through the on call coverage system. A patient can call to book an appointment or to obtain telephonic clinical advice. In addition, Practice C provides after hours office visits.
Calls received at Practice C outside of these extended hours or on holidays will be automatically forwarded to our external call center. This call center operates 24x7, 365 days a year. Upon receipt of a patient's call the On-Call Provider is contacted to assess and respond to patient needs. For utilization of patient assessment the on call provider has access to the patient's electronic health record remotely. Assessment findings and clinical advice are documented in the clinical record within 72 hours of the interaction

Purpose: To ensure that all Practice C patients can access the clinician and care team for routine and urgent care needs after hours.

On Call Service and On Call Provider answering after hours calls
1. After-hours patient calls are forwarded to the external answering service, whose staff pages the on-call Practice C provider. The answering service instructs the patient to call back if they are not contacted by the provider within 30 minutes. If the provider fails to respond, the answering service will repeat the pages and calls, escalating to the site's Practice Manager if necessary.
2. The answering service supports all major languages spoken by Practice C patients.
3. The on-call provider may review the patients electronic health record remotely and will contact the patient and assesses whether to take any or all of the following actions:
Provide telephonic advise, prescribing as appropriate and/or
Refer patient to emergency room or urgent care
Ask patient to come to Practice C at next available time for assessment/treatment
4. The Practice C provider or designated staff records the details of the phone contact, in the Electronic Health Record within 72 hours of the encounter.

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Safe Transitions Project

COMMUNITY PHYSICIAN OFFICE BEST PRACTICES MEASURES[1]

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
1. Provide the Emergency Department (ED) with clinical information when referring patients for evaluation	ED	ED provided with clinical information at the time of patient referral	Medical record or electronic audit trail	Yes: Documentation of provision of clinical information by the referring physician's office either: • At the time of patient referral for ED evaluation, or • Within 1 hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician. No: No documentation of above	Inclusions: All patients referred for ED evaluation by their community physician Exclusions: Patients who are cared for by their community physician's office while in the ED	• Clinical information: Verbal or written information that includes the main reason for referral to the ED, expectation, problem list, medication list, and applicable labs or studies • Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • Patients referred for ED evaluation: Patients sent to the ED by their community physician or another clinician in their physician's office for further evaluation of a clinical problem that may or may not lead to inpatient admission. This can occur either from the office or following a phone call during which the physician office directed the patient to the ED. • Patients cared for by their community physician: Patients whose care is supervised/directed by their community physician while in the ED • Referring physician's office: A staff member or clinician at the community physician's office • Supported by community discussions, e.g., with the PCP Advisory Council at HEALTH

[1] Endorsements: Blue Cross & Blue Shield of Rhode Island; Leading Age Rhode Island; the Primary Care Physician Advisory Council, and the Rhode Island Health Center Association's Clinical Leadership Committee (pending RIHCA Board approval). Also included in the Chronic Care Sustainability Initiative (CSI) physician contracts.

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
2. Respond to time-sensitive ED and hospital clinical questions verbally, if needed	ED and Hospital	Outpatient staff member spoke to ED or hospital clinician about time-sensitive clinical questions, if needed	Medical record or electronic audit trail	Yes: Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred: • A direct call between the ED or hospital clinician and an outpatient staff member, or • A return phone call from an outpatient staff member within 1 hour of the ED or hospital clinician's phone call to the community physician's office. No: No documentation of above	Inclusions: All ED or hospital patients whose care requires ED or hospital clinician phone calls to the community physician's office for time-sensitive clinical conversations Exclusions: Patients: • Without a known PCP, or • Who are followed by their community physician's office while in the ED or hospital.	• Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting and is contacted by the ED or hospital • Direct call: A phone call during which the ED or hospital clinician is connected with an outpatient clinician who can answer clinical questions about the patient's care • Documentation: Included in the data source(s) • ED or hospital clinician: Physician, NP, PA, or nurse who care for the patient • Outpatient staff member: Clinical or clerical staff who can address the ED or hospital clinician's specific question • Return phone call: A phone response to a message from the ED or hospital clinician from an outpatient staff member who can answer clinical questions about the patient's care • Time-sensitive clinical question: Whether or not a patient's care "requires" a conversation and in what timeframe is a subjective determination left to the ED or inpatient clinician's discretion, with the understanding that outreach is intended to be limited to situations where information is needed to inform the patient's care. All patients whose ED or hospital clinician phones the community physician office are included in the metric. • May alert community physicians to "serious" decision-making (e.g., EOL discussions, significant status changes) and afford them the opportunity to go on-site to participate in discussions with their patient or patient's family, if desired by the physician and patient/family. • Supported by community discussions, e.g., with the PCP Advisory Council at HEALTH

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
3. Provide ED and hospital clinicians with access to outpatient clinical information, if needed	ED and Hospital	Community physician office provided ED or hospital clinician with clinical information, if needed	Medical record or electronic audit trail	Yes: Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request No: No documentation of above	Inclusions: All ED or hospital patients whose care requires ED or hospital clinician outreach to obtain outpatient clinical information. Exclusions: Patients: • Without a known PCP, or • Who are followed by their community physician's office while in the ED or hospital.	• Clinical information: Verbal or written information that includes the information requested by the ED/hospital and may include clinical complaint/problem, main reason for referral to the ED, expectation, problem list, medication list, and applicable labs or studies • Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • ED or hospital clinician: Physician, NP, PA, or nurse who care for the patient • Provision of clinical information: Provision of requested clinical information via email, phone, fax, or through remote access to medical record (e.g., ED or hospital clinician read-access to the community physician office's electronic medical record)

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
4. Confirm outpatient receipt of discharge information from the hospital (may be optional)	Community Physician	Community physician office confirmed receipt of hospital discharge information	Medical record or electronic audit trail	Yes: Documentation of the community physician office's confirmation of receipt of hospital discharge information No: No documentation of above	Inclusions: All hospital patients Exclusions: Patients who: • Are followed by their community physician while in the ED or hospital, or • Are discharged to acute care, long-term care, or skilled nursing.	• Confirmed receipt: Written documentation in the medical record or electronic audit trail that the community physician office has confirmed its receipt of the discharge information • Discharge information: In accordance with the Hospital Discharge Best Practices, the hospital is required to provide of one of the following within one business day of hospital discharge: o A Continuity of Care Form that includes a brief narrative of the hospital visit in the "clinician comments" section, o A Continuity of Care Form, plus a verbal hand-off, or o A draft Discharge Summary or final Discharge Summary, if completed within two days of discharge For the purpose of this measure, physician offices should confirm the receipt of the Continuity of Care Form or Discharge Summary (draft or final). • Documentation: Included in the data source(s) • Evidence base includes Project BOOST and NQF-endorsed Safe Practice (SP-15). Note that both of which are written from the hospital perspective, not the community physician office's perspective.

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
5. Outreach to high-risk patients via phone after ED or hospital discharge	Patient	High-risk patients contacted via phone after ED or hospital discharge	Medical record or electronic audit trail	Yes: Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital No: No documentation of above	Inclusions: All ED or hospital patients who are characterized as high-risk Exclusions: Patients who: • Are followed by their community physician's office while in the ED or hospital, • Are discharged to acute care, long-term care, or skilled nursing, • Refuse a follow-up phone call, or • Have an outpatient follow-up appointment within 72 hours of ED or hospital discharge	• Documentation: Included in the data source(s) • Follow-up phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up • High-risk patients: Patients with one or more of the following: o Age 80 years or older, o A diagnosis of cancer, chronic obstructive pulmonary disease, or congestive heart failure, o Polypharmacy (8+ medications), or o A hospitalization in the previous 6 months. • Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office • Evidence base includes Project BOOST; also supported by community discussions, e.g., with the PCP Advisory Council at HEALTH. There was no consensus from community physicians on whether or not this should occur with 100% of ED visits (e.g., education for improper ED use as well as appropriate follow-up).

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
6. Conduct follow-up visit with patients discharged from the hospital to the community	Patient	Follow-up visit conducted after patient discharge from the ED or hospital	Medical record or electronic audit trail	Yes: Documentation of one of the following: • An outpatient clinician phone call to the patient, family, or caregiver within 3 business days of discharge, or • A follow-up appointment scheduled within 14 days of discharge, unless otherwise documented in the medical record. No: No documentation of above	Inclusions: All hospital patients Exclusions: Patients who: • Are followed by their community physician's office while in the hospital, • Are discharged to acute care, long-term care, or skilled nursing, or • Refuse a follow-up phone call and appointment.	• Community physician: PCP or specialist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • Follow-up appointment scheduled: A community physician office visit scheduled either by the ED/hospital or the community physician's office • Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office • Outpatient follow-up: A phone call or office visit with an outpatient clinician from the community physician's office • Phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up • Evidence base includes the Care Transitions Intervention (CTI) Model, Project BOOST, RED Education, NQF-endorsed Safe Practice (SP-15), and the Commonwealth Fund's "Health Care Leader Action Guide to Reduce Avoidable Readmissions"

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
7. Perform outpatient medication reconciliation for patients discharged from the ED or hospital to the community	Patient	Medication reconciliation performed after ED or hospital discharge	Medical record or electronic audit trail	Yes: Documentation of an outpatient clinician performing medication reconciliation within 14 days of ED or hospital discharge, either: • In-person at the community physician's office, or • Via phone by an outpatient clinician or CNA. And providing a copy to the patient, family, or caregiver. No: No documentation of above	Inclusions: All ED or hospital patients Exclusions: Patients who are discharged to acute care, long-term care, or skilled nursing	• Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting • Documentation: Included in the data source(s) • Medication reconciliation: The process of the community physician's office reviewing the patient's complete discharge medication regimen and comparing it with previous medications to ensure there are no inadvertent inconsistencies • Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office • Evidence base includes the Care Transitions Intervention (CTI) Model, RED Education, and NQF-endorsed Safe Practice (SP-15)

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South County Patient-Centered Medical Community/Specialty Compact

A) Purpose

- **To provide optimal health care for our patients.**
- **To provide a framework for highly effective collaboration between primary care and specialty care providers.**

B) Principles

- **High quality and timely patient care is our central goal.**
- **Effective communication between primary care and specialty care is an essential component to providing optimal patient care, including defining the responsibility of the primary care provider, specialist and patient.**

C) Definitions

- **Patient-Centered Medical Community (PCMC) – a collaboration of patient–centered medical homes and South County Hospital to ensure accessible, coordinated, comprehensive and continuous health care in the local community, using local resources when appropriate.**
- **Medical Neighborhood – a system of care that integrates the PCMC with the medical specialists in the community through enhanced, bidirectional communication and collaboration with and on behalf of the patient.**

Expectations for Primary Care and Specialty Practice	
Primary Care	**Specialty Care**
o Discuss the need, purpose and goals of specialty visit with the patient	o Have timely appointment availability to meet patient care needs
o Communicate need for referral and send relevant information to specialist (including labs, scans, progress notes)	o Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX and refills
o Schedules appointment with specialist or provide patient with contact information	o Informs patient and provider of diagnosis, prognosis, and follow-up recommendations
o Contacts specialist by phone for urgent problems and consultations. Transfers appropriate information as soon as possible	o Send consultation reports, lab reports, procedure notes and biopsy results to primary care provider in a timely manner
o Follow up with patients and coordinate care plan with specialist recommendations	o Discuss secondary referrals with the PCP, prior to referral
	o Notify PCP of deterioration in patient condition
	o Join the appropriate Health Information Exchange and open a direct account within 6-9 months

Patient-Centered Medical Community **Date**

Specialist(s) **Date**

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currentcare
A service of the Rhode Island Quality Institute

Helping CSI practices succeed as PCMHs

Jonathan Leviss, MD
Chief Medical Officer, RIQI
Physician, Thundermist Health Center

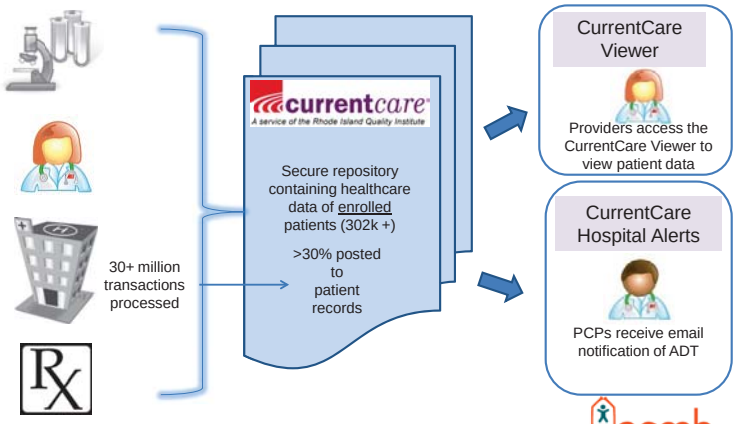
Some questions you might have…

- What is CurrentCare?
- Are any PCMH practices using CurrentCare?
- How do we enroll patients?
- Could CurrentCare help my practice and patients (WII-FM)?

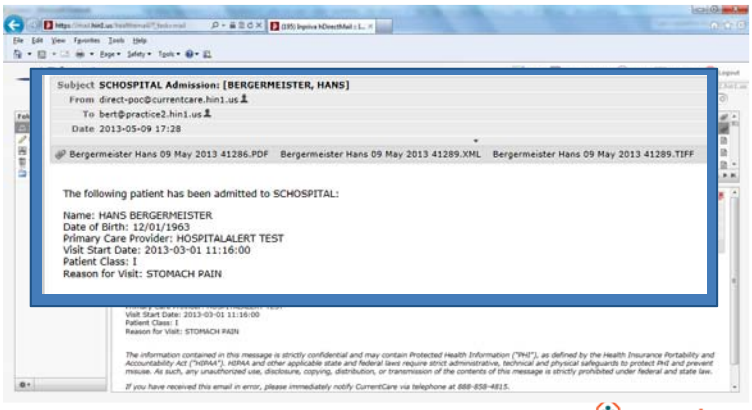
Why do PCMH's use CurrentCare?

Dr. David Fried
Coastal Medical—*an early adopter of CurrentCare*

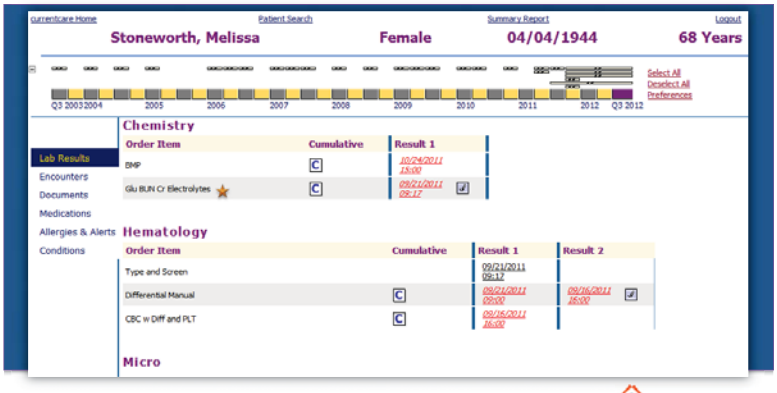
CurrentCare: connecting the knowledge in the system



What does a Hospital Alert look like?

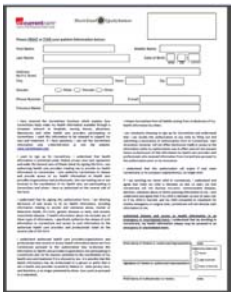


CurrentCare Viewer - Labs



CurrentCare Viewer - Medications

Enrollment—please don't skip the step



- Make it part of patient care
- Help everyone "own" enrollment
- Don't forget the voice of the provider

A perspective on Enrollment

Dr. Karen Blackmer
University Family Medicine—*an early adopter of CurrentCare*

Remember RIQI…

- CurrentCare resource
  - Viewer adoption
  - Hospital Alerts implementation
  - Enrollment assistance
- EHR adoption/MU resource
- PCMH quality metrics

currentcare®
A service of the Rhode Island Quality Institute

Nurse Care Manager Job Description

Reports To: CSI-RI Pilot Practice Site Physician
FLSA Status: Exempt

Description

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill and/or ability required for this position. Reasonable accommodations may be made, upon request, to enable individuals with disabilities, who otherwise meet the qualifications, to perform the essential functions of the position.

JOB SUMMARY

The Nurse Care Manager will have the opportunity to work on and promote team based -interdisciplinary healthcare in a primary care setting. He/she will be part of a pilot program charged with setting up and implementing primary care medical home care model and administering evidence based health care in a new and innovative way. The Nurse Care Manager is responsible for providing comprehensive screenings, assessment, care coordination services, disease education and self-management support with patients who have chronic health conditions – with particular attention but not limited to coronary artery disease, depression, and diabetes.The Nurse Care Manager will be integrated into the office-based healthcare team to work in partnership to promote patient-centered care, frequent contact with primary care providers and medical home team members, and actively participate in interdisciplinary patient-centered team meetings.

ESSENTIAL JOB DUTIES AND RESPONSIBILITIES

- Completes initial patient assessment, including a comprehensive medical, psychosocial, and functional assessment of the patient, including in office or the home setting as needed; review with provider and clinical team members
- Provides detailed education about patient's specific chronic illness, including the pathology, signs and symptoms, complications, and medications used in treatment.
- Assures that screening tests, immunizations and urgent referrals are up to date; perform outreach when additional action is needed.
- Utilizes a interdisciplinary team approach to address opportunities to plan and coordinate care; acts in a supportive capacity to other team members (i.e. medical assistants, receptionist , office manager, provider, behavioral health provider) in supporting patient and the and treatment plan.
- Helps to arrange contact with other resources needed to support the treatment plan.
- Develops care management plans, interventions, and treatment goals in collaboration with patient/family; utilizes motivational interviewing techniques to assist patients with establishing self-management goals, and action plans with timeframes.
  - Promotes success with chronic care plan.
  - Coordinates care and communicates with multiple providers, with particular attention to transitions of care; acts as a liaison to hospital, long term care, specialists and home care.
  - Reviews test results and tracks outcomes.
  - Reviews medications and work with provider/pharmacist as needed to assist with medication management
  - Reviews patient risk issues and work with patient/family/team to reduce risk.
  - Works one-on-one with patients.
  - Arranges group visits.
- Leverages EMR / chronic disease registry/Current Care reporting to prioritize patient follow-up.
- Identifies and utilizes cultural and community resources.
- Generates quarterly reports on service volume, distribution of patients by plan, and types of services provided; analyze data and develop and implement performance improvement strategies to meet /exceed quality of care expectations.
- Ensures open communication, regarding patient status, with physicians and office staff.
- Provides training to non-RN Quality Assistant and other practice staff as needed.
- Attends required training and collaboration sessions [i.e., learning sessions (3), outcomes congress (1), care management collaboration meetings (up to 2 hours every 2 weeks), and practice team meetings] as scheduled.

General Requirements

- Performs quality work within the primary care office setting consistent with evidence based treatment guidelines and NCQA Patient Centered Medical Home Recognition Standards within deadlines with or without direct supervision.
- Shares best practices among all teams, serve as a medical home advocate, mentor and lead by example to support a

positive work environment, and encourage other staff to do the same.
- Represents the practice in a positive manner to all patients and all applicable external clients.
- Brings issues to the appropriate manager(s) in a timely manner for resolution.
- Performs other related duties as assigned.

Minimum Qualifications

Education and Experience

- RN from an accredited program; licensed RN, State of Rhode Island.
- Three (3) to five (5) years experience in community health setting, public health, chronic disease management, community nursing, case management preferred.
- Experience working with primary care providers to coordinate care and disease management.
- Experience working with patients regarding their care coordination and disease management / education is preferred.

Skills and Training

- Ability to work independently and collaboratively to achieve goals.
- Ability to role model and apply patient centered medical home principles including promoting shared decision making with patients;
- Highly organized and detailed.
- Exercise sound judgment and decision-making. Able to assess and differentiate priorities.
- Excellent interpersonal skills and ability to work with and other eople to get the job done.
- Excellent written and verbal communication skills.
- Able to maintain confidentiality with all aspects of information (including patient data) in accordance with the practice's philosophy and policy, and state and federal regulations. Must handle the most sensitive and confidential matters with the utmost discretion.
- Proficiency with computer skills (i.e., Microsoft Word, Excel and Access, and Web-based applications)
- Continue progressive professional development

Licenses and/or Specialized Knowledge

- Licensed RN, State of Rhode Island
- Certified as Diabetic Educator or other chronic care area within 12 months of employment

Environment

Work Environment

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. This position will work under normal physician office conditions, and may also include visits to patients' home settings.

Physical Demands

The tasks of this position are normally performed in a physician office setting when key members of the clinical team are available. Some tasks will be completed sitting at a desk, using a computer. Mobility is required to attend meetings and give presentations. The ability to travel to various locations in the state, typically via car is required. Regular lifting of up to 10 pounds and occasional lifting of up to 25 pounds is expected. Must be able to maintain a good attendance record.

Moving to Team-Based Care: Hiring and Training the NCM

Shirley Carter, RIPCPC

RHODE ISLAND PHYSICIANS CORPORATION PRIMARY CARE

Delivering excellence in primary care for over 15 years

Hiring Qualifications

- Licensed RN, State of Rhode Island
- Three (3) to five (5) years experience in community health setting, public health, chronic disease management, community management
- Case Management experience preferred
- Experience working with primary care providers and patients regarding care coordination/disease management

Important Skills

- Ability to work independently
- Excellent interpersonal, written, verbal communication skills
- Highly organized and detailed
- Sound judgment and decision making

What is a Nurse Care Manager (NCM)?

- They provide:
  - Care management and coordination of services to a targeted set of patients.
  - Specific services based on individual patient/family needs.

Care Management

- Follows up on inpatient and ED discharges
- Care management plans for patients
- Monitors patients' progress with physicians
- Works one-on-one with patients to assess progress towards goals

Outreach

- Patient education about specific chronic illnesses/prevention
- Community and cultural resources
- Supports family caregivers with care at home

Collaboration

- Multidisciplinary team approach
- Huddles
- Best Practices, Quality Improvement
- Facilitates monthly meetings and meets weekly with physicians to discuss patient needs/progress
- Medical Home Mentor

Documentation Responsibilities

- In patients' charts
- Care Plans
- Communication with providers
- BCBS Tracking

** NCMs must fulfill all documentation duties in order for physicians to receive NCQA accreditation

Training

- Learn multiple EMRs
- Comply with HIPPA regulations
- Weekly meetings with Noah and Shirley
- Monthly teleconference with BC
- Attend PCMH collaborations
- Monthly in-person training sessions by BC
- Maintain current licenses and certificates

FAST FACTS

The Guided Care Nursing Course and Certificate in Guided Care Nursing

What is Guided Care?

Guided Care is an interdisciplinary model of health care designed to improve the quality of life and effectiveness of health care for persons with multiple comorbidities. It uses best practices in chronic disease management, case management, self-management, lifestyle modification, caregiver education and support, transitional care, and geriatric evaluation and management. Guided Care Nurses most often work in primary care in partnership with several providers, empowering patients and caregivers and coordinating patient-centered, cost-effective care.

Why should I complete the Guided Care Certificate program?

As a Guided Care Nurse, new career opportunities may be open to you in primary care practices, particularly in settings that implement the "medical home" concept. You may also be interested in the program because you want to learn new skills and be more effective in caring for older adults, particularly those living in the community.

What is the Guided Care Nursing Course and Certificate?

The Institute for Johns Hopkins Nursing (IJHN) provides a six-week online course and examination leading to the American Nurses Credentialing Center's new Certificate in Guided Care Nursing. Upon completion of the course, the nurse is eligible to take the online examination leading to the **American Nurses Credentialing Center**'s new **Certificate in Guided Care Nursing**. This is not a certification, but rather a one-time recognition of professional achievement.

The course was developed in partnership with the Johns Hopkins Bloomberg School of Public Health, with funding from the John A. Hartford Foundation. The Guided Care Nursing Course features core and supplemental modules, live webinars and simulations, and expert support from IJHN faculty. It is endorsed by the National Gerontological Nursing Association and sponsored by SeniorBridge.

What are the employment opportunities for a nurse who successfully completes the Guided Care Nursing Course?

A nurse who successfully completes the Guided Care Nursing course will be well positioned to work in many "medical homes," health care organizations that provide comprehensive, coordinated, continuous care to their patients, including those with chronic conditions who require complex services. Two national Medical Home Demonstrations will begin soon, plus other demonstrations are underway in more than 30 states. For details, please visit **http://www.cms.hhs.gov/demoprojectsevalrpts/md/list.asp** (scroll down to list to Medicare Medical Home Demonstration) and **http://pcpcc.net/content/pcpcc-pilot-projects** for activity in the private sector.

How long will the course take?

The course includes about forty hours of content and learning activities to be taken over six weeks. About twenty hours is core content and is taken sequentially. Five live webinars help you master the skills and competencies in the core content. Another twenty hours of supplemental content and learning activities are also available. Following the six-week course, you will have an additional month of access to the online modules for review and self-study.

What equipment do I need to take the online course?

You'll need reliable access to a computer with broadband connection and speakers and a telephone. A Windows-based PC should run Windows XP or Vista with a current version of Internet Explorer, Netscape Navigator, or Mozilla Firefox. A Macintosh should run Mac OS X v10.4 and Safari or Mozilla Firefox.

How can I register for the course?

Register on the Institute for Johns Hopkins Nursing (IJHN) website: **www.ijhn.jhmi.edu**. The course is accessible from several pages including course listings in the Virtual Learning Calendar (click on Calendar in the top right hand corner, and then select Virtual Learning). Click on the course you're

How much does it cost for the Certificate in Guided Care Nursing?
Tuition of $1,900 includes all course materials and activities, the online examination, and the ANCC Certificate in Guided Care Nursing. Group and professional organization discounts are available.

Do the state boards recognize the certificate program?
No. But you will receive contact hours from IJHN upon completion of the course, which can be used to meet re-licensure requirements in some states or for re-certification in many specialties.

The Institute for Johns Hopkins Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Why can't I register for the exam on ANCC's website?
Upon completion of the Guided Care Nursing Course, you will be eligible to take the exam. IJHN will notify ANCC of your eligibility and send you the information you will need to take the exam. You will be able to take the exam between 30 and 120 days after the end of the course.

How do I renew the Guided Care Certificate?
The certificate cannot be renewed. Certificates are recognition of your professional development and achievement of a specific goal. Like a diploma, they are provided once and do not require ongoing demonstration of competencies.

Who can I call for more information on the Guided Care Program?
Call The Institute for Johns Hopkins Nursing: 443-287-4745, email IJHN: guidedcare@son.jhmi.edu

What topics are taught in the online Guided Care Nursing Course?

Core Topics

Unit I. Foundations of Guided Care Nursing
- Overview of Guided Care
- Patient preferences for care
- Motivational Interviewing (MI) for patient self-management
- Communicating with physicians and other providers
- Triage and Nurse Decision Making
- Assisting patients and caregivers with Medicare coverage
- Health Information Technology (HIT)

Unit II. Establishing New Patients and Caregivers
- Assessing patients' general status
- Assessing patients' specific conditions
- Interviewing patients' caregivers
- Care planning

Unit III. Ongoing Guided Care
- Monitoring and Coaching
- Community Resources
- Supporting Caregivers
- Coordinating Providers
- Transitional Care

Unit IV: Conducting Guided Care
- Integration into Practice
- Teamwork Boundaries

Supplemental Topics

Cultural Competence
Patient Education
Elder Abuse

Treating chronic diseases in vulnerable adults:
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Delirium
- Dementia
- Depression
- Diabetes
- Falls
- Heart Failure
- Hypertension
- Osteoarthritis
- Osteoporosis
- Pain
- Urinary Incontinence

Certified Diabetes Outpatient Educator (CDOE) Information

What is a Diabetes Educator?

Diabetes educators are healthcare professionals who focus on educating people with and at risk for diabetes and related conditions to achieve behavior change goals which, in turn, lead to better clinical outcomes and improved health status. Diabetes educators apply in-depth knowledge and skills in the biological and social sciences, communication, counseling, and educational fields to provide self-management education/self-management training.
Services provided by diabetes educators are eligible for third party reimbursement. In addition to coverage for diabetes self-management training/education (DSMT/E), services for discipline-specific counseling, such as medical nutrition therapy provided by dietitians/nutritionists, or medication therapy management services provided by pharmacists are available.

Diabetes Educators:

- Provide their services in hospitals, physician offices, outpatient settings, pharmacies, managed care organizations, home health care agencies, local community facilities and other settings.
- Facilitate behavior change by counseling patients and families on how to adopt informed lifestyle decisions and incorporate healthier choices into their self-management.
- Provide self-management training/education, and Diabetes Self-Management Support (DSMS) and other interventions to prevent the development of diabetes. An important part of sustaining outcomes (or continual improvement) is to ensure that ongoing support and reinforcement is provided (by a variety of different professionals and non-professionals—including diabetes educators).
- Are the key to coordination of the interdisciplinary diabetes team and development of the plan of care for the individual patient.

CDOE Qualifications

- Are you a Rhode Island licensed Dietitian, Pharmacist or Nurse with a passion for empowering your patients with the tools necessary for managing their diabetes and a desire to network with other professionals to collaborate and share best practices?
- If you are, then consider becoming a CDOE and joining this group of professionals who have been extensively trained to provide diabetes self-management education and are certified by the State of Rhode Island Department of Health.
- You can make a difference in the lives of your patients living with diabetes!

The above information and more information about becoming a CDOE is available at:
http://ridiabeteseducators.org/join-us

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COMMUNITY HEALTH NETWORK PROGRAM GUIDE

Do you have a long term health condition? Are you living with chronic pain?
Take control of your health!
Join us and learn how to manage your condition

Here is a list of programs that can help you live better. For more information or to register for a program call Rose Moretti at the Health Department (401) 222-3329 or email Rose.Moretti@health.ri.gov

FOR ADULTS WITH CHRONIC DISEASES AND/OR PAIN (e.g. heart disease, diabetes, COPD, arthritis)

☐ **Chronic Disease Self-Management (Living Well Rhode Island)**
Purpose of Program: Facilitated by certified Peer Leaders, this workshop teaches people ways to manage symptoms and medications, communicate with family and doctors, handle difficult emotions, relax, eat well, exercise, and set goals to improve health and lifestyles.
Format: Groups sessions 2 ½ hours per week for 6 weeks. Facilitated in both English and Spanish.
The Spanish version called Tomando Control de Su Salud.
Eligibility: Anyone18 years of age or older or caregivers of anyone with a chronic condition (for example: Asthma, Arthritis, Cancer, COPD, Diabetes, and/or Heart Disease)
Cost: Free and incentives are provided to participants.

☐ **Chronic Pain Self-Management (Living Well Rhode Island)**
Purpose of Program: Facilitated by certified Peer Leaders, this workshop teaches people ways to manage chronic pain by explaining how medications for chronic pain work, communicating about pain with family and doctors, and debunking myths about chronic pain.
Format: Groups sessions 2 ½ hours per week for 6 weeks.
Eligibility: Anyone 18 years of age or older experiencing chronic pain with or without a chronic condition.
Cost: Free and incentives are provided to participants.

FOR ADULTS WITH ARTHRITIS

☐ **Arthritis Foundation Exercise Program**
Purpose of Program: Community-based, recreational exercise program that includes gentle, joint-safe exercises developed specifically for people with arthritis to help relieve stiffness, decrease arthritis pain and improve balance. The low-impact exercises can be done while sitting, standing or on the floor. Led by certified instructors.
Format: Group sessions meet at various locations throughout the state and run twice a week for one hour for 6 weeks.
Eligibility Requirements: People aged 18 years of age or older with arthritis.
Cost: Varies by site offering program – from $0 to $45.

☐ **Arthritis Foundation Walk With Ease Program**
Purpose of Program: The Arthritis Foundation *Walk With Ease* program is designed to help people living with arthritis better manage their pain and is also ideal for people without arthritis who want to make walking a regular habit. Led by a certified leader, this program has been shown to reduce pain and increase balance and walking pace.
Format: Walk with Ease programs meet for 6 weeks, 3 times per week at various locations throughout the state.
Eligibility Requirements: Anyone who can be on their feet for 10 minutes without increased pain.
Cost: Varies and usually includes the cost of a book – from $0 to $15.

FOR ADULTS WITH DIABETES

☐ **Diabetes Self-Management (Living Well Rhode Island)**
Purpose of Program: Facilitated by certified Peer Leaders, this workshop teaches techniques to deal with symptoms of diabetes, fatigue, pain, stress, depression and anger. It also promotes exercise, proper use of medications, healthy eating, and effective communication techniques.
Format: Groups sessions 2 ½ hours per week for 6 weeks. Facilitated in both English and Spanish.
The Spanish version is called Tomando Control de Su Diabetes
Eligibility: Anyone18 years of age or older or caregivers of anyone with diabetes.
Cost: Free and incentives are provided to participants.

☐ **Certified Diabetes Outpatient Educator (CDOE)**
Purpose of Program: CDOEs are Registered Nurses, Dietitians and Pharmacists who teach patients how to manage their glucose, blood pressure, cholesterol, medication, and nutrition.
Format: Individual or group consultations in doctors' offices, pharmacies, CDOE sites, around the state.
Eligibility: People aged 18 years of age or older with diabetes. Requires a health provider order.
Cost: Covered under most private health insurance plans. May require a co-pay.

FOR ADULTS WITH PRE-DIABETES

☐ **YMCA's Diabetes Prevention Program**
Purpose of Program: This program teaches people how to lower their risk of getting Type 2 Diabetes by eating healthier, increasing physical activity and losing weight.
Format: Group sessions are held once a week for 16 weeks
Eligibility: Adults18 years of age or older with pre-diabetes or a person who are at risk for developing Type 2 Diabetes.
Cost: Member $199; Non-Member $249, Y membership included for the duration of the core 16 sessions Financial Assistance and payment plans are available.

FOR ADULTS WITH HEART DISEASE

☐ **Certified Cardiovascular Disease Outpatient Educator (CVDOE) Program**
Purpose of Program**:** CVDOEs are Registered Nurses, Dietitians and Pharmacists who teach individuals how to manage their blood pressure and cholesterol, how to properly use medication, and the basics of a healthy diet.
Format: Individual or group consultations in doctors' offices, pharmacies, CDOE sites, around the state.
Eligibility: People aged 18 years of age or older with cardiovascular disease with a health provider order.
Cost: Covered by some health insurance plans. May require a co-pay.

FOR CHILDREN WITH ASTHMA

☐ **Draw a Breath Asthma Program**
Purpose of Program: Asthma education program for children and their parents designed to provide families with the knowledge, skills, and tools to effectively manage asthma, reduce emergency room and overnight hospital stays for asthma. The program improves child and family knowledge and confidence in managing asthma so they can take effective action towards controlling it.
Format: The group-based approach creates a unique learning environment in which both children and caregivers learn from, and are motivated by, each other.
Eligibility: Families with a child with asthma are eligible to take part in the program.
Cost: Program services all families, regardless of their insurance status or ability to pay.

FOR ADULTS WHO NEED LIFESTYLE MODIFICATION

☐ Health Smart Behaviors (YMCA)

Purpose of Program: Behavior change program specifically designed for African Americans which focuses on nutrition education and small goals related to healthy lifestyle changes.
Format: This is an eight week program targeting the African American/Hispanic Latino population. The program works with the whole family to develop short- and long-term goals based on their household. The program combines nutrition education and physical activity.
Eligibility: African American/Hispanic Latino
Cost: Free

☐ YMCA's Healthy Lifestyles Behavior Change Program

Purpose of Program: Helps individuals successfully make lifestyle changes to improve their health & well-being by exploring ways to overcome barriers, stay motivated and build support networks.
Format: 22-session group program. Held once a week for the first 4 sessions, and then bi-weekly for the remaining 18 sessions. Can be held at a Y or within the community.
Eligibility: At least 18 years of age and ready to make behavior changes
Cost: Member $199; Non-Member $249, Y membership included for duration of the program. Financial Assistance and payment plans are available.

☐ Salsa, Sabor Y Salud (YMCA

Purpose of Program: Teaches Hispanic families about the benefits of physical activity and healthy eating to make small, sustainable lifestyle changes. Families will make short- and long-term goals based on the family needs. Format: This is an eight week program that focuses on the whole family.
Eligibility: Hispanic Latino
Cost: Free

FOR YOUTH WITH OR AT RISK FOR DISABILITIES

☐ Healthy Lifestyles for Youth with Disabilities

Purpose of the Program: Presented by certified Youth Health Coaches & adult mentors, this 16-hour accessible, interactive curriculum takes participants through the self-discovery process, helps them to explore healthy life choices, and concludes with personal action plan development.
Format: Workshops are held in a three full-day or two and a half hour series over a period of six to eight day time frames. A minimum of 10 participants are needed, fifteen ideal, 20 maximum. Groups benefit when peers, mentors, teachers, and others participate to provide more support.
Eligibility: Transition-age youth (14-24) with special health care needs, disabilities, or who are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services beyond what is required by children generally
Cost: Free - snacks are provided and an incentive for participants who complete the program.

FOR ADULT CANCER SURVIVIORS

☐ LIVESTRONG at the YMCA

Purpose of Program: This cancer survivorship program is a 12- week small-group program designed for adult cancer survivors who have become de-conditioned or chronically fatigued from their treatment and/or disease, and helps them reclaim their health through improved muscle strength, cardiovascular endurance and functional ability.
Format: Supervised physical activity twice per week for 12 weeks at all branches within the Greater Providence YMCA network.
Eligibility: Cancer Diagnosis
Cost: Free and includes free YMCA membership.

FOR OLDER ADULTS AT RISK FOR FALLS

☐ **Matter of Balance: Managing Concerns About Falls**
Purpose of Program: Facilitated by Peer Leaders, group workshops teach techniques to reduce fears of falling and increase activity levels among older adults.
Format: Eight two-hour sessions for a small group led by a trained facilitator.
Eligibility: Adults 60 years of age and older who are ambulatory and able to problem solve
Cost: Free or up to $15.00.

FOR FAMILIES LIVING WITH MENTAL ILLNESS

☐ **The National Alliance on Mental Illness of Rhode Island (NAMI)**
Purpose of Program: Offers the NAMI Family-to-Family Education course for family caregivers of individuals with mental illnesses and Inside Mental Illness, the Peer-to-Peer education program about mental illness for junior high and high school students**.**
Format: Group and individual
Eligibility: Individuals with mental illness and family members
Cost: Free

FOR FAMILIES WHO NEED SOCIAL SUPPORT

☐ **Peer Resource Specialists**
Purpose of Program: Resource Specialists/Peer Navigators are trained to help people navigate healthcare systems, coordinate care, and become better advocates for families. They help with access to basic needs that often interfere with health and wellness (housing, transportation, employment, etc)
Format: Resource services are offered at participating doctor's offices, in the home, hospitals, and community agencies.
Eligibility: People who could benefit from peer support and system navigation to achieve better health outcomes.
Cost: Services are free for families of children with special needs.

FOR PERSONS WHO WANT TO QUIT SMOKING

☐ **RI Smoker's Helpline**
Purpose of Program: The Rhode Island Smokers' Helpline is the state's Quitline, which is a free evidence-based service that provides multi-session telephone counseling, provides quit tips, quit self-help materials, and referral to other quit smoking services in RI. Any individual in RI seeking to quit smoking can call 1-800-QUIT-NOW (1-800-784-8669)
Format: multi-session telephone counseling
Eligibility: Any RI resident
Cost: Free

☐ **QuitWorks-RI**
Purpose of Program: The QuitWorks-RI Program provides tobacco cessation educational training for physicians and other healthcare providers, training and support on use of fax-referral system to the Smokers' Helpline for patients who desire to quit smoking, and follow up report on patient progress with Program.
Format: Healthcare provider referral to RI Smoker's Helpline
Eligibility: Any RI resident
Cost: Free

INSTRUCTIONS FOR USING THE COMMUNITY HEALTH NETWORK REFERRAL FORM

- Under the **Healthcare Provider Information** box: Complete the information requested on the form for the referral provider or agency and the person being referred.
- Under the **Patient Information** box: Provide the referee's name and demographic information. Make sure the person provides you with the best number to call during the day
- Under **Special Accommodations**: Indicate any special needs the person being referred may have such as language or any physical accommodations such as ramp access, elevator, close proximity to speaker due to hearing issues, etc.
- Under **Patient Concern**: Check all the chronic conditions for which this person is being referred. If the condition is not on the list, please check the "Other" box.
- Under **Available Evidence-Based Programs,** select one or more programs to which you would like to refer this person. Program descriptions are provided on the **Chronic Condition Self-Management Education Program Guide**.
- For referrals to a Certified Diabetes Outpatient Educator only, a Physician, Nurse Practitioner or Physician Assistant signature is required.
- Complete the Authorization of Release of Information on the back side of the referral form. Have the person being referred sign and date the form.
- Provide a copy of the Chronic Condition Education and Self-Management Program Guide to the person being referred and indicate the program (s) to which he/she is being referred by checking the corresponding box.
- Fax the form to the fax number provided. This is a secure fax. You may also scan and e-mail the referral form to Rose.Moretti@health.ri.gov if the e-mail can be sent in a secure format.
- Rose Moretti is the Chronic Condition Resource Specialist at Department of Health. She will process the referral and contact the person being referred up to three times to assist them to attend the program. She will also forward the referral on to the contact person of the program to which the person is being referred.
- Progress reports will be sent from the program to the referring provider using the **Physician Communication Form**.
- If at any time you have any questions, please call Rose at 222-3329.

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Summary of Target 2 of the Developmental Contract

Practices will agree to un-blinded, public reporting of approved performance metrics on the PCMHRI website, amongst the CSI-RI community.

Target #2 Quality and Patient Experience (Provider Metrics): Reporting and Measurement for Target #2 will be reviewed annually by the CSI-RI Data and Evaluation Committee with recommendations to the CSI-RI Executive Committee to modify the specific benchmarks.

a. Quality: Practice will achieve the CSI-RI clinical quality measures (provided). If the benchmark is not achieved, the target will also be considered as met if the Practice achieves half the distance between the baseline rate and the target, as long as half the distance equals at least a 2.5 % point improvement. The quality measures are based on industry- standards metrics. See Attachment C: Reporting and Measurement for Target #2.

b. Patient Experience: Practice will allow the conduct of the CAHPS-PCMH survey and present findings to the RI CSI-RI Executive Committee by the end of the transition year, along with a plan for the incorporation of these findings into their practice redesign. Details of the CAHPS survey are provided.

Clinical Quality Benchmark Values for 2014:

Measure	Used for Payment	Threshold
Adult BMI (18-64)	✓	**57%**
Adult BMI (65+)	✓	**69%**
Depression Screen		90%
DM A1c Good Control (<8)	✓	**69%**
DM A1c Poor Control (>9)		23%
DM BP Control (<140/90)	✓	**76%**
DM BP Good Control (<130/80)		40%
DM LDL Good Control	✓	**50%**
Hypertension BP Control (<140/90)	✓	**72%**
Hypertension BP Measurement		99%
Tobacco Assessment		95%
Tobacco Cessation	✓	**85%**
DM LDL patients w/ Result		
DM HbA1c patients w/ Result		
DM BP patients w/Measurement		
Total # active patients 18+		

CSI Measure Logic

Total Active Patients 18+

- Seen by provider during measurement year or year prior
- Age 18 and over
- Exclude patients who are deceased, unsuccessful contact three times, discharged or transferred

Diabetic Patients

- Active patients age 18-75
- Has problem list entry of diabetes (active/chronic/unresolved)
- Or
- ICD-9 codes: 250, 357.2, 362.0, 366.41, 648.0 (active/chronic/unresolved)
- Exclude ICD-9 codes: 249, 251.8, 962.0 – steroid induced DM 648.8, PCOS 256.4 – gestational DM

Diabetes Patients with A1c Measured

- A1c result documented within 12 month reporting period

Diabetes Patients with A1c Control (<8%)

- Most recent A1c less than 8% within 12 month reporting period

Diabetes Patients with LDL Result

- LDL result documented within 12 month reporting period

Diabetes Patients with LDL Control

- Most recent LDL < 100 within 12 month reporting period

Diabetic Patients with Poor A1c Control

- Most recent A1c > 9% or not documented within 12 month reporting period

Diabetic Patients with BP Recorded

- BP documented within 12 month reporting period

Diabetic Patients with BP Control

- Most recent BP < 140/90 within 12 month reporting period

Diabetic Patients with BP Good Control

- Most recent BP < 130/80 within 12 month reporting period

Depression Screening

- Active 18+
- Seen 2 or more times or for 1 preventive visit during 24 month reporting period
- Exclude ICD-9 290, 294, 318

Meeting the Measure

- PHQ-2 completed at least once during 24 month reporting period

Tobacco Use Assessment

- Active 18+
- Seen 2 or more times or for 1 preventive visit during 24 month reporting period

Meeting the Measure

- Documented assessment at least once during 24 month reporting period

Tobacco Cessation

- Active 18+
- Seen 2 or more times or for 1 preventive visit during 24 month reporting period
- Identified as tobacco users in most recent assessment

Meeting the Measure

- Cessation intervention documented at least once during 24 month reporting period

Adult BMI – Age 18 – 64

Population

- Active patients age 18 to 64
- Seen during 12 month reporting period
- Optional exclusions: terminal illness, pregnancy, BMI not recorded for patient, medical or system reasons

Meeting the Measure

- Patients with calculated BMI documented during 12 month reporting period within normal range (18.5 to 25, non-inclusive)
- Or
- Patients with calculated BMI documented during 12 month reporting period not in normal range with a care plan documented

Adult BMI – Age 65+

Population

- Active patients age 65 and over
- Seen during 12 month reporting period
- Optional exclusions: terminal illness, pregnancy, BMI not recorded for patient, medical or system reasons

Meeting the Measure

- Patients with calculated BMI documented during 12 month reporting period within normal range (22 to 30, non-inclusive)
- Or
- Patients with calculated BMI documented during 12 month reporting period not in normal range with a care plan documented

Hypertension Patients BP Measurement

Population

- Active 18+
- Diagnosis of hypertension
- Seen at least 2 times during 12 month reporting period
- ICD-9 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93

Meeting the Measure

- Hypertension patients with BP recorded during 12 month reporting period

Hypertension Patients BP Control

Population

- Active, age 18 to 85
- Diagnosis of hypertension starting prior to 6 months before end of 12 month reporting period
- Seen by practice during 12 month reporting period
- ICD-9 401, 401.0, 401.1, 401.9
- Exclusions: pregnant (630-679, v22, v23, v28), ESRD (585.6)

Meeting the Measure

- Patients with most recent BP < 140/90 during 12 month reporting period

Fall Risk

Population

- Active patients age 66 or older on date of visit
- Seen by PCP at least once during 12 month reporting period

Meeting the Measure

- Fall Risk assessment completed at least once during 12 month reporting period
- Assessment tool must include at least these 2 questions:
    - Have you fallen two or more times in the past year?
    - Have you fallen once with injury in the past year?

Chlamydia Screening – Sexual History

Population

- Active female patients, age 18 to 24 on date of visit
- Seen for preventive visit within 12 month reporting period
- CPT 99201-99215 with ICD-9 v20.x, v22.x, v23.x, v70.x, v72.31 or 99385, 99395

Meeting the Measure

- Patients with documented sexual history during 12 month reporting period

Chlamydia Screening – Testing

Population

- Active female patients age 18 to 24 on date of visit
- Seen for preventive visit during reporting period
- Documented as sexually active

Meeting the Measure

- CPT: 87110, 87270, 87320, 87490, 87491, 87492, 87810
- CPT not the only form of documentation accepted; other structured fields may also be included.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Population

- Number of outpatient visits during reporting period by active patients 18 to 64 years old on date of visit
- Diagnosis of bronchitis 466.0 with CPT 99201-99205, 99211-99215

Meeting the measure

- Visits where antibiotic was prescribed by PCP on date of visit
- Note: this measure is reported as in inverted rate [1-(numerator/eligible population)]

CSI Measure Definitions

Contents

Revision History

Date	Revision
12/15/2011	Base
6/13/2013	Update to DM LDL Control – most recent LDL value must be used
7/18/2013	Remove references to Beacon Program. Addition of revision history table.
8/7/2013	Add 3 new measures to be reported beginning 1Q2014: Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis (18-64), Chlamydia Screening for Women (2 parts) and Fall Risk Management
9/12/2013	Update to 2 Adult BMI measures – specifies that most recent BMI should be used, not any BMI taken during the measurement period.
9/12/2013	Clarification of allowable use of Meaningful Use measures. Maybe be used only by single provider practices

Diabetes Mellitus – HbA1c Poor Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with poorly controlled disease (having an A1c value greater than 9.0%)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator with the most recent HbA1c >9.0% in the measurement period or whose HbA1c reading was not taken or is missing.
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	Based on NQF 0059
Measure Domain/ Type	Outcome

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Diabetes Mellitus – Blood Pressure Good Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with well controlled blood pressure (having a blood pressure value less than 130/80)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure test result value during the measurement period is less than 130/80*
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	HEDIS 2011 and NQF 0061
Measure Domain/ Type	Outcome

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

*If multiple BP measurements occur on the same date or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled." Controlling High Blood Pressure (CBP)HEDIS 2011

Blood pressure is viewed as two separate values: systolic and diastolic. The lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record may be used. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on the date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

NQF MEASURE DETAILS -0061
http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=1235#k=diabetes&e=1&st=&sd=&mt=&cs=&s=n&so=a&p=1

Diabetes Mellitus – Blood Pressure Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 who had a blood pressure value less than 140/90)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure test result value during the measurement period is less than 140/90*
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0, PCOS 256.4 Gestational diabetes: 648.8
Measure source	Based on NQF 0061
Measure Domain/ Type	Outcome

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

*If multiple BP measurements occur on the same date or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled." ***Controlling High Blood Pressure (CBP)HEDIS 2011***

Blood pressure is viewed as two separate values: systolic and diastolic. The lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record may be used. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on the date as the representative BP. The systolic and diastolic results do not need to be from the same reading ***NQF MEASURE DETAILS -0061***

http://www.qualityforum.org/MeasureDetails.aspx?actid=0&SubmissionId=1235#k=diabetes&e=1&st=&sd=&mt=&cs=&s=n&so=a&p=1

Diabetes Mellitus – LDL-C Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with well controlled LDL cholesterol (having LDL-C value less than 100 mg/dL)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent LDL value in the measurement period is less than 100mg/dL .
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	Based on NQF 0064
Measure Domain/ Type	Outcome

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Tobacco Cessation Intervention

Definition	The percentage of tobacco users in the total Active Patient population, given tobacco cessation advice including one or more of the following: advice to quit, counseling, referral for counseling, and/or pharmacologic therapy during the measurement period
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the last 24 months. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	Patients in the denominator who were given tobacco cessation intervention at least one time during any face-to-face encounter, including one with a nurse care manager, during the measurement period. Tobacco cessation intervention includes advice to quit, counseling, referral for counseling, and/or pharmacologic therapy (smoking cessation agent), active or ordered.
Denominator	Active patients age 18 and older who were seen two or more times or for 1 preventive visit, by a primary care clinician of the PCMH within the last 24 months and were identified as tobacco users in the most recent tobacco use assessment.
Exclusions	None
Measure source	Based on NQF 0028b
Measure Domain/ Type	Process

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Depression Screening

Definition	The percentage of patients age 18 and older screened one or more times for depression during the measurement period, using a standardized screening tool (PHQ-2 or other validated tool)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	Patients in the denominator who received a depression screen one or more times within the measurement period using the PHQ-2 or other validated tool. Include patients who have documented diagnoses with the following codes in the numerator. 296, 300.4, 311, 293.83, 298.0, 309.0, 309.1, 309.28
Denominator	Active patients age 18 and older who were seen two or more times **or for one preventive visit** by a primary care clinician of the PCMH within the last 24 months
Exclusions	Patients diagnosed with the following ICD-9 codes: 290,294,318
Measure source	Based on: Veterans' Health Administration measure http://www.qualitymeasures.ahrq.gov/content.aspx?id=16177
Measure Domain/ Type	Process

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Tobacco Use Assessment

Definition	The percentage of patients age 18 and older who were queried one or more times about tobacco use during the measurement period
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the last 24 months. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	Patients in the denominator who were queried, with a documented response, one or more times about tobacco use within the measurement period
Denominator	Active patients age 18 and older who were seen two or more times or for 1 preventive visit, by a primary care clinician of the PCMH within the last 24 months
Exclusions	None
Measure source	Based on NQF 0028a
Measure Domain/ Type	Process

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Diabetes Mellitus – HbA1c Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with controlled disease (having an A1c value less than 8.0%)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator with the most recent HbA1c <8.0% in the measurement period
Denominator	Active patients between the ages of 18-75 years at any time during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4
Measure source	Based on NQF 0575
Measure Domain/ Type	Outcome

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Adult Body Mass Index – Age 18-64

<table>
<tr><td>Definition</td><td>Percentage of patients age 18-64 whose calculated BMI is either in the normal range or is above or below the normal range and have a documented follow up plan within the measurement year.</td></tr>
<tr><td>Active Patient</td><td>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:
Patients who have left the practice by the end of the measurement year, as determined by:
• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice
• Patient has passed away
• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person
• Patient has been discharged</td></tr>
<tr><td>Measurement Period</td><td>12 months</td></tr>
<tr><td>Numerator</td><td>Patients in the denominator who meet the following criteria:
1. Patients whose most recent calculated BMI during the measurement period is in normal range:
2. Patients whose most recent calculated BMI during the measurement period is ABOVE or BELOW normal range AND have a documented care plan during the measurement period

<table><tr><th>BMI Range</th><th>Age 18- 64 years</th></tr><tr><td>ABOVE Normal</td><td>≥25 kg/m^2</td></tr><tr><td>NORMAL</td><td>greater than 18.5 kg/m^2 but less than 25 kg/m^2</td></tr><tr><td>BELOW Normal</td><td>≤18.5 kg/m^2</td></tr></table></td></tr>
<tr><td>Denominator</td><td>Active patients age 18-64 years who were seen by a primary care clinician of the PCMH during the measurement year</td></tr>
<tr><td>Exclusions</td><td>Optionally, these exclusions may be applied:
• Patients diagnosed with a terminal illness in the measurement year
• Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28)
• Patients for whom the exam was not done for patient reason
• Patients for whom the exam was not done for medical reason
• Patients for whom the exam was not done for system reason</td></tr>
<tr><td>Measure source</td><td>Based on NQF 0421</td></tr>
<tr><td>Measure Domain/ Type</td><td>Process</td></tr>
</table>

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Adult Body Mass Index – Age 65 and Older

<table>
<tr><td>Definition</td><td>Percentage of patients age 65 years and older whose calculated BMI is either in the normal range or is above or below the normal range and have a documented follow up plan within the measurement year.</td></tr>
<tr><td>Active Patient</td><td>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:
Patients who have left the practice by the end of the measurement year, as determined by:
• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice
• Patient has passed away
• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person
• Patient has been discharged</td></tr>
<tr><td>Measurement Period</td><td>12 months</td></tr>
<tr><td>Numerator</td><td>Patients in the denominator who meet the following criteria:
1. Patients whose most recent calculated BMI during the reporting period is in normal range:
2. Patients whose most recent calculated BMI during the reporting period is ABOVE or BELOW normal range AND have a documented care plan during the reporting period

<table><tr><th>BMI Range</th><th>Age 65 years and older</th></tr><tr><td>ABOVE Normal</td><td>≥30 kg/m^2</td></tr><tr><td>NORMAL</td><td>greater than 22 kg/m^2 but less than 30 kg/m^2</td></tr><tr><td>BELOW Normal</td><td>≤22 kg/m^2</td></tr></table></td></tr>
<tr><td>Denominator</td><td>Active patients age 65 years and older who were seen by a primary care clinician of the PCMH during the measurement year</td></tr>
<tr><td>Exclusions</td><td>Optionally, these exclusions may be applied:
• Patients diagnosed with a terminal illness in the measurement year
• Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28)
• Patients for whom the exam was not done for patient reason
• Patients for whom the exam was not done for medical reason
• Patients for whom the exam was not done for system reason</td></tr>
<tr><td>Measure source</td><td>Based on NQF 0421</td></tr>
<tr><td>Measure Domain/ Type</td><td>Process</td></tr>
</table>

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Hypertension: Blood Pressure Measurement

Definition	The percentage of patient visits for patients age 18 and older with a diagnosis of hypertension who have been seen for at least 2 office visits in the last 12 months, with blood pressure recorded
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator who have had a blood pressure recorded in the measurement period
Denominator	Active patients age 18 and older with a diagnosis of hypertension who have been seen at least 2 times by a primary care clinician of the PCMH during the last 12 months. The ICD-9 codes for hypertension: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93
Exclusions	None
Measure source	NQF 0013
Measure Domain/ Type	Process

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

Hypertension: Blood Pressure Control

Definition	The percentage of patients age 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year (having a BP value of <140/90)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure is adequately controlled (having a blood pressure value <140/90) in the measurement period*
Denominator	Active patients age 18-85 with an active diagnosis of hypertension for more than 6 months before the end of the reporting period who have been seen by a primary care clinician of the PCMH. Use the following ICD-9 codes: 401, 401.0, 401.1, 401.9
Exclusions	• Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28) • Patients who are diagnosed with ESRD (ICD code 585.6)
Measure source	Based on NQF 0018 and HEDIS 2011 Controlling High Blood Pressure (CBP)
Measure Domain/ Type	Process

EHR Meaningful Use Reports - EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the reports results in duplication of patients.

* If multiple BP measurements occur on the same date or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is "not controlled." ***Controlling High Blood Pressure (CBP)HEDIS 2011***

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Begin reporting 1Q2014

Definition	The percentage of visits with a diagnosis of acute bronchitis for patients 18–64 years of age on the date of visit, who were not dispensed an antibiotic prescription. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Visits in the denominator where an antibiotic medication (Table A) was prescribed by a primary care clinician of the PCMH on the date of visit.
Denominator	Outpatient visits during the reporting period to the primary care clinician by active patients age 18-64 on the date of the visit with a diagnosis of acute bronchitis. ICD-9 code for Acute Bronchitis: 466.0 CPT Codes for visit type: - 99201-99205, 99211-99215
Exclusions	None
Measure source	Based on HEDIS 2013
Measure Domain/ Type	Process

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Table A: Antibiotic Medications

Description	Prescription		
Aminoglycosides	• Amikacin • Gentamicin	• Kanamycin • Streptomycin	• Tobramycin
Aminopenicillins	• Amoxicillin	• Ampicillin	
Antipseudomonal penicillins	• Piperacillin	• Ticarcillin	
Beta-lactamase inhibitors	• Amoxicillin-clavulanate • Ampicillin-sulbactam	• Piperacillin-tazobactam	• Ticarcillin-clavulanate
First-generation cephalosporins	• Cefadroxil	• Cefazolin	• Cephalexin
Fourth-generation cephalosporins	• Cefepime		
Ketolides	• Telithromycin		
Lincomycin derivatives	• Clindamycin	• Lincomycin	
Macrolides	• Azithromycin • Clarithromycin	• Erythromycin • Erythromycin ethylsuccinate	• Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	• Aztreonam • Chloramphenicol • Dalfopristin-quinupristin	• Daptomycin • Erythromycin-sulfisoxazole • Linezolid	• Metronidazole • Vancomycin
Natural penicillins	• Penicillin G benzathine-procaine • Penicillin G potassium	• Penicillin G procaine • Penicillin G sodium	• Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	• Dicloxacillin	• Nafcillin	• Oxacillin
Quinolones	• Ciprofloxacin • Gatifloxacin • Gemifloxacin	• Levofloxacin • Lomefloxacin • Moxifloxacin	• Norfloxacin • Ofloxacin • Sparfloxacin
Rifamycin derivatives	• Rifampin		
Second generation cephalosporin	• Cefaclor • Cefotetan	• Cefoxitin • Cefprozil	• Cefuroxime • Loracarbef
Sulfonamides	• Sulfadiazine • Sulfamethoxazole-trimethoprim	• Sulfisoxazole	
Tetracyclines	• Doxycycline	• Minocycline	• Tetracycline
Third generation cephalosporins	• Cefdinir • Cefditoren • Cefixime	• Cefotaxime • Cefpodoxime • Ceftazidime	• Ceftibuten • Ceftriaxone
Urinary anti-infectives	• Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate • Trimethoprim	

Chlamydia Screening – Obtaining Sexual History
Begin reporting 1Q2014

Definition	The percentage of women 18–24 years of age on the date of visit who were screened for sexual history during the measurement year.
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	The number of patients in the denominator who were screened for sexual history during the measurement year.
Denominator	Active female patients age 18-24 on the date of visit who were seen for a preventive visit by a primary care clinician of the PCMH within the 12 month reporting period. **CPT Codes to identify preventive visit:** 99201 – 99215 with preventive diagnosis code (v20.x, v22.x, v23.x, v70.x, v72.31) or preventive visit 99385, 99395
Exclusions	None
Measure source	Based on HEDIS 2010
Measure Domain/ Type	Process

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Chlamydia Screening – Testing
Begin reporting 1Q2014

<table>
<tr><td>Definition</td><td>The percentage of women 18–24 years of age on the date of visit who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.</td></tr>
<tr><td>Active Patient</td><td>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:
Patients who have left the practice by the end of the measurement year, as determined by:
• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice
• Patient has passed away
• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person
• Patient has been discharged</td></tr>
<tr><td>Measurement Period</td><td>12 months</td></tr>
<tr><td>Numerator</td><td>The number of patients in the denominator with documentation of at least one test for Chlamydia during the measurement year.

Codes to Identify Chlamydia Screening (NCQA CHL-C 2013)

<table><tr><th>CPT</th><th>LOINC</th></tr><tr><td>87110, 87270, 87320, 87490, 87491, 87492, 87810</td><td>557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2</td></tr></table>
NOTE: These codes are not the only form of test documentation. Data from other structured fields may also be included.</td></tr>
<tr><td>Denominator</td><td>Active female patients age 18-24 on the date of visit who were seen for a preventive visit and documented as sexually active, during the measurement.

CPT Codes to identify preventive visit:

99201- 99215 with preventive diagnosis code (V20.X, V22.X, V23.X, V70.X, V72.31) or
Preventive Visit: 99385, 99395</td></tr>
<tr><td>Exclusions</td><td>None</td></tr>
<tr><td>Measure source</td><td>Based on HEDIS 2013</td></tr>
</table>

Measure Domain/ Type	Process

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Fall Risk Management
Begin reporting 1Q2014

Definition	The percentage of patients age 66 and older on the date of visit who were screened for fall risk during the measurement period.
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator who were screened for fall risk during the measurement year. At a minimum, the following questions must be asked: • Have you fallen two or more times in the past year • Have you fallen once with injury in the past year
Denominator	Active patients age 66 and older on the date of visit who were seen by a primary care clinician of the PCMH within the 12 month reporting period. CPT codes: 99201-99205, 99212-99215,99387,99397 G codes: G0402, G0438, G0439
Exclusions	None
Measure source	Based NQF 0101 Part A
Measure Domain/ Type	Process

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Chronic Sustainability Initiative
Practice Reporting and Clinical Quality Improvement

Orientation August 1, 2013

Elizabeth Fortin, LICSW
Sr. Director of Practice Transformation & Innovation

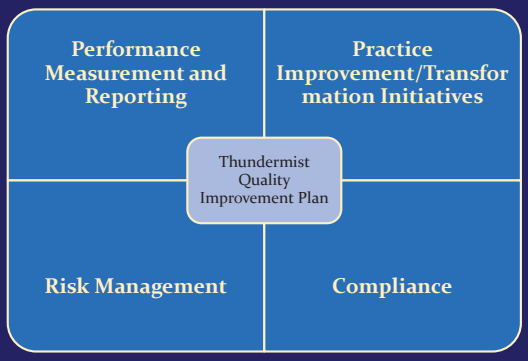
Thundermist HEALTH CENTER

pcmh

Practice Reporting Committee
Materials in the Orientation Manual

- Committee Charge
  - CQ measurement, analysis & reporting
  - Standardization of methods, data validation, supportive discussion on challenges
  - Feedback to D&E on measurement feasibility
  - Collaborate with PT on best practice opportunities
- Practice Participation
  - Contract requirement
  - Representative most knowledgeable of data
- Measure Definition/Specs
  - NQF/HEDIS based
  - Harmonized across PCMH initiatives
- CSI CQ Template for Reporting
- Reporting details & timelines
  - Quarterly by 15th of month
- August 27th session devoted to new practices

Quality Improvement Strategy
approach to change



Quality Improvement Strategy
measurement promotes change

- Measurement is an essential component of PCMH Transformation
- Provides feedback to staff, providers, leaders, board members and patients
- Demonstrates progress, areas for improvement and engages participants

"Measurement is the first step that leads to control and eventually to improvement. If you can't measure something, you can't understand it. If you can't understand it, you can't control it. If you can't control it, you can't improve it," —*H. James Harrington, MD.*

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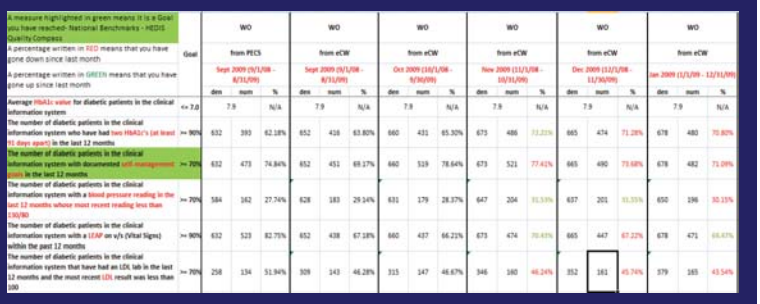
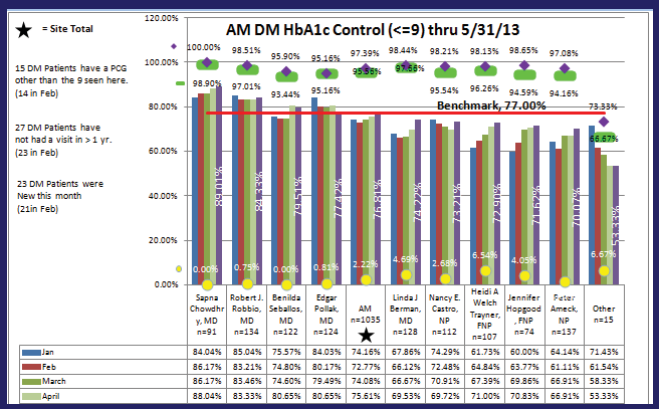
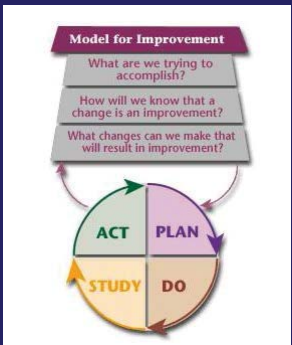
Use of Data to Guide Change



Thundermist … now



Quality Improvement Strategy Model for Improvement



Use of data … Pre Visit Planning

From: Tonni St. Michel
To: **Diabetes Collaborative**
Cc:
Subject: PreVisit Planning.

Message | DM Pre Visit Planning.xlsx (39 KB)

Here is the previsit planning sheets for next week. Have a fantastic weekend!

Tonni ☺

visittype for next upcoming scheduled appointment in a Medical Facility	date of most recent LEAP in last 9 months	date of most recent SM goal in last 9 months	date of most recent Flu Vac in last 9 months	had a Retinal DI or a Retinal Document scanned in in last 9 months?	date of most recent HbA1c in last 9 months	date of most recent LDL in last 9 months
Follow Up	Nov 1, 2012	Aug 1, 2012	Nov 1, 2012		Nov 1, 2012	Nov 1, 2012
Follow Up	Oct 25, 2012				Oct 25, 2012	Nov 8, 2012
Diabetic	May 9, 2012	May 9, 2012		yes	Aug 9, 2012	Aug 9, 2012
Follow Up		Sep 5, 2012		yes	Sep 5, 2012	Sep 5, 2012
Diabetic	Feb 24, 2012	Aug 22, 2012			Aug 22, 2012	Aug 22, 2012
Follow Up		Sep 11, 2012	Oct 29, 2012	yes	Jul 18, 2012	Jul 18, 2012
Diabetic	Jul 25, 2012	Aug 20, 2012		yes	Nov 12, 2012	Jul 11, 2012

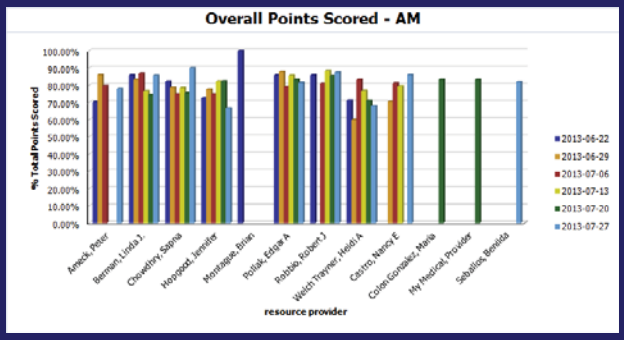
Engaged Team Accountabilities – MAs learning to use Excel, performing pre-visit planning – record prep, huddles. What ever works best.

Use of data … missed opportunities

		# DM Patients Seen	# Possible Points	# Points Scored	% Total Points Scored	# Patients adherent	% LEAP Compliant	# Patients adherent	% SMG Compliant	# Patients adherent	% Flu Vac Compliant	# Patients adherent	% Retinal Exam	# Patients adherent	% HbA1c Compliant	# Patients adherent	% LDL Compliant
THC AM	Ameck,	19	114	89	78.07%	13	68.42%	14	73.68%	14	73.68%	10	52.63%	19	100.00%	19	100.00%
	Berman,	21	126	108	85.71%	15	71.43%	19	90.48%	17	80.95%	15	71.43%	21	100.00%	21	100.00%
	Castro,	12	72	62	86.11%	10	83.33%	10	83.33%	10	83.33%	8	66.67%	12	100.00%	12	100.00%
	Chowdh	5	30	27	90.00%	4	80.00%	5	100.00%	5	100.00%	4	80.00%	5	100.00%	4	80.00%
	Hoggoo	5	30	20	66.67%	4	80.00%	5	100.00%	1	20.00%	2	40.00%	5	100.00%	3	66.00%
	Pollak,	19	114	93	81.58%	16	84.21%	16	84.21%	11	57.89%	13	68.42%	19	100.00%	18	94.74%
	Robbio,	12	72	63	87.50%	12	100.00%	11	91.67%	10	83.33%	6	50.00%	12	100.00%	12	100.00%
	Seballos	13	78	64	82.05%	10	76.92%	12	92.31%	10	76.92%	6	46.15%	13	100.00%	13	100.00%
	Welch	13	78	53	67.95%	10	76.92%	9	69.23%	5	38.46%	3	23.08%	13	100.00%	13	100.00%
	THC AM	119	714	579	81.09%	94	78.99%	101	84.87%	83	69.75%	67	56.30%	119	100.00%	115	96.64%
THC Medical of SC	Bennett,	8	48	35	72.92%	8	100.00%	5	62.50%	4	50.00%	2	25.00%	8	100.00%	8	100.00%
	Buchana	3	18	12	66.67%	2	66.67%	3	100.00%	0	0.00%	1	33.33%	3	100.00%	3	100.00%
	Glenn,	4	24	22	91.67%	4	100.00%	4	100.00%	3	75.00%	3	75.00%	4	100.00%	4	100.00%
	Roth,	10	60	50	83.33%	10	100.00%	9	90.00%	8	80.00%	4	40.00%	10	100.00%	9	90.00%
	THC	25	150	119	79.33%	24	96.00%	21	84.00%	15	60.00%	10	40.00%	25	100.00%	24	96.00%
THC Medical of WW	Buxton,	3	18	16	88.89%	3	100.00%	3	100.00%	2	66.67%	2	66.67%	3	100.00%	3	100.00%
	Delapor	7	42	34	80.95%	6	85.71%	7	100.00%	5	71.43%	3	42.86%	7	100.00%	6	85.71%
	Douglas,	9	54	44	81.48%	9	100.00%	9	100.00%	5	55.56%	4	44.44%	9	100.00%	8	88.89%
	Filip,	2	12	10	83.33%	2	100.00%	2	100.00%	1	50.00%	1	50.00%	2	100.00%	2	100.00%
	Fowlkes,	6	36	26	72.22%	4	66.67%	6	100.00%	3	50.00%	2	33.33%	6	100.00%	5	83.33%
	Hang,	4	24	20	83.33%	4	100.00%	4	100.00%	2	50.00%	2	50.00%	4	100.00%	4	100.00%
	Levins,	1	6	5	83.33%	1	100.00%	1	100.00%	1	100.00%	0	0.00%	1	100.00%	1	100.00%
	Martino,	10	60	48	80.00%	9	90.00%	10	100.00%	7	70.00%	2	20.00%	10	100.00%	10	100.00%
	Piecyk,	1	6	4	66.67%	1	100.00%	1	100.00%	0	0.00%	0	0.00%	1	100.00%	1	100.00%
	Rodrigu	10	60	51	85.00%	8	80.00%	9	90.00%	7	70.00%	8	80.00%	10	100.00%	9	90.00%
	THC	53	318	258	81.13%	47	88.68%	52	98.11%	33	62.26%	24	45.28%	53	100.00%	49	92.45%
THC Pedi	Needha	1	6	6	100.00%	1	100.00%	1	100.00%	1	100.00%	1	100.00%	1	100.00%	1	100.00%
	Zerdelia	1	6	1	16.67%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	100.00%	0	0.00%
	THC	2	12	7	58.33%	1	50.00%	1	50.00%	1	50.00%	1	50.00%	2	100.00%	1	50.00%
THC WH	Macleod	1	6	5	83.33%	1	100.00%	1	100.00%	1	100.00%	0	0.00%	1	100.00%	1	100.00%
	Williams	4	24	21	87.50%	4	100.00%	4	100.00%	3	75.00%	2	50.00%	4	100.00%	4	100.00%
	THC WH	5	30	26	86.67%	5	100.00%	5	100.00%	4	80.00%	2	40.00%	5	100.00%	5	100.00%
Summary		204	1,224	989	80.80%	171	83.82%	180	88.24%	136	66.67%	104	50.98%	204	100.00%	194	95.10%

Weekly feedback

Use of data… team report cards driving improvement



Posted in the department

Sustaining Change

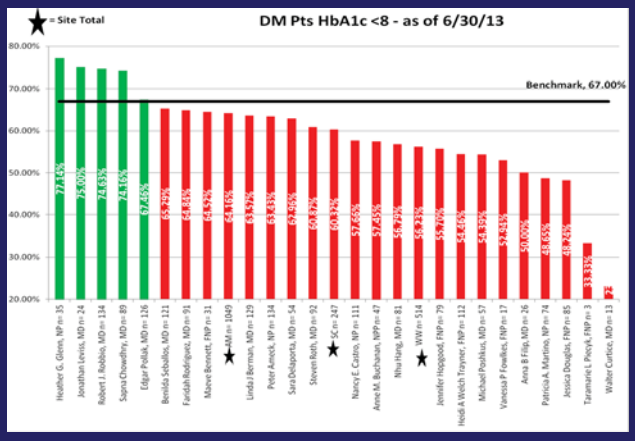
QI Policy and Infrastructure

- Outline goals
- Support process improvement
- Opportunities for success

Practice Team Development

- Clearly defined roles & responsibilities for improved accountability
- Competencies to support working to the top of license or skill set

Demonstrating success … with data



Welcome New Practices!

Practice Reporting Committee

8:00 am to 9:30 am, every 4th Tuesday
Rhode Island Primary Care Physicians' Corp.
1150 New London Ave. Suite 20
Cranston, RI 02920

Co-Chairs
Christine Grey
Rob Mencunas

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Practice Reporting Committee Charter

Charge: The Practice Reporting Committee is responsible for establishing production schedules, producing and coordinating reports, and conducting quality control activities for all practice reporting requirements as established by the Data and Evaluation Committee. These activities include, but are not limited to, the following:

- Discussion and working through data quality, analysis and reporting issues and concerns to achieve the use of standardized definitions and data retrieval criteria
- Establishment of practical, consistent approaches to the query, analysis and reporting of CSI measures across CSI practices
- Sharing of analysis and reporting issues and providing feedback to the Data and Evaluation Committee on proposed measures or other practice reporting topics
- Identification of topics that may need further discussion or coordination with Practice Transformation Committee

The committee co-chairs will be responsible for:

- Identification of activities and coordination of tasks among applicable CSI Management on projects related to data quality, data completeness and reporting
- Reporting to the Data and Evaluation Committee on the activities of the committee, including potential topics or concerns that may need to be addressed by the Data and Evaluation Committee.
- Reporting to the CSI Steering Committee on the clinical measures data submitted quarterly.

Agenda Development: Driven by work plans, feedback and requests from the Data and Evaluation Committee and participating practices. Standing agenda items include review of appropriate reports, measurement related materials and minutes from CSI subcommittees. Agendas may also include items that coordinate with other projects related to data quality, measurement, and evaluation and reporting.

Committee Participants:

Co-chairs**:** representative from a CSI practice
Staff**:** CSI Project Manager and (RIQI) Project Staff
Members**:** Membership is open to all CSI practices, participating health plans and additional members or agents of the RI PCMH community; as such additional members may be identified and invited from time to time by the Data and Evaluation Committee. Members are self-nominating, and shall include data analysts and quality improvement managers who can speak to data query, collection, analysis, reporting and/or data-driven QI processes within their respective organizations

Expectations of Members: Engaged participation in meetings and work in between; commitment to the success of the projects; identifying and prioritizing organizational resources to ensure success of group's work; resolving any internal resource conflicts; sharing among participants of all data and findings deemed relevant and non-proprietary.

Meeting Frequency: Fourth Thursday of every month, with meeting materials to be distributed beforehand. CSI practices are required to have representation at the Practice Reporting Committee, ideally at every meeting but required at the quarterly meeting when data is presented and reviewed.

Review and Submission of Reports: Clinical data and annotations for CSI Clinical Quality Reports shall be submitted by each CSI practice *site* quarterly by the 15th of the month following the close of the quarter. Data for CSI reporting shall be aggregated analyzed and distributed to the practices for review and discussion at the next standing Practice Reporting Committee meeting, prior to the end of the month. Final changes will be made and data is submitted to the CSI Management representative. Aggregate and comparative data shall be presented to the CSI Steering Committee and to all participating practices.

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RIQI Services for CSI-RI Sites

Jennifer Bowdoin & Brian Miller
Rhode Island Quality Institute

August 1, 2013

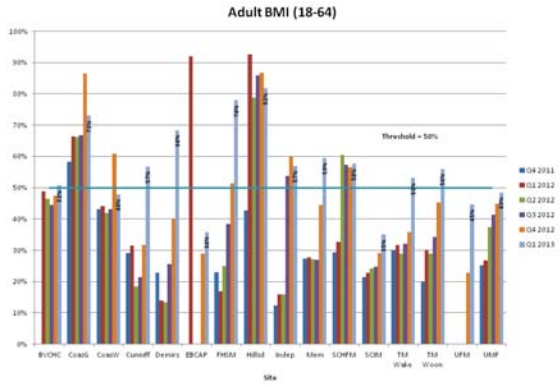
RI REGIONAL EXTENSION CENTER
a service of the Rhode Island Quality Institute

RIQI Services for CSI-RI Sites

- Aggregate clinical quality data and report results
- Provide clinical quality measurement support
- Manage patient experience survey administration
- Manage the CSI PCMH portal
- Deliver Meaningful Use assistance and other RIQI services to practices

RIQI Services – Clinical Quality Data

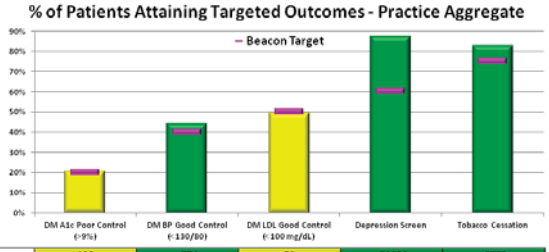
- Aggregate clinical quality data and report results



RIQI Services – Clinical Quality Data

- Aggregate clinical quality data and report results

Based on Reporting Period 4/15/2013 — Released 5/3/2013



	DM A1c Poor Control (<9%)	DM BP Good Control (<130/80)	DM LDL Good Control (<100 mg/dL)	Depression Screen	Tobacco Cessation
Patients to Goal	192	-774	59	-52128	-2583
Numerator	3683	7867	8668	166379	28290
Denominator	17457	17728	17450	190416	34275

FIGURE 1. Percentage of patients, among all reporting Beacon Practices, attaining the targeted outcomes in each of the Beacon Clinical Quality Measures for the 1Q2013 reporting period. The pink bars indicate the Target Value for that measure. Column colors indicate level of Target attainment. Targets for BP Control, Depression and Tobacco Cessation have been attained.

RIQI Services – Clinical Quality Data

- What you need to know
  - **Measure Specifications**: *CSI_Measure definitions 12_15_11update7_18_2013* is the most current version of the CSI Measure Specifications
  - **Reporting Due Date**: The 15th of the month following the close of the quarter
    - E.g., reports for the period 4/1/2013-3/31/2014 are due 4/15/2014
  - **Format:** CSI quality measures reporting template
    - Marie Sarrasin will email a reminder notice with a reporting template prior to the end of the reporting period
  - **Questions**: Contact Marie Sarrasin, 401 276-9141 ext. 239, msarrasin@riqi.org

RIQI Services – Clinical Quality Data

Practice Name	Practice Type	Practice Site	CSI Measure	Period Ending	Numerator	Denominator	Value	Annotation	Comment/ question
			Total # Active Pts 18+						
			Depression Screen						
			DM A1c Poor Control						
			DM BP Good Control						
			DM LDL Good Control						
			Tobacco Cessation						
			DM-BP Pts w/ Measurement						
			DM-HbA1c Pts w/ Result						
			DM-LDL Pts w/ Result						
			DM A1c Good Control (<8)						
			DM BP Control (<140/90)						
			Tobacco Assessment						
			Adult BMI (18-64)						
			Adult BMI (65+)						
			Hypertension BP Measurement						
			Hypertension BP Control (<140/90)						

RIQI Services –Clinical Quality Measurement Support

- Between August 1, 2013 and March 31, 2014, each new CSI RI practice site can receive 10 hours of support to assist with reporting on the clinical quality measures
- The support is customized to the needs of each site
- The support can include but is not limited to:
  - Understanding CSI measures and definitions
  - Developing EHR reports to calculate measures
  - Developing workflows and processes to regularly produce reports, perform quality assurance, and submit data
  - Analyzing and improving the quality of EHR data
  - Training on how to use the PCMHRI.org website

RIQI Services – Clinical Quality Measurement Support

- What you need to know
  - **How to access the support:**
    - Contact your Relationship Manager in the RI Regional Extension Center at RIQI OR wait for your Relationship Manager to contact you (beginning this month)
    - Unsure who your Relationship Manager is? See the Orientation Manual or contact Monique Cote at mcote@riqi.org
  - **What to expect:**
    - Your Relationship Manager will schedule a brief site visit to assess your needs and develop a plan to provide the support
    - Depending on your needs, the Relationship Manager may deliver the support directly or coordinate with other staff to provide support
    - Support may be delivered in person, via phone, or via email, depending on your needs and preferences
  - **Don't need help with quality measurement?** You can use the 10 hours of support for assistance with Meaningful Use or NCQA recognition instead

RIQI Services – Patient Experience Survey

- CAHPS PCMH survey
  - 52 items
  - Composite measures
    - Weighted averages of 2-6 questions related to specific PCMH domains
      - Access, communication, shared decision-making, self-management support, comprehensiveness (behavioral health), office staff
      - Two additional homegrown composite measures: information items, coordination of care items
  - Top box scores
    - Typically a single top or best choice for a yes/no question or a 4-point Likert scale

RIQI's Role – Patient Experience Survey

- Conducted annually
  - Timing TBD, likely in fall/winter
- NCQA certified vendor
- NCQA and HEDIS approved methodology
  - Mixed mode – 1 survey mailing, 5 follow-up phone calls
  - English and Spanish
  - Oversampling at sites expected to have low response rates
- Adults age 18 and older
  - Child survey can be conducted for interested sites for a fee
- Support NCQA recognition
- NCQA Special Distinction in Patient Experience Reporting
  - Optional
  - $265 fee per site

RIQI's Role – Patient Experience Survey

- What you need to know
  - There is no cost to participate
    - Optional fee to submit results to NCQA
  - Practices can use their own vendor (at their own expense)
    - Conditions/requirements are available from CSI
  - **How to participate:**
    - Jen Bowdoin(jbowdoin@riqi.org) will contact your site via email prior to the survey
    - Execute a Business Associate Agreement with the vendor
    - Provide a patient data file that meets the vendor's requirements
      - 12 month look back
      - Primarily demographic information
      - Sent to the vendor using HIPAA-compliant method
    - Provide other requested information (e.g., practice logo and contact information to include on survey cover letter)
    - OPTIONAL: "Purchase" NCQA Special Distinction in Patient Experience Reporting on NCQA account and pay fee to vendor

RIQI's Role – Patient Experience Survey

- What you need to know
  - **What to expect:**
    - Your practice will be notified via email before the survey is fielded
    - Patients may have questions or complaints about the survey
      - RIQI or the vendor will provide a set of answers to frequently asked questions
      - Complaints should be directed to Jen Bowdoin
    - Results are available about a month after the survey is completed
    - Additional analyses are available upon request
  - **Questions:** Jen Bowdoin, 401-276-9141 x 238, jbowdoin@riqi.org

RIQI's Role – CSI PCMH Portal

- What you need to know
  - **CSI PCMH Portal Access**:
    - Email Marie Sarrasin (msarrasin@riqi.org) with name, email address (if not coming directly from user), practice, and site name
    - You will receive an email containing confidential username/password and navigation instructions
  - **How to find the portal:**
    - Go to http://www.pcmhri.org
    - Click on *Collaborative Portal Access*
    - Enter username and password
  - **Questions**: Contact Marie Sarrasin, 401-276-9141 x 239, msarrasin@riqi.org

RIQI's Role – Meaningful Use Assistance

- Provide assistance with achieving Meaningful Use
  - Subsidies of up to $2,500 per provider (up to 10 in one office) based on milestone achievements
  - Access to RI REC's Vendor Marketplace, a group of pre-qualified software vendors, technical service consultants, and Health Information Service Providers (HISPs)
  - Pre-negotiated discounts from pre-qualified EHRs
  - Assistance with meeting Meaningful Use criteria for maximum federal EHR incentive payments
  - Individualized assistance
  - Assessment of your EHR's interoperability to participate in RI's health information exchange (HIE)
  - Educational materials and invitations to health IT events

RIQI Services – Meaningful Use Assistance and Other Services

- What you need to know
  - Your Relationship Manager is your account manager for most RIQI services
  - **How to access the services:**
    - Contact your Relationship Manager in the RI Regional Extension Center at RIQI
    - Unsure who your Relationship Manager is? See the Orientation Manual or contact Monique Cote at mcote@riqi.org
  - **What to expect:**
    - Each program has different training, legal, and other requirements for participation
    - Your Relationship Manager will explain the requirements to you and walk you through what's needed to participate

RIQI Services – Meaningful Use Assistance and Other Services

- Meet the Relationship Managers
  - Kerri Costa, kcosta@riqi.org, 401-276-9141 x 235
  - Sue Dettling, sdettling@riqi.org, 401-276-9141 x 236
  - Courtney Greenwood, cgreenwood@riqi.org, 401-276-9141 x 293
  - Andréa Levesque, alevesque@riqi.org, 401-276-9141 x 262

- REC Manager
  - Darlene Morris dmorris@riqi.org 401-276-9141 x 246

Questions???

Jennifer Bowdoin
Senior Associate, Project Management
jbowdoin@riqi.org
401-276-9141 x 238

Brian Miller
Senior Associate, Program Development
bmiller@riqi.org
401-276-9141 x 286

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RIQI IT Support with Clinical Quality Measurement and Reporting

Between August 1, 2013 and March 31, 2014, each new CSI-RI practice site can receive 10 hours of IT support from Rhode Island Quality Institute (RIQI) to assist with reporting on the clinical quality measures. The support will be customized based on the needs of each site. Examples of the types of support that sites can receive from RIQI include (but are not limited to):

- Understanding CSI-RI measures and definitions
- Developing EHR reports to calculate measures
- Developing workflows and processes to regularly produce reports, perform quality assurance, and submit data
- Analyzing and improving the quality of EHR data
- Training on how to use the PCMHRI.org website

Sites that do not need assistance with clinical quality measurement and reporting may alternatively use the 10 hours of support for assistance with Meaningful Use or NCQA recognition.

How to access the support:

Contact your Relationship Manager in the RI Regional Extension Center (REC) at RIQI. Relationship Managers will also initiate contact with the new CSI sites beginning in August to start delivering the support.

If you are unsure who your Relationship Manager is, see the Orientation binder, tab 1 "Current CSI-RI Practice Information" or contact Monique Cote at mcote@riqi.org.

What to expect:

In most instances, Relationship Managers will schedule a brief site visit to assess each site's needs and develop a plan to provide the support. Depending on the site's needs, the Relationship Manager may deliver the support directly or coordinate with other staff at RIQI to provide the support. The support may be delivered in person, via phone, or via email, depending on the site's needs and preferences.

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Practice Data Reporting Template

PCMH Program	Practice Name	Practice Type	Practice Site -	Provider Name	CSI Measure	Date End Quarter	Num 2Q2013	Denom 2Q2013	Value 2Q2013	Annotation 2Q2013:	Comment/question 2Q2013:
CSI	Blackstone	CHC			Total # Active Pts 18+	6/30/2013					
CSI	Blackstone	CHC			Depression Screen	6/30/2013					
CSI	Blackstone	CHC			DM A1c Poor Control	6/30/2013					
CSI	Blackstone	CHC			DM BP Good Control	6/30/2013					
CSI	Blackstone	CHC			DM LDL Good Control	6/30/2013					
CSI	Blackstone	CHC			Tobacco Cessation	6/30/2013					
CSI	Blackstone	CHC			DM-BP Pts w/ Measurement	6/30/2013					
CSI	Blackstone	CHC			DM-HbA1c Pts w/ Result	6/30/2013					
CSI	Blackstone	CHC			DM-LDL Pts w/ Result	6/30/2013					
CSI	Blackstone	CHC			DM A1c Good Control (<8)	6/30/2013					
CSI	Blackstone	CHC			DM BP Control (<140/90)	6/30/2013					
CSI	Blackstone	CHC			Tobacco Assessment	6/30/2013					
CSI	Blackstone	CHC			Adult BMI (18-64)	6/30/2013					
CSI	Blackstone	CHC			Adult BMI (65+)	6/30/2013					
CSI	Blackstone	CHC			Hypertension BP Measurement	6/30/2013					
CSI	Blackstone	CHC			Hypertension BP Control (<140/90)	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Total # Active Pts 18+	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Depression Screen	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM A1c Poor Control	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM BP Good Control	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM LDL Good Control	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Tobacco Cessation	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM-BP Pts w/ Measurement	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM-HbA1c Pts w/ Result	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM-LDL Pts w/ Result	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM A1c Good Control (<8)	6/30/2013					
CSI	Coastal Medical	Group	Greenville		DM BP Control (<140/90)	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Tobacco Assessment	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Adult BMI (18-64)	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Adult BMI (65+)	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Hypertension BP Measurement	6/30/2013					
CSI	Coastal Medical	Group	Greenville		Hypertension BP Control (<140/90)	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Total # Active Pts 18+	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Depression Screen	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM A1c Poor Control	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM BP Good Control	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM LDL Good Control	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Tobacco Cessation	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM-BP Pts w/ Measurement	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM-HbA1c Pts w/ Result	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM-LDL Pts w/ Result	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM A1c Good Control (<8)	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		DM BP Control (<140/90)	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Tobacco Assessment	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Adult BMI (18-64)	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Adult BMI (65+)	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Hypertension BP Measurement	6/30/2013					
CSI	Coastal Medical	Group	Wakefield		Hypertension BP Control (<140/90)	6/30/2013					

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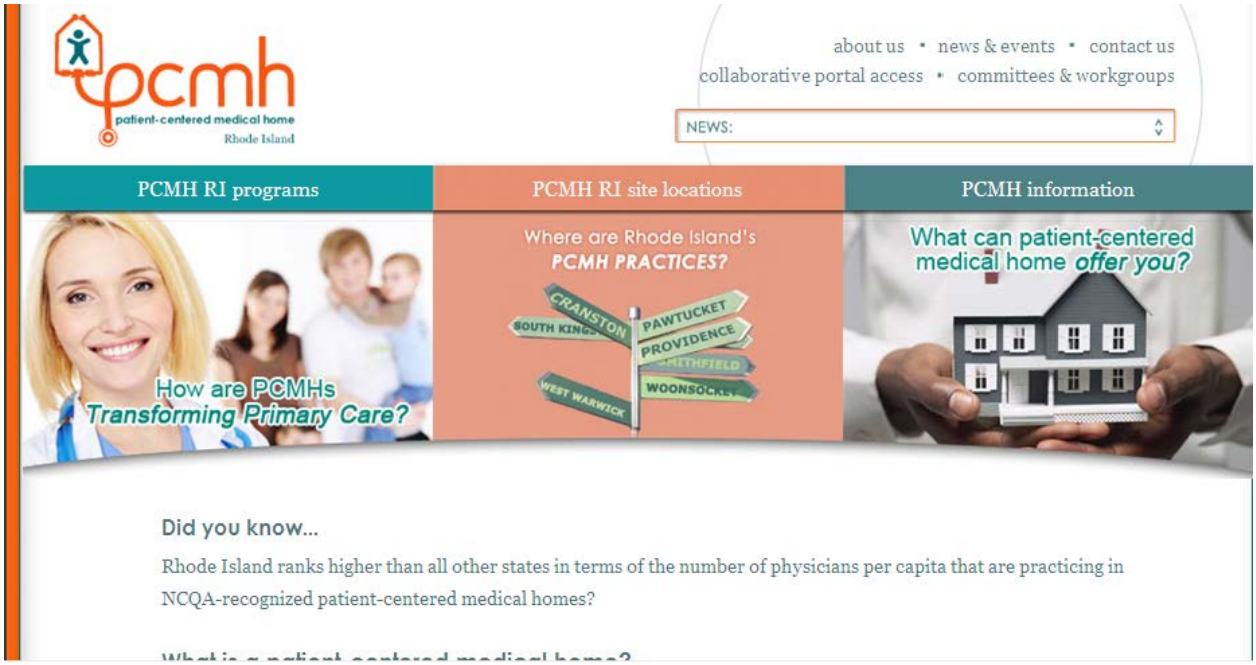
CSI-RI PMCHRI.org Web Portal

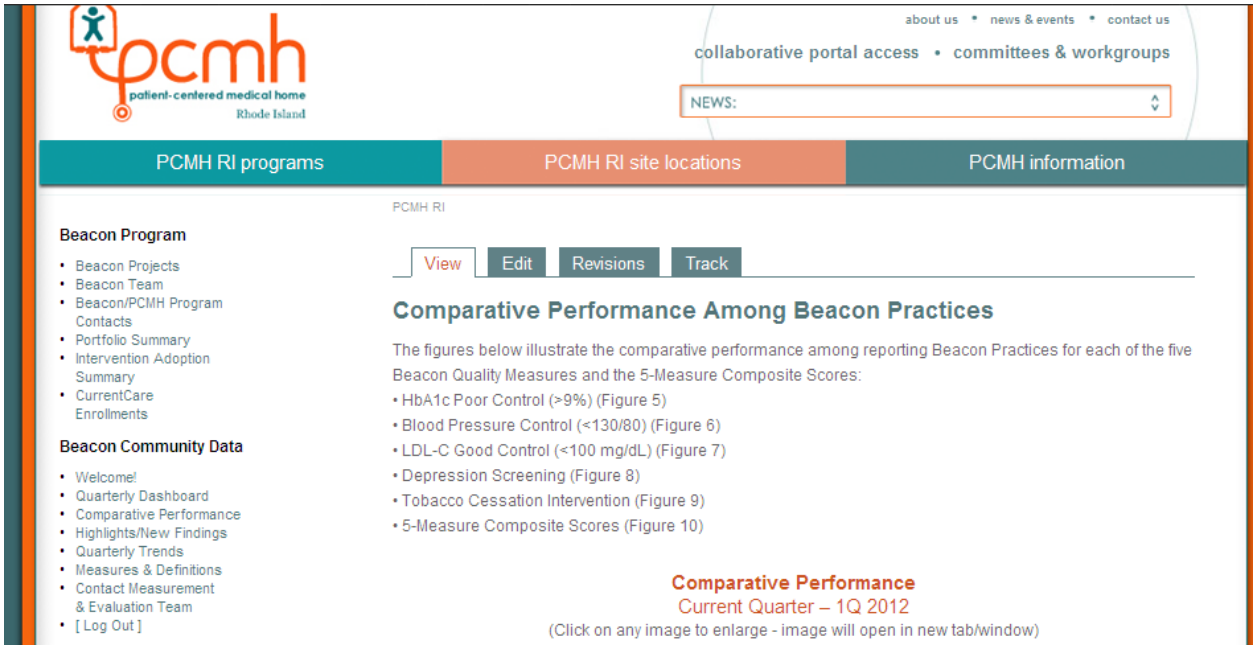
To login to the Patient-Centered Medical Home – RI Web Portal go to: PCMHRI.org

Click on **Collaborative Portal Access** to view key data.

To receive login credentials, contact:

Marie Sarrasin
Business/Systems Analyst
Rhode Island Quality Institute
401-276-9141 x239
Cell 401-301-3237
msarrasin@riqi.org





Beacon Utilization Data
- Hospital and Emergency Utilization Trends

CSI Program
- CSI and Beacon Steering Committee Meetings

Practice Blinding Codes
- Restricted Access

Practice-Level Data - A
- Individual Practice Data
- Your Blinding Codes

Practice-Level Data - C
- Individual Practice Data
- Your Blinding Codes

Practice-Level Data - D
- Individual Practice Data
- Your Blinding Codes

Practice-Level Data - E
- Individual Practice Data
- Your Blinding Codes

Practice-Level Data - F

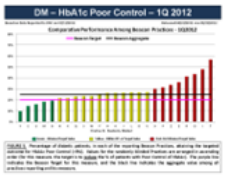


Figure 5

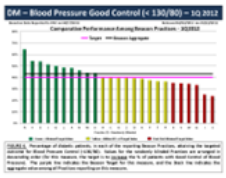


Figure 6

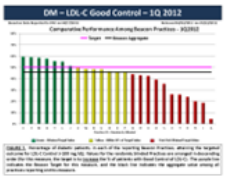


Figure 7

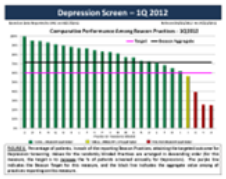


Figure 8

Figure 9

Figure 10

Post/ Read comments below relate to figures 5-10

***NOTE**: Once posted, comments cannot be edited or deleted by our users. If you wish to have a comment removed, please contact the Measurement & Evaluation team.*

Summary of Target 3 of the Developmental Contract

Practices will agree to un-blinded, public reporting of approved performance metrics on the PCMHRI website, amongst the CSI-RI community.

Target #3 Utilization Metric (aggregated metric): Reporting and Measurement for Target # 3 will be reviewed annually by the CSI-RI Data and Evaluation Committee with recommendations to the CSI-RI Executive Committee to modify the specific benchmarks.

a. Practice will achieve the CSI-RI Utilization measures (provided)
b. Plan shall provide to the data aggregator and evaluation vendor identified by CSI-RI Management sufficient claims detail by product to support the reporting for the Inpatient and ER metrics as identified in Target #3. As of February 28, 2012, the data aggregator is the Rhode Island Quality Institute and evaluator is RTI.
c. Plan shall provide the claims data to the data aggregator and evaluation vendor, within fifteen (15) days of the end of each quarter.
d. CSI-RI Project Management designated vendor will aggregate and report the results within thirty (30) days of receipt of all of the Plans' data.
e. Plan will then make the necessary retroactive payment adjustment (if any) and pay the revised PMPM consistent with the earned amount for Targets #1-3 with Contract Quarter six (6) payment.

Utilization Benchmarks:

- CSI-RI Practices will achieve a five percent (5%) relative reduction in hospital admissions per thousand as compared to similar, non-PCMH providers during the same measurement period. "Non-PCMH practices" will be defined by the Data and Evaluation Committee and approved by Executive Committee and voting members of the CSI-RI Steering Committee.
    - For example, if the comparison non-PCMH practices have decreased their rate of hospitalization from 50 hospital admission/1000 to 49 hospital admissions/1000 (2% reduction), CSI-RI Practices will achieve a rate deduction of 7% to meet target, i.e. 75 hospital admissions/1000 to (75– [75 X .07]) = 69.75 hospital admissions/1000).
- CSI-RI Practices will achieve seven and a half percent (7.5%) relative reduction in ED visits per thousand as compared to similar, non-PCMH practices during the same measurement period.
    - For example, if the comparison non-PCMH practices decreased their rate of ED visits from 300 ED visits/1000 to 270 ED visits/1000 (10% reduction), CSI-RI Practices will achieve a reduction of 17.5% to meet target, i.e. 250 visits/1000 to (250 – [250 X .175] = 206.25 ER visits/1000).

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Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

Improving the Safety of Care Transitions through Best Practices and Community Collaboration

Lynne Chase
Senior Program Administrator – Safe Transitions Program
Healthcentric Advisors

2013 CSI: New Practice Orientation
Reducing Costs - ED & Hospitalization
August 1, 2013

Quality Improvement Organizations
Sharing Knowledge, Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Time For Change

- Complex and cross-setting communication required
- RI: 25% of Medicare patients readmitted in 30 days
  - Most within 5 days
  - Readmission diagnoses: AMI, CHF, PNE
- Poor transitions negatively impact patient safety, outcomes, satisfaction and cost
- Motivated providers
  - Starting in fiscal year 2013, decreased Medicare payments for all Medicare discharge for hospitals with higher-than-expected readmission rates

What We Are Trying To Achieve

Reducing ED Visits and Readmissions Community Opportunity

- Drivers of Poor Transitions
  - Incomplete, inaccurate or delayed transfer of information
  - Lack of patient/caregiver activation
  - Inconsistent implementation of standard and known processes
- Key Players
  - Community Physicians: PCPs & Specialists
  - Hospitals, Nursing Homes, Home Health, Hospice
  - Assisted Living, Adult Day, Senior Center, Senior Advocates
  - Stakeholders: Payors, Regulators, Legislators
  - Patients, Families, Caregivers

Improve Internal Processes

- Implement Safe Transitions Best Practices
- Implement plan-do-study-act (PDSA) cycles to address opportunities
  - Root cause analysis
  - Evidence-based interventions
  - Tracking (process), measuring short term impact (proximal) and utilization/satisfaction results (outcome)
  - Analysis: review data against goals

Link Patients/Caregivers to Social & Community Supports

THE POINT - Rhode Island's Aging and Disability Resource Center

- Refer to THE POINT to connect your patients to community-based home care services, financial and insurance benefit programs, housing information, long-term care planning, and independent living services for individuals with disabilities.

Call: 401-462-4444

CareBreaks - Respite for RI Caregivers

- Refer to CareBreaks to provide in-home care or care at a facility/day program for your patients when their family /caregiver needs a break.

Call: 401-421-7833

Interested in learning more- or to request materials for your office, contact Sheryl Leary (sleary@healthcentricadvisors.org or 401-528-3218)

Collaborate In Your Community

209 communities across the nation… providers (traditional/non) working together to improve transitions of care…

- **Newport:** Sue Dugan/Andrea Ripa
- **Northern Rhode Island:** Amy Paul/Linda Wheeler/ Sue Bleuel
- **Providence Transitions Coalition:** Jenny Cellar/Mary Biello/JoAnn Cote
- **Warwick:** Fran Falsey
- **Washington County:** Lynne Driscoll/Karen Hockhousen/Jennifer Fairbanks

7

Spread & Sustain Improvement via Statewide Learning and Action

- Quarterly learning sessions
  - Share best practices
  - Highlight innovation
- Collaboration Tools
  - Listserv
  - Safe Transitions SharePoint Site
  - LinkedIn Group

8

To Learn More, contact

Lynne Chase
Senior Program Administrator
Healthcentric Advisors
401-528-3253
lchase@healthcentricadvisors.org

9

Plan Ahead:

SAVE-THE-DATES!

Newport Transitions of Care Coalition 2013 Calendar

Monday February 25, 2013	10:00am – 11:30am	*Newport Hospital*
Monday April 22, 2013	10:00am – 11:30am	*Newport Hospital*
Monday June 24, 2013	10:00am – 11:30am	*Newport Hospital*
Monday August 26, 2013	**10:00am – 11:30am**	***Newport Hospital***
Monday October 28, 2013	**10:00am – 11:30am**	***Newport Hospital***
Monday December 30, 2013	**10:00am – 11:30am**	***Newport Hospital***

Plan Ahead:

Mark your calendar!

Northern RI Transitions of Care Coalition 2013 Calendar

Thursday January 10, 2013	**8:00am – 10:00am**	**Healthcentric Advisors** *235 Promenade Street – Suite 500, Providence* *401.528.3200* *Contact: Lynne Chase*
Thursday March 14, 2013	**8:00am – 10:00am**	**Atria Bay Spring Village** *147 Bay Spring Avenue, Barrington* *401.246.2500* *Contact: Pamela Dumont*
Thursday May 9, 2013	**8:00am – 10:00am**	**Bayberry Commons Nursing & Rehabilitation Center** *181 Davis Drive, Pascoag* *401.568.0600* *Contact: Sue Hawver*
Thursday July 11, 2013	**8:00am – 10:00am**	**Cortland Place** *20 Austin Avenue, Greenville* *401.949.3880* *Contact: Kayli Graveline*
Thursday September 12, 2013	**8:00am – 10:00am**	**Greenville Center** *735 Putnam Pike, Greenville,* *401.949.3860* *Contact: Colleen Powers Miller*
Thursday November 14, 2013	**8:00am – 10:00am**	**Trinity Health & Rehabilitation Center** *4 St. Joseph Street, Woonsocket* *401.765.5844* *Contact: Linda Wheeler-Omiunu*

Plan Ahead:

Mark your calendar!

Safe Transitions Project

PTC Meeting Calendar

Thursday **January 10, 2013**	**2:00pm – 4:00pm**	**Rhode Island Hospital** ***593 Eddy Street, Providence, APC 702*** ***401.444.4000*** *Contact: Pamela Gregoire/Jo-Ann Cote*
Thursday **March 14, 2013**	**2:00pm – 4:00pm**	**Steere House** **Nursing & Rehabilitation** *100 Borden Street, Providence* *401.454.7970* *Contact: Robin Knoderer*
Thursday **May 9, 2013**	**2:00pm – 4:00pm**	**Elmwood Health Center** **Nursing & Rehabilitation** *225 Elmwood Avenue, Providence* *401.272.0600* *Contact: Jen Campbell*
Thursday **July 11, 2013**	**2:00pm – 4:00pm**	**Saint Elizabeth Manor** *1 Dawn Hill Road, Bristol* *401.253.2300* *Contact: Jessica Normandin*
Thursday **September 12, 2013**	**2:00pm – 4:00pm**	**Elmhurst Extended Care** *50 Maude Street, Providence* *401.456.2600* *Contact: Cheryl Fitzgerald*
Thursday **November 14, 2013**	**2:00pm – 4:00pm**	**Home & Hospice Care of Rhode Island** *1085 North Main Street, Providence.* *401.415.4200* *Contact: Marsha Stephenson*

Revised DRAFT

Care Continuum Warwick Coalition Team Calendar

December, 2012-November, 2013

Note: as of 1/13, meetings will occur on the 4th Thursday of the month

Day/Date	Time	Location/Host
Tuesday-12/11/12	3:00p	Kent Hospital Board Room
Thursday – 1/24/13	3:00p	Westview
Thursday – 2/28/13	3:00p	Riverview
Thursday – 3/28/13	3:00p	Coventry
Thursday – 4/25/13	3:00p	West Shore
Thursday – 5/23/13	3:00p	Kent
Thursday – 6/27/13	3:00p	Kent
Thursday – 7/25/13	3:00p	Greenwood Care & Rehab
Thursday – 8/22/13	3:00p	Healthcentric Advisors
Thursday – 9/26/13	3:00p	Thundermist Health Center
Thursday – 10/24/13	3:00p	Kent Regency
Thursday – 11/21/13 *	3:00p	Kent Hospital Trowbridge Building 102/103

*Third Thursday due to Thanksgiving Holiday

Plan Ahead:

Mark your calendar for 2013 meetings

Safe Transitions

Washington County Meeting Calendar

Thursday **February 7th**	**6:00pm – 7:00pm**	**Apple Rehab Clipper** *161 Post Road, Westerly* *401.322.8081* *Contact: Amy Calhoun*
***** Thursday****** **March 28th** 	**3:00pm – 4:00pm**	***Washington County: National Learning Session Presentation- Shining Stars Around the County*** ***Participate in the webinar from anywhere:*** *https://qualitynet.webex.com /password: community* *conference line: 1-866-639-0744* *Feel free to join the presenters & other coalition members:* ***South County Hospital*** *100 Kenyon Avenue, Wakefield* *Contact: Lynne Driscoll*
Thursday **April 11th**	**6:00pm – 7:00pm**	**South Kingston** *2115 So. County Trail, West Kingston* *401.783.8568* *Contact: Maria Berdi*
Thursday **June 13th**	**6:00pm – 7:00pm**	**BrightView Commons** *57 GrandeVille Court, Wakefield* *401.789.8777* *Contact: Bonnie Pollard-Johnson*
Thursday **August 8th**	**6:00pm – 7:00pm**	**The Westerly Hospital** *25 Wells Street, Westerly* *401. 348.3972* *Contact: Kim Kralicky*
Thursday **October 10th**	**6:00pm – 7:00pm**	**Scallop Shell** *981 Kingstown Road, Wakefield* *401.789.3006* *Contact: Felicia Catallozzi*
Thursday **December 12th**	**6:00pm – 7:00pm**	**South County Nursing & Rehab** *740 Oak Hill Road, North Kingstown* *401.294.4545* *Contact: Jennifer Fairbanks*

Plan Ahead:

Mark your calendar for the 10th SOW schedule!

Safe Transitions Project

LEARNING & ACTION NETWORK

Event Schedule

2012	
January 25, 2012	8:00am - 11:00am*
March 15, 2012	8:00am - 11:00am*
June 7, 2012	8:00am - 11:00am*
September 20, 2012	8:00am - 11:00am*

2013	
January 17, 2013	8:00am - 11:00am*
March 21, 2013	8:00am - 11:00am*
June 6, 2013	8:00am - 11:00am*
September 19, 2013	8:00am - 11:00am*

2014	
January 16, 2014	8:00am - 11:00am*
March 20, 2014	8:00am - 11:00am*
June 5, 2014	8:00am - 11:00am*

** Note that registration opens at 7:30 am and meetings will begin promptly at 8:00am. Space is limited, so pre-registration is required for attendance.*

Unless otherwise noted, all meetings will be hosted at:

Healthcentric Advisors
235 Promenade Street, Suite 500
Providence, RI 02908

CSI RI Practice Facilitation Plan

What is Practice Facilitation?

Practice facilitation consists of supportive services aimed at fostering transformation along the PCMH continuum as well as an environment of sustainable change within your practice and/or group. A major goal of practice facilitation is to increase your internal capacity for improving health outcomes, helping patients have better care experiences and managing overall costs – with special emphasis placed on transitions of care and emergency department and inpatient utilization.

What Practice Facilitation Services will be available to my practice?

Practice Facilitation Services will be customized to the needs of the practice and will include:

1. On site practice facilitators
    a) Practice assessments
    b) Development of PCMH principles, as articulated in the Safety Net Medical Home Initiative and NCQA
    c) Interpretation and actionable use of data
    d) NCQA support
    e) Sustainability
2. Incentive payment model that rewards sharing and incorporating best practices between two practices
3. IT Support
4. Best practice sharing across the entire program
5. Identification and facilitation of training

What are your Practice Expectations for working with the Practice Facilitator?

- Time and Commitment Active participation in Practice Transformation and Facilitation services across all roles has been found to drastically improve the sustainability of change in a practice. The Practice Facilitator will work with the practice leadership and clinical team to conduct an in-depth practice assessment, and to design, implement and carry out selected re-design activities based on practice needs. Expectations and time commitments will be discussed in more depth between the practice facilitator and practice leadership during the individual practice kick off meeting.
- Using Population Based Quality Data to Improve Quality Quality improvement informed by data aggregation and reporting is an integral part of the CSI program. As such, along with the Practice Reporting and Data and Evaluation Committees, practice facilitators will assist in addressing quality data related issues either directly or by leveraging community-based resources (i.e. RIQI)
- Partnering for Best Practice Best practice sharing and committee based learning is one of the fundamental strengths of the CSI program. Practices have varied backgrounds and affiliations, but all have the common goal of improved quality, enhanced patient experience, and cost containment. As a new practice to CSI, you will be expected to participate in best practice sharing – not only to learn from others, but also to offer your experiences with others.
- Active Participation CSI-RI Governance Practice representation in CSI Governance and Steering committees is expected as part of your contract.

Timeline for Expected Activities The Practice Facilitation Plan will begin in August 2013 and extend through March 2014. The next budget cycle for Practice Facilitation will start April 1, 2014 and activities for that budget cycle will be defined at that time. The Practice Facilitator will be available to work with practices 3-4 hours a week (Start-Up Practices) 2 hours per week (Transition Practices)

Activity	Timeline
New Practice Orientation: Welcome to CSI RI	August 1, 2013
On Site visits to practices: Clarify expectations with Practice Leadership, Physician Champion, Practice team (including office staff, nurse, medical assistant, quality staff); Identify practice assessment strategy and next steps	August-September 2013
Practice Assessment using the PCMH-A MacColl Survey and the Self-Assessment for NCQA recognition, if applicable (some practices may have recently completed an assessment process through another PCMH program). (Practice Facilitator will administer)	August-September 2013
Conduct Gap analysis ; Practice to identify a team comprised of practice leaders with representation form providers, clinical support, front office and administration	October-November 2013
Team will work with Practice Facilitator to develop and implement a customized plan with goals and proposed timeline to address at least 3 practice needs, incorporating the goals of the CSI developmental practice; continually evaluate progress against measures and the practice re-design	December 2013-March 2014
Evaluate progress based on 3 identified goals	March 2014

The NCQA Patient-Centered Medical Home (PCMH) Recognition Process

Before you start:

- All PCMH materials can be obtained from http://www.ncqa.org/tabid/631/Default.aspx or call (888) 275-7585, M-F, 8:30 a.m. – 5:00 p.m. ET.
- We recommend that you order the **PCMH 2011** Standards and Guidelines (free) and receive training (work through step 4c below) before you order any other materials.
- Later, you will need to order both a PCMH online application (free) and an electronic survey tool (The Interactive Survey System, or ISS, PCMH tool, $80@) for PCMH submissions.
- Practices may use the Standards and Guidelines to self-assess prior to submitting to NCQA. However, the survey tool must be submitted online (instructions follow).
- After you order the online application and survey tool, NCQA will send you a response e-mail for each order. Please keep these e-mails available as they contain important access information that you will need going forward.
- For help with usernames, passwords, missing e-mails, and technical difficulties, please contact NCQA at 1-888-275-7585.

Please follow these instructions carefully as you begin this process:

1. **Information technology (IT) requirements to complete the PCMH recognition process:**
    a. You will need a computer with:
        i. Access to the Internet
        ii. Microsoft Word
        iii. Microsoft Excel
        iv. Adobe Acrobat Reader (available for free online)
    b. This computer should also have access to the practice's clinical and administrative systems
    c. Please note that the survey system should be accessed and the survey completed using Internet Explorer. Other internet programs may not be compatible (i.e. Firefox, Safari).

2. **Your organization's key staff members**
    a. The organization's party responsible for the PCMH submission should assess the resources required prior to making work assignments.
    b. NCQA needs a Primary Contact designated in the online application to receive communications. The organization may grant access to other staff member to the online application and ISS survey tool.
    c. Your practice should designate one or more staff members to complete all necessary application information and the ISS survey tool.

3. **Support from a sponsor, state, or organization**
    a. If you have a sponsor, determine if you or the sponsor will be paying the PCMH submission fees.
    b. If you sponsor is officially engaged with NCQA, you may be eligible for a 20% discounts on single site PCMH submissions.

c. Confirm your sponsor's timeline. NCQA requires up to 60 days for decisions once you have submitted your ISS survey tool. Allow yourself plenty of time; the PCMH submission process is complex.
d. Determine your sponsor's contact information, and what help they may offer to you.
e. NCQA does not provide information on incentive programs or financial rewards offered by sponsors.

4. PCMH training and self assessment

a. NCQA provides two types of free PCMH training: PCMH Standards and Guidelines, and the ISS survey tool.
b. We strongly encourage all practices to attend both types of training. Each training session is about 2 hours long. You may choose to attend more than once. You'll find the training schedule and instructions at www.ncqa.org/rptraining.aspx.
c. Training will help you understand how to name your practice at the time you order your online application and ISS survey tool.
d. At this point, order your online application (free) and ISS survey tool. Watch for those response e-mails from NCQA and safeguard them.
e. Self assess. Use the Standards and Guidelines to determine your total score. Pay special attention to the Must Pass Elements.
f. Understand the scoring. Refer to the Standards and Guidelines to determine the Level of Recognition you will earn based on your self assessment.

5. Initializing your PCMH ISS survey tool

a. Please refer to the e-mails you received from NCQA when you ordered your ISS survey tool.
b. Follow the instructions in the e-mail to access your ISS survey tool.
c. Information on the license number for your survey can be found on the first welcome screen after logging into the online survey tool. Note your license number.
d. Select your three important clinical conditions.
e. Enter your three important clinical conditions in the tool.
f. Save your entries.
g. You will return to complete your ISS survey tool at a later date.

6. The Online Application

a. Please refer to the e-mails you received from NCQA when you ordered on your online application.
b. Launch your online application following the instructions in the e-mail.
c. If fees are being paid for by a Sponsor, you can ignore the fee instructions. Information on Sponsor must be entered for each site to use the discounted application fee schedule. The fee schedule is posted on the Web site and available in the resources for the application system.
d. Add your clinicians and your application to your practice site. Enter your ISS survey tool license number into the application. By entering your license number you will link your ISS tool and your online application. This will cause your three clinical important conditions to auto populate in the online application.
e. You must sign the Business Associate Agreement (BAA) and PCMH Agreement. You may also choose to sign the Attestation. We encourage you to do so electronically through the online application. If you need to make custom changes to the two Agreements download the Manual Signature versions on each of the Agreements starting page. Red line any changes you would like made to the Agreement and submit to NCQA at the address below. Please note you will not be able to submit your application until any customized Agreements are accepted, signed, and uploaded by NCQA.

NCQA Attn: PCMH Program
1100 13th Street NW
Suite 1000
Washington, DC 20005

f. If your practice is a multi-location practice (3 or more sites) that would like to complete the medical home assessment for the multiple locations, follow the special set of instructions in the application system.
g. The online application must be received prior to submitting the ISS survey tool. You will receive an e-mail from NCQA confirming the receipt of your online application and an additional e-mail to inform you that NCQA is ready to receive your ISS survey tool.

7. Preparing your PCMH ISS survey for submission

a. Your PCMH program fee is due when you submit your ISS tool. Use the fee schedule in effect as of the date of submission. Fees are available on NCQA's website. Send your fee to Recognition Programs, NCQA, 1100 13th St. NW, Washington DC 20002. If you would like to pay by credit card, request a form by e-mailing pcmh@ncqa.org.
b. Refer once again to NCQA's e-mail containing the link to your ISS survey tool and log in.
c. The *Help & Instructions* at the top right corner of the screen are always available within the tool.
d. Through the training sessions and by reading the resource materials, you know how to respond to Elements and attach documentation to the ISS library.
e. Upload your saved documents to the document library. Verify the location of your files.
f. Perform the completeness check available in the "Submit Survey Tool" menu. Verify that your documents have been uploaded.
g. Self assess again. Note your total points and the Must Pass Elements.
h. If you are satisfied with your self assessment, submit your ISS survey.
i. You will receive an error message if:
    i. you did not have your application processed
    ii. You did not upload any documents
j. After you have submitted your online survey, you will receive e-mail confirmation from NCQA.
k. You will receive an e-mail within 60 days informing you of NCQA's decision.

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NCQA Standards and Application Resources

1. NCQA: Patient-Centered Medical Home (PCMH) Recognition Resources
   http://www.ncqa.org/tabid/631/Default.aspx
   - PCMH 2011 Content and Scoring Summary
   - Standards and Guidelines
   - Application Materials and Survey Tool
   - 3rd Quarter Training Schedule (September schedule pasted below)
   - Recorded/On-Demand Web Trainings
     http://www.ncqa.org/tabid/109/Default.aspx#GetOnBoardPcmh
     (scroll down to "*Recorded Trainings*").
     For example: *How to use the Record Review Workbook:*
     http://www.youtube.com/watch?v=lITAOlJOqwc
   - View Frequently Asked Questions Submit to questions to pcmh@ncqa.org
   - Submit questions to pcmh@ncqa.org . Please use the email box to :
     - Ask about interpretation of standards or elements
     - After license purchase or multi-site review, a manager & technical analyst will be assigned as your direct contact. Please use this e-mail box to:
       - Ask about interpretation of standards or elements
       - After license purchase or multi-site review, a manager and technical

September - 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 Labor Day	4 Diabetes Recognition Program (DRP) Standards 2:00 - 3:00 PM - ET (Telephone)	5 Heart Stroke Recognition Program (HSRP) Standards 2:00 – 3:00 PM – ET (Telephone) Patient Centered Medical Home 2011 (PCMH 2011) Part 1 Standards Workshop 3:30 – 5:30 PM - ET (Telephone)	6 Use of the Web-based Data Collection tool (DCT) for Diabetes or Heart Stroke Programs 2:00 - 3:30 PM - ET (Web Ex)	7	8
9	10 Getting on Board Patient Centered Medical Home (PCMH) 10:00 – 11:30 AM - ET (Web Ex)	11	12	13 The PCMH 2011, PPC-PCMH, and PPC Online Application; How to submit as a Multi-site practice 3:00 - 4:30 PM - ET (Web Ex)	14	15
16	17 Getting on Board Patient Centered Medical Home (PCMH) 3:00-4:30 PM - ET (Web Ex)	18 Patient Centered Medical Home (PCMH 2011) Part 2 Standards Workshop 10:00 – 12:00 PM - ET (Telephone)	19 Using the Interactive Survey System (ISS) for PCMH 2011, PPC-PCMH, or PPC 2:00 – 3:30 PM - ET (Web Ex)	20 The PCMH 2011, PPC-PCMH, and PPC Online Application; How to submit as a Multi-site practice 2:00 – 3:30 PM – ET (Web Ex)	21	22
23	24	25	26 Stand Out! An Introduction to Becoming a Nationally Accredited ACO 3:00-4:00 PM- ET (Web Ex)	27	28	29
30						

Note: To access our Workshop/WebEx, Please scroll down to the last page to view log in instructions. ET = Eastern Standard Time

NCQA Standards and Application Resources (continued)

2. Community Care, North Carolina (CCNC) – Emerging Initiatives – PCMH Central – NCQA 2011:
   https://www.communitycarenc.org/emerging-initiatives/pcmh-central1/2011-pcmh-resources/
   Within this resource page, look for:
   - Webinars for each standard – with examples of tools, templates for standardization.
   - 2011 PCMH Workbook: A detailed overview and "how-to" document that provides guidance and examples of documentation for the entire PCMH process.
   - CCNC PCMH Recognition Checklist: -- a checklist of the policies and procedures needed to achieve recognition (PDF, 190KB)
     Hyperlink: https://www.communitycarenc.org/media/files/pcmh-2011-cheat-sheet.pdf

3. Primary Care Development Corp (PCDC) –
   http://www.pcdc.org/resources/patient-centered-medical-home/
   - How-To Manual: PCDC's How-To Manual offers a comprehensive project management framework for providers and practices seeking medical home recognition from the NCQA.
   - Assessment Tool: PCDC developed this self-assessment tool to help providers and staff navigate the National Committee for Quality Assurance's Patient-Centered Medical Home 2011 recognition process, identify and manage gaps.

NCQA Resource Bibliography – Resources by Standard

Patient Management:

- Education and Self-Management Tools: CCNC Patient Management Resource Page, most conditions.
  https://www.communitycarenc.org/patient-management-tools/

Care Management:

- **Care Coordination** Webinars - Patient-Centered Primary Care Collaborative (PCPCC)
  http://www.pcpcc.net/content/care-coordination
- **Population Management** CCNC Page –Standardized Care Management Plan:
  https://www.communitycarenc.org/media/related-downloads/standardized-care-management-plan.pdf

Self-Management Action Plans

- **Massachusetts templates!**

Medication Management:

- Patient-Centered Primary Care Collaborative – Medication Management Resources
  http://www.pcpcc.net/medication-management

Behavioral Health Integration

- Patient-Centered Primary Care Collaborative – BH Integration
  http://www.pcpcc.net/behavioral-health

	Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
☆50%	PCMH1	A	☆1	Same-Day Appts.	Y		5 days			
			2	Timely clinical advice by telephone	Y		5 days of response times			
			3	Timely clinical advice by secure electronic messages	Y		one week of response times			
			4	Document clincal advice in ehr	Y		one month report		3 examples of advice	
	PCMH1	B	1	access to routine and urgent care appts. outside of bus. hours	Y		report on availability OR		materials communicating practice hours	
			2	EMR info when office is not open	Y					
			☆3	Provide timely clinical advice by telephone when office is closed	y		5 days of call response times			
			4	Provide timely clinical advice using electronic system when closed	y		5 days on response time			
			5	Document after-hours clinical advice in record	y				3 Examples of advice documented	
	PCMH1	C	1	More than 50% patients who request EHR receive within 3 business days through pt. portal			12 Months (3 months if recent implementation)			
			2	At least 10% pts have electronic access to current health info within 4 bus days through pt. portal			12 Months (3 months if recent implementation)			
			3	Clin Summaries provided to > 50% of pt within 3 bus days. through pt. portal			12 Mo. (3 mo. recent start)			
			4	2-way communication btw. pts and practice through pt. portal					screenshot	
			5	request for pres. Refills through pt. portal					screenshot	
			6	request for test results through pt. portal					screenshot	

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH1	D	1	Expect pts. To choose a clinician	y					
		2	Document the patient's choice					screenshot	
		3	Patient visits with their PCP/team			1 week data showing total % enc. which occurred with pcp			
PCMH1	E	1	coordinate care across multiple settings	Process for giving out info				Actual Materials provided to patients	
		2	Instructions on obtaining care and advice during office hours & when closed	Process for giving out info				Actual Materials provided to patients	
		3	better care if complete medical history and info about care received outside the practice	Process for giving out info				Actual Materials provided to patients	
		4	Care team gives pt access to evidence-basaed care and self-management support	Process for giving out info				Actual Materials provided to patients	
PCMH1	F	1	Assessing racial and ethnic diversity			population-wide			
		2	Assessing language needs			population-wide			
		3	Provide interpretation of bilingual services	doc. of avail. of interpreter or policy for use of bilingual staff					
		4	Printed materials also in language of population					show access to materials in other language / screenshot	

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH1	G	1	Define roles for clinical and nonclinical team members					Job descriptions roles & functions	
		☆2	Regular team meetings or structured communication process					description of structured team communications & samples of meeting summaries, agendas, or memos	
		3	Standing orders for services					Written standing orders	
		4	Training & Assigning care teams to coordinate care					Job descriptions roles & functions	
		5	Training and assigning care teams to support patients in self-management					Job descriptions roles & functions	
		6	Training and assigning care teams for pt.					Job descriptions roles & functions	
		7	training and designating care team members in communication skills					Job descriptions roles & functions	
		8	involving care team staff in practice's performance eval and QI activities					description of staff roles in the practice evaluation & improvement process	
PCMH2	A	1	Date of Birth			12 mo %			
		2	Gender			12 mo %			
		3	Race			12 mo %			
		4	Ethnicity			12 mo %			
		5	Preferred Language			12 mo %			
		6	Telephone numbers			12 mo %			
		7	e-mail address			12 mo %			
		8	dates of previous visit			12 mo %			
		9	legal guardian/health care proxy			12 mo %			
		10	primary caregiver			12 mo %			
		11	presence of advance directives			12 mo %			
		12	Health insurance information			12 mo %			

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH2	B	1	Up to date problem list			12 mo report			
		2	Allergies, and reactions for >80%			12 mo report			
		3	Blood pressure & date taken >50% age 2+			12 mo report			
		4	Height for > 50% age 2+			12 mo report			
		5	Weight for >50% age 2+			12 mo report			
		6	System calcs & displays BMI					screenshot	
		7	System can plot and display growth charts and bmi percentile					screenshot	
		8	status of tobacco 13+ for >50%			12 mo report			
		9	List of meds with dates for >80% of pts.			12 mo report			
PCMH2	C	1	Doc of immu and screenings appropriate to age	can do a process for all ***OR*** --				de-identified completed patient assessment - Can do one pt. assessmennt for all of PCMH2-C	
		2	family/social/cultural characteristics					de-identified completed patient assessment	
		3	communiaction needs					de-identified completed patient assessment	
		4	medical history of pt. and family					de-identified completed patient assessment	
		5	advance care planning					de-identified completed patient assessment	
		6	behaviors affecting health					de-identified completed patient assessment	
		7	patient and family mental health/ substance abuse					de-identified completed patient assessment	
		8	Developmental screening using stardardized tool					de-identified completed patient assessment	
		9	depression screning for adults and adolescents using standard tool					de-identified completed patient assessment	

	Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
☆50%	PCMH2	D	1	reminders sent to pts/clinicians for at least 3 preventive care services			12 months showing pts. Identified and reached out to.		materials showing how pts. are notified: letters, script or documentation of phone reminders, screenshot of e-notice	
			2	reminders sent to pts/clinicians for at least 3 different chronic care services			12 months showing pts. Identified and reached out to.		materials showing how pts. are notified: letters, script or documentation of phone reminders, screenshot of e-notice	
			3	reminders sent to pts/clinicians for pts. Not seen recently at practice			12 months showing pts. Identified and reached out to.		materials showing how pts. are notified: letters, script or documentation of phone reminders, screenshot of e-notice	
			4	reminders sent to pts/clinicians for services needed for specific medications			12 months showing pts. Identified and reached out to.		materials showing how pts. are notified: letters, script or documentation of phone reminders, screenshot of e-notice	
	PCMH3	A	1	manages care for patients based on their condition and needs and on evidence-based guidelines - First important condition					list the three important conditions; Provide name and source of evidence-based guidelines for each condition; Demonstrate how the guidelines for each condition are implemented (chart tools, screenshots or workflow organizers; Example of guideline implementation, organizers, flow sheets or templates based on condition; EHR screenshots showing templates for treatment plans and documenting progress	
			2	manages care for patients based on their condition and needs and on evidence-based guidelines - Second important condition						
			☆3	manages care for patients based on their condition and needs and on evidence-based guidelines - third important condition related to unhealthy behaivors or mental health or substance abuse						

	Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
	PCMH3	B	1	Criteria and systematic process to identify high risk/complex pts	identify Process and criteria to identify					
			2	% of high-risk/complex pts in population			showing % of pt. pop. IDed at high risk or complex			
☆50%	PCMH3	C	1	Conducts pre-vist prep			% of high risk or complex pts. with 1+ visits in 3 mo			
			2	Collabs with pt. to develop indiv. Care plan w/ goals reviewed each visit			% of high risk or complex pts. with 1+ visits in 3 mo			
			3	gives pt written plan of care			% of high risk or complex pts. with 1+ visits in 3 mo			
			4	assesses and addresses barriers when goals not met			% of high risk or complex pts. with 1+ visits in 3 mo			
			5	gives clinical summary at each visit			% of high risk or complex pts. with 1+ visits in 3 mo			
			6	identifies pt who may benefit from additional care and management			% of high risk or complex pts. with 1+ visits in 3 mo			
			7	follows up with those who have not kept important appts.			% of high risk or complex pts. with 1+ visits in 3 mo			

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH3	D	☆1	Review and reconcile med with >50% of pts care transitions			% of qualifying pts. with 1+ visits in 3 mo			
		2	Review and reconcile meds with >80% for care transitions			% of qualifying pts. with 1+ visits in 3 mo			
		3	Provide info about new presc. to >80% pts.			% of qualifying pts. with 1+ visits in 3 mo			
		4	Assess pt. understanding of meds for >50% pts with date			% of qualifying pts. with 1+ visits in 3 mo			
		5	Assess pt. response to med and barriers to adherence for >50% pts w/ date			% of qualifying pts. with 1+ visits in 3 mo			
		6	Document otc meds, herbal therapies, and supplements for >50% pts with date of update			% of qualifying pts. with 1+ visits in 3 mo			
PCMH3	E	1	Generates and transmits > 40% of eligible rx to pharm.			12 mo.			
		☆2	generates >75% of eligible rx electronically			12 mo.			
		3	Enters e-rx orders in record for >30% pts with at least 1 med			12 mo.			
		4	Perform pt. specific checks for drug-drug and drug-allergy interactions					report or screenshot showing capability	
		5	alert prescriber of generic alternative					report or screenshot showing capability	
		6	alert prescriber to formulary status					report or screenshot showing capability	
		1	Provide ed. Resources to >50% pt. to assist in self mgmt.			3 mo.			

	Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
☆50%	PCMH4	A	2	Use EHR to identify ed. Resources and provide to >10% pts.			3 mo.			
			3	Develop & document self-mgmt plans with >50% pts.			3 mo.			
			4	Document self-mgmt abilities for >50% pts.			3 mo.			
			5	Provide self-mgmt tools to record self-care results to >50% pts.			3 mo.			
			6	Counsel >50% pts to adopt healthy behaviors			3 mo.			
	PCMH4	B	1	Maintain current resource list on five topics or key community service areas of important to pt. population					list of programs with categories (e.g. smoking cessation)	
			2	Track referrals provided to pts.			log or report; minimum 1 mo.			
			3	arrange or provide treamemtn for mental health & substance abuse	y				sample of avail. resources	
			4	offer opportunities for health ed. programs	y				sample of avail. resources	

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH5	A	☆1	Tracks lab results are available and flag and follow-up overdue results	y				example of how it is met	
		☆2	track imaging tests until results avaialble, flag and follow up on overdue results	y				example of how it is met	
		3	Flag abnormal lab results to provider	y				example of how it is met	
		4	flag abnormal imaging results to provider	y				example of how it is met	
		5	notify pt. of abnormal and normal lab and imaging results	y				example of how it is met	
		6	follow up with inpatient facilities on newborn hearing and blood-spot screening	y				example of how it is met	
		7	e-communicate with labs or order tests and retrieve results	y				example of how it is met	
		8	e-communicate with facilities to order and retrieve imaging results	y				example of how it is met	
		9	e-incorporate >40% of all clinical lab test results into structured fields in EHR (MU)			12 mo.			
		10	e-incorporate imaging test results into EHR	y				example of how it is met	

	Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
☆50%	PCMH5	B	1	Give Consultant or specialist clinical reason for referral and pertinent info			1 week report or log			
			2	Tracking status of referrals including required timing for receiving a specialist's report			1 week report or log			
			3	follow up to obtain a specialist's report			1 week report or log			
			4	establish and document agrements with specialist in the medical record if co-management is needed	y				at least 3 examples	
			5	ask patients/familes about self-referrals and requesting reports from clinicians	y				at least 3 examples	
			6	demonstrate the capability for electronic exchange of info between clinicians					screenshot or other documentation	
			7	provide an e-summary of the care record to antoher provider for <50% referrals			12 mo.			

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH5	C	1	Demonstrate process for IDing pts with hospital admission or ER visit	y, ***OR***		report listing ptt.s seen in ER or hospital, ***OR***		Log of pts receiving care from other facilities	
		2	Demonstrate process for sharing clinical info with admittign hospitals or ER	Y				3 deidentified examples of info sent.	
		3	Demonstrate process for obtaining pt discharge summaries	y				at least 3 examples of discharge summaries	
		4	Demonstrate process for contacting pts for appropriate follow-up care within appropriate period	y, with appropriate period defined. ***OR***				at least 3 examples of documented patient follow-up; ***OR*** a log with at least 1 week.	
		5	Demonstrate process for exchanging pt. information with the hospital during hospitalization	y				examples of two-way communication	
		6	collaborate with the pt to develop a written care plan for pts transitioning from pediatric to adult					copy of written transition of care plan	
		7	demonstrate capability for e-exchange of key clinical info with outside clinicians					screenshot or other documentation showing test of capability	
		8	Provide an e-summary of care record to another care facility for >50% of transitions of care			12 mo.			

	Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
	PCMH6	A	☆1	Indentify at least 3 preventive care measures in which to improve			Reports showing performance in IDed areas			
			☆2	Identify at least 3 chrnoic or acute care clinical measures			Reports showing performance in IDed areas			
			3	Identify at least two utilization measures affecting health care costs			Reports showing performance in IDed areas			
			4	Performance data stratified for vulnerable populations			Reports showing performance in IDed areas			
	PCMH6	B	1	Practice conducts pt. satisfaction survey					Survey Reports w/ results	
			2	practice uses CAHPS PCMH survey tool					Survey Reports w/ results	
			3	Practice obtains feedback on experience of vulnerable pt. groups					Survey Reports w/ results	
			4	practice obtains feedback from pts through qualitative means					Survey Reports w/ results	
☆50%	PCMH6	C	1	Set goals and act to improve performance on at least 3 Element A measures					completed PCMH Quality Measurement and Improvement Worksheet ***OR*** report	
			2	Set goals and act to improve performance on at least 1 Element B measures					completed PCMH Quality Measurement and Improvement Worksheet ***OR*** report	
			3	Set goals and address at least one aidentified disparity in care for vulnerable pop.					completed PCMH Quality Measurement and Improvement Worksheet ***OR*** report	
			4	Involve pts in quality improvement teams or on the advisory council	y				examples of how it meets the process (meeting notes /agenda	

Measure	Element	#	Description	Documented Process/ Policy	✓	Report?	✓	Other	✓
PCMH6	D	1	Tracking results over time					completed PCMH Quality M&I Worksheet ***OR*** report	
		2	asessing the effect of actions					completed PCMH Quality M&I Worksheet ***OR*** report	
		3	achieving improved performance on one measure					completed PCMH Quality M&I Worksheet ***OR*** report	
		4	achieving improved performance on a second measure					completed PCMH Quality M&I Worksheet ***OR*** report	
PCMH6	E	1	Performance data from element A and B by individual clinician			blinded reports given to practice and explained			
		2	Performance data from element A and B across the practice			blinded reports given to practice			
		3	Share performance data to patients or publicly					example of reporting provided to patients or the public	
PCMH6	F	1	Electronically report cqm to cms or state					report of data transmission	
		2	electronically report cqm to external entities					report of data transmission	
		3	electronically report data to immunization registries					report of transmission or screenshot	
		4	electronically report syundromci surveillance data to public health agencies					report of transmission or screenshot	
PCMH6	G	1	Certified EHR					Enter CHIT # in comment box	
		2	Security Risk Analysis					Enter Yes in survey tool - attest to conducting the required survey risk analysis	

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Resources for Completing NCQA application

Materials to Support Your PCMH Application Process
http://www.massgeneral.org/stoecklecenter/assets/pdf/patient_exper/materials_to%20support_PCMH%20application_%20process_june2011.pdf

PCMH Policies and Procedures Guidebook by Elizabeth W. Woodcock MBA, FACMPE, CPC
MGMA-ACMPE
104 Inverness Terrace East
Englewood, CO 80112-5306
877-275-6462

QTip Quality through Technology and Innovation in Pediatrics: NCQA Patient Centered Medical Home Toolkit July 28, 2012 https://msp.scdhhs.gov/qtip/site-page/**pcmh**

Community of North Carolina PCMH Recognition Checklist:
https://www.**community**carenc.org/.../**pcmh**.../2011-**pcmh**-resources/

Webinars Available in Rhode Island

Rhode Island Department of HEALTH offers Learning Sessions through the Rhode Island Chronic Care Collaborative. Four programs are being offered fall, 2013, with some of the details still being worked out.

1) September 12: Motivational Interviewing
2) October: Patient Centered Medical Home Orientation
3) November: Self-Management Goal Setting
4) December: Quality Improvement

All sessions are web-based and accessible any time and have CME and CEU's. Sessions can also be attended in person at HEALTH on the day that it is conducted so that people can meet the speakers.

For more information, you can check the Rhode Island Department of Health website: http://www.health.ri.gov/partners/collaboratives/chroniccare/

Brown University offers Best Practice Sharing Opportunities throughout the year

August 2, 7:30-9:00 am: "Why PCMH: Costs and Benefits" at the Brown Medical School.

Practice Transformation Committee Charter

Staff: CSI Project Manager

Co-Chairs: Steering Group member, practice representative

Members: The Committee should be composed of representatives from participating CSI Practices, non-CSI PCMH's, practices interested in becoming a PCMH, relevant health plan representatives, and other PCMH stakeholders. Participants may join Committee by self-nomination or by Steering Committee or Co-Chair invitation. Representatives from a diverse mix of practice roles should be on Committee such as physicians, nurse care managers, medical assistants, office managers.

Charge: To support and facilitate ongoing PCMH practice transformation, oversee collaborative training of CSI practice sites, convene best practice learning collaborative sessions, support practice-based coaching and technical assistance, serve as liaison to other CSI committees and external organizations leading workforce development for PCMH (e.g. NCM, MA, BH).

Services include, for example:

- Support PCMH on-boarding
- Identify training and support needs of practices
- Support leadership development
- Promote performance improvement
- Promote NCQA support
- Facilitate integration and standardization of the nurse care manager's role
- Endorse a standardized assessment tool and process
- Identify training and support needs of practices
- Make recommendations for addressing those needs via CSI Training and Support Vendor(s) and external tools and resources;
- Oversee the work of the CSI Training and Support Vendor(s)

The Committee will regularly communicate with the Practice Reporting and Data and Evaluation Committees and will designate liaisons to each of these committees to ensure that the work is coordinated and that each committee has the information necessary to efficiently perform its functions.

Agenda Development: Co-chairs; driven by work plans, Committee member requests/feedback, and Steering Group requests/directives

Expectations of Members: Engaged participation in meetings and work in-between meetings; commitment to the success of the project; collaboration and cooperation with project management and stakeholders on work related to the project

Meeting Frequency: Third Thursday of every month

Subgroups: Nurse Care Manager Best Practice Sharing, Provider Best Practice Sharing

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Practice Facilitation Worksheet

Identify your top three concerns:

1)_____

2) _____

3)_____

Identify three things you would like to change in your practice:

1) _____

2) _____

3) _____

What practice facilitation help would be most useful to you?

1) _____

2) _____

3) _____

What strengths do you bring to CSI?

1) _____

2) _____

3) _____

Practice Site: _____