# CSI – RI Orientation 2014
# Table of Contents

## Tab 5: Improving Quality

- Summary of Target 2 (228-233)
- Summary of Target 3 (234)
- CSI Measure Definition (see Tab 2 – Sample Developmental Contract) (91-130)
- CSI Measure Logic (235-238)

## Tab 6: Improving Patient Experience

- DataStat: CAHPS Vendor (240-241)
- Submitting sample files (242-246)
- DataStat: HIPAA BAA Agreement (247-254)
- Sending Logos and Signature (255-256)
- Template for Survey files (257-265)

## Tab 7: Patient-Centered Medical Home

- IT Resources- How to Use CSI RI PCMH Portal (267-270)
- Helping New England Programs Reach New Heights Through Quality Improvement Services (271-277)
- Making All Transition Safe Transitions (278)
- Safe Transitions Project Community Coalitions (279)
- Medication Safety and Adverse Drug Event Prevention (280)
- Resources for Completing NCQA Application (281)

# CSI-RI Orientation 2014

# Tab 1: Orientation Program

# *Join us for the 2015 CSI-RI Expansion Orientation*

## When:

Tuesday, December 9, 2014
4:45pm (registration)
5:00 – 8:00pm (event)

## Where:

222 Richmond Street, Providence, RI 02903

*CSI-RI will introduce our newly accepted practices to the CSI-RI management team and key stakeholders, and provide practices with an overview of the CSI-RI management team and stakeholders, and introduce practices to the CSI-RI developmental contract, reporting requirements, committees and available resources.*

**Each new practice is expected to send* the following team members:**
*Provider champion, nurse care manager (if hired), office manager, organizational leader*

*There is space for each practice to bring up to four people. Practices may include an additional staff member such as a medical assistant, quality person and or practice reporting person – come learn as a team!*

***Participants must register by DECEMBER 1, 2014 to attend this event.**
To register, visit:

**https://www.eventbrite.com/e/csi-new-practice-orientation-tickets-13997796787**

**Questions about the Orientation? Please contact: cynthia.anderson@umassmed.edu**

**CSI-RI 2015 New Practice Orientation**
Agenda for Tuesday, December 9, 2014

| | |
|---|---|
| 4:45-5:00 PM | **Registration and Brown Bag Dinner** |
| 5:00-5:05 PM | **Welcome and Congratulations**<br>*Debra Hurwitz, CSI-RI Co-Director*<br>*Pano Yeracaris MD, CSI-RI Co-Director* |
| 5:05-5:10 PM | **CSI-RI Health Care Strategic Initiative**<br>*Neil Steinberg, Rhode Island Foundation President CEO* |
| 5:10-5:15 PM | **CSI-RI an Investment in Primary Care**<br>*Kathleen Hittner MD, Health Insurance Commissioner* |
| 5:15-5:35 PM | **CSI-RI Developmental Contract – Payment for Value: Expectations – Practice Infrastructure Investments**<br>*Debra Hurwitz, CSI-RI Co-Director*<br>*Pano Yeracaris MD, CSI-RI Co-Director* |
| 5:35-5: 50 | **Compacts: How to identify and develop strategies to improve care coordination**<br>*Andrea Galgay, Director of ACO Development, RIPCPC* |
| 5:50 -6:00 | **Culture Change: What does it take?**<br>*Pano Yeracaris MD, CSI-RI Co-Director* |
| 6:00-6:10 PM | **What Difference Does PCMH Make? – Engaged Leadership: What does it take? What does it look like?**<br>*Tom Bledsoe MD, University Medicine* |
| 6:10--6:25 PM | **CSI-RI Quiz and Break** |
| 6:25-7:05 PM | **Practice Transformation**<br>*Joanna Brown, MD, MPH Practice Transformation Director, Brown Primary Care Transformation Initiative, Co-chair Practice Transformation Committee*<br>*Jacqueline Bessette Lefebvre, RN,BS, CCM,CPEHR,PCMH-CCE Practice Facilitator* |
| 7:05-7:20PM | **NCM and Team Based Care: Hiring NCM, developing workflows to support team based care for high risk patients**<br>*Maureen Claflin, Nurse Care Manager University Medicine, Member of CSI-RI Executive Committee* |
| 7:20-7:45PM | **Improving Quality Practice Reporting: What are reporting expectations? What are potential resources? How to use data to improve performance**<br>*Kathryn Amalfitano MBA, Practice Manager, University Medicine, Co-Chair of Practice Reporting Committee*<br>*Cyndi Souther, Director of QI and Analytics, Thundermist Health Center*<br>*Co-Chair of Practice Reporting Committee*<br><br>**Deep Domain: A Best Practice Option**<br>*Brian Stephens, Director of Strategic Relationships*<br><br>**Practice Experience**<br>*Alysha Gutoski, Ambulatory Practice Manager, Women's Medicine Collaborative* |
| 7:45-8:00PM | **Questions/Wrap-up/Committee Sign Up** |

# CSI-RI Developmental Contract Payment for Value: Expectations Practice Infrastructure Investments

**New Practice Orientation**
**December 9, 2014**
**Debra Hurwitz, MBA, BSN, RN**
**CSI Co-Director**

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

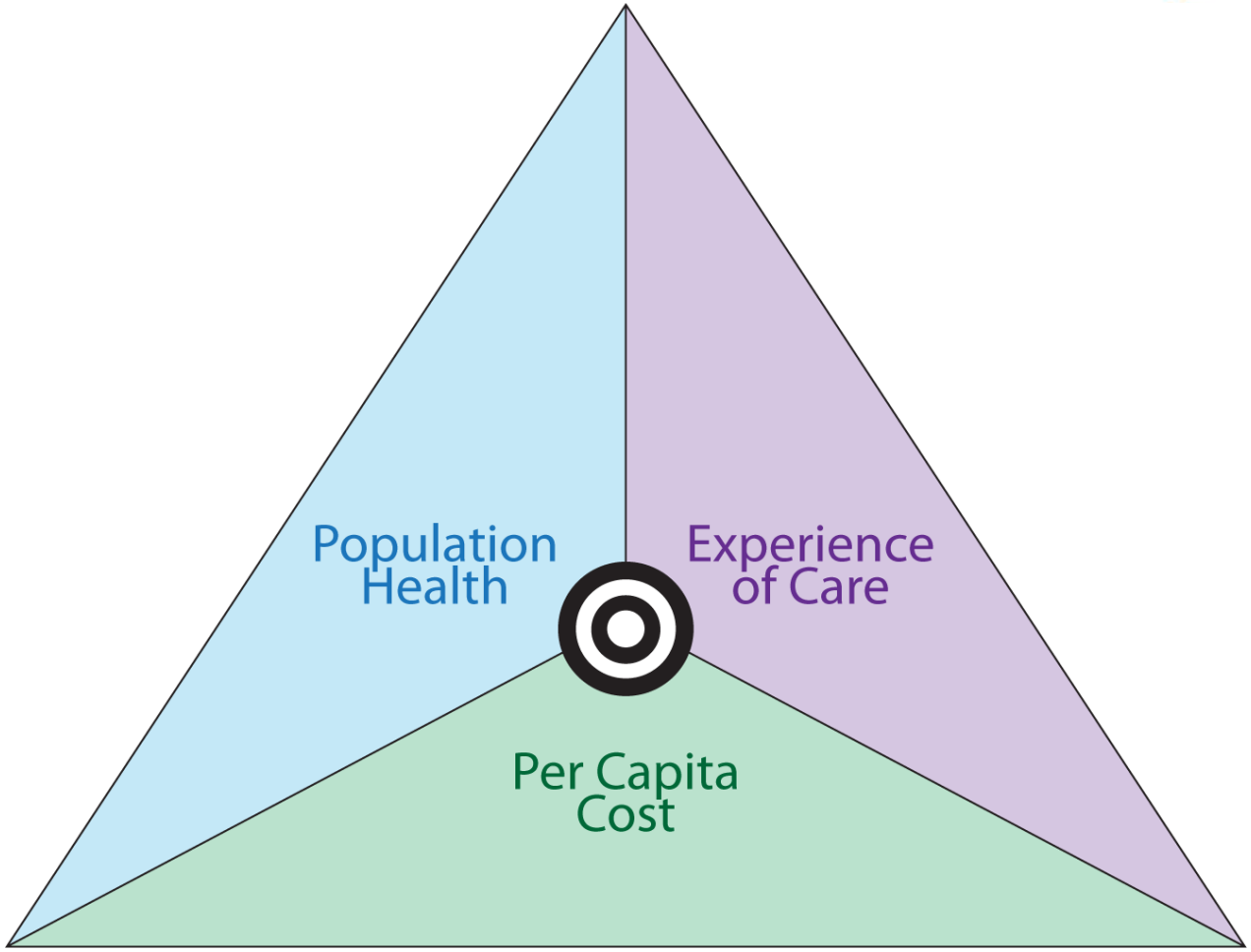
**Vision**:

- Rhode Islanders enjoy excellent health and quality of life. They are engaged in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care.

**Mission**:

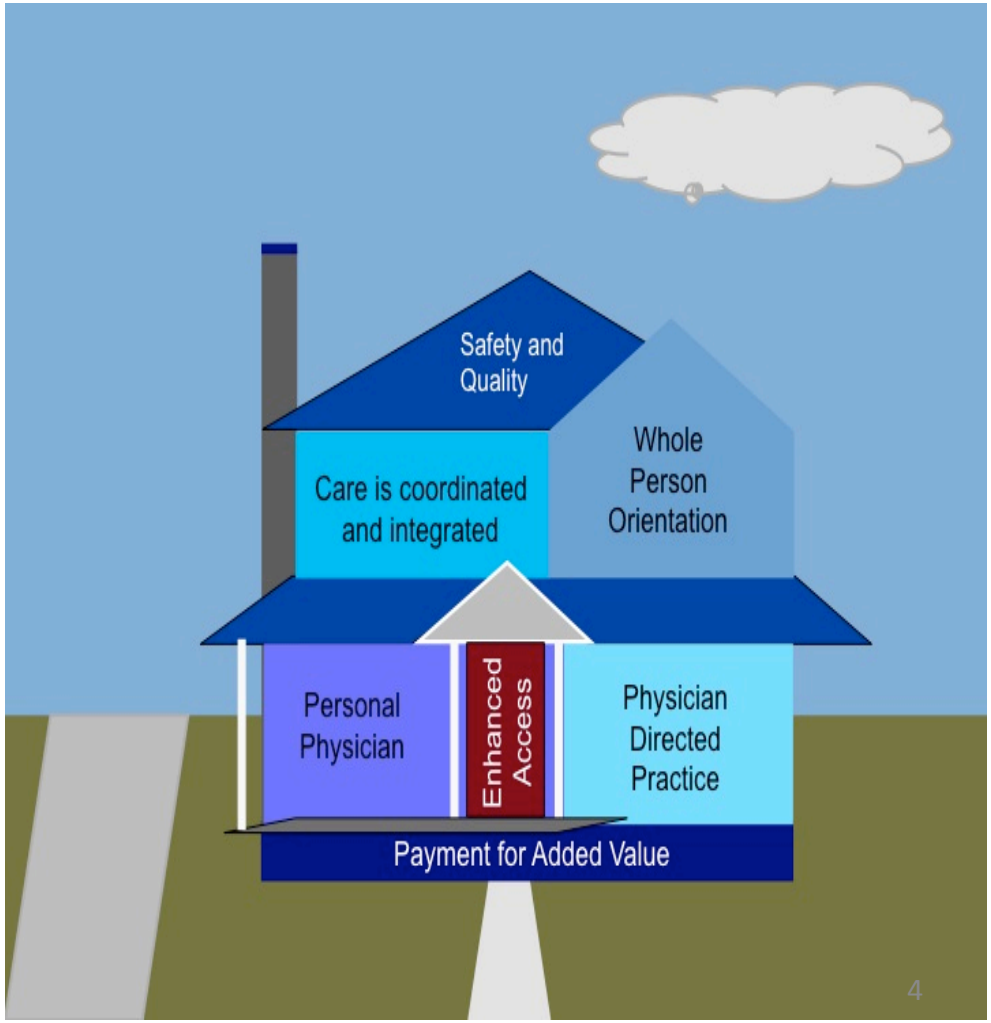
- To lead the transformation of primary care in Rhode Island in the context of an integrated health care system. CSI-RI brings together critical payers, providers, purchasers, consumers, educators and other leaders to develop, implement, evaluate, refine and spread models to deliver, pay for, and sustain high quality comprehensive primary care.

# The key to building PCMH is measured progress toward the Triple Aim



# CSI-RI helps plans and practices build sustainable Patient-Centered Medical Homes

- Data-driven practice transformation
- NCQA Level 3
- Nurse Case Manager on the team
- Common Contract
- All-payers involved
- PMPM paid on attributable lives
- PMPM based on performance



# Developmental Contract

| | Developmental Stage | PMPM Rates by contract year | Requirements |
|---|---|---|---|
| **Stage 1 (max 1 yr)** | Start up | $3.00 base<br>$2.50 NCM<br><br>**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<br>Target 2: Establish quality data reporting for harmonized measures<br>Target 3: Practice implements interventions to reduce ED visits and IP admissions |
| **Stage 2 (max 1 yr)** | Transition | $3.00 Base<br>$2.50 NCM<br><br>$0.50<br>**Max:$6.00** | Target 1: All structural components in place and achieve NCQA level 2<br>Target 2: Quality data is stable; baseline established; practice is working to achieve quality benchmarks;<br>Target 3: Focus interventions to reduce ED visits and IP admissions. Build Capacity for Nurse Care Manager Measurement System. |
| **Stage 3** | Performance I | $3.00 base<br>$2.50 NCM<br><br>$0.50<br>$0.50<br><br>$0.50<br>$0.50<br>**Max: $7.50** | **Target 1:** all structural requirements in place and achieve NCQA level 3 (if not achieved base is reduced by $0.50)<br>**Achievement of thresholds according to attachment F**<br>**Target 2a:** Clinical quality measures: achieve 4 of 6 thresholds<br>**Target 2b:** Patient Experience: achieve thresholds using top box scores, according to contractual performance standards<br>**Target 3a:** All-Cause Inpatient Admissions (5%)<br>**Target 3b:** All-Cause ED (5%) |
| **Stage 4** | Performance II | $3.00 base<br>$2.50 NCM<br><br>$0.50<br>$0.25<br>$0.50<br><br>$1.25<br>$0.75<br>**Max: $8.75** | **Target 1:** structure in place and maintain NCQA level 3<br>if not maintained base is reduced by $0.50)<br>**Achievement of thresholds according to attachment F**<br>**Target 2a:** Clinical quality measures: achieve 4 of 6 thresholds<br>**2a additional performance incentive:** achieve 6 of 6 thresholds<br>**Target 2b:** Patient Experience: achieve thresholds using top box scores, according to contractual performance standards<br>**Target 3a:** All-Cause Inpatient Admissions (5%)<br>**Target 3b:** All-Cause ED (5%) |

# Practice Investment $5.50

| Deliverable | Investment |
| --- | --- |
| **Required** | **Required** |
| ▪ **Hire NCM** | **$2.50 pmpm** |
| ✓ Work with high risk patients and referred patients | |
| ▪ **Practice reporting** | **Recommended** |
| ▪ **NCQA recognition** | ▪ **$0.50 pmpm** |
| ▪ **Practice Transformation** | ▪ **$0.50 pmpm** |
| ✓ Monthly Team Meetings | ▪ **$1.00 pmpm** |
| ✓ Daily Patient Huddles | |
| ✓ Team Support for Care Coordination | |
| ✓ CAHP Survey | |

# Other Investments $1.00

## CSI RI Committee

### Required

- Practice Reporting (clinical and reporting staff members)

### Recommended

- Practice Transformation
- NCM
- Steering
- Contracting

## Process Measures

### Required

- Compacts with specialists, hospitalists and behavioral health provider
- After hour protocols
- Transition of Care “Best Practice Attestation

### Recommended

- Patient Engagement Strategy

# Performance Year 1 and 2 Investments

**Performance Year 1 Max $7.50**

**$0.50: Clinical Quality** measures 4 out of 6

**$0.50: Patient Experience:** (including access )

$**0.50 All Cause Admission** (5%)

**$0.50 All Cause ED (5%)**

**$3.00 base NCQA Level 3**

**$2.50 NCM**

**Performance Year 2 Max $8.75**

**$0.50 Clinical Quality** measures 4 out of 6

**$0.25 Clinical Quality** achieve 6 out of 6

**$0.50 Patient Experience** (including access)

**$1.25 All Cause Admissions (5%)**

**$0.75 All Cause ED (5%)**

**$3.00 Base NCQA Level 3**

**$2.50 NCM**

# Anticipated Outcomes

- ✓ Improved quality of care
- ✓ Improved patient experience
- ✓ Reduced cost as measured by reduced ER/IP utilization
- ✓ Improved staff satisfaction
- ✓ Practice readiness for shared savings

# Developing Successful Compacts

## Rhode Island Primary Care Physicians Corporation

# Benefits of Compacts

- CSI Contractual Requirement
- Set clear roles and responsibilities for both the PCP and specialist practices
- Set expectations for patients on what they should expect when they are referred to a specialist with whom you have a compact
- Act as an opportunity to collaborate with “difficult” high volume specialty providers

# History of RIPCPC

- RIPCPC formed in 1994 as an Independent Practice Association (IPA) with a focus on quality improvement
  - Quality based contracts with insurers
  - Original CSI members
- RIPCPC is the largest IPA in Rhode Island
  - 140 Primary Care Physicians (began with 40)
  - Cover over 220,000 Rhode Island Lives
  - 25% of Rhode Island's Pediatricians are Members
  - 7 RIPCPC practices are existing CSI

# Compacts Development Areas

- Urgent Care
- Behavioral Health
- Eye Care
- Gastroenterology
- Cardiology

# Urgent Care

- We assembled a team of our primary care physicians and also included urgent care / walk-in facilities from around the State
- Set clear expectations on:
  - Communication back to PCP
  - Ordering patterns
  - Referral back to PCP for follow-up
- Patient education
  - Creation of education campaign to patients on what to do when their PCP is unavailable
  - Brochures
- Provider tools
  - Brochures/posters/pamphlets

# How did we choose the participating facilities?

- We asked all of our PCPs what facilities they would send their patients to for after hours care
- We asked them to consider:
  - Does this facility communicate with them?
    - Treatment summary? Call?
  - Is the treatment provided appropriate?
    - EBG's? Too many tests? Over prescribe antibiotics?
- We tabulated the results then invited those facilities to join our committee
  - They received a call by our committee chair
  - If they refused to engage, they would not be included on our listing of approved facilities

# Successes and Challenges

- Successes
  - Our communication has dramatically improved with our ‘approved facilities’
  - ‘Treatment Summary’ form key for PCP follow-up
  - Facilities can identify RIPCPC patients
  - Agreement with Urgent Care / Walk-In facilities on delivery of appropriate care
- Challenges
  - Track effectiveness of program
  - Urgent Care / Walk-In facilities have higher staff turnover
    - Must retrain front office personnel on identifying RIPCPC patients
    - New ‘Moonlighting’ physicians are often slow to consistently get the ‘treatment summary’ to PCPs
    - Facilities often change ownership

# Behavioral Health

- Provide better behavioral health services to patients
- Increase and improve communication between physicians and behavioral health clinicians
- Establish a network and formalized database of BH providers accessible to PCP's
- Develop measures for tracking patient outcomes
- *FROM THIS…*

# Behavioral Health Committee

- We assembled a team of primary care physicians, behavioral health professionals and IT staff. We have been meeting for over 2 ½ years.
- These regular monthly meetings focus on:
  - Improving **access** to Behavioral Health Providers
  - Improving **communication** between Behavioral Health Providers and PCP's
  - Building a strong BH provider network

# Behavioral Health Network

- An organized network of behavioral health clinicians
- Independent BH providers and community BH facilities have affiliated with RIPCPC to create a Behavioral Health POD (our first official meeting was October 22nd)
- All providers participating see the value of combining Behavioral Health & Primary Care
- There is a strong commitment to this integration of BH and Primary Care for the benefit of the patient through:
  - Improved access
  - Better communication

# Access & Communication

## Access

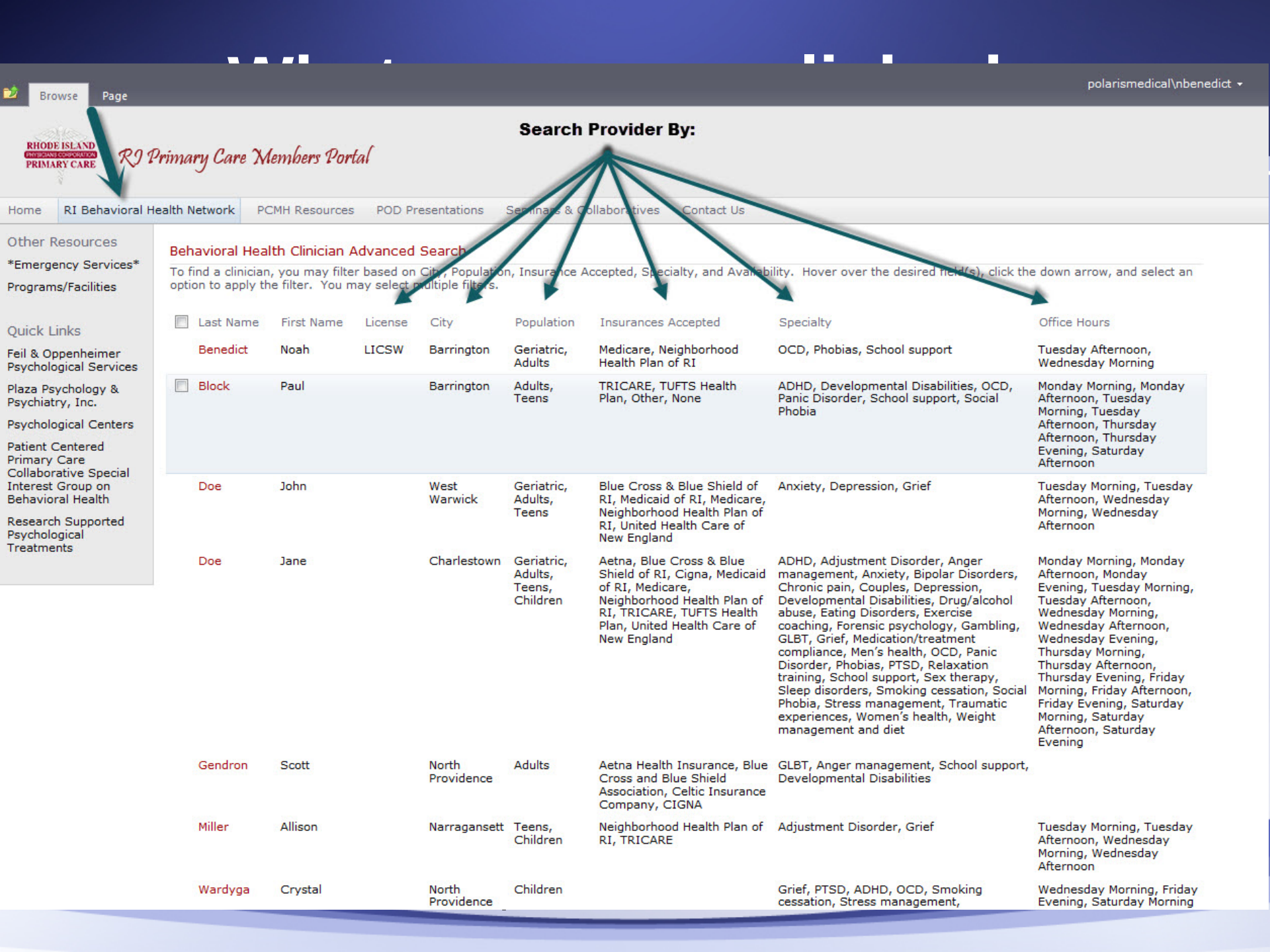
- Willing to accept appropriate referrals and follow-up with referred patient
- Willing to see urgent referrals within the next business day when requested by referring PCP
- Offer appointments for new referrals to be seen within 3 business days when requested by referring PCP

## Communication

- Electronic Communication
- Contact PCP within 2 hours for urgent communication
- Same day written documentation of consultations with new patients referred urgently (or verbally, with written documentation provided the next day)
- Written documentation of initial consultations with patients (not referred urgently) within one week from initial contact
- Written documentation of ongoing meetings with patients monthly, and additionally, as clinically indicated and mutually agreed upon with PCP

# How Does the Referral System Work?

- Primary Care Provider identifies patient in need of BH
- PCP accesses data base and searches for appropriate BH clinicians
- Referral is made through Direct Mail to BH provider
- Provider receives referral and responds in a timely fashion


Browse
Page
polarismedical\nbenedict
Search Provider By:
RHODE ISLAND PHYSICIANS CORPORATION PRIMARY CARE
RI Primary Care Members Portal
Home
RI Behavioral Health Network
PCMH Resources
POD Presentations
Seminars & Collaboratives
Contact Us
Other Resources
*Emergency Services*
Programs/Facilities
Quick Links
Feil & Oppenheimer Psychological Services
Plaza Psychology & Psychiatry, Inc.
Psychological Centers
Patient Centered Primary Care Collaborative Special Interest Group on Behavioral Health
Research Supported Psychological Treatments
Behavioral Health Clinician Advanced Search
To find a clinician, you may filter based on City, Population, Insurance Accepted, Specialty, and Availability. Hover over the desired field(s), click the down arrow, and select an option to apply the filter. You may select multiple filters.
Last Name
First Name
License
City
Population
Insurances Accepted
Specialty
Office Hours
Benedict
Noah
LICSW
Barrington
Geriatric, Adults
Medicare, Neighborhood Health Plan of RI
OCD, Phobias, School support
Tuesday Afternoon, Wednesday Morning
Block
Paul
Barrington
Adults, Teens
TRICARE, TUFTS Health Plan, Other, None
ADHD, Developmental Disabilities, OCD, Panic Disorder, School support, Social Phobia
Monday Morning, Monday Afternoon, Tuesday Morning, Tuesday Afternoon, Thursday Afternoon, Thursday Evening, Saturday Afternoon
Doe
John
West Warwick
Geriatric, Adults, Teens
Blue Cross & Blue Shield of RI, Medicaid of RI, Medicare, Neighborhood Health Plan of RI, United Health Care of New England
Anxiety, Depression, Grief
Tuesday Morning, Tuesday Afternoon, Wednesday Morning, Wednesday Afternoon
Doe
Jane
Charlestown
Geriatric, Adults, Teens, Children
Aetna, Blue Cross & Blue Shield of RI, Cigna, Medicaid of RI, Medicare, Neighborhood Health Plan of RI, TRICARE, TUFTS Health Plan, United Health Care of New England
ADHD, Adjustment Disorder, Anger management, Anxiety, Bipolar Disorders, Chronic pain, Couples, Depression, Developmental Disabilities, Drug/alcohol abuse, Eating Disorders, Exercise coaching, Forensic psychology, Gambling, GLBT, Grief, Medication/treatment compliance, Men's health, OCD, Panic Disorder, Phobias, PTSD, Relaxation training, School support, Sex therapy, Sleep disorders, Smoking cessation, Social Phobia, Stress management, Traumatic experiences, Women's health, Weight management and diet
Monday Morning, Monday Afternoon, Monday Evening, Tuesday Morning, Tuesday Afternoon, Wednesday Morning, Wednesday Afternoon, Wednesday Evening, Thursday Morning, Thursday Afternoon, Thursday Evening, Friday Morning, Friday Afternoon, Friday Evening, Saturday Morning, Saturday Afternoon, Saturday Evening
Gendron
Scott
North Providence
Adults
Aetna Health Insurance, Blue Cross and Blue Shield Association, Celtic Insurance Company, CIGNA
GLBT, Anger management, School support, Developmental Disabilities
Miller
Allison
Narragansett
Teens, Children
Neighborhood Health Plan of RI, TRICARE
Adjustment Disorder, Grief
Tuesday Morning, Tuesday Afternoon, Wednesday Morning, Wednesday Afternoon
Wardyga
Crystal
North Providence
Children
Grief, PTSD, ADHD, OCD, Smoking cessation, Stress management,
Wednesday Morning, Friday Evening, Saturday Morning

# Behavioral Health Committee Initiatives

- *Current work includes:*
  - A focus on the collaborative model approach
  - Strengthen network and build lasting relationships
  - Assist patients in making better choices and measure those patient outcomes (healthier lifestyle = lowered health care costs)
  - Improve our communication and access with BH specialists for the benefit of our patients, this will help us better manage our patient population in an ACO/AQC/RISK environment
    - Successful behavioral health integration is vital to containing costs!

# How Does the Membership Work?

- Providers join RIPCPC as BH specialty members
- RIPCPC BH members are included in the database
- RIPCPC physicians make behavioral health referrals to the providers in the database
- Timely communication expectation (criteria set within BH provider agreement) using Direct Mail Messaging (soon)
- Forms for shared information (intake, progress notes) are provided

# Benefits for Primary Care

- Access to licensed clinicians with identified specialties in Behavioral Health
- Assurance that referrals are being accepted in a timely and appropriate manner
- Complex  behavioral health issues are being addressed
- Clinical updates about patients are being received
- Shared communication between health care providers

# Benefits for Patients

- Fewer barriers in accessing specialty care
- Access to skilled clinicians and quality care
- Healthcare providers are communicating!
- Improved outcomes!

# What the Future Holds

- Explore new innovative ways to integrate Behavioral Health within the primary care setting
- Implement ‘Direct messaging’ as preferred medium of communication
- Focus on helping patients make better choices and measure those patient outcomes
- Additional specialties – eye care, cardiology, and gastroenterology

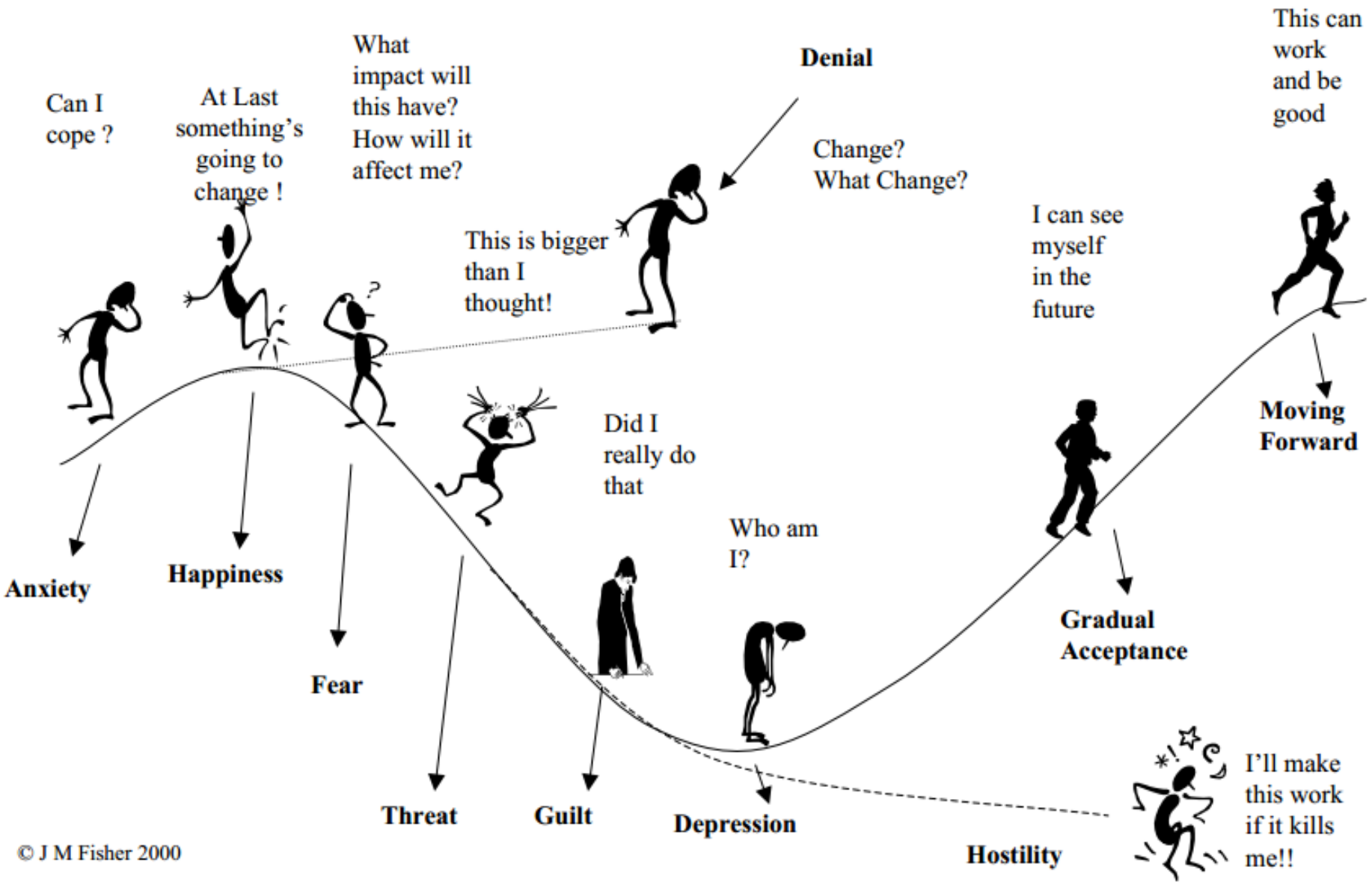
# Questions?

Andrea Galgay
agalgay@ripcpc.com
654-4000 *110

# Sustaining Culture Change

DECEMBER 9, 2014

# The Process of Transition



# Culture and Behaviors

- Shared patterns of behaviors and interactions, similar challenges to patient needing behavior change
- What do you want your culture to be?
- Habits – recurrent (automatic), “grooved” behaviors
- How to “get out of the groove”? It starts with ourselves
- How to sustain the change?
- Team, practice, organization

pcmh
patient-centered medical home
CSI-Rhode Island

# Sustaining Culture Change (1)

- Many ways to change behavior
- Leadership is critical and can be quite a challenge - The role of the Champion – what training is required? Being open and willing is much of the battle
- Patient focused team-based care – patient advisors can be very effective to keep us humble and focused on the goal

# Sustaining Culture Change (2)

- Need attention and reinforcement and how small actions fit into larger picture (celebration, financial) “daily reminders”, recognition
- Individual motivations, emotions play crucial role
- CQI as a “challenge” and an “answer”

# CTC Practice Facilitation Program

- Support to understand and respond to Teamwork Survey results, practice site visits, one on one provider champion /CEOconsultation
- Practical approaches to CQI, how to use data and measurement for improvement
- Best practice sharing
- Patient focus AND Population focus

# In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices

*Christine A. Sinsky, MD*[1]
*Rachel Willard-Grace, MPH*[2]
*Andrew M. Schutzbank, MD*[3,4]
*Thomas A. Sinsky, MD*[1]
*David Margolius, MD*[2]
*Thomas Bodenheimer, MD*[2]

[1]Medical Associates Clinic and Health Plans, Dubuque, Iowa

[2]Center for Excellence in Primary Care, University of California, San Francisco, California

[3]Beth Israel Deaconess Medical Center, Boston, Massachusetts

[4]Iora Health, Cambridge, Massachusetts

**MORE ONLINE**
www.annfammed.org

*Conflicts of interest: none reported.*

**CORRESPONDING AUTHOR**

Christine A. Sinsky, MD
Medical Associates Clinic and Health Plans
Dubuque, IA 52001
csinsky1@mahealthcare.com

## ABSTRACT

We highlight primary care innovations gathered from high-functioning primary care practices, innovations we believe can facilitate joy in practice and mitigate physician burnout. To do so, we made site visits to 23 high-performing primary care practices and focused on how these practices distribute functions among the team, use technology to their advantage, improve outcomes with data, and make the job of primary care feasible and enjoyable as a life's vocation. Innovations identified include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders, and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping. Our observations suggest that a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

*Ann Fam Med* 2013;11:272-278. doi:10.1370/afm.1531.

*Working at Starbucks would be better.*
Benjamin Crocker, MD, October 3, 2007

*I look forward to going to work each day. I'm loving it!*
Benjamin Crocker, MD, July 13, 2011

## INTRODUCTION

By all reports, primary care physicians are at high risk of burnout.[1-3] Fewer physicians are choosing primary care; many are leaving it.[4-6] Although waning interest in adult primary care careers is multifactorial, driven by such forces as the primary care–subspecialty income gap, medical schools' devaluing of primary care, and the unsustainable primary care work life, we focus on the work life issue. One study suggests that the difficult work life may be the most influential factor discouraging medical students from primary care careers.[7]

Those who practice adult primary care are often deeply dissatisfied,[1] spending much of their days performing functions that do not require their professional training.[8] More than one-half of general internists and family physicians have symptoms of burnout.[1] Time pressure, chaotic work environments, increasing administrative and regulatory demands, an expanding knowledge base, fragmentation of care delivery, and greater expectations placed on primary care contribute to the strain.[9] Workdays are getting longer[10] and rewards are diminishing. Joy is in short supply.

We propose *joy in practice* as a deliberately provocative concept to describe what we believe is missing in the physician experience of primary care. The concept of physician satisfaction suggests innovations that are limited to tweaking compensation or panel size. If, however, as the litera-

ture suggests, physicians seek out the arduous field of medicine, and primary care in particular, as a calling because of their desire to create healing relationships with patients, then interventions must go far deeper. Joy in practice implies a fundamental redesign of the medical encounter to restore the healing relationship of patients with their physicians and health care systems.

Joy in practice includes a high level of physician work life satisfaction, a low level of burnout, and a feeling that medical practice is fulfilling. Physicians who dread going to work each day are not experiencing joy in practice.[11-17] Physician fulfillment in daily work is tightly related to the organization of the practice environment, including relief from paperwork and administrative hassles,[18,19] the opportunity to form meaningful relationships with patients,[20,21] and the ability to provide high-quality care to patients.[22]

Why should joy in practice matter? Physician burnout is associated with diminished patient satisfaction and reduced adherence to treatment plans[2,11,12]; it also contributes to students' avoidance of primary care careers.[13]

In the face of the dismal current primary care climate, we explored whether there are places where physicians and other staff are thriving and whether some practices have found innovative solutions to the challenges of office organization. This report focuses on practice innovations that we believe can address barriers to the healing relationship between physician and patient, take advantage of the resources of the health care team, and improve care for patients, thereby enhancing physician joy in practice.

We approached 23 high-performing practices we believed were likely to support both quality of care and physician work life satisfaction. The practices represented different geographic regions and include small private practices, large integrated delivery systems, academic medical centers, the Veterans Affairs, and Federally Qualified Health Care Centers.

Most of the practices had achieved patient-centered medical home recognition. Participation in meaningful use electronic health records and the Physician Quality and Reporting System were also tracked as surrogate markers of quality (Supplemental Appendix 1, http://annfammed.org/content/11/3/272/suppl/DC1).

Our study was certified as exempt by the University of California San Francisco Human Research Protection Program Committee on Human Research.

## Site Visits

At least 1 of the authors visited each of 21 sites (Table 1), shadowing physicians and their teams for a day and meeting with administrative and clinical leaders. We made virtual visits to 2 additional practices with a telephone interview and follow-up e-mail communication with leaders or practitioners. A semistructured site visit questionnaire (Supplemental Appendix 2, available online-only at http://annfammed.org/content/11/3/272/suppl/DC1) guided observations and interviews.

Although a description of how these practices made their changes, as well as quantitative data as to whether these changes directly and independently improved patient care, is beyond the scope of this report, a narrative summary describing in greater depth the care model and in some cases the change process, along with the investigators' personal reflections on the mod-

**Table 1. Specialty, Setting, and Clinicians at Study Sites**

| Site | On-Site Visits | | |
|---|---|---|---|
| | Specialty | Setting | No. of Physicians |
| In-person visits | | | |
| Ambulatory Practice of the Future | GIM[a] | Urban | 2 |
| Brigham and Woman's Hospital | GIM | Urban | 7 |
| Cleveland Clinic Strongsville | FM[b] | Suburban | 103 |
| Clinica Family Health Services | FM | Rural | 46 |
| Clinic Ole | FM | Rural | 15 |
| Fairview Rosemont Clinic | GIM/FM | Urban | 2 |
| Group Health Olympia | FM | Urban | 36 |
| Harvard Vanguard Medford | GIM | Suburban | 14 |
| La Clinica de la Raza | FM | Urban | 16[a] |
| Martin's Point-Evergreen Woods | GIM | Rural | 4[a] |
| Mayo Red Cedar | FM | Rural | 13 |
| Medical Associates Clinic | GIM | Urban | 115 |
| Mercy Clinics East | FM | Urban | 7 |
| Multnomah County Health Department | IM | Urban | 40 |
| Newport News Family Practice | FM | Urban | 5 |
| Quincy, Office of the Future | FM | Rural | 2 |
| Sebastopol Community Health Centers | FM | Rural | 8[a] |
| Southcentral Foundation | FM | Urban | 115 |
| ThedaCare-Oshkosh | FM | Urban | 5. |
| University of Utah-Redstone | IM | Rural | 5 |
| West Los Angeles VA | IM | Urban | 12[a] |
| Virtual visits | | | |
| Allina-Cambridge | FM/IM | Rural | |
| North Shore Physicians Group | FM/GIM | Urban | 200 |

FM = family medicine; GIM = general internal medicine; IM = internal medicine; VA = Veterans Affairs.

[a] Includes physicians, physician assistants, nurse practitioners.

el's strengths and weaknesses, was composed for each site (a full report is available at http://www.abimfoundation.org).

## SOLUTIONS TO COMMON PROBLEMS

During our site visits, we observed a number of solutions to problems commonly faced in primary care; these solutions include (1) proactive planned care, with previsit planning and previsit laboratory tests; (2) sharing clinical care among a team, with expanded rooming protocols, standing orders and panel management; (3) sharing clerical tasks with collaborative documentation (scribing), nonphysician order entry, and streamlined prescription management; (4) improving communication by verbal messaging and in-box management; and (5) improving team functioning through co-location, team meetings, and work flow mapping (Table 2). Below we organize our findings as solutions to common problems in primary care.

**Table 2. Problems and Innovations**

| Problem | Innovation |
|---|---|
| Unplanned visits with overfull agendas | Previsit planning |
| | Preappointment laboratory tests |
| Inadequate support to meet the patient demand for care | Sharing the care[a] |
| | Expanded nurse or medical assistant rooming protocol |
| | Standing orders |
| | Extended responsibility for health coaching, care coordination, and integrated behavioral health to nonphysician members of the team |
| | Team responsibility for panel management |
| Great amounts of time spent documenting and complying with administrative and regulatory requirements | Scribing |
| | Assistant order entry |
| | Standardized prescription renewal |
| Computerized technology that pushes more work to the physician | In-box management |
| | Verbal messaging |
| Teams that function poorly and complicate rather than simplify the work | Improving team communication through |
| | Co-location |
| | Huddles |
| | Regular team meetings |
| | Improving team functioning |
| | Systems planning |
| | Work flow mapping |

[a] These roles require 2- or 3-to-1 clinical support per physician.

### Reducing Work Through Previsit Planning and Preappointment Laboratory Tests

Primary care visits are often disorganized and rushed.

#### Solution

Many high-functioning sites have learned that previsit planning and previsit laboratory tests can reduce the total volume of work to be done, save time, and improve care.

**Example** At Mayo Red Cedar Medical Center patients have their laboratory tests done a few days before their appointments and are able to discuss results and engage in shared decision making at the time of the visit. This system eliminates an hour or more per day of post-appointment results reporting. David Eitrheim, MD, reported (e-mail, July 9, 2012):

> Patients like to discuss the results of their lab work at the time of their office visit. I can't imagine going back to the day when I used to send out letters to patients with results of $HbA_{1c}$ and lipid profiles and not use those results as an opportunity for motivational interviewing, goal setting and developing an action plan.

### Adding Capacity by Sharing the Care Among the Team

In many practices, patients cannot reliably see their own primary care physician the same day a need arises. In addition, most patients are not receiving all recommended prevention and chronic illness care.[23]

#### Solution

Improving access and increasing adherence to clinical guidelines requires building additional capacity into the practice. Many sites accomplished capacity building by transforming the roles of medical assistants, licensed practical nurses, registered nurses, and health coaches so that they assume partial responsibility for elements of care.[24,25] In addition, some practices have an extended care team of social workers, behavioralists, nutritionists, and pharmacists, usually working with several clinician–medical assistant teamlets.[24,26]

**Example 1** At North Shore Physicians Group (NSPG) in the Boston area, the medical assistant's role has been transformed. When a patient is taken to an examination room (rooming), the process has been expanded from 3 minutes to 8 minutes and now includes medication review, agenda setting, form completion, and closing care gaps. For example, the medical assistant reviews health-monitoring reminders, gives immunizations, and proactively books appointments for mammograms and DXA (dual-energy x-ray absorptiometry) scans for osteoporosis. A medical assistant training curriculum is available at http://www.safetynetmedicalhome.org. The role transformation for medical assistants is part of a larger team-care initiative at NSPG, which has resulted in a 14% increase in primary care physician satisfaction scores. "We knew our physicians were dissatisfied with the quality of the

interaction with the patient because of all the things they had to do in the exam room that were nonphysician work," said Sharon Lucie, Vice President for Operations, during an interview (December 11, 2011). "Now providers are begging us to get them started in the new model."

**Example 2** Clinica Family Health Services near Denver, Colorado, has created standing orders empowering registered nurses to diagnose and treat simple problems without a physician's involvement. These problems include streptococcal throat infections, conjunctivitis, ear infections, head lice, sexually transmitted diseases, uncomplicated urinary tract infections, and warfarin management.

**Example 3** At Clinica Family Health Services[27] nonprofessional health coaches provide patient education and counseling to help patients with chronic conditions set goals and formulate action plans. Medical assistants sensing depression symptoms administer the 9-item Patient Health Questionnaire depression screen and then contact the team's behaviorist.

**Example 4** Group Health Cooperative (GHC) couples centralized population management with team-based panel management. Centrally, GHC sends birthday letters to patients reminding them of overdue preventive services. Medical assistants on clinical teams are responsible for outreach to patients who do not respond and address remaining care gaps during the rooming process.

We observed that team development must often overcome an anti–team culture. Institutional policies (only the doctor can perform order entry), regulatory constraints (only the physician can sign paperwork for hearing aid batteries, meals delivery, or durable medical equipment), technology limitations (electronic health record work flows are designed around physician data entry), and payment policies that only reimburse physician activity constrain teams in their efforts to share the care. An extended care team of a social worker, nutritionist, and pharmacist may be affordable only in practices with external funding or global budgeting.

## Eliminating Time-Consuming Documentation Through In-Visit Scribing and Assistant Order Entry

Physicians across our study sites reported spending about 2 hours per day on visit note documentation, and some physicians reported spending up to an additional hour per day on computerized order entry.

### Solution

Six sites have extended the concept of sharing the care by empowering nurses and/or medical assistants to become an integral part of the visit: scribing the note, entering orders, preparing the after-visit summary, and reinforcing the plan with the patient.

**Example** At the Cleveland Clinic Strongsville, primary care physicians work with 2 medical assistants or 1 medical assistant and 1 registered nurse. The nurse or medical assistant first completes an expanded rooming protocol, then returns with the physician to record notes while the physician talks with and examines the patient. After 1 year in the new model, average daily visits increased from 21 to 28, thereby improving access and continuity. Revenue was up 20% to 30%, which has exceeded the cost of the additional medical assistant or nurse. Quality metrics, as well as patient, staff, and physician satisfaction scores, improved. Kevin Hopkins, MD, the family physician leading the innovation noted (in conversation, December 6, 2011):

> The MAs and nurses are more fully engaged in patient care than they have ever been and they enjoy their work…. They have increased knowledge about medical care in general and about their individual patients in particular. I am far more satisfied. I leave work an hour earlier every day and have a very fulfilling relationship with my team…. We're having fun.

## Saving Time by Reengineering Prescription Renewal Work Out of the Practice

Managing calls, e-mails, and faxes regarding prescription renewals consumes many health care resources.[28]

### Solution

By separating prescription renewal from chronic illness appointment adherence, and by providing 12- to 15-month prescriptions for stable medications, practices can avoid repeating the same work multiple times throughout the year.

**Example** At Allina-Cambridge in the Minneapolis area, medications are renewed for a full year at the annual comprehensive care visit, thus avoiding unnecessary interval handling of stable prescriptions. For example, a 3-month supply with 4 refills covers the patient until the next annual visit. Prescriptions initiated at interval appointments will have refills remaining. These prescriptions are resynchronized with all other chronic prescriptions once a year. Amy Haupert, MD, explained (personal communication, July 10, 2012): "Two to 5 minutes spent refilling all medications for the upcoming year saves us time dealing with phone calls and refill requests later throughout the year."

## Reducing Unnecessary Physician Work Through In-box Management

Tasks previously entrusted to receptionists, pharmacists, nurses, and transcriptionists have been transferred to the physician with many electronic health record implementations.

**Solution**

In several practices the nurse or medical assistant filters all the electronic and paper information, passing on to the physician only that information which specifically requires a physician's level of expertise. In addition, replacing asynchronous electronic messaging with verbal messaging reduces the volume of in-box messages.

**Example** Fairview Clinic in Minneapolis has decreased the in-box work from 90 minutes to only a few minutes per day for many physicians. All messages are first directed to the medical assistant or nurse, who filters out normal laboratory results, prescription renewals, or requests that can be managed by protocol, passing through to the physician only messages that require physician-level attention.

Whenever possible, electronic messaging is replaced by more time-efficient verbal messaging between nurse and physician. Dr Haupert of Allina (personal communication, November 15, 2011) commented that "communication throughout the day is crucial to efficiency. We can answer questions on the fly rather than waiting to get back to the computer and pinging messages back and forth."

### Improving Team Communication Through Co-location, Huddles, and Team Meetings

If nurses and medical assistants cannot quickly run a problem by the physician, the problem loops around the office via time-consuming asynchronous e-messaging, creating more work and delays for patients. In addition, the lack of meeting time precludes development of improved work flows.

**Solution**

Co-location can make minute-to-minute communication more efficient. Team meetings provide protected time to improve processes and strengthen trust and reliance among the team.

**Example 1** In the team care model at NSPG the medical assistant and physician sit side-by-side in "flow stations." One of the early adopters was an established physician with a large panel of patients (2,500) with highly complex conditions. Previously this physician took 2 to 3 hours of work home each night; with co-location that facilitates efficient verbal communication and the expanded role for medical assistants, he routinely leaves the office with all of his work completed.

**Example 2** At the Cleveland Clinic, the physician and clinical staff meet weekly to review data and refine their work flows. Dr Hopkins explained (in conversation, December 6, 2011):

> We set aside 1 hour every Friday morning to go over the week: what worked well, what didn't, what changes do we need to make. We do some education as to why do we do microalbumins on diabetic,s etc. Learning why we do certain things gains buy-in.

### Improving Team Functioning Through Systems Planning and Work Flow Mapping

Medical care involves a large number of recurrent tasks: registration, rooming, ordering studies, making referrals, refilling prescriptions, informing patients of laboratory results, forms completion, etc. These work flows can be efficient, rapid, and promote patient safety, or they can be complex and fraught with hazards. Without careful planning, new work flows developed in response to changing regulations or technology can push much of the work onto the physician.

**Solution**

Adopting a systems approach to practice redesign can improve efficiency and reduce waste.

**Example** ThedaCare-Oshkosh in central Wisconsin saw its performance on clinical and operational metrics move from last to first place in its 22-clinic organization. The group attributes this to systematic work flow planning using Lean techniques, which include identification and elimination of waste through value stream mapping and process standardization.[29] Clinic site director, Kathy Markofski, reported (in conversation, September 26, 2011), "The team maps out the work flow of a patient visit. We identify wait times, do a root cause analysis, develop countermeasures and then quickly reassess with data."

## DISCUSSION

The current practice model in primary care is unsustainable. We question why young people would devote 11 years preparing for a career during which they will spend a substantial portion of their work days, as well as much of their personal time at nights, on form-filling, box-ticking, and other clerical tasks that do not utilize their training. Likewise, we question whether patients benefit when their physicians spend most of their work effort on such tasks.[30] Primary care physician burnout threatens the quality of patient care, access, and cost-containment within the US health care system.

We set out in search of joy in practice. What we found were pockets of professional satisfaction. Even at the best of practices, physicians are still often caught in what Chesluk has coined the "frantic bubble,"[31] trying to manage an overwhelming burden of clerical work, conform to constraining regulations, and deal with cumbersome technology workarounds, all in a time-pressured environment. Our observations suggest that these 23 innovative sites are pointing the way to

a better model. No single practice has solved every issue; each practice still struggles to overcome its own unique set of constraints.

There were unifying themes among our sites. Practices that build stable, well-trained teams which work together every day and meet regularly to improve their work can create efficient work flows and rewarding practice environments. Standardized work flows with higher levels of clinical support personnel can make practices less chaotic, save time, and meet patients' needs more quickly. Teamwork is facilitated by proximity of workstations and frequent forums for interaction. Thoughtful physical layout with co-location of staff and line of sight enhances communication. Face-to-face verbal communication is often more effective, efficient, and enjoyable than circulating asynchronous electronic messaging.

Despite these unifying themes, we found contrasting approaches to several common issues in primary care among our study sites, including the details of delegating responsibility, scheduling, and documentation.

### Sharing Responsibility Among Team Members

Physicians can share the care with a team in 2 distinct ways. In the first model physicians are involved with every patient visit but entrust responsibility for many visit-based tasks (medication reconciliation, order entry, after-visit summary, visit note documentation, self-management support) to other team members. These practices prioritize access, continuity, and relationship with the same physician, maximally leveraging the skills of the physician. In the second model physicians perform most visit-based tasks, but they are involved with only a subset of patient visits, while directing the patient to other team members for discrete episodes of care: a pharmacist for hypertension or a nurse for anticoagulation. These practices prioritize continuity with the larger care team.

### Scheduling

We observed 2 distinct approaches to scheduling in attempt to de-stress the physician's workday. One approach, exemplified by GHC, decreases the number of visits per day and reduces physician panel size.[32] Another approach, developed by Newport News, Allina, Cleveland Clinic, and Mayo Red Cedar Medical Center, increases capacity and access by directing clerical tasks away from the physician.

### Scribing and Team Order Entry as an Antidote to Waste

The volume of work associated with record keeping and order entry has increased during the past decade with the introduction of electronic health records, quality-monitoring initiatives, and increasingly complex billing regulations. Tasks that took a few seconds in the pre–electronic health record world can take several minutes in the electronic world. Visit notes have become lengthy documents, formatted on a billing template, complicating rather than facilitating the cognitive work of finding key information. Scribing is a powerful tool to reduce the burden of record keeping and order entry and to free the physician to focus more fully on direct patient care and relationship building.

## FUTURE RESEARCH

The observations described here could lead to a series of hypotheses for future research (Supplemental Appendix 3, at http://annfammed.org/content/11/3/272/suppl/DC1). For example, do physician burnout scores diminish when a practice initiates standing orders that empower team members to assume new responsibilities? Does patient and nonphysician staff satisfaction change when such standing orders are instituted? To add context to such quantitative studies, physicians, nonphysician staff, and patients can be interviewed individually or in focus groups to gain greater understanding of the impact of team-empowering standing orders. Similar research questions can be asked about scribing and about each of the innovations listed in Table 2. Furthermore, although staff satisfaction and the patient experience fell outside the scope of the project, some managers and staff reported that professional satisfaction was increased for medical assistants and nurses with each of these innovations—another area for future study.

The core work of primary care remains meaningful and rewarding, but this work has been crowded out by increasingly complex regulatory, technological, and administrative requirements. Primary care physicians across the country now spend much of their time on large volumes of clerical work, including visit note documentation, order entry, prescription processing, and clearing the in-box. As a result, primary care physicians experience low levels of professional satisfaction[1] and underutilize the training that society has invested in them. We believe a shift from a physician-centric model of work distribution and responsibility to a shared-care model, with a higher level of clinical support staff per physician and frequent forums for communication, can result in high-functioning teams, improved professional satisfaction, and greater joy in practice.

**To read or post commentaries in response to this article, see it online at http://www.annfammed.org/content/11/3/272.**

**Key words:** personal satisfaction, physician; health care delivery; health services research; patient-centered care; primary health care; patient care team; burnout, professional; organizational innovation; primary health care

Submitted May 13, 2012; submitted, revised, October 20, 2012; accepted November 20, 2012.

**Author contributions:** All authors participated in the site visits. C. Sinsky, Willard, T. Sinsky, and Bodenheimer prepared the initial and revised manuscripts. Schutzbank and Margolius offered critical input and revisions. All authors read and approved the final manuscript.

**Funding support:** The American Board of Internal Medicine Foundation provided financial support for the site visits and manuscript preparation.

**Acknowledgments:** The authors are grateful for the project's Advisory Council, its support, and the associated conference, Primary Care Innovation: Improving the Efficiency and Appeal of Practice, March 12, 2012, Philadelphia. Organizations represented on our advisory council include the Agency for Healthcare Research and Quality, the American Academy of Family Physicians, the American Academy of Nursing, the American College of Physicians, the Institute for Healthcare Improvement, the National Partnership for Women & Families, the Patient Centered Primary Care Collaborative, Primary Care Progress, the Stoeckle Center for Primary Care Innovation and TransforMED. We are also thankful to Richard Baron, Daniel Wolfson and Timothy Lynch for their thoughtful review of the manuscript.

## References

1. Shanafelt TD, Boone S, Tan L, et al. Burnout and satisfaction with work-life balance among US physicians relative to the general US population. *Arch Intern Med*. 2012;172(18):1377-1385.
2. Dyrbye LN, Shanafelt TD. Physician burnout: a potential threat to successful health care reform. *JAMA*. 2011;305(19):2009-2010.
3. Okie S. Innovation in primary care—staying one step ahead of burnout. *N Engl J Med*. 2008;359(22):2305-2309.
4. Bodenheimer T, Chen E, Bennett HD. Confronting the growing burden of chronic disease: can the US health care workforce do the job? *Health Aff (Millwood)*. 2009;28(1):64-74.
5. National Residency Matching Program. 2010 Match Results. http://www.nrmp.org/data/index.html
6. Sox HC. Leaving (internal) medicine. *Ann Intern Med*. 2006;144(1):57-58.
7. Dorsey ER, Jarjoura D, Rutecki GW. Influence of controllable lifestyle on recent trends in specialty choice by US medical students. *JAMA*. 2003;290(9):1173-1178.
8. Altschuler J, Margolius D, Bodenheimer T, Grumbach K. Estimating a reasonable patient panel size for primary care physicians with team-based task delegation. *Ann Fam Med*. 2012;10(5):396-400.
9. Grumbach K, Bodenheimer T. A primary care home for Americans: putting the house in order. *JAMA*. 2002;288(7):889-893.
10. Howard J, Clark EC, Friedman A, et al. Electronic health record impact on work burden in small, unaffiliated, community-based primary care practices. *J Gen Intern Med*. 2013;28(1):107-113.
11. Murray A, Montgomery JE, Chang H, Rogers WH, Inui T, Safran DG. Doctor discontent. A comparison of physician satisfaction in different delivery system settings, 1986 and 1997. *J Gen Intern Med*. 2001;16(7):452-459.
12. Landon BE, Reschovsky JD, Pham HH, Blumenthal D. Leaving medicine: the consequences of physician dissatisfaction. *Med Care*. 2006;44(3):234-242.
13. McKinlay JB, Marceau L. New wine in an old bottle: does alienation provide an explanation of the origins of physician discontent? *Int J Health Serv*. 2011;41(2):301-335.
14. Dunn PM, Arnetz BB, Christensen JF, Homer L. Meeting the imperative to improve physician well-being: assessment of an innovative program. *J Gen Intern Med*. 2007;22(11):1544–52
15. Kassler WJ, Wartman SA, Silliman RA. Why medical students choose primary care careers. *Acad Med*. 1991;66(1):41-43.
16. Karsh BT, Beasley JW, Rogers RL. Employed family physician satisfaction and commitment to their practice, work group, and health care organization. *Health Serv Res*. 2010;45(2):457-475.
17. Pink DH. *Drive—The Surprising Truth About What Motivates Us*. New York, NY: Penguin Group; 2009.
18. Kaiser Family Foundation. National survey of physicians Part III: doctors' opinions about their profession. 2002. http://www.kff.org/kaiserpolls/upload/Highlights-and-Chart-Pack-2.pdf.
19. Pathman DE, Konrad TR, Williams ES, Scheckler WE, Linzer M, Douglas J; Career Satisfaction Study Group. Physician job satisfaction, dissatisfaction, and turnover. *J Fam Pract*. 2002;51(7):593-601.
20. Richardsen AM, Burke RJ. Occupational stress and job satisfaction among physicians: sex differences. *Soc Sci Med*. 1991;33(10):1179-1187.
21. Stoddard JJ, Hargraves JL, Reed M, Vratil A. Managed care, professional autonomy, and income: effects on physician career satisfaction. *J Gen Intern Med*. 2001;16(10):675-684.
22. DeVoe J, Fryer GE Jr, Hargraves JL, Phillips RL, Green LA. Does career dissatisfaction affect the ability of family physicians to deliver high-quality patient care? *J Fam Pract*. 2002;51(3):223-228.
23. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med*. 2003;348(26):2635-2645.
24. Ghorob A, Bodenheimer T. Share the Care: building teams in primary care practices. *J Am Board Fam Med*. 2012;25(2):143-145.
25. Bodenheimer T, Laing BY. The teamlet model of primary care. *Ann Fam Med*. 2007;5(5):457-461.
26. Sinsky CA, Sinsky TA, Althaus D, Tranel J, Thiltgen M. Practice profile. 'Core teams': nurse-physician partnerships provide patient-centered care at an Iowa practice. *Health Aff (Millwood)*. 2010;29(5):966-968.
27. Primary Care Insight [website]. 2011. http://www.primarycareprogress.org/insight.
28. Baron RJ. What's keeping us so busy in primary care? A snapshot from one practice. *N Engl J Med*. 2010;362(17):1632-1636.
29. Womack JP, Jones DT. *Lean Thinking: Banish Waste and Create Wealth in Your Corporation*. New York, NY; Simon and Schuster; 2003
30. Verghese A. Culture shock—patient as icon, icon as patient. *N Engl J Med*. 2008;359(26):2748-2751.
31. Chesluk BJ, Holmboe ES. How teams work—or don't—in primary care: a field study on internal medicine practices. *Health Aff (Millwood)*. 2010;29(5):874-879.
32. Reid RJ, Fishman PA, Yu O, et al. Patient-centered medical home demonstration: a prospective, quasi-experimental, before and after evaluation. *Am J Manag Care*. 2009;15(9):e71-e87.

**CSI-RI Quiz** **Practice Site : _____**

CSI-RI an Investment in Primary Care:

1. What does CSI-RI stand for?
   a. Crime Scene Investigation Rhode Island
   b. Rhode Islanders who Can't Say It/Can't Spell It
   c. Chronic Care Sustainability Initiative of Rhode Island
   d. Consumer Safety Initiative

2. How often do practices have to submit clinical quality data?
   a. Quarterly
   b. Monthly
   c. Every 6 months
   d. Yearly

3. Clinical quality data is collected on which of the following measures (select all that apply)
   a. BMI
   b. LDL
   c. BP
   d. DINKA

4. Practices in Performance 1 or 2 will receive financial incentives for clinical quality measures that:
   a. Meet the benchmarks
   b. Show improvement that is halfway between the last measurement and the benchmark of at least 2.5%
   c. a and b
   d. a only

5. Nurse care managers are responsible for, among other duties:
   a. identifying and reaching out to patients with a high risk of adverse health outcomes, and working with the practice team to reduce risk and meet needs
   b. calling all patients discharged from the hospital or following an emergency room visit
   c. providing high quality, evidenced based care to analyze and treat medical conditions
   d. contacting patients and lab facilities to ensure that ordered lab work has been carried out
6. Engaged leaders:

a. Provide visible and sustained leadership to lead overall culture change.
b. Dedicate time and resources to ensure success of the PCMH culture
c. Ensure that all team members have protected time to conduct activities beyond direct patient care
d. All of the above

7. The $2.50 per member per month (PMPM) payment from CSI should be used to fund:

   a. General operating expenses
   b. Additional medical assistants
   c. Cash bonuses
   d. Nurse care managers

8. Practices must meet the benchmark (or achieve 2.5% improvement) on the CAHPS customer experience survey for which category in order to obtain any financial incentive?
   a. Access
   b. Communication
   c. Office staff
   d. Clinical quality

9. Practices are required to send representatives to which of the following committees?
   a. NCM
   b. Practice Reporting
   c. Practice facilitation collaborative
   d. Steering

10. Practice facilitators can help your practice:
    a. Find and hire appropriate staff
    b. Provide appropriate art for the waiting room walls
    c. Monitor staff for union violations
    d. Support your practice in the implementation of key PCMH principles

**CSI RI Practice Transformation Program**

The CSI RI practice transformation program is focused on primary care transformation within the context of a changing health care delivery system. The program continues to evolve, is collaborative in nature, and designed to help prepare practices for patient centered population health management and to perform successfully in alternative payment contracts. There are multiple facets to the program including collaborative learning sessions, support for Patient Centered Medical Home transformation (PCMH), a focus on data and measurement to support improvement, and support for sustained culture change within the practices. Practice facilitators are assigned to a specific practice to assist with these efforts.

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. Practice facilitators provide coaching and consultation to assist your practice with becoming actively engaged in transformation.

What practice transformation support will be available to my practice?

1. Practice facilitation:

a) One on one site visits and support from practice facilitators
b) Practice assessment and gap analyses
c) Guidance in development of a practice transformation plan
d) Assistance in developing new job descriptions and work flows that support team based care
e) Support in the implementation of core PCMH principles, such as engaged leadership, team building and patient engagement, improving partnership with specialists and community partners
f) Assistance in establishing care plans that are sensitive to the population you serve, including the high risk patient population
g) Help in optimizing scheduling to provide same day access and after hour access
h) Interpretation of data for quality and process improvement
i) Assistance with data collection needs
j) Support with your NCQA application process
k) Help in integration the nurse care manager into the care team
l) Assistance with the development of workflows to surrounding high risk patients
m) Assistance in meeting CSI deliverables

2. Incentive payment model that rewards sharing and incorporating best practices between two practices
3. IT Support through RIQI
4. Best practice sharing across the entire program
5. Identification and facilitation of training

What are the expectations of your practice for working with the practice facilitator?

Time and commitment:

Active participation in practice transformation and facilitation services across all roles has been found to dramatically 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. There is a minimum expectation that the practice will meet with the practice facilitator according to the following schedule: Start up: twice a month; Transition: once a month; Performance Year 1: once a quarter

What additional opportunities and expectations exist?

Population based approaches to improve quality:

Quality improvement informed by data 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 the practice in addressing quality data related issues either directly or by leveraging community-based resources (i.e. RIQI). Minimum practice expectations: The practice will appoint a PCMH team which will meet a minimum of once a month to develop systems to support principles of being a patient centered medical home and practicing quality improvement, such as developing and implementing PDSA (Plan, Do Study, Act) cycles to drive and sustain improvement.

Partnering for best practice:

Best practice sharing and committee based learning are some 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 to others.

Active Participation CSI-RI Committees:

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 January 2015 and extend through June 30, 2016.

| **Activity** | **Timeline** |
|---|---|
| Practice completion of PCMH readiness using the MacColl Survey | December 1, 3014 |
| New Practice Orientation: Welcome to CSI RI | December 9, 2014 |
| On-site visits by practice facilitators: Clarify expectations with practice leadership, physician champion, practice team (including office staff, nurse, medical assistant, quality staff); Identify practice assessment strategy and next steps; Review CSI expectations for contract requirements | January –March 2015 |
| Practice Assessment and Gap analysis ; Practice to identify a team comprised of practice leaders with representation from providers, clinical support, front office and administration; assessment will address clinical and operational health of the practice | April-June 2015 |
| 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 and evaluating progress against measures and the practice re-design. Practice will meet with the practice facilitator to collaborate on monthly reporting of progress | March 2015 and on going |
| Evaluation of progress based on 3 identified goals ,and CSI program expectations, performance metrics, culture change and practice transformation ; Practice is expected to apply regular, rapid small tests of change as part of the quality improvement work | March 2015 and on-going |

Practices that choose not to use practice facilitation services will be required to provide a regularly submitted work plan as defined by CSI that addresses how the practice is meeting the above expectations to CSI .

## RIQI IT Support with Clinical Quality Measurement and Reporting

Between January 1, 2015 and June 30, 2016, each new CSI-RI practice site can receive 10 hours of ITsupport 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):

- Help understanding CSI-RI measures and definitions
- Help developing EHR reports to calculate measures ; this may require laison with EHR vendor for custom reports, other IT resource, or other CSI practice who can assist them with pulling the quality data from their EHR systems.
- Developing workflows and processes to regularly produce reports, perform quality assurance, and submit data
- Analyzing and making suggestions for 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 Sasha Zapata at szapata@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.

# 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 would practice facilitation help would be most useful to you?

1) _____

2) _____

3) _____

---

What strengths do you bring to CSI?

1) _____

2) _____

3) _____

Practice Site: _____

University Medicine

# CSI New Practice Orientation: Integrating NCM into Practices

Maureen Claflin, MSN, RN
NCM University Medicine Governor St.

December 9, 2014

University Medicine

# What is a Nurse Care Manager:

- Experienced RN who can provide care management & coordination of care services to patients with complex medical conditions.
- Patient educator
- Liaison from practice to other providers/community resources

University Medicine

# Qualifications for Consideration When Hiring:

- Licensed RN, State of Rhode Island
- Three (3) to five (5) years experience in community health, public health, chronic disease management, community management.
- Experience in care management
- Experience working in the Ambulatory Care setting with primary care teams.

University Medicine

# Key Attributes for Consideration:

- Excellent interpersonal skills, written, verbal communications skills
- Critical thinking/problem-solving skills
- Demonstrated leadership skills
- Knowledge of QI methodology
- Networking/community resources

University Medicine

# Training opportunities:

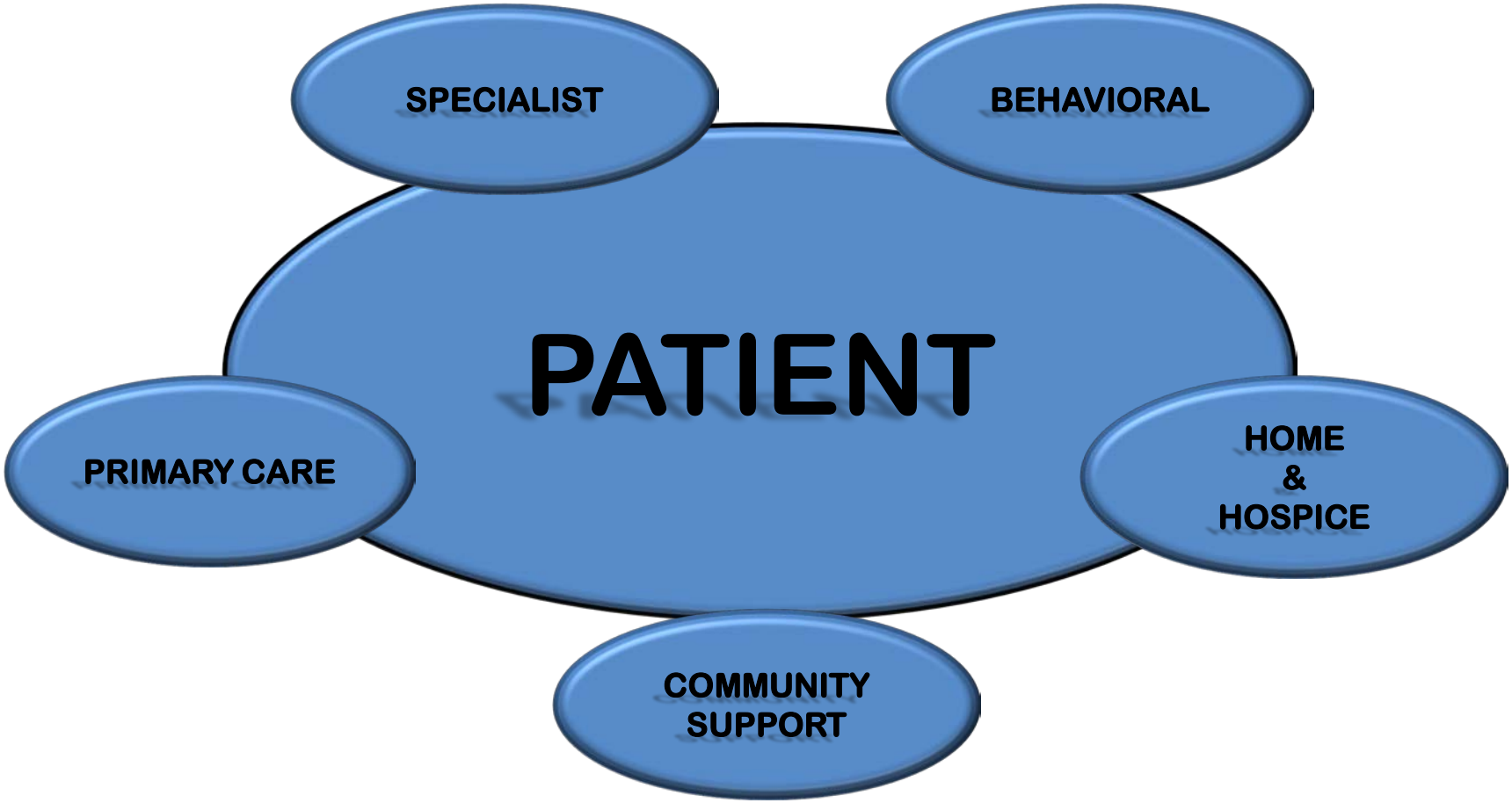
- What is PCMH
- Chronic Care Model
- Motivational Interviewing
- Care coordination
- Patient self-management/activation
- Community resources

University Medicine

# How Does NCM provide Value to Practice:

- In-patient/Emergency encounter follow-up
- Chronic disease patient management
- Patient care coordination
- Integration of care with behavioral health
- Patient education & support
- Leadership role with the practice

University Medicine



# Team-Based Care

- Daily care team huddles
- Pre-visit planning
- Standing Orders
- Evidence based guidelines
- Patient education
- Patient activation/self-management

# Education & Outreach

- Chronic disease management
- Educational tools
- Patient self-management
- Goals/monitoring
- Linkage with community resources
- Care coordination

University Medicine

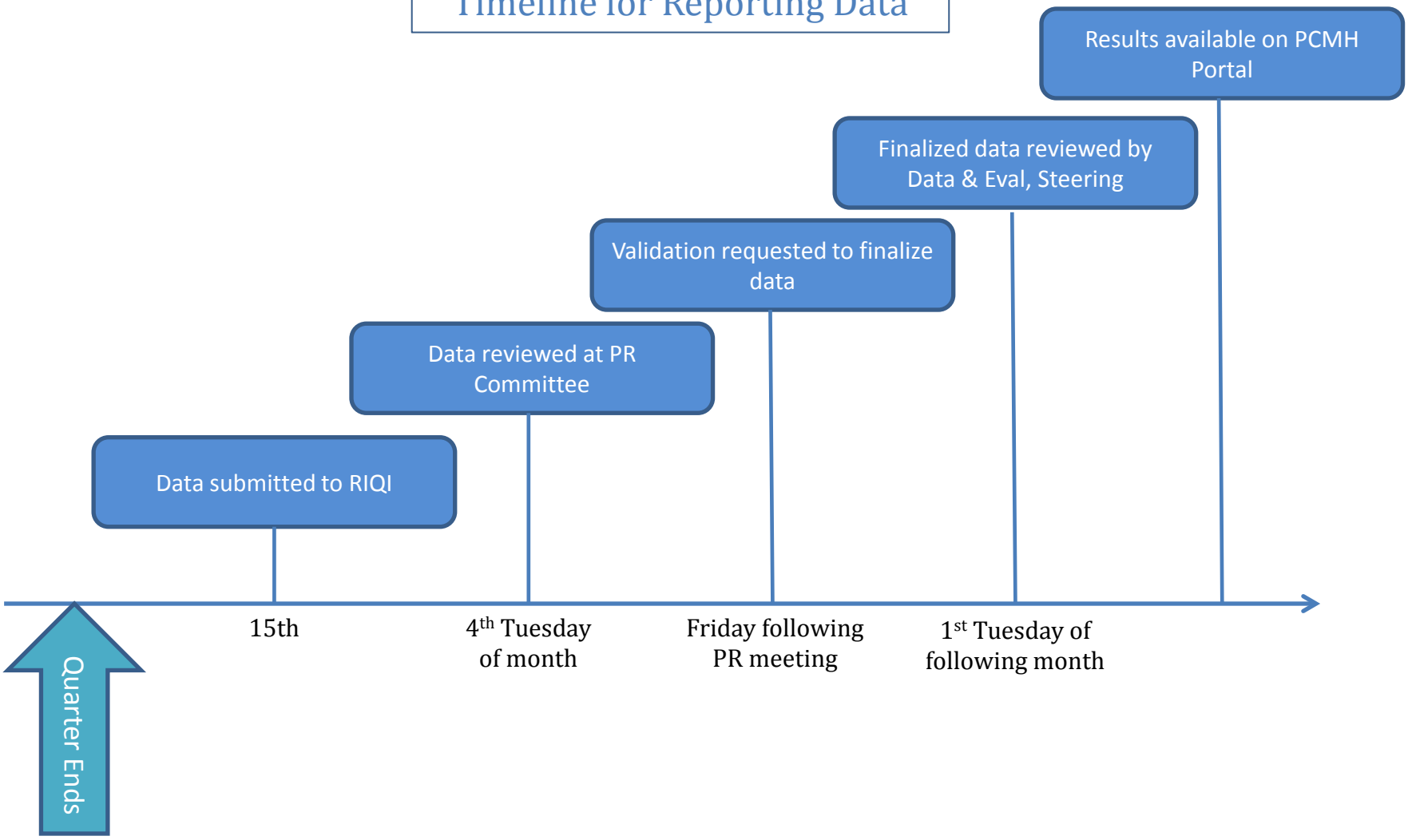
# Patient Utilization Management

- ED & hospital encounter follow up/ensures appropriate f/u with PCP/specialists
- Assists coordination of TOC/resources with hospital case manager
- Medication reconciliation

# What to expect at Practice Reporting

- Who should attend?
  - Person/s most familiar with the data extraction and how it used for quality improvement
- Review and understanding of the measures
- Keeping up on relevant timelines
- Review of quarterly data from the practices
- Best practice sharing

# Timeline for Reporting Data



## *Definition of 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

# Data Template for Reporting

| Practice Name | Practice Type | CSI Measure | Quarter | Numerator | Denominator | Result | Annotation | Comment/questions |
|---|---|---|---|---|---|---|---|---|
| PCMH Practice A | CHC | Total # Active Pts 18+ | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Depression Screen | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM A1c Poor Control | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM BP Good Control | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM LDL Good Control | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Tobacco Cessation | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM-BP Pts w/ Measurement | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM-HbA1c Pts w/ Result | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM-LDL Pts w/ Result | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM A1c Good Control (<8) | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | DM BP Control (<140/90) | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Tobacco Assessment | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Adult BMI (18-64) | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Adult BMI (65+) | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Hypertension BP Measurement | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Hypertension BP Control (<140/90) | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Fall Risk Management | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Chlamydia - Sexual History | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Chlamydia - Testing | 9/30/2013 | | | | | |
| PCMH Practice A | CHC | Avoidance of antibiotics - Bronchitis | 9/30/2013 | | | | | |

# Helpful Hints

- **BMI Measure**: not only looks for patients with BMI documented, but for those with BMI outside of normal range, must have care plan documented.
- **BMI Measure**: must be most recent BMI.
- **DM A1c Poor Control**: include DM patients with no test results.
- **Tobacco Cessation**: cessation advice must be during face-to-face encounter.
- **Depression, Tobacco Use** and **Tobacco Cessation** have 24 month look-back.

# CSI Benchmarks

| Measure | Target |
|---|---|
| Adult BMI 18-64 | 70% |
| Adult BMI 65+ | 75% |
| DM A1c Control | 70% |
| DM BP Control | 76% |
| HTN BP Control | 76% |
| Tobacco Cessation | 90% |

# How to Successfully Pass a Measure

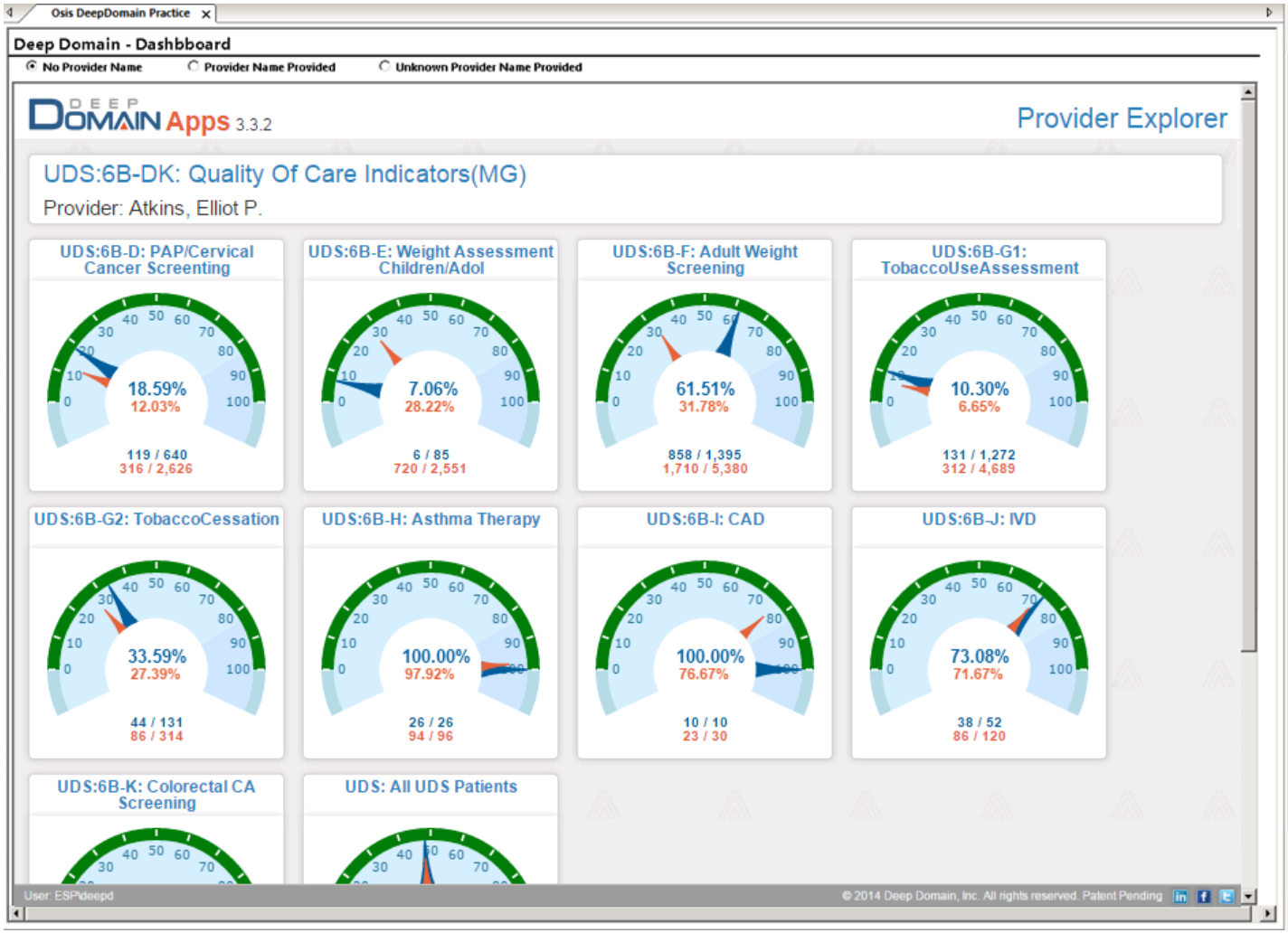
*Success in a domain is defined as:*

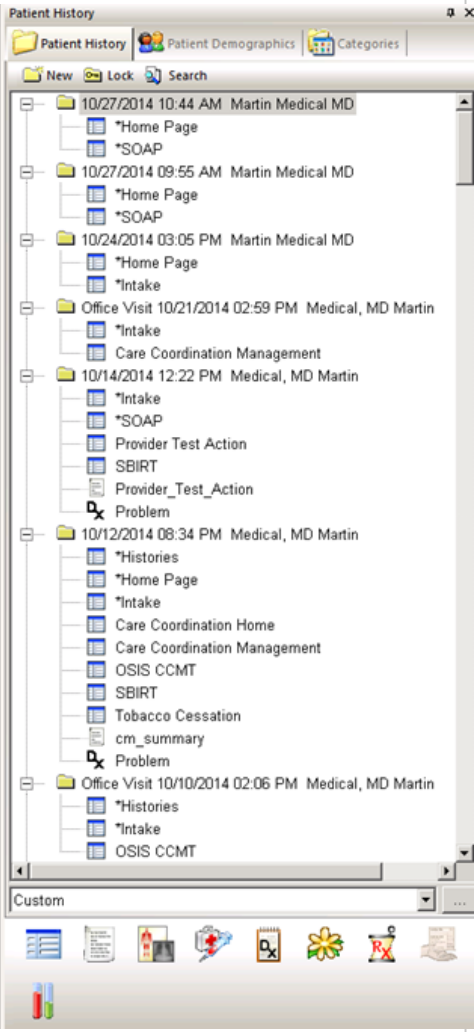
1. Achieving results in 2015that meet or exceed the 2014 median.
2. If the difference between 2014 baseline to 2015 follow-up is 5% points or greater, then a practice can succeed if the improvement achieved is at least half the distance between the baseline result and the 2014 median ("target"), at least a 2.5% point improvement. If there was no 2014 measurement, then the 2014 median must be attained.

DEEP DOMAIN™

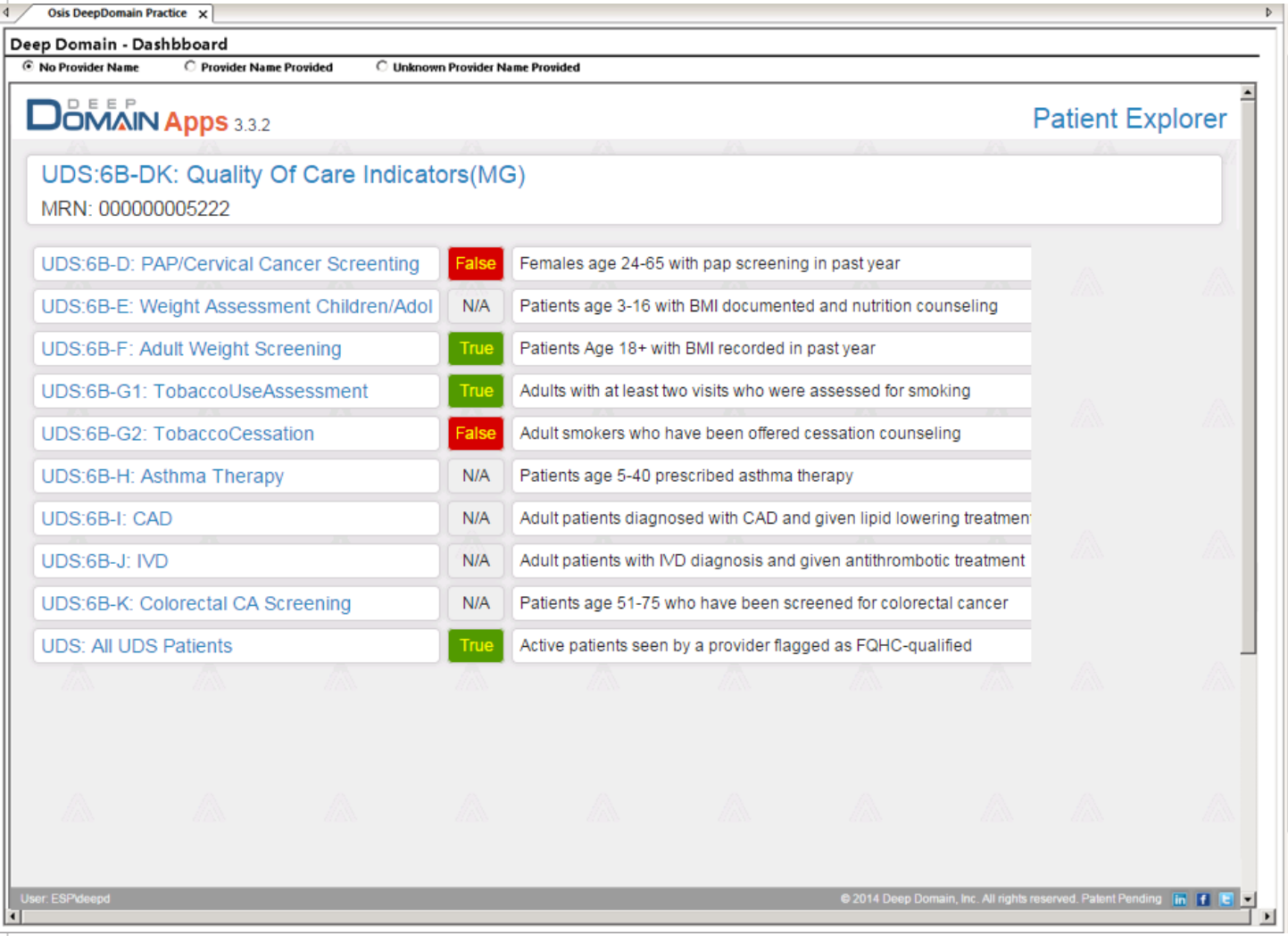
# Q1 CSI Measures

DEEP DOMAIN™



DEEP DOMAIN™



High Cost/High Utilization Patients

Poorly Controlled/Complex Patients

Payer Identified High Impact Patients

# Contact

Brian J. (Bj) Stephens
Director of Strategic Relationships
Deep Domain
913.617.6729

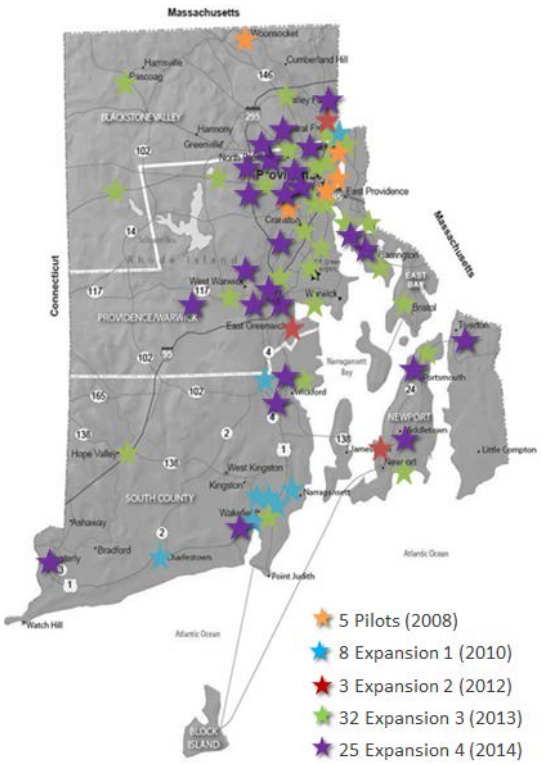
www.deepdomain.com

Trust & Confidence through Transparency.

# CSI-RI Orientation 2014

# Tab 2: About CSI-RI

**Map of CTC-RI Practices**




## The Rhode Island Care Transformation Collaborative (CTC-RI)

*CTC-RI's mission is to lead the transformation of primary care in Rhode Island. CTC-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 (CTC-RI) brings together key health care stakeholders to promote care for patients with chronic illnesses through the patient-centered medical home (PCMH) model.

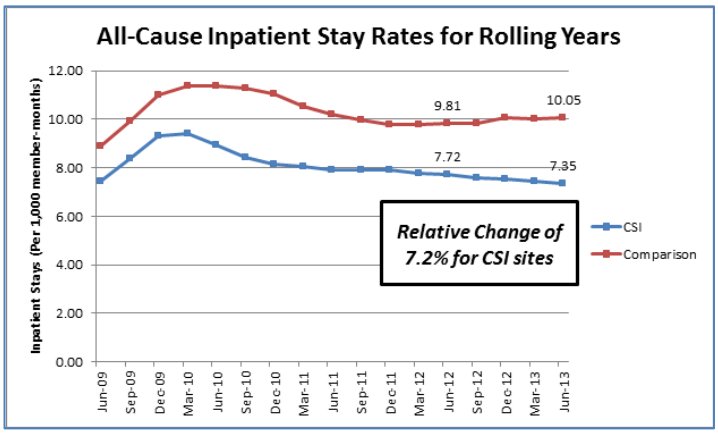
CTC-RI began with five pilot sites in 2008 and has grown to 43 practices with 73 practice sites. Currently, approximately 300,000 Rhode Islanders receive their care from CTC-RI practices. **Over the next four years, up to 20 practices will be added each year, with the goal of providing over 500,000 Rhode 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, CTC-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*

- CTC-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 six quality measures. They have done so for the last four years.




*Utilization*

- In 2013, the practices in the most experienced CTC cohort realized a 7.2% reduction in hospital admissions

*Patient experience*

- According to 2014 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, patients are realizing the immediate benefits of PCMHs. CTC-RI practices as a whole have met targets for access, communication and office staff with directional improvement noted in shared decision making, self-management support and behavioral support

*National recognition*

- CTC-RI practices were among the first in the country to be recognized as medical homes of the highest quality. Of the 29 sites eligible to apply for NCQA recognition, 22 sites have applied; all sites that applied have obtained the highest level of recognition (Level 3)

*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 CTC-RI (2008-2010). Dr. Rosenthal found that at the end of two years, CTC-RI practices had higher NCQA scores, greater provider job satisfaction and improvements on a number of quality measures, particularly those related to diabetes.

**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.

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

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% |

| 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** |

**Participating Practices**

- Anchor Medical Associates (Lincoln, Providence, and Warwick)
- Aquidneck Medical Associates (University Medicine: Newport and Portsmouth)
- Arcand Family Medicine
- Associates in Primary Care (Warwick)
- Barrington Family Medicine
- Solmaz Behtash
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- John Chaffey
- Charter Care Medical Associates
- Coventry Primary Care Associates
- 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 Center
- Family Medical Middletown
- Family Medicine at Women's Care (Pawtucket)
- Duane Golomb Associates
- Internal Medicine Center (Pawtucket)
- Internal Medicine Partners (North Providence)
- Kristine Cunniff, MD (Narragansett)
- Linden Tree Health Center
- Medical Associates of RI (Bristol and Barrington)
- Memorial Hospital Family Care Center (Pawtucket)
- Nardone Medical Associates (Pawtucket
- North Kingstown Family Practice
- Ocean State Medical (Johnston)
- Primary Care of Barrington
- Primary Care Medical Groups of Warwick
- Providence Community Health Centers (Capital Hill, Central, chad Brown, Chaffee, Crossroads, North Main Street, Prairie Avenue, Olneyville)
- Richard Del Sesto (East Greenwich)
- South County Hospital Family Medicine (East Greenwich)
- South County Hospital Primary Care and Internal Medicine IWakefield)
- 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)
- Tiverton Family Practice
- 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)
- Wickford Family Medicine
- Women's Primary Care, Women's Medical Collaborative (Providence)
- Wood River Health Services (Hope Valley)

# CTC – RI Management Team

## Providence Office:

RI Foundation
One Union Station
Providence, RI 02903


**Pano Yeracaris, MD, MPH**
*Co-Project Director, CTC-RI*
Ph: 617 953-5501
pyeracaris@gmail.com

**Debra Hurwitz, MBA, BSN, RN**
*Co-Project Director, CTC-RI*
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 508-856-4270 (o)
Ph: 978-502-9811 (c)
Debra.Hurwitz@umassmed.edu

**Susanne Campbell, RN, MS**
*Senior Project Director*
CTC - RI Project Management Team
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 508-856-3608
Susanne.Campbell@umassmed.edu

**Michael Mobilio**
*Project Coordinator*
CTC - RI Project Management Team
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 508-856-3606
Michael.Mobilio@umassmed.edu

**Shannon Massaroco**
*Project Coordinator*
CTC - RI Project Management Team
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 401.274.4564 ext. 4112
C: 401.374.6675
E: shannon.massaroco@umassmed.edu

**Catherine Sampson**
*MAPCP Project Manager*
CTC-RI Project Team
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 508-421-5919
Catherine.Sampson@umassmed.edu

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Pilot Sites (participating since October 2008):* | | | |
| **Coastal Medical, Inc. – Greenville**<br>10 Davol Square, Suite 400, Providence, RI<br>Physician Champion: Dr. John Gaines (drsgaines@cox.net) | **E Clinical Works** | **Declined Facilitation - BCBSRI** | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Coastal Medical, Inc. - Hillside Avenue Family & Community Medicine**<br>727 East Avenue, Pawtucket, RI<br>Physician Champion: Dr. Chris Campanile (chris.campanile@cox.net) | **E Clinical Works** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Family Health and Sports Medicine**<br>725 Reservoir Avenue, Cranston, RI<br>Physician Champion: Dr. Albert Puerini, Jr. (apuerini@ripcpc.com) | **Epichart** | **Declined Facilitation - BCBSRI** | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **Thundermist Health Center – Woonsocket**<br>450 Clinton Street, Woonsocket, RI<br>Physician Champion: Dr. David Bourassa (DavidB@thundermisthealth.org) | **E Clinical Works** | **Declined facilitation: Brown PCMH** | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **University Medicine – Governor Street Primary Care Center**<br>285 Governor Street, Providence, RI<br>Physician Champion: Dr. Thomas Bledsoe (Thomas_Bledsoe@brown.edu) | **E Clinical Works** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Expansion 1 Sites (participating since April 2010)* | | | |
| **Coastal Medical, Inc. – Narragansett**<br><br>360 Kingstown Rd, Suite 200, Narragansett, RI<br>Physician Champion: Dr. Dariusz Kostrzewa (dkostrzewa@hotmail.com) | **E Clinical Works** | **Declined Facilitation - BCBSRI** | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Coastal Medical, Inc. – Wakefield**<br>70 Kenyon Ave, Suite 215, Wakefield, RI<br>Physician Champion: Dr. J. Russell Corcoran (rcorcoran@pol.net) | **E Clinical Works** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Kristine Cunniff, MD**<br>350 Kingstown Rd, Narragansett, RI<br>Physician Champion: Kristine Cunniff (kcunniff@cox.net) | **Epichart** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **Memorial Hospital Family Care Center**<br>111 Brewster Street, Pawtucket, RI<br>Physician Champion: Dr. David Ashley (david_ashley_md@brown.edu) | **GE Centricity** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **South County Hospital Family Medicine**<br>3461 South County Trail, East Greenwich, RI<br>Physician Champion: Dr. Laura Henseler (lhenseler@schospital.com) | **Greenway** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **South County Internal Medicine**<br>481 Kingstown Rd, Wakefield, RI<br>Physician Champion: Dr. Paul Barratt (pbarratt@scim.necoxmail.com) | **AllScripts** | **Declined Facilitation - BCBSRI** | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Stuart Demirs, MD**<br>4099 Old Post Rd, Charlestown, RI<br>Physician Champion: Dr. Stuart Demirs (sdemirs@cox.net) | **Epichart** | **Declined Facilitation** | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| **Thundermist Health Center of South County**<br>1 River Street, Wakefield, RI<br>Physician Champion: Dr. David Bourassa (DavidB@thundermisthealth.org) | **E Clinical Works** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| *Expansion 2 Sites (participating since October 2012)* | | | |
| **Blackstone Valley Community Health Center**<br>42 Park Place, Pawtucket, RI<br>Physician Champion: Dr. Jerald Fingerut (jfingerut@bvchc.org) | **NextGen** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | **Sue Dettling**<br>SDettling@RIQI.org<br>401-276-9141 x 236 |
| **East Bay Community Action Program - Newport**<br>19 Broadway, Newport, RI<br>Physician Champion: Dr. Eileen Gonzalez (drg@ebcap.org) | **NextGen** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **University Family Medicine**<br>1351 South County Trail, Suite 301<br>East Greenwich, RI<br>Physician Champion: Dr. Karen Blackmer (karenblackmer@verizon.net) | **Epichart** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Expansion Third Wave (participating since October 2013)* | | | |
| **Anchor Medical Associates**<br>1 Commerce Street, 2nd Floor, Lincoln, RI<br><br>1 Hoppin Street, 3rd Floor, Providence, RI<br><br>400 Bald Hill Road, Suite 520, Warwick, RI<br>Physician Champion: Dr. Diane Siedlecki (dsiedlecki@lifespan.org) | **Athena health** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **Aquidneck Medical Associates member of University Medicine**<br>50 Memorial Boulevard, Newport, RI 02840<br><br>77 Turnpike Avenue, Portsmouth, RI 02871<br>Physician Champion: Dr. David Gorelick (d-gorelick-09@aquidneckmed.com) | **E Clinical Works** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Associates in Primary Care**<br>857 Post Road, Warwick, RI 02888<br>Physician Champion: Dr. Martin Kerzer (martin_kerzer@brown.edu) | **Athena health** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **Comprehensive Community Action Program**<br>311 Doric Avenue, Cranston, RI 02910<br><br>191 MacArthur Boulevard, Coventry, RI 02816<br><br>226 Buttonwoods Avenue, Warwick, RI 02886<br>Physician Champion: Dr. Elena Kwetkowski (ekwetkowski@comcap.org) | **NextGen** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Sue Dettling**<br>SDettling@RIQI.org<br>401-276-9141 x 236 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Expansion Third Wave (participating since October 2013)* | | | |
| **East Bay Community Action Program**<br>100 Bullocks Point Avenue, East Providence, RI 02915<br>Physician Champion: Dr. Sarah Fessler (sfessler@ebcap.org) | **NextGen** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **Family Medicine at Women's Care**<br>407 East Avenue, Suite 150, Pawtucket, RI 02860<br>Physician Champion: Dr. Emily Harrison (eharrison@women-care.com) | **Epic** | **Joanna Brown**<br>Joanna_brown@brown.edu<br>(401) 258-1283 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Internal Medicine Center**<br>111 Brewster Street, Pawtucket, RI 02860<br>Physician Champion: Dr. Dino Messina (dmessina@carene.org) | **GE Centricity** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Internal Medicine Partners**<br>1635 Mineral Spring Avenue, Suite 200, North providence, RI 02904<br>Physician Champion: Dr. Puneet Sud (psud91@hotmail.com) | **Athena health** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Medical Associates of RI**<br>1180 Hope Street, Bristol, RI 02809<br><br>286 Maple Avenue, Barrington, RI 02806<br>Physician Champion: Dr. Pamela Harrop (pharrop@lifespan.org) | **E Clinical Works** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Nardone Medical Associates**<br>333 School Street, Suite 112, Pawtucket, RI 02860<br>Physician Champion: Dr. Ahmad Al-Raqqad (kasebmed@yahoo.com) | **MedNet Solutions** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **Ocean State Medical**<br>1539 Atwood Avenue, Suite 101, Johnston, RI 02919<br>Physician Champion: Dr. Frank Savoretti (lawyerdoc@cox.net) | **E Clinical Works** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Expansion Third Wave (participating since October 2013)* | | | |
| **Richard Del Sesto**<br>3461 South County Trail, Suite 203, East Greenwich, RI 02818<br>Physician Champion: Dr. Richard Del Sesto (rmdelsesto@verizon.net) | **Epichart** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **South County Walk-In and Primary Care**<br>360 Kingstown Road, Suite 104, Narragansett, RI 02882<br>Physician Champion: Dr. Monica Gross (mgross@southcountywalkin.com) | **Soapware** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Thundermist Health Center**<br>186 Providence St, West Warwick, RI 02893<br>Physician Champion: Dr. Michael Poshkus (michaelpo@thundermisthealth.org) | **E Clinical Works** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Tri-Town Community Action Program**<br>1126 Hartford Avenue, Johnston, RI 02857<br>Physician Champion: Dr. Richmond Ramirez (rramirez@tri-town.org) | **NextGen** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **University Internal Medicine**<br>407 East Ave, Suite 120, Pawtucket, RI 02860<br>Physician Champion: Dr. David Marcoux (dmarcoux@lifespan.org) | **Intergy by Vitera** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Expansion Third Wave (participating since October 2013)* | | | |
| **University Medicine**<br>1275 Wampanoag Trail, Suite 200, East Providence, RI 02915<br><br>1035 Post Road, Warwick, RI 02888<br><br>111 Plain Street, 3rd Floor, Providence, RI 02905<br><br>909 North Main Street, Suite 300, Providence, RI 02904<br><br>407 East Avenue, Suite 110, Pawtucket, RI 02860<br><br>Physician Champion: Dr. Francis Basile (fbasile@lifespan.org) | **E Clinical Works** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092<br>**Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Kerri Costa**<br>KCosta@RIQI.org<br>401-276-9141 x 235 |
| **WellOne Primary Medicine**<br>36 Bridge Way, Pascoag, RI 02859<br><br>308 Callahan Road, North Kingstown, RI 02852<br><br>142A Danielson Pike, Foster, RI 02825<br><br>Physician Champion: Dr. Andrea Marcote (amarcote@welloneri.org) | **NextGen** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Women's Primary Care, Women's Medical Collaborative**<br>146 West River Street, Providence, RI 02904<br>Physician Champion: Dr. Iris Tong (itong@lifespan.org) | **E Clinical Works** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **WoodRiver Health Services**<br>823 Main Street, Hope Valley, RI 02832<br>Physician Champion: Dr. Christopher Campagnari (ccampagnari@wrhsri.org) | **NextGen** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |

# Current CSI-RI Practices

| Practice | EHR | Practice Facilitator | REC Relationship Manager |
|---|---|---|---|
| *Expansion (participating since December 2014)* | | | |
| **South County Hospital Primary Care Family and Internal Medicine**<br>70 Kenyon Avenue, Suite 211<br>Wakefield, RI 02879<br>Physician Champion: Dr. Hana Hagos<br>hhagos@schospital.com<br><br>**Primary Care Westerly**<br>11 Well Street<br>Westerly, RI 02891<br>Physician Champion: Dr. Robert Fox<br>rfox@schospital.com | **Greenway /Prime Suite V17.0**<br><br>**Greenway /Prime Suite V17.0** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602<br><br>**Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **John Chaffey, DO, LTD.**<br>215 Tollgate Road, Suite 209<br>Warwick, RI 02818<br>Physician Champion: Dr. John Chaffey<br>drjchaffey@cox.net<br><br>**Coventry Primary Care Associates**<br>1620 Nooseneck Hill Road<br>Coventry, RI 02816<br>Physician Champion:<br>Key Contact: Kelly Manown<br>kellymanown@gmail.com | **Meditouch – HealthFusion 2014**<br><br>**Caretracker –v.10** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092<br><br>**Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Providence Community Health Centers**<br>375 Allens Avenue<br>Providence, RI 02905<br>Physician Champion: Dr. Andrew Saal<br>asaal@providencechc.org<br><br>**PCHC – Capital Hill**<br>40 Candace Street<br>Providence, RI 02908<br>Physician Champion: TBD<br><br>**PCHC Central** | **PCHC – Intergy V 9.0**<br><br>**TPC - Essentia** | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023<br><br>**Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023<br><br>**Suzanne Herzberg** | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |

# Current CSI-RI Practices

| | | | |
|---|---|---|---|
| 239 Cranston Street<br>Providence, RI 02907<br>Physician Champion: Dr. Shalini Solanki | | Suzanne_herzberg@brown.edu<br>401-263-6023 | |
| **PCHC Chad Brown**<br>285 A Chad Brown Street<br>Providence, RI 02908<br>Physician Champion: Dr. John Paul Abroguena | | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | |
| **PCHC Chaffee**<br>1 Warren Way<br>Providence, RI 02905<br>Physician Champion: Dr. Mario Martinez | | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | |
| **PCHC Crossroads**<br>160 Broad Street<br>Providence, RI 02903<br>Physician Champion: Dr. Ivan Wolfson | | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | |
| **North Main Street**<br>530 North Main Street<br>Providence, RI 02904<br>Physician Champion: Dr. Judith Nudelman | | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | |
| **PCHC Prairie Avenue**<br>355 Prairie Avenue<br>Providence, RI 02905<br>Physician Champion: TBD | | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | |
| **PCHC Olneyville**<br>100 Curtis Street<br>Providence, RI 02909<br>Physician Champion: Dr. Karen Ng | | **Suzanne Herzberg**<br>Suzanne_herzberg@brown.edu<br>401-263-6023 | |

# Current CSI-RI Practices

| | | | |
|---|---|---|---|
| **Primary Medical Group of Warwick**<br>215 Toll Gate Road, Suite 104<br>Warwick, RI 02914<br>Physician Champion: Dr. Christopher Furey<br>christophermfurey@gmail.com | **Epic** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Duane Golomb and Associates/Brookside Family Medicine**<br>766 Washington Street<br>Coventry, RI 02816<br>Physician Champion: Dr. Duane Golomb<br>Justin Feeney, DO<br>jfeeney@kentri.org | **Epic** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | |
| **Arcand Family Medicine**<br>1079 Main Street<br>West Warwick, RI 02893<br>**Physician Champion: Dr. Denise Arcand**<br>**arcandfamilymedicine@carene.org**<br>**Dr. Christopher Furey**<br>**christophermfurey@gmail.com** | **Epic** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | |
| **SouthCoast Health System**<br>**Linden Tree Family Health Center**<br>2444 East Main Road<br>Portsmouth, RI 02871<br>Physician Champion: Dr. Julia DeLeo<br>morgerar@southcoast.org | **Epic** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |
| **Family MediCenter**<br>672 Aquidneck Avenue, Polo Center<br>Middletown, RI 02842<br>Physician Champion: Luke Logan<br>loganl@southcoast.org | **Epic** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | |
| **Family Medical Middletown**<br>714 Aquidneck Avenue, Polo Center<br>Middletown, RI 02842<br>Physician Champion: Dr. Wendy Regan | **Epic** | **Jacqueline Lefebvre**<br>Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | |
| **Tiverton Family Practice** | **Epic** | **Jacqueline Lefebvre** | |

# Current CSI-RI Practices

| | | | |
|---|---|---|---|
| 1334 Main Road<br>Tiverton, RI 02878<br>Physician Champion: Scott Keigwin, Do<br>Stacey DiStefano<br>staceyd@yourprojectoffice.com | | Jacqueline.lefebvre@bcbsri.org<br>401-459-2092 | |
| **Barrington Family Medicine**<br>60 Bay Spring, Unit 6B<br>Barrington, RI 02806<br>Physician Champion: Dr. Andrea Arena<br>nkfpdoc@gmail.com<br><br>**North Kingstown Family Practice**<br>320 Phillips Street<br>N. Kingstown, RI 02852<br>Physician Champion: Dr. Lynn Ho<br>nkfpdoc@gmail.com<br><br>**Wickford Family Medicine**<br>320 Phillips Street<br>N. Kingstown, RI 02852<br>Physician Champion: Dr. John Machata<br><br>**Primary Care of Barrington**<br>60 Bay Spring, Unit A1<br>Barrington, RI 02806<br>Physician Champion: Dr. Gregory Sadovnikoff<br><br>**Solmaz Behtash, DO**<br>126 Prospect Street #101<br>Pawtucket, RI 02860<br>Physician Champion: Solmaz Behtash, DO | **Amazing Charts V7.0.12**<br><br>**eClinical Works V10** | **Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402<br><br>**Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402<br><br>**Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402<br><br>**Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402<br><br>**Anne Pushee**<br>Annepushee@verizon.net<br>401-338-3402 | **Sue Dettling**<br>sdettling@riqi.org<br>401-276-9141 x 236 |
| **Charter Care Medical Associates**<br>1500 Pontiac Avenue<br>Cranston, RI 02920<br>Physician Champion: Dr. Matthew Salisbury<br>matthew.salisbury@chartercare.org | **Athena** | **Aimee Schayer**<br>Aimee.Schayer@bcbsri.org<br>401-459-5602 | **Andrea Levesque**<br>ALevesque@RIQI.org<br>401-276-9141 x 262 |

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: _____ |

# Contract Attachments

## Attachment A:  CSI-RI Practices

- Anchor Medical Associates (Lincoln, Providence, and Warwick)
- Aquidneck Medical Associates (University Medicine: Newport and Portsmouth)
- Aracand Family Medicine
- Associates in Primary Care (Warwick)
- Barrington Family Medicine
- Solmaz Behtash
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- John Chaffey
- Charter Care Medical Associates
- Coventry Primary Care Associates
- 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 Center
- Family Medical Middletown
- Family Medicine at Women's Care (Pawtucket)
- Duane Golomb Associates
- Internal Medicine Center (Pawtucket)
- Internal Medicine Partners (North Providence)
- Kristine Cunniff, MD (Narragansett)
- Linden Tree Health Center
- Medical Associates of RI (Bristol and Barrington)
- Memorial Hospital Family Care Center (Pawtucket)
- Nardone Medical Associates (Pawtucket)
- North Kingstown Family Practice
- Ocean State Medical (Johnston)
- Primary Care Barrington
- Primary Care Medical Groups of Warwick
- Providence Community Health Centers
- Richard Del Sesto (East Greenwich)
- South County Hospital Family Medicine (East Greenwich)
- South county Hospital Primary Care and Internal Medicine/Wakefield
- 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)Tiverton Family Practice
- 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)

- Wickford Family Medicine
- Women’s Primary Care, Women’s Medical Collaborative (Providence)
- Wood River Health Services (Hope Valley)

**Attachment B: Nurse Care Manager Roles and Responsibilities**
**Nurse Care Manager Job Description**

**Position Summary:** A registered nurse, working in conjunction with a care team, to identify and proactively manage the care needs of high-risk patients and other patients identified by the practice as needing targeted support within the primary care practice setting. The Nurse Care Manager is responsible for providing comprehensive screenings, assessment, care coordination services with particular attention to transitions of care, disease education and self-management support. The Nurse Care Manager will be integrated into the patient centered medical home (PCMH), and will work in partnership with the health care team to promote the triple aim of reduced costs, improved health outcomes and increased patient satisfaction. The Nurse Care Manager will have frequent contact with primary care providers and other medical home team members and will actively participate in interdisciplinary patient-centered team meetings. The Nurse Care Manager will work with patients' families and other caregivers as warranted by patient needs. Work will be documented and integrated into the office's electronic medical record (EMR) system.

**Essential Job Duties and Responsibilities:**

- Provides care management services under the direction of the practice manager or provider.
- Works with the care team to identify and reach out to patients with a high risk of adverse health outcomes as defined by CSI or identified by payers and care providers.
- Completes initial patient assessment, including a comprehensive medical, psychosocial and functional evaluation of the patient, in the office or home setting as needed; reviews assessment with provider and clinical team members.
- Uses behavior change techniques such as motivational interviewing to establish therapeutic relationships with patients enabling effective intervention and support.
- Supports the patient in identification of actionable goals to optimize health outcomes;
- Develops a plan of care with the patient that promotes improved health care outcomes and quality of life informed by patient's goals, strengths and barriers;
- Implements the patient approved plan of care in collaboration with the patient through the practice's care team, community resources and home based visits and telephonic support;
- Provides other aspects of comprehensive care management including self-management support and health promotion,
- Advocates for patients to ensure access and timely service delivery across the continuum of care and community resources, including behavioral health, community based organizations and social supports to address barriers to optimum patient health;
- Supports the team with reviewing and addressing clinical quality measures, emergency room

and hospital utilization, access to care, communication with patients and patient satisfaction

- Provides or provides access to culturally and linguistically appropriate services as needed.
- Supports the team in providing access to age-appropriate patient services as needed**.**
- Works with providers to facilitate effective transitions to/from specialists, hospitals and other care providers through the timely communication of necessary information for patient care and discharge planning.
- Conducts medication reconciliation as appropriate and communicates any need for adjustment to care team and providers. Provides support to patients to enhance medication adherence. Documents any changes in patient's EMR.
- Works with careg**i**vers as appropriate to clarify the patient's needs, assess caregiver burden and provide support to family and caregivers.
- Meets practice policies and procedures related to documentation utilizing software tools that track care management activities and their effectiveness.
- Generates reports on service volume and distribution of patients by plans and types of services provided.
- Handles confidential information in accordance with HIPAA as well as state and federal privacy and confidentiality rules.
- Works with interdisciplinary team to plan and monitor quality improvement initiatives
- Communicates with care management staff from health care plans as appropriate

**General Requirements:**

- Participates as a member of the care team.
- Performs work consistent with evidence based treatment guidelines, office policies and procedures and NCQA PCMH Recognition Standards.
- Shares best practices among all team members, serves as a medical home advocate, mentors and leads by example to support a positive work environment and encourages other staff to do the same.
- Participates in meetings and huddles as appropriate.
- Participates in regular CSI NCM meetings for peer support and education
- Conducts pre-visit planning and post-visit follow-up for the care managed patients.
- Provides feedback to providers regarding patient progress and barriers encountered.

- Prepares for and participates in case review meetings to share discoveries, concerns and collaborate in the development of plans of care.

**Position Qualifications:**

- RN from an accredited program: licensed in State of RI.
- Excellent communication skills and ability to form collaborative partnerships across all service settings.
- Knowledge of community resources
- Experience of 3-5 years in community health setting, public health, chronic disease management, community nursing, or case management preferred.
- Certified as diabetic educator or in another chronic care area, preferably within 12 months of employment.
- Additional care management training and certification is strongly encouraged.

## 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 6 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 composite domain scores of CAHPS PCMH
   b. This is a Practice Level Performance measure
   c. Benchmarks, defined as 2014 medians, are as follows: Access (60%), Communication (84%), Office Staff (76%), Shared Decision making (68%); Self-Management (51%); Comprehensive-Adult Behavioral Health (57%);
   d. Practices must pass the "gate" using the measure of Access:
      Performance Year 1: A practice can successfully pass this metric via the following two ways:

      i. Method 1: A practice meets or exceeds the threshold for Access and meets/exceeds the threshold for Office Staff or Communication composite measure;
      ii. Method 2: A practice does not meet the threshold but improves their Access score by 2.5% from their prior year's score and meets/exceeds the threshold for both Office Staff and Communication composite measures.

      Performance Year II:

      i.Method 1: A practice meets or exceeds the threshold for Access and meets/exceeds the threshold for three (3) of the following composite measures: Communication, Shared Decision Making, Self-Management, Comprehensive-Adult Behavioral Health or Office Staff
      ii.Method 2: A practice does not meet the threshold, but improves their Access score by 2.5% from the prior year's score and meets/exceeds the threshold for four(4) of the following composite measures: Communication, Shared Decision Making, Self-Management, Comprehensive-Adult Behavioral Health or Office Staff.

   e. Success in any domain, other than Access, is defined as achieving results in the 2014-2015 that meets or exceed the threshold. In addition, if the difference between 2013-

2014 baseline to Q1 2014-2015 follow-up is 5% points or greater, then a practice can succeed if the improvement achieved is at least half the distance between the 2013-2014 baseline result and the 2015 target, if it is also at least a 2.5% point improvement. If there was no 2013-2014 measurements, then the 2014-2015 target must be attained.

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 2014 through March 2015 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, 2014 date, but does not achieve the benchmark during the April 2014 – March 2015 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.
    f. Improving their performance from 50% to 64% during the measurement year, thereby meeting the CSI-RI benchmark value; or
    g. 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 six benchmarks by either one of these methods, or any combination of the two methods.
4. Performance Year II: Practices must meet four out of six thresholds for success, via the appropriate method. Practices will be eligible for the additional performance incentive (as indicated in the developmental contract) if they successfully achieve thresholds for six out of six measures, via the appropriate method.

**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 November 4, 2014.

Practices must meet the benchmark on four (4) out of the six (6) measures to meet Target #2. Practices will continue to measure and report on all 13 measures. Only the indicated six (6) will be used to meet the requirements of target #2.

| Measure | Used for Payment | Threshold |
|---|---|---|
| **Adult BMI (18-64)** | ✓ | 70% |
| **Adult BMI (65+)** | ✓ | 75% |
| Depression Screen | | 91% |
| **DM A1c Good Control (<8)** | ✓ | 70% |
| DM A1c Poor Control (>9) | | 21% |
| **DM BP Control (<140/90)** | ✓ | 78% |
| **Hypertension BP Control (<140/90)** | ✓ | 76% |
| Tobacco Assessment | | 98% |
| **Tobacco Cessation** | ✓ | 90% |
| DM HbA1c patients w/ Result | | 89% |
| Chlamydia Screening-Sexual History | | N/A |
| Chlamydia Screening-Testing | | N/A |
| Fall Risk Management | | N/A |
| Total # active patients 18+ | | |

# 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 |
| 5/26/2014 | Added clarification of inverted rate measurement in the numerator of Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis and removed it in the description.<br>Reorganized the order of the measures in the document.<br>Added E&M and G Codes for Prevention Visits.<br>Removed DM BP <130/80 as not reported anymore. |
| 6/23/2014 | Added to the descriptions for BMI Measures and various Control Measures.<br>Added to the descriptions for BMI Measures and various Control Measures.<br>Removed DM LDL as not reported anymore. |
| 6/26/2014 | Moved contract measures up to beginning of document and designated as such.<br>Removed HTN BP Measurement as not reported anymore |
| 7/14/2014 | Removed HEDIS as measurement source for Chlamydia measures. Waiting for update from Data & Evaluation. |
| 8/13/2014 | ICD-9 formats changed to the XXX.xx structure<br>BMI Care Plans more thoroughly defined<br>HTN BP Measure changed to reflect new standards. |
| 9/29/2014 | Updated Chlamydia Test denominator to state that patients can be considered screened for sexual activity in 2 ways: being screened or having a Chlamydia test. |
| 10/7/2014 | Removed Acute Bronchitis measure. This measure is suspended. |
| 11/24/2014 | Update HTN BP Control numerator to match HEDIS 2015 specifications. |

# Adult Body Mass Index – Age 18-64 (In Range or Care Plan) – Contract measure

<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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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:<br>1. Patients whose most recent calculated BMI during the measurement period is in normal range:<br>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 . A documented care plan can be: Structured Data, Visit with or Referral to Nutritionist/Dietician, CPT code, Weight Counseling by Health Care Professional, Providing Patient Educational Materials on Nutrition, ICD-9 Code: V65.3 - dietary counseling.<br><br>
<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:<br>• Patients diagnosed with a terminal illness in the measurement year<br>• Patients who are pregnant (ICD-9 codes – 630.xx-679.xx, V22.xx, V23.xx, V28.xx)<br>• Patients for whom the exam was not done for patient reason<br>• Patients for whom the exam was not done for medical reason<br>• 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 (In Range or Care Plan) – Contract measure

<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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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:<br>1. Patients whose most recent calculated BMI during the reporting period is in normal range:<br>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. A documented care plan can be: Structured Data, Visit with or Referral to Nutritionist/Dietician, CPT code, Weight Counseling by Health Care Professional, Providing Patient Educational Materials on Nutrition, ICD-9 Code: V65.3 - dietary counseling.
<table>
<tr><th>BMI Range</th><th>Age 65 years and older</th></tr>
<tr><td>ABOVE Normal</td><td>$\geq$30 kg/m$^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>$\leq$22 kg/m$^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:<br>• Patients diagnosed with a terminal illness in the measurement year<br>• Patients who are pregnant (ICD-9 codes – 630.xx-679.xx, V22.xx, V23.xx, V28.xx)<br>• Patients for whom the exam was not done for patient reason<br>• Patients for whom the exam was not done for medical reason<br>• 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.

# Diabetes Mellitus – HbA1c Control (<8) – Contract measure

| | |
|---|---|
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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:<br><br>ICD 9 Code groups for Diabetes:<br>250.xx, 357.2x, 362.0x, 366.41, 648.0x |
| **Exclusions** | Patients with gestational diabetes or steroid-induced diabetes during the measurement year.<br><br>ICD-9 Codes for:<br>Steroid induced diabetes: 249.xx, 251.8x, 962.0x<br>Gestational diabetes: 648.8x, PCOS 256.4x |
| **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.

# Diabetes Mellitus – HbA1c Poor Control (>9 or NONE)

| | |
|---|---|
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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 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:<br><br>ICD 9 Code groups for Diabetes:<br>250.xx, 357.2x, 362.0x, 366.41, 648.0x |
| **Exclusions** | Patients with gestational diabetes or steroid-induced diabetes during the measurement year.<br><br>ICD-9 Codes for:<br>Steroid induced diabetes: 249.xx, 251.8x, 962.0x<br>Gestational diabetes: 648.8x, PCOS 256.4x |
| **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 Control (<140/90) – Contract measure

| | |
|---|---|
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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 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:<br><br>ICD 9 Code groups for Diabetes:<br>250.xx, 357.2x, 362.0x, 366.41, 648.0x |
| **Exclusions** | Patients with gestational diabetes or steroid-induced diabetes during the measurement year.<br><br>ICD-9 Codes for:<br>Steroid induced diabetes: 249.xx, 251.8x, 962.0x<br>Gestational diabetes: 648.8x, PCOS 256.4x |
| **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

# Hypertension: Blood Pressure Control (<140/90) - Contract measure

| | |
|---|---|
| **Definition** | The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:<br>• Members 18–59 years of age whose BP was <140/90 mm Hg.<br>• Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.<br>• Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. |
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• Patient has been discharged |
| **Measurement Period** | 12 months |
| **Numerator** | Patients in the denominator whose most recent blood pressure (both systolic and diastolic) is adequately controlled in the measurement period* based on the following criteria:<br>• Members 18–59 years of age as of the last day of the reporting period whose BP was <140/90 mm Hg.<br>• Members 60–85 years of age as of the last day of the reporting period and diagnosed with diabetes (ICD 9 Code groups for diabetes: 250.xx, 357.2x, 362.0x, 366.41, 648.0x ) whose BP was <140/90 mm Hg.<br>• Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg. |
| **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.xx, |
| **Exclusions** | • Patients who are pregnant (ICD-9 codes – 630.xx-679.xx, V22.xx, V23.xx, V28.xx)<br>• Patients who are diagnosed with ESRD (ICD code 585.6x) |
| **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***

# 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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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<br><br>Codes to identify preventive visits:<br>99381-99387, 99391-99397, G0402-G0405, G0438-G0439 |
| **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.

# Tobacco Cessation Intervention - Contract measure

| | |
|---|---|
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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.<br><br>Codes to identify preventive visits:<br>99381-99387, 99391-99397, G0402-G0405, G0438-G0439 |
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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.<br><br>296.xx, 300.4x, 311.xx, 293.83, 298.0x, 309.0x, 309.1x, 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<br><br>Codes to identify preventive visits:<br>99381-99387, 99391-99397, G0402-G0405, G0438-G0439 |
| **Exclusions** | Patients diagnosed with the following ICD-9 codes:<br><br>290.xx, 294.xx ,318.xx |
| **Measure source** | Based on: Veterans' Health Administration measure<br>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.

# Fall Risk Management

| | |
|---|---|
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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:<br>• Have you fallen two or more times in the past year<br>• 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.<br>CPT codes: 99201-99205, 99212-99215,99387,99397<br>G codes: G0402, G0438, G0439 |
| **Exclusions** | None |
| **Measure source** | Based NQF 0101 Part A |
| **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.

# Chlamydia Screening – Obtaining Sexual History

| | |
|---|---|
| **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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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.<br><br>**CPT Codes to identify preventive visit:**<br>99201 – 99215 with preventive diagnosis code (v20.xx, v22.xx, v23.xx, v70.xx, v72.31) or preventive visit : 99385, 99395 |
| **Exclusions** | None |
| **Measure source** | |
| **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.

# Chlamydia Screening – Testing

<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:<br>Patients who have left the practice by the end of the measurement year, as determined by:<br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• 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.<br><br>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><br>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 year. Patients can be considered sexually active in either of 2 ways: Screening for Sexual History; Having a Chlamydia Test.<br>CPT Codes to identify preventive visit:<br>99201- 99215 with preventive diagnosis code (V20.XX, V22.XX, V23.XX, V70.XX, V72.31) or<br>Preventive Visit: 99385, 99395</td></tr>
<tr><td>Exclusions</td><td>None</td></tr>
<tr><td>Measure source</td><td></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.

## 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. `

    b. CSI-RI Practices will achieve five percent (5%) relative reduction in ED visits per thousand as compared to similar, non –PCMH practices during the same measurement period.

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–<br>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.<br><br>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.<br><br>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."<br><br>http://qualitymeasures.ahrq.gov/content.aspx?id=34130&search=emergency+department<br><br>https://www.bluecrossma.com/staticcontent/npi_docs/UB_04FormLocatorAppendices.pdf<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>ED visits are identified by at least one of the following[1]:<br>• CPT codes 99281–99285 with UB revenue codes 045x, 0981<br>• CPT codes 10040–69979 with POS 23.<br>• HCPCS codes G0380–G0385.[2]<br><br>Exclude ED visits occurring on the same day as an admission or the day before an admission.[3]<br><br>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<br>• UB revenue code 0760 (general classification category) or 0762 (observation room); and<br>• HCPCS code G0378 (hospital observation service, per hour) or G0379 (direct admission of patient for hospital observation care).[5]<br><br>Exclude visits where the principal diagnosis is any of the following pregnancy related ICD-9 codes[6]:<br>• Complications of Pregnancy, Childbirth, and the Puerperium (630.xx–679.xx)<br>• Newborn (Perinatal) Guidelines (760.xx–779.xx)<br>• V20.xx Health supervision of infant or child<br>• V22.xx Normal pregnancy<br>• V23.xx Supervision of high-risk pregnancy<br>• V24.xx Postpartum care and evaluation<br>• V27.xx Outcome of delivery<br>• V28.xx Antenatal screening<br>• V29.xx Observation and evaluation of newborns for suspected condition not found<br>• 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]<br>• CPT codes 90801–90899<br>• principal ICD-9-CM diagnosis codes 290.xx–326.xx<br>• ICD-9-CM procedure code 94.26, 94.27, or 94.6<br>• 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.<br><br>Exclude visits where the principal diagnosis is dental related (ICD-9 codes 520.xx–525.xx).[8] |



[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 | 4/15/2015 |
| Report 14 | 7/15/2015 |
| Report 15 | 10/15/2015 |
| Report 16 | 1/15/2016 |
| Report 17 | 4/15/2016 |
| Report 18 | 7/15/2016 |
| Report 19 | 10/15/2016 |
| Report 20 | 1/15/2017 |

# 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<br>$2.50 NCM<br><br><br><br><br>**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<br>Target 2: Establish quality data reporting for harmonized measures<br>Target 3: Practice implements interventions to reduce ED visits and IP admissions |
| Stage 2 (max 1 yr) | Transition | $3.00 Base<br>$2.50 NCM<br>$0.50 to measure<br><br>**Max:$6.00** | Target 1: All structural components in place and achieve NCQA level 2<br>Target 2: Quality data is stable; baseline established; practice is working to achieve quality benchmarks;<br>Target 3: Focus interventions to reduce ED visits and IP admissions. |
| Stage 3 | Performance I | $3.00 base<br>$2.50 NCM<br><br>$0.50<br>$0.50<br><br>$0.50<br>$0.50<br>**Max: $7.50** | **Target 1:** all structural requirements in place and achieve NCQA level 3 (if not achieved base is reduced by $0.50)<br><br>**Target 2a:** Achieve 4 out of 7 quality benchmarks;<br>**Target 2b**: Achieve top box score of 53% on "Access" and either 80% on "Communication" or 72% "Office Staff" **PCMH CAHPS**<br>**Target 3a:** All-Cause Inpatient admissions<br>**Target 3b:** All-Cause ED |
| Stage 4 | Performance II | $3.00 base<br>$2.50 NCM<br><br>$0.50<br>$0.25<br>$0.50<br><br>$1.25<br>$0.75<br>**Max: $8.75** | **Target 1:** structure in place and maintain NCQA level 3<br>if not maintained base is reduced by $0.50)<br><br>**Target 2a:** Achieve 4 out of 7<br>If achieve 6 out of 7 quality benchmarks<br>**Target 2b:** Achieve top box score of 53% on "Access" and either 80% on "Communication" or 72% "Office Staff" **PCMH CAHPS**<br>**Target 3a:** All-Cause Inpatient Admissions (5%)<br>**Target 3b:** All-Cause ED (7.5%) |
| Stage 4 a | Performance IIa | $3.00 base<br>$2.50 NCM<br><br><br>$0.50<br><br><br>$0.50<br><br>$0.50<br>$0.50<br>$1.25 | **Target 1:** structure in place and maintain NCQA level 3<br><br>if not maintained base is reduced by $0.50)<br><br>**Target 2a:** Achieve 5 out of 7 clinical quality measures and testing of any new measures as defined by the CSI-RI Data and Evaluation Committee (e.g. Nurse Care Manager Measurement)<br>**Target 2b:** Achieve for 4 out of 6 CAHPS survey patient experience measures as defined by the CSI-RI Data and Evaluation Committee<br>**Target 3a:** All-Cause Inpatient Admissions (5%)<br>**Target 3b:** All-Cause ED (5%)<br>**Target 4:** Management of high risk patients and reporting on transitions of care, nurse care manager metrics as defined by the CSI-RI Data and Evaluation Committee. |

# Comparison CSI Attribution Methodologies
May 01, 2013

| | UHC | TUFTS | BCBS RI | NHP RI | MAPCP Demonstration | Common contract language |
|---|---|---|---|---|---|---|
| Look back period | 27 months | 27 months | 24 months | 27 months | 24 months | 24 Months |
| Patient Attribution Method | Last PCP seen in look back period. If multiple providers seen on the day of most recent visit, most visits during look back. If no visits in look back, use pharmacy claims | Last physician seen in look back period for E&M visit | 1. Self-selection (i.e., member who has self-selected a PCP). If no PCP has been self-selected, then;<br><br>2. PCP with the most recent well visit is attributed as the PCP, if there is no well visit, then;<br><br>3. PCP with the greatest number of sick visits is attributed as the PCP. In the event of two or more PCP's have the same number of sick visits, the PCP with the most recent sick visit will be attributed as the PCP. | PCP selected by member at enrollment | PCP with greatest number qualifying claims | PCP with most recent well visit or PCP w/ greatest # of sick visits. |
| Codes used for attribution | Evaluation/Management: 99201-99205, 99211-99215<br>Consults: 99241-99245<br>Preventative Med: 99381-99387, 99391-99397 | CPT® codes 99201-99215 and 99381-99397, 99381-99387, 99391-99397; If not well visit, then greatest # of sick visits: codes 99201-99205, 99211-99215 | well visit (CPT codes: 99381-99387, 99391-99397) Preventative Med: 99381-99387, 99391-99397<br>sick visits (CPT codes: 99201-99205, 99211- 99215) | | Evaluation/Management: 99201-99205, 99211-99215<br>Consults: 99241-99245<br>Nursing Facility: 99304-99306, 99307-99310<br>Domiciliary: 99324-99328, 99334-99337<br>Home services: 99341-99345, 99347-99350<br>Prolonged services: 99354, 99355<br>Preventative Med: 99381-99387, 99391-99397<br>Medicare covered wellness: G0402, G0438, G0439<br>Counseling risk factor: 99401-99404, 99406-99409, 99411-99412<br>Other Prevent. Med: 99420, 99429<br>FQHC – global visit: 0521, 0522 | Most recent well visit: CPT codes 99381-99387, 99391-99397<br>If not well visit, then greatest # of sick visits: codes 99201-99205, 99211-99215 |
| When PCP leaves a practice | Attribute patient up to 6 months or until primary care claim w/ other doc (mid- quarter grace period) | Attribute patient until E&M claim with other participating physician or patient would fall out at next attribution calculation if most recent visit is with physician who left a practice and that physician is no longer participating in the CSI | Attribute patient up to 6 months or until primary care claim w/ other doc | Patient stays with practice until a visit with another practice. | Uses look back period | Uses 24 month look-back period |

| | UHC | TUFTS | BCBS RI | NHP RI | MAPCP Demonstration | Common contract language |
|---|---|---|---|---|---|---|
| Account for children? | Not accounting for members <18 | All ages are included (must be seen by CSI participating physician) | No age restriction on members attributed to practices. Capture for family medicine, not for pediatrics. | Count those <18 in their attribution | | Were included if they were seen in CSI family/internal med practice site, not if seen by a pediatrician/ pediatric clinic/other site co-located at a CSI participating site |
| Rhody-Health partners | Included | N/A | N/A | Included | | |
| Other | Patients no longer enrolled in plan on date of attribution calculation are eliminated. PCP specialty must be family practice, internal medicine or pediatrics. | Patients must have been enrolled in plan as of the end of the attribution look back period. Include members who have seen an MD in the CSI participating physician list only. | Patients no longer enrolled in plan on date of attribution calculation are eliminated. PCP specialty must be internal medicine or family practice.<br><br>Members excluded from the Attribution Process are as follows: host members (i.e., members accessing the RI provider network from another Blue Cross Blue Shield plan and are not enrolled with BCBSRI), National Federal members, members residing in an out-of-state long term care facility and members receiving hospice care. Hospice care is defined as Medicare members who begin home-based or facility-based hospice coverage. | | Patients must:<br>- Reside in RI<br>- Have Medicare Pts A & B<br>- be covered under traditional Medicare Fee-for-Service program/not in a Medicare advantage or other Medicare health plan<br>- Medicare is primary payer | |
| Contact for attribution related issues | Randie Cadigan | Heather Keith-Lucas | Patricia Cotter | Charles Scaletta | Project management | |

# Safe Transitions Best Practice Measures

## for Community Physician Offices

*Setting-specific process measures focused on cross-setting communication and patient activation, supporting safe patient care across the continuum*

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

Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

This material was prepared by Healthcentric Advisors (10SOW-RI—C.8-102013-931), 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.

**MEASURE SET:**

## Safe transitions best practice measures for community physician offices

**MEASURES:**

The best practice measures for community physician offices are seven (7) process measures:

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. Confirmation of receipt of discharge information sent to hospital
5. High-risk patients contacted via phone after ED or hospital discharge
6. Follow-up visits conducted after patient discharge from the hospital
7. Medication reconciliation completed after ED or hospital discharge

**PURPOSE:**

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. Community physician offices can use these measures to evaluate performance and implement targeted improvement to: 1) improve partnerships with inpatient and outpatient providers, 2) improve patient experience and/or 3) reduce unplanned utilization.

Some of these processes are adapted from interventions proven to improve care transitions outcomes, such as hospital readmission, in the medical literature. Others are based on national campaigns and standards.

**POPULATION:**

Varies by measure, but generally includes patients currently in or recently discharged from the ED or the hospital

**CARE SETTING:**

Community physician offices

**RECIPROCAL MEASURES:**

In addition to the best practices for community physician offices, Healthcentric Advisors developed five (5) additional sets of setting-specific measures, for:

1. Emergency departments
2. Home health agencies
3. Hospitals
4. Nursing homes
5. Urgent care centers

**NOTES:**

Because these measures are intended to set minimum standards for all patients, no sampling guidelines are provided. Providers who cannot calculate the measures electronically may wish to implement a representative sampling frame to calculate performance on an ongoing basis.

Providers may also wish to implement small-scale pilots to measure baseline performance and implement targeted improvement strategies before expanding efforts facility wide.

For those seeking assistance, Healthcentric Advisors provides consultative services related to quality improvement, measurement and care transitions.



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**MEASURE SET HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**LAST UPDATED:**

21 October 2013

**MEASURE:**

## Clinical information sent with emergency department referrals

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #1)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices send clinical information to the emergency department (ED), when referring a patient for evaluation.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[1] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1]

Although information is sparse regarding communication from primary care providers to the ED, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers (PCPs) and hospital physicians occurs infrequently, in only 3%-20% of cases.[2] ED clinicians express a desire to have pertinent, up-to-date clinical information accompany arriving patients. This information transfer allows ED clinicians to more effectively focus their work-up and management strategies, without repeat testing or duplication of other services, and ensures that a PCP's specific concerns are adequately addressed.

**NUMERATOR:**

Documentation of provision of clinical information and contact information by the referring physician's office either:

- At the time of patient referral for ED evaluation, or
- Within one hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician.

**DENOMINATOR:**

All patients referred for ED evaluation by their community physician

**EXCLUSIONS:**

Patients whose care is supervised/directed by their community physician while in the ED

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| 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: | Primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. |
| Contact information: | Phone number that connects the ED to office staff who can address the ED clinician's clinical question. |
| 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 directs the patient to the ED. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

None

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.

**MEASURE:**

## Real-time verbal information provided to emergency department or hospital clinicians, if needed

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #2)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices respond to emergency department (ED) and hospital clinicians' verbal requests for time-sensitive clinical information at the time of the initial call or within one hour.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes, and the Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1] Although information is sparse regarding primary care providers' response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers (PCPs) and hospital physicians occurs infrequently, in only 3%-20% of cases.[2]

ED and hospital clinicians indicate that they may have difficulty reaching patients' PCPs, when they have a time-sensitive need for clinical information to inform patient care. Reasons may include lack of information about the patient's PCP and the inability to speak directly with a clinician in a timely manner.

**NUMERATOR:**

Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred:

- A conversation between the ED or hospital clinician and the community physician or an outpatient staff member who can address the question at the time of the initial call, or
- A return phone call from the community physician or an office staff member who can address the question within 1 hour of the ED or hospital clinician's phone call to the office

**DENOMINATOR:**

All patients whose care requires a phone call from the ED or hospital to the community physician's office for time-sensitive clinical conversations

**EXCLUSIONS:**

None

**RISK ADJUSTMENT:**

None

**DEFINITIONS**

| | |
|---|---|
| Community physician: | The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| ED or hospital clinician: | Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient. |
| Office staff member: | Clinical or clerical staff who can address the ED or hospital clinician's specific question. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| | |
|---|---|
| Time-sensitive clinical question: | Whether or not a patient's care "required" a conversation and in what timeframe is a subjective determination left to the ED or hospital 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. |

**NOTES:**

The verbal information provided by the community physician to the ED or hospital clinician in this Best Practice differs from the information described in BP #3. This verbal communication is intended to capture time-sensitive information that will immediately inform clinical decision-making; BP #3, in contrast, addresses clinical information that is still important to patient care but may be less time-sensitive (in certain scenarios), such as an updated medication list or recent office visit notes.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Making care safer by reducing harm caused in the delivery of care<br>Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.

**MEASURE:**

## Clinical information provided to emergency department or hospital clinicians, if needed

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #3)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices respond to emergency department (ED) and hospital clinicians' requests for outpatient clinical information within 2 hours of the request.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[1] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1]

Although information is sparse regarding primary care providers' (PCPs') response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between PCPs and hospital physicians occurs infrequently, in only 3%-20% of cases.[2] ED clinicians report occasional difficulty obtaining outpatient clinical information to inform patient care, particularly after regular business hours.

**NUMERATOR:**

Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request

**DENOMINATOR:**

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

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| 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: | The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a PCP, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| ED or hospital clinician: | Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient. |
| Provision: | Via email, phone, fax, remote access to office medical record or other electronic means. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

The clinical information provided by the community physician's office to the ED or hospital clinician in this Best Practice differs from the verbal information described in BP #2. This communication is intended to capture clinical information that is still important to patient care but may be less time-sensitive (in certain scenarios), such as an updated medication list or recent office visit notes; BP #2, in contrast, addresses time-sensitive information that will immediately inform clinical decision-making.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Making care safer by reducing harm caused in the delivery of care<br>Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.

**MEASURE:**

## Confirmation of receipt of discharge information sent to hospital

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #4)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices confirm receipt of the discharge information sent to them by the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[1] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care,[1] but a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers and hospital physicians occurs infrequently, in only 3%-20% of cases.[2]

The Society of Hospital Medicine recommends that community physician offices confirm their receipt of discharge information.[3] This ensures that the hand-off between settings is complete and provides the hospital confirmation that discharge information has been received by the correct physician and location.

**NUMERATOR:**

Documentation of the community physician office's confirmation of receipt of hospital discharge information

**DENOMINATOR:**

All patients discharged from the hospital

**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.

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Confirmed receipt: | Communication back to the hospital to acknowledge that the office has received the discharge information that the hospital sent. |
| Discharge summary: clinical information | In accordance with the Safe Transitions Best Practice Measures for Hospitals, the hospital is required to provide, at minimum: the presenting complaint and reason for hospitalization, major diagnoses, significant tests and procedure results, presence of pending tests, name of hospital physician, updated medication list with reason for any changes, discharge condition, discharge instructions and recommended follow-up.<br><br>This may be accomplished via written information, such as a standardized form, that includes: 1) a brief narrative of the hospital visit, or 2) a verbal hand-off between the hospital clinician and primary care provider. |

**NOTES:**

None



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.
[3] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.

**MEASURE:**

## High-risk patients contacted via phone after emergency department or hospital discharge

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #5)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices call high-risk patients within 72 hours of patients' discharge from the emergency department (ED) or hospital.

Patients are at risk for poor outcomes and increased healthcare utilization if they: are over the age of 80 years; have cancer, chronic obstructive pulmonary disease or congestive heart failure; have polypharmacy (8+ medications); or have experienced a hospitalization in the previous 6 months.[1] This risk could be exacerbated by poor health literacy, stress and other factors, making it important for the patient's outpatient clinician to ascertain the patient's condition and their adherence to recommended care and follow-up quickly after a healthcare episode.

The follow-up phone call may be particularly important if the patient's scheduled follow-up visit does not immediately follow ED or hospital discharge, to preemptively catch any potential problems and to ensure that the patient knows that their primary care provider is now responsible for their care, and how they can outreach with questions.

**NUMERATOR:**

Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital

**DENOMINATOR:**

All patients discharged from the ED or hospital 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

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Follow-up phone call: | An outpatient clinician phone call with the patient, family or informal caregiver (such as a family member) 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:<br>• Age 80 years or older,<br>• A diagnosis of cancer, chronic obstructive pulmonary disease or congestive heart failure,<br>• Polypharmacy (8+ medications),<br>• A hospitalization in the previous 6 months, or<br>• Any other risk factors identified by the community physician office |
| Outpatient clinician: | Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be an office location, facility or clinic. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

None

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care<br>Ensuring that each person and family are engaged as partners in their care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |
| or | |
| | who visit the ED and are discharged home |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.

**MEASURE:**

## Follow-up visits conducted after patient discharge from the hospital

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #6)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices conduct office visits with patients discharged from hospital.

The post-hospital follow-up visit provides an opportunity for the community physician office to fully assume responsibility for patient care—which is transferred from the hospital to the office at the time of hospital discharge—and to ascertain the patient's condition and their adherence to recommended care and follow-up. The visit is also an opportunity to activate and engage patients and their informal caregivers (such as family) in their care and to prevent any worsening signs or symptoms from resulting in an avoidable emergency department (ED) visit or hospital admission.[1]

**NUMERATOR:**

Documentation of one of the following:

- A follow-up phone call within 72 hours of patient discharge from the hospital, or
- A follow-up appointment scheduled within 14 days of discharge (or the timeframe otherwise specified and documented in the hospital discharge instructions)

**DENOMINATOR:**

All patients discharged from the hospital

**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.

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Community physician: | The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a PCP, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| Follow-up appointment scheduled: | A community physician office visit scheduled either by the ED or hospital or the community physician's office. |
| Hospital visit: | Outpatient observation or an inpatient admission. |
| Informal caregiver: | A person, such as a family member, who provides care and support to the patient. |
| Outpatient clinician: | Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be a PCP or specialist, and can be an office location, facility or clinic. |
| Outpatient follow-up: | A phone call or office visit with an outpatient clinician from the community physician's office, which can be an office location, facility or clinic. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| | |
|---|---|
| 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. |

**NOTES:**

Patients discharged from the ED are not targeted by this measure for a number of reasons, including the fact that many patients self-refer to the ED (sometimes resulting in inappropriate ED utilization, for conditions that could have been addressed in an outpatient setting) and the fact that ED discharge disposition is highly variable (follow-up may not always be necessary or appropriate). Community physicians should use their discretion regarding the necessity of follow-up office visits for patients discharged from the ED.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care<br>Ensuring that each person and family are engaged as partners in their care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.

**MEASURE:**

## Medication reconciliation completed after emergency department or hospital discharge

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #7)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices perform medication reconciliation after their patients are discharged from the emergency department (ED) or hospital.

Studies demonstrate that medication errors or discrepancies are relatively common at hospital discharge (occurring among 14% of elderly patients) and are associated with a higher risk of poor outcomes and hospital readmission.[1] Guidelines for post-hospital office visits stress the importance of medication reconciliation to identity and resolve any medication problems, helping to ensure patient safety and prevent excess utilization.[2]

**NUMERATOR:**

Documentation that an outpatient clinician performed medication reconciliation within 14 days of ED or hospital discharge, either in-person at the office or via phone

**DENOMINATOR:**

All patients discharged from the ED or hospital

**EXCLUSIONS:**

Patients who are discharged to acute care, long-term care or skilled nursing

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Community physician: | The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| Hospital visit: | Outpatient observation or inpatient admission |
| Informal caregiver: | A person, such as a family member, who provides care and support to the patient |
| Medication reconciliation: | The process of:<br>1) Reviewing the patient's discharge medication regimen (name, dose, route, frequency, and purpose),<br>2) Comparing the discharge medication regimen with what the patient is currently taking (including non-prescription medications), as well as with their prior medication regimen, to identify and resolve any discrepancies, and<br>3) Providing an updated list to the patient or informal caregiver (such as family). |
| Outpatient clinician: | Physician, nurse practitioner, physician assistant, nurse or certified nursing assistant at the community physician's office, which can be an office location, facility or clinic. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

In addition to performing medication reconciliation, the multi-disciplinary Transitions of Care Consensus Policy Statement also recommends that patients be provided with a medication list that is accessible (paper or electronic), clear and dated.[3] A checklist for post-hospital discharge office visits is also available and recommends that outpatient clinicians use a "teach back" mechanism to test patients' comprehension of their medications' purpose and instructions.[2]

Outpatient clinicians seeking to exceed the minimum standard set forth by this best practice may consider adopting medication reconciliation as an "always event" that is completed during every patient encounter, not only those immediately following ED or hospital utilization.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Making care safer by reducing harm caused in the delivery of care<br>Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission or who visit the ED and are discharged home |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med*. 2005; 165(16):1842–7.
[2] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.
[3] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med*. 2009; 24(8):971-6.

**SELECTED SOURCES:**

## Safe transitions best practice measures for community physician offices

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their community partners (e.g., hospitals) and stakeholders (e.g., state agencies and payors).

Selected sources from Steps #1 (the medical literature, national campaigns and standards) and #2 (community preferences) are below.

| Author, Year | Discharge Setting | Intervention or Observation | Findings | Related Best Practice Measure(s) for Community Physician Offices |
|---|---|---|---|---|
| Coleman et al., 2009[1] | Hospital | Provided a transitions coach to help improve patient education and self-management in the 30 days after hospital discharge | Using the Care Transitions Intervention (CTI) chronically ill hospitalized patients and their caregivers to take a more active role in their care reduced rates of hospital readmission. The coaching tenets include assessing patient comprehension and helping patients use a personal health record, understand their condition, perform medication reconciliation and undertake recommended follow-up. | 5-7 |
| Coleman, 2011[2] | n/a | Offers a proposed checklist for efficient communication and collaboration between inpatient and outpatient physicians after a hospital stay | Per the author, "the post-hospital follow-up visit presents an ideal opportunity for the primary care physician to prepare the patient and family caregiver for self-care activities and to head off situations that could lead to readmission." This issue brief provides a checklist for post-hospital follow-up with the primary care provider's office and incorporates tenets of Coleman's CTI model (above), such as medication reconciliation. | 2,6-7 |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| Author, Year | Discharge Setting | Intervention or Observation | Findings | Related Best Practice Measure(s) for Community Physician Offices |
|---|---|---|---|---|
| Community Preference (Rhode Island) | n/a | Incorporated community preference (and later, input and endorsement) into the development of the Safe Transitions Best Practice Measures for Hospitals | The multi-stage stakeholder consensus process allowed Healthcentric Advisors to ensure that all of the best practice measures addressed the local causes of poor transitions and were feasible within the local context. | 1-3 |
| Joint Commission, 2013[3] | Multiple | Developed "National Patient Safety Goals" | Along with other patient safety goals, the Joint Commission outlines expectations for medication reconciliation in the emergency department and hospital. | 7 |
| Institute for Healthcare Improvement[4] | Hospital | A guide designed to support office practice-based teams and their community partners (such as hospitals) in designing and implementing care processes to ensure that patients who discharged from the hospital transition smoothly back to the community | This guide is intended to be a resource for clinicians and staff in office practices as they create new ways to provide optimal care for their patients. The guide includes recommended changes; infrastructure and strategies necessary to achieve results; case studies; and measures, resources and references. | 2,7,8 |
| National Quality Forum, 2010[5] | Multiple | Includes 34 Safe Practices for Better Healthcare that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events, including poor care transitions | The Safe Practices include recommendations for medication reconciliation and for discharge systems. Discharge systems must have: a "discharge plan" prepared for each patient at the time of hospital discharge, including a scheduled follow-up appointment; standardized communication that occurs between the inpatient and outpatient clinicians; and the confirmed receipt of summary clinical information by receiving providers. | 1,4,7 |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| | | | | |
|---|---|---|---|---|
| National Transitions of Care Coalition, 2011[6] | Multiple | Bundle of seven essential interventions applicable for any setting | This bundle of essential care-transition intervention strategies, applicable for any provider and any care transition, includes descriptions and examples of medication management, transition planning, patient and family engagement/education, information transfer, follow up care, healthcare provider engagement, and shared accountability across providers and organizations. | 1-8 |
| Physician Consortium for Performance Improvement, 2009[7] | ED, hospital | Developed the "Care Transitions Performance Measurement Set (Phase I: Inpatient Discharges & Emergency Department Discharges)" | Multiple physician professional societies came together to identify and define quality measures for patients undergoing care transitions. For patients discharged from the hospital, suggested process measures included: 1) a transition record with specific minimum elements, 2) timely transmission of the transitions record, and 3) provision of medication reconciliation list to patients. | 5-7 |
| Society of Hospital Medicine,2008[8] | Hospital | A national initiative to improve the care of patients transitioning from the hospital to home | Project BOOST (Better Outcomes for Older adults through Safe Transitioning) is a Society of Hospital Medicine program that includes resources, tools and recommendations related to information flow between inpatient and outpatient providers and targeted patient intervention to improve satisfaction and reduce hospital readmission rates. | 4-6 |
| Snow et al., 2009[9] | Multiple | Developed consensus policy statement about care transitions | Co-authored by many physician professional societies, including the Society of Hospital Medicine; establishes principles and standards for managing transitions, including timely communication among providers and patient involvement. Suggests establishing local and national standards for continuous quality improvement and accountability. | 1-3,5-7 |

**KEY:**

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. Confirmation of receipt of discharge information sent to hospital



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

5. High-risk patients contacted via phone after ED or hospital discharge
6. Follow-up visits conducted after patient discharge from the hospital
7. Medication reconciliation completed after ED or hospital discharge

**REFERENCES:**

[1] Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med*. Sep 12 2005;165(16):1842-1847.

[2] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.

[3] Joint Commission. National patient safety goal on reconciling medication information (Jt. Comm). Available at: http://www.jointcommission.org/standards_information/npsgs.aspx. Accessed Jan 17, 2013.

[4] Insitute for Healthcare Improvement. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations. Available: http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx, 24 Oct 2013.

[5] National Quality Forum. Safe Practices. 2010. Available: http://www.qualityforum.org/Projects/Safe_Practices_2010.aspx, 11 Apr 2013.

[6] National Transitions of Care Coalition. Care Transition Bundle Seven Essential Intervention Categories. 2011. Available: http://www.ntocc.org/Toolbox/ Accessed Oct 29, 2013.

[7] ABIM Foundation, American College of Physicians, Society of Hospital Medicine, The Physician Consortium for Performance Improvement (PCPI). Care transitions performance measurement set (Phase I: Inpatient discharges & emergency department discharges). Available at: http://www.abimfoundation.org/News/ABIM-Foundation-News/2009/~/media/Files/PCPI%20Care%20Transition%20measures-public-comment-021209.ashx. Accessed Jan 17, 2013.

[8] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.

[9] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

# CTC-RI 2014 Committee Meeting Schedule

| | |
|---|---|
| **CTC Board of Directors**<br><br>Charge: Responsible for strategic direction and overall governance of the program.<br><br>Meeting Date: 4th Friday, 7:30-9AM<br>Location: BVCHC, 39 East Ave, Pawtucket, RI<br>President: Tom Bledsoe (Thomas_Bledsoe@brown.edu)<br>Chairs: Kathleen Hittner (Kathleen.Hittner@ohic.ri.gov), Deidre Gifford (Deidre.Gifford@ohhs.ri.gov)<br>*(Committee members only)* | **Steering Committee (open)**<br><br>Charge: Make recommendations regarding the strategic direction and overall governance of the program.<br><br>Meeting Date: 2nd Friday, 7:30-9AM<br>Location: RIQI, 50 Holden Street, Providence 3rd floor<br>Co-Chairs: Tom Bledsoe (Thomas_Bledsoe@brown.edu), Kathleen Hittner (Kathleen.Hittner@ohic.ri.gov), and Deidre Gifford (Deidre.Gifford@ohhs.ri.gov)<br>*(Recommend attendees: provider champions and organization leadership, all staff welcome)* |
| **Practice Reporting Committee (required)**<br><br>Charge: Review practice data quarterly, perform data validation, public reporting via CTC-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.<br><br>Meeting Date: 4th Tuesday, 8-9:30AM (7:30 – 8:30 New practices)<br>Location: 301 Metro Center Blvd, Warwick, RI #203; February/March only: RIQI, 50 Holden St, Providence 3rd floor (subject to change)<br>Co-Chairs: Kathryn Amalfitano (kwojcik@Lifespan.org) and Cynthia Souther (cynthias@thundermisthealth.org)<br>*(Recommend attendees: staff member pulling reports)* | **Practice Transformation Committee (open)**<br><br>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.<br><br>Meeting Date: 3rd Thursday, 7:30-9AM<br>Location: RIQI, 50 Holden Street, Providence 3rd floor<br>Co-Chairs: Andrea Galgay (agalgay@ripcpc.com) and Joanna Brown (Joanna_Brown@brown.edu)<br>*(Recommend attendees: provider champions and PCMH leaders)* |
| **Data and Evaluation Committee**<br><br>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.<br><br>Meeting Date: 1st Tuesday, 7:30-9AM<br>Location: Memorial Hospital, 111 Brewster Street, Pawtucket; Center for Primary Care Building 2nd floor<br>Co-Chairs: Peter Hollmann (Peter.Hollmann@bcbsri.com) and Chris Grey (CGrey@bvchc.com ); Jay Buechner (jbuechner@nhpri.org<br>*(Recommend attendees: IT/HIT/data analysts)* | **Contracting Committee**<br><br>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.<br><br>Meeting Date: 4th Tuesday, 7:30-9AM (subject to change)<br>Location: RIQI, 50 Holden Street, Providence 3rd Floor<br>Facilitators: Deb Hurwitz (Debra.Hurwitz@umassmed.edu) and Pano Yeracaris (pano.yeracaris@umassmed.edu)<br>*(Recommend attendees: health plans, provider champions and organization leadership)* |

Updated 3/3/2015

| | |
|---|---|
| **Nurse Care Manger Best Practice Sharing Collaborative (open)**<br><br>Meeting Date: 2nd Tuesday of every month 8-9:30AM<br>Location: RIQI, 50 Holden Street, Providence 3rd floor<br>Facilitator: Deb Hurwitz (Debra.Hurwitz@umassmed.edu) and Susanne Campbell (Susanne.Campbell@umassmed.edu)<br>*(Recommend attendees: nurse care manager)* | **Provider Best Practice Sharing Collaborative (open)**<br><br>Meeting Date: Ad-Hoc Meeting<br>Location: RIQI, 50 Holden Street, Providence<br>Facilitator: Pano Yeracaris (Pano.Yeracaris@umassmed.edu)<br>*(Recommend attendees: all providers)* |
| **Community Health Team Planning Committee**<br><br>Charge: Develop a plan for implementation and evaluation of a community health team in South County and Pawtucket.<br><br>Meeting Date: 2nd and 4th Friday, 9:30-11 AM<br>Location: (2nd Friday) RIQI, 50 Holden St, Providence (4th Friday) BVCHC, 39 East Ave, Pawtucket, RI<br>Chair: Paco Trilla (FTrilla@nhpri.org)<br>*(Recommend attendees: CHT leader at participating site)* | **Integrated Behavioral Health Planning Workgroup (open)**<br><br>Charge: Establish a workgroup to lead the transformation of primary care in RI in the context of an integrated health care system<br><br>Meeting Date: 3rd Thursday, 3:30-5 PM<br>Location: RIQI, 50 Holden St, Providence 3rd Floor<br>Chairs: Matt Roman (MatthewRo@thundermisthealth.org) and Roanne Osborne-Gaskin (rosborne@nhpri.org)<br>*(Recommend attendees: primary care and behavioral health providers, and nurse care managers)* |
| **Practice Facilitation**<br>**(Practice Facilitators only)**<br><br>Charge: For practice facilitators to meet and share and define best practices for practice facilitation in CTC.<br><br>Meeting Date: 2nd and 4th Tuesday of the month, 1:00 – 3:00 PM<br>Location: RIQI, 50 Holden Street, Providence 3rd floor | **Program Evaluation Committee**<br>**(Committee members only)**<br><br>Meeting Date: 4th Monday of the month, 9:00 – 10:30 AM<br>Location: RIQI, 50 Holden Street, Providence 3rd floor<br>Chairs: Jay Buechner; Bill McQuade; Brad Crough |

# CTC-RI Orientation 2014

# Tab 3: CTC-RI Process Measures

## 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 providing patients with access to care 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. Practices are expected to provide patients with some hours of operation beyond the normal work week (Monday through Friday 9:00 am to 5:00 pm. 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 "Safe Transitions: Best Practice Measures for Community Physician Offices" is provided together with a attestation form. .

c. Compacts with High Volume Specialists: Practice will establish compacts such that one (1) compact is established and approved by the Plan by March 31, 2015. Two (2) additional compacts are established by the Practice and approved by the Plan June 30, 2015 and a total of no less than five ) compacts with five (5) different specialties (one of whom is behavioral health) shall be established by June 30, 2016 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.

# 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.

**Associates in Primary Care Medicine, Inc**
**857 Post Road Warwick, RI 02888**
**Phone: 401-467-3115**
**Fax: 401-467-9120**
**www.apcmweb.com**

## Office Hours:

**Monday: 8:00-5:00**
**Tuesday: 8:00-5:00**
**Wednesday: 7:00-5:00**
**Thursday: 7:00-6:30**
**Friday: 8:00-4:00**
**Saturday: 9:00-2:00 (Two Saturdays a month)**

---

## Providers' Schedules:

**Martin Kerzer, D.O.**
Monday: 8:00-3:30*
Tuesday: 9:00-3:00**
Wednesday: 7:00-12:30
Thursday: 7:00-12:30
Friday: No appointments
***The 1st Monday of the month 9:30-3:30**
****The 3rd Tuesday of the month 10:00-6:00**

**Gregory Steinmetz, M.D.**
Monday: 8:30-3:30*
Tuesday: 8:30-3:30**
Wednesday: No appointments
Thursday: 10:00-6:30
Friday: 8:00-3:00
**The 1st Monday of the month 9:30-3:30**
**The 3rd Tuesday of the month 10:00-3:30**

---

**Julie Rousseau, FNPC**
Monday: 9:00-4:00*
Tuesday: 9:00-3:00
Wednesday: 9:00-3:00
Thursday: 11:00-6:00
Friday: 8:00-2:00
Saturday: 9:00-2:00**
***The First Monday of the month 9:30-4:00**
**The 3rd Monday of the month-OFF**
****The 2nd Saturday of the month**

---

**Desirae Heys, FNPC**
Monday: 8:00-5:00*
Tuesday: OFF
Wednesday: 8:00-3:00
Thursday: 10:00-6:30
Friday: 8:00-3:00

***The first Monday of the month 9:30-5:00**

**Sara Brown, FNPC**
Monday: OFF
Tuesday: 8:00-5:00
Wednesday: 8:00-5:00
Thursday: 1:00-6:30*
Friday: OFF
Saturday: 9:00-2:00**
***OFF the 2nd Thursday of the month**
****The 2nd Saturday of the month**

---

# ACCESS DURING OFFICE HOURS

## ROUTINE APPOINTMENTS

All patient appointments, including cancelled and reschedules are logged into the EMR and can be tracked.
Twenty-four hours' notice is required to cancel or reschedule an appointment *
Patients are scheduled with their primary care provider of their choice whenever possible

### Appointment Types and time allotment:

Follow up Routine-10 minutes
Follow up Comprehensive-20 minutes
New Patient-30-60 minutes
Sick visit-10-20 minutes
Physical Exams-20-40 minutes
Nurse Care Manager-30-60 minutes
Diabetes Follow up-10-20 minutes
Well-Child visits-30 minutes

## SAME DAY APPOINTMENTS

We offer same day sick appointments to established patients. We block off approximately 10 slots per day for same day appointments, the number of open slots vary depending on the number of providers working each day. Additional slots may open due to cancellations. It is the policy of our office to not turn away sick patients, if there aren't any open appointment slots left for the day, the medical assistant will seek guidance from the appropriate provider.

Appointments are confirmed with an automated system via athenaNet (EMR) 2 days prior to the appointment. If the reschedule option is selected, patients will be able to speak with an athenaNet (EMR) operator who can reschedule their appointment.

### Pre-Visit Planning

Pre-visit Planning is done two weeks prior to appointment date for diabetic patients and well child visits. **Diabetic pre-visit planning includes:** outstanding labs, eye exam, outstanding consults. **Well-Child pre-visit planning includes:** immunizations, labs, age appropriate guidelines/developmental tests. Pre-visit planning is documented in either the diabetic flow sheet in the EMR or in the messaging section of the EMR.

Associates in Primary Care Medicine, Inc participates in Currentcare. Currentcare is Rhode Island's Health Information Exchange (HIE). It is a secure, encrypted electronic network, protected by law that gives authorized medical professionals access to their patients' most up-to-date health information so their patients can get the best possible health care. The practice receives electronic alerts via a Direct account on patients who have had an emergency room visit, a hospital admission or discharge. Currentcare gives providers access to laboratory results, tests, consults, etc. It is a valuable, cost saving resource that allows our practice to contact and follow up with our patients who have had emergency room visits or hospital discharges in a timely manner and it also helps providers to

eliminate duplicate labs/tests. All patients are encouraged by the medical assistants and providers to enroll in Currentcare. Participation is free. If patients have questions they may call 888-858-4815 or visit the website at www.currentcareri.com. Enrollment is documented in the patient's EMR.

**On-site resources include:**

- Nurse Care Manager
- Nutritionist
- Lab
- Diabetes Group Visits
- Diabetes Education

**Specialists:**

- Cardiology
- Behavioral Health
- Urology
- Podiatry
- Gastroenterology
- Physical Therapy

Patients without health insurance are offered to join our **Health Access Program** (see Health Access).

## TELEPHONE CALLS FOR CLINICAL ADVICE

Messages are taken for all non-urgent calls and will be addressed by the end of the business day or sooner when providers have time between patients. Mark patient case (message) in the patient's EMR as Urgent if necessary, follow the telephone triage protocol.

### Associates in Primary Care Medicine, Inc
### Telephone Triage Protocol

A medical assistant answers all phone calls. When taking patient phone calls it is extremely important to decide how to handle the patient's concern appropriately. Emergencies need to be advised to call 911 and go to the hospital. Urgent matters need to be dealt with either immediately with a same day appointment or an urgent message to the appropriate provider. This protocol is intended as a guideline, so please use your judgment and speak with a provider with any questions or concerns with how to handle a situation. Routine problems and concerns are still important, but do not require immediate attention.

**Potential Emergencies:** anything threatening someone's life or limb

**Examples include:** chest pain, abdominal pain, sudden loss of vision, sudden loss of feeling/movement/speech (or other signs of stroke), dizziness, head or neck injury.

**Action:** Notify the provider immediately, verbally. Interrupt the provider from whatever he/she is doing. If a provider is not immediately available, advise the patient to call 911. Then notify the provider when he/she available both verbally and with a typed patient case (message) in the patient's EMR to the provider.

**Urgent Matters:** conditions that are not immediately life threatening, but are important to be treated quickly and properly to improve outcomes and to address the patient's concerns.

**Examples include:** sprains, minor trauma, acute psychological stress, headache, etc.

**Action:** offer the patient an appointment within the next 24 hours. If the patient cannot come in within the next 24 hours, notify the provider with a patient case (message) in the patient's EMR. If the appointment cannot be made, the patient is to be contacted by telephone by the end of the business day by the provider or staff member about the disposition of their condition (i.e. make an appointment, deal with issue over the phone, or send to urgent care or emergency room).

**Routine Matters:** conditions that can be followed up within the next few days, weeks, or months, depending on the circumstances.

**Action:** work with the patient to address their needs. If an appointment is made in a timely manner to fit the patient's concerns, no further action is necessary. If the patient's question or concern cannot be addressed a timely manner in this way, a message is sent to the provider for review by the end of the business day. If the patient is not completely satisfied with appointment of plan, notify the provider with a patient case (message) that day.

## SECURE ELECTRONIC MESSAGING DURING OFFICE HOURS

Patients are encouraged to sign up for our Patient Portal. The Patient Portal is an important component of our EHR (athenaNet). The web-based Patient Portal gives patients secure and convenient access to their health care information.

Patients can use the Patient Portal to view, download, and transmit their health information, and send a secure message to their provider.

In athenaNet, the practice can see when a patient viewed, downloaded, or transmitted their health information

**Patients can**:

- Update personal information

- Exchange secure messages with your office. With the Portal Secure Messaging feature, for practices that are participating in Meaningful Use Stage 2, patients can securely message your practice.
- Make appointments
- View upcoming appointments
- View their past medications, past allergies, and past problems
- Preview their health record and download their record for their own use
- Transmit their health data to Microsoft HealthVault (a personal health record site)
- Fill out forms
- Retrieve test results. The result must be in closed status in order for the result to appear on the document that the patient can view, download, or transmit. If the result remains in review status, it will not appear on the document that the patient can see on the Patient Portal.
- View account statements
- Pay balances
- Research health topics
- Get directions to your practice

Messages sent from the portal will be addressed within two business days, but in most cases by the end of the business day. The Patient Portal is not meant for Urgent Matters.

## DOCUMENTING CLINICAL ADVICE

Clinical Advice provided to patients/families by phone is documented in the patient case (message) in the patient's EHR. Non-clinical advice is documented in the messaging section in athenaNet (EMR)

Clinical Advice provided during an office visit is documented in the SOAP note in the patient's EMR.

Clinical Advice provided by the Nurse Case Manager is documented in either a patient case (message) or in the Nurse Case Manager Encounter section in athenaNet (EMR)

## AFTER HOURS ACCESS

There is always a provider on call. If you call the office after hours, your call will be picked up by an automated system, you will have the option to contact the provider who is on call, and you will be prompted to leave your name, phone number and message (phone numbers must be unblocked). Your message is sent via text message to alert the provider on call and your call will be returned within 30 minutes.

Patients that call after hours will also have the option to leave a general voicemail message for the office staff, messages will be returned on the next business day.

Messages sent through the patient portal will be answered within 2 business days.

See also "What to do when sick" brochure

## CONTINUITY OF MEDICAL RECORD INFORMATION FOR CARE AND ADVICE

Providers have access to athenaNet while on call and are able to provide care and advice after hours. Patient Care Summaries provided for each office visit.

# Safe Transitions Best Practice Measures

## for Community Physician Offices

*Setting-specific process measures focused on cross-setting communication and patient activation, supporting safe patient care across the continuum*

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

Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

This material was prepared by Healthcentric Advisors (10SOW-RI—C.8-102013-931), 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.

**MEASURE SET:**

## Safe transitions best practice measures for community physician offices

**MEASURES:**

The best practice measures for community physician offices are seven (7) process measures:

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. Confirmation of receipt of discharge information sent to hospital
5. High-risk patients contacted via phone after ED or hospital discharge
6. Follow-up visits conducted after patient discharge from the hospital
7. Medication reconciliation completed after ED or hospital discharge

**PURPOSE:**

The best practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between any two settings. Community physician offices can use these measures to evaluate performance and implement targeted improvement to: 1) improve partnerships with inpatient and outpatient providers, 2) improve patient experience and/or 3) reduce unplanned utilization.

Some of these processes are adapted from interventions proven to improve care transitions outcomes, such as hospital readmission, in the medical literature. Others are based on national campaigns and standards.

**POPULATION:**

Varies by measure, but generally includes patients currently in or recently discharged from the ED or the hospital

**CARE SETTING:**

Community physician offices

**RECIPROCAL MEASURES:**

In addition to the best practices for community physician offices, Healthcentric Advisors developed five (5) additional sets of setting-specific measures, for:

1. Emergency departments
2. Home health agencies
3. Hospitals
4. Nursing homes
5. Urgent care centers

**NOTES:**

Because these measures are intended to set minimum standards for all patients, no sampling guidelines are provided. Providers who cannot calculate the measures electronically may wish to implement a representative sampling frame to calculate performance on an ongoing basis.

Providers may also wish to implement small-scale pilots to measure baseline performance and implement targeted improvement strategies before expanding efforts facility wide.

For those seeking assistance, Healthcentric Advisors provides consultative services related to quality improvement, measurement and care transitions.



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**MEASURE SET HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**LAST UPDATED:**

21 October 2013

**MEASURE:**

## Clinical information sent with emergency department referrals

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #1)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices send clinical information to the emergency department (ED), when referring a patient for evaluation.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[1] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1]

Although information is sparse regarding communication from primary care providers to the ED, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers (PCPs) and hospital physicians occurs infrequently, in only 3%-20% of cases.[2] ED clinicians express a desire to have pertinent, up-to-date clinical information accompany arriving patients. This information transfer allows ED clinicians to more effectively focus their work-up and management strategies, without repeat testing or duplication of other services, and ensures that a PCP's specific concerns are adequately addressed.

**NUMERATOR:**

Documentation of provision of clinical information and contact information by the referring physician's office either:

- At the time of patient referral for ED evaluation, or
- Within one hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician.

**DENOMINATOR:**

All patients referred for ED evaluation by their community physician

**EXCLUSIONS:**

Patients whose care is supervised/directed by their community physician while in the ED

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| 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: | Primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. |
| Contact information: | Phone number that connects the ED to office staff who can address the ED clinician's clinical question. |
| 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 directs the patient to the ED. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

None

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.

**MEASURE:**

## Real-time verbal information provided to emergency department or hospital clinicians, if needed

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #2)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices respond to emergency department (ED) and hospital clinicians' verbal requests for time-sensitive clinical information at the time of the initial call or within one hour.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes, and the Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1] Although information is sparse regarding primary care providers' response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers (PCPs) and hospital physicians occurs infrequently, in only 3%-20% of cases.[2]

ED and hospital clinicians indicate that they may have difficulty reaching patients' PCPs, when they have a time-sensitive need for clinical information to inform patient care. Reasons may include lack of information about the patient's PCP and the inability to speak directly with a clinician in a timely manner.

**NUMERATOR:**

Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred:

- A conversation between the ED or hospital clinician and the community physician or an outpatient staff member who can address the question at the time of the initial call, or
- A return phone call from the community physician or an office staff member who can address the question within 1 hour of the ED or hospital clinician's phone call to the office

**DENOMINATOR:**

All patients whose care requires a phone call from the ED or hospital to the community physician's office for time-sensitive clinical conversations

**EXCLUSIONS:**

None

**RISK ADJUSTMENT:**

None

**DEFINITIONS**

| | |
|---|---|
| Community physician: | The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| ED or hospital clinician: | Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient. |
| Office staff member: | Clinical or clerical staff who can address the ED or hospital clinician's specific question. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| | |
|---|---|
| Time-sensitive clinical question: | Whether or not a patient's care "required" a conversation and in what timeframe is a subjective determination left to the ED or hospital 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. |

**NOTES:**

The verbal information provided by the community physician to the ED or hospital clinician in this Best Practice differs from the information described in BP #3. This verbal communication is intended to capture time-sensitive information that will immediately inform clinical decision-making; BP #3, in contrast, addresses clinical information that is still important to patient care but may be less time-sensitive (in certain scenarios), such as an updated medication list or recent office visit notes.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Making care safer by reducing harm caused in the delivery of care<br>Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.

**MEASURE:**

## Clinical information provided to emergency department or hospital clinicians, if needed

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #3)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices respond to emergency department (ED) and hospital clinicians' requests for outpatient clinical information within 2 hours of the request.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[1] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care.[1]

Although information is sparse regarding primary care providers' (PCPs') response to requests from the ED for information, a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between PCPs and hospital physicians occurs infrequently, in only 3%-20% of cases.[2] ED clinicians report occasional difficulty obtaining outpatient clinical information to inform patient care, particularly after regular business hours.

**NUMERATOR:**

Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request

**DENOMINATOR:**

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

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| 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: | The PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a PCP, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| ED or hospital clinician: | Physician, nurse practitioner, physician's assistant or nurse who is taking care of the patient. |
| Provision: | Via email, phone, fax, remote access to office medical record or other electronic means. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

The clinical information provided by the community physician's office to the ED or hospital clinician in this Best Practice differs from the verbal information described in BP #2. This communication is intended to capture clinical information that is still important to patient care but may be less time-sensitive (in certain scenarios), such as an updated medication list or recent office visit notes; BP #2, in contrast, addresses time-sensitive information that will immediately inform clinical decision-making.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Making care safer by reducing harm caused in the delivery of care<br>Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.

**MEASURE:**

## Confirmation of receipt of discharge information sent to hospital

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #4)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices confirm receipt of the discharge information sent to them by the hospital.

Timely and adequate information transfer is an important component of safe patient transitions between care settings and has been linked to improved patient experience and outcomes.[1] The Transitions of Care Consensus Conference recommends timely communication that includes both physicians (sending and receiving) involved in a patient's care,[1] but a summary of the literature by a Society of Hospital Medicine and Society of General Internal Medicine Task Force found that direct communication between primary care providers and hospital physicians occurs infrequently, in only 3%-20% of cases.[2]

The Society of Hospital Medicine recommends that community physician offices confirm their receipt of discharge information.[3] This ensures that the hand-off between settings is complete and provides the hospital confirmation that discharge information has been received by the correct physician and location.

**NUMERATOR:**

Documentation of the community physician office's confirmation of receipt of hospital discharge information

**DENOMINATOR:**

All patients discharged from the hospital

**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.

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Confirmed receipt: | Communication back to the hospital to acknowledge that the office has received the discharge information that the hospital sent. |
| Discharge summary: clinical information | In accordance with the Safe Transitions Best Practice Measures for Hospitals, the hospital is required to provide, at minimum: the presenting complaint and reason for hospitalization, major diagnoses, significant tests and procedure results, presence of pending tests, name of hospital physician, updated medication list with reason for any changes, discharge condition, discharge instructions and recommended follow-up.<br><br>This may be accomplished via written information, such as a standardized form, that includes: 1) a brief narrative of the hospital visit, or 2) a verbal hand-off between the hospital clinician and primary care provider. |

**NOTES:**

None



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009; 24(8):971-6.
[2] Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831–41.
[3] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.

**MEASURE:**

## High-risk patients contacted via phone after emergency department or hospital discharge

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #5)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices call high-risk patients within 72 hours of patients' discharge from the emergency department (ED) or hospital.

Patients are at risk for poor outcomes and increased healthcare utilization if they: are over the age of 80 years; have cancer, chronic obstructive pulmonary disease or congestive heart failure; have polypharmacy (8+ medications); or have experienced a hospitalization in the previous 6 months.[1] This risk could be exacerbated by poor health literacy, stress and other factors, making it important for the patient's outpatient clinician to ascertain the patient's condition and their adherence to recommended care and follow-up quickly after a healthcare episode.

The follow-up phone call may be particularly important if the patient's scheduled follow-up visit does not immediately follow ED or hospital discharge, to preemptively catch any potential problems and to ensure that the patient knows that their primary care provider is now responsible for their care, and how they can outreach with questions.

**NUMERATOR:**

Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital

**DENOMINATOR:**

All patients discharged from the ED or hospital 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

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Follow-up phone call: | An outpatient clinician phone call with the patient, family or informal caregiver (such as a family member) 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:<br>• Age 80 years or older,<br>• A diagnosis of cancer, chronic obstructive pulmonary disease or congestive heart failure,<br>• Polypharmacy (8+ medications),<br>• A hospitalization in the previous 6 months, or<br>• Any other risk factors identified by the community physician office |
| Outpatient clinician: | Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be an office location, facility or clinic. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

None

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care<br>Ensuring that each person and family are engaged as partners in their care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |
| or | |
| | who visit the ED and are discharged home |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.

**MEASURE:**

## Follow-up visits conducted after patient discharge from the hospital

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #6)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices conduct office visits with patients discharged from hospital.

The post-hospital follow-up visit provides an opportunity for the community physician office to fully assume responsibility for patient care—which is transferred from the hospital to the office at the time of hospital discharge—and to ascertain the patient's condition and their adherence to recommended care and follow-up. The visit is also an opportunity to activate and engage patients and their informal caregivers (such as family) in their care and to prevent any worsening signs or symptoms from resulting in an avoidable emergency department (ED) visit or hospital admission.[1]

**NUMERATOR:**

Documentation of one of the following:

- A follow-up phone call within 72 hours of patient discharge from the hospital, or
- A follow-up appointment scheduled within 14 days of discharge (or the timeframe otherwise specified and documented in the hospital discharge instructions)

**DENOMINATOR:**

All patients discharged from the hospital

**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.

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Community physician: | The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a PCP, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| Follow-up appointment scheduled: | A community physician office visit scheduled either by the ED or hospital or the community physician's office. |
| Hospital visit: | Outpatient observation or an inpatient admission. |
| Informal caregiver: | A person, such as a family member, who provides care and support to the patient. |
| Outpatient clinician: | Physician, nurse practitioner, physician assistant or nurse at the community physician's office, which can be a PCP or specialist, and can be an office location, facility or clinic. |
| Outpatient follow-up: | A phone call or office visit with an outpatient clinician from the community physician's office, which can be an office location, facility or clinic. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| | |
|---|---|
| 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. |

**NOTES:**

Patients discharged from the ED are not targeted by this measure for a number of reasons, including the fact that many patients self-refer to the ED (sometimes resulting in inappropriate ED utilization, for conditions that could have been addressed in an outpatient setting) and the fact that ED discharge disposition is highly variable (follow-up may not always be necessary or appropriate). Community physicians should use their discretion regarding the necessity of follow-up office visits for patients discharged from the ED.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Promoting effective communication and coordination of care<br>Ensuring that each person and family are engaged as partners in their care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.

**MEASURE:**

## Medication reconciliation completed after emergency department or hospital discharge

**MEASURE SET:**

Safe transitions best practice measures for community physician offices (Best Practice #7)

**MEASURE DESCRIPTION:**

This measure estimates the frequency with which community physician offices perform medication reconciliation after their patients are discharged from the emergency department (ED) or hospital.

Studies demonstrate that medication errors or discrepancies are relatively common at hospital discharge (occurring among 14% of elderly patients) and are associated with a higher risk of poor outcomes and hospital readmission.[1] Guidelines for post-hospital office visits stress the importance of medication reconciliation to identity and resolve any medication problems, helping to ensure patient safety and prevent excess utilization.[2]

**NUMERATOR:**

Documentation that an outpatient clinician performed medication reconciliation within 14 days of ED or hospital discharge, either in-person at the office or via phone

**DENOMINATOR:**

All patients discharged from the ED or hospital

**EXCLUSIONS:**

Patients who are discharged to acute care, long-term care or skilled nursing

**RISK ADJUSTMENT:**

None – see exclusions

**DEFINITIONS**

| | |
|---|---|
| Community physician: | The primary care provider (PCP) or specialist, such as cardiologist, who cares for the patient in an outpatient setting. This can include a primary care physician, specialist or mid-level practitioner, or be an office location, facility or clinic. |
| Hospital visit: | Outpatient observation or inpatient admission |
| Informal caregiver: | A person, such as a family member, who provides care and support to the patient |
| Medication reconciliation: | The process of:<br>1) Reviewing the patient's discharge medication regimen (name, dose, route, frequency, and purpose),<br>2) Comparing the discharge medication regimen with what the patient is currently taking (including non-prescription medications), as well as with their prior medication regimen, to identify and resolve any discrepancies, and<br>3) Providing an updated list to the patient or informal caregiver (such as family). |
| Outpatient clinician: | Physician, nurse practitioner, physician assistant, nurse or certified nursing assistant at the community physician's office, which can be an office location, facility or clinic. |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

**NOTES:**

In addition to performing medication reconciliation, the multi-disciplinary Transitions of Care Consensus Policy Statement also recommends that patients be provided with a medication list that is accessible (paper or electronic), clear and dated.[3] A checklist for post-hospital discharge office visits is also available and recommends that outpatient clinicians use a "teach back" mechanism to test patients' comprehension of their medications' purpose and instructions.[2]

Outpatient clinicians seeking to exceed the minimum standard set forth by this best practice may consider adopting medication reconciliation as an "always event" that is completed during every patient encounter, not only those immediately following ED or hospital utilization.

**CLASSIFICATION:**

| | |
|---|---|
| National Quality Strategy Priorities: | Making care safer by reducing harm caused in the delivery of care<br>Promoting effective communication and coordination of care |
| Actual or Planned Use: | Quality improvement with benchmarking; contracting; pay for performance |
| Care Setting: | Community physician office |
| Patient Condition: | Not applicable – all patients |
| Data Source: | Medical record or electronic audit trail |
| Level of Analysis: | Practitioner, unit, facility or community (e.g., health system or state) |
| Measure Type: | Process measure |
| Target Population: | All patients in the hospital for outpatient observation or an inpatient admission or who visit the ED and are discharged home |

**MEASURE HISTORY:**

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. The measures have since been updated.

This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their partners (e.g., EDs and hospitals) and stakeholders (e.g., state agencies and payors). This quality improvement process was deemed exempt by the Rhode Island Department of Health's Institutional Review Board. As a quality improvement project that incorporated local preference, these measures may not be generalizable to other states and regions, but can inform the development of local standards.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

**MEASURE DEVELOPED:**

2009

**MEASURE LAST UPDATED:**

21 October 2013

[1] Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med*. 2005; 165(16):1842–7.
[2] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.
[3] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med*. 2009; 24(8):971-6.

**SELECTED SOURCES:**

## Safe transitions best practice measures for community physician offices

These measures were developed by Healthcentric Advisors, the Medicare Quality Improvement Organization for Rhode Island, using a multi-stage stakeholder consensus process. This process involved: 1) reviewing the medical literature (where it exists) and national campaigns and standards, 2) collecting input about community preferences, 3) drafting measures, and 4) and obtaining input (measure content and feasibility) and endorsement from the targeted provider group (community physician offices) and their community partners (e.g., hospitals) and stakeholders (e.g., state agencies and payors).

Selected sources from Steps #1 (the medical literature, national campaigns and standards) and #2 (community preferences) are below.

| Author, Year | Discharge Setting | Intervention or Observation | Findings | Related Best Practice Measure(s) for Community Physician Offices |
|---|---|---|---|---|
| Coleman et al., 2009[1] | Hospital | Provided a transitions coach to help improve patient education and self-management in the 30 days after hospital discharge | Using the Care Transitions Intervention (CTI) chronically ill hospitalized patients and their caregivers to take a more active role in their care reduced rates of hospital readmission. The coaching tenets include assessing patient comprehension and helping patients use a personal health record, understand their condition, perform medication reconciliation and undertake recommended follow-up. | 5-7 |
| Coleman, 2011[2] | n/a | Offers a proposed checklist for efficient communication and collaboration between inpatient and outpatient physicians after a hospital stay | Per the author, "the post-hospital follow-up visit presents an ideal opportunity for the primary care physician to prepare the patient and family caregiver for self-care activities and to head off situations that could lead to readmission." This issue brief provides a checklist for post-hospital follow-up with the primary care provider's office and incorporates tenets of Coleman's CTI model (above), such as medication reconciliation. | 2,6-7 |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| Author, Year | Discharge Setting | Intervention or Observation | Findings | Related Best Practice Measure(s) for Community Physician Offices |
|---|---|---|---|---|
| Community Preference (Rhode Island) | n/a | Incorporated community preference (and later, input and endorsement) into the development of the Safe Transitions Best Practice Measures for Hospitals | The multi-stage stakeholder consensus process allowed Healthcentric Advisors to ensure that all of the best practice measures addressed the local causes of poor transitions and were feasible within the local context. | 1-3 |
| Joint Commission, 2013[3] | Multiple | Developed "National Patient Safety Goals" | Along with other patient safety goals, the Joint Commission outlines expectations for medication reconciliation in the emergency department and hospital. | 7 |
| Institute for Healthcare Improvement[4] | Hospital | A guide designed to support office practice-based teams and their community partners (such as hospitals) in designing and implementing care processes to ensure that patients who discharged from the hospital transition smoothly back to the community | This guide is intended to be a resource for clinicians and staff in office practices as they create new ways to provide optimal care for their patients. The guide includes recommended changes; infrastructure and strategies necessary to achieve results; case studies; and measures, resources and references. | 2,7,8 |
| National Quality Forum, 2010[5] | Multiple | Includes 34 Safe Practices for Better Healthcare that have been demonstrated to be effective in reducing the occurrence of adverse healthcare events, including poor care transitions | The Safe Practices include recommendations for medication reconciliation and for discharge systems. Discharge systems must have: a "discharge plan" prepared for each patient at the time of hospital discharge, including a scheduled follow-up appointment; standardized communication that occurs between the inpatient and outpatient clinicians; and the confirmed receipt of summary clinical information by receiving providers. | 1,4,7 |



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

| | | | | |
|---|---|---|---|---|
| National Transitions of Care Coalition, 2011[6] | Multiple | Bundle of seven essential interventions applicable for any setting | This bundle of essential care-transition intervention strategies, applicable for any provider and any care transition, includes descriptions and examples of medication management, transition planning, patient and family engagement/education, information transfer, follow up care, healthcare provider engagement, and shared accountability across providers and organizations. | 1-8 |
| Physician Consortium for Performance Improvement, 2009[7] | ED, hospital | Developed the "Care Transitions Performance Measurement Set (Phase I: Inpatient Discharges & Emergency Department Discharges)" | Multiple physician professional societies came together to identify and define quality measures for patients undergoing care transitions. For patients discharged from the hospital, suggested process measures included: 1) a transition record with specific minimum elements, 2) timely transmission of the transitions record, and 3) provision of medication reconciliation list to patients. | 5-7 |
| Society of Hospital Medicine,2008[8] | Hospital | A national initiative to improve the care of patients transitioning from the hospital to home | Project BOOST (Better Outcomes for Older adults through Safe Transitioning) is a Society of Hospital Medicine program that includes resources, tools and recommendations related to information flow between inpatient and outpatient providers and targeted patient intervention to improve satisfaction and reduce hospital readmission rates. | 4-6 |
| Snow et al., 2009[9] | Multiple | Developed consensus policy statement about care transitions | Co-authored by many physician professional societies, including the Society of Hospital Medicine; establishes principles and standards for managing transitions, including timely communication among providers and patient involvement. Suggests establishing local and national standards for continuous quality improvement and accountability. | 1-3,5-7 |

**KEY:**

1. Clinical information sent with emergency department (ED) referrals
2. Real-time verbal information provided to ED or hospital clinicians, if needed
3. Clinical information provided to ED or hospital clinicians, if needed
4. Confirmation of receipt of discharge information sent to hospital



235 Promenade Street / Suite 500 / Box 18 / Providence, Rhode Island 02908 ~ Voice: 401.528.3200 / Fax: 401.528.3210 / healthcentricadvisors.org

5. High-risk patients contacted via phone after ED or hospital discharge
6. Follow-up visits conducted after patient discharge from the hospital
7. Medication reconciliation completed after ED or hospital discharge

**REFERENCES:**

[1] Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med*. Sep 12 2005;165(16):1842-1847.

[2] Coleman EA. The post-hospital follow-up visit: A physician checklist to reduce readmissions. Available: http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist, 11 Apr 2013.

[3] Joint Commission. National patient safety goal on reconciling medication information (Jt. Comm). Available at: http://www.jointcommission.org/standards_information/npsgs.aspx. Accessed Jan 17, 2013.

[4] Insitute for Healthcare Improvement. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations. Available: http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx, 24 Oct 2013.

[5] National Quality Forum. Safe Practices. 2010. Available: http://www.qualityforum.org/Projects/Safe_Practices_2010.aspx, 11 Apr 2013.

[6] National Transitions of Care Coalition. Care Transition Bundle Seven Essential Intervention Categories. 2011. Available: http://www.ntocc.org/Toolbox/ Accessed Oct 29, 2013.

[7] ABIM Foundation, American College of Physicians, Society of Hospital Medicine, The Physician Consortium for Performance Improvement (PCPI). Care transitions performance measurement set (Phase I: Inpatient discharges & emergency department discharges). Available at: http://www.abimfoundation.org/News/ABIM-Foundation-News/2009/~/media/Files/PCPI%20Care%20Transition%20measures-public-comment-021209.ashx. Accessed Jan 17, 2013.

[8] Project Better Outcomes for Older adults through Safer Transitions (BOOST). Available: www.hospitalmedicine.org/BOOST/, 11 Apr 2013.

[9] Snow V, Beck D, Budnitz T, Miller DC, Potter J, Wears RL, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. *J Gen Intern Med.* 2009; 24(8):971-6.

**MEASURE INFORMATION:**

Lynne Chase
Senior Program Administrator, Healthcentric Advisors
lchase@healthcentricadvisors.org or 401.528.3253

**CONSULTING SERVICES:**

Kara Butler, MBA, MHA
Senior Manager, Corporate Services, Healthcentric Advisors
kbutler@healthcentricadvisors.org or 401.528.3221

IV: b. CSI RI Contract Requirement: Performance Metric Requirement for Hospital Outpatient Transition Best Practice

Attestation Form

Practice Site: _____ Parent Organization: _____
Address: _____

Requirement: Attestation to compliance with Healthcentric Advisors "Safe Transitions Best Practice Measures for Community Physician's Offices Policy" by the end of the Startup year, inclusive of a formal written vision related to care coordination

Purpose: The Best Practice measures are intended to improve provider-to-provider communication and patient activation during patient transitions between two settings.

Practice Vision for Care Coordination: (practice to articulate)

_____

_____

I attest, on behalf of my practice site, that the practice site has systems in place to support that follow actions steps and staff adhere to the following standards to support safe transitions. The practice monitors performance against these standards and takes action to improve performance based on such review.

1. Clinical information is sent with the emergency room referrals 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 week-end phone call with the community physician
   Exclusion: Patient whose care is supervised/directed by office provider

2. Real time verbal information is provided to the emergency department or hospital clinicians if needed. If an ED or hospital clinician calls the office, one of the following occurs: a) conversation between the ED or hospital clinician and the practice provider or an outpatient staff member who can address the question at the time of the initial call or b) a return phone call from the practice provider or an office staff member who can address the question within 1 hour of the ED or hospital clinician's phone call to the office.

3. Clinical information is provided to emergency department or hospital clinicians, if needed. The provider or outpatient staff member provides clinical information within 2 hours of ED or hospital request for information.

Exclusion: Patients without a known PCP or who are followed by provider while in the ED/hospital

4. The practice site confirms receipt of the discharge information sent to them by the hospital
   Exclusion: Patients who are followed by practice provider while in the ED or hospital or are discharged to acute care, long term care or skilled nursing

5. High risk patients receive a follow up phone call within 72 hours of patient discharge from the ED or hospital. Patients considered high risk include: a) patient age 80 and older b) having a diagnosis of cancer, chronic obstructive pulmonary disease or congestive heart failure c) polypharmacy (8+ medications d) a hospitalization in the previous 6 months d) any other risk factor defined by the practice/CSI
   Exclusion: Patients who are followed by practice provider while in the ED or hospital, are discharged to acute care, long term care or skilled nursing, refuse a follow-up call or have an outpatient follow-up appointment within 72 hours of ED or hospital discharge

6. Patients have a follow-up phone call within 72 hours of patient discharge from the hospital or a follow-up appointment scheduled within 14 days of discharge (or the timeframe otherwise specified and documented in the hospital discharge instructions).
   Exclusions: Patients, who are followed by practice provider while in the hospital, are discharged to acute care, long term care or skilled nursing or refuse a phone and appointment.

7. Practice provides medication reconciliation after the emergency department or hospital discharge within 14 days of ER or hospital discharge, either in-person at the office or via phone.
   Exclusion: Patients who are discharged to acute care, long-term care or skilled nursing

Person completing the form and attesting to Performance metric for outpatient Transition Best

Practice _____ Position: _____

Date of completion: _____ Date submitted to CSI _____
Practice comments, if applicable:
_____
_____

---

Date received by CSI RI _____ Reviewed by: _____

Comments: _____

# Draft Hospitalist Compact

## A) Purpose

- To provide optimal health care for our patients.
- To provide a framework for highly effective collaboration and timely communication between primary care and hospitalist providers and the patients.

## B) Principles

- High quality and timely patient care is our central goal.
- Effective real time communication between primary care and hospitalist is an essential component to providing optimal patient care.

## C) Definitions

- 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 patient specific health care across all stages of life.
- Medical Neighborhood – a system of care that integrates the PCMH with the medical specialists in the community through enhanced, bidirectional communication and collaboration on behalf of the patient.

| Expectations for Primary Care and Hospitalist | |
|---|---|
| **Primary Care** | **Hospitalist** |
| □ Inform patients of the relationship with hospitalist in the event of an admission to hospital<br><br>□ Provide hospitalist with any necessary medical information for the admission including medications and chronic disorders, etc<br><br>□ Confer with hospitalist to provide list of preferred specialists if indicated<br><br>□ Be available for phone consultation to assist hospitalist. | □ Contact PCP on all high risk/complex in-patient admissions on the day of admission through phone call, or secure email<br><br>=Review clinical information that is sent by the PCP<br><br>□ Contact PCP during the hospital admission for any serious complications or change in status and collaborate on recommended plan to support the patient/family<br><br>□ When obtaining in hospital specialty consultations utilize specialists commonly used by PCP, if known.;<br><br>New Referrals recommended post hospital discharge would be acted upon by the PCP<br><br>□ Contact PCP on day of discharge through phone |

| | |
|---|---|
| □ Be available to confer with patient or patient's family when necessary, particularly with serious change in condition<br><br>□ Contact patient via telephone within 2 business day from discharge,<br><br>□ Schedule follow-up appointment within one week of discharge; complex/high risk patient within 72 hours ; 14 days for other patients unless otherwise documented in medical record<br><br>□ Resume care of patient on discharge and acts on care plan developed by hospitalist or care team<br><br>;Complete timely medication reconciliation | call, email or text message and provide PCP with care plan for complex/high risk patients<br><br>Ensures care team to care team communication for all discharges that do not involve a direct physician to physician communication.<br><br>□ Informs patient of diagnosis, prognosis, and follow-up recommendations<br><br>□ Ensures that a complete discharge summary is sent to the PCP in a timely fashion (Recommended time frame: 72 hours) |

# Collaborative Care Management

***Mutual Agreement*** between Quality Behavioral Health Management Services and Generic

- Define responsibilities between Generic and Quality Behavioral Health (QBH)
- Define scope of practice and identify care team

| **Expectations for specialty Psychiatric and Behavioral Health services provided by Quality Behavioral Health Management Services** | |
|---|---|
| **Generic** | **Psychiatric (Behavioral Health) services provided by Quality Behavioral Health Management Services** |
| ☐ Provide adequate space for the evaluation and treatment of residents (patients) on site | ☐ Have timely appointment availability within a reasonable timeframe to meet patient care needs |
| ☐ Informs patient of need, purpose, expectations, and goals of the Psychiatric (Behavioral Health), visit with Quality Behavioral Health Management Services | ☐ The QBH care team will consist of a Board Certified Licensed Psychiatrist, a Nurse Practitioner (APRN) for medication management, a licensed Social Worker to provide psychotherapy, and a Neuro-Psychologist to provide neuro-psychological testing where appropriate. |
| ☐ Communicates reason for referral and sends relevant information to Quality Behavioral Health Management Services such as laboratory results, scans, etc. [or informs of documents in EHR] | ☐ Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX and refills while the patient is under direct care of Quality Behavioral Health Management Services specialty Psychiatric and Behavioral Health care. |
| ☐ Schedules appointments with Quality Behavioral Health Management Services for patient or provides patients with the contact information and expected timeframe for the appointment with Quality Behavioral Health Management Services | ☐ Informs patient of diagnosis, prognosis, and follow-up recommendations |
| ☐ Ensures QBH provider is informed of any changes in a patient's condition if changes are relevant to behavioral health care. | ☐ Provides appropriate educational materials and resources for patient/family |
| ☐ Follows up with patients who did not follow through with appointments to assist in problem solving | ☐ Sends timely reports to PCP to include a care plan, follow up, recommendations, and results of psychiatric evaluations or therapeutic interventions |
| ☐ Resumes care of Patient when patient returns from behavioral health care and acts on care plan developed by QBH providers | ☐ Confers with PCP or establishes other protocol before referring to secondary or tertiary specialist, obtains prior authorizations, if required. |
| ☐ Utilizes urgent availability (2-7 business days) and "curbside consultation" access provided by QBH in an appropriate Manner that recognizes such access as a highly valued resource | ☐ Agrees to work with Generic to ensure shared population receives all appropriate medical evaluations, medication management and evidenced based psychotherapy. |

| | |
|---|---|
| ☐ Agrees to work with QBH to ensure shared population receives all appropriate medical evaluation before or after consultation with QBH<br><br>☐ Agrees to engage in collaborative discussion with QBH leadership regarding future opportunities to employ outcome measures and actionable utilization data to improve health and healthcare and reduce healthcare costs for the shared population of patients | ☐ Recommends appropriate follow-up with PCP<br><br>☐ QBH Psychiatrist will provide consultation services with Generic nursing staff upon request and upon agreed on remuneration<br><br>☐ Agrees to engage in collaborative discussion with Generic leadership regarding future opportunities to employ outcome measures and actionable utilization data to improve health and healthcare and reduce healthcare costs for the shared population of patients |

_____ _____

Robert P. Arruda, Director Date

**Quality Behavioral Health Management Services**

_____ _____

Date

**Generic**

# 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.<br>☐ Transfers information as outlined in Patient Transition Record.<br>☐ Orders appropriate studies that would facilitate the specialty visit.<br>☐ Informs patient of need, purpose (specific question), expectations and goals of the specialty visit<br>☐ Provides patient with specialist contact information and expected timeframe for appointment. | ☐ Determines and/or confirms insurance eligibility<br>☐ Provides single source referral contact person<br>☐ 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: _____

_____

_____

_____

# 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.<br>☐ Determines reasonable time frame for specialist appointment.<br>☐ Provide a secure email option for communication with patient and specialist. | ☐ Notifies PCP of 'no-shows'<br>☐ Provides visit availability according to patient needs.<br>☐ Be available to the patient for questions to discuss the consultation.<br>☐ Schedule first patient appointment with physician.<br>☐ Be available to PCP for pre-consultation exchange by phone and/or secure email.<br>☐ Provide a secure email option for communication with patient and provider.<br>☐ Provides PCP with list of practice physicians who agree to compact principles. |



Additional agreements/edits: _____

_____

_____

_____

_____

_____

# 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.<br>☐ Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills.<br>☐ Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines.<br>☐ Reviews and acts on care plan developed by specialist.<br>☐ Resumes care of patient when patient returns from specialist care.<br>☐ 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<br>☐ Addresses referring provider and patient concerns.<br>☐ Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization.<br>☐ Confers with PCP or establishes other protocol before refers to secondary or tertiary specialists. Obtains proper prior authorization.<br>☐ Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions.<br>☐ Notifies the PCP of major interventions, emergency care or hospitalizations.<br>☐ Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs.<br>☐ 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.<br>☐ Determines appropriate time frame for visit to specialist.<br>☐ Provides specialist name and contact information.<br>☐ Explains specialist results and treatment plan to patient, as necessary.<br>☐ 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.<br>☐ Provides educational material and resources to patient.<br>☐ Recommends appropriate follow-up with PCP.<br>☐ Will be accountable to address patient phone calls/concerns regarding their management.<br>☐ Participates with patient care team. |

Additional agreements/edits: _____

_____

_____

_____

_____

# 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


- Chen, AH, Improving the Primary Care-Specialty Care Interface. Arch Intern Med. 2009;169:1024-1025
- Forrest, CB, A Typology of Specialists' Clinical Roles. Arch Intern Med. 2009;169:1062-1006
- 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)

# CTC-RI Orientation 2014

# Tab 4: Nurse Care Manager

**Attachment B: Nurse Care Manager Roles and Responsibilities**
**Nurse Care Manager Job Description**

**Position Summary:** A registered nurse, working in conjunction with a care team, to identify and proactively manage the care needs of high-risk patients and other patients identified by the practice as needing targeted support within the primary care practice setting. The Nurse Care Manager is responsible for providing comprehensive screenings, assessment, care coordination services with particular attention to transitions of care, disease education and self-management support. The Nurse Care Manager will be integrated into the patient centered medical home (PCMH), and will work in partnership with the health care team to promote the triple aim of reduced costs, improved health outcomes and increased patient satisfaction. The Nurse Care Manager will have frequent contact with primary care providers and other medical home team members and will actively participate in interdisciplinary patient-centered team meetings. The Nurse Care Manager will work with patients' families and other caregivers as warranted by patient needs. Work will be documented and integrated into the office's electronic medical record (EMR) system.

**Essential Job Duties and Responsibilities:**

- Provides care management services under the direction of the practice manager or provider.
- Works with the care team to identify and reach out to patients with a high risk of adverse health outcomes as defined by CSI or identified by payers and care providers.
- Completes initial patient assessment, including a comprehensive medical, psychosocial and functional evaluation of the patient, in the office or home setting as needed; reviews assessment with provider and clinical team members.
- Uses behavior change techniques such as motivational interviewing to establish therapeutic relationships with patients enabling effective intervention and support.
- Supports the patient in identification of actionable goals to optimize health outcomes;
- Develops a plan of care with the patient that promotes improved health care outcomes and quality of life informed by patient's goals, strengths and barriers;
- Implements the patient approved plan of care in collaboration with the patient through the practice's care team, community resources and home based visits and telephonic support;
- Provides other aspects of comprehensive care management including self-management support and health promotion,
- Advocates for patients to ensure access and timely service delivery across the continuum of care and community resources, including behavioral health, community based organizations and social supports to address barriers to optimum patient health;
- Supports the team with reviewing and addressing clinical quality measures, emergency room

and hospital utilization, access to care, communication with patients and patient satisfaction

- Provides or provides access to culturally and linguistically appropriate services as needed.
- Supports the team in providing access to age-appropriate patient services as needed**.**
- Works with providers to facilitate effective transitions to/from specialists, hospitals and other care providers through the timely communication of necessary information for patient care and discharge planning.
- Conducts medication reconciliation as appropriate and communicates any need for adjustment to care team and providers. Provides support to patients to enhance medication adherence. Documents any changes in patient's EMR.
- Works with careg**i**vers as appropriate to clarify the patient's needs, assess caregiver burden and provide support to family and caregivers.
- Meets practice policies and procedures related to documentation utilizing software tools that track care management activities and their effectiveness.
- Generates reports on service volume and distribution of patients by plans and types of services provided.
- Handles confidential information in accordance with HIPAA as well as state and federal privacy and confidentiality rules.
- Works with interdisciplinary team to plan and monitor quality improvement initiatives
- Communicates with care management staff from health care plans as appropriate

**General Requirements:**

- Participates as a member of the care team.
- Performs work consistent with evidence based treatment guidelines, office policies and procedures and NCQA PCMH Recognition Standards.
- Shares best practices among all team members, serves as a medical home advocate, mentors and leads by example to support a positive work environment and encourages other staff to do the same.
- Participates in meetings and huddles as appropriate.
- Participates in regular CSI NCM meetings for peer support and education
- Conducts pre-visit planning and post-visit follow-up for the care managed patients.
- Provides feedback to providers regarding patient progress and barriers encountered.

- Prepares for and participates in case review meetings to share discoveries, concerns and collaborate in the development of plans of care.

**Position Qualifications:**

- RN from an accredited program: licensed in State of RI.
- Excellent communication skills and ability to form collaborative partnerships across all service settings.
- Knowledge of community resources
- Experience of 3-5 years in community health setting, public health, chronic disease management, community nursing, or case management preferred.
- Certified as diabetic educator or in another chronic care area, preferably within 12 months of employment.
- Additional care management training and certification is strongly encouraged.

Draft: Nurse Care Manager Specifications: The CSI practices that are part of the pilot cohort and two voluntary CSI practice sites (WellOne and Anchor) are asked to assist with piloting the nurse care manager measurement system targeting the identified high risk conditions. Outlined below are the draft specifications for those high risk conditions. Note: Discussion on interventions to be reported is underway between the practices and the health plans and has not been finalized. The NCM measurement group is still in the process of determining how to best utilize the health plan information on high risk patients and how to conduct a clinical review of the health plan claims data high risk patient information.

**High Cost/Utilization**

| | |
|---|---|
| **Definition** | Definition of high cost/utilization :<br>1) had 3 or more emergency room visits in the last six (6) months;<br>2) had 3 or more hospitalizations in the last (6) months<br><br>1. The number of patients age 18 and older who met the definition of high cost high utilization and the number of nurse care manager encounters by visit types (face to face OV, face to face HV, telephone encounter; if practice as portal, NCM portal visit) .<br><br>2. The percentage of patients age 18 and older who met the definition of high cost high utilization and had no NCM activity |
| **Data Source** | 1) Information obtained through Current Care<br>2) Information received at the practice site from hospital<br>3) Reports from the health plans that indicate that the patient has had an emergency room and/or inpatient event<br>Aim: Practices to create and utilize high risk registry with real time practice site reports that capture the ER and/or inpatient event |
| **Attributed Active Patient** | Patient who has been attributed to a primary care provider at a CSI practice site; Definition of primary care clinician includes the following: : MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP)<br><br>Exclusions:<br>Patients who have left the practice by the end of the measurement as determined by:<br><br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice |

| | |
|---|---|
| | • Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• Patient has been discharged |
| **Measurement Period** | 6 months |
| **Practice measurement reporting on NCM activity** (number of encounters by type: telephone, office and home visits) **for patients who met the definition of high cost/high utilizer. This is reported as numbers, not as percentages** | Practices will report on number of patients who meet the definition of high cost/high utilization for : 1)all cause ER visits 2) all cause hospital admissions<br>For both ER and IP measures, practices will report on the number of Nurse care manager encounters by activity types (telephonic, home visit, office visit)<br>For both ER and IP measures, practices will report (with numerator and denominator) on the number of patients without any NCM encounter in 6 months and two weeks<br><br><u>Reporting on number of patients who met the definition of high cost/high utilizer for ER and the number of NCM encounters</u><br>1. a) Total number of patients who had 3 or more ER visits (dates recorded based on date of ER visit) in a 6 month time period and the number of telephonic NCM encounters in 6 months 2 weeks<br>b)Total number of patients who had 3 or more ER visits (dates recorded based on date of ER visit) in a 6 month time period and the number of offices NCM encounter in 6 months 2 weeks<br>c) Total number of patients who had 3 or more ER visits (dates recorded based on date of ER visit) in a 6 month time period and the number of home visit NCM encounters in 6 months 2 weeks<br><br><u>.</u><br><u>Reporting on the number of patients who met the definition of high cost/high utilizer for IP and the number of NCM encounters</u><br>2. a) Total number of patients who had 3 or more inpatient admissions(dates recorded based on date of IP discharge) in a 6 month time and the number of telephonic nurse care manager encounters in 6 months and 2 weeks<br>b) Total number of patients who had 3 or more inpatient admissions (dates recorded based on date of IP |

| | |
|---|---|
| | discharge) in a 6 month time period and the number of office NCM encounters in 6 months 2 weeks<br>c) Total number of patients who had 3 or more inpatient admissions (dates recorded based on date of IP discharge) in a 6 month time period and the number of home NCM encounters in 6 months 2 weeks |
| **Numerator** | <u>Reporting on percentage of patients who met the definition of high cost/high utilizer for ER and had no NCM activity (reported with both a numerator and denominator)</u><br>1. a Patients who had 3 or more ER visits (dates recorded based on date of ER visit) in a 6 month time period who had no NCM encounters in 6 months 2 weeks<br><u>Reporting on the number of patients who met the definition of high cost/high utilizer for IP and had no NCM activity (reported with both a numerator and denominator)</u><br>2. a Patients who had 3 or more inpatient admissions (dates recorded based on date of IP discharge) in a 6 month time period and had no NCM encounters |
| **Denominator** | 1) Number of patients who have had 3 or more ER visits in the last 6months<br>_____<br>2) Number of patients who have had 3 or more hospitalizations in the last 6months |
| **Methods used to identify patients** | <u>Process for identification</u>: ER, and Inpatient: practice site receives notification of patient being seen in the ER or having been hospitalized through the following mechanisms: a) Current Care Direct Alert, b) fax from hospital; 3) direct access into hospital portal 4) insurance report;<br><br><u>Process for identifying ER/hospital inpatient and hospital observation activity in the electronic health record</u> <u>:</u> Practice site develops a work flow for identifying patients in the electronic health record who have had an ER or inpatient event (i.e. dummy code/structured field in history of present illness ) |
| **Method used to identify NCM encounters** | Practice site is responsible for creating templates for various types of nurse care manager encounter types. Fields for intervention for the NCM template are under discussion. |

**Poorly Controlled or Complex Patients**

| | |
|---|---|
| **Definition** | Definition of poorly controlled/complex patient:<br>Patients with 3 or more of the following chronic conditions:<br>1) a diagnosis of diabetes (type 1 or 2) age 18-75 seen in the last measurement year or year prior and whose most recent HbA1c measurement is greater than 9 ;<br>2) a diagnosis of asthma (18+)<br>3) a diagnosis of COPD (18+)<br>4) a diagnosis of hypertension age 18-85 seen for at least 2 office visits in the measurement year with a recorded measurement reading greater than 140/90* for ages 18-59; greater than 150/90 for ages 60+<br>5) diagnosis of CHF (age 18+)<br>6)a diagnosis of depression (category includes major depression as well as depression) age 18+<br>7) a diagnosis of schizophrenia or bi-polar disorder<br>*If multiple BP measurements are taken on the same day, lowest systolic and lowest diastolic reading can be used<br><br>1. The number of patients (age identified for each diagnosis) who met the definition of poorly controlled/complex patient and number of nurse care manager encounters by visit types (face to face OV, face to face HV, telephone encounter; if practice as portal, NCM portal visit).<br>2. The percentage of patients (age identified for each diagnosis) who met the definition of poorly controlled/complex patients and had no NCM encounter |
| **Active Patient** | Patients seen by a primary care clinician of the PCMH anytime within the 12 month time period; Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP).<br><br>Exclusions:<br>Patients who have left the practice in the by the end of the measurement, , as determined by:<br><br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person |

| | |
|---|---|
| | • Patient has been discharged |
| **Measurement Period** | 12 months |
| **Practice measurement reporting on NCM activity** (number of encounters by type: telephone, office and home visits) **for patients who met the definition of Poorly Controlled and/or Complex. This is reported as numbers, not percentages** | Practices will report on total number of patients who met the definition of complex/poorly controlled and the number of Nurse care manager encounters by activity types (telephonic, home visit, office visit)<br>a) Total number of patients who met the definition of poorly controlled /complex and the number telephonic Nurse care manager encounters in 3 months and 2 weeks<br>b) Total number of patients who met the definition of poorly controlled/complex and the number of office Nurse care manager encounters in 3 months and 2 weeks<br>c) Total number of patients who meet the definition of poorly controlled/complex and the number of home visit Nurse care manager encounters in 3 months and 2 weeks |
| **Numerator** | Practices will report (with numerator and denominator) on the percentage of patients without any NCM encounter in 6 months and two weeks<br>Total number of patients who met the definition of poorly controlled/complex that had no NCM encounters in 3 months and 2 weeks |
| **Denominator** | Patients (age defined per diagnosis) that were seen by the primary care clinician of the PCMH anytime within the 12 month time period and had an assessment for the ICD-9 condition in the 12 month time frame that have 3 or more of the following conditions:<br><br>ICD 9 codes for diabetes : 250.xx; 357.2x; 362.0x;366.41;648.0x<br><br>Exclusions: ICD-9 codes for:<br>Steroid induced diabetes: (249.xx 251.8x, 962.0x<br>Gestational diabetes: 648.8x, PCOS 256.4x<br>Patients with a HbA1c less than 9<br>Patient age less than 18; greater than 75 |

| | |
|---|---|
| | ICD 10 codes for asthma: J45.50; ICD-9 for asthma ; 493.0; 493.22; 493.8-493.82; 493.9-493.92 (age 18+)<br><br>ICD 9 codes for COPD: 492; 494, 496 (age 18+)<br><br>ICD 9 codes for CHF: 428.0;428.1;428.20;428.21;428.22;428.23;428.30'428.31;428.32;428.33;428.40;428.41; 428.43;428.9 (age 18+)<br><br>ICD 9 codes for hypertension:<br>401.xx,<br>Exclusion:<br>Patients with a BP reading less than 140/90 (age 18-59) or less than 150/90 for ages 60+ who have been seen less than 2 times in the last 12 months<br>Patients less than 18 years of age ; age greater than 85<br>Patients who are pregnant (ICD-9 codes-630xx-679.xx,V22xx, V23xx,V28xx)<br>Patients who are diagnosed with ESRD (ICD-9 code 585.6)<br><br>ICD-9 for Depression (includes major depression)<br><br>311.xx296.3x; 296.2x; 300.4x; 311 (age 18+) |

| | |
|---|---|
| | _____<br><br>Patients who have a diagnosis of schizophrenia or bi-polar disorder<br><br><u>ICD-9 codes for schizophrenia:</u><br><br>295.xx<br><br><u>ICD-9 codes for bi-polar disorder</u><br><br>296.0x,296.40;296.4x;296.5x;296.6x;296.7x;296.80;296.89;301.13 |
| **Methods used to identify patients** | Report from electronic health record for patients with 3 or more of the identified ICD-9 codes for chronic conditions and/or poorly controlled chronic conditions |
| **Method used to identify NCM encounters; fields for intervention TBD** | Practice site is responsible for creating templates for various types of nurse care manager encounter types (telephonic, face to face in office, face to face in home, face to face group visit, patient portal) |
| **Other reporting on NCM activity for none high risk patients** | a) Total number of NCM telephonic visits and number of none-high risk patients<br><br>b) Total number of NCM office visits and the number of none-high risk patients<br><br>c) Total number of NCM home visits and the number of none-high risk patients |

**Patients who have been identified by outside organization and identified by practice as being high impact**

| | |
|---|---|
| **Definition** | The percentage of patients age 18 who are identified by health insurance companies based on risk status and selected by the provider as being high impact who have NCM encounters (face to face OV, face to face HV, telephone encounter; if practice as portal, NCM portal visit) .<br><br>**United definition:**<br>• Commercial: ERG score greater than 2 can be used as a guide for patients who have high cost; recommend that NCM's review list with provider to identify patients who are high risk, high cost and/or high impact . Practice uses the top 5% of patients based on ERG score<br>• Managed Medicaid: Predictive modeling using Impact Pro. Top 5% cost members including diagnostic and cost driver categories. Stratified by opportunity, including ER > 4, inpatient >2, BH, no OP care.<br>**Blue Cross definition**:<br>• Commercial and Medicare Advantage<br>Population stratification is done using John Hopkins Adjusted Clinical Groups (ACG) to predict health care resources. Populations are categorized into Resource Utilization Bands (RUB) based on risk, cost and utilization. NCM focus on the RUB category 4 (high) and 5 (very high). NCM work with provider to identify patients on the list who are also high impact for NCM focus<br>**Tufts definition**;<br>• Commercial:<br>Members are identified through predictive modeling and direct referral that are high cost high risk due to medical complexity and/or utilization and cost patterns. It is anticipated that NCM would address 3-5% of membership who are anticipated to meet the criteria for high risk/high cost and selected by the provider as being high impact<br>**NHPRI definition**:<br>• Managed Medicaid<br>high risk and high cost is determined using the MARA (a Millman predictive tool); factors considered: 1) age 2) gender 3) COT codes 4)claims (primarily hospital costs, ER visits, total cost); then remove patients with lower opportunity for short term cost reduction 1) high pharmacy costs 2) dialysis 3) metastatic cancer<br>**MAPCP definition**:<br>• Medicare fee for service<br>HCC score (Hierarchical Condition Category Score) which is based on ACG Clinical output by patients using a |

| | |
|---|---|
| | 12 month claims history. HCG tier information is based on risk, cost, resource use estimates, predictive value, chronic condition counts, type of providers seen, frailty flag, etc. NCM would use list patients categorized as "very high" and selected by the provider as being high impact |
| **Active Patient** | Patients age 18 years and older who are on a provider panel. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP).<br><br>Exclusions:<br>Patients who have left the practice in the 3 month time period, as determined by:<br><br>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice<br>• Patient has passed away<br>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person<br>• Patient has been discharged |
| **Measurement Period** | 3 months |
| **Numerator** | a) Number of identified high risk/high impact patients that have a Nurse Care manager encounters (face to face OV, face to face HV, telephone encounter; if practice as portal, NCM portal visit). |
| **Denominator** | a) Number of patients on health insurance report that are identified as high risk in the last 3 months and for whom the provider has indicated is high impact<br>Note: Have not yet determined if there will be a common definition used for "high impact" |
| **Methods used to identify patients** | Report from health insurance company or Medicare (if part of Medicare demonstration project)<br>NCM meets with provider to review the list and select patients who are identified by the provider as being high impact. Clinical review questions: 1) would you be surprised if the patient died in the next year? 2) Does the patient have an addictive disorder, add/or significant behavioral health condition? 3) Is the patient on 5 or more medications? 4) Do you have concerns about the person's ability to follow recommended treatment plan? |
| **Method used to identify NCM encounters; fields for intervention TBD** | Practice site is responsible for creating templates for various types of nurse care manager encounter types (telephonic, face to face in office, face to face in home, face to face group visit, patient portal) |

Team-Based Roles and Responsibilities to Support Patients who are at High Risk

Directions: Taking care of high risk patients takes a team approach. Practices are encouraged to work as a team and use this outline to identify team member roles and responsibilities in addressing work flows needed to take care of patients who are high risk.

| | Provider | MA | Other practice staff /pharmacy /nutrition | NCM | Front Desk | Nurse | Behavioral Health | Reporting Staff | Organizational Leaders | Health Plan Staff |
|---|---|---|---|---|---|---|---|---|---|---|
| **Patient has ER visit** | | | | | | | | | | |
| **Patient has IP Admission** | | | | | | | | | | |
| **Patient has 3 or more chronic poorly controlled condition** | | | | | | | | | | |
| **Health Plan lists of high risk patients** | | | | | | | | | | |
| **New Patients** | | | | | | | | | | |
| **Patients in SNF or Assisted Living** | | | | | | | | | | |
| **Patients who need DME support** | | | | | | | | | | |
| **Palliative Care** | | | | | | | | | | |

**Rhode Island College School of Nursing**
**NURSING CARE MANAGER (NCM) EDUCATIONAL OPTIONS**

## 1. Nursing Care Management Course and Graduate Nursing Certificate Program.

- The NCM *course* can be taken alone to prepare for certification in case management by the American Nurses Credentialing Center (ANCC) or as part of the certificate program. This *course* counts towards the 30 hours of NCM continuing education required by the ANCC to be eligible for certification.
- The NCM *program* is a 15-credit graduate nursing *program* consisting of five courses taught in the evenings, some using a hybrid course design that blends in-person with online learning.
    - Students take courses with other nurses studying for advanced practice roles; such as clinical nurse specialists, nurse anesthetists, nurse practitioners, and public health nurses.
    - Participants must have a Bachelor of Science degree to register for the graduate certificate program.
    - Nursing Care Managers who want to earn a Master's of Science in Nursing degree may transfer credits from the five courses into the nursing graduate program and then continue on with their education.
- Course Descriptions:

  a. Nursing Care Management Course (NURS 518): Students examine best practices for the coordination of comprehensive services to populations across the continuum of health care systems. Care management processes are explored that enhance a client-centered, inter-disciplinary approach to evidence-based practice, outcomes-based quality improvement, and cost containment.

  b. Healthcare Systems Course (NURS 502): Students analyze organizational structure, resources, current technology, informational systems, outcome measures, safety initiatives, health care policy and ethics. The patient's central role in health care decision-making is examined.

  c. Professional Role Development Course (NURS 503): Students clarify advanced practice nursing roles and examine behaviors to promote change and collaboration in practice environments; including concepts of leadership, communication, power, and problem solving.

  d. Epidemiology Course (NURS 507): The focus is on the causes, frequencies, and distribution of diseases and health issues in various populations. The methods of epidemiology allow the student to collect, tabulate, analyze and interpret statistical facts about the occurrence of health problems, risk factors, disease and deaths in a community.

  e. Public Health Science Course (NURS 508): The historical development and concepts of public health practice are examined. Students gain an understanding of the tools used for public health practice including research, epidemiology and policy development. Public health substantive areas such as environmental health, occupational health, bio-terrorism and disaster preparedness, prevention and control of disease and injury, vulnerable populations and global health issues are analyzed.

## 2. RN-to-BSN Program

The RN-to-BSN Program is designed for RN students who want to earn their BSN degree. Nurses apply to RIC as transfer students and are granted 37 credits for their basic nursing program and additional credits for other academic work. The program includes general education requirements and some higher-level nursing courses.

**For further information, please contact Jeanne Schwager, PhD, APHN-BC, RN Population/Public Health Nursing Coordinator, at** jschwager@ric.edu

October, 2014

# 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**

# Community Health Network Program Referral

**Healthcare Provider Information**

Provider Name | Date / /

Agency / Practice | Phone

Street Address | Fax

City / State / Zip Code | E-mail

Send feedback to: ☐ Same as above or Name:

Phone | Fax

**Patient Information**

Name | Gender ☐ Male ☐ Female

Address

Birth Date / /

Program Preference: ☐ Morning ☐ Afternoon ☐ Evening ☐ Weekend

Best Phone to call: | Best time to call:

Currently enrolled in WISEWOMAN? ☐ Yes ☐ No

Special Accommodations?

Language ☐ Spanish ☐ Other (Please specify)_____ ☐ Physical or other special needs: _____

Primary Insurance: ☐ BCBS of RI ☐ United Healthcare ☐ Neighborhood Health Plan ☐ Tufts ☐ Medicare

Medicaid (check one): ☐ Rite Care ☐ ConnectCare ☐ Rhody Health ☐ None ☐ Other _____

**Patient Concern** (Check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer Survivor
- ☐ COPD
- ☐ Diabetes
- ☐ Fall-risk
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Nutrition Counseling/Healthy Eating
- ☐ Pain
- ☐ Pre-Diabetes
- ☐ Youth with Special Needs
- ☐ Tobacco Use
- ☐ Weight Management
- ☐ Other chronic condition:_____

Specific Program Request:

☐ Patient enrolled in onsite program, CHN Patient Navigator contact not needed. Program Name:_____

**All referrals require a Physician/NP/PA Order**

Healthcare Provider Signature:

Healthcare Provider Notes:

- Please have the person being referred sign the authorization to disclose information to Community Health Network Programs.
- Keep a copy for your records.
- Provide the person referred with the Community Health Network Program materials.
- **Send this form to Cindy Ariza or Catherine Cabral through secure fax (401-222-4418).**
- **Call Cindy Ariza (401-222-7636) or Catherine Cabral (401-222-7623) if you have any questions.**
- The patient progress reports will be emailed or faxed to the number provided on this form.

**Department of Health use only:**

Date entered | Entered by | Referral ID number

# Authorization to Disclose Confidential Information about My Chronic Conditions for Better Self-Management Care

I, _____
(Program Participant)
hereby voluntarily authorize disclosure of my name, address, phone number, date of birth and gender for the purpose of my referral to a chronic disease education and/or self-management program or services.

My information is to be disclosed by:

_____
(Name of Referring Practice/Organization)

_____
(Street Address)

_____
(City, State, Zip)

I understand that my personal information(listed above) may be shared only to help me better manage my health and only between and among my referring health care provider, the Rhode Island Department of Health, and individual or community program involved with chronic condition education /self-management program or services to which I have been referred. Information to be shared include letting my referring health care provider know whether I participated in programs to which I was referred, and the outcome of my participation.

I also understand that I may revoke this authorization at any time by writing to the healthcare provider who referred me to the programs. If I revoke this authorization my personal healthcare information will no longer be shared and will be protected by federal and state law. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a later expiration date.

_____ _____
Signature of Person Referred Date

_____
Expiration Date of Authorization (One year from today, or later if you write a later date above.)

_____ _____
Signature of Authorized Representative of Healthcare Provider Date

Ask your healthcare provider to refer you to a program, or call 401-222-5960 / RI Relay 711 to sign up.

Rhode Island Department of Health

# COMMUNITY HEALTH NETWORK

**"The most helpful thing for me is… just being there and listening to other people. They know exactly what you're going through."**

Rhode Island Department of Health
3 Capitol Hill, Providence, RI 02908
HEALTH Information Line, 401-222-5960 / RI Relay 711
**health.ri.gov/communityhealthnetwork**

This project was supported, in part by grant number 90CS0040, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.

Do you have asthma, arthritis, cancer, diabetes, heart disease, lung disease, chronic pain, or another long-term illness?

Do you want to reduce your chances of getting one of these illnesses?

**health.ri.gov/communityhealthnetwork**

**"For the first time in years, I felt comfortable enough with my balance to dance at a wedding!"**

## Community Health Network programs give you the tools you need to feel better and improve your health.

They help you learn how to stay active, eat well, solve everyday problems, deal with stress, and talk more easily with your family and healthcare providers about your concerns. They also allow you to meet others like you who want to improve their health.

These programs are offered in many communities in Rhode Island. Most are free or low-cost. Programs offered in Spanish are noted on the website.

- A Matter of Balance: Managing Concerns about Falls
- Arthritis Foundation Exercise Program
- Arthritis Foundation Walk With Ease Program
- Certified Cardiovascular Disease Outpatient Educator Program
- Certified Diabetes Outpatient Educator (CDOE)
- Chronic Disease Self-Management (Living Well Rhode Island)
- Chronic Pain Self-Management (Living Well Rhode Island)
- Diabetes Prevention Program (YMCA)
- Diabetes Self-Management (Living Well Rhode Island)
- Draw a Breath Asthma Program
- EnhanceFitness (YMCA)
- Health Smart Behaviors (YMCA)
- Healthy Lifestyles Behavior Change Program (YMCA)
- Healthy Lifestyles for Teens and Young Adults
- LIVESTRONG at the YMCA
- Peer Resource Specialists (Rhode Island Parent Information Network)
- QuitWorks-RI
- Rhode Island Smokers' Helpline (1-800-QUIT-NOW)
- Salsa, Sabor Y Salud (YMCA)

**"In the program, you give and get encouragement from others as you learn practical ways to take control of your health."**

For more information, an updated program list, or to sign up for a program call **401-222-5960** / RI Relay 711 or visit **health.ri.gov/communityhealthnetwork**

# CTC-RI Orientation 2014

# Tab 5: Improving Quality

## 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:**

| Measure | Used for Payment | Threshold |
|---|---|---|
| **Adult BMI (18-64)** | ✓ | **70%** |
| **Adult BMI (65+)** | ✓ | **75%** |
| **DM A1c Good control (<8)** | ✓ | **70%** |
| Depression Screen | | 91% |
| DM A1c Poor Control (>9) | | 21% |
| **DM BP Control (<140/90)** | ✓ | **78%** |
| **DM-HbA1 with results** | | **89%** |
| **Hypertension BP Control (<140/90) (Updating measure according to 2014 HEDIS update** | ✓ | **76%** |
| Tobacco Assessment | | 98% |
| **Tobacco Cessation** | ✓ | **90%** |
| **Chlamydia Screening-Sexual History** | | **N/A** |
| **Chlamydia Screening-Testing** | | **N/A** |
| **Fall Risk Management** | | **N/A** |
| 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

**Diabetic Patients with Poor A1c Control**

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

**Diabetic Patients with BP Control**

- Most recent BP < 140/90 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 or PHQ-9 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**

- 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+**

- 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 Control**

- 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*

- Members 18–59 years of age as of the last day of the reporting period whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of the last day of the reporting period and diagnosed with diabetes (ICD 9 Code groups for diabetes: 250.xx, 357.2x, 362.0x, 366.41, 648.0x ) whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

**Fall Risk**

- 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**

- 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**

- 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.

## Other Potential Reporting Requirements

- A systematic way to track and report on NCM activity including determining telephonic versus face-to-face visit types.
- A systematic way to track and report on patients who were hospitalized or visited the emergency department.
- A systematic way to flag in your EHR and report on high-risk/complex patients.

## 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) payments.

**Utilization Benchmarks:**

- CSI-RI Practices will achieve a five percent (5%) favorable difference in hospital admissions per thousand using the trend change in the cohort vs. comparison group ( similar, non-PCMH providers) during the same measurement period using rolling years. . "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.

  .
- CSI-RI Practices will achieve five percent (5%) favorable difference in ED visits per thousand using a trend change in the cohort vs. comparison group (similar, non-PCMH practices) using rolling years during the same measurement period.

**Timeframe for the Data**

Claims data running through the end of Quarter 2 2014 will be used to generate data point for performance affecting 2015/6 payment

**Measurement Cohorts**

1. Cohort 1: current Pilot, 2008 Expansion sites, BVCHC and UFM
2. Cohort 2: current 2013 Expansion PY 1 sites and ECAP-Newport
3. Cohort 3: Current 2013 Expansion Transition year sites

## 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

**Diabetic Patients with Poor A1c Control**

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

**Diabetic Patients with BP Control**

- Most recent BP < 140/90 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 or PHQ-9 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**

- 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+**

- 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 Control**

- 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*

- Members 18–59 years of age as of the last day of the reporting period whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of the last day of the reporting period and diagnosed with diabetes (ICD 9 Code groups for diabetes: 250.xx, 357.2x, 362.0x, 366.41, 648.0x ) whose BP was <140/90 mm Hg.
- Members 60–85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

**Fall Risk**

- 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**

- 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**

- 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.

## Other Potential Reporting Requirements

- A systematic way to track and report on NCM activity including determining telephonic versus face-to-face visit types.
- A systematic way to track and report on patients who were hospitalized or visited the emergency department.
- A systematic way to flag in your EHR and report on high-risk/complex patients.

# CTC-RI Orientation 2014

# Tab 5: Improving Quality


DataStat is pleased to be a part of the 2015 RIQI and CSI PCMH survey project. As the certified data vendor on this project, we will administer the survey to and collect data from the patients at your practice site. For the project to be successful, we need each practice site to generate and submit sample frame files and materials to us in a consistent and timely manner. We want this submission process to go as smoothly as possible, so we have created this collection of training materials to help practice sites. Included in this packet you will find:

- A timeline of project milestones.
- Instructions on when and how to submit your sample frame data files to DataStat.
- Sample frame data file layout specifications and a sample template.
- Key Definitions from *Specifications for the CAHPS PCMH Survey 2014.*

If you have any questions or concerns, please contact Donna Fowlkes at (734) 994-0540 ext. 143 or email dfowlkes@datastat.com.

| MILESTONE | Dates |
|---|---|
| RIQI sends logo/signature sign off sheets to practices | November 10, 2014 |
| DataStat sends transfer center invitations to practices with new sample contact person | November 10-17, 2014 |
| Practices Set Up any new Transfer Center Accounts | November 10-17, 2014 |
| Practices pull Test Sample | November 17, 2014 |
| Practices submit test sample to DataStat via the transfer center | November 17-21, 2014 |
| Final deadline for logos/signatures to DataStat | November 21, 2014 |
| Practices *Pull* Real Sample Frames | December 15, 2014 |
| Practices *Submit* Real Sample Frames to DataStat via the transfer center | December 15-29, 2014 |
| Survey Fielding Begins | January 15, 2015 |
| Final date for practices to decide if they are submitting to NCQA | January 30, 2015 |
| Survey Fielding Ends | February 26, 2015 |
| Datastat Submits Final Datasets to RIQI | March 31, 2015 |
| Datastat Submits Final Summary Reports to RIQI | April 30, 2015 |

# Submitting Sample Files to DataStat

Each participating practice site must submit a sample frame data file to DataStat for selection. To facilitate a smooth transfer, each practice site is asked to submit a test sample data file approximately 1 month prior to the actual sample submission deadline.

The method of submission is through the DataStat Transfer Center (DTC). **For privacy reasons, sample frame files cannot be submitted via e-mail**. To use the DTC, you must be invited to create an account. DataStat will send out invitations to any new sample contact persons between 11/10/14 and 11/17/14. **Sites should have their DTC accounts set up no later than November 17, 2014.**

**Test Sample Deadlines:**

- Test sample files should be submitted between November 17 and November 21, 2014.
- The measurement year for the test sample is defined as November 18, 2013 through November 17, 2014. The last day of the test measurement period is November 17, 2014.
- Test sample frame files must be received at DataStat by November 21, 2014.
- The guidelines below should be followed when generating the test sample with the exception of adjusting the measurement year accordingly.

**Real Sample Deadlines:**

- Real sample files must be submitted between **December 15 and December 19, 2014.**
- The measurement year for the real sample is defined as December 16, 2013 through December 15, 2014. **The last day of the measurement period is December 15, 2014**.
- **Real sample frame files must be received at DataStat by December 19, 2014**.

**Generation Guidelines**

- The measurement period is defined as:
    - Test sample: November 18, 2013 through November 17, 2014
    - Real sample: December 16, 2013 through December 15, 2014
- All eligible patients that had a visit (scheduled or walk-in) with an eligible clinician within the measurement period must be included in the sample frame. For a description of an eligible clinician, please see the attached documentation *Key Definitions* from *Specifications for the CAHPS PCMH Survey 2014.*
- Patient eligibility is defined as, for adults, 18 years old or older as of the last day of the measurement period. For children, 17 years old or younger as of the last day of the measurement period.
- DataStat would prefer adult and child sample frame data files be submitted separately, but combined files can be accepted if adult and child cases are clearly identified with a flag variable (see the sample layout).
- Multiple sites may be submitted as separate files or a combined file. If the file is combined, cases must be clearly stratified by the 'practice unique ID variable'. For combined submissions, a crosswalk of the variable 'practice unique ID' must be included (see the sample layout).
- Files may be submitted in an excel file or as a flat, ASCII, rectangular, fixed field width file with no delimiters. Either file type must follow the sample specifications included.
- DataStat will check sample frame data files for accuracy and completeness. If data files are found to be inaccurate or incomplete, the practice site will need to resubmit the data file before the submission deadline.

## Sample Frame Data File Elements - Standardized Layout

Each of the elements listed below should be included in the sample frame provided to the survey vendor. The columns and widths indicated in the Data Format column describe a flat, ASCII, rectangular, fixed field width file with no delimiters. *If your file does not match this description, it is critical that the practice deliver a detailed dataset description including the order of variables and relevant coding schemes.*
**If a field is blank (such as add2), leave it blank. Do NOT put N/A, Missing OR Null.**

| # | Required Data Element | Specifications and Value Labels | Field Position and Data Format |
|---|---|---|---|
| 1 | Practice name | Name of practice to be used in survey materials and scripts. Provide practice name MOST recognizable to patients. | Columns: 1-60<br>Width: 60<br>Type: Alpha-Numeric |
| 2 | Patient first name | First name only. Exclude middle name and middle initial. | Columns: 61 - 85<br>Width: 25<br>Type: Alpha |
| 3 | Patient middle initial | Middle initial only. Exclude first and last name. | Columns: 86<br>Width: 1<br>Type: Alpha |
| 4 | Patient last name | Last name only. Exclude middle initial and first name. | Columns: 87 - 111<br>Width: 25<br>Type: Alpha |
| 5 | Patient gender | 1=Male<br>2=Female<br>9=Missing/not available | Columns: 112 Width: 1 Type: Numeric |
| 6 | Patient date of birth | In **MMDDYYYY format with no slash separators**. Single digit months and days must be preceded by a zero; i.e., April 8, 1965 would be 04081965. | Columns: 113 - 120<br>Width: 8 Type: Alpha-Numeric |
| 7 | Patient mailing address 1 | Used to generate cover letters and mail questionnaires. Put simple street address here. For example: 100 Main St. | Columns: 121 - 170<br>Width: 50<br>Type: Alpha-Numeric |
| 8 | Patient mailing address 2 | Use as necessary for apartment number, apartment complex name or other long addresses; otherwise leave blank. | Columns: 171 - 220<br>Width: 50<br>Type: Alpha-Numeric |
| 9 | Patient - City | | Columns: 221 - 250<br>Width: 30<br>Type: Alpha |
| 10 | Patient - State | 2-character postal service state code. | Columns: 251 - 252<br>Width: 2 Type: Alpha |
| 11 | Patient - Zip Code (5 digit) | 5-digit zip code. Use leading zero if appropriate. | Columns: 253 - 257<br>Width: 5 Type: Numeric |
| 12 | Patient telephone number | Home phone number. Area code and phone number with **no punctuation**, e.g. 7342256162. Members without phone numbers should still be included in the sampling list. If there is no phone number, leave this field blank. | Columns: 258 - 267<br>Width: 10<br>Type: Numeric |
| 13 | Patient email address | *Optional, please leave blanks if not including* | Columns: 268 - 317<br>Width: 50<br>Type: Alpha-Numeric |
| 14 | Clinician first name | Name of the clinician who provided care at the patient's most recent visit during the measurement period. This clinician need not be the patient's regular clinician or primary care provider. | Columns: 318 - 342<br>Width: 25<br>Type: Alpha |
| 15 | Clinician middle initial | | Columns: 343 Width: 1 Type: Alpha |
| 16 | Clinician last name | | Columns: 344 - 368<br>Width: 25<br>Type: Alpha |
| 17 | Clinician credentials | For example: MD, PA, RN | Columns: 369 - 378<br>Width: 10 Type: Alpha-Numeric |

| | | | |
|---|---|---|---|
| 18 | Clinician Nation Provider Identifier (NPI) | | Columns: 379 - 388<br>Width: 10<br>Type: Numeric |
| 19 | Date of most recent office visit during the measurement period | In **MMDDYYYY format with no slash separators**. Single digit months and days must be preceded by a zero; i.e., April 8, 2014 would be 04082014. | Columns: 389 - 396<br>Width: 8 Type: Alpha |
| 20 | Parent/caretaker first name | Optional. Provide for child survey only if mailing materials to be addressed to parent or caretaker.<br>*Please leave blanks if not including.* | Columns: 397 - 421<br>Width: 25<br>Type: Numeric |
| 21 | Parent/caretaker middle initial | Optional. Provide for child survey only if mailing materials to be addressed to parent or caretaker.<br>*Please leave blanks if not including.* | Columns: 422 Width: 1 Type: Numeric |
| 22 | Parent/caretaker last name | Optional. Provide for child survey only if mailing materials to be addressed to parent or caretaker.<br>*Please leave blanks if not including.* | Columns: 423 - 447<br>Width: 25<br>Type: Numeric |
| 23 | Patient Visit Count (optional) | Total number of visits the patient had during the 12 months prior to the date the eligible population data file was generated (include visits with any eligible clinician).<br>*Please leave blanks if not including.* | Columns: 448-450<br>Width: 3 Type: Numeric |
| 24 | Patient survey group | 1=Adult survey<br>2=Child survey | Columns: 451<br>Width: 1<br>Type: Numeric |
| 25 | Practice unique ID | Provide for multi-practice sample frames. Please include a crosswalk for this variable. Example: 01=Main St, 02=St. John's,03=Madison Heights | Columns: 452-453<br>Width: 2 Type: Numeric |
| 26 | Indicate if Spanish language materials are required (if known) | 01= Spanish Language Materials Required<br>02=NO Spanish Language Materials Required<br>03=Unknown/not available<br>*This variable is optional. Please leave blanks if not including.* | Columns: 454-455<br>Width: 2 Type: Numeric |

# HEDIS Reporting

## 1. HEDIS Reporting

CAHPS PCMH Survey results are collected and reported at the practice level. Because results are collected and reported separately for adult and child populations, each practice is eligible to report one or both of two HEDIS measures:

1. CAHPS PCMH Survey, Adult Version
2. CAHPS PCMH Survey, Child Version.

## 2. Defining the HEDIS Reporting Entity

To determine how many CAHPS PCMH Surveys to administer, the practice must define itself using criteria specified by NCQA and described below.

If the practice is seeking NCQA Recognition, or is already NCQA Recognized, CAHPS PCMH Survey results must be representative of the recognized entity.

If the practice is not seeking NCQA Recognition, it must define itself using the criteria below. If the practice cannot determine the HEDIS reporting entity, contact the NCQA Policy Department via the PCS system at www.ncqa.org/pcs for assistance.

## 3. Defining the Practice

A **practice** is one or more clinicians who practice together and provide patient care at a single geographic location. The practice must provide primary care for all patients in its practice, not just for selected patients. **Practicing together** means that, for all the clinicians in a practice:

- The practice care team follows the same procedures and protocols.
- Medical records (paper and electronic) for all patients treated at the practice site are available to all clinicians and are shared by all clinicians, as appropriate.
- The same systems (paper based or electronic) and procedures support both clinical and administrative functions (e.g., scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up).

A rehabilitation facility or hospital may not define itself as a practice; however, hospital-based primary care practices and residency clinics are eligible to be defined as practices.

## 4. Multi-Site Group

A **multi-site group** is three or more practice sites using the same systems and processes including an electronic medical record system shared across all practice sites.

A multi-site group must collect and report CAHPS PCMH Survey results separately by practice site.

## 5. Identifying Eligible Practice Clinicians

Only clinicians who can be selected by a patient/family as a personal clinician are eligible for inclusion. Eligible clinicians include physicians, nurse practitioners and physician assistants who practice in the specialty of internal medicine, family medicine or pediatrics and serve as the personal, primary care clinician for their patients. Clinicians must have an active, unrestricted license as a doctor of medicine, doctor of osteopathy, nurse practitioner or physician assistant. All eligible clinicians practicing together at a practice site must be included when identifying the CAHPS PCMH Survey eligible population.

***Note:*** *Specialists, nurse practitioners and physician assistants who do not have their own panel of patients or who do not practice in primary care are not typically eligible.*

## 6. Measurement Period

The **measurement period** is the 12 months prior to the date when the practice generates the eligible population file.

The eligible population includes patients who had a visit during the measurement period. The practice defines the measurement period based on the date when it creates the eligible population file.

Survey questions ask about patients' experience "in the last 12 months." To maximize the overlap between the measurement period and the "last 12 months":

- The practice generates the eligible population within 1 month of the end of the measurement period.
- The survey vendor begins survey administration within 1 month of when the eligible population file is generated.

# HIPAA BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT is made as of the _____day of _____, 2015 by and between _____ ("Covered Entity") and DataStat Inc.

RECITALS:

WHEREAS, **DataStat Inc.** (hereinafter referred to as Business Associate), provides services for Covered Entity (the "Service Arrangement") pursuant to which Covered Entity may disclose Protected Health Information ("PHI") to Business Associate in order to enable Business Associate to perform one or more functions for Covered Entity related to Treatment, Payment or Health Care Operations; and

WHEREAS, the parties desire to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Final Rule for Standards for Privacy of Individually Identifiable Health Information adopted by the United States Department of Health and Human Services and codified at 45 C.F.R. part 160 and part 164, subparts A & E (the "Privacy Rule"), the HIPAA Security Rule, codified at 45 C.F.R. Part 164 Subpart C (the "Security Rule") and Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH") including 45 C.F.R. Sections 164.308, 164.310, 164.312 and 164.316.

NOW THEREFORE, the parties to this Agreement hereby agree as follows:

1. Definitions. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 164.501 and 164.502.

2. Obligations and Activities of Business Associate.

    a. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement, as Required by Law or as permitted by law, provided such use or disclosure would also be permissible by law by Covered Entity.

    b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Business Associate agrees to implement Administrative Safeguards, Physical Safeguards and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the confidentiality, integrity and availability of PHI as required by the "Security Rule" , including those safeguards required pursuant to 45 C.F.R. §§ 164.308, 164.310, 164.312, 164.314 and 164.316, in the same manner that those requirements apply to Covered Entity pursuant to 45 C.F.R. § 164.504.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure for the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware.

e. Business Associate agrees to ensure that any agent, including a subcontractor or vendor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.

f. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and format; or, if not, in a readable electronic form and format as requested by Covered Entity.

g. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall notify Covered Entity upon receipt of such request.

h. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for the purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule and Security Rule.

i. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered

Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 §C.F.R. 164.528.

k. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it shall, following the discovery of a breach of such information, promptly notify Covered Entity of such breach. Such notice shall include: a) the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.

l. Business Associate agrees that it will not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 13405(d) of the HITECH Act applies.

m. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 C.F.R. §164.501 unless permitted by the HITECH Act.

n. If applicable, Business Associate agrees that it will not use or disclose genetic information for underwriting purposes, as that term is defined in 45 C.F.R. § 164.502.

o. Business Associate hereby agrees to comply with state laws applicable to PHI and personal information of individuals' information it receives from Covered Entity, including the Massachusetts Data Security Regulations, 201 CMR 17.00, as applicable, during the term of the Agreement.

    i. Business Associate agrees to: (a) implement and maintain appropriate physical, technical and administrative security measures for the protection of personal information as required by any state law, including 201 CMR 17.00 as applicable; including, but not

limited to: (i) encrypting all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information to be transmitted wirelessly; (ii) prohibiting the transfer of personal information to any portable device unless such transfer has been approved in advance; and (iii) encrypting any personal information to be transferred to a portable device; and (b) implement and maintain a Written Information Security Program as required by any state law, including, 201 CMR 17.00, as applicable.

ii. The safeguards set forth in this Agreement shall apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" shall not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

p. Business Associate agrees that no PHI may be received, maintained, stored, accessed or transmitted outside of the United States of America.

3. Permitted Uses and Disclosures by Business Associate.

a. Except as otherwise limited to this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Service Arrangement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity required by 45 C.F.R. §164.514(d).

b. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it

was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504 (e)(2)(i)(B).

e. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

4. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, provided that, to the extent permitted by the Service Arrangement, Business Associate may use or disclose PHI for Business Associate's Data Aggregation activities or proper management and administrative activities.

6. Term and Termination.

a. The term of this Agreement shall begin as of the effective date of the Service Arrangement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Section.

b. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Service Arrangement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity.

ii. Immediately terminate this Agreement and the Service arrangement if Business Associate has breached a material term of this Agreement and cure is not possible; or

iii. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Except as provided in paragraph (d) of this Section, upon any termination or expiration of this Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall ensure that its subcontractors or vendors return or destroy any of Covered Entity's PHI received from Business Associate.

d. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous.

a. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy and Security Rules and HITECH.

c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement shall survive the termination of this Agreement.

d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and HITECH.

e. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

f. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

g. Modification of the terms of this Agreement shall not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.

h. This Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.

i. Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.

j. This Agreement and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Rhode Island, including all matters of construction, validity and performance.

k. All notices and communications required or permitted to be given hereunder shall be sent by certified or regular mail, addressed to the other part as its respective address as shown on the signature page, or at such other address as such party shall from time to time designate in writing to the other party, and shall be effective from the date of mailing.

l. This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signature hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

m. Business Associate shall maintain or cause to be maintained sufficient insurance coverage as shall be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Business Associate Agreement and such insurance coverage shall apply to all services

provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible identity theft, financial harm, reputational harm, or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first set forth above.

**COVERED ENTITY**

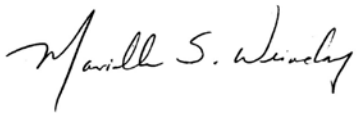
By:_____

Title: _____

Address: _____

Date: _____

**DataStat Inc.**

By:__  _____

Title: Health Care Research Director_____

Address: 3975 Research Park Dr. Ann Arbor, MI 48108_____

Date: _____

# Sending Logos and Signatures

**Logo File**
Practice sites may send a logo that will be printed in black ink on all correspondence and questionnaires. If no logo is received by **TBD**, then in lieu of a logo, the practice name will be printed in black ink on the mail materials. Please do not scan or fax logos. Please adhere to the following guidelines when sending the logo:

- Please send a black/white copy and a color copy of the logo.
- The preferred formats are .gif, .tiff or .jpg.
- Images of 300 dpi are required but 600 dpi is preferred.
- Please include a list of practices when submitting the file if the logo is to be used for multiple practices.

Email or DataStat Transfer Center delivery is preferred. If sending by email, send to **dfowlkes@datastat.com.**

**Signature File**
Practice sites should send an executive signature to be used on all correspondence. Please adhere to the following guidelines when sending the signature and title:

- Please send a black/white copy of the signature.
- The preferred electronic formats are .gif, .tiff or .jpg. We can also accept signatures that are in Microsoft Word docs.
- Please use the form on page 2 if no electronic signature is available. You can deliver the completed form as a scanned document.
- Please include with the signature the printed name of the executive, the executive's title and the complete name of the practice, as it should be printed on mail materials.
- Please include a list of practices when submitting the file if the signature is to be used for multiple practices.

Email or DataStat Transfer Center delivery is preferred. If sending by email, please send to **dfowlkes@datastat.com.** Please include the printed name of the executive, the executive's title and the complete name of the practice, as it should be printed on mail materials.

If you have any questions or concerns please contact Donna Fowlkes at (734) 994-0540 ext. 143 or email dfowlkes@datastat.com.

## Signature Submission Form

- Please provide 3 example signatures, one per box.
- For best scanning, use a heavy black pen
- **Signature should remain completely inside the box- do not run over the edges**
- **Do not put the person's title/position/degrees inside the box!**
- Once signatures are captured and form is complete please email to:
  dfowlkes@datastat.com

***Printed name of executive signing mail materials:*** _____

***Title of executive signing mail materials:*** _____

***Complete practice name as it should appear on mail materials:*** _____

| Practice name | Patient first name | Patient middle initial | Patient last name |
|---|---|---|---|
| Neighborhood Clinic | John | J | Doe |

| Patient gender (1= Male, 2= Female, 9= Missing/ not available) | Patient date of birth (MMDDYYYY) | Patient mailing address 1 | Patient mailing address 2 | Patient City |
|---|---|---|---|---|
| 1 | 02061972 | 125 Main St. | Apt. 204 | Anywhere |

| Patient State | Patient - Zip Code (5 digit). Use leading zero if appropriate. | Patient telephone number (No punctuation) | Patient email address (Optional) | Clinician first name | Clinician middle initial | Clinician last name | Clinician credentials- for example MD, PA, RN |
|---|---|---|---|---|---|---|---|
| MI | 02149 | 2223334444 | | Marcus | M | Welby | MD |

| Clinician Nation Provider Identifier (NPI) | Date of most recent office visit during the measurement period MMDDYYYY | Parent/caretaker first name (Optional) | Parent/caretaker middle initial (Optional) | Parent/caretaker last name (Optional) | Patient Visit Count (Optional) |
|---|---|---|---|---|---|
| 1234567890 | 06082014 | | | | 3 |

| Patient survey group (if both adult and child are in the sample file, 1=Adult, 2=Child) | Practice unique ID (if more than 1 practice is in the same file) | Spanish materials requested<br>01=Spanish requested<br>02=No Spanish requested<br>03=Unknown<br>(Optional) |
|---|---|---|
| 1 | | |

| | | |
|---|---|---|
| Practice name | Name of practice to be used in survey materials and scripts. Provide practice name MOST recognizable to patients. | Width: 60<br>Type: Alpha-Numeric |
| Patient first name | First name only. Exclude middle name and middle initial. | Width: 25<br>Type: Alpha |
| Patient middle initial | Middle initial only. Exclude first and last name. | Width: 1<br>Type: Alpha |
| Patient last name | Last name only. Exclude middle initial and first name. | Width: 25<br>Type: Alpha |
| Patient gender | 1=Male<br>2=Female<br>9=Missing/not available | Width: 1<br>Type: Numeric |
| Patient date of birth | In MMDDYYYY format with no slash separators. Single digit months and days must be preceded by a zero; i.e., April 8, 1965 would be 04081965. | Width: 8<br>Type: Alpha-Numeric |
| Patient mailing address 1 | Used to generate cover letters and mail questionnaires. Put simple street address here. For example: 100 Main St. | Width: 50<br>Type: Alpha-Numeric |
| Patient mailing address 2 | Use as necessary for apartment number, apartment complex name or other long addresses; otherwise leave blank. | Width: 50<br>Type: Alpha-Numeric |

| | | |
|---|---|---|
| Patient - City | | Width: 30<br>Type: Alpha |
| Patient - State | 2-character postal service state code. | Width: 2<br>Type: Alpha |
| Patient - Zip Code (5 digit) | 5-digit zip code. Use leading zero if appropriate. | Width: 5<br>Type: Numeric |
| Patient telephone number | Home phone number. Area code and phone number with **no punctuation**, e.g. 7342256162. Members without phone numbers should still be included in the sampling list. If there is no phone number, leave this field blank. | Width: 10<br>Type: Numeric |
| Patient email address<br>Optional | *Optional, please leave blanks if not including* | Width: 50<br>Type: Alpha-Numeric |
| Clinician first name | Name of the clinician who provided care at the patient's most recent visit during the measurement period. This clinician need not be the patient's regular clinician or primary care provider. | Width: 25<br>Type: Alpha |
| Clinician middle initial | | Width: 1<br>Type: Alpha |
| Clinician last name | | Width: 25<br>Type: Alpha |
| Clinician credentials | For example: MD, PA, RN | Width: 10<br>Type: Alpha-Numeric |

| | | |
|---|---|---|
| Clinician Nation Provider Identifier (NPI) | | Width: 10<br>Type: Numeric |
| Date of most recent office visit during the measurement period | In MMDDYYYY format with no slash separators. Single digit months and days must be preceded by a zero; i.e., April 8, 1965 would be 04081965. | Width: 8<br>Type: Alpha |
| Parent/caretaker first name Optional | Optional. Provide for child survey only if mailing materials to be addressed to parent or caretaker.<br>*Please leave blanks if not including.* | Width: 25<br>Type: Numeric |
| Parent/caretaker middle initial Optional | Optional. Provide for child survey only if mailing materials to be addressed to parent or caretaker.<br>*Please leave blanks if not including.* | Width: 1<br>Type: Numeric |
| Parent/caretaker last name Optional | Optional. Provide for child survey only if mailing materials to be addressed to parent or caretaker.<br>*Please leave blanks if not including.* | Width: 25<br>Type: Numeric |
| Patient Visit Count (optional) | Total number of visits the patient had during the 12 months prior to the date the eligible population data file was generated (include visits with any eligible clinician).<br>*Please leave blanks if not including.* | Width: 3<br>Type: Numeric |
| Patient survey group | 1=Adult survey<br>2=Child survey<br>Include if both adults and children are in the same sample file. | Width: 1<br>Type: Numeric |

| | | |
|---|---|---|
| Practice unique ID | Provide for multi-practice sample frames. Please include a crosswalk for this variable. Example: 01=Main St,02=St. Johns,03=Madison Heights | Width: 2<br>Type: Numeric |

# CTC-RI Orientation 2014

# Tab 7: Patient-Centered Medical Home

# CSI-RI PMCHRI.org Web Portal

The CSI portal provides convenient and efficient online access, by qualified registered users, to analyses and reports at aggregate-, practice- and site-level information pertaining to CSI performance on:

- CSI Clinical quality measures
- CSI Hospital and ED utilization measures
- CSI Patient experience survey results

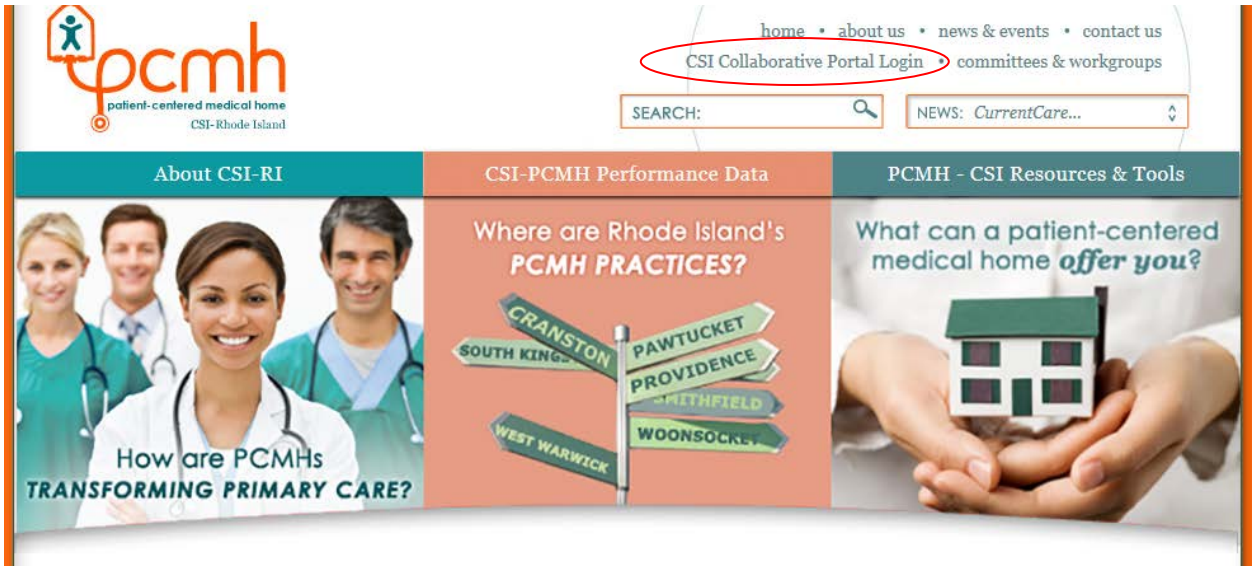
The site offers quarterly results, trends and comparative results from analyses conducted by CSI and the PCMH performance measurement team. The site also includes numerous opportunities to post and read comments to foster the sharing of questions and ideas to support collaborative learning.

## Getting Started:

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

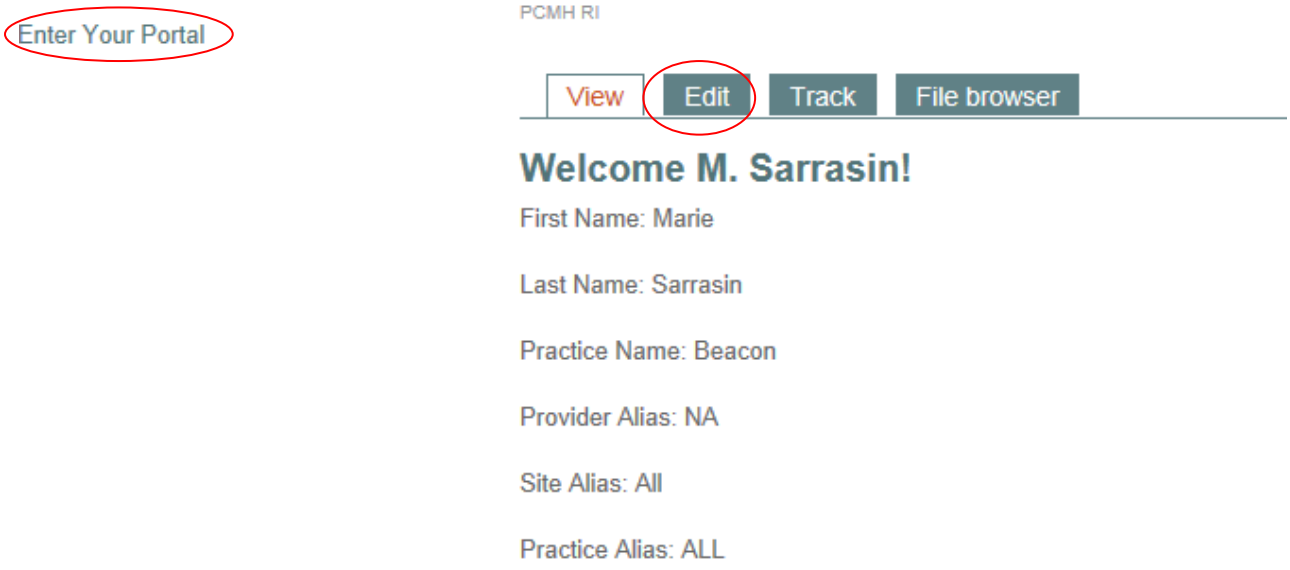
Navigate to http://www.pcmhri.org and click on **"CSI Collaborative Portal Login"** at the top right section of the page. This will take you to a section entitled "**User Account**" which allows you to login to the restricted portion of website.




After you have logged in for the first time, you may **change your username and password** by doing the following:

1. Click on the "**Edit**" box above your name and change your username and password

2. Click **"Save"** at the bottom of the page

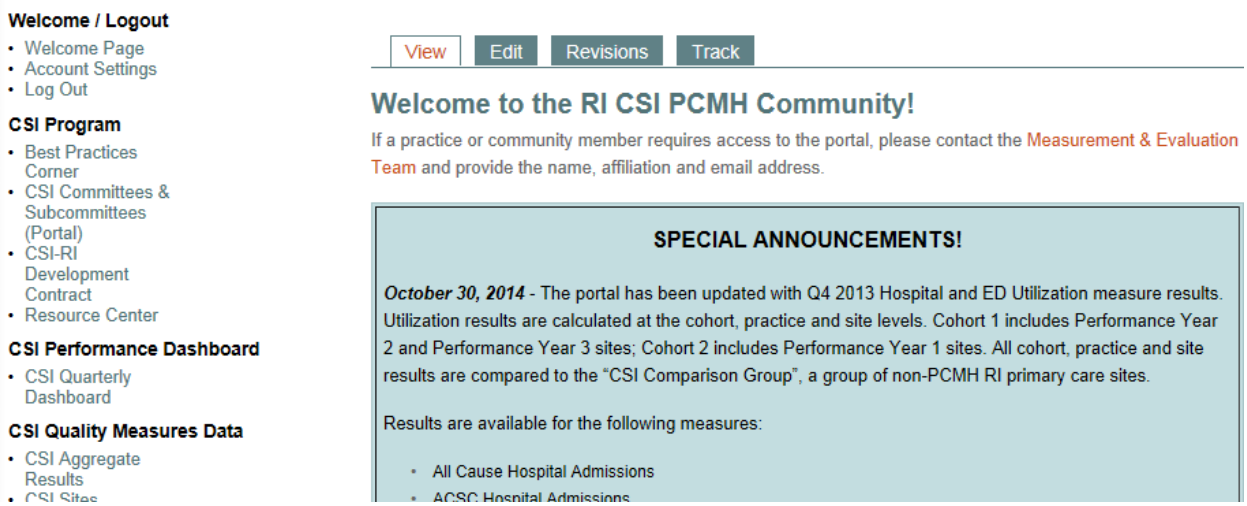



3. If you are already on the **Welcome** page, you can click on **Account Settings** underneath the **Welcome/Logout** heading. This will bring you to your account information where you can change your username and password.

4. Return to the website content by clicking **Enter Your Portal.**

**Navigating the Site:**

Once you have logged in, you should have been directed to the main welcome section entitled **"Welcome to the RI CSI PCMH Community!"** This page provides an overview of the portal, updates regarding new content and tips for navigating the site and posting comments. Please take a minute to read through this section.




You will see all or some (depending on practice affiliation) of these major section headings in the left navigation menu:

1. CSI Program – this section has information about the CSI program and minutes and agendas from CSI Steering Committee meetings.
2. CSI Performance Dashboard - This section includes the Practice Report Card that displays site progress on the CSI contractual targets. This section also shows aggregate results for quality, utilization and patient experience results.
3. CSI Quality Measures Data – This section contains aggregate and comparative results for the CSI sites' performance in the clinical quality measures.


4. CSI Utilization Measures Data – This section contains aggregate results in six hospital and ED utilization measures.

5. Patient Experience Survey – This section contains CSI site performance in the CAHPS PCMH Adult Survey. Results for 2013 vs. 2014 are included.

6. Practice/site Level Data - All practice and site level data is available under the site names on the left navigation bar (sites have access to only their own data). You can access your site's utilization, quality and patient experience data in this section.

Please post comments in each of the sections, and if you see comments, please reply to them. Each data page has a comments box at the bottom of the page.

HELPING NEW ENGLAND PROVIDERS

# REACH NEW HEIGHTS

***THROUGH QUALITY IMPROVEMENT SERVICES***

Quality Improvement Organizations

Sharing Knowledge. Improving Health Care.

*CENTERS FOR MEDICARE & MEDICAID SERVICES*

NEW ENGLAND QUALITY INNOVATION NETWORK

*Administered By Healthcentric Advisors in Partnership with Qualidigm*

# CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO) 11th Statement of Work

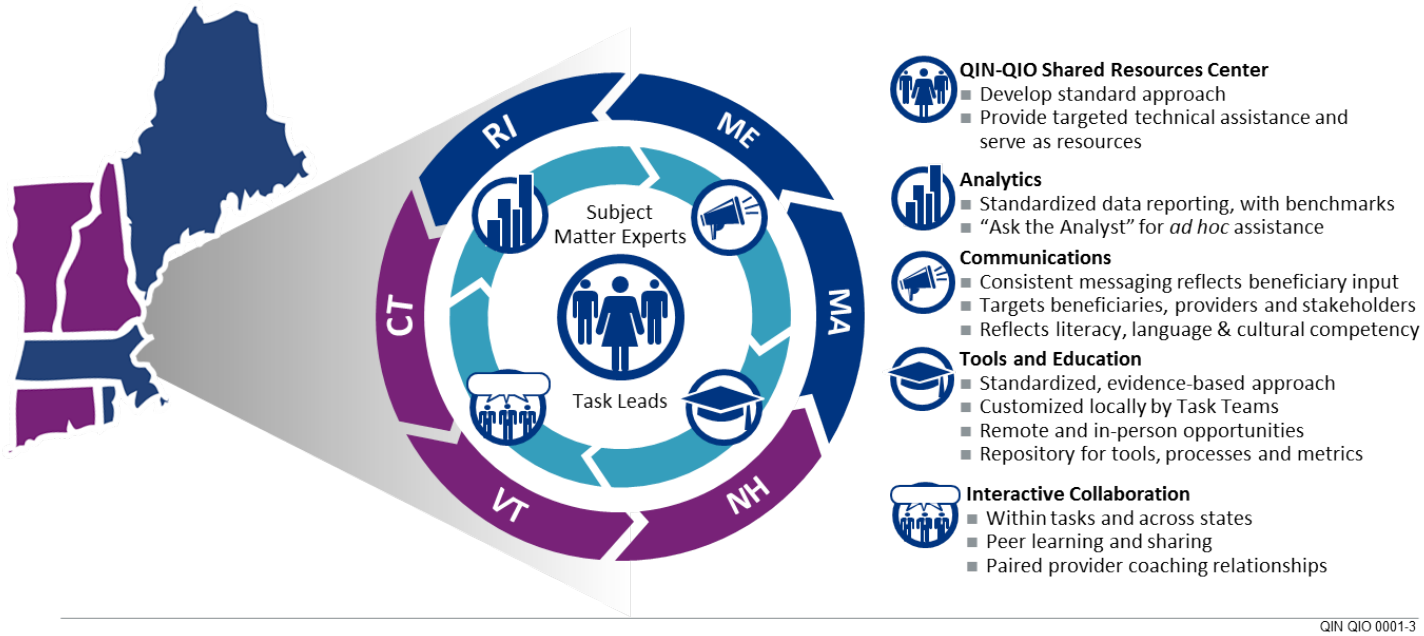
August 1, 2014 - July 31, 2019

Fourteen organizations nationwide were awarded five-year contracts by The Centers for Medicare & Medicaid Services under the newly restructured, multi-state QIN-QIO program. The QIN-QIOs work with providers and stakeholders to improve the quality and safety of healthcare provided to Medicare beneficiaries and assist in the transformation of the nation's healthcare delivery system.

Healthcentric Advisors, as the prime contractor, in partnership with Qualidigm, the former incumbent QIO for Connecticut as a subcontractor, will be serving as the QIN-QIO for all 6 New England states. While overseeing the administration of the overall New England QIN-QIO contract, Healthcentric Advisors will focus its efforts in Maine, Massachusetts and Rhode Island. Qualidigm will serve as the lead organization for the states of Connecticut, New Hampshire and Vermont. Together, this partnership will be branded as the New England Quality Innovation Network – Quality Improvement Organization.

NEW ENGLAND
QUALITY INNOVATION NETWORK
*Administered By Healthcentric Advisors in Partnership with Qualidigm*

## Centralized Resources and Subject Matter Expertise for Sharing Among all of New England




Our team of clinical, analytic and quality improvement experts are providing tools, education and assistance to support providers in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. This regional approach, affords health care communities the opportunity to connect, learn from others and share their innovations and successes throughout New England.

# 11th Statement of Work Focus Areas

| Task | Primary Objective | Settings/Care |
|---|---|---|
| **Patient Safety** | | |
| **Safe Transitions** | Improve care transitions by convening providers in cross-setting community coalitions that target the root causes of poor transitions, with a particular focus on adverse drug events, behavioral health and vulnerable patients (e.g., Medicare/Medicaid dual-eligible or with cognitive impairments, multiple co-morbidities, or high-risk medications). | Acute-Care Hospitals, Community Providers, Health Centers, Home Health Agencies, Nursing Homes, Pharmacy, Physician Offices, Psychiatric Hospitals |
| **Healthcare-Associated Infections** | Reduce health care-associated infections (HAIs) by convening a learning collaborative of acute-care hospitals, assisting facilities with targeted Quality Improvement, and fostering collaboration across the care continuum in the community coalitions. | Hospitals |
| **Healthcare-Acquired Conditions** | Reduce health care-acquired conditions (HACs) by convening a learning collaborative with 75% of nursing homes, to ensure that every resident receives high-quality care to optimize outcomes related to antipsychotic drug use, falls, and mobility. | Nursing Homes |
| **Chronic Disease Prevention** | | |
| **Cardiac Health** | Improve cardiac health and reduce health care disparities by partnering with providers and home health agencies to support the Million Hearts® initiative, promote health literacy, engage patients and families, increase electronic reporting of select measures, and (in physician offices) implement practice transformation. | Home Health Agencies, Physician Offices |
| **Diabetes Care** | Reduce disparities in diabetes care, by increasing the number of diabetes training sites and educators. Partnering with providers to promote health literacy, engage patients and families in diabetic self-management, and improve targeted clinical outcome measures by engaging by engaging patients in the *Everyone with Diabetes Counts* Project. | Diabetes Training Sites, Physician Offices |
| **Use of HIT** | Help physician offices and hospitals to adopt and optimize HIT, so they can improve preventive care by engaging patients and families. This includes participating in electronic QI initiatives, such as Meaningful Use and PQRS, using clinical decision supports, and reporting specific measures. | Hospitals, Physician Offices |
| **Other Quality Improvement** | | |
| **Value-Based Payment, Value-Based Purchasing and Quality Reporting** | Promote high-quality and more efficient health care for patients by assisting 100% of providers with PQRS reporting, value-based payment modifier, value-based purchasing, quality reporting (hospitals) and electronic reporting (physicians). | Acute and Critical Access Hospitals, Ambulatory Surgical Centers, In-Patient Psychiatric Facilities, and Physician Offices |

Healthcentric Advisors
Advancing Healthcare Quality | Empowering People

# Who we are ... What we do

## We don't provide health care

***We provide education and technical assistance to those who do so they can deliver health care that is higher quality, safer, more accessible, of greater value, and more person-centered***

- We are a nationally recognized, non-profit organization providing health care quality improvement and patient safety education, consulting, technical support, research, analytical and project management services.
- We work with federal and state government agencies, providers, foundations, national associations, educational institutions, research organizations, and other private community entities to improve health care quality, experience, and outcomes.
- Since 1995, we have served as the CMS Quality Improvement Organization (QIO) contractor for Rhode Island.
- While serving as a leading QIO contractor, we were selected by CMS to administer prominent Medicare engagements in subjects such as long-term care quality improvement and culture change, safe transitions and readmissions reduction and advance care planning/palliative care.
- In 2014, we were awarded a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contract for all six New England states.
- With a staff of nearly 60 dedicated and skilled associates and consultants, we have an annual operating budget in excess of $12 million.

# Our Core Competencies

## Long-Term Care Quality Improvement & Patient Safety

- Developed the HATCh™ organizational culture change model used in nursing homes and other health care organizations nationwide
- Authored the highly regarded nursing home "Staff Stability Tool Kit"
- Served as the National Medicare Nursing Home Quality Improvement Support Center (QIOSC)

## Health Care Performance & Outcomes Public Reporting, Research & Analytics

- Developed the first statewide public reporting program of hospital and health care performance outcomes in the nation
- Recipient of AHRQ research grant to develop a new public reporting program for home care agency performance

## Safe Transitions & Readmissions Reduction

- Administered CMS project to improve the safety of safe transitions and reduce readmissions
- Demonstrated safe transitions expertise with impressive outcomes and extensive peer-reviewed publications

## Physician & Ambulatory Care HIT Adoption & Optimization

- Assisted physician offices and community health centers in optimizing the use of HIT
- Developed unique PCMH approaches to system redesign and staff workflow for community health centers

## Specialized Project Management, Implementation & Research

- Developed and managed the nationally acclaimed Rhode Island ICU Patient Safety Collaborative
- Administered CMS special innovation projects on advance care planning and palliative care

NEW ENGLAND
QUALITY INNOVATION NETWORK
*Administered By Healthcentric Advisors in Partnership with Qualidigm*

## The New England QIN-QIO Approach

*At Healthcentric Advisors and Qualidigm, we believe that working with providers and stakeholders in a collaborative and partnership-like relationship creates the best foundation for sustainable improvement in health care quality, safety and value. We may have specialized knowledge, expertise and resources, but we do not have all the answers or solutions.*

*Our providers, stakeholders and partners know their organizations, patients and clients the best. Our role is to offer technical assistance, data analytics, tools and other resources so they can improve their performance. As a neutral convener, we facilitate the sharing and education of best practices among providers, stakeholders and communities that improve the delivery of health care for all New Englanders.*

*We will carry out our role by having an in-state, local presence within each of the New England states. Each state will have a full-time, dedicated QIN-QIO state director, QIO staff and a Stakeholder Advisory Council that will provide feedback on how the QIN-QIO contract is being administered in their respective state.*

## Contact Information


**H. John Keimig, MHA, FACHE**
*President & Chief Executive Officer*
T 877 - 904 - 0057 X3238
jkeimig@healthcentricadvisors.org

**Gail Patry, RN**
*Chief Program Officer*
T 877 - 904 - 0057 X3256
gpatry@healthcentricadvisors.org

**Melissa Miranda**
*Rhode Island Program Director*
T 877 - 904 - 0057 X3269
mmiranda@healthcentricadvisors.org

**Brenda Jenkins, RN, D.Ay., CDOE, CPEHR, PCMH CCE**
*Physician Office*
T 877 - 904 - 0057 X3246
bjenkins@healthcentricadvisors.org

**Kathy Calandra, RN, BSN, CPHQ**
*Transitions of Care*
T 877 - 904 - 0057 X3204
kcalandra@healthcentricadvisors.org

**Lauren Capizzo, MBA, CPEHR, PCCMH CCE**
*Physician Office & HIT*
T 877 - 904 - 0057 X3239
lcapizzo@healthcentricadvisors.org

**Maureen Marsella, RN, BS, CCM**
*Hospital*
T 877 - 904 - 0057 X3223
mmarsella@healthcentricadvisors.org

**Nelia Silva Odom, RN, BSN, MBA, MHA, WCC**
*Nursing Home*
T 877 - 904 - 0057 X3212
nodom@healthcentricadvisors.org

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

NEW ENGLAND QUALITY INNOVATION NETWORK
Administered By Healthcentric Advisors in Partnership with Qualidigm

# Make All Care Transitions – Safe Transitions

*Participate in this initiative to support and encourage a healthcare system where discharged patients and their caregivers are engaged in their health and are supported by healthcare professionals who have access to the right information, at the right time.*

As part of this effort, we will provide training and support, connect partners across the care continuum and share best practices across New England. Together, we will focus on enhancing transitions for patients, especially those who are most vulnerable for poor transitions, such as those who have multiple co-morbidities, are taking high-risk medications, have behavioral health conditions, dementia or other cognitive impairments, or are dually-eligible for Medicare and Medicaid.

Partnering across the continuum will help you improve transitions of care for your patients, reduce unplanned utilization and decrease the prevalence of adverse drug events. All providers are encouraged to participate.

## Approach

We will help you implement evidence-based interventions and best practices that target your root causes of poor transitions of care. In addition to providing individualized training and support for organizations and care settings, the cross-setting collaborative framework includes community coalition building, face-to-face and web-based educational events, sharing calls and web-based training tools and resources.

## Benefits of Participation

- Improve patient experience, care and outcomes
- Promote patient and family engagement in care
- Improve safety culture through enhanced teamwork and communication
- Build or enhance community partnerships
- Align with other important initiatives (e.g., Meaningful Use, NCQA certification standards and new payment models and programs)
- Earn distinction being engaged in a nationally recognized quality improvement effort

## Expectations

**Leadership commitment to**:

- Prioritize transitions of care
- Identify an internal cross-functional team
- Ensure organizational adherence to requirements

**Organizational requirements:**

- Perform root cause analysis
- Implement evidence-based interventions and best practice
- Collect and submit data
- Join a community coalition
- Participate in educational events

***To participate or learn more, contact:***

***Kathy Calandra - kcalandra@healthcentricadvisors.org*** *or 401 – 528 – 3204*

This material was prepared by New England Quality Innovation Network-Quality Improvement Organization (QIN-QIO), the Medicare Quality Improvement Organization for New England, 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. 11SOWRI-C3_092014_1013

# Safe Transitions Project
# Community Coalitions

| | |
|---|---|
| **Purpose** | To improve care transitions, with the dual goals of: (1) reducing hospital readmissions by 20% or more and (2) elevating care transitions for all Rhode Island patients, regardless of payer. |
| **Vision** | A healthcare system where discharged patients understand their conditions and medications, know who to contact with questions (and when), and are supported by healthcare professionals who have access to the right information, at the right time. |

There are currently four community coalitions in Rhode Island that are working to support the purpose and vision.

| Coalition | Meeting Schedule | Upcoming 2014 Meetings | Other Information |
|---|---|---|---|
| Greater Providence County Coalition | Alternating Wed/Thursday every other month 2:00-4:00 pm | December or January TBA | Local providers alternate as host of meetings |
| Warwick Coalition | Monthly, 3rd Thursday 3:00-4:00 pm | November 20, 2014 | Kent Hospital hosts meetings |
| Washington County | Every other month, 2nd Thursday 6:00-7:00 pm | December 11, 2014 | Apple Rehab Clipper 161 Post Road Westerly, RI 02891 |
| Newport Coalition | Every other month 4th Monday 10:00-11:30 am | November 24, 2014 | Newport Hospital hosts meeting |

2015 Schedules should be available end of December.

Healthcentric Advisors Contacts for More Information, to learn who the chairpersons are for each coalition and/or to join a coalition:

Kathy Calandra, RN, BSN, CPHQ 528-3204 k.calandra@healthcentricadvisors.org
Maureen Marsella, RN, BS, CCM, CPC, mmarsella@healthcentricadvisors.org
Nelia Odom, RN, BSN, MBA, MHA nodom@healthcentricadvisors.org

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

NEW ENGLAND QUALITY INNOVATION NETWORK
Administered By Healthcentric Advisors in Partnership with Qualidigm

# Medication Safety and Adverse Drug Event Prevention

*Given the US' aging population, increased medication exposure and polypharmacy, the potential for harm from an adverse drug event (ADE) is a critical patient safety and public health challenge.*

We invite you to join the New England Quality Innovation Network – Quality Improvement Organization (NE QIN-QIO) collaborative effort to improve medication safety and reduce adverse drug events.

An *adverse drug event (ADE)* is an injury resulting from medical intervention related to a drug. This may include patient harm directly caused by a drug through a medication error, adverse drug reaction, allergic reaction or an overdose.[1] National estimates suggest that ADEs contribute an additional $3.5 billion to US health care costs.[2] By collaborating in this Medicare Initiative, we will better understand the magnitude of the issue and improve drug safety practices, reduce medication errors and develop innovative care standards.

This work will expand existing efforts, such as the Hospital Engagement Network (HEN), into all care settings. Our priority will be to understand and address opportunities around high risk medications, such as anticoagulants, diabetic agents and/or opioids.

## Approach

We will collaborate with national and state professional organizations, providers and pharmacies across all care settings throughout New England. In addition, we will provide education, tools and resources that will support evidence-based strategies for medication therapy management, medication reconciliation post discharge, and the importance of high risk medication safety.

## Benefits of Participation

- Improve patient experience, care and outcomes
- Improve medication safety culture through enhanced teamwork and communication
- Build or enhance community partnerships around medication safety
- Collaborate with local, state, and national organizations about initiatives focused on improving medication safety and reducing the prevalence of ADEs

## Expectations

**Leadership commitment:**

- Prioritize medication safety
- Identify an internal team
- Ensure organizational adherence to requirements

**Organizational requirements**:

- Screen patients for adverse drug events
- Collect and submit data
- Implement evidence-based interventions and best practices
- Join a medication safety community coalition
- Participate in medication safety educational events

***To participate or learn more, contact:***

***Pam Quinn, RN, CPHQ*** *- pquinn@healthcentricadvisors.org or 401 – 528 – 3242*

***Melissa Pollock PharmD, CGP, RPh*** *- mpollock@healthcentricadvisors.org or 877 – 904 – 0057 X3202*

*1. Institute of Medicine Committee on Identifying and Preventing Medication Errors. Preventing Medication Errors: Quality Chasm Series. Washington, DC: The National Academies Press, 2006.*

*2. National Action Plan for Adverse Drug Event Prevention. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2014.*

This material was prepared by New England Quality Innovation Network-Quality Improvement Organization (QIN-QIO), the Medicare Quality Improvement Organization for New England, 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. 11SOWRI-C3_092014_1052

# Resources for Completing NCQA application

## 2014 Patient Centered Medical Home Recognition:

BizMed Solutions: Provides free PCMH management software and consultation for NCQA Recognition www.bizmedsolutions.com

NCQA website: www.ncqa.org

## 2011 Patient Centered Medical Home Recognition:

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

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