

Contract Attachments

Attachment A: CSI-RI Practices

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

Attachment B: Nurse Care Manager Role and Responsibilities

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

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

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

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

1. Achieve the below Clinical Quality benchmarks for 4 out of 7 clinical quality measures at the end of the measurement year; AND
2. Achieve the Patient Experience Survey benchmarks according to the following:
 - a. Use “top box” (Always) for three composite domain scores of CAHPS PCMH: Access, Communication and Office Staff
 - b. This is a Practice Level Performance measure
 - c. Benchmarks, defined as 2012 medians, are as follows: Access (53%), Communication (80%), Office Staff (72%)
 - d. Success in a domain is defined as 2013 result being at or above the 2012 median OR the practice improves from 2012 to 2013 so that the improvement achieves half the distance between the baseline rate and the 2012 median (“target”), as long as half the distance equals at least a 2.5 % point improvement. If there was no 2012 measurement, then the 2012 median must be attained.
 - e. Success for this contractual measure is success in the Access Domain and at least one of the other two domains. If the Access domain target/improvement threshold is not achieved, it does not matter (for contractual success) what the scores were in the other domains.
 - f. All questions of the domains are included.

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

Achieving Clinical Quality Benchmarks:

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

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

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

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

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

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

CSI-RI Benchmark Values

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

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

Description and Details for all CSI-RI Harmonized Measures

Diabetes Mellitus – HbA1c Poor Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with poorly controlled disease (having an A1c value greater than 9.0%)
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator with the most recent HbA1c >9.0% in the measurement period or whose HbA1c reading was not taken or is missing.
Denominator	<p>Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes:</p> <p>ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0</p>
Exclusions	<p>Patients with gestational diabetes or steroid-induced diabetes during the measurement year.</p> <p>ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4</p>
Measure source	Based on NQF 0059
Measure Domain/ Type	Outcome

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

Diabetes Mellitus – Blood Pressure Good Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with well controlled blood pressure (having a blood pressure value less than 130/80)
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure test result value during the measurement period is less than 130/80*
Denominator	<p>Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes:</p> <p>ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0</p>
Exclusions	<p>Patients with gestational diabetes or steroid-induced diabetes during the measurement year.</p> <p>ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4</p>
Measure source	HEDIS 2011 and NQF 0061
Measure Domain/ Type	Outcome

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

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

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

NQF MEASURE DETAILS -0061

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

Diabetes Mellitus – Blood Pressure Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 who had a blood pressure value less than 140/90)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure test result value during the measurement period is less than 140/90*
Denominator	Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0
Exclusions	Patients with gestational diabetes or steroid-induced diabetes during the measurement year. ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0, PCOS 256.4 Gestational diabetes: 648.8
Measure source	Based on NQF 0061
Measure Domain/ Type	Outcome

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

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

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

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

Diabetes Mellitus – LDL-C Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with well controlled LDL cholesterol (having LDL-C value less than 100 mg/dL)
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent LDL value in the measurement period is less than 100mg/dL .
Denominator	<p>Active patients between the ages of 18-75 years at anytime during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes:</p> <p>ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0</p>
Exclusions	<p>Patients with gestational diabetes or steroid-induced diabetes during the measurement year.</p> <p>ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4</p>
Measure source	Based on NQF 0064
Measure Domain/ Type	Outcome

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

Tobacco Cessation Intervention

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

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

Depression Screening

Definition	The percentage of patients age 18 and older screened one or more times for depression during the measurement period, using a standardized screening tool (PHQ-2 or other validated tool)
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:</p> <p>Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	24 months
Numerator	<p>Patients in the denominator who received a depression screen one or more times within the measurement period using the PHQ-2 or other validated tool. Include patients who have documented diagnoses with the following codes in the numerator.</p> <p>296, 300.4, 311, 293.83, 298.0, 309.0, 309.1, 309.28</p>
Denominator	Active patients age 18 and older who were seen two or more times or for one preventive visit by a primary care clinician of the PCMH within the last 24 months
Exclusions	<p>Patients diagnosed with the following ICD-9 codes:</p> <p>290,294,318</p>
Measure source	Based on: Veterans' Health Administration measure http://www.qualitymeasures.ahrq.gov/content.aspx?id=16177
Measure Domain/ Type	Process

Tobacco Use Assessment

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

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

Diabetes Mellitus – HbA1c Control

Definition	The percentage of diabetic patients (Type 1 or 2) age 18-75 with controlled disease (having an A1c value less than 8.0%)
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator with the most recent HbA1c <8.0% in the measurement period
Denominator	<p>Active patients between the ages of 18-75 years at any time during the measurement period, who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes:</p> <p>ICD 9 Code groups for Diabetes: 250, 357.2, 362.0, 366.41, 648.0</p>
Exclusions	<p>Patients with gestational diabetes or steroid-induced diabetes during the measurement year.</p> <p>ICD-9 Codes for: Steroid induced diabetes: 249, 251.8, 962.0 Gestational diabetes: 648.8, PCOS 256.4</p>
Measure source	Based on NQF 0575
Measure Domain/ Type	Outcome

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

Adult Body Mass Index – Age 18-64

Definition	Percentage of patients age 18-64 whose calculated BMI is either in the normal range or is above or below the normal range and have a documented follow up plan within the measurement year.								
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:</p> <p>Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged 								
Measurement Period	12 months								
Numerator	<p>Patients in the denominator who meet the following criteria:</p> <ol style="list-style-type: none"> 1. Patients whose calculated BMI is in normal range: 2. Patients whose calculated BMI is ABOVE or BELOW normal range AND have a documented care plan <table border="1" style="margin-left: 40px;"> <thead> <tr> <th>BMI Range</th> <th>Age 18- 64 years</th> </tr> </thead> <tbody> <tr> <td>ABOVE Normal</td> <td>$\geq 25 \text{ kg/m}^2$</td> </tr> <tr> <td>NORMAL</td> <td>greater than 18.5 kg/m^2 but less than 25 kg/m^2</td> </tr> <tr> <td>BELOW Normal</td> <td>$< 18.5 \text{ kg/m}^2$</td> </tr> </tbody> </table>	BMI Range	Age 18- 64 years	ABOVE Normal	$\geq 25 \text{ kg/m}^2$	NORMAL	greater than 18.5 kg/m^2 but less than 25 kg/m^2	BELOW Normal	$< 18.5 \text{ kg/m}^2$
BMI Range	Age 18- 64 years								
ABOVE Normal	$\geq 25 \text{ kg/m}^2$								
NORMAL	greater than 18.5 kg/m^2 but less than 25 kg/m^2								
BELOW Normal	$< 18.5 \text{ kg/m}^2$								
Denominator	Active patients age 18-64 years who were seen by a primary care clinician of the PCMH during the measurement year								
Exclusions	<p>Optionally, these exclusions may be applied:</p> <ul style="list-style-type: none"> • Patients diagnosed with a terminal illness in the measurement year • Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28) • Patients for whom the exam was not done for patient reason • Patients for whom the exam was not done for medical reason • Patients for whom the exam was not done for system reason 								
Measure source	Based on NQF 0421								
Measure Domain/ Type	Process								

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

Adult Body Mass Index – Age 65 and Older

Definition	Percentage of patients age 65 years and older whose calculated BMI is either in the normal range or is above or below the normal range and have a documented follow up plan within the measurement year.								
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:</p> <p>Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged 								
Measurement Period	12 months								
Numerator	<p>Patients in the denominator who meet the following criteria:</p> <ol style="list-style-type: none"> 1. Patients whose calculated BMI is in normal range: 2. Patients whose calculated BMI is ABOVE or BELOW normal range AND have a documented care plan <table border="1" style="margin-left: 40px;"> <thead> <tr> <th>BMI Range</th> <th>Age 65 years and older</th> </tr> </thead> <tbody> <tr> <td>ABOVE Normal</td> <td>$\geq 30 \text{ kg/m}^2$</td> </tr> <tr> <td>NORMAL</td> <td>greater than 22 kg/m^2 but less than 30 kg/m^2</td> </tr> <tr> <td>BELOW Normal</td> <td>$\leq 22 \text{ kg/m}^2$</td> </tr> </tbody> </table>	BMI Range	Age 65 years and older	ABOVE Normal	$\geq 30 \text{ kg/m}^2$	NORMAL	greater than 22 kg/m^2 but less than 30 kg/m^2	BELOW Normal	$\leq 22 \text{ kg/m}^2$
BMI Range	Age 65 years and older								
ABOVE Normal	$\geq 30 \text{ kg/m}^2$								
NORMAL	greater than 22 kg/m^2 but less than 30 kg/m^2								
BELOW Normal	$\leq 22 \text{ kg/m}^2$								
Denominator	Active patients age 65 years and older who were seen by a primary care clinician of the PCMH during the measurement year								
Exclusions	<p>Optionally, these exclusions may be applied:</p> <ul style="list-style-type: none"> • Patients diagnosed with a terminal illness in the measurement year • Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28) • Patients for whom the exam was not done for patient reason • Patients for whom the exam was not done for medical reason • Patients for whom the exam was not done for system reason 								
Measure source	Based on NQF 0421								
Measure Domain/ Type	Process								

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

Hypertension: Blood Pressure Measurement

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

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

Hypertension: Blood Pressure Control

Definition	The percentage of patients age 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year (having a BP value of <140/90)
Active Patient	Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions: Patients who have left the practice by the end of the measurement year, as determined by: <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged
Measurement Period	12 months
Numerator	Patients in the denominator whose most recent blood pressure is adequately controlled (having a blood pressure value <140/90) in the measurement period*
Denominator	Active patients age 18-85 with an active diagnosis of hypertension for more than 6 months before the end of the reporting period who have been seen by a primary care clinician of the PCMH. Use the following ICD-9 codes: 401, 401.0, 401.1, 401.9
Exclusions	<ul style="list-style-type: none"> • Patients who are pregnant (ICD-9 codes - 630-679, V22, V23, V28) • Patients who are diagnosed with ESRD (ICD code 585.6)
Measure source	Based on NQF 0018 and HEDIS 2011 Controlling High Blood Pressure (CBP)
Measure Domain/ Type	Process

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

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

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Begin reporting 1Q2014

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

Table A: Antibiotic Medications

Description	Prescription		
Aminoglycosides	<ul style="list-style-type: none"> • Amikacin • Gentamicin 	<ul style="list-style-type: none"> • Kanamycin • Streptomycin 	<ul style="list-style-type: none"> • Tobramycin
Aminopenicillins	<ul style="list-style-type: none"> • Amoxicillin 	<ul style="list-style-type: none"> • Ampicillin 	
Antipseudomonal penicillins	<ul style="list-style-type: none"> • Piperacillin 	<ul style="list-style-type: none"> • Ticarcillin 	
Beta-lactamase inhibitors	<ul style="list-style-type: none"> • Amoxicillin-clavulanate • Ampicillin-sulbactam 	<ul style="list-style-type: none"> • Piperacillin-tazobactam 	<ul style="list-style-type: none"> • Ticarcillin-clavulanate
First-generation cephalosporins	<ul style="list-style-type: none"> • Cefadroxil 	<ul style="list-style-type: none"> • Cefazolin 	<ul style="list-style-type: none"> • Cephalexin
Fourth-generation cephalosporins	<ul style="list-style-type: none"> • Cefepime 		
Ketolides	<ul style="list-style-type: none"> • Telithromycin 		
Lincomycin derivatives	<ul style="list-style-type: none"> • Clindamycin 	<ul style="list-style-type: none"> • Lincomycin 	
Macrolides	<ul style="list-style-type: none"> • Azithromycin • Clarithromycin 	<ul style="list-style-type: none"> • Erythromycin • Erythromycin ethylsuccinate 	<ul style="list-style-type: none"> • Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	<ul style="list-style-type: none"> • Aztreonam • Chloramphenicol • Dalbapristin-quinupristin 	<ul style="list-style-type: none"> • Daptomycin • Erythromycin-sulfisoxazole • Linezolid 	<ul style="list-style-type: none"> • Metronidazole • Vancomycin
Natural penicillins	<ul style="list-style-type: none"> • Penicillin G benzathine-procaine • Penicillin G potassium 	<ul style="list-style-type: none"> • Penicillin G procaine • Penicillin G sodium 	<ul style="list-style-type: none"> • Penicillin V potassium • Penicillin G benzathine
Penicillinase resistant penicillins	<ul style="list-style-type: none"> • Dicloxacillin 	<ul style="list-style-type: none"> • Nafcillin 	<ul style="list-style-type: none"> • Oxacillin
Quinolones	<ul style="list-style-type: none"> • Ciprofloxacin • Gatifloxacin • Gemifloxacin 	<ul style="list-style-type: none"> • Levofloxacin • Lomefloxacin • Moxifloxacin 	<ul style="list-style-type: none"> • Norfloxacin • Ofloxacin • Sparfloxacin
Rifamycin derivatives	<ul style="list-style-type: none"> • Rifampin 		
Second generation cephalosporin	<ul style="list-style-type: none"> • Cefaclor • Cefotetan 	<ul style="list-style-type: none"> • Cefoxitin • Cefprozil 	<ul style="list-style-type: none"> • Cefuroxime • Loracarbef
Sulfonamides	<ul style="list-style-type: none"> • Sulfadiazine • Sulfamethoxazole-trimethoprim 	<ul style="list-style-type: none"> • Sulfisoxazole 	
Tetracyclines	<ul style="list-style-type: none"> • Doxycycline 	<ul style="list-style-type: none"> • Minocycline 	<ul style="list-style-type: none"> • Tetracycline
Third generation cephalosporins	<ul style="list-style-type: none"> • Cefdinir • Cefditoren • Cefixime 	<ul style="list-style-type: none"> • Cefotaxime • Cefpodoxime • Ceftazidime 	<ul style="list-style-type: none"> • Cefibuten • Ceftriaxone
Urinary anti-infectives	<ul style="list-style-type: none"> • Fosfomycin • Nitrofurantoin • Nitrofurantoin macrocrystals 	<ul style="list-style-type: none"> • Nitrofurantoin macrocrystals-monohydrate • Trimethoprim 	

Chlamydia Screening – Obtaining Sexual History Begin reporting 1Q2014

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

Chlamydia Screening – Testing Begin reporting 1Q2014

Definition	The percentage of women 18–24 years of age on the date of visit who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.				
Active Patient	<p>Patients seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician's Assistant (PA) and Certified Nurse Practitioner (CNP). Exclusions:</p> <p>Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> • Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice • Patient has passed away • Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person • Patient has been discharged 				
Measurement Period	12 months				
Numerator	<p>The number of patients in the denominator with documentation of at least one test for Chlamydia during the measurement year.</p> <p>Codes to Identify Chlamydia Screening (NCQA CHL-C 2013)</p> <table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;">CPT</th> <th style="text-align: center;">LOINC</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">87110, 87270, 87320, 87490, 87491, 87492, 87810</td> <td style="text-align: center;">557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2</td> </tr> </tbody> </table> <p>NOTE: These codes are not the only form of test documentation. Data from other structured fields may also be included.</p>	CPT	LOINC	87110, 87270, 87320, 87490, 87491, 87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2
CPT	LOINC				
87110, 87270, 87320, 87490, 87491, 87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2				
Denominator	<p>Active female patients age 18-24 on the date of visit who were seen for a preventive visit and documented as sexually active, during the measurement.</p> <p>CPT Codes to identify preventive visit:</p> <p>99201- 99215 with preventive diagnosis code (V20.X, V22.X, V23.X, V70.X, V72.31) or Preventive Visit: 99385, 99395</p>				
Exclusions	None				

Measure source	Based on HEDIS 2013
Measure Domain/ Type	Process

DRAFT

Fall Risk Management Begin reporting 1Q2014

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

Reporting Requirements:

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

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

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

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

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

1. CSI aggregator shall provide to the Practice reports on items described in attachment D:
 - a) Hospital Emergency Department (ED) visits / 1000 – Quarterly; claims data to CSI management for aggregator;
 - b) Hospital admissions / 1000 – Quarterly,
 - c) Ambulatory Care Sensitive Admissions / 1000
 - d) Thirty (30) day hospital re-admissions/ 1000
 - e) Ambulatory Care Sensitive ED visits

2. In order to meet contractual requirements for the corresponding PMPM rate, CSI-RI practices must achieve the following benchmarks:

- a. CSI-RI Practices will achieve a five percent (5%) relative reduction in hospital admissions per thousand as compared to similar, non –PCMH providers during the same measurement period. “Non-PCMH practices” will be defined by the Data and Evaluation Committee and approved agreed to Executive Committee and voting members of the by the CSI-RI Steering Committee.

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

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

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

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

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

Emergency Department visits: All Cause

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

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

Technical Specifications

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

	<p>Multiple visits on same date count as only one visit.</p> <p>ED visits are identified by at least one of the following¹:</p> <ul style="list-style-type: none"> • CPT codes 99281–99285 with UB revenue codes 045x, 0981 • CPT codes 10040–69979 with POS 23. • HCPCS codes G0380–G0385.² <p>Exclude ED visits occurring on the same day as an admission or the day before an admission.³</p> <p>Exclude ED visits occurring on the same day as an observation stay or the day before an observation stay.⁴ Observational stays are identified as</p> <ul style="list-style-type: none"> • UB revenue code 0760 (general classification category) or 0762 (observation room); and • HCPCS code G0378 (hospital observation service, per hour) or G0379 (direct admission of patient for hospital observation care).⁵ <p>Exclude visits where the principal diagnosis is any of the following pregnancy related ICD-9 codes⁶:</p> <ul style="list-style-type: none"> • Complications of Pregnancy, Childbirth, and the Puerperium (630.xx–679.xx) • Newborn (Perinatal) Guidelines (760.xx–779.xx) • V20.xx Health supervision of infant or child • V22.xx Normal pregnancy • V23.xx Supervision of high-risk pregnancy • V24.xx Postpartum care and evaluation • V27.xx Outcome of delivery • V28.xx Antenatal screening • V29.xx Observation and evaluation of newborns for suspected condition not found • V30.xx–V39.xx Liveborn infant according to type of birth
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¹ Specifications for Beacon-CSI-RI use has items grouped differently (The codes are there, but the grouping may make a difference):

- CPT codes 99281–99285 and POS = 23
- CPT codes 10040–69979 and POS = 23
- UB rev codes 0450, 0451, 0452, 0459, 0981 and POS = 23

² These are not included in the specifications for Beacon-CSI-RI use.

³ Specifications for Beacon-CSI-RI use are inconsistent on this point. In one place it indicates same day or day before, but in another place it says just the same day. Same goes for observation stay.

⁴ Specifications for Beacon-CSI-RI use define observation stays as revenue codes of 760, 761, 762, 769. Specifications for Beacon-CSI-RI use also indicates, “Exclude claims with a day bed code” with no specific codes listed.

⁵ We currently are not counting revenue codes 0761 and 0769 as observation stays because they may be treatment rooms and not true observation stays. Claims with CPT codes 99217–99220 are also not counted as observation stays.

⁶ Specifications for Beacon-CSI-RI use do not have these exclusions.

	<p>Exclude visits where the principal diagnosis is for mental health purposes or the visit is related to chemical dependency, as defined by⁷</p> <ul style="list-style-type: none"> • CPT codes 90801–90899 • principal ICD-9-CM diagnosis codes 290.xx–326.xx • ICD-9-CM procedure code 94.26, 94.27, or 94.6 • principal ICD-9-CM diagnosis codes 960.xx–979.xx with secondary ICD-9-CM diagnosis codes 291.xx–292.xx or 303.xx–305.xx. <p>Exclude visits where the principal diagnosis is dental related (ICD-9 codes 520.xx–525.xx).⁸</p>
Risk Adjustment	
Risk adjustment strategy to be determined and incorporated into Round 2.	
Sampling	
No sampling; patients assigned to practices according to the Beacon-CSI-RI attribution methodology.	

Hospital Admissions: All Cause

Measure Set ID	#4	Version Number	3
Version Effective Date	April 2, 2012	Date Endorsed	
Care Setting	Hospital	Unit of Measurement	1,000 member months
Measurement Duration	Quarterly	Measurement Period	April 1, 2009– March 31, 2013
Measure Type	Outcome	Measure Scoring	Rate/1,000 member months
Payer source	Commercial claims initially	Improvement notation	Higher rates indicate poorer quality
Origin of Measure	Beacon-CSI-RI Modifications done in accordance with the Beacon-CSI-RI working group consensus.		
Measure description	Number of hospital admissions per 1,000 member months, excluding any admissions for pregnancy, mental health, or chemical dependency services in adults ages 18 years and older.		
References	https://www.bluecrossma.com/staticcontent/npi_docs/UB_04FormLocatorAppendices.pdf Beacon-CSI-RI Phase 1 Utilization and Cost Metrics—Proposed Health Plan Reporting Specifications		
Release Notes/ Summary of Changes	V2: Clarified that exclusion for mental health purposes or the visit is related to chemical dependency is based upon principal diagnosis. Added exclusion for dental-related visits. V3: Removed text “except where the end date of coverage in the quarter is the date of death” for denominator exclusions.		

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

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

Attachment E: Reporting Due Dates

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

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

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



Safe Transitions Project

COMMUNITY PHYSICIAN OFFICE BEST PRACTICES MEASURES¹

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
1. Provide the Emergency Department (ED) with clinical information when referring patients for evaluation	ED	ED provided with clinical information at the time of patient referral	Medical record or electronic audit trail	<p>Yes: Documentation of provision of clinical information by the referring physician's office either:</p> <ul style="list-style-type: none"> At the time of patient referral for ED evaluation, or Within 1 hour of patient referral for ED evaluation, if the patient is referred following an after-hours or weekend phone call with the community physician. <p>No: No documentation of above</p>	<p>Inclusions: All patients referred for ED evaluation by their community physician</p> <p>Exclusions: Patients who are cared for by their community physician's office while in the ED</p>	<ul style="list-style-type: none"> Clinical information: Verbal or written information that includes the main reason for referral to the ED, expectation, problem list, medication list, and applicable labs or studies Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting Documentation: Included in the data source(s) Patients referred for ED evaluation: Patients sent to the ED by their community physician or another clinician in their physician's office for further evaluation of a clinical problem that may or may not lead to inpatient admission. This can occur either from the office or following a phone call during which the physician office directed the patient to the ED. Patients cared for by their community physician: Patients whose care is supervised/directed by their community physician while in the ED Referring physician's office: A staff member or clinician at the community physician's office Supported by community discussions, e.g., with the PCP Advisory Council at HEALTH

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

This material was prepared by Quality Partners of Rhode Island (109079-01--7.2-122011 - 796), the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Healthcentric Advisors' Safe Transitions Project

Physician Best Practice Measures

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
2. Respond to time-sensitive ED and hospital clinical questions verbally, if needed	ED and Hospital	Outpatient staff member spoke to ED or hospital clinician about time-sensitive clinical questions, if needed	Medical record or electronic audit trail	<p>Yes: Documentation that if an ED or hospital clinician called the community physician office, one of the following occurred:</p> <ul style="list-style-type: none"> A direct call between the ED or hospital clinician and an outpatient staff member, or A return phone call from an outpatient staff member within 1 hour of the ED or hospital clinician's phone call to the community physician's office. <p>No: No documentation of above</p>	<p>Inclusions: All ED or hospital patients whose care requires ED or hospital clinician phone calls to the community physician's office for time-sensitive clinical conversations</p> <p>Exclusions: Patients:</p> <ul style="list-style-type: none"> Without a known PCP, or Who are followed by their community physician's office while in the ED or hospital. 	<ul style="list-style-type: none"> Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting and is contacted by the ED or hospital Direct call: A phone call during which the ED or hospital clinician is connected with an outpatient clinician who can answer clinical questions about the patient's care Documentation: Included in the data source(s) ED or hospital clinician: Physician, NP, PA, or nurse who care for the patient Outpatient staff member: Clinical or clerical staff who can address the ED or hospital clinician's specific question Return phone call: A phone response to a message from the ED or hospital clinician from an outpatient staff member who can answer clinical questions about the patient's care Time-sensitive clinical question: Whether or not a patient's care "requires" a conversation and in what timeframe is a subjective determination left to the ED or inpatient clinician's discretion, with the understanding that outreach is intended to be limited to situations where information is needed to inform the patient's care. All patients whose ED or hospital clinician phones the community physician office are included in the metric. May alert community physicians to "serious" decision-making (e.g., EOL discussions, significant status changes) and afford them the opportunity to go on-site to participate in discussions with their patient or patient's family, if desired by the physician and patient/family. Supported by community discussions, e.g., with the PCP Advisory Council at HEALTH

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
3. Provide ED and hospital clinicians with access to outpatient clinical information, if needed	ED and Hospital	Community physician office provided ED or hospital clinician with clinical information, if needed	Medical record or electronic audit trail	<p><u>Yes:</u> Documentation of the community physician office's provision of clinical information within 2 hours of ED or hospital request</p> <p><u>No:</u> No documentation of above</p>	<p><u>Inclusions:</u> All ED or hospital patients whose care requires ED or hospital clinician outreach to obtain outpatient clinical information.</p> <p><u>Exclusions:</u> Patients:</p> <ul style="list-style-type: none"> Without a known PCP, or Who are followed by their community physician's office while in the ED or hospital. 	<ul style="list-style-type: none"> <u>Clinical information:</u> Verbal or written information that includes the information requested by the ED/hospital and may include clinical complaint/problem, main reason for referral to the ED, expectation, problem list, medication list, and applicable labs or studies <u>Community physician:</u> PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting <u>Documentation:</u> Included in the data source(s) <u>ED or hospital clinician:</u> Physician, NP, PA, or nurse who care for the patient <u>Provision of clinical information:</u> Provision of requested clinical information via email, phone, fax, or through remote access to medical record (e.g., ED or hospital clinician read-access to the community physician office's electronic medical record)

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
4. Confirm outpatient receipt of discharge information from the hospital (may be optional)	Community Physician	Community physician office confirmed receipt of hospital discharge information	Medical record or electronic audit trail	<p><u>Yes:</u> Documentation of the community physician office's confirmation of receipt of hospital discharge information</p> <p><u>No:</u> No documentation of above</p>	<p><u>Inclusions:</u> All hospital patients</p> <p><u>Exclusions:</u> Patients who:</p> <ul style="list-style-type: none"> Are followed by their community physician while in the ED or hospital, or Are discharged to acute care, long-term care, or skilled nursing. 	<ul style="list-style-type: none"> <u>Confirmed receipt:</u> Written documentation in the medical record or electronic audit trail that the community physician office has confirmed its receipt of the discharge information <u>Discharge information:</u> In accordance with the Hospital Discharge Best Practices, the hospital is required to provide one of the following within one business day of hospital discharge: <ul style="list-style-type: none"> A Continuity of Care Form that includes a brief narrative of the hospital visit in the "clinician comments" section, A Continuity of Care Form, plus a verbal hand-off, or A draft Discharge Summary or final Discharge Summary, if completed within two days of discharge <p>For the purpose of this measure, physician offices should confirm the receipt of the Continuity of Care Form or Discharge Summary (draft or final).</p> <ul style="list-style-type: none"> <u>Documentation:</u> Included in the data source(s) Evidence base includes Project BOOST and NQF-endorsed Safe Practice (SP-15). Note that both of which are written from the hospital perspective, not the community physician office's perspective.

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
5. Outreach to high-risk patients via phone after ED or hospital discharge	Patient	High-risk patients contacted via phone after ED or hospital discharge	Medical record or electronic audit trail	<p>Yes: Documentation of a follow-up phone call within 72 hours of patient discharge from the ED or hospital</p> <p>No: No documentation of above</p>	<p>Inclusions: All ED or hospital patients who are characterized as high-risk</p> <p>Exclusions: Patients who:</p> <ul style="list-style-type: none"> Are followed by their community physician's office while in the ED or hospital, Are discharged to acute care, long-term care, or skilled nursing, Refuse a follow-up phone call, or Have an outpatient appointment within 72 hours of ED or hospital discharge 	<ul style="list-style-type: none"> Documentation: Included in the data source(s) Follow-up phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up High-risk patients: Patients with one or more of the following: <ul style="list-style-type: none"> Age 80 years or older, A diagnosis of cancer, chronic obstructive pulmonary disease, or congestive heart failure, Polypharmacy (8+ medications), or A hospitalization in the previous 6 months. Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office Evidence base includes Project BOOST; also supported by community discussions, e.g., with the PCP Advisory Council at HEALTH. There was no consensus from community physicians on whether or not this should occur with 100% of ED visits (e.g., education for improper ED use as well as appropriate follow-up).

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
6. Conduct follow-up visit with patients discharged from the hospital to the community	Patient	Follow-up visit conducted after patient discharge from the ED or hospital	Medical record or electronic audit trail	<p>Yes: Documentation of one of the following:</p> <ul style="list-style-type: none"> An outpatient clinician phone call to the patient, family, or caregiver within 3 business days of discharge, or A follow-up appointment scheduled within 14 days of discharge, unless otherwise documented in the medical record. <p>No: No documentation of above</p>	<p>Inclusions: All hospital patients</p> <p>Exclusions: Patients who:</p> <ul style="list-style-type: none"> Are followed by their community physician's office while in the hospital, Are discharged to acute care, long-term care, or skilled nursing, or Refuse a follow-up phone call and appointment. 	<ul style="list-style-type: none"> Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting Documentation: Included in the data source(s) Follow-up appointment scheduled: A community physician office visit scheduled either by the ED/hospital or the community physician's office Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office Outpatient follow-up: A phone call or office visit with an outpatient clinician from the community physician's office Phone call: An outpatient clinician phone call with the patient, family, or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up Evidence base includes the Care Transitions Intervention (CTI) Model, Project BOOST, RED Education, NQF-endorsed Safe Practice (SP-15), and the Commonwealth Fund's "Health Care Leader Action Guide to Reduce Avoidable Readmissions"

Physician Best Practice Process	Target	Measure Title	Data Source	Specifications	Population	Comments/Definitions
7. Perform outpatient medication reconciliation for patients discharged from the ED or hospital to the community	Patient	Medication reconciliation performed after ED or hospital discharge	Medical record or electronic audit trail	<p>Yes: Documentation of an outpatient clinician performing medication reconciliation within 14 days of ED or hospital discharge, either:</p> <ul style="list-style-type: none"> In-person at the community physician's office, or Via phone by an outpatient clinician or CNA. <p>And providing a copy to the patient, family, or caregiver.</p> <p>No: No documentation of above</p>	<p>Inclusions: All ED or hospital patients</p> <p>Exclusions: Patients who are discharged to acute care, long-term care, or skilled nursing</p>	<ul style="list-style-type: none"> Community physician: PCP or specialist, such as cardiologist, who cares for the patient in an outpatient setting Documentation: Included in the data source(s) Medication reconciliation: The process of the community physician's office reviewing the patient's complete discharge medication regimen and comparing it with previous medications to ensure there are no inadvertent inconsistencies Outpatient clinician: Physician, NP, PA, or nurse at the community physician's office Evidence base includes the Care Transitions Intervention (CTI) Model, RED Education, and NQF-endorsed Safe Practice (SP-15)

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

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Colorado Primary Care - Specialty Care Compact

I. Purpose

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

II. Principles

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

III. Definitions

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

Colorado Primary Care - Specialty Care Compact

- **Technical Procedure** – transfer of care to obtain a clinical procedure for diagnostic, therapeutic, or palliative purposes.
- **Patient-Centered Medical Home** – a community-based and culturally sensitive model of primary care that ensures every patient has a personal physician who guides a team of health professionals to provide the patient with accessible, coordinated, comprehensive and continuous health care across all stages of life.
- **Medical Neighborhood** – a system of care that integrates the PCMH with the medical community through enhanced, bidirectional communication and collaboration on behalf of the patient.

Types of Care Management Transition

- **Pre-consultation exchange** – communication between the generalist and specialist to:
 1. Answer a clinical question and/or determine the necessity of a formal consultation.
 2. Facilitate timely access and determine the urgency of referral to specialty care.
 3. Facilitate the diagnostic evaluation of the patient prior to a specialty assessment.
- **Formal Consultation (Advice)** – a request for an opinion and/or advice on a discrete question regarding a patient's diagnosis, diagnostic results, procedure, treatment or prognosis with the intention that the care of the patient will be transferred back to the generalist after one or a few visits. The specialty practice would provide a detailed report on the diagnosis and care recommendations and not manage the condition. This report may include an opinion on the appropriateness of co-management.
- **Complete transfer of care to specialist for entirety of care (Specialty Medical Home Network)** – due to the complex nature of the disorder or consuming illness that affects

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

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

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

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

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IV. Mutual Agreement for Care Management

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

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Transition of Care	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> Maintain accurate and up-to-date clinical record. Agree to standardized demographic and clinical information format such as the Continuity of Care Record [CCR] or Continuity of Care Document [CCD] Ensure safe and timely transfer of care of a prepared patient 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> PCP maintains complete and up-to-date clinical record including demographics. <input type="checkbox"/> Transfers information as outlined in Patient Transition Record. <input type="checkbox"/> Orders appropriate studies that would facilitate the specialty visit. <input type="checkbox"/> Informs patient of need, purpose (specific question), expectations and goals of the specialty visit <input type="checkbox"/> Provides patient with specialist contact information and expected timeframe for appointment. 	<ul style="list-style-type: none"> <input type="checkbox"/> Determines and/or confirms insurance eligibility <input type="checkbox"/> Provides single source referral contact person <input type="checkbox"/> When needed, be ready to communicate with the PCP prior to the appointment to assist in the preparation of patient and appropriate pre-referral work-up

Additional agreements/edits: _____

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Access	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> Be readily available for urgent help to both the physician and patient via phone or e-mail. Provide visit availability according to patient needs. Be prepared to respond to urgencies. Offer reasonably convenient office facilities and hours of operation. Provide alternate back-up when unavailable for urgent matters. 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Communicate with patients who "no-show" to specialists. <input type="checkbox"/> Determines reasonable time frame for specialist appointment. <input type="checkbox"/> Provide a secure email option for communication with patient and specialist. 	<ul style="list-style-type: none"> <input type="checkbox"/> Notifies PCP of 'no-shows' <input type="checkbox"/> Provides visit availability according to patient needs. <input type="checkbox"/> Be available to the patient for questions to discuss the consultation. <input type="checkbox"/> Schedule first patient appointment with physician. <input type="checkbox"/> Be available to PCP for pre-consultation exchange by phone and/or secure email. <input type="checkbox"/> Provide a secure email option for communication with patient and provider. <input type="checkbox"/> Provides PCP with list of practice physicians who agree to compact principles.

Additional agreements/edits: _____

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Collaborative Care Management	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> Define responsibilities between PCP, specialist and patient. Clarify who is responsible for specific elements of care (drug therapy, referral management, diagnostic testing, care teams, patient calls, patient education, monitoring, follow-up). Maintain competency and skills within scope of work and standard of care. Give and accept respectful feedback when expectations, guidelines or standard of care are not met Agree on type of specialty care that best fits the patient's needs. 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Follows the principles of the Patient Centered Medical Home or Medical Home Index. <input type="checkbox"/> Manages the medical problem to the extent of the PCP's scope of practice, abilities and skills. <input type="checkbox"/> Follows standard practice guidelines or performs therapeutic trial of therapy prior to referral, when appropriate, following evidence-based guidelines. <input type="checkbox"/> Reviews and acts on care plan developed by specialist. <input type="checkbox"/> Resumes care of patient when patient returns from specialist care. <input type="checkbox"/> Explains and clarifies results of consultation, as needed, with the patient. Makes agreement with patient on long-term treatment plan and follow-up. 	<ul style="list-style-type: none"> <input type="checkbox"/> Reviews information sent by PCP <input type="checkbox"/> Addresses referring provider and patient concerns. <input type="checkbox"/> Confers with PCP or establishes other protocol before orders additional services outside practice guidelines. Obtains proper prior authorization. <input type="checkbox"/> Confers with PCP or establishes other protocol before refers to secondary or tertiary specialists. Obtains proper prior authorization. <input type="checkbox"/> Sends timely reports to PCP to include a care plan, follow-up and results of diagnostic studies or therapeutic interventions. <input type="checkbox"/> Notifies the PCP of major interventions, emergency care or hospitalizations. <input type="checkbox"/> Prescribes pharmaceutical therapy in line with insurance formulary with preference to generics when available and if appropriate to patient needs. <input type="checkbox"/> Provides useful and necessary education/guidelines/protocols to PCP, as needed

Additional agreements/edits: _____

Colorado Primary Care - Specialty Care Compact

Patient Communication	
<i>Mutual Agreement</i>	
<ul style="list-style-type: none"> Engage and utilize a secure electronic communications platform for high risk patients such as ReachMyDoctor or CORHIO. Prepare the patient for transition of care. Consider patient/family choices in care management, diagnostic testing and treatment plan. Provide to and obtain informed consent from patient according to community standards. Explores patient issues on quality of life in regards to their specific medical condition and shares this information with the care team. 	
<i>Expectations</i>	
Primary Care	Specialty Care
<ul style="list-style-type: none"> <input type="checkbox"/> Informs patient of the reason for care transfer and expectations. <input type="checkbox"/> Determines appropriate time frame for visit to specialist. <input type="checkbox"/> Provides specialist name and contact information. <input type="checkbox"/> Explains specialist results and treatment plan to patient, as necessary. <input type="checkbox"/> Engages patient in the Medical Home concept. Identifies whom the patient wishes to be included in their care team. 	<ul style="list-style-type: none"> <input type="checkbox"/> Informs patient of diagnosis, prognosis and follow-up recommendations. <input type="checkbox"/> Provides educational material and resources to patient. <input type="checkbox"/> Recommends appropriate follow-up with PCP. <input type="checkbox"/> Will be accountable to address patient phone calls/concerns regarding their management. <input type="checkbox"/> Participates with patient care team.

Additional agreements/edits: _____

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V. Appendix

- PCP Patient Transition Record

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

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

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- **Specialist Patient Transition Record**

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

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

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- Direct Referrals Model - Quality Health Network communication
- Principles of Service Agreements for PCMH and PCMH-N, American College of Physicians internal document 10-09.
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Attachment H: Per-Member-Per-Month Payment Grid

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

Attachment I: CSI-RI Committee Structure

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

Steering Committee

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

Membership: Open to all interested in PCMH practice transformation in Rhode Island

Executive Committee

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

Membership: Committee members only

Practice Transformation Committee

Charge: Support practice transformation through conferences; convene best practice learning collaborative sessions; support practice based coaching and technical assistance. Serve as liaison to other committees and external organizations; and supports workforce development for PCMH.

Committee is tasked with deploying resources to practices for items such as practice coaching, NCM training and NCQA application assistance.

Membership: Open to all practices interested in PCMH transformation

Data and Evaluation Committee

Charge: lead performance improvement, measure selection and harmonization, develop goals and benchmarks, evaluation, research, liaison with the APCD, and serve as liaison between committees

Members: CSI-RI practice representatives and committee members only

Practice Reporting Committee

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

Members: CSI-RI practice representatives and committee members only

Contracting Committee

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

Membership: Committee members only

Service Expansion Committee

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

Membership: TBD

Marketing and Communications Subcommittee

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

Membership: TBD

Patient Advisory Subcommittee

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

Membership: TBD

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