CARE TRANSFORMATION COLLABORATIVE
RHODE ISLAND

Mission

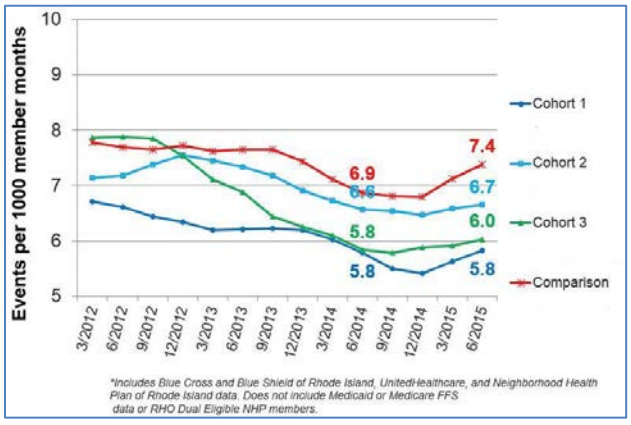
CTC-RI's mission is to lead the transformation of primary care in Rhode Island in the context of an integrated health care system; and to improve the quality of care, the patient experience of care, the affordability of care and the health of the populations we serve. CTC-RI brings together critical stakeholders to implement, evaluate and spread effective models to deliver, pay for and sustain high quality, comprehensive, accountable primary care.

History

Convened in 2008 by the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS), CTC-RI began with five pilot sites and has grown to 80 primary care practice sites, including internal medicine, family medicine, and pediatrics, through PCMH-Kids. Currently, approximately 350,000 Rhode Islanders receive their care from CTC-RI practices. CTC-RI anticipates continued expansion in support of state leadership goals to increase the number of PCMHs in the state.

In 2015 CTC-RI incorporated as a 501c3, establishing a Board of Directors as its governing body. CTC-RI is supported by funding from public and private payers in Rhode Island, along with grant funding from government and non-governmental sources.

The health plans also provide direct support for the practices through the Common Contract, an agreement negotiated between the health plans and the participating practices under the auspices of OHIC and EOHHS. The contract calls supplemental per member per month payments designed to drive practice transformation and quality improvement. These payments allow the practices to make structural enhancements to apply for national PCMH recognition, hire on-site care management/coordination to impact the patients with the highest needs, and enhance data capabilities to manage and improve population health.



Effect

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.

Utilization

Since 2012, CTC has tracked the number of inpatient hospitalizations, organized in 3 cohorts. Compared with non CTC practices, all 3 cohorts have greater reduction rates of patient hospital admissions, compared to the comparison group

Clinical Quality

Performance incentives on clinical quality measures related to diabetes, high blood pressure, tobacco cessation and hypertension in adults have proven to drive population health improvements in CTC-RI practices. Practices have met initiative-wide benchmarks set for each measure and/or made significant improvement over their baseline results. In 2016, pediatric practices will begin to report on measures related to obesity and developmental screening.

Patient Experience

According to 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, patients are realizing the immediate benefits of CTC-RI. 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.

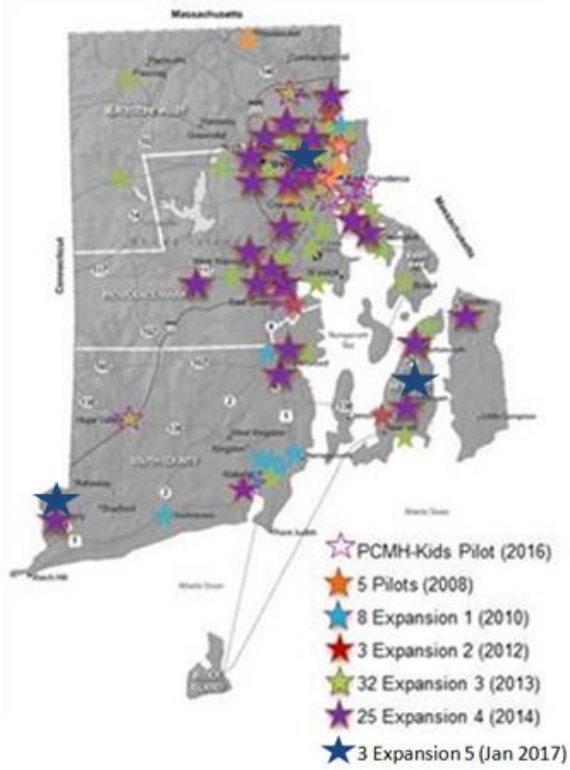
Enhanced Learning and Services

Integrated Behavioral Health

In 2016, 12 CTC-RI internal and family medicine practices began pilot-testing the on-site integration of behavioral health providers. This pilot project aims to test a clinical model of increased screening for behavioral health disorders, intervention at the primary care site for mild to moderate conditions, and increased collaboration with specialty behavioral health providers. This pilot also aims to establish a sustainable financial model for integrated behavioral health. Additionally, PCMH-Kids practices will participate in behavioral health learning, taking a deep dive into ADHD and the intersection of primary care, pharmacy, schools, and communities.

Community Health Teams

While the focus of this Initiative is the transformation of primary care, CTC-RI recognizes that 80% of our health is determined outside the walls of the primary care office. Therefore, CTC-RI has piloted two regional community health teams of multi-disciplinary staff that serve as an extension of the primary care team to address the social, behavioral, and environmental needs that impact a patient's physical health. Early evaluations show promising results and several state initiatives are expanding the community health team model to serve more Rhode Islanders.



Advanced Collaborative

As practices advance through the Common Contract, CTC-RI has convened a forum for practices to stay engaged in transformational learning in a multi-payer environment. The Advanced Collaborative explores topics such as implications for primary care in advanced payment contracts and quickly spreads the learning to all CTC-RI practices at quarterly provider champion meetings.

Looking forward

CTC-RI will continue to play a critical role in the transformation of practices by providing on-site practice coaching and support for national PCMH recognition, offering best practice learning and collaboration opportunities, focusing on the identification and management of patients of the highest need, promoting patient and family engagement and identifying and addressing the social determinants of health.

Participating Practices

- **Anchor Medical Associates** (**Lincoln**, Providence, and Warwick)
- Associates in Primary Care (Warwick)
- Barrington Family Medicine, Solmaz Behtash, North Kingstown Family Practice, Primary Care Barrington, Wickford Family Medicine
- Blackstone Valley Community Health Center (Central Falls and Pawtucket)
- John Chaffey, Coventry Primary Care Associates
- Charter Care Medical Associates
- **Coastal Medical** (**East Providence, Narragansett**, Pawtucket, Providence, and Wakefield)
- Comprehensive Community Action Program (Cranston, Coventry, and Warwick)
- **East Bay Community Action Program** (**East Providence** and Newport)
- **East Greenwich Pediatrics (East Greenwich)**
- Family Health and Sports Medicine (Cranston)
- **Hasbro Pediatric Primary Care (Providence)**
- **Hasbro Medicine-Pediatric Primary Care Clinic (Providence)**
- Internal Medicine Partners (North Providence)
- Kristine Cunniff, MD (Narragansett)
- Medical Associates of RI (Bristol and Barrington)
- Memorial Hospital Family Care Center (Pawtucket), Internal Medicine Center (Pawtucket), Family Medicine at Women's Care (Pawtucket)
- Nardone Medical Associates (Pawtucket)
- Brookside Medical Associates (Cumberland)
- Robert Carrellas, MD (Middletown)
- Ocean State Medical (Johnston)
- **Pediatric Associates (East Providence)**
- Providence Community Health Centers
- Richard Del Sesto (East Greenwich)
- SouthCoast Health System (Linden Tree Health Center, Tiverton Family Practice, Family Medical Middletown, Family Medicine Center)
- South County Hospital Family Medicine (East Greenwich)
- South County Hospital Primary Care and Internal Medicine/ Wakefield and Westerly
- South County Internal Medicine (Wakefield)
- South County Walk-In and Primary Care (Narragansett)
- Stuart Demirs, MD (Charlestown)
- Thundermist Health Center (Wakefield, West Warwick, and Woonsocket)
- Tri-Town Community Action Program (Johnston)
- University Family Medicine (East Greenwich)
- University Internal Medicine (Pawtucket)
- University Medicine (8 sites – East Providence, Newport, Portsmouth, Providence and Warwick)
- WellOne Primary Medical and Dental Care (Foster, North Kingston, and Pascoag)
- Women's Primary Care, Women's Medical Collaborative (Providence)
- **Wood River Health Services (Hope Valley)**
- Ocean State Primary Care Center of Westerly (Westerly)

Care Transformation Collaborative of Rhode Island (CTC – RI)

Management Team

Rhode Island Office:
Healthcentric Advisors
235 Promenade Street, Suite 500
Providence, RI 02903

Debra Hurwitz, MBA, BSN, RN
Executive Director
Healthcentric Advisors
235 Promenade Street, Suite 500
Providence, RI 02903
Ph: 401-528-3271
C: 978-502-9811 (c)
DHurwitz@healthcentricadvisors.org

Pano Yeracaris, MD, MPH
Chief Clinical Strategist
Healthcentric Advisors
235 Promenade Street, Suite 500
Providence, RI 02903
C: 617-953-5501
pyeracaris@gmail.com

Susanne Campbell, RN, MS
Senior Project Director
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Office: 508 856 3608
Cell Ph: 401 477-0011
Susanne.Campbell@umassmed.edu

Michele Brown, MPA
PCMH-Kids and IBH Project Coordinator
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 508-421-5919
Michele.Brown@umassmed.edu

Candice Brown, BS
Project Coordinator
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 401-528-3277
Candice.Brown@umassmed.edu

Jennifer Capewell, BA
Project Coordinator
UMass Medical School
333 South Street
Shrewsbury, MA 01545
Ph: 508-856-8219
Jennifer.Capewell@umassmed.edu

CTC-RI 2017 Committee Meeting Schedule

CTC Board of Directors (Committee Members only)

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

Meeting frequency: 4th Friday Monthly, 7:30-9AM
Location: HealthCentric Advisors, 235 Promenade St, # 500, Providence
President: Tom Bledsoe (Thomas_Bledsoe@brown.edu)
Co-Conveners: Kathleen Hittner (Kathleen.Hittner@ohic.ri.gov); and

(Committee members only)

Contracting Committee (open)

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

Meeting frequency: 2nd Tuesday Monthly, 7:30-9AM
Location: HealthCentric Advisors, 235 Promenade St, # 500, Providence

Facilitators: Deb Hurwitz (DHurwitz@healthcentricadvisors.org); and Pano Yeracaris (Pano.Yeracaris@umassmed.edu)
Co-Chairs: Mary Craig (mary_a_craig@uhc.com); and

(Recommend attendees: health plans, provider champions and organization leadership)

Practice Reporting Committee (open)

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.

Meeting frequency: 4th Tuesday Monthly, 8-9:30AM
(7:30-8:30AM New practices)
Pediatric practices additionally attend meeting in (Jan, Apr, Jul, Oct)
Location: RIQI, 50 Holden Street, 3rd floor, Providence
Co-Chairs: Patty Kelly-Flis (pkelly-flis@welloneri.org); and Andrea Galgay (agalgay@ripcpc.com)

(Recommend attendees: staff member that generate and analyze practice reports)

Integrated Behavioral Health Committee (open)

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

Meeting frequency: 2nd Thursday Monthly, 7:30-9AM
Pediatric Pilot Program (Mar, Jun, Sep, Dec)
Adult Pilot Program (Jan, Apr, July, Oct)
Location: RIQI, 50 Holden St, 3rd Floor, Providence
Co-Chairs: Matt Roman (MatthewRo@thundermisthealth.org) and Rena Sheehan (Rena.Sheehan@bcbsri.org)

(Recommend attendees: primary care and behavioral health providers, and nurse care managers)

Clinical Strategy (Committee Members Only)

Charge: Identify and test clinical and financial strategies to improve quality and reduce cost.

Meeting frequency: 3rd Friday Monthly, 7:30-9:00AM
Location: University Medicine Patient Center, 375 Wampanoag Trail, E. Providence (Large Conference Room)

Chair: Matthew Collins (Matthew.Collins@bcbsri.org)

(Committee members only)

Nurse Care Manager/Coordinator Best Practice Sharing Collaborative (open)

Charge: Best practice sharing amongst CTC NCMs and Care Coordinators

Meeting frequency: 3nd Tuesday Monthly, 8-9:30AM
PCMH-Kids required meeting with pediatric-topic (Feb, May, Aug, Nov)
No meeting in October for Annual Learning Collaborative.
Location: 301 Metro Centro Blvd,2nd Floor, Warwick
Facilitator: Deb Hurwitz (DHurwitz@healthcentricadvisors.org); and Susanne Campbell (Susanne.Campbell@umassmed.edu)

(Recommend attendees: nurse care managers; care coordinators from PCMH Kids practices)

Clinical Practice Champion Learning Session (open)

Charge: Quarterly meeting of CTC practice clinical champions and office leaders to focus on: best practice sharing, learning to strengthen team based care, and foster joy in work as critical components of advanced primary care/ PCMH transformation.

Meeting frequency: 2nd Friday Quarterly, 7:30-9AM
(Mar, Jun, Dec)
Location: Shriner's Imperial Room, 1 Rhodes Place, Cranston, RI
(Recommend attendees: clinical practice champions, practice leaders, and nurse care managers.)

Community Health Team Operation and Oversight Meeting (open)

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

Meeting frequency: 2nd Friday Monthly, 9:30-10:30AM
Location: HealthCentric Advisors, 235 Promenade St, # 500, Providence
Chair: TBN

(Recommend attendees: CTC CHT leader at participating site and health plan representative)

CTC-RI 2017 Committee Meeting Schedule

Practice Transformation Committee (open) Charge: Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice-based coaching and technical assistance; and support workforce development for PCMH. Meeting frequency: 3rd Thursday Monthly, 7:30-9AM ***PCMH-Kids required meeting with pediatric-topic (Jan, Apr, July)*** ***No meeting in October.*** Location: HealthCentric Advisors, 235 Promenade St, # 500, Providence Co-Chairs: Charlotte Crist (charlotte.crist@bcbsri.org); and Sarah Fessler (sfessler@ebcap.org) *(Recommend attendees: provider champions, practice managers and PCMH leaders)*	**Data and Evaluation Committee (open)** Charge: Lead performance improvement, measure selection and harmonization; develop goals and benchmarks, evaluation, research, and liaison with the APCD. Serve as liaison to other committees. Meeting frequency: 1st Tuesday Monthly, 7:30-9AM Location: HealthCentric Advisors, 235 Promenade St, # 500, Providence Co-Chairs: Peter Hollmann (Peter.Hollmann@bcbsri.com); and Jay Buechner (jbuechner@nhpri.org *(Recommend attendees: IT/HIT/data analysts)*
PCMH-Kids Stakeholder Committee (open) Charge: to guide and drive the activities within the PCMH-Kids Initiative. Meeting frequency: 1st Thursday Quarterly 7:30-8:30AM (Mar, Jun, Sep, Dec) Location: HealthCentric Advisors, 235 Promenade St, # 500, Providence Co-Chairs: Pat Flanagan (pflanagan@lifespan.org); and Elizabeth Lange (elizlange@cox.net) (Recommend attendees: health plans and PCMH-Kids Practice Champions or designees and key stakeholders.	**Finance Committee** Meeting Frequency : 5 times a year Dates and times: Set by Finance Committee Location : HealthCentric Advisors 235 Promenade St. #500 Providence Co-Chair : Al Charbonneau

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2017_Jan 5th Exp. Sites ***Start Up-Measurement Period 1***	**Brookside Medical Associates** 106 Nate Whipple Hwy, Suite 101 Cumberland, RI 02864	Jenna Boutilier, APRN jenna@brooksidemedical.com 401-658-1197 (office) 401-741-9265 (cell)	Kristina Mayer kris@brooksidemedical.com 401-480-1892 (cell)	n/a	n/a	ECW	**Jayne Daylor**	**Sue Dettling Ashley Kurpiewski**
2017_Jan 5th Exp. Sites ***Start Up-Measurement Period 1***	**Robert A. Carrellas, MD** 700 Aquidneck Ave, Building A Middletown, RI 02842	Robert Carrellas, MD bobcarrellas@yahoo.com	Susan Whitlock swswhitlock@gmail.com 401-847-9955	n/a	n/a	Caretracker	**Jayne Daylor**	**Sue Dettling Ashley Kurpiewski**
2017_Jan 5th Exp. Sites ***Start Up-Measurement Period 1***	**Ocean State Primary Care of Westerly** 77 Franklin Street #1 Westerly, RI 02891		Susan Ritacco sue@osuc.net 401-596-6464 ext. 1310	n/a	n/a	ECW	**Jayne Daylor**	**Sue Dettling Ashley Kurpiewski**
2013_Oct 3rd Exp. Sites **PY 2**	**Internal Medicine Partners** 1635 Mineral Spring Ave, Suite 200 North providence, RI 02904	Dr. Puneet Sud psud91@hotmail.com	Neerja Sud (neej69@hotmail.com *401.649.4600*	2014/L3	10/12/16 - 10/12/19	Athena health	**Jillian Sanchez**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*Affinity* **Primary Medical Group of Warwick** 215 Toll Gate Road, Suite 104 Warwick, RI 02914	Dr. Christopher Furey christophermfurey@gmail.com	*Office Manager: Crystal Carpenter* CLCarpenter@KentRI.org *401.736.4570*	2014/L3	4/4/16 - 4/14/19	Epic	**Chrystal Boza**	**Ashley Kurpiewski**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2015_Jan 4th Exp. Sites **Transition**	*Affinity* **Brookside Family Medicine** 766 Washington Street Coventry, RI 02816	Cameron Biller, PA Cbiller@kentri.org	*Office Manager: Carmella* *401.822.2772*	2014/L3	4/14/16 - 4/14/19	Epic	**Chrystal Boza**	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	*Affinity* **Arcand Family Medicine** 1079 Main Street West Warwick, RI 02893	Dr. Denise Arcand arcandfamilymedicine@carene.org	*Office Manager: Marcia Mallette* *401.828.7353*	2014/L3	4/16/19 - 4/14/19	Epic	**Chrystal Boza**	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**Charter Care Medical Associates** 1500 Pontiac Avenue Cranston, RI 02920	Dr. Matthew Salisbury matthew.salisbury@chartercare.org	*Office Manager: Christine Rebello* CRebello@Chartercare.org *401.943.2286*	2011/L3	4/7/15 - 4/7/18	Athena	**Jillian Sanchez**	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	*South County Hospital* **Primary Care Family and Internal Medicine** 70 Kenyon Avenue, Suite 211 Wakefield, RI 02879	Dr. Hana Hagos hhagos@schospital.com	Jayne Daylor jdaylor@schospital.com *401.471.6767*	2011/L3	4/29/15 - 4/29/18	Greenway / Prime Suite V17.0	**Chrystal Boza**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*South County Hospital* **Primary Care Westerly** 268 Post Road, Suite 203 Westerly, RI 02891	Dr. Robert Fox rfox@schospital.com	Jayne Daylor jdaylor@schospital.com *401.471.6767*	2014/L3	5/18/16 5/18/19	Greenway / Prime Suite V17.0	**Chrystal Boza**	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 1**	**Richard Del Sesto** 3461 South County Trail, Suite 203 East Greenwich, RI 02818	Dr. Richard Del Sesto rmdelsesto@verizon.net	Denise Leonard (dmleonard@cox.net *401.471.6510*	2011/L3	12/16/14 12/16/17	Epic	**Chrystal Boza**	**Ashley Kurpiewski**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2013_Oct 3rd Exp. Sites **PY 1**	**South County Walk-In and Primary Care** 360 Kingstown Road, Suite 104 Narragansett, RI 02882	Dr. Monica Gross mgross@southcountywalkin.com	Dr. Monica Gross mgross@southcountywalkin.com	2011/L3	3/9/15-3/9/18	Epic	**Chrystal Boza**	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 1**	**Women's Primary Care, Women's Medical Collaborative** 146 West River Street Providence, RI 02904	Dr. Iris Tong itong@lifespan.org	Jennifer Pickering JPickering@lifespan.org *401.793.7414*	2011/L3	Exp 3/16/18	Epic	**Heidi Perreault**	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**Coventry Primary Care Associates** 1620 Nooseneck Hill Road Coventry, RI 02816	DB Hebb MD dbhebb24@gmail.com	Kelly Manown, Office Manager kellymanown@gmail.com	2014/L3	11/8/16 - 11/8/19	Caretracker –v.10	**Chrystal Boza**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	**John Chaffey, D.O., Ltd.** 215 Tollgate Road, Suite 209 Warwick, RI 02818	Dr. John Chaffey drjchaffey@cox.net	Cynthia Forseca cfonseca0402@gmail.com *401.825.8200*	2011/L3	4/27/15 - 4/27/18	Meditouch – HealthFusion 2014	**Chrystal Boza**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*SouthCoast Health System* **Family Medical Middletown** 714 Aquidneck Avenue, Polo Center Middletown, RI 02842	Dr. Wendy Regan	Senior Project Director Jennifer Cheney-DiPasqua CheneyJ@southcoast.org *508.973.2777 / 508.525.0774*	N/A		Epic	**Jillian Sanchez**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*SouthCoast Health System* **Linden Tree Family Health Center** 2444 East Main Road Portsmouth, RI 02871	Dr. Julia DeLeo morgerar@southcoast.org	Senior Project Director Jennifer Cheney-DiPasqua CheneyJ@southcoast.org *508.973.2777 / 508.525.0774*	N/A		Epic	**Jillian Sanchez**	**Sue Dettling**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2015_Jan 4th Exp. Sites **Transition**	*SouthCoast Health System* **Family MediCenter** 672 Aquidneck Avenue, Polo Center Middletown, RI 02842	Luke Logan loganl@southcoast.org	Senior Project Director Jennifer Cheney-DiPasqua CheneyJ@southcoast.org *508.973.2777 / 508.525.0774*	N/A		Epic	**Jillian Sanchez**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*SouthCoast Health System* **Tiverton Family Practice** 1334 Main Road Tiverton, RI 02878	Scott Keigwin, DO	Senior Project Director Jennifer Cheney-DiPasqua CheneyJ@southcoast.org *508.973.2777 / 508.525.0774*	N/A		Epic	**Jillian Sanchez**	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 2**	**Comprehensive Community Action Program - Coventry** 191 MacArthur Boulevard Coventry, RI 02816	Dr. Elena Kwetkowski ekwetkowski@comcap.org	Lois Teitz lteitz@comcap.org *401.732.9090 ext 3503*	2014/L2	10/24/16–10/24/19	NextGen	**Suzanne Herzberg**	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 2**	**Comprehensive Community Action Program – Cranston** 311 Doric Avenue Cranston, RI 02910	Dr. Elena Kwetkowski ekwetkowski@comcap.org	Lois Teitz lteitz@comcap.org *401.732.9090 ext 3503*	2014/L3	10/24/16–10/24/19	NextGen	**Suzanne Herzberg**	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 2**	**Comprehensive Community Action Program – Warwick** 226 Buttonwoods Avenue Warwick, RI 02886	Dr. Elena Kwetkowski ekwetkowski@comcap.org	Lois Teitz lteitz@comcap.org *401.732.9090 ext 3503*	2014/L3	10/24/16 - 10/24/19	NextGen	**Suzanne Herzberg**	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 1**	**Family Care Internal Medicine Center** 111 Brewster Street Pawtucket, RI 02860	Dr. Dino Messina dmessina@carene.org	Paula Goncalves PGoncalves@carene.org	2011/L3	7/9/14 - 9/9/17	Epic	**Scott Hewitt**	**Sue Dettling**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2013_Oct 3rd Exp. Sites **PY 2**	**Thundermist Health Center – West Warwick** 186 Providence St West Warwick, RI 02893	Dr. Michael Poshkus michaelpo@thundermisthealth.org	Victoria Lamourtvy VictoriaL@thundermisthealth.org	2014/L3	Exp: 11/3/19	ECW	**Caitlin Towey** Suzanne Herzberg	**Ashley Kurpiewski**
2013_Oct 3rd Exp. Sites **PY 2**	**WoodRiver Health Services** 823 Main Street Hope Valley, RI 02832	Dr. Christopher Campagnari ccampagnari@wrhsri.org	lgreene@wrhsri.org *401.387.9620*	2014/L3	11/7/16 - 10/23/17	NextGen	**Scott Hewitt**	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	*Ideal Family Medicine* **North Kingstown Family Practice** 320 Phillips Street N. Kingstown, RI 02852	Dr. Lynn Ho nkfpdoc@gmail.com	Dr. Lynn Ho nkfpdoc@gmail.com *NCM: Pat Trudeau nkfprn@gmail.com*	2011/L3	9/24/14 9/24/17	Amazing Charts V7.0.12	**Suzanne Herzberg**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*Ideal Family Medicine* **Wickford Family Medicine** 320 Phillips Street N. Kingstown, RI 02852	Dr. John Machata *drmachata@gmail.com*	Dr. John Machata *drmachata@gmail.com*	2011/L3	2/20/15 - 2/20/18	Amazing Charts V7.0.12	**Suzanne Herzberg**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*Ideal Family Medicine* **Solmaz Behtash, DO** 126 Prospect Street #101 Pawtucket, RI 02860	Dr. Solmaz Behtash solmazbehtash@gmail.com	Dr. Solmaz Behtash solmazbehtash@gmail.com	2011/L3	4/10/15 - 4/10/18	ECW V10	**Suzanne Herzberg** Caitlin Towey	**Sue Dettling**
2013_Oct 3rd Exp. Sites **PY 1**	**Affinity : Family Medicine at Women's Care** 21 Division Street, Pawtucket, RI 02860	Dr. Emily Harrison eharrison@women-care.com	Vanessa Cumplido vcumplido@carene.org *401.727.4800*	2011/L2	6/9/14 6/9/17	Epic	**Scott Hewitt**	**Ashley Kurpiewski**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2015_Jan 4th Exp. Sites **Transition**	*Ideal Family Medicine* **Barrington Family Medicine** 60 Bay Spring, Unit 6B Barrington, RI 02806	Dr. Andrea Arena andrea_arena@brown.edu *co lead lisadenny@aol.com*	Dr. Andrea Arena andrea_arena@brown.edu *co lead* Lisa_Denny@brown.edu	2011/L3	4/7/15 - 4/7/18	ECW V10	**Suzanne Herzberg**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	*Ideal Family Medicine* **Primary Care of Barrington** 60 Bay Spring, Unit A1 Barrington, RI 02806	Dr. Gregory Sadovnikoff drgreg@drgregri.com	Dr. Gregory Sadovnikoff drgreg@drgregri.com	2014/L3	5/16/16 - 5/16/19	Epic	**Suzanne Herzberg**	**Sue Dettling**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Capitol Hill** 40 Candace Street Providence, RI 02908	Vinod Tomas MD VThomas@providencechc.org	**Dr. Andrew Saal** asaal@providencechc.org **Frederick Craig** fcraig@providencechc.org Site Director: Ralph Chartier rchartier@providencechc.org	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Central** 239 Cranston Street Providence, RI 02907	Sharon Philbin MD sphilbin@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** Site Director: Jean LaMarre JLamarre@providencechc.org	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Chad Brown** 285 A Chad Brown Street Providence, RI 02908	John Paul Abroguena MD jabroguena@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** Site Director: Jean LaMarre JLamarre@providencechc.org	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Chafee** 1 Warren Way Providence, RI 02905	Mario Martinez MD mmartinez@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** *Site Director: Michael Spoerri mspoerri@providencechc.org*	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Crossroads** 160 Broad Street Providence, RI 02903	Ivan Wolfson MD Iwolfson@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** *Site Director: Deborah Burbank dlburbank@providencechc.org*	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – North Main** 530 North Main Street Providence, RI 02904	Judith Nudelman MD jnudelman@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** *Site Director: Deborah Burbank dlburbank@providencechc.org*	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Olneyville** 100 Curtis Street Providence, RI 02909	Karen Ng MD Kng@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** *Site Director: Tammy Hession THession@providencechc.org*	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**
2015_Jan 4th Exp. Sites **Transition**	**PCHC – Prairie Avenue** 355 Prairie Avenue Providence, RI 02905	Natasha Bica MD NBica@providencechc.org	**Dr. Andrew Saal** **Frederick Craig** Site Director: Christopher Camillo ccamillo@providencechc.org	2011/L3	6/20/14 - 6/20/17	PCHC – Intergy V 9.0 TPC - Essentia	**Suzanne Herzberg** Scott Hewitt Caitlin Towey	**Ashley Kurpiewski**

CTC Start Date	Practice	Physician Champion (Name, Email and/or phone number)	Primary Contact (Name, Email and/or phone number)	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2013_Oct 3rd Exp. Sites **PY 1**	**Nardone Medical Associates** 333 School Street, Suite 112 Pawtucket, RI 02860	Dr. Ahmad Al-Raqqad kasebmed@yahoo.com	Nancy Latendresse nancylatendressee@yahoo.com *401.726.9790*	2011/L3	4/23/15 - 4/23/18	MedNet Solutions	**Suzanne Herzberg**	**Sue Dettling**

PCMH-Kids

CTC Start Date	PCMH-Kids Practice	Physician Champion	Primary Contact	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2016 Jan **Year 1: Start-Up**	**Anchor Pediatrics** 1 Commerce Street Lincoln RI, 02865	Michael Cummings mcummings1@lifespan.org	Christine Carr ccarr1@lifespan.org	2011/L3	11/2/14 – 11/2/17	Athena	**Lauren Capizzo**	**N/A**
2016 Jan **Year 1: Start-Up**	**Coastal Narragansett Bay Pediatrics** 65 Village Square Drive Suite 101 Wakefield, RI 02879	Mary Murray mmurray@coastalmedical.com	Andi Srabian asrabian@coastalmedical.com	2014/L3	6/23/16 – 6/23/19	eCW	**Putney Pyles**	**N/A**
2016 Jan **Year 1: Start-Up**	**Coastal Waterman Pediatrics** 900 Warren Avenue Suite 200 East Providence, RI 02914	Elizabeth Lange elizlange@cox.net	Elizabeth Lange elizlange@cox.net	2014/L3	6/23/16 – 6/23/19	eClinical Works	**Putney Pyles**	**N/A**
2016 Jan **Year 1: Start-Up**	**East Bay Community Action Program** 100 Bullocks Point Avenue East Providence, RI 02915	Sarah Fessler sfessler@ebcap.org	Betsy Dennigan bdennigan@ebcap.org	2014/L3	9/1/16 - 8/7/17	NextGen	**Putney Pyles**	**N/A**
2016 Jan **Year 1: Start-Up**	**East Greenwich Pediatrics** 1377 South County Trail Suite 2B East Greenwich, RI 02818	Peter Pogacar PRPogacar@gmail.com	Diane DiCola ddicola56@aol.com	2011/L3	12/11/14 - 12/11/17	Athena	**Lauren Capizzo**	**N/A**

Practice Supports: Practice Facilitators and Relationship Managers

CTC Start Date	PCMH-Kids Practice	Physician Champion	Primary Contact	NCQA	NCQA Range	EHR	Practice Facilitator	REC RM
2016 Jan **Year 1: Start-Up**	**Hasbro Medicine-Pediatric Primary Care Center** 245 Chapman Street Suite 100 Providence, RI 02905	Suzanne McLaughlin smclaughlin1@lifespan.org	Sheri Sharp ssharp1@lifespan.org	N/A – submission planned by 12/31/16		EPIC	**Lauren Capizzo**	**N/A**
2016 Jan **Year 1: Start-Up**	**Hasbro Pediatric Primary Care** 593 Eddy Street, Providence, RI 02903	Carol Lewis Clewis2@lifespan.org	Judy DaSilva jadasilva@lifespan.org	N/A - submission planned by 12/31/16		EPIC	**Lauren Capizzo**	**N/A**
2016 Jan **Year 1: Start-Up**	**Pediatric Associates, Inc.** 450 Veterans Memorial Parkway, Building 10 East Providence, RI 02914	Kimberley Townsend kimberley_townsend@yahoo.com	Kimberley Townsend kimberley_townsend@yahoo.com	N/A - submission planned by 12/31/16		eCW	**Putney Pyles**	**N/A**
2016 Jan **Year 1: Start-Up**	**Wood River Health Services, Inc.** 823 Main Street Hope Valley, RI 02832	Lisa Menard-Manlove lmenard-manlove@wrhsri.org	Lynda Greene lgreene@wrhsri.org	2014/L3	11/7/16 - 10/23/17	NextGen	**Scott Hewitt**	**N/A**

Practice Facilitators

- CTC-RI Adult
  - Chrystal Boza, Chrystal.Boza@bcbsri.org, 401.459.1511, cell 401.865.0786
  - Heidi Perreault, Heidi.Perreault@bcbsri.org, 401.459.5006
  - Jillian D. Sanchez, Jillian.Sanchez@bcbsri.org, 401.459.2941
  - Scott Hewitt, Scott_Hewitt@brown.edu, 401.465.1011
  - Suzanne Herzberg, Suzanne_Herzberg@brown.edu, 401.263.6023
  - Caitlin Towey, caitlin_towey@brown.edu, 908.451.6517
- PCMH Kids
  - Lauren Capizzo, lcapizzo@healthcentricadvisors.org, 401.528.3239
  - Putney Pyles, ppyles@healthcentricadvisors.org, 401.528.3216

- CTC-RI/CPC Plus
    - Jayne Daylor, sdaylor@cox.net 401.529.7678

REC RMs

- Sue Dettling, sdettling@riqi.org, 401.276.9141 x 236
- Ashley Kurpiewski, akurpiewski@riqi.org, 401.276.9141 x 270

PCHC Primary Contacts for All Sites

- Dr. Andrew Saal, asaal@providencechc.org
- Frederick Craig, fcraig@providencechc.org

This Rhode Island Care Transformation Collaborative Initiative Agreement (the "Agreement") is entered into this First day of January 2017, by and between HEALTHPLAN, (hereinafter "Plan"), and PROVIDER NAME. (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 Care Transformation Collaborative ("CTC-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, CTC-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:

APPLICABILITY

The provisions of this Appendix apply for services to be paid under this Agreement, rendered to Program Customers covered by commercial, Medicare Advantage and [RIte Care Subscribers Benefit Plans].

SECTION 1
Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the underlying network participation Agreement between the parties (hereinafter "Agreement") (or the meanings assigned in the Agreement to equivalent terms, such as "Benefit Contract" instead of "Benefit Plan", "Member" instead of "Customer"(patients), "Payor" instead of "Payer" and "Health Services" instead of "Covered Services"). If any definition in this Appendix conflicts with another definition in the Agreement (including a definition of an equivalent term), the definition in this Appendix controls, with regard to Benefit Plans subject to this Appendix. Further, the definitions in this Appendix are independent of any other definition in any part of the Agreement outside this Appendix, of the same or similar terms. Any definitions of those terms in any part of the Agreement outside this Appendix therefore have no bearing on the terms defined in this Appendix.

Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

Care Delivery Requirements: Activities or measure results that Program Provider must complete or achieve for a given Measurement Period. HEALTHPLAN's Care Delivery Requirements are described in the Care Delivery Requirements set forth care delivery requirements as described online at www.ctc-ri.org**.**

Care Management Payment: The payment made to Program Provider for meeting the Care Delivery Requirements.

Comprehensive Primary Care Services: Health care services, including but not limited to the following functions:

i) Care Management,
ii) Planned Care: Population Health/Quality Reporting
iii) Access and Continuity
iv) Patient /family/caregiver Engagement, and
v) Comprehensiveness and Coordination
vi) Practice Transformation

Care Transformation Collaborative (CTC): The State of Rhode Island's multi-payer patient centered medical home initiative.

Customer/Patient: A person eligible and enrolled to receive coverage from a Payer for Covered Services.

Performance Payment: The per member per month (pmpm) annual payment to Program Provider made to Program Provider retrospectively for performance of the CTC Milestones and as further described in this Appendix.

Measurement Period or MP: Each 12-month period during which the Program is in effect. Each Measurement Period will begin on January 1st and end on December 31st of the applicable year.

Member Month: A month in which a Customer/Patient is a Program Customer/Patient under this Program.

Payment Quarter: A 3-month period with the 1st quarter starting on the 1st day of the Measurement Period. For example, the 1st Payment Quarter of an applicable Measurement Period runs from January 1st through March 31st. The 2nd Payment Quarter will run from April 1st through June 30th. The 3rd Payment Quarter will run from July 1st through September 30th. The last Payment Quarter of an applicable Measurement Period will run from October 1st through December 31st.

Payment Summary Report: A report that identifies the number of Member Months for Program Customers and the Program Provider's Care Management Payment for that applicable Payment Quarter.

PCP or Primary Care Professionals Roster: The list of Program Providers HEALTHPLAN NAME has identified as PCPs or Primary Care Professionals as defined below and attached as **Exhibit 3.**

Performance Measure: A metric upon which Program Provider's performance will be measured.

Performance Score: The Program Provider's actual score for the defined Measurement Period that is based on their aggregate practice performance for any Performance Measure as Program Provider reports it to or is determined by CTC.

Primary Care Professionals or PCP a/ka/ Program Providers: A physician, nurse practitioner, or physician assistant who is a Program Provider and who meets one of the following criteria:

i) All Program Providers must be under a network participation agreement with the Plan and be considered "in-network"; and credentialed by the Plan with a specialty in Geriatrics,

Internal Medicine, or Family Practice (or any midlevel practitioners employed by the Geriatrics, Internal Medicine or Family Practice providing primary care services) and listed in Exhibit 3.

HEALTHPLAN NAME reserves the right to make, but is not obligated to make, changes to the PCP Roster based on any changes HEALTHPLAN confirms are accurate (but the CTC list and/or HEALTHPLAN NAME's system is inaccurate) with Program Provider even if they are not consistent with PCPs identified under (i) above.

With respect to subsection (i) above, a Program Provider Professional who is added to the Program Provider under the Agreement will be considered a Program Provider Professional for a given Payment Quarter only if Program Provider submitted the Program Provider Professional's information to CTC and HEALTHPLAN NAME for inclusion in the Program Provider at least 60 days prior to the 1st day of the Payment Quarter if the acquisition or addition of new Program Providers will not increase the existing physician complement by more than 5% or Program Customers by 25%. To the extent the addition of Program Provider Professionals will result in an increase to the existing physician complement by more than 5% or Program Customers by 25%, the new Program Provider Professionals will become Program Provider Professionals only as mutually agreed in writing by HEALTHPLAN NAME, CTC and Program Provider.

A new Program Provider Professional's information will not be considered submitted until that Program Provider Professional has successfully completed the credentialing process. PCP does not include any Program Provider Professional who is no longer listed in HEALTHPLAN NAME's system as part of Program Provider.

Program Customer/Patient: A Customer/Patient who has been attributed to a Program Provider PCP in accordance with the Attribution Method **Exhibit 1** of this Appendix.

Program Provider Professionals: The medical group, physician, healthcare professional, federally qualified health center (FQHC) or any other provider that is a party to this Appendix.

Program Provider Participating Location(s): The list of Program Provider location(s) participating in this Program, as described in the Program Provider Participating Locations **Exhibit 3** of this Appendix.

HEALTHPLAN NAME**:** The affiliates or business units of HEALTHPLAN NAME Insurance Company that underwrite or manage those Benefit Plans that are subject to this Appendix.

SECTION 2
Care Management Payment

2.1 Program Provider Eligibility. In order to be eligible for consideration to receive a Care Management Payment under this Appendix, Program Provider must meet the following requirements:

i) Must employ a nurse care manager (or care coordinator for pediatric practice) dedicated to care coordination to support the implementation and maintenance of the Care Delivery Requirements as described online www.ctc-ri.org.

ii) Meet the Care Delivery Requirements in the Care Delivery Requirements set forth online at www.ctc-ri.org in addition to CTC's Program care delivery requirements. HEALTHPLAN may utilize CTC to assist with auditing a practice or HEALTH PLAN may audit Program Provider to determine Program Provider's achievement of the Care Delivery Requirements.

iii) Upon request, Program Provider will provide HEALTHPLAN NAME with the same information related to the Care Delivery Requirements as Program Provider disclosed to CTC.

iv) Designate a contact person who will be responsible for receiving and distributing the reports provided by HEALTHPLAN NAME under this Appendix.

v) A Program Provider may not exceed one (1) year per each level of practice transformation. Movement to the next level is determined by CTC at the end of each one-year period. Program Provider must contact CTC prior to Care Management requirement delivery schedule as described online at www.ctc-ri.org if Program Provider is unable to meet said requirements. Program Provider must request an extension no less than 30 days prior to the requirement due date as described online at www.ctc-ri.org and provide a corrective action plan as described in the CTC policy to request an extension.. Such request is subject to CTC's prior approval and monitoring for successful correction. If Program Provider fails to advance to next level of transformation within the 12-month period, continued participation in the CTC project will be reviewed and determined by voting members of the CTC board of directors.

vi) If applicable, eligible RIte Care Subscriber payments will only be made to Program Provider with two hundred (200) or more Eligible Subscribers.

2.2 Measurement Period and Care Management Payment Rate. The applicable Measurement Period and Care Management Payment Rates for this Appendix are described in the Measurement Period Table:

Measurement Period Table:

Measurement Period	Measurement Period	Care Management Base Payment Rate
MP 1	1-1-2017 through 12-31-2017	$ 3.00
MP 2	1-1-2018 through 12-31-2018	$ 3.00
MP 3	1-1-2019 through 12-31-2019	$ 3.00

HEALTHPLAN NAME will provide to Program Provider the Care Management Payments no later than the last day of the 1st month of an applicable Payment Quarter.

2.3 Care Management Payment Calculation. The Care Management Payment for each Payment Quarter is calculated as follows:

Care Management Payment =
(Care Management Payment Rate X # Program Customers) X # of Program Months

For purposes of this Section, Program Months means the number of whole months in the applicable Payment Quarter during which this Appendix is in effect.

2.4 Adjustment to Care Management Payment.

i) If HEALTHPLAN determines a Care Management Payment for a prior Payment Quarter was inaccurate, then HEALTHPLAN reserves the right to determine the overpayment or underpayment resulting from the inaccuracy. Any overpayment or underpayment will be offset or paid in a future Care Management Payment. If HEALTHPLAN makes the determination after the final Care Management Payment under this Appendix, then HEALTHPLAN will pay any underpayment within 60 days of its determination or Program

Provider will pay to HEALTHPLAN the overpayment within 60 days after HEALTHPLAN notifies Program Provider of the overpayment.

ii) If at any time the Program Provider reasonably expects to be without a staff person for Care Coordination for a period of thirty (30) days or more, the Practice will notify the CTC Board of Directors and the Plan. If more than thirty (30) days passes and the Program Provider has not been able to replace the staff person for Care Coordination, the parties will attempt to reach a mutually agreeable alternative arrangement to perform the roles and responsibilities of Care Coordination as outlined in Attachment J. However, if a mutually agreeable alternative is not reached, the Plan will have the unilateral right to reduce or suspend the PMPM by an amount of no more than $2.50 which is the PMPM rate for the Care Manger or terminate this Agreement with the Program Provider.

2.6 No Reconsideration. Except as provided in Section 3.1(i) of this Appendix with respect to requests for review of the PCP Roster, no reconsideration will be available for HEALTHPLAN determination of the Care Management Payment, including but not limited to, attribution methodology or determination of Program Customers.

SECTION 3
Reports

3.1 Program Provider Reports. HEALTHPLAN will provide the following reports:

i) **High Risk Patient Lists**. HEALTHPLAN will provide quarterly High Risk Patient Lists as agreed upon by CTC and the HEALTHPLAN

ii) **Payment Summary Report.** HEALTHPLAN will provide the Payment Summary Report to Program Provider no later than the last day of 1st month of each Payment. This report includes a list of Program Provider's Program Customers/Patients for whom HEALTHPLAN paid a Care Management Payment to Program Provider, the total number of Program Customers for each Program Provider PCP and the Care Management Payments paid for each Program Provider PCP's Program Customers.

iii) **Emergency Room and Inpatient Activity Reports.** HEALTHPLAN or its delegate will provide to Program Provider a report of Program Customers' utilization each Payment Quarter.

iv) **Additional Reports.** HEALTHPLAN may provide other reports as it determines in its sole discretion and/or by the CTC board of directors.

3.2 Program Provider Reports. Provider will provide the following reports to CTC as described online at www.ctc-ri.org:

i) Quality Metrics
ii) Process and or Outcome Measures for the following:
iii) After Hours Care Policy and Procedure
iv) Transition of Care Policy and Procedure
v) Medication Reconciliation Report for high risk patients who are hospitalized
vi) Medication Reconciliation Report for high risk patients who are seen in emergency department
vii) Compacts established with 2 specialty group (including one compact with a behavioral health provider)
viii) Provider panel and 3rd next available appointment
ix) Provider schedule demonstrating improved access
x) Quality improvement report (quality, customer experience, utlization)
xi) Patient Portal Functionality Screenshot
xii) Nurse Care Manager/Care Coordinator Engagement/FTE Report

SECTION 4
Performance Incentive

HEALTHPLAN will determine the Performance Incentive Bonus in accordance with the methodology set forth online at www.ctc-ri.org and payment according to the Performance Incentive Exhibit 2 to this Appendix.

4.1 Performance Incentive Bonus Due Date. HEALTHPLAN will pay the Performance Incentive Bonus, if applicable, within 60 days after Healthplan receipt of results from CTC. 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 online at www.ctc-ri.orgrelating to updating its Practitioner listing.

SECTION 5
Program Provider Responsibilities

5.1 Collaboration with HEALTHPLAN and CTC**.** Program Provider will meet with HEALTHPLAN and/or CTC, upon HEALTHPLAN's and/or CTC's request, up to once a quarter. Program Provider agrees to cooperate with HEALTHPLAN to further the purposes of this Program. Discussions will include, but are not limited to:

i) Program Provider's progress on the Care Delivery Requirements;

ii) Reporting and Program Provider's opportunities to improve Program Customer's quality, total cost of care and health care;
iii) Care management plans and care management services for Program Customers.

5.2 Program Provider Data. Program Provider agrees to provide data including, but not limited to, quality and utilization data for Program Customers, as specified by CTC in conjunction with CTC and other health plans participating in CTC's Program that is determined to be necessary for the effectuation of the Program.

5.3 PCP or Primary Care Provider Roster. Program Provider agrees to provide CTC Quarterly Provider Roster due 45 days prior to the beginning of the Quarter. CTC will provide provider panel information to the HEALTH PLAN. Program Provider is responsible for adhering to HEALTH PLAN policy on notification of change of provider.

5.4 Audits. Program Provider will cooperate with HEALTHPLANand/or CTC's audits with respect to the Program, including, but not limited to, the achievement of the Care Delivery Requirements in the Care Delivery Requirements as described online at www.ctc-ri.org.

SECTION 6
Term and Termination

6.1 Termination by HEALTHPLAN. HEALTHPLAN may terminate this Appendix, without terminating the Agreement:

i) With at least 30 days prior written notice to Program Provider based on HEALTHPLAN's determination that the Care Delivery Requirements are not met by Program Provider (inclusive of approved Request for Extension and plan of correction); or
ii) Effective upon CTC's termination of Program Provider's participation in the CTC Program; or
iii) With at least 30 days prior written notice to Program Provider if HEALTHPLAN terminates its participation in Program; or
iv) Upon the Effective Date of Program Provider's participation in a different incentive program with HEALTHPLAN. With at least 30 days prior written notice of the effective date and in accordance with the Agreement, Program Provider will notify HEALTHPLAN if they join a care delivery system that participates in an incentive program with HEALTHPLAN; or
v) With at least 30 days prior written notice to Program Provider, if Rhode Island Care Transformation Collaborative (CTC) determines that a Program Provider did not meet the Care Delivery Requirements.

Any termination of this Appendix pursuant to the reasons stated above will be effective on the last day of the Payment Quarter that ends at least 30 days after HEALTHPLAN provides notice to Program Provider.

6.2 Termination by Either Party. Either party may terminate this Appendix, without terminating the Agreement, as follows:

i) upon 60 days written notice to the other party of a material breach of this Appendix by the party receiving the notice, except that termination described in this clause will not take effect if the material breach is cured during the 60 days notice period. Termination under this Section will not be deferred during any dispute resolution process as described in the Agreement.
ii) upon 90 days written notice if CTC terminates its participation in the CTC Program, so long

as the notice is provided within 60 days of the effective date of CTC's' termination.

6.3 Automatic Termination. This Appendix will terminate automatically either on the effective date of termination of the underlying network participation Agreement between the parties for any reason or on the last day of Measurement Period 3.

6.4 Effect of Termination on Care Management Payments.

i) No Care Management Payments will be due or made to Program Provider after the effective date of termination. Except as otherwise provided in this Appendix, Program Provider will be entitled to Care Management Payments accrued prior to the effective date of termination.

ii) In the event that this Appendix or the Agreement terminates due to a material breach by Program Provider, then Program Provider will not be entitled to a Care Management Payment for the Payment Quarter in which the termination becomes effective.

iii) In the event that this Appendix terminates on any day other than the last day of a Payment Quarter due to any reason other than material breach by Program Provider, then Program Provider will be entitled to a Care Management Payment for the Payment Quarter in which the termination becomes effective.

6.5 Effect of Termination on Performance Payments. No Performance Payments will be due or made to Program Provider if Program Provider terminates this Program for any reason during the applicable Measurement Period. However, that Participating Program Provider's data and Care Management Payments through the effective date of termination will be included in calculations of Performance Payments and may impact any Performance Payment made to the remaining Participating Program Providers.

ATTRIBUTION METHOD EXHIBIT 1

Payment Appendix – Care Transformation Collaborative of RI Program

The following definitions will apply:

HEALTHPLAN attribution logic

Performance Incentive Exhibit 2
Payment Appendix – Care Transformation Collaborative of RI Program

The Program Provider agrees to fulfill CTC's Performance Measures and Performance Score requirements, as described online at CTC's Program care delivery requirements, as described online at www.ctc-ri.org.

Program Provider must achieve the Performance Measures and Performance Scores in order to earn a Performance Incentive Bonus PMPM for each Performance Measure as outlined in the Performance Incentive Table below. HEALTHPLAN will use the Performance Measure results provided by either CTC to determine Program Provider's Performance Score.

Performance Incentive Table

Measurement Period	Performance Measure	Performance Incentive Bonus PMPM
MP 2	Quality reporting /transformation data	$0.50
	Quality measure achievement (3 out of 5)	$0.25
	Customer experience target	$0.25
MP 3	Clinical Quality Measures	Up to $[0.75]
	Patient Experience Metrics	$[0.50]
	Utilization – Inpatient Admissions metric	$[1.25]
	Utilization – Emergency Department	$[0.75]

PROGRAM PROVIDER PARTICIPATING LOCATIONS AND PROGRAM PROVIDER'S PRIMARY CARE PROFESSIONALS AND PCP EXHIBIT 3
Payment Appendix – Care Transformation Collaborative of RI Program

If Program Provider adds any PCP during the term of this Appendix, then those PCPs will be added to this Appendix. If Program Provider adds a PCP not listed in the table below, Program Provider will provide CTC with a notice quarterly by the end of the 2nd month of the previous Quarter in order for PLAN to pay the CTC Payment for the next Quarter:

PRACTICE LOCATIONS (complete one for each service location)

Practice Location Name	**Provider Last Name**	**Provider First Name**	**Provider Type PCP, NP, AP**	**Provider NPI**
Street Address				
City				
State and Zip Code				
Phone Number				

Practice Location Name	**Provider Last Name**	**Provider First Name**	**Provider Type PCP, NP, AP**	**Provider NPI**
Street Address				
City				
State and Zip Code				
Phone Number				

Practice Location Name	Provider Last Name	Provider First Name	Provider Type PCP, NP, AP	Provider NPI
Street Address				
City				
State and Zip Code				
Phone Number				

PCMH CTC Adult Service Delivery Requirements July 2017 Expansion

Practices agree to fulfill CTC's Program care delivery requirements as described on line (www.ctc.ri.org). All reports and measures identified in the Care Delivery Requirements use methodology as defined and approved by the CTC Data and Evaluation Committee. Requirements may be subject to change based on changes to requirements (i.e. OHIC, NCQA).

Measurement Period	Care Delivery Requirement	Date Due (if applicable) Due last day of month
Start Up (MP 1) 7/1/17 to 6/30/18		
Care Management	Hire 1.0 Nurse Care Manager (NCM)/Care Coordinator for every 3,000 attributed patients ($2.50 pmpm)	September 30, 2017
	Develop High Risk Registry and reportable fields for care management. Confirm completion with CTC	November 30, 2017
	NCM/CC completes standardized learning program as defined by CTC	December 31, 2017
	Report level(s) of engagement of high risk patients as defined by CTC	January 31, 2018
	Submits to OHIC Cost Management Attestation	October 15
Planned Care: Population Health /Quality Reporting	Submit clinical quality data as defined in Performance Incentives Exhibit 3	Month 6
	Submits to OHIC quality measure information	October 15
Access and Continuity	Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients	Month 6
	Submit before and after hours protocol, as defined by CTC	Month 9
Patient/Family Engagement	CAHPS survey: Submits patient panel to approved data vendor (or "How's Your Health" option to be determined	October 2017
Comprehensiveness and Coordination	Submits Transition of Care Policy and Procedure	Month 6
	Identifies high volume specialists serving patient population and submits 2 compacts**:** a) high volume specialist b) behavioral health	Month 9
Practice transformation	Submits budget and staffing plan and use of funds to support care delivery model to CTC	October 2017
	Submit NCQA PCMH work plan to CTC	Month 9
	Meets with Practice Facilitator 1-2 x a month	Month 1 and on-going
	Attends 50% of learning network meetings [1]	Month 1 and on-going

[1] Learning Network Meetings: Orientation, Best Practice Meetings, Breakfast for Champions, and Large Learning Collaborative

Measurement Period 2 (MP 2) 7/1/18 to 6/30/19	**CTC PCMH Adult Care Delivery Requirements**	**Due Date (if applicable) Due last day of month**
Care Management	Submits reports on high risk patients, as defined by CTC, to Health Plans and CTC and achieves 40% engagement rate	Quarterly (July/October/January/April)
	Submits to OHIC Cost Management Strategy Attestation	October 15
	Submits report that demonstrates 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days	Month 12
Planned Care: Population Health /Quality Reporting	Submits quarterly quality data	January/April/July/October
	Submits to OHIC quality data information	October 15
Access and Continuity	Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients	Quarterly
	Submit to CTC screenshots demonstrating patient access to a secure web portal, enabling secure messaging, appointment requests, referrals, and prescription refills.	Month 3
	Submits schedule demonstrating that it has expanded office hours as defined by OHIC Cost Management Strategies	Month 6
Patient/Family Engagement	Submits patient panel for CAHPS survey to qualified data vender (or "How's Your Health" option to be determined)	Timeframe determined by CTC
Comprehensiveness and Coordination	Provides report that demonstrates that 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days	Month 6
Practice Transformation	Submits a quality improvement activity for improving a performance measure (Quality/customer experience/utilization)	Month 2
	Submits a quality improvement activity demonstrating performance to improve a performance measure	Month 7
	Submits NCQA PCMH recognition application	Month 9
	Meet with practice facilitators at a minimum of once per month	On-going
	Attends 50% of Learning Network Meetings	On-going

Measurement Period MP 3 7/1/19 -6/30/20	**CTC PCMH Adult Care Management Requirement**	**Due Date (if applicable) Last day of month**
Care Management	Submits reports on high risk patients, as defined by CTC, to Health Plans and CTC and achieves 40% engagement rate	Quarterly (July/October/January/April)
	Provides report that demonstrates that 75% high risk patients with ED visit receive a follow interaction including medication reconciliation within 1 week of discharge 6 month	Month 6
	Submits attestation to OHIC and demonstrates achievement 80% of Cost Management Strategy elements	Oct 15
Planned Care: Population Health /Quality Reporting	Submits quarterly data	July/October /January/April
	Submits to OHIC quality data measurement report	October 15
Access and Continuity	Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients	Quarterly
Patient/Family Engagement	Submits patient panel for CAHPS survey to approved data vender (or How's Your Health option to be determined)	Timeframe determined by CTC
Comprehensiveness and Coordination	Submits 2 additional compacts as defined by OHIC cost management strategies	Month 6
Practice Transformation	Achieves NCQA PCMH recognition	Month 2
	Meet with CTC practice facilitators once per quarter	Month 1 and quarterly
	Attends 50% of Learning Network meetings	Month 1 and quarterly

Comparison CTC Attribution Methodologies
May 2017

	UHC	TUFTS	BCBSRI	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; 2. PCP with the most recent well visit is attributed as the PCP, if there is no well visit, then; 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 Consults: 99241-99245 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 sick visits (CPT codes: 99201-99205, 99211- 99215)		Evaluation/Management: 99201-99205, 99211-99215 Consults: 99241-99245 Nursing Facility: 99304-99306, 99307-99310 Domiciliary: 99324-99328, 99334-99337 Home services: 99341-99345, 99347-99350 Prolonged services: 99354, 99355 Preventative Med: 99381-99387, 99391-99397 Medicare covered wellness: G0402, G0438, G0439 Counseling risk factor: 99401-99404, 99406-99409, 99411-99412 Other Prevent. Med: 99420, 99429 FQHC – global visit: 0521, 0522	Most recent well visit: CPT codes 99381-99387, 99391-99397 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	BCBSRI	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)	Not accounting for members <18	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.	Host members (i.e., members accessing the RI provider network from another Blue Cross Blue Shield plan and are not enrolled with BCBSRI) are included in the attribution process. Patients no longer enrolled in plan on date of attribution calculation are eliminated. PCP specialty must be internal medicine or family practice. Members excluded from the Attribution Process are as follows: 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: - Reside in RI - Have Medicare Pts A & B - be covered under traditional Medicare Fee-for-Service program/not in a Medicare advantage or other Medicare health plan - Medicare is primary payer	
Contact for attribution related issues	Dale Greer	Adam McHugh	Allendre McGovern-Siembab	Charles Scaletta	Project management	

Performance Incentive
Care Transformation Collaborative of RI Program
January 2017 Expansion

The Program Provider agrees to fulfill CTC's Performance Measures and Performance Score requirements, as described online at CTC's Program care delivery requirements, as described online at www.ctc-ri.org.

Program Provider must achieve the Performance Measures and Performance Scores in order to earn a Performance Incentive Bonus PMPM for each Performance Measure as outlined in the Performance Incentive Table below. HEALTHPLAN will use the Performance Measure results provided by either CTC to determine Program Provider's Performance Score.

Performance Incentive Table

Measurement Period	Performance Measure	Performance Incentive Bonus PMPM
MP 2	Quality reporting /transformation data	$0.50
	Quality measure achievement (3 out of 5)	$0.25
	Customer experience target	$0.25
MP 3	Clinical Quality Measures	Up to $[0.75]
	Patient Experience Metrics	$[0.50]
	Utilization – Inpatient Admissions metric	$[1.25]
	Utilization – Emergency Department	$[0.75]

CTC-RI Adult Quality and Customer Experience Contractual Performance Standards 2016-2017 (5/8/17)

Contents

2016-2017 Adult Clinical Quality Measure Recommendations

Measures, Thresholds, and retirement of measures

The following measures are to be reported on and used for performance defined as noted in the table, below. Note starting in the 2017-2017 contract year, there will be FQHC and non-FQHC thresholds. FQHC thresholds* will additionally be used for practices that have 50% or more Medicaid patient panel at the time of contract adjudication. Note: CTC will prepare a separate document for PCMH Kids at a later point in time.

Measure	Contractual performance metric	2015-2016 Threshold	2016-2017 Non-FQHC threshold	2016-2017 FQHC* threshold	Comments
Adult BMI (new measure)	✓	N/A	90%	90%	Adopted new BMI measures, consistent with SIM alignment. Care plan no longer a requirement of new measure
DM A1c Good Control (<8)	✓	72%	72%	67%	
DM BP Control (<140/90)		80%			No longer reported - 2016
Hypertension BP Control (<140/90)	✓	80%	80%	68%	
Tobacco Cessation	✓	90%	90%	90%	Capped at 90% 2014
Depression Screen and follow up	✓		50%	50%	Adopted new measure, consistent with SIM alignment. Care plan or additional evaluation a requirement of new measure
Adult BMI (18-64)		85%			Replaced with new measure 2016
Adult BMI (65+)		90%			Replaced with new measure 2016
DM A1c Poor Control					No longer reported - 2016
DM-HbA1c Pts w/ Result					No longer reported - 2016
Tobacco Assessment					No longer reported - 2016
Chlamydia Screening – Sexual History					No longer reported - 2016
Chlamydia Screening –					No longer reported - 2016

Testing					
Fall Risk Management					No longer reported - 2016

Timing for adjudication

1. Q1 2017 data will be the data used for contract adjudication. Rates for FY 2018 will be set by 05/31/2017.

Methods for successful achievement of measures

1. Success in a domain is defined as achieving results in Q1 2017 that meet or exceed the 2016-2017 thresholds. In addition, if the difference between **2016 baseline** to **2016-2017 threshold** for a given practice 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 2016 threshold, i.e., at least a 2.5% point improvement. If there was no 2016 measurement, then the threshold must be attained.
2. Practices must successfully meet thresholds according to the rate sheet, in the developmental contract. If the appropriate number of thresholds are met (e.g. 3 out of 5), the corresponding performance incentive will be paid accordingly to the practice.
    a. Performance Year I: Practices must meet three out of five thresholds for success, via the appropriate method.
    b. Performance Year II: Practices must meet three out of five 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 five out of five measures, via the appropriate method.

*CTC will use baseline information from quarter 2 2017 due to timing of when new quality measurement specifications were adopted.

2016-2017 CAHPS PCMH Survey Recommendations

Timing for surveys and adjudication

1. Surveys will be administered in Fall of 2016.

about_pcmh-item-set-cg30-2314.pdf

Details of data review

1. We will continue to use top box scores for each domain as this allows for comparison to national standards, averages, and benchmarks.
2. One threshold will be set for all performance levels on each measure
3. Due to restructuring of questions in the Shared *Decision Making, Self-Management,* and *Comprehensiveness-Adult Behavioral Health* domains, by NCQA, it was recommended that these measures no longer be used for contract adjudication.
4. Due to the restructuring of access and communication composite questions with use of version 3 CAHPS survey, practice scores for 2015-2016 for access and communication have been re-calculated to allow for comparison between years. Thresholds have additionally been re-set for access and communication to reflect revised median scores.

Thresholds for 07/01/2017 Adjudication

Measure	2015-2016 Threshold	2016-2017 Threshold	Recalculated thresholds
Access	60%	60%	69%
Communication	84%	84%	86%
Office Staff	76%	76%	No change
Shared Decision Making	68%	N/A	
Self-Management	54%	N/A	
Comprehensiveness – Adult Behavioral Health	61%	N/A	

Methods for successful achievement of measures

1. Practices must pass the "gate" using the measure of *Access*, but there will be a new method for success.
    a. 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 measures.
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 thresholds for <u>both</u> *Office Staff* and *Communication* composite measures.

Note: the 2.5% improvement method described under the quality measures can be applied to the Office Staff and Communication composite measures.

Other Policies

CAHPS PCMH Patient Satisfaction Survey Policy for use of alternate vendors

Should a CTC-RI Practice Site, operating under the CTC-RI Developmental Contract, choose to contract with a vendor other than that selected/contracted via the CTC Committee structure, they must do so according to the following policies and guidelines:

1. If a practice chooses to use an alternate vendor, the selected vendor must be an NCQA recognized vendor.
2. The cost of administering the survey will be the responsibility of the practice.
3. A CAHPS PCMH standard survey, as defined by NCQA, must be used
    a. Mixed mode methods are required along with NCQA's minimum sampling requirements
4. The survey must be administered along the same timeline as that used by CTC. If a different timing method is used (i.e. continuous), the practice is responsible for securing results that meet the timelines required for CTC, including the survey measurement period.
5. If a practice fails to report follow-up results before or on the same day as CTC results are reported, they are not eligible for the PMPM incentive payment.
6. If a practice fails to provide a baseline measurement, they will not be eligible to meet the approved thresholds by the baseline to threshold improvement method.
7. If results are successfully reported, on time, then they will be included in the appropriate median calculation and be eligible for PMPM payments

Should a practice not follow this policy for using an outside vendor for CAHPS survey administration, they will not be eligible for the associated PMPM incentive payment.

Sample: 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, and 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 CTC 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.

xGLearn™ Care Management Training Summary

xG Health provides adult education solutions that are unique in the industry. We prepare students—your current and future care managers, ancillary health professionals, and care management leaders—by equipping them with the insights, experience, and education they need to assess, coordinate, and evaluate patient and population care.

Our Care Management training is presented through xGLearn™, a multi-modality adult learning system using multi-media online and in-person training, and practice-site immersion experiences, all using evidence-based care management practices.

We educate your staff using collaborative sessions and innovative curricula that you can conveniently access through the xGPortal™ available through your Web browser. Upon completion, we put training in action with a practice-site immersion in a successful healthcare environment. Coaching sessions are held after course completion to support the client case managers incorporate in their practices what they learned.

We empower you to scale up your care team training with innovative train-the-trainer programs for various groups in your organization—from care managers to coaches and supervisors.

Geisinger and xG Health professionals who are experts in their topics present the xGLearn courses. The solution is:

- Enriched with assessments, case studies, reflective scenario-based exercises
- Focused on conditions and soft skills, powered by real-life, practical, field experience of Geisinger and xG Health clinical experts
- Enhanced by expert interaction through discussion groups, team assignments, and cutting-edge interaction focused on curricula content
- Put in practice with Care Management Training Immersion Experience, training that includes an intense observation and interaction with a seasoned preceptor. The immersion period

FEATURES OF TRAINING MODULES

Primarily nurse taught

Blended learning with audio and video, facilitator-led classes

In-class activities

Highly interactive, with assessments, reflective exercises, case studies and scenarios, and homework

Includes soft skills appropriate for new and experienced Care Managers

is on location with a strategic partner, care-management team member.

Care Management Training includes a Companion Guide for this training – documents that follow Care Management Training content from start to finish.

Care Management Training Module Descriptions

The xGLearn™ Care Management training solution includes curricula that use xG Health evidence-based care management practices. Each course is developed for delivery by nurses, social workers, and community health assistants, depending on course content.

Brief descriptions for each course and module in the series follow.

Module	Description
1. Introduction to xGLearn™ Care Management Training	This module explains the xGLearn™ Care Management model of care delivery and the goals of education. In addition to the multi-media presentations, there are several articles that the learner is asked to read to support understanding and set the stage for the educational experience.
2. Five Core Components of Medical Home	In this module, you will learn about the five components that make up the core of a highly effective, patient-centered medical home. Each of the components is explored. The embedded case manager is a crucial component of the medical home, and the concept of the embedded case manager is illustrated in detail during this course.
3. Patient Populations – Identification, Stratification, and Priority Settings	In this class, you will learn the importance of and process for the identification and priority stratification of patient populations. Knowing which patients would benefit the most from receiving services is one of the first steps in a strong care management strategy. Directing care efforts to appropriate patients is vital to achieving positive outcomes.
4. Right Care, Right Place, Right Time – Criteria Based level of Care Determination	A Geisinger subject matter expert discusses the importance of ensuring that a patient receives care in the most appropriate setting associated with their need at that time. You will also learn about the role of case managers to help assure that a patient is treated in the correct setting across the continuum of care. This module includes case study activities.
5. Concept of the Medical Home	This module provides information on the key components of a successful patient-centered medical home. You will learn how the components complement and support the efforts of the care management team, as well as the Case Manager's vital role as a care team member in the Medical Home.
6. Stakeholders' Role in the Medical Home	Many people and roles are involved in a successful patient-centered medical home. In this module, a subject matter expert explains who the stakeholders are, their responsibilities in delivering patient care, and how the Case Manager interacts with

Module	Description
	each of them to promote and lead optimal patient care. The role of the case manager is also discussed in detail.
7. Medical Home Workflow: Implementing Practice Redesign	This module explores the components that are needed for success of a patient-centered medical home. The module presents information on current work flow process, staffing, and overall site functions. These components help design an optimal environment for the entire medical home team to improve patient outcomes and satisfaction in a cost-effective manner.
8. Population Based Case Management – An Introduction	You will be introduced to the concepts in population-based care management. The concepts are delivered through educational activities as well as multi-media presentations.
9. Introduction to Targeted Conditions: Guidelines to Identify and Manage	Care management provides a positive effect on patient care delivery and outcomes. However, not all patients are appropriate for program intervention. Case managers need to know which populations they should target to maximize their effect. In this module, a Geisinger subject matter expert explains which patients can be affected the most by care management services.
10. Heart Failure	Heart failure is a serious condition that affects millions of people in the United States. Since it is a condition with no cure, many people mistakenly believe that nothing can be done for patients with heart failure. In fact, there is a lot that case managers can do to help improve the quality of life for these patients. In this module, a subject matter expert explains how case management services can help patients with heart failure.
11. Diabetes Mellitus	Throughout this module, you will participate in education and training on diabetes care. We review the differences between diabetes types, as well as the interventions used to control glucose levels including nutrition, lifestyle, and pharmacology. You will also become familiar with the interventions that care management can use to educate and support patients with this condition. In addition to multi-media presentations, this module includes case study activities and a number of links to required external reading.
12. Chronic Obstructive Pulmonary Disease (COPD)	Chronic obstructive pulmonary disease (COPD) is a progressive disease that has no known cure. However, there are ways to improve quality of life and minimize symptoms. In this module, a Geisinger subject matter expert explores how care management interventions can help patients with COPD. The pathophysiology, classifications, signs, and symptoms of COPD are also outlined. In addition to multi-media presentations, this module includes case study activities and a number of links to required external reading.

Module	Description
13. Transitions of Care	Transitions of care are one of the most challenging times for patients and healthcare workers. Case managers have a vital role in managing patient transitions of care. The skilled patient management that a case manager provides can significantly lessen the stress and error margin. In this module, a Geisinger subject matter expert explains how case managers can affect transitions of care and discusses the importance of these transitions.
14. Population Based Case Management Concepts	In this module, the concepts that make up population-based care management are discussed in detail. The xG Health case management model is also explained, and each job role is defined.
15. Time Management for Case Managers	You will learn several tactics to help you manage your day and your case load. Case study activities are also part of this module.
16. Triple Aim – Case Manager's Role in Achieving	In this module students learn about the Triple Aim and why it is the driving force of healthcare reform in the United States. You will also learn how the Case Manager and other members of the Care Management team can help achieve the goals of the Triple Aim, which include improving the health of the population, enhancing the experience and outcomes of the patient, and reducing per-capita cost of care.
17. Effective Communication Techniques in Team Based Care Delivery	In Effective Communication, an xG Health subject matter expert explains how honing excellent communication skills helps develop a highly effective and functional team. Different types of communication are defined, and there is a special question-and-answer session with an expert who offers tips to case managers who spend most of their time talking to people over the phone.
18. Medical Home Meeting	In this module, you will watch an actual Medical Home Meeting. You will observe the Patient-Centered Medical Home Team at the Geisinger Health System Mount Pocono, Pennsylvania location as they discuss their patients and review processes.

Additional Training in Care Management

xG Health's additional Care Management training curricula include:

- Motivational Interviewing techniques prepare your care managers to move patients toward behavioral change by helping them recognize that change is possible, and commit to the change.
- Train the Trainer scales your training program with nurse preceptors and education facilitators who learn to instruct future care managers.
- Supervisor training prepares your staff managers to supervise your care managers.
- Specialty Care (Medicaid) management provides training for your staff on topics such as high-risk pregnancies, complex pediatric management, HIV and hepatitis, and behavioral health.

CTC Nurse Care Management (NCM) Measure Specifications

Table of Contents

NCM Measure Specifications for Engagement with Complex/High Risk Patients:

CTC, together with practices and health plans, formulated a common definition of high risk patients and interventions. Practices may continue to use these common definitions for internal reporting purposes to meet RI Office of the Health Insurance Commission Cost Containment Strategies and NCQA PCMH requirements.

Effective 4/15/17, CTC has simplified the CTC requirements for reporting on NCM activity with complex/high risk patients.

1) For CTC, Practices provide summary information on health plan identified high risk patients and NCM engagement with those high risk patients, together with other required practice information. The CTC Summary Report on Engagement with High Risk Patients can be found on page 6; Reporting is done through the website: https://ctc-ri.org . Reports are due at the same time as quality reporting.
2) Practices provide health plans (BCBSRI, Tufts, and NHPRI) with patient specific information on NCM engagement activity. United expects practices to access the information on United high risk patients (Commercial and Managed Medicaid), outreach and engage but does not require practices to submit patient specific information directly to the health plan.

CTC expects practices to include NCM engagement activity with United identified high risk patients in their summary report.

Definitions:

Term	Definition
Active Patient 18+	*Any patient age 18 and older as of the last day of the reporting period*
Active Patient	*All patients age 18+ years who were identified as being a high risk complex patient through the most recent reports from the insurers*
Engagement as defined by the health plans and CTC	Practices provide patient specific report to health plans (BCBSRI, Tufts and NHPRI) on NCM engagement activity with health plan identified high risk patients and an aggregated summary report to CTC; engagement information is identified as: 1) NCM last encounter date (which would be the date of the NCM most current assessment) 2) Patient intervention : Type is based on NCM assessment of frequency of intervention : a) High intensity /Complex: NCM activity more than once a week over a 60-90 day time period b) Moderate intensity : NCM activity once a week for 30-60 day time period c) Low intensity/short term : NCM activity for less than 30 day time period; NCM may provide oversight of other team members interventions with complex patients; When such NCM oversight is provided (i.e. patients referred to CHT for added intervention; patients referred for behavioral health intervention as part of complex/care team meetings), NCM may document on this engagement activity as part of follow up intervention.
Full time equivalent (FTE)	Full time equivalent is calculated as 40 hours per week.
Practice Identified High risk patients	Using information from a variety of sources including payer and practice clinicians, method practice uses for identifying patients at high risk for future avoidable high cost services. Risk assessment methodology includes at a minimum consideration of the following factors: a) Assessment of patient based on co-morbidities

	b) Inpatient utilization c) ED utilization
Health plan identified high risk patients	Each health plan uses its own predictive modeling methodology to identify complex/high cost patients based on cost, utilization and/or chronic conditions

For reference purposes:

Encounter	**Any documented activity that was performed with the patient.**
Face-to-Face Encounter	An encounter that occurred between the patient and the healthcare clinician. This encounter may have occurred in an office visit and/or at the patient's home.
Telephone Encounter	An encounter that occurred between the patient and the healthcare clinician over the phone.
Web Encounter	An encounter that occurred between the patient and the healthcare clinician via a secured electronic exchange (i.e. portal).
Home Visit	An encounter that occurred between the patient and the healthcare clinician that took place at the patient's home.
Office visit Encounter	An encounter that occurred between the patient and the healthcare clinician that took place as a face to face encounter in the office setting
Active Patient 18+	*Any patient age 18 and older as of the last day of the reporting period*
Active Patient Category 3	*All patients age 18+ years who were identified as being a high risk complex patient through the most recent reports from the insurers (see details in "Notes" on identifying patients*

Practice Patient Specific Report to Each Health Plan on Health Plan Referred Complex/ High Cost Patients

Health Plan Referred Complex/ High cost Patients	Each health plan uses its own predictive modeling methodology to identify complex/high cost patients based on cost, utilization and/or chronic conditions. Health plans provide CTC practices with patient specific complex/high cost information on at least a quarterly basis. The below criteria must be used to identify complex/high cost patients referred from the health plans: 1. <u>For Blue Cross and Blue Shield of Rhode Island:</u> a. Patients highlighted in Red and Orange on the monthly panel reports that are distributed the last week of thee calendar month b. Blue Cross Blue Shield also provides transition in care reports; it is expected that high risk patients on this lists would receive timely follow up; 2. <u>Neighborhood Health Plan of Rhode Island (NHPRI):</u> a. Distributes list to practices that have 200 attributed patient lives the 22nd of each month. b. NHPRI provides a list of identified high risk patients. All patients on this file must be included. 3. <u>Tufts:</u> a. Distributes list the end of the month for each quarter (January, April, July and October). b. Tufts provide a list of identified high risk patients. All patients on this file must be included. 4. <u>United Medicaid:</u> a. Distributes a prioritized list of patients on a quarterly basis (January, April, July and October) and calls the practices when a Top 5% member who is on their panel is in the hospital b. Practice must use the quarterly report and provide information on patients that are in the highest, higher and high priority category and those members on the top 5% report that the health plan has contacted the NCM to report a hospital admission. 5. <u>United Commercial:</u> a. Distributes a list on all patients with a prospective risk score that reflects the relative resources expected to be required for patient care on a quarterly basis (January, April, July and October) b. Practice must report on patients that are in the top 5% of the commercial report.
NCM Case load Reconciliation	Nurse care manager case load for each full time staff is expected to be 150 active patients; it is anticipated that NCM will outreach to patients on the high risk lists and successfully engage (inclusive of care plan) with 40% of patients high risk patients on the high risk lists
Practice Report to the health plan	Practices are responsible for providing each health plans with a list of identified complex/high cost patients based on the above criteria with the identified fields below on a monthly basis. *The practice uses the health plan report from the previous 30 day period. For example, the April report would be based on health plan list received by the end of February.* *Practices are advised to send any patient information through a secure email account that is HIPPA compliant. Practices may ask health plans to send information through a secure email and then respond back to the health plan through that same secure email process.* Practices are responsible for providing a list of identified complex/high cost patients with the following columns: 1) <u>Demographic Data:</u> Patient Name, DOB, Insurance 2) <u>Practice Information:</u> NCM Name, Practice Name 3) <u>NCM last Encounter Date:</u> (which would be the date of NCM most current assessment) *4)* <u>Patient Intervention</u>*: Type is based on nurse care manager assessment of frequency of intervention is offered as a general guideline with the NCM making the final determination of intensity based on patient assessment :* a) <u>High Intensity/Complex:</u> Nurse Care Manager activity more than once a week over a 60-90day time period

	b) Moderate intensity: Nurse Care Manager activity once a week for 30-60 day time period c) Low Intensity/Short Term : Nurse Care Manager activity for less than a 30 day time period 5) Closed : a) Discharged from practice (i.e. patient transferred care to another provider; patient has re-located to long term care (SNF) as permanent location)) b) Patient expired c) Goals met d) Patient refused e) Patient is followed for complex care management due to pregnancy f) Unable to reach patient after three attempts and there has been consultation with health plan around locating patient. For each health plan: number of patients on NCM caseload
Notes	Practice site is responsible for assigning responsibility to a non-clinical practice resource to obtain the health plan referred complex/high cost patient list per health plan posting mechanism and providing NCM with the patient data so NCM can work to outreach and engage complex high cost patients Health plans are expected to provide practices with actionable mechanism for removing complex/high cost patients from the health plan list based on patient status (deceased, discharged). Blue Cross and Blue Shield of Rhode Island require monthly reporting.
Practice report to health plan	Practice provides health plan with patient specific report generated from electronic health record and/or through reporting mechanism identified by health plan. Practices provide health plan with patient specific data by 20th of every month. Blue Cross is expecting monthly reports; other health plans (Tufts and NHPRI require quarterly reporting. • Tufts: Secure email to: Michele Wolfsberg - michele_wolfsberg@tufts-health.com (617 972 9400 x 59747) • BCBS: Established Secure File Transfer Portal (SFTP) connection and/or Population Health Registry Portal; Files should be returned via the same mechanism as received by the practice. If submitting via secure email, submit via secure/encrypted email according to organizational requirements for exchanging PHI to PCMH@bcbsri.org with the email subject line in the same format as the file name (file format: Contracted Group_Practice Site_NCM Engagement MMYYYY For clinical questions call 401 459 CARE (2273). • United Commercial: Secure email to: ctcincmreportsc-uhc@uhc.com For questions on portal, contact Amy Larochelle Amy.larochelle@uhc.com 952-406-5674 • United Medicaid: Secure email to: mcaidreports@uhc.com • NHPRI: Secure email to: YFreeman@nhpri.org 401-459-6186
Data Source	Health Plan generated high risk patient lists; Nurse Care Manager engagement information: Practice generates from EHR or through other mechanism such as NCM reporting on share point site. When NCM provides oversight of other team member high risk intervention, (i.e. referral and conferencing with Community Health Team, behavioral health complex care conferencing), NCM may document on this activity as part of the engagement report.
Measure/ Domain Type	Process
Measure/ Domain	Process

CTC Summary Report on Engagement with High Risk Patients

Primary care practice: _____ **Date:** _____(Due when quality metrics are submitted via portal CTC-RI.org)

Nurse care manager engagement report : Practice provides summary information based on a) health plan identified high risk patients and NCM engagement with those high risk patients and b) practice identified high risk patients and patient engagement

Comments

1	**Does the practice have a High Risk Registry, including Inpatient Utilization, ED Utilization and co-morbidity as required by OHIC?**	
2	**Does the practice have a defined methodology for identifying patients at high risk? (please include)**	
3	**What is the NCM FTE this quarter? (Assume 40 hour work week)**	
a.	**Are there any vacant positions, or months when NCM positions was not staffed in the reporting period?**	

EXAMPLE

4 What is the % of engaged High Risk Patients?:

Definition of engagement: 1) NCM last Encounter Date: (which would be the date of NCM most current assessment)
2) Patient Intervention: Type is based on nurse care manager assessment of frequency of intervention is offered as a general guideline with the NCM making the final determination of intensity based on patient assessment :
a) High Intensity/Complex: Nurse Care Manager activity more than once a week over a 60-90day time period
b) Moderate intensity: Nurse Care Manager activity once a week for 30-60 day time period
c) Low Intensity/Short Term : Nurse Care Manager activity for less than a 30 day time period

Overall, and by Payer	**Payor Specific Reporting**				
	Blue Cross*	**Tufts**	**NHPRI**	**United Medicaid****	**Overall Totals**
# of High Risk identified by the Health Plan (D)					0
# Engaged (N)					
% Engagement					0
	Payor Agnostic Reporting (Practice high risk patients identified from patient panel using practice methodology)				
# of High Risk identified by the Practice (using methodology in #2)	0	This category is not mutually exclusive from payor-based reporting. A patient may appear in both categories.			
# Engaged (N)					
% Engagement	0				

Overall, and by Payer	**Payor Specific Reporting**				
	Blue Cross*	**Tufts**	**NHPRI**	**United Medicaid ****	**Overall Totals**
# of High Risk identified by the Health Plan (D)	50	150	500	100	800
# Engaged (N)	20	100	200	50	
% Engagement					0
	Payor Agnostic Reporting (Practice high risk patients identified from practice panel using practice methodology)				
# of High Risk identified by the Practice (using methodology in #2)	0	This category is not mutually exclusive from payor-based reporting. A patient may appear in both categories.			
# Engaged (N)					
% Engagement	0				

*Use the NCM active caseload for high risk patients from your most recent

**United Medicaid continues to send practices the list of high risk patients and expects practices to engage with these patients but does not require practices to provide patient specific report on engagement with high risk patients to United

For Reference Purposes: Category 1a – ED High Utilizers: Percentage of Emergency Department High Utilizers who had a Nurse Care Management Activity (Phase 1)

Definition	Percentage of patients age 18+ who had 3 or more Emergency Department (ED) visits during the 6 months prior to one month before the last day of the quarter, and who had a Nurse Care Manager activity during the past 7 months.
Numerator 1	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the past 7 months (7 month look back is to allow for time for the NCMs to outreach to the patients seen near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30.
Numerator 2	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 7 months (7 month look back is to allow for time for the NCMs to outreach to the patients that visit the ED near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30. *Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.*
Denominator	Patients age 18+ years who were identified as part of the PCMH practice and who had 3 or more Emergency Department visits in the most recent 6 months ending 1 month prior to the last day of the quarter. i.e. if quarter ends on 9/30 then denominator is 3/1 – 8/31. You *may* include patients that visited the ED and were subsequently admitted as an inpatient. Do *not* include patients that visited Urgent Care.
Exclusions	Patients who have left the practice by the end of the reporting period, 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 • Urgent Care visits should not be counted as an ED visit
Notes	Practice site is responsible for creating a structured way to document and track: 1. Types of nurse care manager activity and encounter type 2. Patients who had an ED event • When practice receives notification of patient being seen in the ED via CurrentCare Direct Alert, fax from hospital, direct access into hospital portal, or via insurance report, each event must be documented in the practice's EMR in a trackable, reportable manner. • *All patients identified on the lists from the insurers as attributed to your practice must be included in the report unless an exclusion applies.* * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient 3. NCQA 2014 Guidelines: 4.1: Care Management and Support Practices establish a systematic process for identifying patients who may benefit from care management support (such as patients who are high cost/high utilizers, poorly controlled or complex conditions, referred by outside organizations) . The care team and patient/family collaborate at relevant visits to develop and update an individual care plan that includes the following features: • Incorporates patient preferences and functional lifestyle goals • Identified treatment goals • Assesses and addresses potential barriers to meeting goals • Includes a self-management plan • Is provided to the patient/family/caregiver Practices will want to consider these NCQA standards and elements with the development of the documentation system for clinical staff, including the NCM.
Data Source	All data must be extracted from practice's EMR or a practice based registry

For Reference Purposes: Category 1b – Hospital High Utilizers: Percentage of Hospital High Utilizers who had a Nurse Care Management Activity (Phase 1)

Definition	Percentage of patients age 18+ who had 3 or more hospital visits during the 6 months prior to one month before the last day of the quarter, and who had a Nurse Care Manager activity during the past 7 months.
Numerator 1	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the past 7 months. (7 month look back is to allow for time for the NCMs to outreach to the patients seen near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30.
Numerator 2	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 7 months. (7 month look back is to allow for time for the NCMs to outreach to the patients that are hospitalized near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30. *Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.*
Denominator	Patients age 18+ years who were identified as part of the PCMH practice and who had 3 or more hospitalizations in the most recent 6 months ending 1 month prior to the last day of the quarter. i.e. if quarter ends on 9/30 then denominator is 3/1 – 8/31. You *may* include patients that visited the ED and were subsequently admitted as an inpatient. Do *not* include patients that visited Urgent Care.
Exclusions	Patients who have left the practice by the end of the reporting period, 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 • Urgent Care visits should not be counted as an ED visit
Notes	Practice site is responsible for creating a structured way to document and track: 1. Types of nurse care manager activity and encounter type 2. Patients who had a hospital/inpatient event • When practice receives notification of patient being seen in the hospital for an inpatient stay via CurrentCare Direct Alert, fax from hospital, direct access into hospital portal, or via insurance report, each event must be documented in the practice's EMR in a trackable, reportable manner. • *All patients identified on the lists from the insurers as attributed to your practice must be included in the report unless an exclusion applies.* * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
Data Source	All data must be extracted from practice's EMR or a practice based registry
Measure Domain/ Type	Process

For Reference Purposes: Category 2 – Co-morbid Conditions: Percentage of Patients who are Poorly Controlled and/or have Comorbid Conditions who had a Nurse Care Management Activity (Phase 1)

Definition	Percentage of active* patients age 18+ who have 3 or more comorbid/poorly controlled conditions and who had a Nurse Care Manager activity during the past 6 months.
***Active Patient 18+**	Any patient age 18 and older as of the last day of the reporting period, and 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
Numerator 1	Active Patients ages 18+ in the denominator who had any Nurse Care Manager activity documented within the EMR during the past 6 months.
Numerator 2	Active Patients ages 18+ in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 6 months. *Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.*
Denominator	Active patients ages 18+ at any time in the last 24 months who were seen by a primary care clinician of the PCMH during the past 24 months and who has **3 or more of the below conditions** as of the last day of the quarter: 1. Poorly Controlled Diabetes (>9.0) • **Active patients** between the ages of 18-75 years at any time during the past 24 months who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: • ***ICD9 Code Groups: 250.xx, 357.2, 362.0x, 366.41, 648.0*** • ICD10 codes: See excel spreadsheet, Tab2 - Diabetes • ***AND*** their most recent A1C HcA1c level >9.0% in the past 12 months. • **Exclusions**: Patients with gestational diabetes, steroid–induced diabetes, or polycystic ovary syndrome during the last 12 months, as identified by one of the following: • ICD–9 codes: • Steroid induced diabetes: 249.xx, 251.8x, 962.0x • Gestational diabetes: 648.8x • PCOS: 256.4x • ICD–10 codes: • See excel spreadsheet, Tab3 – DM Exceptions 2. Asthma • Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as asthmatic via the following codes: • ***ICD9 Code Groups: 493.0, 493.22, 493.80-493.82, 493.90-493.92*** • ICD10 codes: See excel spreadsheet, Tab9 - Asthma

3. COPD
    - Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having COPD via the following codes:
        - ***ICD9 Code Groups: 492.xx, 494.xx, 496.xx***
        - ICD10 codes: See excel spreadsheet, Tab10 - COPD
4. CHF
    - Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having CHF via the following codes:
        - ***ICD9 Code Groups: 425.x, 428.x***
        - ICD10 codes: See excel spreadsheet, Tab11 - CHF
5. Depression
    - Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having depression via the following codes:

- ***ICD9 Code Groups:***
    - ***ICD-9 codes: 296.20-296.25, 296.30-296.35, 298.0x, 311.xx***
    - ICD-10 codes: See excel spreadsheet: Tab 6 – Depression

6. Hypertension BP Uncontrolled
    - **Active patients** ages 18-85 at any time during the past 24 months and who are listed in the registry or problem list as having hypertension via the following codes:
        - ***ICD9 Code Groups: 401.0, 401.1, 401.9***
        - ICD10 codes: See excel spreadsheet, Tab3 - Hypertension
    - **AND** their most recent blood pressure (both systolic and diastolic) is uncontrolled in the past 12 months defined by:
        - 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 the last day of the reporting period and flagged as not having a diagnosis of diabetes whose BP was >150/90 mm Hg.
    - **Exclusions**: Patients who are pregnant or are diagnosed with ESRD, as identified by one of the following:
        - ICD–9 codes:
            - Pregnant: 630.xx-679.xx, V22.xx, V23.xx, V28.xx
            - ESRD: 585.6x
        - ICD–10 codes:
            - See excel spreadsheet, Tab1 – Pregnancy, Tab5 - ESRD
7. Schizophrenia or Bi-Polar Disorder
    - Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having schizophrenia via the following codes:
        - ***ICD9 Code Groups: 295.xx***
        - ICD10 codes: See excel spreadsheet, Tab12 - Schizophrenia
    - ***OR*** who have bi-polar disorder via the following codes:
        - ***ICD9 Code Groups: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7***

	• ICD10 codes: See excel spreadsheet, Tab13 – Bi-polar
Exclusions	None
Notes	Practice site is responsible for creating a structured way to document and track: Types of nurse care manager activity and encounter type * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
Data Source	All data must be extracted from practice's EMR or a practice based registry
Measure Domain/ Type	Process

For Reference Purposes: Category 3 – Complex/High Cost: Percentage of Complex/High Cost Patients who had a Nurse Care Management Activity (Phase 1)

Definition	Percentage of complex/high cost patients age 18+ identified by health insurance companies based on risk status and who had a Nurse Care Manager activity during the last 6 months.
Numerator 1	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the last 6 months.
Numerator 2	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 6 months. *Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.*
Denominator	Patients age 18+ years who were identified as part of the PCMH practice and who are identified as being a high risk/complex patient through the most recent reports from the insurers (details in notes on identifying patients). Note: Health plan provides timeframe for the identified patient list.
Exclusions	Patients who have left the practice by the end of the reporting period, 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
Notes	Practice site is responsible for creating a structured way to document and track: 1. Types of nurse care manager activity and encounter type 2. Patients who are identified as complex from health insurance plans: • Blue Cross: Patients identified in red and orange on panel listing • United Commercial: Top 5% of patients identified as having the highest prospective risk score • United Medicaid: All patients on high-risk patient list • Tufts: All patients on high-risk patient list • NHPRI: All patients on high-risk patient list * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
Data Source	All data must be extracted from practice's EMR or a practice based registry
Measure Domain/ Type	Process

For Reference Purposes: Percentage of Total High Risk Patients who had a Nurse Care Management Activity

Definition	Percentage of unduplicated high risk patients who had any Nurse Care Manager activity during the last 6 months.
Numerator : *Any type of NCM Activity*	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the time specified for the given measure.
Denominator	Unduplicated patients who were identified as part of the PCMH practice (for timeframe see definition of active patient) and who are identified as being a high risk patient by meeting any of the denominators for the below measures: • ED High Utilizer • Hospital High Utilizer • Patients who are Poorly Controlled and/or have comorbid conditions • Complex/High Cost Patients from Insurers
Exclusions	Patients who have left the practice by the end of the reporting period, 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
Notes	Practice site is responsible for creating a structured way to document and track: Types of nurse care manager activity and encounter type * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
Data Source	All data must be extracted from practice's EMR or a practice based registry
Measure Domain/ Type	Process

For Reference Purposes: Percentage of Non-High Risk Patients who had a Nurse Care Management Activity

Definition	Total numbers of non-high risk patients who had any Nurse Care Manager activity during the last 6 months Total Patient Panel minus the number of high risk patients)
Total Encounter Numbers	Total number of NCM encounters, during the last 6 months •
Numerator 1: *Any type of NCM Activity*	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the last 6 months.
Numerator 2: *Face-to-Face NCM Activity*	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 6 months. *Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.*
Denominator	Patients age 18+ years (for timeframe, see definition of active patient) who were identified as part of the PCMH practice and who are not identified as being a high risk patient by meeting any of the denominators for the below measures: • ED High Utilizer • Hospital High Utilizer • Patients who are Poorly Controlled and/or have comorbid conditions • Complex/High Cost Patients from Insurers
Exclusions	Patients who have left the practice by the end of the reporting period, 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
Notes	Practice site is responsible for creating a structured way to document and track: Types of nurse care manager activity and encounter type * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
Data Source	All data must be extracted from practice's EMR or a practice based registry
Measure Domain/ Type	Process

CTC Summary Report on Engagement with High Risk Patients

Primary care practice: _____ **Date:** _____(Due when quality metrics are submitted via portal CTC-RI.org)

Nurse care manager engagement report : Practice provides summary information based on a) health plan identified high risk patients and NCM engagement with those high risk patients and b) practice identified high risk patients and patient engagement

Comments

1	**Does the practice have a High Risk Registry, including Inpatient Utilization, ED Utilization and co-morbidity as required by OHIC?**	
2	**Does the practice have a defined methodology for identifying patients at high risk? (please include)**	
3	**What is the NCM FTE this quarter? (Assume 40 hour work week)**	
a.	**Are there any vacant positions, or months when NCM positions was not staffed in the reporting period?**	

EXAMPLE

4 What is the % of engaged High Risk Patients?:

Definition of engagement: 1) NCM last Encounter Date: (which would be the date of NCM most current assessment)
2) Patient Intervention: Type is based on nurse care manager assessment of frequency of intervention is offered as a general guideline with the NCM making the final determination of intensity based on patient assessment :
a) High Intensity/Complex: Nurse Care Manager activity more than once a week over a 60-90day time period
b) Moderate intensity: Nurse Care Manager activity once a week for 30-60 day time period
c) Low Intensity/Short Term : Nurse Care Manager activity for less than a 30 day time period

Overall, and by Payer	**Payor Specific Reporting**				
	Blue Cross*	**Tufts**	**NHPRI**	**United Medicaid****	**Overall Totals**
# of High Risk identified by the Health Plan (D)					0
# Engaged (N)					
% Engagement					0
	Payor Agnostic Reporting (Practice high risk patients identified from patient panel using practice methodology)				
# of High Risk identified by the Practice (using methodology in #2)	0	This category is not mutually exclusive from payor-based reporting. A patient may appear in both categories.			
# Engaged (N)					
% Engagement	0				

Overall, and by Payer	**Payor Specific Reporting**				
	Blue Cross*	**Tufts**	**NHPRI**	**United Medicaid ****	**Overall Totals**
# of High Risk identified by the Health Plan (D)	50	150	500	100	800
# Engaged (N)	20	100	200	50	
% Engagement					0
	Payor Agnostic Reporting (Practice high risk patients identified from practice panel using practice methodology)				
# of High Risk identified by the Practice (using methodology in #2)	0	This category is not mutually exclusive from payor-based reporting. A patient may appear in both categories.			
# Engaged (N)					
% Engagement	0				

*Use the NCM active caseload for high risk patients from your most recent

**United Medicaid continues to send practices the list of high risk patients and expects practices to engage with these patients but does not require practices to provide patient specific report on engagement with high risk patients to United

How to Access High Risk Reports from Health Plans and Communicate with Health Plans

Each health plan has agreed to deliver to practices on a quarterly (at least) basis a list of high risk patients whom they wish to be referred for care management services. Health plans use different predicative modeling methodologies to produce these lists based on cost, utilization and/or chronic conditions. Health plans also have different methods of delivering these reports to practices, as outlined below; however, all lists will be labeled as "High Risk Report, Quarter, Year."

CTC Management asks practices to designate three contacts at the practice to be the recipients of the high risk lists from health plans that send via secure email. These designees should be confirmed at least quarterly. The designated contacts can be identified and updated by contacting Candice Brown for practices in Adult CTC program (Candice.Brown@umassmed.edu) and Michele Brown for practices in the PCMH Kids program (Michele.Brown@umassmed.edu).

Practices should review the patients that are referred from the health plans at least quarterly with the clinical team and determine which patients are "high impact." CTC has identified a common definition of "high risk" patients that is used by all CTC practices.

Health Plans have identified a "point person" that practices can use when assistance is needed to access high risk lists and a "point person" for clinical needs and for health plan high risk issues. This document included health plan contact information.

Contents

Blue Cross & Blue Shield of Rhode Island

Blue Cross & Blue Shield of Rhode Island (BCBSRI) provides practices with monthly patient panels of all active, attributed BCBSRI members, including those identified as high risk. These panels provide clinical and cost information to assist NCMs/CCs in their management of members. Patient panels are made available through the BCBSRI Population Health Management Tool, *Blue Insights*.

BCBSRI identifies high risk members through the use of The Johns Hopkins ACG System. The ACG system is a statistically valid, diagnosis-based, case-mix methodology that describes and predicts future healthcare utilization and costs. This system is based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden. BCBSRI assigns a risk category (Red or Orange) to further assist practices in identifying members with the highest need for case management intervention and support. Criteria are as follows:

Adult (18+)	Pediatric (0-17)
Red	
Patients identified as RUB 4 or RUB 5 with at least one of the following criteria:	
• Predicted probability of inpatient admission of 30% or more	
• Medicare Advantage members with an HCC score of 2.5 or higher	**Patients identified as a RUB 5**
• Total cost of $100,000+	
Or:	
Patients identified as a RUB 3 with a diagnosis of Congested Heart Failure	
Orange	
Patients identified as RUB 4 or RUB 5 with at least one of the following criteria:	**Patients identified as RUB 4 with at least one of the following criteria:**
• 3+ Inpatient Admission (IP) in last 6 months	• 3+ IP in last 6 months
• 3+ Emergency Department (ED) in last 12 months	• 3+ ED in last 12 months
• 3+ Chronic Conditions, with a prospective risk score of 2 or higher	• 6+ specialist visits in the last 12 months

Nurse Care Managers (NCMs) and Care Coordinators (CCs) are responsible for case management (CM) of identified high risk members. NCMs/CCs will document engagement of BCBSRI high risk members in *Blue Insights*. BCBSRI defines engagement as members who have agreed to participate in case management with the NCM/CC and have an active care plan in place. BCBSRI has an engagement target of 45% of identified high risk members. NCMs/CCs need to document all CM services provided in the previous calendar quarter by no later than the 20th calendar day, or closest business day, of the first month of each calendar quarter (January 20th, April 20th, July 20th, and October 20th).

Contact Information:
Please contact your assigned Practice Facilitator for PCMH program-related questions. Additional points of contact include:

- General program questions, access to *Blue Insights* : PCMH@bcbsri.org

Referral to BCBSRI Registered Dieticians and Behavioral Health Case Managers: (401) 459-CARE (2273)

Neighborhood Health Plan

NHP will not deliver high risk patient lists to practices with less than 200 members.

Practices must log on to the NHPRI Provider Report Portal to access the high risk list. Access to the portal, training of the site and setup at the site requires configuration by NHP.

Updated high risk lists will be posted on the 22nd of each month.

- CTC sites with the exception of those sites discussed previously receive the efficiency suite and the high cost report from Neighborhood.
- The reports for CTC all are available in excel format. **This allows for filtering and manipulation of data.**
- The high cost report in particular is more comprehensive than the data elements identified for the CTC high risk report. There are more data elements in the report.
- The high cost report contains pharmacy, behavioral health and medical expenses in addition to ER and inpatient utilization.

*CTC practices could utilize this report to identify patients for different levels of care management. See below as to the report labels.

Member Name	Admits	Days	ALOS	ER Visits	Unique NDC Categories	Total Rx Claims	Medical Paid	BH Paid	RX Paid	Total Paid

Ex.) A patient with high medical cost, no inpatient utilization, high ER utilization, no BH claims and pharmacy costs under a $100. This patient could be flagged to receive care management touch.

For questions or concerns on the NHP high risk lists, and/or to remove a patient from the high risk list contact Yvonne Heredia at YFreeman@nhpri.org or 401-459-6186 (direct)

UM Transitions: Jackie Fernandes-Manager-(401) 459-6003 (direct); Andrea McGinn-Team leand (401) 459-6521 (direct)

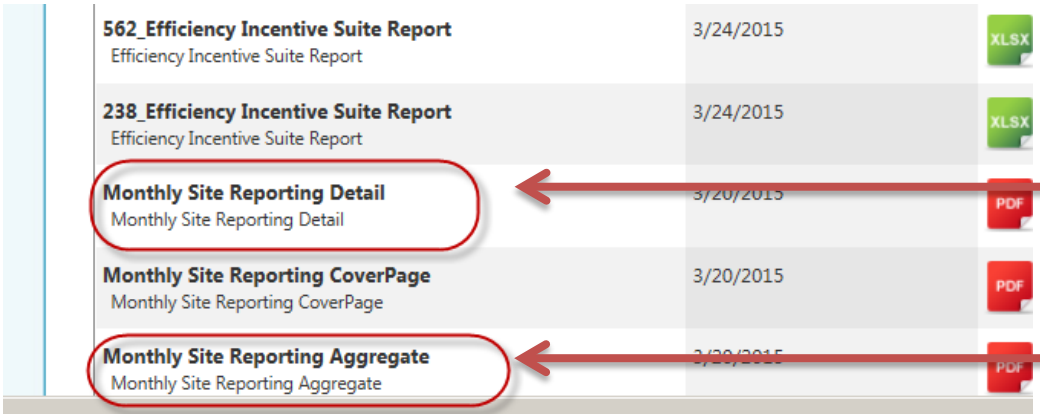
CM Transitions: Donna Bianco-Team Lead (401) 459-6074 (direct)

Screen shot of NHP high risk list

	A	B	C	D	E	F	G	H
1	MEMBER_ID	DOB	Age Group	Gender	Site Name	PRIMARY_CONDITION	TOTAL_PAID	CCHG_Code
2	XXXXXXX00	12/9/1983	30.2	F	So County Int Med	C_0044 - Anemia	$16,508.22	117 Mental retardation/disability congentia anom
3	XXXXXXX00	10/28/1976	37.3	F	So County Int Med	C_0080 - Bacterial Infection	$10,958.49	119 Other mental health/substance abuse
4	XXXXXXX00	3/25/1974	39.9	M	So County Int Med	C_0397 - Headaches	$15,211.32	116 Neurologic disorders
5	XXXXXXX00	8/28/1985	28.5	F	So County Int Med	C_0397 - Headaches	$149,843.23	101 Major psychosis
6	XXXXXXX00	6/22/1978	35.7	F	So County Int Med	C_0441 - Hypertension	$9,754.94	112 Diabetes without CAD
7	XXXXXXX00	10/19/1981	32.4	F	So County Int Med	C_0455 - Ileitis	$8,184.74	116 Neurologic disorders
8	XXXXXXX00	5/3/1978	35.8	F	So County Int Med	C_0610 - Paralysis	$7,693.23	125 Other chronic conditions
9	XXXXXXX00	6/4/1968	45.7	M	So County Int Med	C_0613 - Parkinsons Disease	$16,274.81	103 Active cancer
10	XXXXXXX00	2/23/1980	34.0	F	So County Int Med	C_0749 - Splenomegaly	$10,097.46	105 Liver disease (Hepatitis, Cirrhosis) – post transplant
11	XXXXXXX00	2/1/1976	38.1	F	So County Int Med	C_1096 - Thrombocytopenia	$9,168.64	137 Healthy Female (16-40)

How to access the report on the Provider Portal

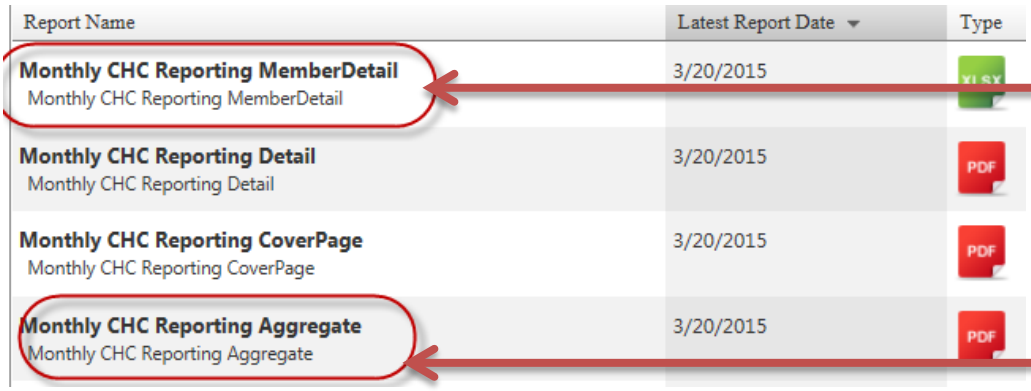
Non- Community Health Centers



Monthly site reporting member detail is the report that has the names of the patients as well as ER/ INPT/and case management status with the health plan

The monthly site reporting aggregate will provide the number of high-risk top 5%

Community Health Centers



Monthly CHC reporting member detail is the report that has the names of the patients as well as ER/ INPT/and case management status with the health plan

The monthly CHC reporting aggregate will provide the number of high-risk top 5%

5 4 17

Tufts

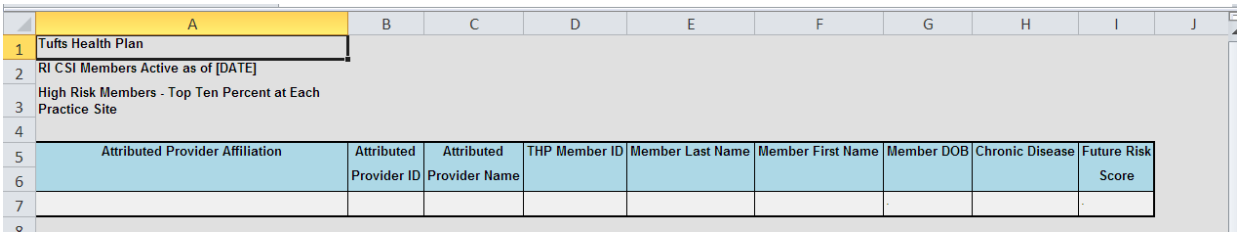
If you do not have any high risk patients, you will be sent a blank report shell.

Tufts send the high risk list via secure email to the three designated contacts at each practice site.

Updated high risk lists will be sent at the end of the month of each quarter (January, April, July, October).

For questions or concerns on the Tufts high risk lists, contact Adam McHugh at Adam_McHugh@Tufts-Health.com or 617-972-9400x2739 or Michele Wolfberg RN MPH micelle_wolfberg@tufts-health.com (617)972-9400 x 59747

Screen shot of Tufts high risk list

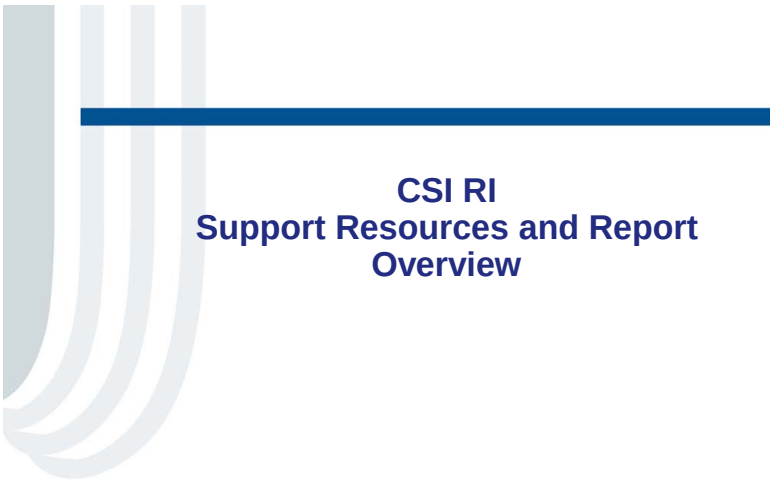


	A	B	C	D	E	F	G	H	I	J
1	Tufts Health Plan									
2	RI CSI Members Active as of [DATE]									
3	High Risk Members - Top Ten Percent at Each Practice Site									
4										
5	Attributed Provider Affiliation	Attributed Provider ID	Attributed Provider Name	THP Member ID	Member Last Name	Member First Name	Member DOB	Chronic Disease	Future Risk Score	
6										
7										
8										

United Commercial and Medicaid

United will not deliver the Medicaid high risk patient list to practices with less than 200 members.

Practices must log on to the United Portal to access the high risk list. Both Commercial and Medicaid high risk lists will be posted on the portal. On the first log-in, practices will need to enter a "Program Identifier Number" (PIN) to access CTC reports. On the United Portal, click here:



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United Commercial assigns patients a risk score as a measure of the relative resources expected to be required for a patient's care. A risk score of 2.0 indicates a patient's expected costs are twice that of a patient with average risk (assigned a score of 1.0).
United Medicaid lists will reflect top 5% of practice's high risk patient list.

Updated high risk lists will be posted at the end of the month following the quarter (January, April, July, October).

For questions or concerns on the United Portal login information, contact Amy.Larochelle@uhc.com 952-406-5674
For questions accessing or interpreting high risk reports (post log-in) contact the Healthcare Measurement Resource Center at 866-270-5588 from 8am-7pm Monday-Friday.
FOR HIGH RISK INPATIENT (ACUTE CARE, SNF, AIR AND LTACH, DISCHARGE PLANNING SERVICES AND EQUIPMENT: : CONTACT KRISTEN WOODS (877) 561-3813;

FOR HIGH RISK MANAGEMENT AT RIH ONLY (ACUTE CARE, SNF, AIR AND LTAACH): PAUL BELANGER RN 855-338-9245 EXT 73148

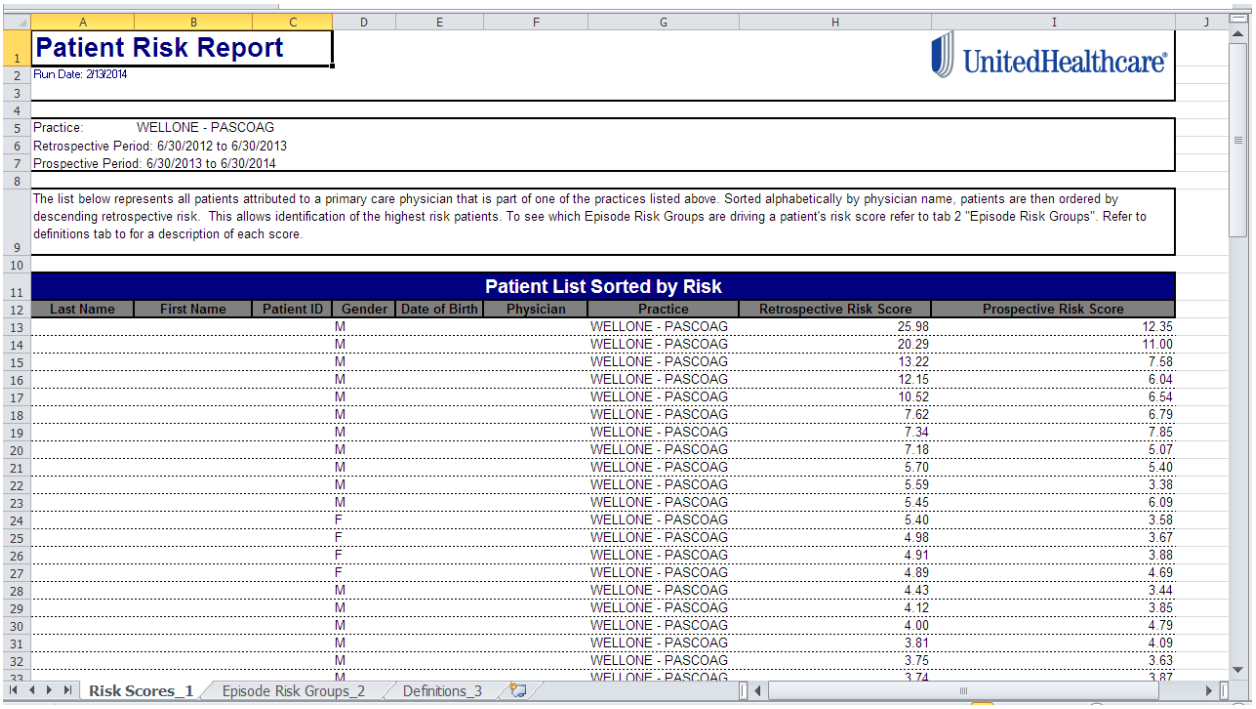
FOR NURSE CARE MANAGER COORDINATION (COMMERCIAL) : CONTACT DALE.R.GEER@UHC.COM 612-632-6543

FOR URGENT ISSUES OR REMOVE PATIENT FROM HIGH RISK LIST: MICHEL DALEY 952-406-5769

COMMERCIAL HEALTH PLAN REFERRED NCM ENGAGEMENT PATIENT SPECIFIC REPORTS CAN BE SENT TO CTCRINCMREPORTSC-UHC@UHC.COM ;

MEDICAID HEALTH PLAN REFERRED NCM ENGAGEMENT PATIENT SPECIFIC NCM ENGAGEMENT REPORTS CAN BE SENT TO MCAIDREPORTS@UHC.COM;

Screen shot of United high risk list 1 of 3



Patient Risk Report

Run Date: 2/13/2014

UnitedHealthcare

Practice: WELLONE - PASCOAG
Retrospective Period: 6/30/2012 to 6/30/2013
Prospective Period: 6/30/2013 to 6/30/2014

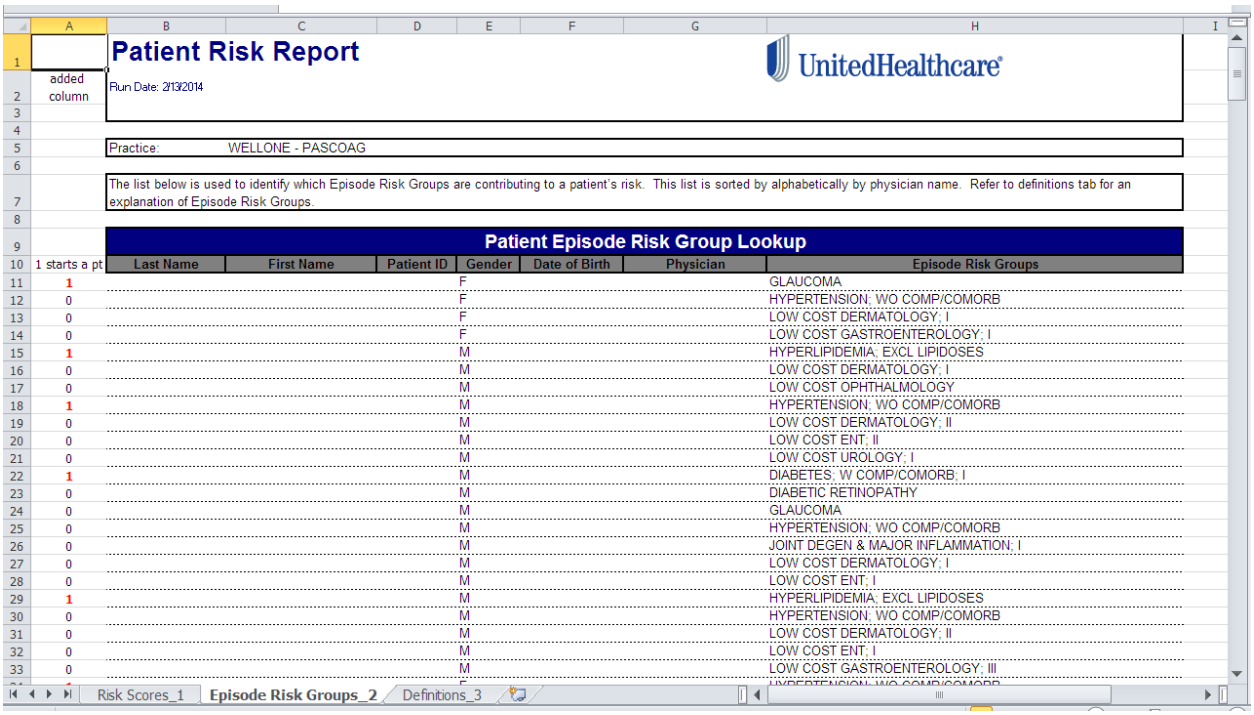
The list below represents all patients attributed to a primary care physician that is part of one of the practices listed above. Sorted alphabetically by physician name, patients are then ordered by descending retrospective risk. This allows identification of the highest risk patients. To see which Episode Risk Groups are driving a patient's risk score refer to tab 2 "Episode Risk Groups". Refer to definitions tab to for a description of each score.

Patient List Sorted by Risk

Last Name	First Name	Patient ID	Gender	Date of Birth	Physician	Practice	Retrospective Risk Score	Prospective Risk Score
			M			WELLONE - PASCOAG	25.98	12.35
			M			WELLONE - PASCOAG	20.29	11.00
			M			WELLONE - PASCOAG	13.22	7.58
			M			WELLONE - PASCOAG	12.15	6.04
			M			WELLONE - PASCOAG	10.52	6.54
			M			WELLONE - PASCOAG	7.62	6.79
			M			WELLONE - PASCOAG	7.34	7.85
			M			WELLONE - PASCOAG	7.18	5.07
			M			WELLONE - PASCOAG	5.70	5.40
			M			WELLONE - PASCOAG	5.59	3.38
			M			WELLONE - PASCOAG	5.45	6.09
			F			WELLONE - PASCOAG	5.40	3.58
			F			WELLONE - PASCOAG	4.98	3.67
			F			WELLONE - PASCOAG	4.91	3.88
			F			WELLONE - PASCOAG	4.89	4.69
			M			WELLONE - PASCOAG	4.43	3.44
			M			WELLONE - PASCOAG	4.12	3.85
			M			WELLONE - PASCOAG	4.00	4.79
			M			WELLONE - PASCOAG	3.81	4.09
			M			WELLONE - PASCOAG	3.75	3.63
			M			WELLONE - PASCOAG	3.74	3.87

Risk Scores_1 | Episode Risk Groups_2 | Definitions_3

Screen shot of United high risk list 2 of 3



Patient Risk Report

added column

Run Date: 2/13/2014

UnitedHealthcare

Practice: WELLONE - PASCOAG

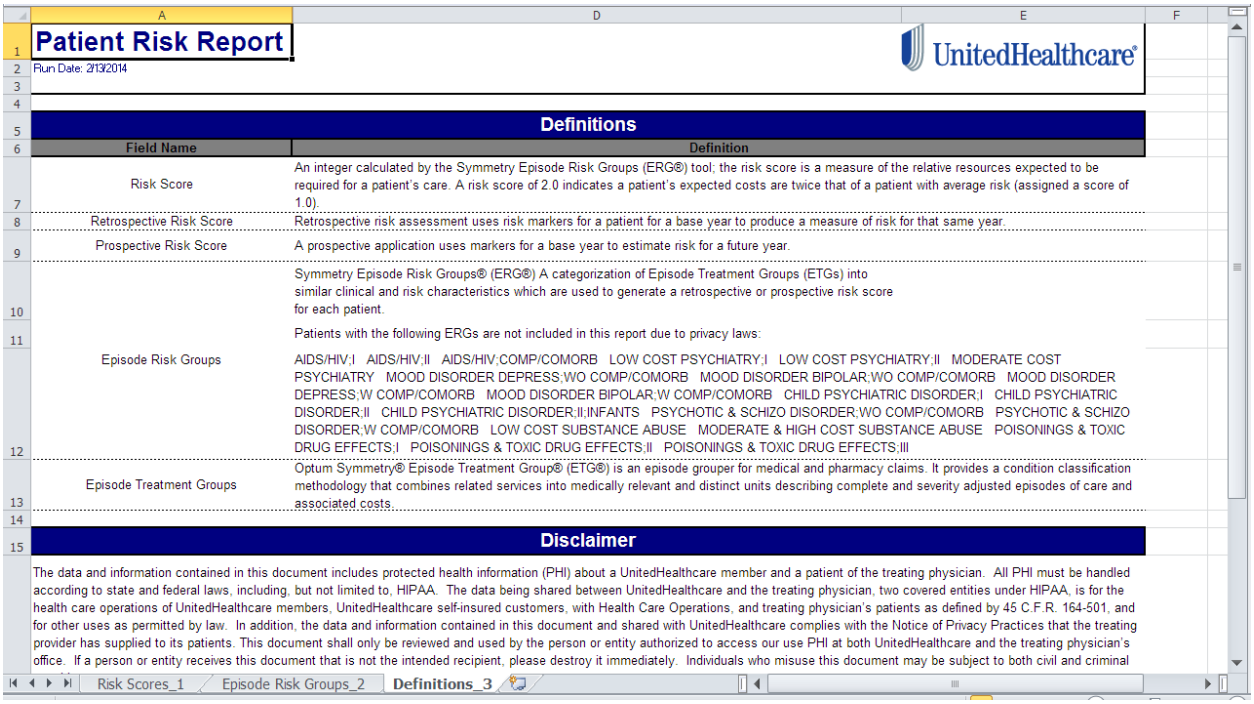
The list below is used to identify which Episode Risk Groups are contributing to a patient's risk. This list is sorted by alphabetically by physician name. Refer to definitions tab for an explanation of Episode Risk Groups.

Patient Episode Risk Group Lookup

1 starts a pt	Last Name	First Name	Patient ID	Gender	Date of Birth	Physician	Episode Risk Groups
1				F			GLAUCOMA
0				F			HYPERTENSION, WO COMP/COMORB
0				F			LOW COST DERMATOLOGY; I
0				F			LOW COST GASTROENTEROLOGY; I
1				M			HYPERLIPIDEMIA, EXCL LIPIDOSES
0				M			LOW COST DERMATOLOGY; I
0				M			LOW COST OPHTHALMOLOGY
1				M			HYPERTENSION, WO COMP/COMORB
0				M			LOW COST DERMATOLOGY; II
0				M			LOW COST ENT; II
0				M			LOW COST UROLOGY; I
1				M			DIABETES, W COMP/COMORB; I
0				M			DIABETIC RETINOPATHY
0				M			GLAUCOMA
0				M			HYPERTENSION, WO COMP/COMORB
0				M			JOINT DEGEN & MAJOR INFLAMMATION; I
0				M			LOW COST DERMATOLOGY; I
0				M			LOW COST ENT; I
1				M			HYPERLIPIDEMIA, EXCL LIPIDOSES
0				M			HYPERTENSION, WO COMP/COMORB
0				M			LOW COST DERMATOLOGY; II
0				M			LOW COST ENT; I
0				M			LOW COST GASTROENTEROLOGY; III

Risk Scores_1 | Episode Risk Groups_2 | Definitions_3

Screen shot of United high risk list 2 of 3



Patient Risk Report

Run Date: 2/13/2014

UnitedHealthcare

Definitions

Field Name	Definition
Risk Score	An integer calculated by the Symmetry Episode Risk Groups (ERG®) tool; the risk score is a measure of the relative resources expected to be required for a patient's care. A risk score of 2.0 indicates a patient's expected costs are twice that of a patient with average risk (assigned a score of 1.0).
Retrospective Risk Score	Retrospective risk assessment uses risk markers for a patient for a base year to produce a measure of risk for that same year.
Prospective Risk Score	A prospective application uses markers for a base year to estimate risk for a future year.
Episode Risk Groups	Symmetry Episode Risk Groups® (ERG®) A categorization of Episode Treatment Groups (ETGs) into similar clinical and risk characteristics which are used to generate a retrospective or prospective risk score for each patient. Patients with the following ERGs are not included in this report due to privacy laws: AIDS/HIV;I AIDS/HIV;II AIDS/HIV;COMP/COMORB LOW COST PSYCHIATRY;I LOW COST PSYCHIATRY;II MODERATE COST PSYCHIATRY MOOD DISORDER DEPRESS;WO COMP/COMORB MOOD DISORDER BIPOLAR;WO COMP/COMORB MOOD DISORDER DEPRESS;W COMP/COMORB MOOD DISORDER BIPOLAR;W COMP/COMORB CHILD PSYCHIATRIC DISORDER;I CHILD PSYCHIATRIC DISORDER;II CHILD PSYCHIATRIC DISORDER;II;INFANTS PSYCHOTIC & SCHIZO DISORDER;WO COMP/COMORB PSYCHOTIC & SCHIZO DISORDER;W COMP/COMORB LOW COST SUBSTANCE ABUSE MODERATE & HIGH COST SUBSTANCE ABUSE POISONINGS & TOXIC DRUG EFFECTS;I POISONINGS & TOXIC DRUG EFFECTS;II POISONINGS & TOXIC DRUG EFFECTS;III
Episode Treatment Groups	Optum Symmetry® Episode Treatment Group® (ETG®) is an episode grouper for medical and pharmacy claims. It provides a condition classification methodology that combines related services into medically relevant and distinct units describing complete and severity adjusted episodes of care and associated costs.

Disclaimer

The data and information contained in this document includes protected health information (PHI) about a UnitedHealthcare member and a patient of the treating physician. All PHI must be handled according to state and federal laws, including, but not limited to, HIPAA. The data being shared between UnitedHealthcare and the treating physician, two covered entities under HIPAA, is for the health care operations of UnitedHealthcare members, UnitedHealthcare self-insured customers, with Health Care Operations, and treating physician's patients as defined by 45 C.F.R. 164-501, and for other uses as permitted by law. In addition, the data and information contained in this document and shared with UnitedHealthcare complies with the Notice of Privacy Practices that the treating provider has supplied to its patients. This document shall only be reviewed and used by the person or entity authorized to access our use PHI at both UnitedHealthcare and the treating physician's office. If a person or entity receives this document that is not the intended recipient, please destroy it immediately. Individuals who misuse this document may be subject to both civil and criminal

Risk Scores_1 | Episode Risk Groups_2 | Definitions_3

MAPCP Portal

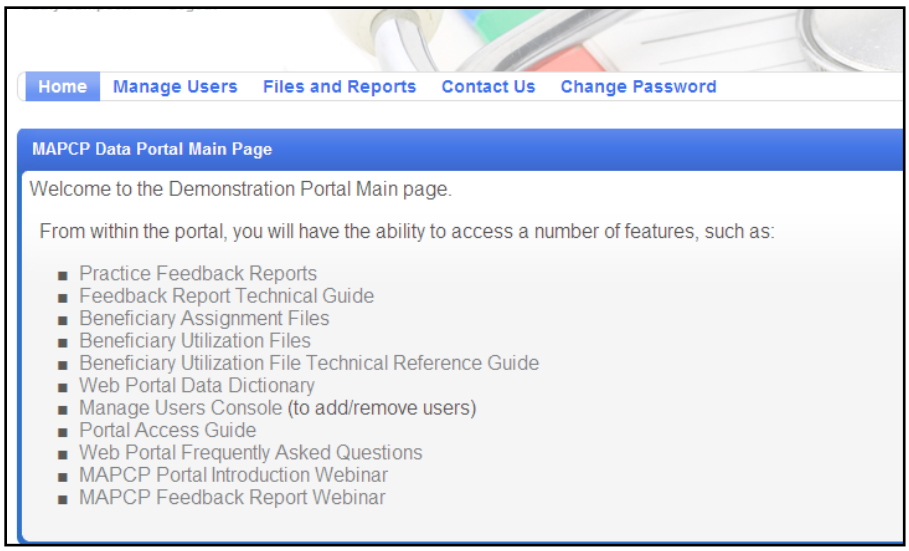
This is the portal for practices who participate in the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration, the Centers for Medicare & Medicaid Services (CMS). All practices that entered the CTC Program prior to 2013 are participants in the MAPCP Demonstration project.

MAPCP Portal Login: https://mapcp.rti.org/

For full login instructions: https://www.pcmhri.org/content/mapcp

For questions or concerns on the MAPCP portal login information, contact:
Nicole Mossey Project Coordinator 508 856 6496 Nicole.Mossey@umassmed.edu

Screen shot of MAPCP Data Portal Mail Page



Reports include the following data fields:

- **Beneficiary Assignment Lists**

Patient ID	MI	HIC
New Patient	Zip	Practice ID
Last Name	County	Medical Home
First Name	DOB	CHO ID
Address	Gender	CHO Name

Dropped Beneficiary Assignment Lists

Patient ID	Zip	Practice ID
Last Name	County	Medical Home
First Name	HIC	CHO ID
MI	DOB	CHO Name
Address	Gender	

Beneficiary Utilization Reports

Patient Number	Chest Pain	Discharge date of 4th

		Hospitalization
Last Name	Spondylosis/Other Back Problems	Facility of 4th Hospitalization
First Name	COPD or Bronchiectasis	Principal Diagnosis 4th Hospitalization
Age	Urinary Tract Infection	ACSC Admission 4th Hospitalization
DOB	Pneumonia	Discharge date of 5th Hospitalization
Gender	Congestive Heart Failure	Facility of 5th Hospitalization
HCC Category	Inpatient Expenditures	Principal Diagnosis 5th Hospitalization
Claims based diagnosis of diabetes	Specialty Provider Expenditures	ACSC Admission 5th Hospitalization
HbA1C Test	Primary Care Provider Expenditures	Discharge date of 6th Hospitalization
Date of HbA1C Test	ER Expenditures	Facility of 6th Hospitalization
Hba1c done by practice	Number of Hospitalizations	Principal Diagnosis 6th Hospitalization
LDL-C Test	Discharge date of 1st Hospitalization	ACSC Admission 6th Hospitalization
Date of LDL-C Test	Facility of 1st Hospitalization	Number of ER visits
LDL-C done by Practice	Principal Diagnosis 1st Hospitalization	Date of 1st ER visit
Eye Exam	ACSC Admission 1st Hospitalization	Facility of 1st ER visit
Eye Exam done by practice	Discharge date of 2nd Hospitalization	Principal Diagnosis 1st ER visit
Nephropathy	Facility of 2nd Hospitalization	Date of 2nd ER visit
Date of Nephropathy Screening	Principal Diagnosis 2rd Hospitalization	Facility of 2nd ER visit
Nephropathy Screening done by practice	ACSC Admission 2nd Hospitalization	
Claims based diagnosis of Heart Disease	Discharge date of 3rd Hospitalization	
Complete Lipid Panel	Facility of 3th Hospitalization	
Date of Complete Lipid Panel	Principal Diagnosis 3rd Hospitalization	
Lipid done by practice	ACSC Admission 3rd Hospitalization	

Practice Feedback Reports

The Feedback Report Technical Guide on the Home Page provides information regarding the Feedback Report.

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										

University Medicine

SAMPLE: **HEALTH ADVOCATE JOB DESCRIPTION**

DESCRIPTION

The Health Advocate is responsible for performing a variety of duties working collaboratively with the PCMH care team to support the successful management of care for the practice's patient population. The focus of the work will be on directly impacting quality and cost drivers which correlate with group deliverables as prescribed in contractual agreements with payors.

PRIMARY DUTIES

- Contacts patients as appropriate to schedule appointments necessary to closing gaps in care.
- Participates in performance improvement activities.
- Manages a specific patient population based on practice need, with specific emphasis on impacting process related measures
- Triages complex cases to more senior members of the care team as well as manages those tasks triages across or down the care team
- Relays follow-up instructions to patient/family
- Provides informational literature
- Documents data collected during the patient care process via electronic or paper medical record
- Maintains the dignity and confidentiality of the patient
- Works collaboratively with all members of the BCBSRI PCMH team
- Performs other duties as assigned

QUALIFICATIONS

- High school graduate or equivalent certificate is required.
- Knowledge of medical terminology preferred.
- Computer experience required, EMR preferred.
- Experience interacting with clinical staff
- CPR certification required. Must have good communication and organizational skills
- Excellent interpersonal skills required to work with a variety of individuals within the practice.
- One to two years physician office experience preferred

WORK ENVIRONMENT **(select all applicable):**

Environmental Conditions:

☐ Work near moving mechanical parts.

Noise Level

☐ Quiet

☐ Work in high, precarious places.

☐ Outdoor weather conditions.

☒ Typical office conditions.

☒ Moderate

☐ Loud

Other Work Environments: N/A

PHYSICAL DEMANDS (select all applicable):

Physical Activity:

☒ Sit, stand, walk, talk, and hear.

☒ Reaching with hands and arms.

☐ Climbing or balancing.

☐ Stoop, kneel, crouch or crawl.

Physical Exertion:

☒ Lift up to 10 pounds.

☐ Lift up to 25 pounds.

☐ Lift up to 50 pounds.

☐ Lift more than 50 pounds.

Vision Requirements:

☐ Close vision.

☐ Distance vision.

☐ Peripheral vision.

☐ Depth perception.

☒ Ability to adjust focus.

Other Physical Demands: N/A

ACCESS TO INFORMATION:

Assign sensitivity level based on the highest level of data sensitivity, and the requirements of specific laws governing the protection or disclosure of this information, required of this position.

___ Level 1: Low Sensitivity- Data used in these positions requires minimal protection. Risks associated with disclosure of this data are minimal, and only minimal precautions to protect the data need to be taken. Data that

is in the public domain, for which any unauthorized disclosures could be expected not to adversely affect the individual and/or the organization.

___ Level 2: Moderate Sensitivity - Data used in these positions is most often collected for analytical purposes and has importance to BCBSRI and its business partners and must be protected. This category would include information of a proprietary nature such as: management information concerning workload, performance, staffing, research, financial and statistical data, and similar data usually in statistical form. This data is not individually identifiable to members. It also includes items such as directories, organizational charts, policies, procedures, and other documents pertaining to internal corporate operational processes.

X Level 3: High Sensitivity – Data used in these positions is sensitive in nature and requires the greatest and most stringent security safeguards as the user level. This category includes, but is not limited to, all individually identifiable data and health care information, however maintained, that require protection due to the risk and magnitude of loss or harm that could result from inadvertent or deliberate disclosure, alteration, or destruction of the data; payment information, benefit information, employee personal information or payroll information, proprietary information, and correspondence and documents that are considered highly sensitive or critical to the organization. Information that could put this sensitive information at risk is also included in this category, such as passwords, encryption keys and detailed information technology related information.

__x__ member demographic information

__x__ financial information

__x__ member medical/health information

__x__ other proprietary information

DISCLAIMER:

This description is not intended to be a complete statement of job content; rather to act as a guide to the essential functions performed. Management retains the discretion to add to or change the duties of the position at any time.

Community Health Network **Program Referral Form**

Patient Information

Name: Gender: ☐ Male ☐ Female ☐ Other

Address: City/Town: State: Zip:

Best Contact Phone: ( ) - Birth Date: / /

Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify)

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

Currently enrolled in WISEWOMAN? ☐ Yes ☐ No

Referral Provider Information

Referral Date: / / Provider Name:

Practice Address:

Phone: ( ) - Fax number for feedback: ( ) -

☐ **Patient enrolled in onsite program, CHN patient navigator contact not needed. Program Name:**

Programs available: (Please check all that apply)

Community Health Network

- ☐ Arthritis Foundation Walk with Ease program
- ☐ Certified Diabetes Outpatient Educator (Registered Nurse, Dietitians, and Pharmacists)
- ☐ Chronic Disease Self-Management (Living Well)
- ☐ Diabetes Self-Management (Living Well)
- ☐ Diabetes Prevention Program (DPP)
- ☐ Draw a Breath Asthma program
- ☐ Enhance Fitness Program (YMCA)
- ☐ Matter of Balance
- ☐ QUITWORKS-RI

For WISEWOMAN Program Only

- ☐ Anytime Fitness (Burrillville only)
- ☐ Health Coaching Plus By CDOE
- ☐ Jazzercise (Greenville Only)
- ☐ One Yoga Center (Foster only)
- ☐ Vida Sana
- ☐ Weight Watchers
- ☐ YMCA membership

Healthcare Provider Signature: Date: / / Notes:

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

I,

(Participant's Name) (Participant's DOB)

hereby voluntarily authorize disclosure of certain information for the purpose of being referred to a chronic disease education/ self-management program or service.

Information shared may include my name, address, phone number, date of birth, primary language, health insurance, and health concerns related to the referral. This personal information may be shared between and among the health care provider listed below, the Rhode Island Department of Health, and the chronic condition education /self-management program or services to which I have been referred.

I understand that the health care provider listed above may be provided additional information related to the referral, including whether I participated in the 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.

(Signature of person referred) (Date)

- Please have the person being referred sign the authorization to disclose information to Community Health Network Programs.
- Keep a copy for your records.
- Please fax this form to Community Health Network through secure fax 401-222-4418.
- Please call Community Health Network Patient Navigator at 401-222-3600 if you have any questions.

Overarching Principles and Definitions	
Active Patients:	Out 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). The following are the eligible CPT/HCPCS office visit codes for determining Active Patient status: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490, 99495-99496, G0402; G0438-G0439 Acceptable Exclusions: Patients who have left the practice, as determined by one or more of the following: 1. Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice 2. Patient has passed away 3. Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person 4. Patient has been discharged according to practice's discharge policy
Outpatient Visit Criteria:	Please refer to the HEDIS® Outpatient Value Set.
Encounter Types:	In addition to following CPT/HCPCS code level of service guidelines to establish an eligible population, report writers should ensure encounter types are limited to include only face to face encounter types for those measures requiring a face to face encounter. Example: Depression screening: Patient turns 18 in July 2016. In the record they have two "encounters" in 2016 – a well visit in April and a nurse care manager phone call in August. Failure to limit encounter types correctly could result in the nurse care manager visit erroneously triggering this patient in the eligible population.
Practices using shared EHR systems:	Denominator calculation are based upon encounters in the PCMH unless otherwise specified. Numerator events may be from any source (e.g. a recorded BMI or lab value).
Value Set Information:	HEDIS® measures reference Value Sets are available for download at store.ncqa.org under the search term: "2016 Quality Rating System (QRS) HEDIS® Value Set Directory." See attached "Instructions for Obtaining "2016 Quality Rating System (QRS) HEDIS® Value Set Directory."

Measure:	Adult BMI Assessment (ABA)
Description:	The percentage of patients 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented using the age acceptable format (percentile versus numeric) during the measurement year or the year prior by any provider
Age criteria:	Eligible population is determined as 18 as of the beginning of the year prior to the measurement year and 74 as of the last day of the measurement year. **Example:** Measurement year 2016 18 as of 1/1/2015 74 as of 12/31/2016 Note: An added age criteria must be applied to determine if the correct format was used for the patient's age at the time of the visit. Since only one recording is required and multiple will likely occur during the reporting period, reporting on the most recent value is easiest.
Numerator Statement:	For patients 20 years of age or older on the date of service, BMI (BMI Value Set) documented during the measurement year or the year prior to the measurement year For patients younger than 20 years of age on the date of service, BMI percentile (BMI Percentile Value Set) documented during the measurement year or the year prior to the measurement year Documentation must include not only the BMI Value or Percentile, but also height and weight.
Denominator Statement:	Patients meeting the above age criteria who had an outpatient visit defined by Outpatient Visit Criteria during the measurement year or the year prior
Acceptable Exclusions:	Patients with a diagnosis of pregnancy (refer to HEDIS® Pregnancy Value Set) during the measurement year of the year prior to the measurement year Outpatient visit codes 99324-99337; 99341-99350; 99495-99496 due to lack of ability to measure height and weight in home setting
Look back Period:	24 months
Source:	HEDIS®

Measure:	Screening for Clinical Depression and Follow Up Plan
Description:	The percentage of active patients 18 years of age and older screened for clinical depression using an age appropriate standardized tool AND, if positive follow up plan is documented on the date of the screen
Age criteria:	Eligible population is determined as 18 at the date of encounter. **Example 1:** Patient turns 18 on 4/15/2016 Date of encounter 4/12/2016 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 4/15/2016 Date of encounter 6/12/2016 Patient is IN denominator
Numerator Statement:	Active patients 18 years of age and older at the date of encounter screened for clinical depression at least once during the measurement period using an age appropriate standardized tool AND, if positive, follow up plan is documented on the date of the screen
Denominator Statement:	Active patients 18 years of age and older on the date of encounter. Encounter must meet the outpatient visit criteria
Acceptable Exclusions:	1. Patient has active diagnosis of depression 2. Patient has a diagnosed bipolar disorder 3. Patient has a diagnosis of dementia
Follow-Up Plan Requirements:	Documented follow-up for a positive depression screening must include one or more of the following: 1. Additional evaluation for depression (e.g. continuation to PHQ-9 if PHQ-2 is abnormal) 2. Suicide Risk Assessment 3. Referral to a practitioner who is qualified to diagnose and treat depression 4. Pharmacological interventions 5. Other interventions or follow-up for the diagnosis or treatment of depression
Adult Screening Tools:	Acceptable tools include the Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2. The tool used must be documented in the record.
Look back Period:	12 months
Source:	PQRS

Measure:	HbA1C Control (<8)
Description:	The percentage of active diabetic patients between 18 and 75 years of age whose most recent HbA1C value was less than 8
Age criteria:	Eligible population is determined as 18 or 75 at the end of the measurement period. Example: Measurement period end date 12/31/2016 Patient age between 18 as of 12/31/2016 to 75 as of 12/31/2016
Numerator Statement:	Active diabetic patients between 18 and 75 years of age at the end of the measurement period whose most recent HbA1C value in the measurement year was less than 8
Denominator Statement:	Active diabetic patients between 18 and 75 years of age at the end of the measurement period with documentation of diabetes during the measurement year or the year prior
Acceptable Exclusions:	1. Patients who do not have a diagnosis of diabetes (Diabetes Value Set) in any setting during the measurement year or year prior AND who had a diagnosis of gestational diabetes or steroid induced diabetes (Diabetes Exclusions Value Set) during the measurement year or year prior 2. Patients who joined the practice less than 6 months prior to the end of the measurement period
Identifying Diabetics:	Practices may identify diabetics in multiple ways including problem lists, encounter diagnoses, and/or active medications.
Diabetics without A1C Documented:	If no A1C reading was rendered during the measurement year, patient counts as non-adherent.
Look back Period:	12 months
Source:	HEDIS®

Measure:	Controlling High Blood Pressure
Description:	The percentage of active patients between 18 and 85 years who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-59 years of age whose BP was <140/90 • Patients 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Patients 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
Age criteria:	Eligible population is determined as 18 or 85 at the end of the measurement period. Example: Measurement period end date 12/31/2016 Patient age between 18 as of 12/31/2016 to 85 as of 12/31/2016
Numerator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period whose BP was adequately controlled during the measurement year based on the following criteria: • Patients 18-59 years of age whose BP was <140/90 mm Hg • Patients 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Patients 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg
Denominator Statement:	Active hypertensive patients between 18 and 85 years of age at the end of the measurement period. Patients are identified as hypertensive if there is at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) or active problem list diagnosis during the first six months of the measurement year.
Acceptable Exclusions:	1. Patients with ESRD (ESRD Value Set: ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis. 2. Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year 3. Patients who had a non-acute inpatient admission during the measurement year. (This exclusion is much more feasible for a health plan to apply than a practice). To identify non-acute inpatient admissions: a. Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). b. Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim.

	c. Identify the discharge date for the stay.
BP Documentation:	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP reading is recorded during the measurement year, assume that the patient is "not controlled."
Look back Period:	12 months
Source:	HEDIS®

Measure:	Tobacco Cessation Intervention
Description:	The percentage of active patients 18 years and older and who were screened for tobacco use one or more times within 24 months AND who received cessation counseling if identified as a tobacco user
Age criteria:	Eligible population is determined as 18 at the date of encounter **Example 1:** Patient turns 18 on 4/15/2016 Date of encounter 4/12/2016 Patient is NOT IN denominator **Example 2:** Patient turns 18 on 4/15/2016 Date of encounter 6/12/2016 Patient is IN denominator
Numerator Statement:	All active patients 18 and older at the date of encounter who were screened for tobacco use at least once within 24 months and were either identified as a non-smoker OR identified as a smoker AND received tobacco cessation intervention
Denominator Statement:	All active patients 18 and older at the date of encounter with at least two visits (see Outpatient Visit criteria) **OR** one preventive visit during the measurement period
Acceptable Exclusions:	None
Tobacco Use and Intervention Definitions:	Tobacco Use – Includes use of any type of tobacco Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy
Patients Not Assessed:	If tobacco use status of patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure.
Look back Period:	There are two different lookback period for this measure: • Documentation of cessation counseling – 24 month look back from most recent office visit • Count of encounters – 24 month look back from end of measurement period to determine if patient has been seen twice for any type of visit or for one preventive visit
Source:	NQF/PQRS

Measure:	Well Child Counseling: Weight Assessment and Counseling for Nutrition and Physical Activity
Description:	Percentage of active patients 3-17 years of age who had an outpatient visit in the last twelve months with a primary care clinician of the PCMH who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation, • Counseling for nutrition, AND • Counseling for physical activity
Age criteria:	Eligible population is determined as 3-17 at the end of the measurement year. Example: Measurement period end date 12/31/2016 Patient age between 3 as of 12/31/2016 to 17 as of 12/31/2016
Numerator Statement:	Patients in the denominator who had evidence of a Body mass index (BMI) percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year • BMI percentile: documentation must include height, weight, and BMI percentile during the measurement year. The height, weight, and BMI must be from the same data source. o Either of the following meets criteria for BMI percentile: ▪ BMI percentile, or ▪ BMI percentile plotted on age-growth chart o Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%). • Counseling for nutrition: documentation of counseling for nutrition or referral for nutrition education during the measurement year. Documentation must include a note indicating the date and at least one of the following: o Discussion of current nutrition behaviors (e.g. eating habits, dieting behaviors) o Checklist indicating nutrition was addressed o Counseling or referral for nutrition education o Patient received educations materials on nutrition during a face to face visit o Anticipatory guidance for nutrition o Weight or obesity counseling • Counseling for physical activity: documentation of counseling for physical activity or referral for physical activity during the measurement year. Documentation must include a note indicating the date and at least one of the following:

	o Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation) o Checklist indicating physical activity was addressed o Counseling or referral for physical activity o Patient received education materials on physical activity during face to face visit o Anticipatory guidance for physical activity o Weight or obesity counseling
Denominator Statement:	All active patients 3-17 at the end of the measurement year with a documented encounter during the measurement year
Acceptable Exclusions:	Patients with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year
Look back Period:	12 months
Source:	HEDIS®

Measure:	Well Child Counseling: Developmental Screening
Description:	The percentage of active patients screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.
Age criteria:	Children who turn 1, 2, or 3 years of age during the measurement year.
Numerator Statement:	The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening in the first, second, and third years of life. The measure is based on three, age-specific indicators. Numerators 1-3 are for your understanding of the measures. Only Numerator 4 is required to report to PCMH-Kids. • **Numerator 1**: Children in Denominator 1 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday • **Numerator 2**: Children in Denominator 2 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their first and before or on their second birthday • **Numerator 3**: Children in Denominator 3 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented after their second and before or on their third birthday • **Numerator 4**: Children in Denominator 4 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthday, i.e., the sum of numerators 1, 2, and 3. Documentation in the medical record must include all of the following: • A note indicating the date on which the test was performed, and • The standardized tool used (see below), and • Evidence of a screening result or screening score Tools must meet the following criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional. 2. Established Reliability: Reliability scores of approximately 0.70 or above 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

	4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above Current recommended tools that meet these criteria: 1. Ages and Stages Questionnaire (ASQ) - 2 months – 5 years 2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3) 3. Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth – 95 months 4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months – 2 years 5. Brigance Screens-II – Birth – 90 months 6. Child Development Inventory (CDI) - 18 months–6 years 7. Infant Development Inventory – Birth – 18 months 8. Parents' Evaluation of Developmental Status (PEDS) – Birth – 8 years 9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) 10. Survey of Wellbeing of Young Children (SWYC) Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.
Denominator Statement:	Active patients who have been seen by the primary care clinician at the PCMH in the previous 12 months who meet the following eligibility requirement based on child's age at end of measurement year • **Denominator 1**: Active Patients who turn 1 during measurement year • **Denominator 2**: Active Patients who turn 2 during measurement year • **Denominator 3**: Active Patients who turn 3 during measurement year • **Denominator 4**: All Active Patients who turn 1, 2, or 3 the measurement year, i.e., the sum of denominators 1, 2, and 3
Acceptable Exclusions:	None
Look back Period:	Screenings must be completed prior to the patient's birthdate. In order to account for patients with birthdates at the beginning of the measurement year, reports should account for these encounters accordingly and place a lookback period on the patient's DOB rather than the measurement period. In order to account for age appropriate screenings, this look back should not exceed a 6 month lookback from the DOB in order to avoid erroneously counting developmental screenings used for prior years of age. Example: Patient 1 DOB: 1/15/2013

	Patient 2 DOB: 5/31/2013 Measurement period for both Patient 1 and 2: 1/1/2016 – 12/31/2016 Lookback period for Patient 1: 7/15/2015 -1/14/2016 Lookback period for Patient 2: 11/15/2015 – 5/30/2016
Source:	Oregon Pediatric Improvement Partnership at Oregon Health and Science University (OHSU)

RI Care Transformation Collaborative (CTC)
Adult Clinical Quality Measures (CQM) Strategy Checklist (v4.17)
(Based on CTC document: "May 2016 CTC/OHIC Measure Specifications")

Rhode Island Quality Institute has developed this checklist to assist practices in achievement of clinical quality measure (CQM) reporting for CTC. This is not an exhaustive plan, but rather a guide to help navigate the requirements. Use this checklist as supplement to: "May 2016 CTC/OHIC Measure Specifications". To learn more about Rhode Island Quality Institute, call(888) 858-4815, e-mail RIREC@riqi.org or go: http://transformyourpracticeri.org/Services

Practice Name:

Reviewed Check list with name/s): **Date(s) Reviewed:**

RI REC Relationship Manager: Sue Dettling (sdettling@riqi.org) OR Ashley Kurpiewski (AKurpiewski@riqi.org)

Current NCQA Level / Expiration: **EHR Vendor/ Version:**

	Important Steps	Notes/ Planning / Timeline
☐	**Define roles, responsibilities and processes for**: ☐ Attend Practice Reporting Workgroup meetings: _____ ☐ Develop and generate EHR reports: _____ ☐ Report to RIQI/CTC: _____ ☐ Disseminate results within practice: _____ ☐ Use results to drive quality improvement activities within practice	
☐	**Understand measure definitions:** ☐ Review Measures ☐ Examine EHR reporting capabilities/ or pursue external vendor ☐ Identify and address any problems with EHR reporting capabilities ☐ Develop reports – run test reports and examine for accuracy	Any questions about quality measure specifications, please contact your Relationship Manager: Sue Dettling – email: sdettling@riqi.org Ashley Kurpiewski - email: AKurpiewski@riqi.org

☐	**Create Milestone Plan for CTC quality measure submission:** ☐ Date Initial Review Completed: _____ ☐ Gather all measures to be reported, including NCM and IBH, if applicable ☐ As submission time approaches, you will receive an email from RIQI with a direct link to your data collection form. Use this link to submit results ☐ Results are due by 15th of month following quarter end)	Any questions about CTC reporting portal, contact Marie Sarrasin - email: msarrasin@riqi.org The portal form assumes all measures are submitted at the same time so it's best to have all results ready at time of submission. If this is not possible, you may submit data on more than one occasion. Be sure to follow instructions on the form about submitting with missing data. -If you do not receive an email about a week before submission deadline, go to https://www.ctc-ri.org, locate your practice site and submit your quality data.
☐	**Timeline for required Quarterly Submission of quality measures:** *(use rolling quarters)* Due 1/15/2017; Q4 2016 (data from 1/1/15 ending 12/31/16) – *completed* Due 4/15/2017; Q1 2017 (data from 4/1/16 ending 3/31/17) Due 7/15/2017; Q2 2017 (data from 7/1/16 ending 6/30/17) Due 10/15/2017; Q3 2017 (data from 10/1/16 ending 9/30/17) Due 1/15/2018; Q4 2017 (data from 1/1/16 ending 12/31/17	Practices that are running the report the first time need to plan to run data one month before due date and meet with Relationship Manager to discuss data and how report was generated. *Practices need to formally ask for an extension if not able to report data; such an extension MUST be APPROVED by CTC. In order to be considered for an exclusion, please send an email to each of these CTC reporting contacts: Andrea Galgay: agalgay@ripcpc.com Patty Kelly-Flis: pkelly-flis@welloneri.org Susanne Campbell: Susanne.Campbell@umassmed.edu Marie Sarrasin: msarrasin@riqi.org

CTC Clinical Quality Measures (CQMs)

Note: These measure definitions are based on the NQF and/or HEDIS measure definitions but are not exactly the same as the quality measures required for Meaningful Use. EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the EHR report may result in duplication of patients.

	Measure	Helpful Tips	Notes/ Planning / Timeline Where Captured in EHR?
☐	**Active Patient criteria –** same definition for ALL measures – refer to *May 2016 CTC/OHIC Measure Specification* document (Spec Doc.) for additional details Patient seen by a primary care clinician of the PCMH anytime within the last 24 months. (outpatient visit)	**Helpful Tip:** Important to "clean" up your data and ensure that you are reporting on your active patients. Be sure to review your lists regularly with your providers (annotate properly who is deceased, or transferred out according to the active patient definition). This will yield more accurate results with your quality data. Have a procedure to make a patient inactive for reasons such as "moved, but did not transfer", "outreach to patient 3 or more times (using 2 or more outreach methods)"	Refer to pg. 1 of *May 2016 CTC/OHIC Measure Specification* document for: CPT office visit codes, acceptable exclusions, outpatient visit criteria and encounter types.
☐	**Adult BMI Assessment (ABA) – Age 18-74 (HEDIS)** **Contract Measure** • Look Back Period: 24 months • 2015- 2016 Threshold: N/A • 2015- 2017 Non-FQHC Threshold: 90% • 2015- 2017 FQHC Threshold: 90%	**Helpful Tips:** It is OPTIONAL to run report with exclusions or not; if exclusions are applied, data will yield more accurate results. Documentation must include BMI value/percentile, height and weight	
☐	**Screening for Clinical Depression and Follow Up Plan (PQRS)** **Contract Measure** • Look Back Period: 12 months • 2015- 2016 Threshold: N/A • 2015- 2017 Non-FQHC Threshold: 50% • 2015- 2017 FQHC Threshold: 50%	**Helpful Tips:** Acceptable tools include the Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2. The tool used must be documented in the record. Completion of PHQ-9 satisfies "follow-up" through means of a continued screening.	

CTC Clinical Quality Measures (CQMs)

Note: These measure definitions are based on the NQF and/or HEDIS measure definitions but are not exactly the same as the quality measures required for Meaningful Use. EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the EHR report may result in duplication of patients.

	Measure	Helpful Tips	Notes/ Planning / Timeline Where Captured in EHR?
☐	**Diabetes Mellitus – HbA1c Control (<8)** **- Age 18-75** **(HEDIS)** **Contract Measure** • Look Back Period to identify diabetics: 24 months • Look Back Period for A1C results: 12 months • 2015- 2016 Threshold: 72% • 2015- 2017 Non-FQHC Threshold: 72% • 2015- 2017 FQHC Threshold: 67%	**Helpful Tips:** Denominator includes active patients with diagnosis of diabetes or listed as diabetic in "problem list"/ or "assessment"; need to be age 18 – 75 at the end of the reporting period with documentation of diabetes during the measurement year or year prior. Practices are required to report on most recent result (if 2 are normal and 3rd most recent is out of range, it still has to be counted; If patient does NOT have A1C recorded, this counts against you; Use **CurrentCare Viewer** to look up missing labs – will allow for more accurate reporting) May use Active Patients who have been on practice panel for at least 6 mos. (see Exclusion on "Spec Doc.")	
☐	**Controlling High Blood Pressure - Age 18-75** **(HEDIS)** **Contract Measure** • Patients age 18-59 w/ BP <140/90 *mm Hg* • Patients age 60 – 85 w/ diagnosis diabetes w/ BP < 140/90 • Patients age 60 – 85 w/out diagnosis diabetes w/ BP < 150/90 • Look Back Period: 12 months • 2015- 2016 Threshold: 80% • 2015- 2017 Non-FQHC Threshold: 80% • 2015- 2017 FQHC Threshold: 68%	**Helpful Tips:** BP is viewed as 2 separate values systolic and diastolic. If there are multiple readings for single date, the lowest of each may be used. Pay close attention to measure definition as it includes diabetics and non-diabetics by age and BP range; Report on ONE Numerator/Denominator by adding all together (age 18 – 85). Practices may limit denominator to only include those patients with a diagnosis of hypertension in the first 6 months of the measurement year, however, most practices include any with an active problem list	*Vitals*

CTC Clinical Quality Measures (CQMs)

Note: These measure definitions are based on the NQF and/or HEDIS measure definitions but are not exactly the same as the quality measures required for Meaningful Use. EHR Meaningful Use certified automated reports may be used only in single provider practices. Aggregation of individual provider numerators and denominators generated by the EHR report may result in duplication of patients.

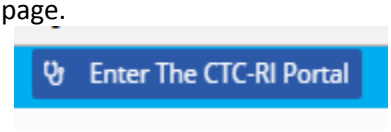
	Measure	Helpful Tips	Notes/ Planning / Timeline Where Captured in EHR?
		diagnosis of hypertension. The first six months rule applies more to health insurers being held accountable to the measure rather than practices, but to remain consistent with specifications, the exclusion was included for CTC. If able, do not include patients with new diagnosis of hypertension in most recent 6 months.	
☐	**Tobacco Cessation Intervention (NQF/PQRS)** **Contract Measure** • Look Back Period: *2 different look back periods; see specification document for details* • 2015- 2016 Threshold: 90% • 2015- 2017 Non-FQHC Threshold: 90% • 2015- 2017 FQHC Threshold: 98%	**Helpful Tips:** patients' use of e-cigarette doesn't constitute as tobacco cessation intervention unless noted by provider as "quit method"	
	Additional Notes:		

Signing up, Navigating and Submitting Measure Results on the CTC Portal

This document describes the procedures associated with CTC Portal use. To get started:

1. Sign up – send your name, email address and practice you are affiliated with to msarrasin@riqi.org. If you'd like, include the ID and password you would like to use to make it easier to remember
2. When your account is activated, you will receive an email with your User ID password and navigation instructions
3. Visit the portal…

Navigate to https://www.ctc-ri.org and click on "Enter the CTC-RI Portal" 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 if you wish 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.

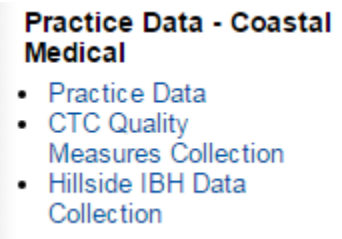
The Home Page

Once you have logged in, you will have been directed to the main welcome section entitled "Welcome to the RI CTC 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.

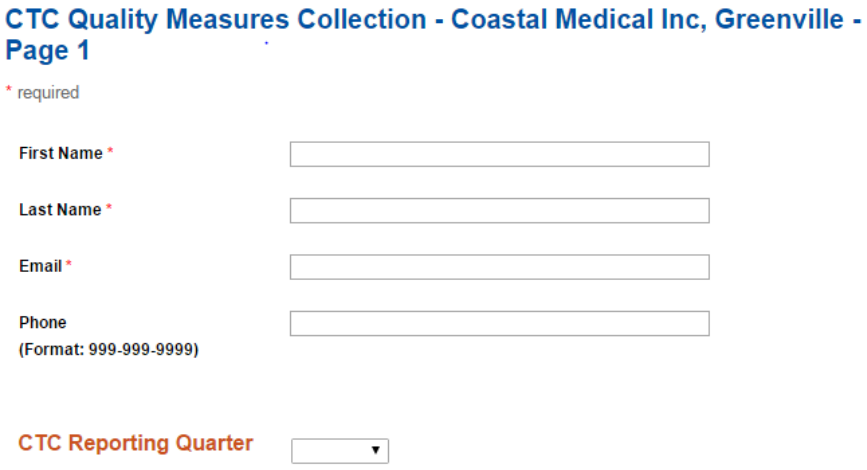
Details about the information available on the portal are included in the next section. The following describes the measure submission process.

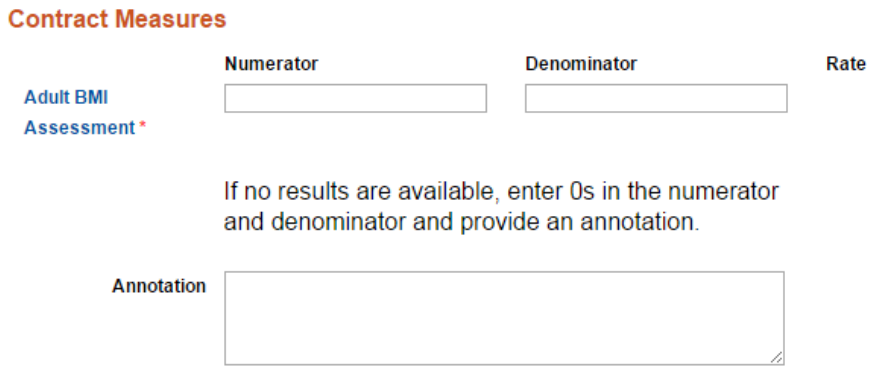
Submitting Quality Measures Data:

1. Log in to the CTC portal
2. Locate your site in the left navigation bar
3. Click on the Quality/IBH Measures Collection link



You will land on your data collection page.
Fields with * are required.





Fill in your contact information, your total number of active pts., the submission quarter and the numerator and denominator for each measure you're submitting. The rate will be calculated. Note the following:

1. There is some basic data validation, e.g., a denominator cannot be larger than the total # patients and a measure numerator cannot be larger than a denominator. You will need to correct these errors before you submit
2. You should enter values in all fields. If you have no results, please enter 0 for a value and make an annotation that explains why there are no results
3. Enter an annotation if you want to comment on the submission, i.e., "rate increased due to retraining of staff"
4. If your practice has more than one site, once you submit the first site's data and click on Submit and Continue, the 2nd site will come up.
5. You will receive an email after you submit with the details of your submission
6. It's best to enter all of your data at once but if you need to submit part of your submission and complete the submission later or you need to update your submission, you will enter 0 for the measure values you have already submitted. you can also send mail to msarrasin@riqi.org, and detail the update you need to make.

Portal Content/Navigating the Portal

On the Welcome page, you will see all or some (depending on practice affiliation) of these major section headings in the left navigation menu:

1. CTC Program – this section has information about the CTC program and minutes and agendas from CTC Committee meetings.
2. CTC Performance Dashboard - This section includes the Quarterly Dashboard that displays site progress on the CTC contractual targets. This section also shows aggregate results for quality measure results

3. CTC Quality Measures Data – This section contains aggregate and comparative results for the CTC sites' performance in the clinical quality measures
4. CTC Integrated Behavioral Health (IBH) Pilot program – Aggregate and comparative results for practices that are participating in the IBH Pilot Program
5. CTC Utilization Measures - This section contains aggregate results in six hospital and ED utilization measures. Note, this data covers the period through Q2 2015. CTC is awaiting current results from the All Payer Claims Database (APCD)
6. Patient Experience Survey – This section contains CTC site performance in the CAHPS PCMH Adult Survey
7. PCMH Kids Quality Measures Data – Aggregate and Comparative results for the practices that are participating in the PCMH Kids program
8. PCMH Kids Patient Experience Survey – This section contains PCMH Kids site performance in the CAHPS PCMH Child Survey
9. 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.

Please note that this information is not currently being made available to others outside the CTC Community. Please do not distribute any of this information to other parties.
Best regards,

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

Practice Reporting: Definition of Stable Data

Data will be declared stable if:

1. Trend in data over time is stable, quarter to quarter
2. Practice demonstrates knowledge of measure specifications
3. Practice has the ability to describe method of extracting data from EHR
4. Data is submitted in a timely manner
5. Annotations are provided to explain any abnormalities

Provider File Timeline

Updated 5/5/17

CTC will email the providers two weeks prior to the due date with a ten day time frame.

2017 Timeline:

- Receive CTC email on August 14, 2017; file due back to CTC on August 25, 2017
- Receive CTC email on November 10, 2017; file due back to CTC on November 20, 2017

2018 Timeline:

- Receive CTC email on February 13, 2018; file due back to CTC on February 23, 2018
- Receive CTC email on May 15, 2018; file due back to CTC on May 25, 2018
- Receive CTC email on August 14, 2018; file due back to CTC on August 25, 2018
- Receive CTC email on November 9, 2018; file due back to CTC on November 19, 2018

2019 Timeline:

- Receive CTC email on February 12, 2019; file due back to CTC on February 22, 2019
- Receive CTC email on May 14, 2019; file due back to CTC on May 24, 2019
- Receive CTC email on August 13, 2019; file due back to CTC on August 23, 2019
- Receive CTC email on November 12, 2019; file due back to CTC on November 22, 2019

The following information will need to be updated:

A. CTC Practice List:
    a. CTC Practice Group
    b. Practice Name
    c. Practice Tax ID
    d. Street Address/City/Zip
    e. Physician Lead and Contact Info
B. CTC Provider List:
    a. Provider first and last name
    b. Individual NPI
    c. Date joined practice
    d. Date left practice
    e. Provider Type (NP, PA, MD, DO)
    f. Provider Specialty
    g. Open/Closed to new practices
    h. Next Open Appointment
C. CTC Contacts:
    a. Contact Name
    b. Role
    c. Email/Phone/Fax
D. CTC Nurse Care Manager (NCM)/Care Coordination Staff (CC):
    a. Practice NCM or CC
    b. Email/phone
    c. Date joined practice
    d. Date left practice
    e. %FTE

Practice Name
Practice Address
Practice City, State, ZIP
Practice Phone

CCM 2A – 1, 2

Policy - Open Access and Continuity of Care: After Hours Protocol, Expanded Office Hours, Triage

Purpose: To describe the practice policies and procedures relating to access to care, scheduling visits, same day access and triage.

A. Scheduling each patient with a personal clinician for continuity of care

1. Patients will be encouraged at the time of their first visit to choose a personal clinician. This information will be documented in the patient's medical record.
2. At each subsequent visit the appointment scheduler will verify the patient's personal clinician from documentation in the patient's medical record and offer an appointment with that provider.
3. Patients will be scheduled with another provider only upon patient request or when the urgent nature of the appointment requires that the patient be seen prior to the personal clinician's next available appointment.
4. The reason for scheduling a patient with a provider other than his or her personal clinician will be noted in the patient's chart.
5. Data from patient records will be reviewed every six months to determine how frequently patients are seen by the provider of choice. The practice goal is that 80% of the time patients will be seen by their selected personal clinician.

B. Triage for appointments scheduling

Appointments will be scheduled based on the following triage protocols. These criteria are to be used by scheduling staff to meet and exceed patient's needs and preferences, whether appointments are requested for the same day or for a specific time in the future.

1. **Urgent** appointments will be scheduled on the same day the appointment is requested by the patient or caregiver. Urgent appointments will be given first priority for same-day scheduling. Urgent appointments are those determined by the triage clinician to require medical evaluation within 1 to 4 hours.

2. **Sick visits** that are not urgent will be scheduled within one day from the appointment date requested by the patient or caregiver.

3. **Follow-up (f/u) visits** will be scheduled on the day requested by the provider, unless the patients has a different preference, in which case f/u appointments will be scheduled on the date preferred by the patient/caregiver.

4. **Well visits and physicals** will be scheduled no later than 14 days from the appointment date requested by the patient or caregiver.

5. **New patient** visits will be scheduled within 14 days from the appointment date requested by the patient or caregiver, unless the visit is determined by the triage clinician to be **Urgent**.

Urgent appointments for new patients will be scheduled on the same day and given the same priority as established patients.

6. All **non-urgent** walk-in/**same- day** appointment requests will be fulfilled on a first come/first served basis on the same day, and no later than the guidelines specified above.

7. All **non-urgent** requests for specific appointment dates, from patients/caregivers will be fulfilled on a first come/first served basis within the guidelines specified above.

8. Spot checks, conducted for a one week interval, will be performed every six months to verify that patients requesting urgent appointments receive same-day appointments 100% of the time, all same-day requests, including routine, are fulfilled at least 60% of the time, and that all other requests are fulfilled within the stated timeframes at least 80% of the time.

C. Capacity for same-day appointments

1. A schedule will be kept maintaining the availability of open scheduling slots to allow same-day appointments as follows:
    a. One 15 minute time slot will be kept open at the end of each hour for each provider between the hours of 8:30 and 10:30 AM and 1:00 and 2:30 PM.
    b. Two 15 minute slots will be kept open for same day appointments for the remaining hours the practice is open on a daily basis.
2. Same-day appointment requests will be triaged and scheduled following the policies specified in **Section B**.

3. Spot checks, conducted for a one week interval, will be performed every six months to verify that capacity for same-day urgent and routine appointments is adequate and meets patients' needs.

D. Capacity for after-hours appointments

After-hours appointments are appointments available after 5:00PM on Monday through Friday, and on Saturdays from 9:00AM to 1:00PM.

1. A schedule will be kept maintaining the availability of after-hours **scheduled, same-day and walk-in** appointments for office visits as follows:
    a. Two scheduled appointment slots are available Monday through Friday between 5:00PM and 6:00PM
    b. Six 15minute slots will be kept open for same day appointments/walk-ins between the hours of 5:00PM and 7:00PM on a daily basis on Mondays through Fridays.
    c. Saturday: Fourteen 15 minutes time slots are available for same-day/walk-in appointments between 9:00AM and 1:00PM every Saturday.
2. Spot checks, conducted for a one week interval, will be performed every six months to verify that capacity for after-hours appointments is adequate and meets patients' needs.

Approved By:

Effective: 1/1/2016

Revised:

Practice Name
Practice Address
Practice City, State, ZIP
Practice Phone

CCM 1B – 1
CCM 2A – 3, 4, 5

Policy – Patient Communications

Purpose: To establish response time frames and documentation policy for telephone and electronic communications with patients/family and caregivers

A. Patient Phone Calls – During Office Hours

The designated physician, nurse or other clinician will provide telephone advice on clinical issues during office hours within the specified time frames below.

1. During office hours **urgent** calls are returned by a clinician within 15 minutes
2. Clinical staff will return non-urgent calls to patients for clinical advice and other requests within two hours of receiving the call.
3. All clinical calls and staff return calls will be recorded in the phone-log and clinical advice provided by staff will be documented in the patient's medical record.
4. Spot checks will be performed every six months to assess adherence to this policy requirement 80% of the time.

B. Patient Phone Calls – After Hours

Clinical advice by phone will be available **24 hours a day, 7 days a week** from a qualified clinician

1. After hours calls will be responded to by the designated provider on call.
2. In case of emergency patients will be instructed to call **9-1-1** immediately
3. Urgent after-hour calls will be returned within 30 minutes.
4. Non-urgent clinical calls that are time sensitive will be returned within one hour
5. All other calls will be returned during the next working day
6. All clinical calls and staff return calls will be recorded in the phone-log and clinical advice provided by staff after hours will be documented in the patient's medical record.
7. Spot checks will be performed every six months to assess adherence to this policy requirement 80% of the time.

C. Electronic Communications

Secure e-mail consultations with the physician or other clinician are provided through the Patient Portal. The patient portal enables patients to send and receive secure messaging, request appointments, request referrals, request prescription refills and review lab and imaging results. Electronic communications will be addressed as follows.

1. Patients will be advised via the portal that the portal should not be used for urgent matters. Appropriate staff will respond to secure e-mails within 4 hours for clinical messages received during office hours and two days for non-clinical messages.

2. After hours e-mail messages will be responded to by the designated provider on call within two hours for clinical messages received before 8:00 pm and considered urgent by the on-call provider. All other clinical e-mail messages will be responded to within the first 4 hours of the next business day.
3. All clinical advice provided through secure e-mail will be documented in the patient's medical record.
4. Computerized reports reviewed monthly will document that this policy is followed 80% of the time.

D. Availability of Medical Records

1. The practice is using <enter EHR name> which is available to all clinical staff during office hours, and after hours through a secure Internet connection. Patient **care plans** reside in the EHR and are available during and after hours to all clinical staff and on call staff as necessary.
    a. Office Hours – Clinical staff will document clinical advice provided to patients and caregivers by phone directly in the medical record as it occurs
    b. After Hours – On call providers will access the patient medical records in the EHR and document clinical advice given to patients and caregivers on the phone. On call providers may request that a secure laptop or other suitable mobile device is provided to them by the practice if necessary.
    c. Electronic communications – Clinical advice provided to patients by secure electronic means is automatically incorporated into the EHR medical record and available through the EHR to all providers during and after office hours.
2. The practice is using <enter name> Patient Portal which is available to all patients, who choose to use it, through the Internet at all times. Practice staff will actively encourage patients to enroll in the Patient Portal and remind patients and caregivers to utilize the Portal at each scheduled visit.
    a. The Patient Portal will contain the following clinical information:
        i. Clinical Summaries – A summary of the patient's clinical information including, but not limited to, medication list, problem list, medical, social and family histories, **care plan** and test results.
        ii. Diagnostic Results – Latest copies of resulted tests and providers evaluation notes
        iii. Immunizations – List of current immunizations status
        iv. Education – Patient education materials pertinent to health status of the patient
    b. Patients and caregivers provided with access to the Portal by the patient can view, download or transmit clinical summaries or other portions of the medical record at all times, to facilitate self-management and care coordination with other providers of care.
3. Patients who choose not to enroll in the Patient Portal will be provided printed copies of their Clinical Summaries during check-out following each encounter, and will be advised to safely store and refer to clinical summaries during routine self-management at home, and/or use the summaries when accessing care from other providers.

Approved By:

Effective: 1/1/2016

Revised:

PCMH 1A – Access Improvement Worksheet

Practice Name: _____

Date Completed: _____

Access Improvement: PCMH 1A-6

A. Access Measure:

B. Opportunity Identified (problem statement):

C. Baseline Measurement:

Reporting Period:

Performance Data:

D. Performance Goal:

E. Implementation Plan:

Implementation Start Date:

Implementation Description:

F. Re-Measurement (impact):

Reporting Period:

Performance Data:

G. Demonstrated Improvement (evaluation):

All information that would let someone identify you or your family will be kept private. The research staff will not share your personal information with anyone without your OK. You may choose to answer this survey or not. If you choose not to, this will not affect the health care you get.

Your responses to this survey are completely confidential. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to DataStat.

You may notice a barcode number on the front of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this survey, please call 1-888-506-5135.

SURVEY INSTRUCTIONS

- **Please be sure to fill the response circle <u>completely</u>. Use only <u>black or blue ink</u> or <u>dark pencil</u> to complete the survey.**

Correct Mark ● **Incorrect Marks** 

- **You are sometimes told to skip over some questions in the survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:**

● **Yes** ➔ ***Go to Question 1***
○ **No**

START HERE

Your Provider

1. **Our records show that you got care from the provider named below in the last 12 months.**

   [CLINICIAN NAME]

   Is that right?

   ○ Yes
   ○ No ➔ ***Go to Question 29***

The questions in this survey will refer to the provider named in Question 1 as "this provider". Please think of that person as you answer the survey.

2. **Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?**

   - ○ Yes
   - ○ No

3. **How long have you been going to this provider?**

   - ○ Less than 6 months
   - ○ At least 6 months but less than 1 year
   - ○ At least 1 year but less than 3 years
   - ○ At least 3 years but less than 5 years
   - ○ 5 years or more

Your Care From This Provider in the Last 12 Months

These questions ask about <u>your own</u> health care. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

4. **In the last 12 months, how many times did you visit this provider to get care for yourself?**

   - ○ None ➔ ***Go to Question 29***
   - ○ 1 time
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5 to 9
   - ○ 10 or more times

5. **In the last 12 months, did you contact this provider's office to get an appointment for an illness, injury or condition that <u>needed care right away?</u>**

   - ○ Yes
   - ○ No ➔ ***Go to Question 7***

6. **In the last 12 months, when you contacted this provider's office to get an appointment for <u>care you needed right away</u>, how often did you get an appointment as soon as you needed?**

   - ○ Never
   - ○ Sometimes
   - ○ Usually
   - ○ Always

7. **In the last 12 months, did you make any appointments for a <u>check-up or routine care</u> with this provider?**

   - ○ Yes
   - ○ No ➔ ***Go to Question 9***

8. **In the last 12 months, when you made an appointment for a <u>check-up or routine care</u> with this provider, how often did you get an appointment as soon as you needed?**

   - ○ Never
   - ○ Sometimes
   - ○ Usually
   - ○ Always

9. **Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?**

   - ○ Yes
   - ○ No

10. In the last 12 months, did you contact this provider's office with a medical question during regular office hours?

- ○ Yes
- ○ No ➔ ***Go to Question 12***

11. In the last 12 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

12. In the last 12 months, how often did this provider explain things in a way that was easy to understand?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

13. In the last 12 months, how often did this provider listen carefully to you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

14. In the last 12 months, how often did this provider seem to know the important information about your medical history?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

15. In the last 12 months, how often did this provider show respect for what you had to say?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

16. In the last 12 months, how often did this provider spend enough time with you?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

17. In the last 12 months, did this provider order a blood test, x-ray, or other test for you?

- ○ Yes
- ○ No ➔ ***Go to Question 19***

18. In the last 12 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

19. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10

Worst Provider Possible — Best Provider Possible

20. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you see a specialist for a particular health problem?

- ○ Yes
- ○ No ➔ ***Go to Question 22***

21. In the last 12 months, how often did the provider named in Question 1 seem informed and up-to-date about the care you got from specialists?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

Please answer these questions about the provider named in Question 1 of the survey.

22. In the last 12 months, did someone from this provider's office talk with you about specific goals for your health?

- ○ Yes
- ○ No

23. In the last 12 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health?

- ○ Yes
- ○ No

24. In the last 12 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress?

- ○ Yes
- ○ No

25. In the last 12 months, did you take any prescription medicine?

- ○ Yes
- ○ No ➔ ***Go to Question 27***

26. In the last 12 months, how often did you and someone from this provider's office talk about all the prescription medicines you were taking?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

Clerks and Receptionists at This Provider's Office

27. In the last 12 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

28. In the last 12 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- ○ Never
- ○ Sometimes
- ○ Usually
- ○ Always

About You

29. In general, how would you rate your overall health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

30. In general, how would you rate your overall <u>mental or emotional</u> health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

31. What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

32. Are you male or female?

- ○ Male
- ○ Female

33. What is the highest grade or level of school that you have completed?

- ○ 8th grade or less
- ○ Some high school, but did not graduate
- ○ High school graduate or GED
- ○ Some college or 2-year degree
- ○ 4-year college graduate
- ○ More than 4-year college degree

34. Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino
- ○ No, not Hispanic or Latino

35. What is your race? Please mark one or more.

- ○ White
- ○ Black or African-American
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other

36. Did someone help you complete this survey?

- ○ Yes ➔ ***Go to Question 37***
- ○ No ➔ ***Thank you. Please return the completed survey in the postage-paid envelope.***

37. How did that person help you? Please mark one or more.

- ○ Read the questions to me
- ○ Wrote down the answers I gave
- ○ Answered the questions for me
- ○ Translated the questions into my language
- ○ Helped in some other way

Thank you for taking the time to complete this survey. Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to mail the survey to:

DataStat, 3975 Research Park Drive, Ann Arbor, MI 48108

DataStat is pleased to be a part of the 2016-17 RIQI 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 patient data 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
- Key Definitions from *Specifications for the CAHPS PCMH Survey 2014*
- Instructions on when and how to submit your patient data files to DataStat
- Patient data file layout specifications and a sample template
- Information on uploading files to the DataStat Transfer Center
- Information on submitting logos and signatures to DataStat

In addition, we have found that it is very helpful if you let your patients and staff know that you will be participating in this survey. Often patients call the practice to confirm that the survey is legitimate. If your front office staff is aware of the survey, they can reassure patients that the survey is legitimate and their patient record has not been compromised. Attached is an English and Spanish version of a notice that you might want to post in your office or send to your patients to encourage their participation.

- Information for patients
- SP Information for patients

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 packet information and BAAs to practices	October 20, 2016
DataStat begins sending Transfer Center invitations to practices with new data contact person	October 24, 2016
RIQI sends logo/signature sign off sheets to practices who participated in 2015	October 24, 2016
Practices sign and return BAAs to RIQI	By November 1, 2016
Final date for practices to decide if they are submitting to NCQA	November 2, 2016
Practices set up any new Transfer Center accounts	By November 4, 2016
Practices *Pull* REAL Patient Data Files (last day of measurement period)	November 7, 2016
Practices *Submit* REAL Patient Data Files to DataStat via the Transfer Center	November 8-18, 2016
Final deadline for practices to submit new logos/signatures to DataStat	November 18, 2016
Survey fielding begins	December 13, 2016
Survey fielding ends	January 30, 2017
DataStat submits Final Datasets to RIQI	February 24, 2017
DataStat submits Final Spreadsheets with scores to RIQI	March 1, 2017
DataStat submits Final Summary Reports to RIQI	March 30, 2017

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.

Eligible Population

Ages	Adults: 18 years and older as of the last day of the measurement period. Children: 17 years or younger as of the last day of the measurement period.
Event	A visit with a practice clinician during the measurement period (scheduled or walk-in). For each patient who had a visit with an eligible clinician during the measurement period, identify the most recent visit during the measurement period and the clinician who provided care during the most recent visit. The clinician need not be the patient's regular clinician or primary care provider.

Submitting Patient Data Files to DataStat

Each participating practice site must submit a patient data file to DataStat. **November 18, 2016 is a firm deadline** for all sites to submit a complete and usable patient data file to DataStat with any issues resolved. Practice sites are encouraged to submit their files to DataStat early so any issues can be resolved before November 18.

Please refer to the section "Sample Frame Data File Elements" or the sample template (template.xls) when creating your file. Files should not contain "NA, N/A, missing," etc. If an item is not available, leave the field blank. Dates should be in the format MMDDYYYY, and phone numbers should not contain parentheses or dashes (if you are unable to format the numbers in this manner, we may still be able to use them).

The method of submission is through the DataStat Transfer Center (DTC). **For privacy reasons, patient data 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 data contact persons between 10/24/16 and 10/31/16. **Sites should have their DTC accounts set up no later than November 4, 2016.**

Real Patient Data File Deadlines:

- Real patient data files must be submitted between **November 8 and November 18, 2016.**
- The measurement year for the real file is defined as November 8, 2015 through November 7, 2016. **The last day of the measurement period is November 7, 2016**.
- **Real patient data files must be received at DataStat by November 18, 2016**. **This is a firm deadline.**

Generation Guidelines

- The measurement period is defined as:
    - Real data file: November 8, 2015 through November 7, 2016.
- All eligible patients that had a visit (scheduled or walk-in) with an eligible clinician within the measurement period must be included in the data file. For a description of an eligible clinician, please see the included documentation from *Specifications for the CAHPS PCMH Survey 2014.*
- Each eligible patient should only be in the file once, with the date of their *most recent visit with an eligible provider*.
- 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 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 patient 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 Width: 60 Type: Alpha-Numeric
2	Patient first name	First name only. Exclude middle name and middle initial.	Columns: 61 - 85 Width: 25 Type: Alpha
3	Patient middle initial	Middle initial only. Exclude first and last name.	Columns: 86 Width: 1 Type: Alpha
4	Patient last name	Last name only. Exclude middle initial and first name.	Columns: 87 - 111 Width: 25 Type: Alpha
5	Patient gender	1=Male 2=Female 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 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 Width: 50 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 Width: 50 Type: Alpha-Numeric
9	Patient - City		Columns: 221 - 250 Width: 30 Type: Alpha
10	Patient - State	2-character postal service state code.	Columns: 251 - 252 Width: 2 Type: Alpha
11	Patient - Zip Code (5 digit)	5-digit zip code. Use leading zero if appropriate.	Columns: 253 - 257 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 Width: 10 Type: Numeric
13	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: 268-292 Width: 25 Type: Alpha
14	Clinician middle initial		Columns: 293 Width: 1 Type: Alpha
15	Clinician last name		Columns: 294-318 Width: 25 Type: Alpha
16	Clinician credentials	For example: MD, PA, RN	Columns: 319-328 Width: 10 Type: Alpha-Numeric
17	Clinician Nation Provider Identifier (NPI)		Columns: 329-338 Width: 10 Type: Numeric

18	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, 2016 would be 04082016.	Columns: 339-346 Width: 8 Type: Alpha
19	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). *Please leave blanks if not including.*	Columns: 347-349 Width: 3 Type: Numeric
20	Patient survey group	1=Adult survey 2=Child survey	Columns: 350 Width: 1 Type: Numeric
21	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: 351-352 Width: 2 Type: Numeric
22	Indicate if Spanish language materials are required (if known)	01= Spanish Language Materials Required 02=NO Spanish Language Materials Required 03=Unknown/not available *This variable is optional. Please leave blanks if not including.*	Columns: 353-354 Width: 2 Type: Numeric

Submitting files via the DataStat Transfer Center

To upload the patient data file after you create it on November 7, log into your transfer center account at https://www.datastat.com/tcenter/ . There are several steps to the uploading process:

From the main menu, select Upload Files.

1. Browse and select your file, then click on the "send this file" button on the right.
2. Enter a description and additional information for this file. All I really need to know is what practice the file is for, please include the site if you are sending separate files for multiple sites. Click on the "add additional files" or "batch is complete" button on the right.
3. Step 3 is for entering additional files if you are uploading separate files for more than one practice or site. You will repeat steps 1 and 2 for each file.
4. Upload files - verify the file name(s) and select a recipient (RIPCMH@datastat.com) Click "continue" at the bottom of the screen.
5. Final - verify recipient and click "submit"
6. Upload complete - **until you get to this screen, the file was not uploaded**. Click "done"

You should receive an email from tcenter@datastat.com telling you the file was successfully uploaded.

If you have any questions or problems, please let me know.

Thank you,
Donna

Donna Fowlkes
Project Manager
DataStat, Inc.
1-734-994-0540 ext. 143
dfowlkes@datastat.com

If you have previously submitted logos and/or signatures to DataStat, in the next few days, you will receive a sign off sheet with the logo and/or signature we have on file for you. You do not need to complete this form, but can communicate with us regarding updates to the logo/signature once you receive your sign off sheet.

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 **November 18, 2016**, 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: _____

Your opinion matters!

During the next two months, a company named DataStat may call you or send you a survey in the mail. They are doing a survey of patients in our practice.

Your opinion is important to us. If DataStat contacts you, please try to complete the survey. Your answers will tell us what you think about our practice. Please be as honest as possible. The results will help us make our services better.

The survey is voluntary. You do not have to do the survey. You can also skip any questions that you do not want to answer.

If you do the survey, we will not see your personal responses. DataStat will give us a summary of the results.

Let us know if you have any questions about the survey.

¡Su opinión es importante!

Durante los próximos dos meses, una compañía llamada DataStat puede estar llamándole o enviándole una encuesta por correo. Ellos están haciendo una encuesta con los pacientes de nuestra práctica.

Su opinión es importante para nosotros. Si DataStat le contacta, por favor complete la encuesta. Sus respuestas nos dirán lo que piensa usted sobre nuestra práctica. Por favor sea lo más honesto posible. Los resultados nos ayudarán a mejorar nuestros servicios.

La encuesta es voluntaria. No tiene que hacer la encuesta. También puede saltar cualquier pregunta que no quiera contestar.

Si contesta la encuesta, nosotros no veremos sus respuestas individuales. DataStat nos dará un resumen de los resultados.

Nos deja saber si tiene preguntas sobre la encuesta.

CC4ME BROCHURE 111616 KG

For more information, get in touch.
We're here to help:

888-858-4815

CurrentCare@riqi.org

Rhode Island Quality Institute

current care

Your medical information at your fingertips

Sign Up.
Sign In.
See It.
CurrentCare for Me

Rhode Island Quality Institute

current care

What *is* **CurrentCare for Me?** It's your **personal health record** at your fingertips

CurrentCare for Me is the only way to directly access your personal medical information — from multiple providers — all in one place. Online. Secure. Just for you.

Sign up is simple. And FREE.

Go to: Enroll.CurrentCareRI.org

1. **Sign Up.**
2. **Sign In.**
3. **See It.**

CurrentCare for Me gives you the ability to:

- Track and double check medications your doctor has prescribed
- Look up lab/test results such as blood work, xrays, MRIs, etc.
- Download and send your records to caregivers, family members and providers

More info. Multiple sources.

CurrentCare for Me connects your medical information from multiple providers — Primary care, specialists, hospitals, and more. And puts it in one place for you.

CurrentCare for Me was created by the healthcare community as a free service to connect you to better health.

CurrentCare for Me helps you stay in direct contact with your own healthcare.

BENEFITS

- Peace of mind knowing you can access your medical information online 24/7 from anywhere
- Track your own health and healthcare
- Better manage care and advocate for family members
- Avoid duplicate tests and procedures (which can save time and money!)
- Avoid prescription errors

CurrentCare Guidebook

A guide to patient information available in CurrentCare

March 1, 2017

CurrentCareRI.org

BENEFITS

- ☑ Improve patient care
- ☑ Save staff time
- ☑ Increase care coordination
- ☑ Helps meet value-based programs

Inside...

Rhode Island Quality Institute

current care®

What is CurrentCare?

CurrentCare is Rhode Island's statewide Health Information Exchange (HIE), designed and built through the cooperative effort of the RI healthcare community. This secure network collects information from practices, hospitals, labs, imaging centers, pharmacies and other data sources to share crucial patient information and avoid fragmented data. When patients opt in to CurrentCare, their provider(s) can access their available healthcare information to provide the right care at the right time. Through CurrentCare, duplicate testing can be avoided and clinical staff can quickly access critical information in real time to support safe and effective transitions of care.

NEW! **Individuals enrolled in CurrentCare can securely access their personal health record online 24/7 with CurrentCare for Me.** ***See Page 13 for more details.***

Systems Sharing Data with CurrentCare

CurrentCare is able to receive clinical information from 14 Electronic Health Record or Health Information Exchange systems:

- Allscripts
- Amazing Charts
- athenahealth
- Cerner
- eHealth Exchange NEW!
- Epic
- Essentia
- GECentricity
- Greenway
- Intergy
- MEDITECH
- Netsmart
- NextGen
- PointClickCare

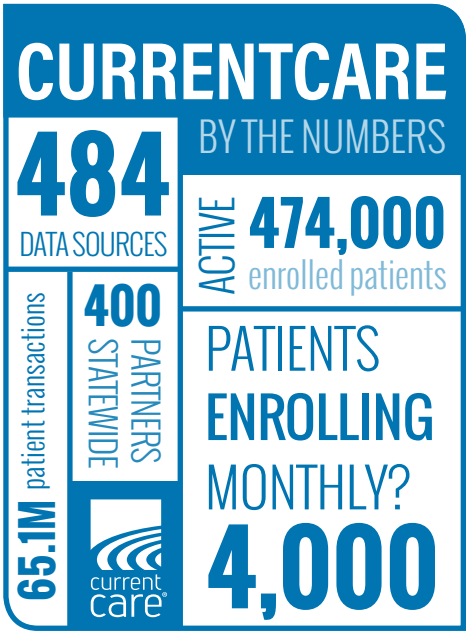
COMING SOON:

- eClinicalWorks
- MatrixCare

The following EHRs receive clinical summaries from CurrentCare directly *into* their patient records:

- athenahealth**
- eHealth Exchange NEW!
- Epic**
- NextGen

***Able to add and reconcile medications, allergies and problems*



What can I find in CurrentCare?

- Encounters
- Clinical Documents
- Discharge Documents
- Allergies & Alerts
- Conditions
- **Medications**
- Lab Results
- Diagnostic Imaging
- EKG Imaging

ENCOUNTERS:
Have your patients been to the ED or seen a specialist? See where they received care (ED, inpt and outpt) and the treating providers.

CLINICAL DOCUMENTS:
A wealth of information. Now includes results and consult notes from the VA!

DISCHARGE DOCUMENTS:
Encounter-specific CoCs(Continuity of Care) and Discharge Summaries!

ALLERGIES & ALERTS:
Allergies are updated each time our data sharing partners verify this critical patient information. Do Not Resuscitate (DNR) status and other key alert data is also found in this section.

CONDITIONS:
Diagnoses and medical problems are updated when patients are treated in a participating hospital or ambulatory practice.

MEDICATIONS:
This section provides the list of medications prescribed by participating providers — and may also let you know if the individual filled it at the pharmacy.

LAB RESULTS:
View up-to-date patient labs from all participating laboratories in one place! View each lab individually or in cumulative view.

DIAGNOSTIC IMAGING:
View imaging reports from participating radiology facilities.

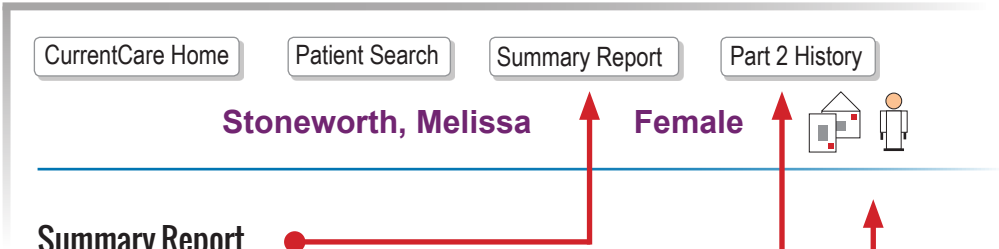
EKG IMAGING:
View EKG reports from participating radiology facilities.

> *"When specialists call me up for labs I've ordered, I say to their staff: 'Enroll in CurrentCare and you can pull these off the website yourselves!'"*
>
> - Dr. Lynn Ho
> North Kingstown
> Family Practice

Read more of Dr. Lynn Ho's CurrentCare Story:
tinyurl.com/DrHo-CCStory

What can I find in CurrentCare?

Continued from Page 3



Summary Report

View a CurrentCare record in a single document that may be converted to a PDF for downloading or printing.

Substance Abuse (42 CFR Part 2 History)

View information from substance abuse and alcohol treatment centers ('Part 2 data') for patients who have consented to share this information. This could include behavioral health and medical information from the following facilities, and is found by clicking the "Part 2 History" button:

Gateway Healthcare
The Providence Center
Butler Hospital
East Bay Community Action Program
(Coming Soon!)

Demographic Information

Addresses and other demographic Information are also available in CurrentCare. You can access this information on the patient summary report or through the icons in the upper right corner on the Viewer home page.

Medication Data Sources

Pharmacies	Pharmacy Benefit Managers (SureScripts)	Providers/Hospitals
Any Prescriptions from:	Prescriptions at any pharmacy through:	Medications as noted by participating provider organizations
CVS	CVS Caremark (CMX)	See Pages 6-13 for a list of provider and hospital organizations sending Clinical Summary data
Rite Aid	Express Scripts (ESI1)	
Walgreens	Optum Rx (ORX)	
	Prime BCBSRI NEW!	
Displays as "Date Dispensed"	Displays as "Date Dispensed"	Displays as "Date Started"

Clinical Data Available...

Encounter Documents

Summaries of your patients' visits to a hospital, ED or outpatient facility:

Clinical Summaries hospitals & ambulatory

Continuity of Care Documents (CCDs) provide a record of the most recent encounter from an organization, including the most up-to-date problems, meds, and allergies. May include vitals, procedures, history, progress notes or other practice-specific information. Titles include: **Summary of Episode Note, Continuity of Care Document or Medical Record Summary.**

Discharge CoCs (Hospitals) available upon discharge

Discharge CoCs (Continuity of Care Documents), required by the State of RI, include a summary of a visit to a hospital or ED. Individual visits can be viewed as separate documents, including prescribed meds, discharged-to location, patient instructions & more! Downloads to your computer, viewable in Word or WordPad.

Discharge Summaries available after provider sign-off NEW!

Discharge summaries are available only after sign off by a treating provider. May include a reason for hospitalization, discharge condition, and patient & family instructions. Frequently it will contain **Hospital Course/Progress notes.** Will typically be available after the resident/provider has signed off, and will be updated after an attending provider signs off.

ADT (Admission, Discharge, Transfer)

Ever wonder where your patients are? When a patient has been admitted or discharged, you can view **Encounter Data** from the hospitals and skilled nursing facilities that share ADT information with CurrentCare.

Encounter Data

You will find encounter-specific data on the following tabs: **Medications, Conditions, Allergies & Alerts**, and you can see a list of encounters on the **Encounters** tab.

Test/Results

You will find results on the following tabs: **Lab Results, Diagnostic Imaging, EKG Imaging**. Also found in the patient's Summary Report and within some Documents.

Clinical Data

Hospital Systems & Facilities	Encounter Documents			ADTs+
	Clinical Summary	Discharge CoC	Discharge Summary	
LIFESPAN				
Rhode Island Hospital (RIH)	✓	✓		✓
Hasbro Children's Hospital	✓	✓		✓
The Miriam Hospital (TMH)	✓	✓		✓
Newport Hospital (NPH)	✓	✓		✓
Bradley Hospital				
Lifespan Labs				
Ambulatory Practices - See Pages 10-13	✓			
Gateway Health Center - Part 2 Data	✓			
CARE NEW ENGLAND				
Kent Hospital			Coming Soon!	✓
Women & Infants (WIH)	✓		Coming Soon!	✓
Memorial Hospital (MHRI)	✓		Coming Soon!	✓
Butler Hospital - Part 2 Data	✓			
Ambulatory Practices - See Pages 10-13	✓			
The Providence Center - Part 2 Data	✓			
CHARTERCARE				
Our Lady of Fatima Hospital	Coming Soon!		NEW!	✓
Roger Williams Medical Center (RWMC)	Coming Soon!		NEW!	✓
Ambulatory Practices - See Pages 10-13	✓			
LANDMARK MEDICAL				
Landmark Medical Center (LMC)				✓
Rehab Hospital of RI (RHRI)				✓
LAWRENCE & MEMORIAL				
L & M				✓
L & M Westerly				✓
SOUTH COUNTY HOSPITAL				
South County Hospital (SCH)	✓		Coming Soon!	✓
Ambulatory Practices - See Pages 10-13	✓			
VA MEDICAL CENTER				
VA Medical Center	NEW!			
Outpatient Clinics	NEW!			

Encounter Data				Tests/Results		
Allergies	Meds	Diagnoses	Problem List	Labs	Imaging	EKG Imaging
✓	✓	✓	✓	✓	✓	
✓	✓	✓	✓	✓	✓	
✓	✓	✓	✓	✓	✓	
✓	✓	✓	✓	✓	✓	
				✓		
✓	✓	✓	✓			
✓	✓	✓	✓			
✓		✓	✓	✓		✓
✓	✓	✓	✓	✓		✓
✓	✓	✓	✓			
✓	✓	✓	✓			
✓	✓	✓	✓			
✓	✓	✓	✓			
✓	Coming Soon!	✓	✓	✓	NEW!	
✓	Coming Soon!	✓	✓	✓	NEW!	
✓	✓	✓	✓			
✓		✓	✓	✓		
✓		✓	✓	✓		
✓		✓	✓	Coming Soon!		
✓		✓	✓	✓		
✓	✓	✓	✓	✓		
✓	✓	✓	✓			
NEW!	NEW!	NEW!	NEW!	✓ (Docs Tab)	✓ (Docs Tab)	
NEW!	NEW!	NEW!	NEW!	✓ (Docs Tab)	✓ (Docs Tab)	

Hashes indicate that data type is not applicable for the source

Empty cell indicates that data from this source is not currently available + ADT = Notification of ED/Inpatient Admission, Discharge and Transfers

Clinical Data

Other Data Sources (Independent Facilities)	Encounter Documents: Clinical Summary	Encounter Documents: Discharge CoC	Encounter Documents: Discharge Summary	ADTs+
URGENT CARE				
Armistice Urgent Care Center	✓			
CVS Minute Clinics (8 sites)	✓			
Providence Community Health Centers Express	✓			
IMAGING				
Advanced Radiology				
Coastal Imaging				
Open MRI of New England				
Rhode Island Medical Imaging				
XRA Medical Imaging				
LABS				
Coastal Medical (labs)				
Dominion Diagnostics				
East Side Clinical labs				
Quest Diagnostics				
SKILLED NURSING FACILITIES				
Genesis HealthCare (see list below)	NEW!			NEW!
Health Concepts (see list below)	Coming Soon!			Coming Soon!

Hashes indicate that data type is not applicable for the source Empty cell indicates that data from this source is not currently availa

SKILLED NURSING FACILITIES > Expanded

Genesis HealthCare

Coventry Skilled Nursing & Rehab
Grand Islander Center
Grandview Center
Greenville Center Skilled Nursing & Rehab
Greenwood Center
Kent Regency
Pawtucket Center Skilled Nursing & Rehab
South County Nursing & Rehab Center
Warren Center Skilled Nursing & Rehab

Health Concepts

Bayberry Commons
Eastgate Nursing & Rehab Center
Elmwood Health Center
Heritage Hills Nursing & Rehab Center
Morgan Health Center
Pine Grove Health Center
Riverview Healthcare Community
South Kingstown Nursing & Rehab Center
Village House Convalescent Home
West Shore Health Center
Westerly Health Center

Encounter Data				Tests/Results		
Allergies	Meds	Diagnoses	Problem List	Labs	Imaging	EKG Imaging
✓	✓	✓	✓			
✓	✓	✓	✓			
✓	✓	✓	✓			
					✓	
					✓	
					✓	
					✓	
					✓	
				✓		
				✓		
				✓		
				✓		
NEW!	NEW!	NEW!	NEW!			
Coming Soon!	Coming Soon!	Coming Soon!	Coming Soon!			

ble + ADT = Notification of ED/Inpatient Admission, Discharge and Transfers

Did you know? You can find **90%** of all RI clinical laboratory results in CurrentCare!

The following is a listing of all the participating sites that share their encounter data with CurrentCare.

Encounter Documents + **Encounter Data**

PRIMARY CARE - Sites Sharing Data with CurrentCare

Aaron Way, DO Osteopathic Family Medicine LLC
Affinity Family Medicine Pawtucket*
Affinity Internal Medicine Pawtucket*
Affinity Internal Medicine Warwick*
Affinity Nicholas Turilli, MD*
Affinity Primary Care East Side*
Arcand Family Medicine*
Atmed Primary Care**
Blackstone Valley Center for Internal Medicine
Blackstone Valley Community Health Center
Brian Kwetkowski, DO**
Brookside Family Medicine*
Center for Primary Care at Women & Infants*
CharterCARE Medical Associates
Coppola Medical Associates**
Cumberland Primary Care*
East Greenwich Family Practice
Family Health and Sports Medicine**
Family Physicians of Newport
Family Physicians of Portsmouth
Family Physicians of Tiverton & Little Compton
Gary King, DO**
Hasbro Children's Hospital Pediatric Primary Care
Herman Ayvazyan, MD**
Jamestown Family Practice
John M. Corsi, DO**
John J. Solomon, DO**
Kristine Cunniff, DO**
Leonard Mannarelli, DO**
Lifespan Physician Group, Primary Care - Newport
Lifespan Physician Group, Primary Care – Tiverton
Lynn Ho, MD
Massasoit Internal Medicine
Memorial Family Care Center*
Memorial Hospital Primary Care Center - Plainville*
Memorial Internal Medicine Center*
Memorial Pediatric Primary Care*
Michael Souza, DO**
Miheala Iovanel, MD**
Northeast Internal Medicine**
NRI Medical Services**
Ocean State Primary Care**
Olga Tverskaya, MD**
Primary Care of Barrington**
Primary Medical Group of Warwick*
Providence Community Health Ctrs (10 sites)
Rhode Island Hospital Center for Primary Care
Rhode Island Medicine**
Rhode Island Hospital Med-Pedi Primary Care Center
Richard DelSesto, MD**
Smithfield Primary Care
South County Hospital Family Medicine
South County Internal Medicine
South County Walk-In & Primary Care*
Stuart V. Demirs, MD**
Thomas David Puleo, MD
University Family Medicine**
VA Medical Center NEW!
Warren Family Practice**
WellOne Primary Medical & Dental (3 sites)
Westerly Medical Center
Wickford Family Medicine
WIH Family Practice N. Dartmouth
Women's Medicine Collaborative
Wood River Health Services
Your Health, Inc.**

*Affiliated with Care New England

**Affiliated with Rhode Island Primary Care Physician Corp. (RIPCPC)

Encounter Documents + **Encounter Data**

SPECIALISTS - Sites Sharing Data with CurrentCare

Affinity Cardiology*
Affinity Hematology and Oncology*
Affinity Neurology Warwick*
Affinity Orthopedics & Sports Medicine*
Affinity Rheumatology*
Affinity Sports Medicine*
Affinity Surgery Pawtucket*
Alzheimer's Disease & Memory Disorders Ctr
Bayside OB-Gyn*
Cardiovascular Institute at Newport Hospital
Cardiovascular Institute at The Miriam Hospital (4 sites)
Cardiovascular Institute, Lifespan Physician Group (12 sites)
Caring for Women (5 sites)*
Center for Wound Care and Hyperbaric Medicine
CharterCARE Medical Associates
Comprehensive Cancer Center at East Greenwich
Comprehensive Cancer Center at Newport Hospital
Comprehensive Cancer Center at Rhode Island Hospital
Comprehensive Cancer Center at The Miriam Hospital
Dermatology,Lifespan Physician Group
Early Childhood Clinical Research Center
East Greenwich Spine & Sport*
Genesis HealthCare (9 sites) NEW!
Hallett Center for Diabetes and Endocrinology
Hasbro Children's Adolescent Weight Management
Hasbro Children's Child Neurodevelopment Center
Hasbro Children's Cleft and Craniofacial Center
Hasbro Children's Diabetes Outpatient Education Center
Hasbro Children's Hospital Adolescent Healthcare Center (3 sites)
Hasbro Children's Hospital Child Protection Center
Hasbro Children's Hospital Cystic Fibrosis Center
Hasbro Children's Hospital Dermatology
Hasbro Children's Hospital Early Intervention Program
Hasbro Children's Hospital Endocrine Disorders
Hasbro Children's Hospital Endocrinology and Metabolism (2 sites)
Hasbro Children's Hospital Families First CEDARR Center
Hasbro Children's Hospital Feeding Program
Hasbro Children's Hospital Food Allergy Center
Hasbro Children's Hospital Foster Care Program
Hasbro Children's Hospital Gastroenterology (3 sites)
Hasbro Children's Hospital Hemophilia Program
Hasbro Children's Hospital Infectious Diseases Clinic
Hasbro Children's Hospital Lead Clinic
Hasbro Children's Hospital Lupus Clinic
Hasbro Children's Hospital Nephrology (3 sites)
Hasbro Children's Hospital Nutrition
Hasbro Children's Hospital Nutrition Center
Hasbro Children's Hospital Occupational Therapy
Hasbro Children's Hospital Partial Hospital Program
Hasbro Children's Hospital Pediatric Heart Center (2 sites)
Hasbro Children's Hospital Pediatric Ophthalmology
Hasbro Children's Hospital Physical Therapy
Hasbro Children's Hospital Rabies Clinic
Hasbro Children's Hospital Refugee Health Clinic
Hasbro Children's Hospital Rehabilitation Services
Hasbro Children's Hospital Teens with Tots
Hasbro Children's Hospital Urology (2 sites)
Hasbro Children's Pediatric Infectious Diseases
Hasbro Children's Respiratory & Immunology Center (3 sites)
Hasbro Children's Sleep Disorder Lab
Hasbro Children's Specialty Practice
Hasbro Children's Ventilator Integration Program
Kent Surgical Associates*

Encounter Documents + **Encounter Data**

SPECIALISTS - Continued...

Laurie Reeder, MD*
Lifespan Lyme Disease Center at Newport Hospital
Lifespan Physician Group Gynecology
Lifespan Physician Group Ophthalmology
Lifespan Physician Group, The Miriam Hospital
LPG Center for Weight and Wellness
Memorial Hospital Ambulatory Care Ctr*
Memorial Hospital Ambulatory Pulmonary Clinic*
Memorial Hospital Cancer Ctr*
Memorial Hospital Neurology*
Memorial Hospital Neurodevelopmental Center
Memorial Hospital Women's Health Care Specialists*
Neurosurgery, Lifespan Physician Group (5 sites)
Newport Dermatology, Lifespan Physician Group
Newport Endocrinology, Lifespan Physician Group
Newport General Surgery
Newport Hospital Rabies Clinic
Newport Hospital Employee Health Services
Newport Hospital Infectious Diseases
Newport Hospital Neurology
Newport Hospital Physiatry
Newport Hospital Rheumatology
Newport Hospital Sleep Disorders Lab
Newport Hospital Women's Health Services (2 sites)
Newport Pulmonary, Lifespan Physician Group
Newport Women's Health - Newport
OB-GYN Associates (6 sites)
Orthopedics Insitute at Rhode Island Hospital
Radiosurgery Center, Rhode Island Hospital
Rheumatology, Lifespan Physician Group
Rhode Island Hospital Audiology
Rhode Island Hospital Burn Center
Rhode Island Hospital Dermatology Clinic
Rhode Island Hospital Ear Nose and Throat Clinic
Rhode Island Hospital Employee & Occupational Health
Rhode Island Hospital Epilepsy
Rhode Island Hospital Food and Nutrition Services
Rhode Island Hospital Gamma Knife Center
Rhode Island Hospital Gastroenterology
Rhode Island Hospital Hematology Clinic
Rhode Island Hospital Hepatology Clinic
Rhode Island Hospital Kidney Transplant Center
Rhode Island Hospital Muscular Dystrophy Clinic
Rhode Island Hospital Neurology
Rhode Island Hospital Neurology Clinic
Rhode Island Hospital Neurosurgery Clinic
Rhode Island Hospital Nutrition Center
Rhode Island Hospital Occupational Therapy
Rhode Island Hospital Ophthalmology
Rhode Island Hospital Otolaryngology Clinic
Rhode Island Hospital Phototherapy
Rhode Island Hospital Physical Therapy
Rhode Island Hospital Plastic Surgery
Rhode Island Hospital Podiatry
Rhode Island Hospital Pulmonary Clinic
Rhode Island Hospital Rabies Clinic
Rhode Island Hospital Rehabilitation Services
Rhode Island Hospital Rheumatology Clinic
Rhode Island Hospital Sleep Disorders Center
Rhode Island Hospital Speech Therapy (2 sites)
Rhode Island Hospital Spine Center
Rhode Island Hospital Surgery Clinic
Rhode Island Hospital Trauma Surgery
Rhode Island Hospital Urology
Rhode Island Hospital Vascular Surgery
Rhode Island Hospital Weight Management
RIH Physical Medicine and Rehabilitation
Sebastian Trombatore, MD*
South County Hospital
South County Hospital Breast Health
South County Hospital Cancer Care
South County Hospital Gynecology (3 sites)
South County Hospital Surgical Services
The Miriam Hospital CHF
The Miriam Hospital Center for Weight and Wellness
The Miriam Hospital Employee & Occ Health

The Miriam Hospital Food and Nutrition Services
The Miriam Hospital Immunology
The Miriam Hospital Kidney Stone Center
The Miriam Hospital Men's Health Center
The Miriam Hospital Neurology Clinic
The Miriam Hospital Nutrition
The Miriam Hospital Occupational Therapy
The Miriam Hospital Physical Therapy
The Miriam Hospital Speech Therapy
The Miriam Hospital STI
The Miriam Hospital Surgical Services
The Miriam Hospital Tuberculosis Clinic
The Miriam Hospital Weight Management Program
The Miriam Hospital Women's Cardiac Center
Tollgate Obstetrics and Gynecology
Tomorrow Fund Clinic
University Ob-Gyn, Inc.*
VA Medical Center NEW!
Vanderbilt Rehab Occupational Therapy
Vanderbilt Rehab Physical Therapy
Vanderbilt Rehab Speech & Language Therapy
Vanderbilt Wound Care Program
West Bay Surgical Associates*
WIH GI Endoscopy Suite*
WIH Health and Well being
WIH Integrated Care
WIH Maternal Fetal Medicine
WIH NeoNatal Followup
WIH Obstetric and Consultative Medicine*
WIH Outpatient Nutrition
WIH Prenatal Diagnosis Center
WIH Radiology
WIH South County
WIH UroGynecology
WIH Westerly Hematology
WIH Women's Gastrointestinal Health*
WIH Women's PT
Women's Care (3 sites)*
Women's Medicine Collaborative

*Affiliated with Care New England

"I find CurrentCare really, really helpful and I use it often. I can generally get lab results the same day the patient has done the lab, and it saves me a lot of time."

- Julia Manning, Pharmacist
South County Hospital - Coumadin Clinic &
South County Family Medicine

Read more: **tinyurl.com/Julia-Manning**

CurrentCare for Me

Enroll.CurrentCareRI.org NEW!

Patients can take control of their own healthcare record online 24/7 with **CurrentCare for Me**. They can keep track of their meds, labs and more. And, patients can designate another person – a designee – to view their healthcare record online with **CurrentCare for Me**.

Top 10 Reasons to Log into CurrentCare Viewer:

1. A patient is coming in for care and there is information missing
2. Your time is being wasted and treatment delayed by having to call different labs and waiting for results to be sent
3. Before trying a medication, you want to understand the patient's clinical history
4. Your patient doesn't remember a part of their medical history
5. It's 2 am, and you need your patient's most recent EKG tracing or imaging report
6. Your patients cannot remember which medications they are taking
7. You want to see the trend in a lab value over time
8. A patient tells you they were in the ED or inpatient, but you don't have a record
9. You want to be informed about all the places your patients are receiving care
10. You're participating in quality/value-based payment models and want to receive full credit for care delivered

Want to learn more? Check out the CurrentCare Knowledge Center

The Rhode Island Quality Institute has created a resource called the CurrentCare Knowledge Center for practices who are using CurrentCare services. Please take a look to learn how to integrate CurrentCare patient Enrollment, Hospital Alerts and Viewer into your workflows and maximize value for your patients and staff.

tinyurl.com/CC-Knowledge-Center

Got Questions? Get in touch!

If you need help with CurrentCare, please give us a call at **888.858.4815, Option 3.**

OR, drop us an email at **CurrentCare@riqi.org**.

Rhode Island
Quality Institute

CurrentCare is operated by:
The Rhode Island Quality Institute
50 Holden Street, Suite 300
Providence, RI 02908
401.276.9141 | info@riqi.org
CurrentCareRI.org

Practice Name
Practice Address
Practice City, State, ZIP
Practice Phone

Policy: Outbound Referrals – Consult, Mental Health, Substance Abuse

Purpose: To establish a policy and procedure relating to referrals to specialists and other services not provided by the practice

A. Co-Management with Specialists and Mental Health Providers

1. The determination to enter into co-management agreements with specialists in the referral network is made by the Medical Director for condition or service specific agreements.
2. Prior to initiating co-management agreements with specialist, the Medical Director will consider the following information:
    a. Any publicly available quality and performance data for the considered consultant
    b. Willingness of consultant to enter into co-management agreements with primary care
    c. Consultant's previous experience with co-management agreements
    d. Insurance plans accepted by consultant as compared to the practice patient population
3. Providers will use standard co-management agreements established with specialist partners if appropriate for a particular patient and based on patient and family preferences.
4. The determination to enter into an ad-hoc co-management agreement with a consultant for a particular patient is made by the provider following a shared decision making process with patients and family.
    a. Providers are responsible for reviewing public performance data for consultant
    b. Providers are responsible for ascertaining that selected consultant is accepting the patient's insurance plan, or that the patient is aware that consultant is out of network.
    c. Providers are responsible for contacting specialists and arranging for the initiation of co-management agreements using standard practice format
    d. Copies of signed and dated co-management agreements will be filed in the medical record
5. Following a determination of co-management initiation
    a. Provider will note in the patient medical record all co-management decisions
    b. Provider will contact specialist to discuss management plans
    c. Provider will monitor that co-management agreements are followed by specialist and notify the Medical Director in the event they are not
6. In cases where the patient has an established relationship with a consultant not willing to enter into co-management agreements with the practice, or the patient requests referral to such consultant
    a. Providers will advise the patient and family that no agreements could be instituted with selected consultant
    b. Providers will note absence of co-management agreements and reason for such absence in the medical record
7. Providers may delegate any and all portions of this process to other team members. However, the ultimate responsibility for consultant selection for each patient rests with the provider of record and all referrals to outside consult must be initiated by the provider.

B. Specialty Consults

1. The determination to refer a patient for specialty consult is made by the provider following a shared decision making process with patients and family and in consideration of existing and possible co-management agreements per **Section A**.
2. Telephone requests for referrals from patients and family are relayed to the patient's personal clinician for decision.
3. Providers will notify the referral coordinator of a referral order (verbal, written or electronic) containing at a minimum the following information for each referral:
    a. Reason for referral
    b. Preferred consultant name (alternates if not available)
    c. List of documentation to be included in referral package (e.g. provider letter/instructions, clinical summary with **care plan**, visit notes, lab results, histories)
    d. Urgency of referral
    e. Requested time frame for consult appointment
4. The referral coordinator will obtain any necessary pre-authorization and precertification for the consult and attach insurance documentation to the referral package
5. Urgent referrals:
    a. The referral coordinator will arrange for a consult appointment before the patient leaves and hand the patient written information on the consult date/time, place of appointment, consultant name and phone number and pre-consult special instructions as applicable.
    b. The referral coordinator will **electronically transmit** the referral package as ordered by the provider to the consultant prior to the appointment date and give the patient a copy to bring to the appointment
6. Non urgent referrals:
    a. For patients unable to make their own consult appointments, such as elderly patients, patients with disabilities, patients with low health literacy levels, or per provider instructions, the referral coordinator will follow the process for Urgent referrals above
    b. For all other patients, the referral coordinator will provide the patient with the name, address and phone number of consultant and any forms required by the patient's insurance plan
    c. The referral coordinator will **electronically transmit** the referral package to the consultant upon request or prior to the scheduled appointment, and give the patient a copy to bring to the appointment
7. In the event that electronic transmission is not possible, referral coordinator will use any means necessary to ensure that pertinent information is provided to consultant prior to appointment date

C. Mental Health and Substance Abuse Referrals

1. The practice does not provide mental health and substance abuse treatment. Patients and families requiring treatment will be referred to other providers and/or community resources per provider recommendation following a shared-decision making process with patients and family, and considering co-management agreements per **Section A**.
2. Patients with serious, chronic or severe mental illness (SMI) and/or addictive disorders will be referred to appropriate community agencies with specialized treatment services.
3. Patients diagnosed with common behavioral health conditions will be referred to an appropriate psychiatric service for consultation and treatment.
4. For emergencies the Crisis Team Unit XXX-XXX-XXXX or **9-1-1** should be contacted for immediate evaluation

5. Referrals for behavioral health will follow policy guidelines in **Sections A and B** above and will be recorded and monitored per **Section D** below to ensure quality transition of care, tracking of results and appropriate follow up.

D. Referral Tracking

1. The referral coordinator will maintain a tracking log for all outbound referrals
2. All provider referral orders are logged and followed up by the referral coordinator as follows:
    a. Urgent and non- urgent referrals are documented in the tracking log on the day they are ordered and include at least: date of referral, patient identity, ordering provider, consulting provider, reason for referral, urgency of referral
    b. Urgent referrals will be dealt with first
    c. Referral coordinator will follow up with consultant on monthly basis to verify that appointments were made and to provide consultant with referral package
    d. Referral coordinator will update tracking log with appointment dates as soon as they become available
    e. Referral coordinator will follow up with consultant two weeks after appointment date if consult report was not received by the practice, in which case consent will be obtained from the patient and faxed to consultant to obtain consult report
    f. Consult reports will be placed in the medical record and flagged for provider review, sign off and follow-up as necessary. Tracking log will be updated accordingly.
    g. Any difficulties in obtaining consult reports will be promptly reported to the patient's provider and brought to the attention of the Medical Director in a timely fashion
3. Spot checks, conducted for a one week interval, will be performed every six months to ensure that the practice is following this policy 80% of the time.

E. Self-Referrals

1. During each encounter, the MA will ask patients and/or family member/care giver if patient has seen a specialist, or was provided other clinical services since his/her last visit at the practice.
2. MA will document all self-referrals and sub-specialty referrals in the patient's medical record and notify providers
3. If consult notes from self-referred or specialist-referred visits cannot be found in the patient's medical record
    a. MA will obtain signed consent for release of information from the patient/family
    b. MA will notify referral coordinator of the need to track and obtain consult notes and provide referral coordinator with the following information
        i. Patient name
        ii. Name of consultant or service accessed by patient
        iii. Date of service (approximate if not known)
        iv. Signed consent form
    c. Referral coordinator will add the reported self-referral/specialty-referral to the practice referral log and track and monitor per the process outlined in **Section D**.

Approved By:

Effective: 1/1/2016

Revised:

Compacts with Specialists: Frequently Asked Questions

Our primary care practice would like to work with you to provide optimum care for our shared patients. To this end, we would like to develop a compact with you. The compact document can serve as a framework for establishing better communication and care coordination for our shared patients. Outlined below are some frequently asked questions related to establishing compacts between your specialty practices and our primary care practice.

1. **Why is our practice interested in forming a compact with your specialty group?**
   We know that our patients need your expertise for meeting their health care needs and we welcome the opportunity to work together to define the type of referral that may be needed. Our practice is a patient centered medical home (PCMH), which means that we look to provide whole person primary care for our patients and having overall responsibility for ensuring the coordination and integration of care provided by all involved physicians and other health care professionals. A compact will help us jointly outline a bi-directional understanding for effective communication and coordination of services for our shared patients. Most importantly a compact can help the primary care provider, the specialist and the patient involved have a better experience.

2. **Why will forming a compact with our primary care office be helpful to your office?**
   Our primary care office is often the first point of contact with the patient and we work together with the patient and family in planning care to meet their needs. Based on this conversation, patients will be better prepared when they come to your office. Specialists will get appropriate referrals, needed clinical information and documentation required for the referral, and understand how to reach the referring provider if necessary. The compact will outline what you can expect from our office; such as providing you with the clinical reason for the referral, other pertinent clinical /social information and being available to you for consultation. The compact will also help to outline what we need from your specialty practice; such as obtaining a follow-up report, and addressing and supporting the patient recommendations that you offer. The referring primary care provider can better understand how they should communicate needed clinical information to your office, what information you require, how quickly you may be able to see a patient, and what type of consult the patient will obtain from your office. The compact will additionally guide determination of responsibility in co-management situations.

3. **How will forming a compact with your office and our primary care office be helpful to the patient/family?**

Patients will be assured that the specialist will have information about their needs and the clinical reason for the referral by the time patients have their specialist visits. Patients will also be assured that their primary care provider gets back the information they need from the specialist.

Our goal is that patients will be prepared and informed about their health care conditions and needs and be able to participate in medical decision making and self-care management. We will work with patients/families to make sure they understand the reason for and importance of the referral and your follow up recommendations. Duplication of lab testing and diagnostic services may be avoided based on the sharing of clinical information.

4. **How will the compact be used between our offices?**

   We are enclosing a sample compact agreement. We would welcome meeting with you so that we could understand what you would like to see from our practice and have a joint discussion of mutual responsibilities. The compact can outline what might be needed depending on the kind of referral that is needed (i.e. consultation, co-management), who is accountable for which processes and outcomes of care within the referral, consultation or co-management arrangements. Also useful will be to define expectations regarding the information content requirements as well as the frequency and timeliness of information flow within the referral process.

Next step:

Please send us the name of the person and contact information on the person you would like us to work with in setting up a joint meeting so we can jointly discuss the compact. This is usually an office manager, practice manager, or administrator of your facility.

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 □ Informs patient of need, purpose, expectations, and goals of the Psychiatric (Behavioral Health), visit with Quality Behavioral Health Management Services □ 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] □ 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 □ Ensures QBH provider is informed of any changes in a patient's condition if changes are relevant to behavioral health care. □ Follows up with patients who did not follow through with appointments to assist in problem solving □ Resumes care of Patient when patient returns from behavioral health care and acts on care plan developed by QBH providers □ 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	□ Have timely appointment availability within a reasonable timeframe to meet patient care needs □ 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. □ 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. □ Informs patient of diagnosis, prognosis, and follow-up recommendations □ Provides appropriate educational materials and resources for patient/family □ Sends timely reports to PCP to include a care plan, follow up, recommendations, and results of psychiatric evaluations or therapeutic interventions □ Confers with PCP or establishes other protocol before referring to secondary or tertiary specialist, obtains prior authorizations, if required. □ 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 □ 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 □ QBH Psychiatrist will provide consultation services with Generic nursing staff upon request and upon agreed on remuneration □ 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 □ Emergency Crisis Evaluation services

_____ _____

Robert P. Arruda, Director Date

Quality Behavioral Health Management Services

_____ _____

Date

Generic

Practice Name
Address
City, State Zip
Phone

Process: Care Transitions to/from Hospital and ED

Purpose: To establish a process for coordinating patient care during and after transitions to acute care settings

A. Hospital Admissions

<Define & describe admission process used and staff responsible (multiple processes may apply)>

1. Hospital admission process - <direct, hospitalist, scheduled, unscheduled, through ED, etc.>
2. Standard documentation provided to hospital for admission <summaries, referrals, notes, reason, special requests, admit orders, shared EHR, etc.>
3. Method of providing documentation to hospital <direct electronic interface, through HIE, fax, patient carries materials, phone calls to hospitalist, shared EHR, etc.>
4. Method of noting admissions in the practice EHR or chart <ability to obtain list of admitted patients from EHR or hospitals (see below)>

B. Hospital Stay

<Define & describe communication process used, staff responsible (multiple processes may apply)>

For high risk patients known to be hospitalized, the Care Management/Care Coordinator resources contacts the patient and or the hospital discharge planner and begins transition of care planning at least 24 hours prior to hospital discharge

1. Agreements with hospitals to obtain daily Census lists <frequency & method of receipt>
2. Information received <calls with attending and/or consulting specialists, status updates, consult notes, hospital rounds, in-hospital consultations, etc.>
3. Information sent <notes, test results, meds, allergies, all consultation models mentioned above>
4. Information exchange <electronic, fax, HIE, phone, in-person consults, patient/family, etc.>

C. Hospital Discharge/SNF

<Define & describe discharge process used and staff responsible (multiple processes may apply)>

1. Notification of discharge from hospital
    a. Discharge list from hospital (or plans) <push by hospital/plans, pull by practice, combination, etc.>
    b. Content <discharge summary, interim letter, other>
    c. Method <direct electronic push, HIE push, faxed push, pull by the practice, access to hospital system, shared EHR, payer portals, sent with patient, other>
    d. Added to patient record <scanned in, electronically attached, etc.>
    e. Time frame < received within XX days from discharge>
2. Actions taken <patient call, call with hospitalist, contact consulting specialist(s), contact with discharge/case manager, scheduled follow up, house call, other>
3. Time frame for follow up <XX days within 30 days period after discharge; For high risk patients within ___ hours after discharge

D. ED Visits

<Define & describe communication process used and staff responsible (multiple processes may apply)> The Care Manager/Care Coordinator Resources contact every known patient who has had an ED visit for a situation or condition that is related to or contributes to the patient's high risk status within ___hours of an ED visit

1. Agreements with ED to <contact PCP, provide daily lists>
2. Information received <calls with ER physician and/or consulting specialists, status updates, ED summary notes. etc.>
3. Information sent <notes, test results, meds, allergies, phone consultation>
4. Information exchange <electronic, fax, HIE, phone, in-person consults, etc.>

E. ED Discharge

<Define & describe discharge process used and staff responsible (multiple processes may apply)>

1. Notification of discharge from ED
    a. Discharge list from ED (or plans) <push by hospital/plans, pull by practice, combination, etc.>
    b. Content <discharge summary, interim letter, other>
    c. Method <direct electronic push, HIE push, faxed push, pull by the practice, access to hospital system, shared EHR, payer portals, sent with patient, other>
    d. Added to patient record <scanned in, electronically attached, etc.>
    e. Time frame < received within XX days from visit>
2. Actions taken <patient call, call with ED, contact consulting specialist(s), contact with discharge/case manager, scheduled follow up, house call, other>
3. Time frame for follow up <XX days after discharge>

F. Medication Reconciliation

1. The Care management/Care Coordinator resources complete a medication reconciliation after a high risk patient has been discharged from inpatient services: to the extent possible, the medication reconciliation is conducted in person within ___ hours of discharge

F. Other Facilities

<Define and describe your process for working with facilities, such as detention centers, halfway houses, juvenile justice facilities, foster care, child or adult protective services or others, to obtain appropriate consent for release of information to treat and coordinate care with those partners who have legal responsibility for certain patients>

Approved By:

Effective: 1/1/2016
Revised:

Sample Primary Care Center/Urgent Care Center
Memorandum of Understanding

A) Purpose

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

B) Principles

- **High quality and timely patient care is our central goal.**
- **When urgent care is required, effective communication between primary care and urgent care center 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 health care across all stages of life.**
- **Medical Neighborhood – a system of care that integrates the PCMH with the medical specialists, and, as needed, urgent care providers and hospitals in the community through enhanced, bidirectional communication and collaboration on behalf of the patient.**

Expectations for Primary Care and Urgent Care Center	
Primary Care	**Urgent Care Center**
Supply results of recent studies that would facilitate the urgent care visit Informs patient of need, purpose, expectations, and goals of the urgent care visit Communicates reason for referral to the urgent care center and sends relevant information to the urgent care center (laboratory results, scans, etc.) [or informs of documents in EHR] Follow up with patients who did not follow through with urgent care center to assist in problem solving Resumes care of patient when patient returns from urgent care center	Is available to see referred patients within the hours of operation which includes ___ (PM hours) and ___ (week end hours) Orders appropriate diagnostic testing and treatment for patient, including the ordering of RX, obtains prior authorization if required Informs patient of diagnosis, prognosis, and follow-up recommendations Provides appropriate educational materials and resources for patient/family Sends timely reports to PCP to include a care plan, follow up, recommendations, and results of diagnostic studies or therapeutic interventions Confers with PCP or establishes other protocol before refers to secondary or tertiary specialist. obtains prior authorization, if required.

_____ _____ _____ _____

Primary Care Physician **Date**

_____ _____ _____ _____

Urgent Care Provider **Date**

CTC-RI Practice Transformation Program

The CTC-RI practice transformation program is focused on assisting your practice with meeting the core elements outlined in the Service Delivery Model which is aligned with CPC+ requirements and the RI Office of the Health Insurance Commissioner Cost management strategies. The program is designed to help prepare your practice for patient centered population health management and to perform successfully in alternative payment contracts.

There are multiple facets to the program including support for: Patient Centered Medical Home transformation (PCMH) and managing information for performance improvement. CTC offers learning network opportunities and incentive payments for achieving results.

A practice facilitator is assigned to your practice 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. Your practice facilitator will provide direct assistance with achieving NCQA practice centered medical home recognition, meeting the Rhode Island Office of the Health Insurance Commissioner's cost management strategies and meeting the CTC-RI contract requirements.

What practice transformation support will be available to your practice?
Practice Facilitation services:

a) One on one site visits from your assigned practice facilitator who will provide direct support with meeting the NCQA patient centered medical home standards and submitting the application;
b) Support in the implementation of core PCMH principles, such as engaged leadership, providing team based care, patient engagement, improving partnership with specialists and building the medical neighborhood;
c) Help in optimizing scheduling to provide same day access and after hour access;
d) Help in the integration the nurse care manager into the care team, inclusive of a web-based core curriculum nurse care manager training curriculum and coaching support from a CTC-RI nurse care manager faculty member;
e) Assistance in meeting the OHIC cost management strategies, establishing high risk patient registries, and offering care management services.

What practice reporting services are available through Rhode Island Quality Institute?

a) Assistance with understanding how to report on the CTC quality measures;
b) Learning how to capture data and information for quality and process improvement
c) Using Current Care to improve care transitions

What are the expectations of your practice?

Time and commitment:

There is a minimum expectation that the practice will meet with the practice facilitator according to the following schedule: Year 1: twice a month; Year 2: once a month; Year 3: once a quarter

Quality improvement informed by data and reporting is an integral part of the CTC program. 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.

Best practice sharing and committee based learning are some one of the fundamental strengths of the CTC 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 CTC, you will be expected to participate in best practice sharing (50% of learning network meetings with Practice Reporting Committee as a required meeting) – not only to learn from others, but also to offer your experiences to others.

What are the benefits to your practice?

Support for providing better patient care within your practice team
Practices that have been part of CTC-RI have indicated that team members learn to work together and develop skills, abilities relationships with other primary care practices that result in better care for the patients and families and more "joy in practice" for the practice team.

Primary Care Voice
The CTC-RI initiative is designed to provide primary care practices with a mechanism for learning from others and being part of a primary care network that works together with the health plans to achieve better care, smarter spending, and healthier people. Your practice will be ready to succeed in other quality payment programs including those offered by the Rhode Island OHIC, and Medicare Access and CHIP Re-authorization Act of 2015 (MACRA).

Obtain Infrastructure and Incentive Payments for Care Transformation
Under CTC, your practice will receive supplemental payments for three years from health plans in the multi-payer initiative to transform your practice and be recognized as a patient centered medical home (PCMH) **$3.00** per member per month for adult practices in Year 1 with added incentives in Year 2 and 3 for achieving improvements in quality, customer experience and utilization thresholds;

Be better prepared to practice within systems of care and receive enhanced payments made available through the Office of the Health Insurance, CMS and Local Health Plans

Example Practice Per-Member-Per-Month Budget

In anticipation of the upcoming year's (January 1, 2017-December 31, 2017) PMPM payment estimates, (insert practice name) intends to use our funding as follows:

Category	PMPM	Percentage
Nurse Care Manager		
Provider Time		
Training		
EHR/Reporting		
Other		

Practice Transformation Staffing Plan

Name	Date of Hire	Hours	Position Title

Understanding the New 2017 NCQA PCMH Standards

The Care Transformation Collaborative of Rhode Island (CTC-RI) will be hosting two learning sessions to assist primary care practices and key stakeholders with understanding the new 2017 NCQA Patient Centered Medical Home Standards:

- NCQA's Introduction to PCMH 2017: Foundational Concepts of the Medical Home (July 17-18th) and
- Advanced PCMH 2017: Succeeding in Medical Home Recognition (July 19th)

The 2017 standards emphasize a practice-wide commitment to sustaining the PCMH transformation, demonstrating patient care and population health management, care coordination and ongoing quality improvement. The advanced course is intended for individuals who have applied NCQA PCMH Recognition requirements in the practice setting. It examines the PCMH 2017 standards and the redesigned assessment process. It takes a "project management" approach to the standards, and a deeper dive to explore the key characteristics of a successful medical home.

Attendees will be able to register for Introduction Only ($375.00), Advanced Only ($350.00), or Both Programs.

Practices currently participating in a CTC-RI Contract will be provided with discount codes to offset program costs - make sure to enter these codes prior to checkout.

Please use this Eventbrite Link to register* for the program and obtain more details.
***We expect heavy demand for this Program. Please Register by May 15, 2017 to ensure your spot. Deadline is June 30, 2017.**

CTC-RI Gratefully Acknowledges our Sponsors:
Rhode Island Quality Institute
Brown University
Coastal Medical
Healthcentric Advisors
Massachusetts League of Community Health Centers
New England States Consortium Systems Organization
Rhode Island Health Center Association
Rhode Island Department of Health
Blue Cross and Blue Shield of Rhode Island
Neighborhood Health Plan of Rhode Island
Tufts Health Plan
UnitedHealthcare

Questions? Contact Candice Brown: Candice.Brown@umassmed.edu or 401-528-3277.

NCQA Resources

Patient Centered Medical Home Recognition:

CTC can provide practices with a discount code for NCQA recognition which provides a 20% reduction in the cost of your application.

Other resources:

BizMed Solutions: Provides free PCMH management software and consultation for NCQA Recognition www.bizmedsolutions.com

NCQA website: www.ncqa.org

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

CPC+ CARE DELIVERY REQUIREMENTS for 2017		NCQA		CTC-RI
ACCESS & CONTINUITY				
TRACK 1	**1.1** Achieve and maintain at least 95% empanelment to practitioner and/or care teams. **REPORTING: ALL QUARTERS**	**AC13 (CREDIT)**	The practice has a process to review the number of patients assigned to each clinician and balance the size of each providers' patient panel. Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and provider workload because supply is balanced with patient demand. The American College of Family Physicians provides a tool for practices to use when considering and managing panel sizes: http://www.aafp.org/fpm/2007/0400/p44.pdf	Year 1; Year 2; Year 3: Quarterly Provider panel report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients
	1.2 Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR. **REPORTING: Q1, Q3**	**AC04 (CORE)**	Patients can telephone the practice any time of the day or night and receive interactive (i.e., from a person, rather than a recorded message) clinical advice. Clinical advice refers to a response to an inquiry regarding symptoms, health status or an acute/chronic condition. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice's expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7- days of such calls.	Year 1: Before and After Protocol Year 2: Schedule demonstrating that practice has expanded office hours
	1.3 Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity. **REPORTING : ALL QUARTERS**	**AC10 (CORE)**	Giving patients/families/caregivers a choice of practitioner emphasizes the importance of the ongoing patient-clinician relationship. The practice documents patients' choice of clinician, gives patients/families/caregivers information about the importance of having a personal clinician and care team responsible for coordinating care, and assists in the selection process. The practice may document a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a practice team. Single clinician sites automatically meet this criterion.	
		AC11 (CORE)	The practice establishes a goal for the proportion of visits a patient should have with the primary care provider and care team. The goal should acknowledge that meeting patient preferences for timely appointments will sometimes be at odds with the ability to see their selected clinician. Empanelment is assigning individual patients to individual primary care providers and care teams, with sensitivity to patient and family preferences. It is the basis for population health management and the key to continuity of care: Patients can build a better relationship with a clinician or team they see regularly.	
TRACK 2 (1.1 - 1.3+)	**1.4** Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends. **REPORTING: Q2, Q4**	**AC06 (CREDIT)**	The practice uses a mode of real-time communication (e.g., a combination of telephone, video chat, secure instant messaging) in place of a traditional in-person office visit with a clinician. The practice provides a report of the number and types of visits in specified time period. Unscheduled alternative clinical encounters, including clinical advice by telephone and secure electronic communication (e.g., electronic message, website) during office hours do not meet the requirement. An appointment with an alternative type of clinician (e.g., diabetic counselor) does not meet the requirement.	Year 2: Submits screenshot demonstrating patient access to secure web portal, enabling secure messaging, appointment requests, referrals and prescription refills
CARE MANAGEMENT				
Track 1	**2.1** Risk-stratify all empanelled patients. **REPORTING: Q2, Q4**	**CM02 (CORE)**	The practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. The practice uses the criteria defined in CM 01 to identify patients who fit defined criteria. Patients who fit multiple criteria count once in the numerator.	
		CM03 (CREDIT)	The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need.	
	2.2 Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. **REPORTING: ALL QUARTERS**	**CM03 (CREDIT)**	The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need.	Year 1: Hires Nurse Care Manager; Year 1: Develops high risk registry with reportable fields; Year 1: NCM completes standardized learning program
	2.3 Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empanelled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management. **REPORTING: ALL QUARTERS**			Year 2; Year 3: Submits reports on high risk patient engagement and achieves 40% engagement rate; Year 2: Submits report that demonstrates 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days; Year 3: provides report that demonstrates that 75% of high risk patients with ED visit receive a follow up interaction including medication reconciliation within 1 week of discharge

	2.4 Ensure patients with ED visits receive a follow up interaction within one week of discharge. **REPORTING: ALL QUARTERS**	**CC16 (CORE)**	The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice's policies define the appropriate contact period in addition to a log documenting systematic follow-up was completed. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encouraging follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs.	Year 1: Submits a Transition of Care Policy
	2.5 Contact at least 75% of patients who were hospitalized in target hospital(s), within 2 business days. **REPORTING: ALL QUARTERS**	**CC16 (CORE)**	SEE ABOVE	
TRACK 2 2.1 (in more depth and), 2.2-2.5 +	**2.1** (more in depth) Use a two-step risk stratification process for all empanelled patients: Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition); Step 2 - adds the care team's perception of risk to adjust the risk-stratification of patients, as needed. **REPORTING: Q2, Q4**	**CM01 (CORE)**	The practice defines a protocol to identify patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A–E. Examples include, but are not limited to: A. Diagnosis of a serious mental illness, psychiatric hospitalizations, substance use treatment. B. Patients who experience multiple ER visits, hospital readmissions, high total cost of care, unusually high numbers of imaging or lab tests ordered, unusually high number of prescriptions, high-cost medications and number of secondary specialist referrals. C. Patients with poorly controlled or complex conditions such as, continued abnormally high A1C or blood pressure results, consistent failure to meet treatment goals, multiple comorbid conditions. D. Availability of resources such as food and transportation to meet daily needs; access to educational, economic and job opportunities; public safety; social support; social norms and attitudes; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). E. Direct identification of patients who might need care management such as, referrals made from health plans, practice staff, patient, family members, or caregivers.	
	2.6 Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management. **REPORTING: Q2, Q4**	**CM04 (CORE)**	The practice has a process to consistently develop patient care plans for the patients identified for care management. To ensure that a care plan is meaningful, realistic and actionable, the practice involves the patient in the plan's development, which includes discussions about goals (e.g., patient function/life style, goal feasibility and barriers) and considers patient preferences. The care plan incorporates a problem list, expected outcome/ prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services. The practice updates the care plan at relevant visits. A relevant visit addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.	

COMPREHENSIVENESS & CARE COORDINATION				
Track 1	**3.1** Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payer's data. **REPORTING: ALL QUARTERS**			Year 1: identifies high volume specialists serving patient population and submits 2 compacts: a) high volume specialist; b) behavioral health Year 3: Submits 2 additional compacts as defined by OHIC Cost Management Strategies
	3.2 Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payer's data. **REPORTING: Q1, Q3**	**CC15 (CORE)**	The practice demonstrates timely sharing of information with admitting hospitals and emergency departments. Shared information supports continuity in patient care across settings. The practice provides three examples of this exchange to meet the criteria.	
		CC19 (CREDIT)	The practice has a process for actively attempting to receive patient discharge summaries. The process may include a local database or active outreach to ensure that the practice is notified when a patient is discharged from a hospital or other care facility. The practice provides the process for obtaining the summaries and at least three examples of obtaining the discharge summary or demonstrates participation in a local admission, discharge, transfer (ADT) system.	
		CC21 (CREDIT)	The practice utilizes an electronic system to exchange patient health record data and other clinical information with external organizations. Exchange of data across organizations supports enhanced coordination of patient care. Practices can demonstrate this by: A. Exchanging patient medical record information to facilitate care management of patients with complex conditions or care needs. B. Submitting electronic data to immunization registries to share immunization services provided to patients. C. Making the summary of care record accessible to another provider or care facility for care transitions. Practices may provide the required evidence for each of the criteria options for up to a total of 3 credits. Each option is part of CC 21 but is listed separately in Q-PASS for scoring purposes.	
Track 2 (3.1-3.2+)	**3.3** Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. **REPORTING: ALL QUARTERS**	**CC08 (CREDIT)**	Relationships between primary care practitioners and specialists support a coordinated, safe, high-quality care experience for patients. The practice has established relationships with nonbehavioral healthcare specialists through formal or informal agreements that establish expectations for exchange of information (e.g., frequency, timeliness, content).	
	3.4 Choose and implement at least one option from a menu of options for integrating behavioral health into care. **REPORTING: Q2, Q4**	**CC10 (CREDIT)**	Behavioral health integration includes care settings that have merged to provide behavioral health services and care coordination at a single practice setting. This is more involved than co-location of practices, because all providers work together to integrate patients' primary care and behavioral health needs, have shared accountability and collaborative treatment and workflow strategies.	
	3.5 Systematically assess patients' psychosocial needs using evidence-based tools. **REPORTING: Q2, Q4**	**KM02 (CORE)**	A comprehensive patient assessment includes an examination of the patient's social and behavioral influences in addition to a physical health assessment. The practice uses evidence-based guidelines to determine how frequently the health assessments are completed and updated. Comprehensive, current data on patients provides a foundation for supporting population needs. As part of the comprehensive health assessment the practice:	
		KM02 (CORE) CONT'D	A. Collects patient and family medical history (e.g., history of chronic disease or event [e.g., diabetes, cancer, surgery, hypertension]) for patient and "first-degree" relatives (i.e., who share about 50% of their genes with a specific family member). B. Collects patient and family behavioral health history (e.g., schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use, maternal depression). C. Evaluates social and cultural needs, preferences, strengths and limitations. Examples include family/household structure, support systems, and patient/family concerns. Broad consideration should be given to a variety of characteristics (e.g., education level, marital status, unemployment, social support, assigned responsibilities). D. Identifies whether a patient has specific communication requirements due to hearing, vision or cognition issues. Note: This does not address language; refer to KM10 for language needs. E. Assesses risky and unhealthy behaviors that go beyond physical activity, alcohol consumption and smoking status and may include nutrition, oral health, dental care, risky sexual behavior and secondhand smoke exposure. F. Assesses a patient's ability to interact with other people in everyday social tasks and to maintain an adequate social life. May include isolation, declining cognition, social anxiety, interpersonal relationships, activities of independent living, social interactions and so on. G. Collects information on social determinants of health: conditions in a patient's environment that affect a wide range of health, functioning and quality-of-life outcomes and risks. Examples include availability of resources to meet daily needs; access to educational, economic and job opportunities; public safety, social support; social norms and attitudes; food and housing insecurities; household/environmental risk factors; exposure to crime, violence and social disorder; socioeconomic conditions; residential segregation (Healthy People 2020). H. For newborns through 3 years of age, uses a standardized tool for periodic developmental screening. If there are no established risk factors or parental concerns, screens are done by 24 months. I. Documents patient/family preferences for advance care planning (i.e., care at the end of life or for patients who are unable to speak for themselves). This may include discussing and documenting a plan of care, with treatment options and preferences. Patients with an advance directive on file meet the requirement.	

	3.6 Conduct an inventory of resources and supports to meet patients' psychosocial needs. **REPORTING: Q2, Q4**	**KM21 (CORE)**	The practice identifies needed resources by assessing collected population information. Practice may assess social determinants, predominant conditions, emergency department usage and other health concerns to prioritize community resources (e.g. food banks, support groups) that support the patient population.	
		KM26 (CREDIT)	The practice maintains a community resource list by selecting five topics or community service areas of importance to the patient population. The list includes services offered outside the practice and its affiliates. Include a date to demonstrate that the list is regularly updated or otherwise demonstrate how the list is maintained. Maintaining a current resource list that prioritizes the central needs and concerns of the population can help a practice guide patients to community resources that support their health and well-being from that additional support.	
	3.7 Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time. **REPORTING: Q3**	**QI1& (CREDIT)**	The practice identifies health disparities in care or services among vulnerable populations. The practice sets goals and acts to improve performance. After assessing performance on the disparities in care (QI 05), the practice sets goals and acts to improve on care or service.	

PATIENT & CAREGIVER ENGAGEMENT				
Track 1	**4.1** Convene a PFAC at least once in PY2017, and integrate recommendations into care, as appropriate. **REPORTING: ALL QUARTERS**	**QI17 (CREDIT)**	The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	
	4.2 Assess practice capability and plan for support of patients' self-management. **REPORTING: Q2, Q4**	**CM06 (CREDIT)**	The practice works with patients/families/caregivers to incorporate patient preferences and functional lifestyle goals in the care plan. Including patient preferences and goals encourages a collaborative partnership between patient/family/caregiver and provider, and ensures that patients are active participants in their care. Functional/lifestyle goals can be individually meaningful activities that a person wants to be able to perform but may be at risk due to a health condition or treatment plan. Identifying patient-centered functional/lifestyle goals is important because people are likely to make the greatest gains when goals focus on activities that are meaningful to them and can make a positive difference in their lives.	
		CM08 (CREDIT)	The practice works with patients/families/ caregivers to develop self-management instructions to manage day-to-day challenges of a complex condition. The plan may include best practices or supports for managing issues related to a complex condition identified in the care plan. Providing tools and resources to self-manage complex conditions can empower patients to become more involved in their care and to use the tools to address barriers toward meeting care plan goals.	
Track 2	**4.1** SAME as above **REPORTING: ALL QUARTERS**	**QI17 (CREDIT)**	The practice has a process for involving patients and their families in its quality improvement efforts or on the practice's patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.	
	4.2 Implement self-management support for at least 3 high risk conditions. **REPORTING: ALL QUARTERS**			
Other				Year 1; Year 2: Year 3: Submits patient panel to approved data vendor (or "How's Your Health" option to be determined)
PLANNED CARE & POPULATION HEALTH				
Track 1	**5.1** Use feedback reports provided by CMS/other payers at least quarterly on at least 2 utilization measures at the practice-level and practice data on at least 3 electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to inform strategies to improve population health management. **REPORTING: Q2, Q4**	**QI01 (CORE)**	Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least:	Year 2: Submits quality improvement activity for improving a performance measure (quality/customer experience/utilization); Submits quality improvement activity demonstrating performance to improve a quality measure
			• One immunization measure. • One preventive care measure (not including immunizations). – A measure on oral health counts as a preventive clinical quality measure. • One chronic or acute care clinical measure. • One behavioral health measure. The data must include the measurement period, the number of patients represented by the data, the rate and the measure source (e.g. HEDIS, NQF #, measure guidance).	Year 1; Year 2; Year 3: Submits clinical quality data as defined by CTC; Year 1; Year 2; Year 3: Submits to OHIC Cost Management attestation and quality measures
Track 2 (5.1+)	**5.2** Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+. **REPORTING Q2, Q4**			
CPC+ CARE DELIVERY Submission Periods for 2017		Practice Transformation		
Quarter 1	Submission period 3/27/17 to 4/14/17			Year 1: Submit NCQA PCMH work plan; Year 3; Submits NCQA application; Year 3: Obtains NCQA recognition
Quarter 2	Submission period 6/26/17 to 7/14/17			Year 1: Meets with practice facilitator 1-2 x per month; Year 2: Meets with practice facilitator once a month; Year 3: Meets with practice facilitator once a quarter
Quarter 3	Submission period 9/25/17 to 10/13/17			Year 1: Submits budget and staffing plan and use of funds to support care delivery model
Quarter 4	Submission period 12/25/17 to 1/19/18			Year 1; Year 2; Year 3: Attends 50% of learning network meetings

Rhode Island PCMH Cost Management Strategies
Self-Assessment Tool
June 13, 2016

Name of Practice: _____

Name of Contact: _____ **e-mail Address:** _____

Practice Address: _____ **Phone Number:** _____

_____

Contracted provider for (check all that are applicable):

____ Blue Cross Blue Shield of Rhode Island **____ Neighborhood Health Plan of Rhode Island**

____ United Healthcare **____ Tufts Health Plan**

NPI numbers for all clinicians managing a patient panel: (list each MD's, NP's, PA's NPI, adding additional spaces, as necessary)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Transformation Year:

- Less than one year ("Year 1"): practice joined CTC on January 1, 2016; joined TCPI in 2016; or practice is not participating in any transformation initiative
- One to two years ("Year 2"): practice joined CTC on January 1, 2015 or independently achieved NCQA PCMH Level 3 recognition during 2015
- Three or more years ("Year 3"): practice joined CTC prior to January 1, 2015 or independently achieved NCQA PCMH Level 3 recognition prior to January 1, 2015.

Date survey completed: _____

Background:

The following standards must be met by primary care practices seeking PCMH designation from Rhode Island payers in order to qualify for medical home financial support, consistent with terms of the OHIC-approved 2016 Care Transformation Plan.

Practices that have received NCQA PCMH Level 3 designation will be deemed to have met all requirements listed below that are substantially the same as one or more NCQA PCMH requirements.

To meet the OHIC definition of a PCMH, practices must have implemented 80% of the requirements specified for their transformation year by the survey date.

Instructions: Please ask the staff most knowledgeable about the activities of the practice to complete the following survey. Please answer honestly using the most accurate information available.

Requirement #1: The practice develops and maintains a high-risk patient registry:

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform all of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services (referred to as "high-risk patients).	NCQA: requirement deemed met if 2011 NCQA PCMH 3, Element B or 2014 NCQA PMCH 4, Element A is met TCPI: requirement deemed met if Milestone 4D is achieved	**X**	**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
2. Using information from a variety of sources, including payers and practice clinicians, the practice updates the list of high-risk patients at least quarterly.	NCQA: requirement deemed met if 2011 NCQA PCMH 3, Element B or 2014 NCQA PCMH 4, Element A is met AND practice is using payers and practice clinicians to update high-risk patient lists AND lists are updated at least quarterly.	**X**	**X**	**X**		
3. To identify high-risk patients, the practice has developed a risk assessment methodology that includes at a minimum the consideration of the following factors: a. assessment of patients based on co-morbidities; b. inpatient utilization, and c. Emergency Department utilization.	NCQA: requirement deemed met if 2011 NCQA PCMH 3 or 2014 NCQA PCMH 4, Element 4 is met.	**X**	**X**	**X**		

Requirement #2: The practice offers Care Management/Care Coordination services with a focus on high-risk patients enrolled with the carriers that are funding the Care Management/Care Coordination services. Other staff may provide Care Management/Care Coordination services in addition to the designated Care Manager or Care Coordinator so long as those services promote care management and care coordination and are provided under the direct supervision of the Care Manager or Care Coordinator.

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has a designated resource(s) that at the minimum includes a trained licensed Registered Nurse or Social Worker Care Coordinator for pediatric practices to provide Care Management/Care Coordination services that focuses on providing services to high-risk patients.	NCQA: requirement deemed met if 2011 NCQA PCMH 3 or 2014 NCQA PCMH 4 is met AND practice employs an RN/LPN or social worker as CM/CC.	**X**	**X**	**X**		
2. The practice has an established methodology for the timely assignment of levels of Care Management/Care Coordination service needed by high-risk patients based on risk level, clinical information including disease severity level and other patient-specific characteristics. The purpose of the assessment is to promptly identify which high-risk patients should be in the Care Manager's/Care Coordinator's active caseload at any point in time.	TCPI: requirement deemed met if Phase 3H is achieved and practice's methodology includes consideration of clinical information, including severity level and other patient-specific characteristics.	**X**	**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
3. The Care Manager/Care Coordinator completes within a specified period of time <u>(from the time that the high-risk patient is placed in the Care Manager's/Care Coordinator's active caseload)</u>[1] a patient assessment based on the patient's specific symptoms, complaints or situation, including the patient's preferences and lifestyle goals, self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk. For children and youth, the care coordinator shall complete a family assessment that includes: a. a family status and environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth & family), and b. a growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance and needs, and emotional/behavioral strengths and needs).	NCQA: requirement is deemed met if NCQA 2011 PCMH 3, Element C or NCQA PCMH 4, Element B is met AND the practice has established and implemented a process within specified timeframes for assessing and adding new patients onto the high-risk patient list, based on care manager capacity.	**X**	**X**	**X**		

[1] Assessment is initiated within one week, with at least three contact attempts (if needed) within two weeks. Assessment must be completed within two weeks of caseload assignment, unless patient is non-responsive to outreach.

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
4. Working with the patient and within two weeks of completing the patient assessment, the Care Manager/Care Coordinator completes a written care plan, that includes: a. a medical/social summary; b. risk factors; c. treatment goals; d. patient-generated goals; e. barriers to meeting goals, and f. an action plan for attaining patient's goals.	NCQA: requirement is deemed met if 2014 NCQA: PCMH 4, Element B is met AND practice is meeting the required timeline.	**X**	**X**	**X**		
5. The Care Management/Care Coordination resources update the written care plan on a regular basis, based on patient needs to affect progress towards meeting existing goals or to modify an existing goal, but no less frequently than semi-annually.	NCQA: requirement is deemed met if NCQA PCMH 3, Element C or 2014 NCQA PCMH 4 is met AND practice is developing care plans for all patients on the high-risk patient list and are meeting the timeframe for updating the care plan.		**X**	**X**		
6. For high-risk patients known to be hospitalized or in a SNF, the Care Management/Care Coordination resources shall contact the patient and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient's discharge.	NCQA: either 2011 or 2014 NCQA PCMH 5, Element C is met AND the practice is beginning TOC planning within the required timeframe.		**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
7. The Care Management/Care Coordination resources contact every high-risk patient who has been discharged from hospital inpatient services after discharge to determine care management needs. • Year 1: within 72 hours after discharge. • Years 2 and 3: within 48 hours after discharge.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element C is met AND the practice is meeting the specific timeframe for completing the outreach contacts. TCPI: requirement is deemed met if Phase 3 N is achieved.	**X**	**X**	**X**		
8. The Care Management/Care Coordination resources contact every known high-risk patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient's high-risk status. • Year 1: within 72 hours of an ED visit. • Years 2 and 3: within 48 hours of an ED visit.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element C is met AND practice is meeting the specific timeframe for completing the outreach contacts. TCPI: requirement is deemed met if Phase 3 N is achieved.	**X**	**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
9. The Care Management/Care Coordination resources complete a medication reconciliation after a high-risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person. • Year 1: within 7 days of discharge. • Years 2 and 3: within 72 hours of discharge.	NCQA: requirement is deemed met if 2011 NCQA PCMH 3, Element D or 2014 NCQA PMCH 4, Element C is met AND the practice is meeting the specific timeframe for completing the medication reconciliations. TCPI: requirement is deemed met if Phase 2 F is met AND the practice selected medication management review as one of its case management strategies.	**X**	**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
10. The Care Management/Care Coordination resources arrange for, and coordinate all medical, developmental, behavioral health and social service referrals and tracks[2] referrals and test results on a timely basis for high-risk patients.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element A is met. TCPI: requirement is deemed met if Phase 4 E is achieved.	**X**	**X**	**X**		
11. The Care Management/Care Coordination resources provide health and lifestyle coaching for high-risk patients designed to enhance the patient's/caregiver's self/condition-management skills.	NCQA: requirement is deemed met if 2011 NCQA PHC 4, Element A or 2014 PCMH 4, Element E is met.	**X**	**X**	**X**		
12. Practices shall provide patient-engagement training to Care Managers/Care Coordinators, as necessary, to achieve these requirements.	NCQA: requirement is met if 2014 NCQA PCMH 2, Element 6 is met. TCPI: requirement is met if Phase 1 D is achieved AND training topics include patient engagement.	**X**	**X**	**X**		
13. The Care Management/Care Coordination resources have in-person or telephonic contact with each high-risk patient at intervals consistent with the patient's level of risk.		**X**	**X**	**X**		

[2] Consistent with 2014 NCQA PCMH recognition Standard 5, Element B, "tracking" here means that the practice "tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports."

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
14. The Care Management/Care Coordination resources participate in relevant team-based care meetings to assure whole-person care is provided to high-risk patients. For pediatric practices, participants in practice-initiated team meetings may include primary care and specialist providers, school liaisons, behavioral health providers, developmental specialists, government support program representatives (e.g., SSI), and social service agency representatives.	NCQA: requirement is deemed met if 2011 NCQA PCMH1, Element G or 2014 NCQA PCMH2, Element D is met.	**X**	**X**	**X**		
15. The Care Management/Care Coordination resources use HIT to document and monitor care management service provision.		**X**	**X**	**X**		
16. The Care Management/Care Coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery	NCQA: Allow deeming. TCPI: Allow partial deeming when Phase 2.H is achieved. Separately verify that PDSA cycles assess and improve effectiveness of care management service delivery Allow deeming when Phase 4.A milestone is achieved.	**X**	**X**	**X**		

Requirement #3: The practice improves access to and coordination with behavioral health service.

Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	
The practice has implemented <u>one</u> of the following approaches to behavioral health integration by the end of Year 1:			**Fully or Substantially Achieved**	**Not Achieved**
1. To promote better access to and coordination of behavioral health services, the practice has developed preferred referral arrangements with community behavioral health providers such that appointments are available consistent with the urgency of the medical and behavioral health needs of the practice's patients and there is an operational protocol adopted by the PCP and the preferred specialists for the exchange of information. The terms of the preferred arrangement are documented in a written agreement.				
2. To promote better access to and coordination of behavioral health services, the practice has arranged for a behavioral health provider(s) to be co-located (or virtually located) at the practice for at least one day per week and assists patients in scheduling appointments with the on-site provider(s).				
3. To promote better access to and coordination of behavioral health services, the practice is implementing or has implemented a co-located (or virtually located), integrated behavioral health services model that is characterized by licensed behavioral health clinicians serving on the care team; the team sharing patients, and sharing medical records, and the practice promoting consistent communications at the system, team and individual provider levels that includes regularly scheduled case conferences, and warm hand-off protocols.				

Requirement #4: The practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am and 5pm).

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has a written policy to respond to patient telephone calls within the following timeframes: a. For urgent medical/behavioral calls received during office hours, return calls are made the same day. b. For urgent calls received after office hours, return calls are made within 1 hour. c. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.	NCQA: requirement is deemed met if 2011 NCQA PCMH 1, Element B or 2014 NCQA PCMH 1, Element B is met AND the practice has written policies that meet the specified time frames for responding to patient calls.	**X**	**X**	**X**		
2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day. • Years 1 and 2: for urgent care only. • Year 3: for urgent and routine care. Routine care is care that patients believe they need but not "right away."	NCQA: requirement is deemed met if 2011 or 2014 PCMH 1, Element A is met.	**X**	**X**	**X**		
3. The practice has an agreement with (or established) an urgent care clinic or other service provider which is open during evenings and weekends when the office is not open as an alternative to receiving Emergency Department care.		**X**	**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
4. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access.	NCQA: requirement is deemed met if NCQA 2014, Element A is met. TCPI: requirement is deemed met if Phase 2 H is achieved and practice's PDSA cycles are designed to assess and improve the effectiveness of its programs to expand access. Requirement is deemed met when Phase 4 is achieved.	**X**	**X**	**X**		

Cost Management Requirement (continued)	Deeming Recommendation	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>at least 2</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
5. The practice has created a secure web portal that enables patients to: • send and receive secure messaging; • request appointments; • request referrals; • request prescription refills, and • review lab and imaging results (beginning in Year 2). The practice clearly communicates to patients that the portal should not be used for urgent matters and that patients should call the practice under such circumstances.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 1, Element C is met.	**X**	**X**	**X**		
6. The practice has expanded office hours so that services are available at least two mornings or two evenings a week for a period of at least 2 hours beyond standard office hours. • Year 2: urgent care only. • Year 3 urgent and routine care.			**X**	**X**		
7. The practice has expanded office hours so that services are available at least four hours over the weekend. Services may be provided by practice clinicians or through an affiliation of clinicians, so long as the affiliated physicians are able to share medical information electronically on a near real- time basis through either a shared EMR system or by ready access to a patient's practice physician who has real-time access to patient's medical records. • Year 2: urgent care only. • Year 3 urgent and routine care.			**X**	**X**		

Requirement #5: The practice refers patients to specialty and ancillary providers who are known to provide high quality, efficient services (e.g., value-based care.)

Cost Management Requirement	Deeming Recommendation	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has developed referral protocols for its patients for at least two of the following: a. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist; b. laboratory services; c. imaging services; d. physical therapy services, and e. home health agency services.	TCPI: requirement is deemed met once Phase 2 B is achieved and formal agreements are with community partners detailed in this requirement.	**X**	**X**	**X**		
2. Should one or more payers provide the practice with readily available, actionable data, the practice has used such data and any other sources to identify referral service providers who provide higher quality services at costs lower than or the same as their peers (i.e., "high-value referral service providers") and prioritizes referrals to those providers.			**X**	**X**		

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER

STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

Dear Rhode Island Primary Care Practice:

Health care in Rhode Island and nationally are both moving away from traditional fee-for-service payment methods and towards methods that reward quality and cost efficiency. For primary care practices, these new payment methods are intended to accompany practice transformation into Patient-Centered Medical Homes (PCMHs). A PCMH is a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It is a model for achieving primary care excellence, where patients are treated with respect, dignity and compassion, and where strong and trusting relationships with providers and staff are enabled.[1]

The Rhode Island Office of the Health Insurance Commissioner (OHIC) has implemented several initiatives to promote primary care through PCMHs. One of those initiatives is to require commercial health plans to contract with an increasing number of PCMHs each year and to provide supplemental payments to designated primary care practices to help finance their PCMH operations ("Support Payments"). OHIC only requires health plans to make these payments to practices that meet OHIC's three-part definition of PCMH.

The enclosed document provides more details about the OHIC initiative to financially support and promote primary care practice transformation into PCMHs and what it might mean to you.

If you have any questions, please do not hesitate to call either Sarah Nguyen or Cory King, OHIC staff responsible for implementing the PCMH initiative, at 401-462-9643.

Sincerely,

Kathleen C. Hittner

Kathleen Hittner, MD
Health Insurance Commissioner

[1] Patient-Centered Primary Care Collaborative. "Defining the Medical Home: A patient-centered philosophy that drives primary care excellence." www.pcpcc.org/about/medical-home

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7/11/2016

Frequently Asked Questions

1. **Why is the Health Insurance Commissioner promoting primary care Patient-Centered Medical Homes?**
    a. The Health Insurance Commissioner is charged by the legislature to address the affordability of health care in Rhode Island and OHIC's initiatives have emphasized the need for a strong primary care infrastructure. Between 2010 and 2016, OHIC directed health plans to increase and then sustain the proportion of total medical spending dedicated to primary care, without adding to the overall cost of health insurance premiums. Since 2011, OHIC has been promoting PCMH transformation through the multi-payer Care Transformation Collaborative-RI (CTC-RI) initiative.[1]
    b. There is solid evidence that primary care practices that function as PCMHs reduce total health care costs by improving the quality of care provided and by better coordinating and managing care.[2]
    c. To expand the PCMH transformation process in the state, OHIC is now requiring commercial health plans to contract with more PCMHs each year.

2. **What are the commercial health plans' targets for PCMH expansion?**
    a. Health plans subject to the Office's Affordability Standards are required to have 80% of their contracted clinicians operating in a PCMH by the end of 2019.

3. **What is the OHIC definition of a PCMH?**
    a. OHIC, with physician and insurer guidance, has developed a three-part definition of PCMH that requires demonstration of practice transformation, cost management initiatives and clinical improvement. OHIC is phasing in the requirements over the next two years and considers a practice's transformation experience and its collection and reporting of EMR-based quality clinical data.
    b. For 2016 a practice will be considered a PCMH if the practice has achieved NCQA PCMH Level 3 recognition[3] (either 2011 or 2014), or is participating in CTC-RI or in any payer- sponsored PCMH transformation program. A practice

[1] See: www.ctc-ri.org/
[2] See: www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015
[3] Should NCQA change its recognition process, OHIC will evaluate these changes and solicit stakeholder input on any necessary amendments to the OHIC definition of a PCMH.

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does not need to verify and submit NCQA PCMH status because OHIC is getting all information it needs from NCQA, CTC-RI and from the health plans.

c. For OHIC PCMH recognition in 2017, the requirements vary based on the experience of the practice.

Transformation Experience	**Participation in Transformation Initiative**	**Cost Management Strategies**	**Performance Improvement Measures**
Practice joined CTC-RI or payer-sponsored program prior to January 1, 2015.	Practice is participating in or has completed a formal transformation initiative.	Practice must complete the Cost Management Strategies Self-Assessment on the OHIC web site by **October 15, 2016** and demonstrate that at least 80% of requirements have been met.	Practice must submit to OHIC via the OHIC web site quality performance measures only for specified measures by **October 15, 2016.** Report period will cover 10/1/2015 – 10/1/2016.
Practice joined CTC or payer-sponsored program on or after January 1, 2015 (including PCMH-Kids) Practice has never participated in CTC-RI or payer-sponsored program	Practice participates in a formal transformation initiative, or has achieved NCQA PCMH Level 3 recognition.	Practice must complete the Cost Management Strategies Self-Assessment on the OHIC web site by **October 15, 2016** for baseline calculation purposes. Practice is not required to demonstrate that 80% of requirements have been met for 2017, but must meet them for 2018.	Practice must submit to OHIC via the OHIC web site quality performance measures only for specified measures by **October 15, 2016.** Report period will cover 10/1/2015 – 10/1/2016.

d. For recognition in 2018, the requirements vary based on the experience of the practice.

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Transformation Experience	Participation in Transformation Initiative	Cost Management Strategies	Performance Improvement Measures
Practice joined CTC-RI or payer-sponsored program prior to January 1, 2015.	Practice is participating in or has completed a formal transformation initiative.	Practice must complete the Cost Management Strategies Self-Assessment by **October 15, 2017** and demonstrate that at least 80% of requirements have been met.	Practice must submit quality performance measures data for all OHIC PCMH measures by **October 15, 2017** and demonstrate the required level of improvement or performance achievement. Report period will cover 10/1/2016 – 10/1/2017.
Practice joined CTC or payer-sponsored program on or after January 1, 2015 (including PCMH-Kids) Practice has never participated in CTC-RI or payer-sponsored program	Practice participates in a formal transformation initiative, or has achieved NCQA PCMH Level 3 recognition	Practice must complete the Cost Management Strategies Self-Assessment by **October 15, 2017** and demonstrate that at least 80% of requirements have been met.	Practice must submit performance measures data for all PCMH measures by **October 15, 2017** and demonstrate the required level of improvement or performance achievement. Report period will cover 10/1/2016 – 10/1/2017.

e. <u>For recognition in 2019 and thereafter, to be considered a PCMH, a practice must</u>:
   i. Participate in or complete a formal transformation initiative (e.g., CTC-RI, PCMH-Kids, RIQI's Transforming Clinical Practice Initiatives (TCPI)[4] or a payer- or ACO-sponsored program) and/or practice has obtained NCQA Level 3 recognition.
   ii. By October 15th of each year, complete the self-administered Cost Management Strategies assessment and achieve at least 80% compliance.

[4] For more information see: www.ctc-ri.org/content/rhode-island-quality-institute-riqi-was-recently-awarded-four-year-83m-grant

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iii. By October 15th each year, submit clinical data demonstrating that the practice has achieved required performance improvement or achievement.

4. What are the Cost Management Strategies?

a. OHIC collected feedback from its stakeholders to develop a set of cost management strategies as part of the OHIC PCMH definition. These strategies include:
   i. Practice develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;
   ii. Practice uses data to implement care management (care coordination for children), focusing on high-risk patients and interventions that will impact ED and inpatient utilization;
   iii. Practice implements strategies to improve access to and coordination with behavioral health services;
   iv. Practice expands access to services both during and after office hours;
   v. Practice develops service referral protocols informed by cost and quality data provided by payers; and
   vi. Practice develops/maintains an avoidable ED use reduction strategy.

b. Practices with more than two years of transformation experience (as defined in tables above) have to meet 80% of the cost management strategies.

5. What are the performance improvement measures?

a. The performance improvement measures all come from a new aligned measure set that commercial insurers will be utilizing for contracting.

b. The measures for internal medicine and family practices are:
   i. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) [Current CTC-RI measure]
   ii. Controlling High Blood Pressure [Current CTC-RI measure]
   iii. Tobacco Use: Screening and Cessation Intervention [Current CTC-RI measure]
   iv. Adult Body Mass Index Assessment
   v. Screening for Clinical Depression and Follow-Up Plan

c. The measures for pediatric practices are:

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i. Body Mass Index Assessment for Children/Adolescents [Current PCMH-Kids measure]
ii. Counseling for Nutrition for Children/Adolescents [Current PCMH-Kids measure]
iii. Counseling for Physical Activity for Children/Adolescents [Current PCMH-Kids measure]
iv. Developmental Screening [Current PCMH-Kids measure]

d. Quality measurement specifications can be found at OHIC's website. Each year there will be a process to review the quality measures for continued alignment with other relevant programs, practice experience, set the Rhode Island benchmark if a national benchmark is not available, and make adjustments as needed.

6. What are the performance improvement requirements?

a. For 2017 recognition:
   i. Internal medicine and family practices: Improve by 3 percentage points on 2 of 3 of the following measures: diabetes HbA1c control, blood pressure control and tobacco use assessment and counseling measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).
   ii. Pediatric practices: Improve by 3 percentage points on 2 of the 4 measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).

b. For 2018 recognition:
   i. Internal medicine and family practices: Improve by 3 percentage points on 3 of the 5 HbA1c, blood pressure control, tobacco use assessment and counseling, adult BMI assessment, and screening for clinical depression measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).
   ii. Pediatric practices: Improve by 3 percentage points on 2 of the 4 measures relative to performance one *or* two years prior or achieve the national 66th percentile benchmark (or a RI benchmark if a national benchmark is not available).

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7. **How do practices submit the required information?**
    a. OHIC will create a web-based process on its website for practices to submit the required information (the cost management strategies survey and performance improvement measures). All forms, along with additional information on the PCMH requirements, will be available on OHIC's website in July 2016.

8. **How will practices know if they have met the requirements?**
    a. OHIC will post on its website a list of practices and which elements of the PCMH definition they have met.
    b. Information will be available the first week in November of each year.
    c. In future years, insurers may elect to audit practice submissions.

9. **What help is available to practices to become PCMHs?**
    a. There are currently two state-wide programs available. One is the Care Transformation Collaborative (CTC-RI) which includes adult practices and pediatric practices though a PMCH-Kids contract, which is supported by all major RI health plans. CTC-RI has been operating since 2010 and currently supports 43 practices, with 80 practice sites. For more information contact: CTCRI@umassmed.edu.
    b. The Rhode Island Quality Institute (RIQI) received a multi-million dollar federal grant to help practices (both primary care and specialty) learn to implement quality improvement initiatives, which is foundational to being a PCMH. For more information contact: info@riqi.org.
    c. Some health plans also provide care transformation support.

10. **If a practice meets the definition of PCMH, when will it get Support Payments?**
    a. Commercial health plans are obliged to pay practices Support Payments when the health plan includes the practice in its OHIC PCMH target count. Plans may make the payments directly to the practice or to the contracting entity with which the practice is affiliated. Plans are not obligated to pay Support Payments to practices that meet the OHIC PCMH definition, but are not included in the health plan's PCMH target count.
    b. The health plan must make payments every year that the practice is included in the PCMH target count. OHIC will be assessing practice achievement in October of each year. A practice that newly meets the definition can expect to receive

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payment during the next calendar year following OHIC PCMH recognition, if the practice is to be included in the health plan's PCMH target count for OHIC.

11. How much will the Support Payment be to practices?

a. The level of Support Payments will be negotiated between the practice and the health plans. OHIC is not setting a payment level, but has told health plans that the levels must be meaningful to the practices.

12. Do the payments apply to all of my patients, or only certain ones?

a. OHIC has regulatory authority only over fully insured commercial health plans. Therefore, payments must apply to your patients who are covered by fully insured benefits. The OHIC regulations also require that fully insured accounts not shoulder more than their fair share of the costs of the PCMH recognition program.
b. Historically, the health plans have also made payments for patients covered by self-insured accounts for practices participating in CTC-RI. OHIC anticipates, but cannot require, that they will continue to do so.

13. What happens if the practice does not meet the definition of PCMH?

a. If the practice does not meet the PCMH definition, the health plans will not be able to include them in their PCMH target count.
b. While under OHIC regulations the health plan will no longer be obligated to make Support Payments if the practice does not meet the PCMH definition, the health plan will not be precluded from doing so. Final decisions on whether a practice that doesn't meet the definition shall receive support payments is the responsibility of the payer. Payers reserve the right to do review the accuracy of practice self-attestation for the purposes of determining payments.

14. Can practices resubmit data to meet the PCMH definition?

a. Practices may submit data annually to OHIC, as described in the response to question 3, above.

15. Once a practice is recognized as a PCMH, will it always be recognized as a PCMH by OHIC?

a. No. A practice must meet each element of the definition of PCMH each year.

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16. **Will OHIC be evaluating whether this PCMH initiative reduces health care costs and is beneficial to practices, health plans and residents of Rhode Island?**
    a. Yes, OHIC, along with other stakeholders, will be conducting an ongoing evaluation of this PCMH initiative. The standards and definition of a PCMH will be examined and revisited each year in a committee process.

17. **Why should practices try to meet the OHIC definition of PCMH?**
    a. Commercial insurers, Medicaid and Medicare are all moving away from fee-for-service payments to more value-based payments that reward improved quality and reduced costs.
    b. Primary care practices continue to serve a vital function in Rhode Island. These new payment models aim to help and support providers in delivering more coordinated care to their patients, while rewarding quality of care and efficiency.
    c. The support programs currently available to practices – CTC-RI and RIQI – offer practices an opportunity to get expert assistance to learn how to transform. The Support Payment rewards practices for their efforts.

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