MSSNY Contract Number: CO24582
Deliverable #5
Sub-Regional Solution
Business Plans

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February 2011
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1. HISTORY AND BACKGROUND

The DOH OHITT/MSSNY PPSO contract is a result of 2005 legislation directing the Department to “issue grant funding to one or more organizations broadly representative of physicians licensed in this state.” Project funding was directed “to include, but not to be limited to”:

   a) efforts to incentivize electronic health record adoption;
   b) interconnection of physicians through regional collaborations;
   c) efforts to promote personalized health care and consumer choice;
   d) efforts to enhance health care outcomes and health status generally through interoperable public health surveillance systems and streamlined quality monitoring.”

The legislation also called for a final report from the Department that includes among other requirements “the appropriateness of a broader application of the health information technology program to increase the quality and efficiency of health care across the state.”

The Medical Society of the State of New York (MSSNY) was awarded a contract in April 2009. The contract Statement of Work calls for MSSNY, along with representatives from NYS DOH and NYeC, to work with rural and solo and small group physician practices to plan, design, build, and initiate operations for PPSO’s that will focus on the following goals to improve the efficiency and effectiveness of health care consistent with the HIT vision and strategy being employed by NYS DOH and NYeC:

1. Performance reporting capabilities and interoperable HIT capacity connecting patients, clinicians, and payors and leveraging health information exchange among all stakeholders
2. Readily available evidence-based care guidelines
3. Improved access to care
4. Enhanced practice-level quality of care evaluation and reporting of health care outcomes
5. Coordination of care for patients with chronic disease
6. Physician practice change management to leverage technology and delivery models
7. A new business model with payors actively supporting physician participation through an enhanced payment system

The following is Deliverable #5 of MSSNY Contract Number CO24582.
2. DELIVERABLE #5 OVERVIEW

Previous deliverables have provided detailed recommendation for establishing governance structures, baseline information of physician practice readiness, the technology structures needed to exchange information, and the type of quality information that is expected to be collected, monitored, and shared between practices and payors.

The New York State Department of Health (NYSDH) began the initial efforts that would turn into the Adirondack (ADK) Medical Home Multi-Payor Demonstration in 2005 by focusing on the recruitment and retention of primary care providers in rural/remote areas of the State. In early 2008, with the assistance of grant-supported consultant services, providers approached the region’s leading payors (including the state Medicaid program) to propose the development of a multi-payor project which would serve the intertwined goals of supporting primary care, improving access to high quality, comprehensive and coordinated care consistent with medical home concepts, and reducing avoidable, low value, health care expenditures. The ADK Demonstration Pilot took shape and has been approved for five years with the full support of the Governor and the specific statutory authority delegated in Article 29-A, Title 2, Section 2959 of Public Health Law enacted in 2009. The NYSDOH is the overarching governing authority for the demonstration project, providing oversight of all collaborative efforts, including the work of the Adirondack Health Institute (AHI).

Each of the three PODs discussed in this document collaborate with the Adirondack Health Institute (AHI). The AHI is an Article 28 organization that assists in coordinating efforts for the three PODs; these include setting standards, contracting, development activities, and new initiatives. In addition, the AHI has helped interview and vet the supporting vendors that will develop a central data repository of patient-level clinical data and assimilate that with the payor-level claims and utilization data. Each POD is structured to pay a portion of their enhanced reimbursement (per member per month, or PMPM) to AHI for the services used; a draft of the proposed AHI to Pod agreement is included as Attachment B.

The goal of this deliverable is to describe the structures and services developed by the PPSOs for use by the participating practices. The descriptions include details outlining the variations and any commonalities for:

1. Organizational Structures
2. Management/Operations
3. Financial Specifications

In some instances, services are the same for all participating practices. Variations in services that occur between PODs are so noted in each section. Services considered include:
1. Access to Care
2. Care Coordination
3. Quality Reporting Programs
4. Performance Reporting

3. REGIONAL OVERVIEW

The practices participating in this pilot have been divided into three geographic Care Coordination Zones (CCZ’s) as illustrated in the graphic at left.

Green represents the practices in the Northern Adirondack PPSO (“Physician Practice Support Organization” – from this point forward, referred to and commonly known as “PODs”), centered in Plattsburgh. Blue represents the practices in the Tri-Lakes POD, centered in Saranac Lake. Red represents the practices in the Lake George POD, centered in Glens Falls.

The Article 28 organizations in each of the three aforementioned communities will assume the role of the POD; they are 1) Adirondack Medical Center (AMC) in Saranac Lake; 2) Hudson Headwaters Health Network (HHHN) in Queensbury (Glens Falls); and 3) Champlain Valley Physicians Hospital (CVPH) in Plattsburgh. While each POD resides within the same defined region, there is significant variation among the three PODs in terms of size, homogenization, community resources, and participating practices. These basic differences have driven natural variations in the formation of the governing structures, and to a smaller extent, the service offering which are discussed in the sections below.

4. GOVERNANCE

Governance and Legal Structures

TRI-LAKES (POD 1): Adirondack Medical Center (AMC) in Saranac Lake

Adirondack Medical Center (AMC) was incorporated on January 1, 1991 when the General Hospital of Saranac Lake and the Placid Memorial Hospital (Lake Placid) consolidated. AMC is a
non-profit, multi-discipline, multi-site, acute-care hospital licensed by the New York State Department of Health, and managed by Brim Healthcare, Inc. AMC is comprised of two acute care inpatient sites licensed to operate 97 beds; two long-term care sites licensed to operate 216 beds; three primary health clinics; a fixed dental clinic and a mobile dental clinic. Fifty physicians, board certified in 21 specialties, work with the hospital to provide a wide range of medical and surgical services.

AMC is located in the heart of the Adirondack Park in rural, upstate New York. The closest comparable medical facility is fifty miles from the main facility in Saranac Lake. AMC is a designated sole community provider hospital by the federal government and the primary and secondary service areas cover over 1,200 square miles. The Medical Center currently provides a broad range of both inpatient and outpatient services to the residents of the Tri-Lakes area that encompasses southern Franklin and northern Essex Counties. Adirondack Medical Center has two acute care hospital sites with the main site located in the Town of Harrietstown (Saranac Lake) and one in the Town of North Elba (Lake Placid), two skilled nursing facilities located in Lake Placid and Tupper Lake as well as clinic sites in the Village of Keene, Town of North Elba (Lake Placid) and the Village of Tupper Lake. In addition, AMC is the principal provider of care for 82% of the 23,590 residents in the primary service area and for approximately 32.2% of the 13,126 residents in the secondary service area.

AMC offers some regional specialties that draw patients from an even larger geographic area; these include the Colby Center for Psychiatry, which serves the inpatient needs of adults fifty-five years of age and older from ten counties, a Sports Medicine program which treats local residents as well as Olympic-caliber athletes, and a regional Bariatric Program which treats people from across upstate New York.

LAKE GEORGE (POD 2): Hudson Headwaters Health Network (HHHN) in Queensbury (Glens Falls)

POD Two’s governance will be directed by the Hudson Headwaters Health Network (HHHN), which is a 501(c)3 not-for-profit system of twelve community health centers providing primary care to residents located over 3,700 square miles in the Adirondack/Lake George/Glens Falls area. HHHN is the sole medical provider in many of these communities, and the 51 physicians and 62 physician extenders render care. Approximately 60,000 beneficiaries use HHHN facilities each year, resulting in over 280,000 annual patient visits. HHHN’s administrative offices are located at 9 Carey Road in Queensbury, NY.

HHHN’s Board of Directors is comprised of representatives from each community in which they operate. Additionally, HHHN utilizes an advisory committee with political leaders, local residents, and members of the Board of Directors to ensure the local health clinics and their delivery of care meets the needs of all stakeholders.
Due to the fact that all providers within this POD are employees of or are affiliated with HHHN, this POD is able to achieve the most standardization among participating practices.

**NORTHERN ADIRONDACKS (POD 3): Champlain Valley Health Network**

Champlain Valley Physicians Hospital (CVPH) Medical Center is a voluntary, not-for-profit, Article 28 organization based at 75 Beekman Street in Plattsburgh with satellite services at a number of other authorized locations as follows:

- H.K. Freedman Renal Center
  91 Plaza Boulevard
  Plattsburg, NY
- CVPH Rehabilitation
  16 DeGrandepre Way
  Plattsburg, NY
- CVPH Diagnostic Center
  89 Plaza Boulevard
  Plattsburg, NY
- CVPH Dental Center
  603 Cornelia Street
  Plattsburg, NY
- CVPH Rehab at PARC
  295 New York Road
  Plattsburg, NY
- CVPH Ambulatory Surgery Center
  77 Plaza Boulevard
  Plattsburg, NY
- CVPH Health Center
  206 Cornelia Street, Suite 201
  Plattsburg, NY
- Dialysis Satellite at Elizabethtown
  Park Street
  Elizabethtown, NY

A voluntary, 15-member Board of Directors provides governance to CPI. It is a subsidiary corporation of Community Providers, Inc., a section 501(c)(3) organization. According to CPI’s Articles of Incorporation, the purposes of the corporate and subsidiary organizations include promoting the health of the community and conducting public programs promoting the health of the community. The organizational structure of CPI and its subsidiary organizations is demonstrated below:
CVPH is also the sole community hospital in Clinton County and provides services for residents of Clinton, Essex, Franklin and St. Lawrence Counties. The mission of CVPH is to provide quality health care for the North Country.

Demographics have not changed significantly however, most notable is the aging population, a trend that is being monitored because of the correlation between age and increased utilization of health services and because of the anticipated increased need for home health and skilled nursing facilities. The focus on the need for coordinated care is not new for CVMC and aligns well with the goals of this program.

Additionally, Elizabethtown Community Hospital (ECH) is a subsidiary member of CPI. ECH is a critical access facility established in 1926. They have a long history of community support and have striven over the years to ensure quality healthcare close to home. They are also a not-for-profit organization focused on providing healthcare services to approximately 17,000 residents.

Organizational/Management Structures

**POD 1 - Tri-Lakes (AMC)**
The Tri-Lakes POD represents three practices, comprised of 16 primary care physicians and five mid-levels. The providers within this POD are listed below:

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<th>Address</th>
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Although the POD is housed under the auspices of the Adirondack Medical Center, day-to-day oversight is provided by Mary Welch, who is the POD Supervisor. In addition, there is a Medical Home Governance/Advisory Committee that has been meeting on a nearly monthly basis.
The members of the Advisory Committee include:

Dr. Patricia Monroe
Dr. Elizabeth Buck
Dr. William Viscardo
Dr. Jennifer Weibel
Dr. Jay Federman
Dr. George Cook
Chandler Ralph
Patrick Facteau

The officers and managers of the Tri-Lakes POD began meeting in November 2009. They have met on a monthly basis to determine the governance and operational functions of the POD based on the input/needs of the participating practices.

The Advisory Committee identified the need for a POD supervisor and selected Ms. Mary Welch in February 2010. Ms. Welch is responsible for the day-to-day operations of the POD, as well as ensuring the activities required for NCQA Patient Centered Medical Home (PCMH) certification are completed by participating practices within the identified timeframe (no later than February 2011).

In addition, during the meetings between March and September 2010, the Committee discussed the standard services which will be utilized by the participating practices within this POD. In the short term, these include:

- Assisting EHR remediation to ensure successful NCQA certification
- Offering NCQA recognition submission support
- Secure portal to allow patient attribution lists between each practice and each payor
- Providing access to fractional portions of centralized support including pharmacy, care management, social work, and quality assurance
- Dedicated staff to continue process evolution
- Advocacy for each participating practice

Additionally, the Committee continues to discuss potential, additional support services on a longer term basis, including:

- Assisting practices to exploit data registry capabilities (on a standardized basis, whenever possible) in order to identify and stratify patients
- Promoting care coordination, including access to pharmacist, social worker, nurse manager and/or staff services when needed
- Reinforcing evidence-based guidelines for diabetes, hypertension, coronary artery disease, pediatric asthma, pediatric obesity, and pediatric prevention
Finally, it is yet to be determined to what degree the Pod will collate and apply data through their established local health information exchange, and how this knowledge will compare, contrast, or supplement the data created and derived from the direct exchange of clinical information from the Practices to and from HIXNY. Some considerations:

- Intake of patient level data from all participating payors and the data warehouse
  - Consolidation and aggregation of patient level data from all the payors
  - Repackaging data into one single per provider list for distribution to the appropriate practice
  - Packaging data at the aggregate level for all providers to enable benchmarking
- Intake of quality reporting data from all participating practices
  - Tracking and trending data for submission to payors; coordination of patient and clinical data against financial/claims data
  - Benchmarking against peers or regional/national data

Detailed meeting minutes from each POD Governance meeting are on file within the POD offices.

Fust Charles Chambers provides accounting, tax, and business advisory and oversight services to AMC. The POD will utilize these services as well. Additionally, the insurance needs of the POD have been discussed, but early consensus of the Governance Committee is that AMC’s existing Liability, Worker’s Compensation, and E&O policies would provide relief.

POD 1 has three practices participating. Due to the relative smaller size of the POD, the staffing needs are minimal. Ms. Mary Welch has been selected as the POD 1 Medical Home Project Manager. She will coordinate day to day activities and report directly to the Tri-Lakes Governance Committee. In addition to Ms. Welch, Sandy Day provides part-time assistance in a variety of IT and other support roles.

Each provider approved for participation within the Tri-Lakes POD is contractually required to fully participate in the activities of the pilot project. They are bound to meet requirements related to enhanced access to care, coordination of care/disease management, longitudinal care (post hospitalization/ER), use of evidence-based guidelines and measurements, reporting quality outcomes, and the sharing of data with AHI electronically.
At one time, the practices were inclined to purchase shared services on an ala carte basis from third party vendors (most notably AMC); recently, however, the practices have indicated a desire to acquire services under a yet to be agreed-upon PMPM payment to the hospital. This method, similar to that in the Northern Adirondack Pod, will greatly reduce the complexity of transactions from an accounting and a practical perspective. Furthermore, the hospital seems willing to measure utilization of Pod services consumed on a continual basis to make certain the proper mix and supply of resources is available to the practices. A draft version of the contractual agreement between AMC and the practices is included as Attachment A.

In addition, this POD has provided support and advocacy to assist each practice in preparing for submission of their NCQA certification application. POD 1 will also provide the secure portal through which patient attributions lists can be securely exchanged between each practice and payor.

**POD 2 – Lake George (HHHN)**

The Lake George POD represents three practices, comprised of forty primary care physicians. All but three of the participating providers are employed by Hudson Headwaters Health Network (HHHN) allowing for significant standardization. The primary care physicians included in this POD are:

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In addition, there are 48 mid-level physician extenders co-located with the primary care physicians. This integrated team provides coordinated primary care to patients in the northern area of New York State.
Dr. Russ Rider and Kevin Bolan, CNP, are the only providers in the Lake George POD not employed by HHHN, and as a result, the work of the POD will be directed by existing HHHN organizational structures. There are several HHHN key personnel with significant involvement in the operations of POD 2. They are:

- **Medical Staff – key personnel**
  - Chief Medical Officer is a joint position
    - Dr. Dan Larson
    - Recruiting and new program development
  - Dr. Paul Bachman
    - Quality assurance and government relations
  - Dr. John Sawyer
    - Scheduling and operations

- **Administrative Staff**
  - Chief Administrative Officer
    - George Purdue
  - Vice President of Operations
    - Deborah Bardin
  - Vice President of Medical Support
    - Cyndi Nassivera-Cordes - credentialing, scheduling, quality services
  - Chief Financial Officer
    - Chris Tournier

The usual HHHN pattern for big projects such as the Medical Home Initiative is to create teams by pairing a physician and an administrator to provide comprehensive leadership and guidance. They have utilized the same structure for POD 2. Day-to-day management decisions will be made by Cyndi Nassivera-Cordes and Dr. John Sawyer, with Dr. Paul Bachman weighing in on quality assessment matters. It should also be noted that Dr. Rider and Kevin Bolan are considered Adjunct Medical Staff, and as such, are included in clinical policy (usually arrived at by consensus during Medical Staff meetings). As Chief Executive Officer, Dr. John Rugge is also active in decision-making. On matters affecting the entire Network, the entire Board of Directors will be consulted.
Given the unique organizational structure of this POD and the associated practices, there has not been the same need for extensive meetings to determine governance, structure, or services. There has, however, been significant work completed on transforming medical care and meeting the objectives of the Medical Home Pilot Program. The efforts, decisions, and operational plans for this POD are outlined within HHHN’s “Blueprint for the Patient Centered Medical Home” which is discussed in Section 5.

Hudson Headwaters has hired two RN Care Management Coordinators and two Support Staff to carry out the functions related to Pre-Visit Planning and Care Management. In addition one FTE Transition Care Coordinator and one Part-time Transition Care Coordinator have been hired to implement the Transition Care Program.

Each provider approved for participation within the POD is contractually required to fully participate in the activities of the pilot project. They are bound to meet requirements related to enhanced access to care, coordination of care/disease management, longitudinal care (post hospitalization/ER), use of evidenced based guidelines and measurements, reporting quality outcomes, and the sharing of data with AHI electronically. Each participating practice within this POD will be utilizing the services discussed to improve care outcomes and ensure efficient resource utilization. The staff available for use by the participating practices includes:

- Two RN Care Management Coordinators
- Two Care Manager Support Staff

HHHN engages RSM McGladrey, to perform an annual external audit of its financial affairs and the intent is to utilize RSM McGladrey for the needs of the POD. The plan is to utilize the same process regarding POD activities. Additionally, insurance needs have been discussed, but consensus is that HHHN’s Liability, Worker’s Compensation, and E&O policies would provide relief.

Each participating practice within the POD is required to deliver on clinical and financial outcomes targeted for this project. The overall framework used is the same for each POD, and the three Supervisors collected data to answer a series of questions associated with each of the five identified categories discussed earlier, in order to define and deploy the most appropriate local approach. Within the HHHN POD, each practice will focus on implementing the clinical guidelines and providing effective care coordination through the cohesive Care Management Program.

After training and education, each primary care practice was required to sign an agreement validating their understanding of the NCQA Medical Home Recognition requirements. In
addition, they confirmed their commitment to work toward certification. This requirement was provided to the payors participating in the Medical Home Demonstration Pilot.

**POD 3: Northern Adirondack (CVHN)**

The Northern Adirondack POD represents 27 practices, comprised of fifty primary care physicians and 42 mid-levels. This is the largest of the PODs and the most diverse. The majority of participating practices within this POD are not employed by a single entity, which creates complexities and diversity of opinion which necessitated the establishment of a robust governance structure to ensure stakeholders were involved and progress made in the short period of time available.

Although the POD is housed under the auspices of the CVPH, the POD hired a Director, Ms. Karen Ashline, to assume responsibility for day-to-day operational decisions. Staffing and financial obligations are presented to the Northern Adirondack Executive Committee during their monthly meetings and if approved, operationalized by Ms. Ashline. The Finance and Services/Quality are subcommittees that also provide additional guidance.

The practices and providers assigned to the POD are listed in the chart provided below:

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<tr>
<th>Practice</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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North Country Medical Group
481 State Route 11
Champlain, NY 12919
Racine, Maurice MD
101301006 14-1549098
McClure, Marilyn NP
1679611057 14-1549098
Robinson, Lori NP
1801987334 14-1549098

Peru Family Health Center
9 Elm St
Peru, NY 12972
Smith, David MD
1356313787 14-1753648
Harris, Sandra NP
1982751830 14-1753648

Plattsburg Pediatrics, PC
151 Bridge St, Plattsburgh, NY 12901
Chaskey Jr., Harold MD
1053408559 03-0441166
Knudson, Clark MD
1730817742 03-0441166
Baker, Danielle PA
1538157722 03-0441166
Eamer, Laurie FNP
1948215494 03-0441166

Peru Family Health Center
481 State Route 11
Champlain, NY 12919
Racine, Maurice MD
1013011006 14-1549098
McClure, Marilyn NP
1679611057 14-1549098
Robinson, Lori NP
1801987334 14-1549098

Peru Family Health Center
9 Elm St
Peru, NY 12972
Smith, David MD
1356313787 14-1753648
Harris, Sandra NP
1982751830 14-1753648

Plattsburg Pediatrics, PC
151 Bridge St, Plattsburgh, NY 12901
Chaskey Jr., Harold MD
1053408559 03-0441166
Knudson, Clark MD
1730817742 03-0441166
Baker, Danielle PA
1538157722 03-0441166
Eamer, Laurie FNP
1948215494 03-0441166

Smith House Health Care Center
39 Farell Rd
Willsboro, NY 12996
D’Amico, Richard MD
1144366311 22-2148818
Fortrell, Megan, PA
1992727325 22-2148818
McMeek-in-Hagadorn, Shannon PA
1710920186 22-2148818

Plattsburg Primary Care
159 Margaret St
Plattsburgh, NY 12901
Ching, Anthony MD
1841255361 14-1816892
Beguin, David MD
1275598559 14-1816892
Meyer, Melissa MD
1073579967 14-1816892

Rainbow Pediatrics
459 Margaret St
Plattsburgh, NY 12901
Cohen, David MD
1942264825 14-1816892
Garami, Anthony MD
1750341913 14-1816892
Qudsi, Sobia MD
1407810740 14-1816892

Plattsburg Primary Care
159 Margaret St
Plattsburgh, NY 12901
Ching, Anthony MD
1841255361 14-1816892
Beguin, David MD
1275598559 14-1816892
Meyer, Melissa MD
1073579967 14-1816892

Plattsburg Primary Care
159 Margaret St
Plattsburgh, NY 12901
Ching, Anthony MD
1841255361 14-1816892
Beguin, David MD
1275598559 14-1816892
Meyer, Melissa MD
1073579967 14-1816892

Smith House Health Care Center
39 Farell Rd
Willsboro, NY 12996
D’Amico, Richard MD
1144366311 22-2148818
Fortrell, Megan, PA
1992727325 22-2148818
McMeek-in-Hagadorn, Shannon PA
1710920186 22-2148818

Ambler, Kristin MD
128 Boynton Ave
Plattsburgh, NY 12901
Ambler, Kristin MD
1407937485 14-1721404

Anderson, David MD
96 Court St
Plattsburgh, NY 12901
Anderson, David MD
1497851646 14-1721896

Castine, Victor MD
135 South Peru
Plattsburgh, NY 12901
Castine, Victor MD
1740251206 14-1338471

Clark, Debra MD
1409 Route 9
Keeseville, NY 12944
Clark, Debra MD
1962473397 14-1715117

Hausrath, Stephen Guy MD
210 Comelia Street #202
Plattsburgh, NY 12901
Hausrath, Stephen Guy MD
1942218268 14-1827992
Schneider, Lynn NPC
1558371344 14-1827992

Hausrath, Carla NP
1508095399 14-1827992

McCullum, Kevin MD
96 Court St
Plattsburgh, NY 12901
McCullum, Kevin MD
1063518975 14-1817304

Pelton, William MD
210 Comelia Street #305
Plattsburgh, NY 12901
Pelton, William MD
1184696841 16-1563058

Schwartzberg, Josh MD
29 Church Street
Lake Placid, NY 12946
Schwartzberg, Josh MD
1013911452 14-1782588

Elizabethtown Community Hospital
75 Park St
Elizabethtown, NY 12932
Davis, Harry MD
1972597516 14-1645153
DeMuro, Rob L MD
1801833191 14-1645153
Rotkowitz, Louis MD
1063678910 14-1645153
Caputo, Pasquale MD
1811952983 14-1645153
Ahem, Elizabeth PA
1821195157 14-1645153
Anderson, Julie PA
1508949009 14-1645153

Andrews, Robert PA
1871710020 14-1645153
Buehler-Brandt, Mary PA
1316090657 14-1645153
Burke, Jae PA
1194808998 14-1645153

Conger, Nicole PA
1995872611 14-1645153
Cran, Jessica PA
1538107388 14-1645153
Finch, Richard PA
1497381663 14-1645153

Hinge, Matthew NP
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Johnston, Patrick NP
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Looney, Connor NP
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McKenna, J. Robert PA
1578730008 14-1645153
Scarpelli, Peter PA
1407959505 14-1645153
Walker, Martha PA
1787262332 14-1645153

Alice Hyde Medical Center
Family Practice
23 Fourth Street Suite 1
Malone, NY 12953
Cahill, Gerald MD
1033292586 14-1745163
Caputo, Pasquale MD
1801833191 14-1645153

Family Practice
24 Fourth Street
Malone, NY 12953
Medved, Marina MD
1801833191 14-1645153
Caputo, Pasquale MD
1801833191 14-1645153

Internal Medicine
183 Park Street
Malone, NY 12953
Sanchez, Myrna MD
1134017600 14-1763247

Internal Medicine
5 Clay Street
Malone, NY 12953
Bhagat, Anjni MD
1013019454 20-0707904

Internal Medicine
183 Park Street
Malone, NY 12953
Sanchez, Myrna MD
1134017600 14-1763247

Internal Medicine
5 Clay Street
Malone, NY 12953
Bhagat, Anjni MD
1013019454 20-0707904

Internal Medicine-Private Practice
63 Third Street
Malone, NY 12953
Richards, Craig MD
1874479939 14-1815109

Pediatrics
5 Elm Street
Malone, NY 12953
Benardot, Emile MD
1275594965 30-0200116
Pod 3 is the largest and most diverse of the PODs. As stated previously, to effectively address the issues in this transformation the participating providers identified the need to establish an Executive Committee, a Finance Committee, and a Services/Quality Committee. These committees met concurrently over the past twelve months to determine the governance, operational, and service provision functions of the POD and to ensure coordination of efforts between governance, finance, and service/quality. Participating providers were surveyed to determine their desire to serve on the Executive, Finance, or Services/Quality Committees. Providers were then assigned to a Committee and expected to fully participate.

The members of the committees are listed on the following page.
While POD 3 has the largest number of independent practices, this POD has developed detailed guidance to allow the POD to maximize the effective support of all participating practices. They immediately selected a POD administrator, Ms. Karen Ashline, who took the lead in coordinating efforts within the POD to ensure consensus was reached regarding the services to be offered by the POD to each participating practice. Additionally, Karen is responsible for ensuring continued commitment from participating practices and communication with AHI and the payors. Furthermore, due to the decentralized nature of this POD, its leadership has also agreed upon a larger number of necessary clinical and administrative services. As a result, the Executive Committee has approved the recruitment of additional support staff to facilitate these services (which included data mining/management, medical home consultation, and care coordination services) with the participating practices.

The POD Executive Governance Committee members have identified the standard services which will be utilized by the participating practices. The services provided by the POD include:

- Support necessary to ensure all participating practices meet NCQA PCMH Level II certification – will vary by practice depending on practice staffing and sophistication
- Single point of intake/distribution of patient level data
  - Consolidation and aggregation of patient level data from all the payors
  - Repackaging data into one single per provider list for distribution to the appropriate practice
- Single point of intake of quality reporting data from all participating practices
  - Submission of data to HIXNY
  - Submission of data to NCQA
  - Tracking and trending data for submission to payors
- Access to support services to include:
  - Information technology support for all EMRs including development of templates to standardize data
  - Data collection, registry/warehousing
  - Care coordination, including access to pharmacist, social worker, nurse manager and/or staff when needed
  - Evidence-based guidelines for diabetes, hypertension, coronary artery disease, pediatric asthma, pediatric obesity, and prevention

Detailed meeting minutes from each POD Executive Committee, Finance Committee, and Quality/Service Committee are on file at the POD offices.
KPMG provides accounting, tax, and business advisory and oversight services to CPI and will be accessed by the POD. Furthermore, additional insurance needs have been discussed, but the early consensus is that CVPH’s Liability, Worker’s Compensation, and E&O policies would provide relief.

POD 3 has the largest staff, which consists of a Director and six current and one anticipated support staff members as illustrated at right. In addition to Karen Ashline, the Northern Adirondack POD support staff is comprised of Lee Wagner (Information Systems Coordinator), Melissa Joyce (Support Coordinator), Lisa Ciphers (Data Consultant), Maria Aguglia (Case Manager), Leita King (Social Worker), and Janet Raville (Care Manager Support), all of whom report directly to Ms. Ashline. In addition, participating practices have access to registered nurses specializing in quality management, case management, as well as social workers and clinical pharmacists.

The staff available within the POD is designed to assist each participating practice in meeting their contractual obligations to fully participate in the activities of the pilot project. They are bound to meet requirements related to enhanced access to care, coordination of care/disease management, longitudinal care (post hospitalization/ER), use of evidenced based guidelines and measurements, reporting quality outcomes, and the sharing of data with AHI electronically. Attachment B is a draft of the contract to access POD services.

Common Contract Relationships with Third Parties

Participating practices assigned to each of the PODs were required to execute a Business Associate Agreement (BAA) for EPH, MAeHC (EMR consultant), and HIXNY (health exchange). The execution of the BAA allows the exchange of patient level claims and clinical data between participating entities. The BAA also ensures all entities are HIPAA compliance and take the necessary precautions to protect patient specific data. The common BAA utilized by each POD is provided as Attachment C.

In addition to BAA agreements, each participating practice with all three PODS was required to validate their understanding of the NCQA Medical Home Recognition requirements and confirm their commitment to achieve Level II (or higher) medical home certification within one year of
the start of the pilot. This agreement was accepted and filed by the Governance Committee at
the State Level. The common attestation form which each participating practice was required
to sign and submit is provided as Attachment D.

Financial Considerations

POD 1 – TRI-LAKES (AMC)
The Providers in the Tri-Lakes Pod are accruing approximately $800,000 annually in Medical
Home payments. Additionally, about $400,000 per year will be paid when Medicare joins the
Pilot in mid-2011. As mentioned before, decisions are yet to be made regarding the allocation
or purchase of centralized services; one practice is inclined to apply their additional payments
internally through the hiring of resources such as a case manager/social worker and Medical
Home nurse, while the two remaining practices are likely to utilize external resources from the
Hospital per a fee schedule to be determined.

AMC has funded the Pod operational expenses incurred to date. They include the pro rata
share of the portal used to exchange patient lists and other secure correspondence to the
Payors, along with the salaries of Mary Welch and Sandy Day until reimbursement from the
State through the MSSNY grant. Additionally, the practices have decided to extend the funding
for Mary’s contract for at least the first six months of 2011.

Basic financial statements for the POD will be created using the Hospital accounting templates.
Pat Facteau is the hospital CFO, and is prepared to provide financial oversight.

POD 2 - Lake George (HHHN)
The Providers in the Lake George Pod are accruing approximately $2.2 million annually through
the Medical Home Pilot; when Medicare payments begin, an additional $1.0 million annually
will be realized. As HHHN accounts for the majority of the providers in the Pod, most of the
revenue from enhanced payments will be utilized towards four budgeted Care Managers, three
support staff, an Assistant Nursing Director, and educational materials. The application of
Pharmacist services is being contemplated as well, as is a new compensation plan for HHHN
providers that will measure and reward clinical outcome improvement.

Again, the majority of the Pod is centered in HHHN – in advance of enhanced payments, HHHN
has fronted the cost of Pod resources (Cyndi’s and other staff salaries, lost productivity, etc.).
Cyndi’s salary for 2010 is also covered by this grant.

HHHN will apply internal financial controls to the Pod revenue and expenses.
POD 3 - Northern Adirondack (CVHN)

It is anticipated that the practices in the Northern Adirondack Pod will receive approximately $3,500,000 in enhanced Medical Home payments annually; this figure will rise to about $4,500,000 annually when Medicare joins the Pilot in mid-2011. Per Executive Committee direction, 50% of these receipts will be paid to the Pod for ongoing services. An early version of an Actual/Anticipated payments report by practice (blinded) is provided below:

The accounting system of Champlain Valley Health Network (CVHN) is being utilized for all Pod Receivable and Payable functions. A separate cost center and bank account have been established, with CVHN financial oversight policies and procedures (signatory responsibilities and limits, expense approval, etc.) applied.

Once it was determined that the practices had been receiving Medical Home payments, and that these payments could be quantified through accompanying reports from the participating payors, invoices were created by the Pod and distributed. An example follows:
CVPH has accrued the operational expenses of the Pod until Account Receivables can be collected. Examples include salaries and benefits (including those of Karen Ashline and her staff), office space, furniture, computers, meeting expenses, and the pro rata portion of the
portal which allows for patient list exchange and other secure communication between the Pod and participating payors. Karen’s 2010 salary is being covered by this grant as well.

This POD has developed basic financial statements. The following example illustrates expenses incurred in July, and corresponding figures for the year to date.

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**Medical Home**  
**July 31, 2010**

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<td>0.0</td>
<td>-0.8</td>
</tr>
</tbody>
</table>

**Operating Revenues:**

- Revenue - OVHN: $93,985  
  $22,196  
  ($71,789)  
  $636,648  
  $39,521  
  ($66,127)
- Revenue - HCC: $3,616  
  $1,220

Total Revenue: $93,985  
$23,826  
($71,159)  
$639,648  
$40,741  
($66,897)

**Expenses:**

- Salaries: $13,555  
  $12,156  
  ($1,399)  
  $94,819  
  $6,799  
  ($33,322)
- Benefits: $2,773  
  $1,138  
  ($1,634)  
  $18,964  
  $4,040  
  ($14,924)
- Minor Equipment: $546  
  $949  
  ($403)  
  $5,627  
  $-  
  ($5,627)
- Supplies and Consumables: $12,414  
  $7,571  
  ($4,843)  
  $49,128  
  $21,304  
  ($27,824)
- Rent: $3,387  
  $-  
  ($3,387)  
  $23,233  
  $-  
  ($23,233)

Total Expenses: $62,395  
$11,420  
($50,975)  
$639,648  
$81,951  
($520,697)

**Net Profit/Loss:**  
$-  
$-  
$-  
$-  
$27,119  
($27,119)
5. **SCOPE OF SERVICES**

**Scope of Duties**

**POD 1 – AMC**

Standard services which will be offered to and utilized by the participating practices within POD 1 include:

- Support for each practice to obtain NCQA recognition, including remediation when appropriate
- Access to a secure portal to allow exchange of patient attribution lists between each practice and each payor
- Providing access to fractional portions of support staff needed to meet PCMH requirements, including pharmacy, care management, social work, and quality assurance
- Dedicated staff to allow continued evolution of PCMH concept
- Advocacy for each participating practice

In addition, the participating practices have discussed the POD offering additional services on a longer term basis. Potential future services include:

- Single point of intake of patient level data from all participating payors and the data warehouse
  - Consolidation and aggregation of patient level data from all the payors
  - Repackaging data into one single per provider list for distribution to the appropriate practice
  - Packaging data at the aggregate level for all providers to enable benchmarking

- Single point of intake of quality reporting data from all participating practices
  - Submission of data to HIXNY
  - Coaching practices for success NCQA submission of data
  - Tracking and trending data for submission to payors benchmarking; coordination of patient/clinical data against financial/claims data
  - Benchmarking against peers

- Access to support services to include:
  - Assist practices in standardizing where possible and exploiting data registry capabilities with individual EMRs to identify and stratify patient
  - Care coordination, including access to pharmacist, social worker, nurse manager and/or staff when needed
  - Evidence based guidelines for diabetes, hypertension, coronary artery disease, pediatric asthma, pediatric obesity, and pediatric hyperactivity
As discussed in Section 4, each POD is required to deliver on clinical and financial outcomes and reporting requirements for this project.

**POD 2 - Tri-Lakes (HHHN)**
Within the Tri-Lakes POD, each practice will focus on implementing the clinical guidelines established for the identified disease states. The POD will provide coordinated access to the evidence-based care guidelines, assist in referral management, data analysis, and care coordination services to the participating practices. To assist in Patient Outreach, the available community resources within the Tri-Lakes POD include access to the following:

- Pharmacists
- Social Workers
- Nurse coordinators
- EMR/IT support

The POD will provide the following data exchange support to participating practices as well:

- Collection and aggregation of patient level data from each payor into single listing for each practice
- Distribution and submission of required reporting information
- Reporting of quality measures/outcomes to AHII and HIXNY
- Submission of NCQA PCMH certification data

To assist in Patient Outreach, the available community resources within the HHHN POD have been grouped by disease type into easy to read handouts. These handouts provide valuable “self management” support information, pertinent websites, and educational resources. Copies of these resources are included in the following pages and address:

- Pediatric asthma
- Diabetes
- Hypertension and coronary artery disease
- Pediatric obesity

**POD 3 - Northern Adirondack (CVHN)**
Within the CVHN POD each practice will focus on implementing the clinical guidelines established for the identified disease states. The POD will provide coordinated access to the evidenced based care guidelines, assist in referral management, data analysis, and care coordination services to the participating practices. To assist in supplementing care through non-physician encounters, the CVHN POD has a number of community resources available for use which will be utilized when appropriate.

**Access To Care**
The highest quality care is not effective if patients cannot adequately access it. An additional area of emphasis within the demonstration project is enhanced access through appropriate
triate, same day appointments, expanded hours, and innovative methods of allowing patients to communicate with their personal physician in a timely manner and in a language which is most comfortable for the patient.

In the NCQA PCMH, there is one Standard and two Elements related to Access to Care, both of which are “Must Pass” criteria. During the initial assessments of practice readiness, only 9% of participating practices within all three PODS meet the “Must Pass” criteria for access standards and averaged only 19% of the potential points. Access to Care is one area in which the participating practices have made improvements; one POD reports 90% compliance with patient access. Attachment E provides a snapshot of one POD’s cumulative measurement against access criteria. EastPoint Health continues to work with the PODs to ensure practice compliance.

Each participating practice is required to meet the Access to Care standards and elements required by the NCQA PCMH certification. In addition, POD 2 (HHHN) has developed an excellent “Blueprint for the Patient Centered Medical Home” which is provided below. This program has been shared a “best practice” for use within each POD. Detailed within this “blueprint” document are the services that each practice will utilize to improve care outcomes and improve efficient resource utilization.

**HUDSON HEADWATERS HEALTH NETWORK**

**BLUEPRINT FOR THE PATIENT CENTERED MEDICAL HOME (PCMH)**

<table>
<thead>
<tr>
<th>Transforming Clinical Operations</th>
<th>Assembling the Care Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standardize Care Delivery</td>
<td>• Leverage Non-Physician Staff</td>
</tr>
<tr>
<td>• Build Patient Management Systems</td>
<td>• Engage Physicians in Practice Transformation</td>
</tr>
<tr>
<td>• Enhance Patient Access</td>
<td>• Train Care Teams</td>
</tr>
<tr>
<td>• Build Cooperative Care Network</td>
<td>• Engage Patients as Active Team Members</td>
</tr>
</tbody>
</table>

**Transforming Clinical Operations**

*Choose Manageable Patient Cohort for Initial Rollout and Standardize Care:*

HHHN determined Diabetes and Hypertension to be our high-volume, high-impact Target Groups for adults, and Asthma and Obesity for pediatrics. Evidence-based clinical practice guidelines have been adopted and put into place. Quality Management tracking is now a part of our Electronic Medical Record (EMR) and is a quick reference for determining patients’ current status and needs.

**Build Patient Management Systems:**

- Rethink delivery of care for office visits – treat the whole patient not just the acute condition.
- Dedicate time for pre-visit planning-pre-planning to identify tests and other needs and have standing orders that allow nursing to follow-up and order test.
- Prioritize dedicated staff time to track and engage patient after visit.
- Re-engage “Lost” patients through the use of disease registries to identify patients who have not been in for a visit or are not compliant with testing. Case Management can reach out to try to re-engage the patient.
Enhance Patient Access

A two-pronged approach can improve access and empower patients.

- Increase in-office availability:
  - Same-Day appointment availability for patients who are determined to need it based on established triage criteria.
  - Work towards stable physician schedules, team approach, and flexing open appointments with seasons or know times of demand.
  - Leverage strengths of team members to offload physician schedules.

- Encourage out-of-Office Communication
  - Improved telephone triage possibly with centralized call intake
  - Utilization of the Patient Portal to share lab results, send patients education materials and assist patients in self-management

Build Cooperative Care Network

- Set Clear Expectations for Referral Coordination including sending appropriate information to specialist and monitoring for report back from specialist
- Reward Engaged Specialist who support medical home practice coordination efforts and communication with a Loyal Referral Base
- Build information sharing with hospitals through interfaces and joint coordination efforts
- Work with community entities including Public Health to address the needs of our patients

Assembling the Care Team

Leverage Non-Physician Staff

Physicians alone cannot provide comprehensive care and maintain panel size. There is not enough time in a day. Currently the majority of physician visit time is spent treating acute conditions. In the PCMH there is more emphasis on chronic care management. To move to this level we need to maximize the capabilities of existing staff, i.e. Team Members work “At Highest Level of Their License”.

<table>
<thead>
<tr>
<th>Typical Primary Care Office</th>
<th>Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician</strong></td>
<td>Patients are proactively scheduled for chronic</td>
</tr>
<tr>
<td>• Spends majority of visit addressing acute ailments</td>
<td>care physician appointments</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>• Uses chronic care guidelines which provide</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>framework for consistency across patients</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>• Prioritizes time for patient follow-up</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>• Proactively reaches out to patients to encourage</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>self-management</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>• Can be scheduled to provide one-on-one patient</td>
</tr>
<tr>
<td>• Provides chronic care management in minutes after acute issues</td>
<td>education</td>
</tr>
<tr>
<td><strong>Registered Nurse</strong></td>
<td>• Perform pre-visit chart review</td>
</tr>
<tr>
<td>• Spends majority of time on acute patient ailments</td>
<td>• Record pre-physician services, ask about eye</td>
</tr>
<tr>
<td>• Takes incoming patient calls concerning medication, lab results</td>
<td>exam, foot exam and conduct smoking assessment</td>
</tr>
<tr>
<td><strong>LPN/MA</strong></td>
<td>• Work with clinical staff to check patient needs</td>
</tr>
<tr>
<td>• Set up patient in room, take vital signs, document reason for</td>
<td>before reminder call</td>
</tr>
<tr>
<td>• Has down time waiting for next patient on slower days</td>
<td>• Obtain outstanding information such as lab</td>
</tr>
<tr>
<td>• Performs reminder calls to patients before scheduled</td>
<td>results and consult reports before patient visit</td>
</tr>
<tr>
<td><strong>Front Desk Staff</strong></td>
<td></td>
</tr>
<tr>
<td>• Triage incoming phone calls</td>
<td></td>
</tr>
<tr>
<td>• Provides reminder calls to patients before scheduled</td>
<td></td>
</tr>
</tbody>
</table>
Establish Case Management: We also need dedicated Case Management staff to support the physician and patient in meeting care goals. Case Managers can:

- Manage Disease Registries
- Conduct pre-visit chart review
- Provide Patient Self-Management Support
- Coordinate care across the healthcare continuum by understanding and leveraging community assets
- Support Quality Improvement activities

Engage Physicians in Practice Transformation

Relationship driven transformation requires a leadership team to dedicate time to practice development. Medical Leadership should be responsive to common physician pushback.

- Fear of “Losing” patients
  - Medical Home is a physician-led team of providers
  - Key relationship built around maximizing patient-physician interaction
  - Physician actively engaged in overall patient care
- Protecting “Physician-Required” tasks
  - Best practices are standardized, maximizing physician time
  - “Triggers” to engage patient can be built into care processes
  - Physician-required tasks are not offloaded to team
- Imposition on Physician Time
  - Role and goal of physician defines how team is used
  - Team extends time available to patient, without requiring additional physician time
- Cost of Creating the Care Team
  - More efficient visits improve financial performance of practice
  - More cost-effective to minimize physician time spent on non-physician tasks
  - Allows team members to operate at the top of their licenses

Re-Look at Incentive Programs

- Incentives may need to be re-aligned to include performance and productivity goals.
- Consider incentives at the Team rather than physician level.

Train Care Team

Ongoing training is necessary to support transformation. Training can be accomplished in many ways including defining and implementing PCMH programs and work flows, sharing success, helping with data analysis, sharing best practices, as well as internal and external training modules.

Foster Active Patient Participation

- Share information about the Patient Centered Medical Home with our patients.
- Establish new educational formats
  - One-on-One In-Person Education to discuss important self-management topics such as diet, lifestyle changes, medication, healthcare goals
  - Telephone or Portal follow-up to address questions and concerns and to check on goals and medication compliance
  - Provide patients with chronic conditions Self-Management goals to improve health outcomes
  - Group support activities including group education, cooking classes, support groups
- Monitor Patient Experience through satisfaction questionnaires and on-site, post-visit kiosk.
Care Coordination
Participating practices within all PODs are utilizing an innovative and collaborative process entitled “The Care Management Program,” which manages an individual’s health needs through assessment, planning, and coordination and monitoring in an effort to best meet an individual’s health needs and to promote quality and cost efficient care.

The Care Management Program’s primary focus is to improve the care for individuals that meet specific criteria. This is accomplished both through new processes and through improved and coordinated dialogue between providers and patients to help guide patients through a continuum of services, rather than to compartmentalize their care. The Care Management Program is proactive and is designed to identify patients at risk, and subsequently intervening with the goal of improving the patient’s outcomes. The Program focuses on the continuum of care (ideally from the time the patient/provider relationship is started), addressing the needs of a defined patient population at a higher-than-average level of coordination and management. The goal of this approach is to maintain the patient at the most appropriate level of care, which should result in both improved outcomes and reduced costs.

In order to achieve the clinical and financial outcomes for this project, new processes must be established to first effectively identify patients needing managed care and then to proactively manage these patients to ensure that they can successfully meet the desired outcomes. These new processes must be patient-centric and coordinate care at the hospital, in the community, and most importantly, the transition in between. Some of these new processes will require technology, some of them will require new personnel, but all of them will re-orient how medical care is provided from purely an episodic delivery model to a model that provides care coordination and active management.

The remainder of this section of the document will focus on the details of how to achieve these goals.

Different Populations Requiring Modification to Standardized Approach
As each POD must deliver care to communities which are unique from each other, the strategy and processes used to reach each POD’s goals will be different. That said, each POD was challenged to develop solutions to similar access-to-care issues to ensure a greater probability of achieving as consistent outcomes as possible. The variability among the PODs is due to the uniqueness of each patient population, the availability of resources internal to the POD, the availability of resources external to the POD, and the capabilities of clinicians and their supporting healthcare information technology infrastructure. Although standard processes overall delivers better outcomes, the uniqueness of each POD prevents total standardization to occur across all three PODs. When possible, the PODs should work to standardize processes internal to the POD. For example, Hudson Headwaters Health Network, a tightly integrated
network of providers with a centralized organizational structure, is able to achieve levels of central standardization and efficiencies unavailable to more diverse PODs. Nevertheless, each POD is working to standardize processes as much as possible to achieve targeted goals. While each POD may not be able to achieve the standards set aside in this document, the goal of this document is to set out the “gold standard”, recognizing that each POD may have to alter the approach to accommodate their differences.

Patient Populations
Six different patient populations have been identified for this Care Management Project with the thought that these would be the starting populations that would most benefit most from this new model of care. Presuming that care can be better coordinated in a more cost effective manner with improved outcomes for these populations, it should be assumed that the scope of this project will be expanded to include other at risk populations.

The six initial patient populations are:

1. Adult - Hypertension
2. Adult - Diabetes
3. Adult - Coronary Artery Disease
4. Pediatrics – Preventive Services (primarily focused on immunizations)
5. Pediatrics – Obesity
6. Pediatrics - Asthma

Overview of New Processes to Manage Patients
The new processes to manage patients fall into five specific categories: 1) Patient Identification and Stratification, 2) Patient Outreach, 3) Clinical Encounter (Physician and Non-physician), 4) Patient Follow-up, and 5) Patient Monitoring. Each of these steps is illustrated in the diagram below, and detailed descriptions follow. Additionally, outlined are the questions posed to each POD to guide them in their development of POD-specific approaches to delivering on the agreed clinical and financial outcomes.
Patient Identification and Stratification

Patient identification is the process used to identify those patients with the targeted disease or condition (see list above). Stratification is the process by which these targeted patients are categorized on a variety of factors to help each POD prioritize outreach to these patients. Factors used for stratification include but are not limited to:

1) Severity of illness
2) Date of most recent visit
3) Willingness to change behavior
4) Does patient’s social/family environment support change? This is extremely important for pediatric patients as the parent’s ability or desire to change can be a much better predictor of success than a patient’s ability or desire to change.
5) Constraints that might prevent access to care or ability to change behavior, such as financial, scheduling, or transportation limitations.

While stratification could become a multi-dimensional process with very elaborate rules put in place, that approach would not be prudent at this point in time. Instead, the recommendation is to categorize patients according to a simple 2x2 grid. If it is necessary to prioritize patients based on limited resources, this grid can help identify which patients should get services in what order.

Each of the boxes in this chart is shaded one of three shades, from light to dark. The lightest shaded box (numbered 1), should be the first patient population to provide service to as they have the highest need and the most likely to take advantage of the program. The next darkest boxes (numbered 2), should be the next patient population to provide services to whereas the darkest shaded box (numbered 3), should be the last patient population to provide services to as the potential impact will be smaller and the difficulty will be higher.
While stratification can be used to segment which population will receive services first, as described above, it can also be used to address the level of intensity or frequency that services are rendered. For example, the patients that have the highest severity of illness should be monitored more frequently and those patients who have more resistance or barriers to change may need more frequent or intensive interventions to help them change their behavior.

The first step in the identification of patients is to isolate the specific clinical criteria (ICD codes {or range}, CPT codes, or lab values) and other specific criteria (such as age) that meet the criteria for each patient population. These criteria should be consistent among all the PODs.

Hudson Headwaters Network has created an outstanding matrix providing detailed information about how best to identify patients per disease state and then follow up accordingly. This information is provided below:

<table>
<thead>
<tr>
<th>Identification</th>
<th>Stratification</th>
<th>Patient Outreach Activities</th>
<th>Outreach Conducted By</th>
<th>Monitoring/Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIABETES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults between the ages of 18 and 75 with a diagnosis of Diabetes as evidenced by: ICD-9 Dx code of 250.0*, 362.0*, 357.2, 366.41, 648.0</td>
<td>1. At Goal: • A1C&lt;7</td>
<td>Inform patient about Patient Portal and Health and Wellness</td>
<td>Athena Communicator call-Athena Support monthly to patients identified during Pre-Visit Planning</td>
<td>Monitor for change in patient’s status quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Low Risk (Light Touch): • No A1C in 12 months • A1C≥7&lt;9</td>
<td>Inform patient about his/her condition and provide Self-Management Support Plan, Community Resources and Self-Management Support Tools</td>
<td>Patient Mailing-Care Management Support to patients identified through Pre-Visit Planning</td>
<td>Monitor for change in patient’s status quarterly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Moderate Risk (Medium Touch) • A1C ≥ 9 • No office visit with primary care provider for chronic condition in 12 months • Newly diagnosed • New to insulin</td>
<td>Direct contact by Care Manager either over the phone or in person to assess readiness to participate in Care Management Program and development of</td>
<td>Care Management to patients identified during Pre-Visit Planning or Disease Registry Query</td>
<td>Ongoing follow-up based on individualized patient-centered plan of care based on risks and patient goals. Typically quarterly contact between Care Manager</td>
</tr>
<tr>
<td>Identification</td>
<td>Stratification</td>
<td>Patient Outreach Activities</td>
<td>Outreach Conducted By</td>
<td>Monitoring/Follow-up</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>Adults between the ages of 18 and 85 with a diagnoses of Hypertension as evidenced by: ICD-9 Dx code of 401.0*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. High Risk (Heavy Touch)</td>
<td>Hospitalization for Diabetes • Frequent Emergency Room use related to Diabetes • Predictive Modeling</td>
<td>Initial contact by Care Manager with needs assessment for referral to Certified Diabetes Educator. Pharm-D and CSW interaction as needed</td>
<td>Care Manager with CSW/Pharm-D/Certified Diabetes Educator as needed</td>
<td>Ongoing follow-up based on individualized patient-centered plan of care based on risks and patient goals</td>
</tr>
<tr>
<td>1. At Goal:</td>
<td>BP&lt;140/90</td>
<td>Inform patient about Patient Portal and Health and Wellness</td>
<td>Athena Communicator call-Athena Support-monthly to patients identified during Pre-Visit Planning</td>
<td>Monitor for change in patient’s status quarterly</td>
</tr>
<tr>
<td>2. Low Risk (Light Touch):</td>
<td>BP&gt;140/90</td>
<td>Inform patient about his/her condition and provide Self-Management Support Plan, Community Resources and Self-Management Support Tools</td>
<td>Patient Mailing-Care Management Support- to patients identified through Pre-Visit Planning</td>
<td>Monitor for change in patient’s status quarterly</td>
</tr>
<tr>
<td>3. Moderate Risk (Medium Touch)</td>
<td>BP&gt;140/90 and LDL&gt;130 • No office visit with primary care provider for chronic condition in 12 months • Newly diagnosed</td>
<td>Direct contact by Care Manager either over the phone or in person to assess readiness to participate in Care Management Program and development of individualized patient-centered plan of care</td>
<td>Care Management- to patients identified during Pre-Visit Planning or Disease Registry Query</td>
<td>Ongoing follow-up based on individualized patient-centered plan of care based on risks and patient goals. Typically quarterly contact between Care Manager and patient</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD)</td>
<td>Adults between the ages of 18 and 85 with a diagnoses of Hypertension as evidenced by: ICD-9 Dx code of 414.0*, 414.2, 414.3, 414.8, 414.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. At Goal:</td>
<td>LDL&lt;100</td>
<td>Inform patient about Patient Portal and Health and Wellness</td>
<td>Athena Communicator call-Athena Support-monthly to patients identified during Pre-Visit Planning</td>
<td>Monitor for change in patient’s status quarterly</td>
</tr>
<tr>
<td>4. Low Risk (Light Touch):</td>
<td>LDL&gt;100</td>
<td>Inform patient about his/her condition and provide Self-Management Support Plan, Community Resources and Self-Management Support Tools</td>
<td>Patient Mailing-Care Management Support- to patients identified through Pre-Visit Planning</td>
<td>Monitor for change in patient’s status quarterly</td>
</tr>
<tr>
<td>5. Moderate Risk (Medium Touch)</td>
<td>LDL &gt; 130 • No office visit with primary care provider for chronic condition in 12 months • Newly diagnosed</td>
<td>Direct contact by Care Manager either over the phone or in person to assess readiness to participate in Care Management Program and development of individualized patient-</td>
<td>Care Management- to patients identified during Pre-Visit Planning or Disease Registry Query</td>
<td>Ongoing follow-up based on individualized patient-centered plan of care based on risks and patient goals. Typically quarterly contact between Care Manager and patient</td>
</tr>
<tr>
<td>Identification</td>
<td>Stratification</td>
<td>Patient Outreach Activities</td>
<td>Outreach Conducted By</td>
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</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>centered plan of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. High Risk (Heavy Touch)</td>
<td>Hospitalization for CAD</td>
<td>Initial contact by Care Manager with needs assessment for referral to Certified Diabetes Educator, Pharm-D and CSW interaction as needed</td>
<td>Care Manager with CSW/Pharm-D/Registered Dietician as needed</td>
<td>Ongoing follow-up based on individualized patient-centered plan of care based on risks and patient goals</td>
</tr>
</tbody>
</table>

Table 1

Identification of patients to be included in this project can occur in one of three different ways:

1. Patient is identified from physician practice’s population as already having met the clinical and other appropriate criteria. The first time this process is done, most of the patients will be identified. However, due to changes in lab values or other clinical indicators, this process will need to be repeated on a regular basis. The following steps should be taken to best accomplish identifying these patients:
   a. Pre-Visit Planning Reports: Every week, a report should be run for the patients scheduled for a visit the following week to identify patients that would meet clinical criteria for inclusion in this program. However, as new appointments will be created after this report is created, the registration process should be modified to flag those patients that might fit criteria.
   b. Disease Registry Monitoring - a Disease Registry should be maintained of patients diagnosed with one or more of the identified disease condition. The registry should contain both demographic and clinical outcomes data (such as pertinent lab values). Registry Reports should be compiled monthly to identify patients who may benefit from Care Management services.
   c. Preventive Screening/Services Reports: Reports to identify patients who are in need of preventive screening/services (i.e. cervical cancer screening, mammogram and colonoscopy) should be run quarterly for the purposes of patient outreach.
   d. Ad Hoc reporting should be available to create as needed reports to supplement those mentioned above.
   e. Collaboration with Insurance Companies – coordination should exist between POD and local insurance companies who actively identify patients in need of care coordination services, so that these patients are referred to the POD for management under this program, presuming appropriate clinical criteria have been met.

2. Patient is identified when seeing physician (PCP or specialist) that he/she newly meets criteria.
3. Patient is identified upon discharge from the hospital (inpatient or ER) that he/she newly meets criteria. Ideally, the hospital personnel will have access to the registry and can identify if a patient should be added to the program. Alternatively, if the POD has access to Daily Admission Activity Reports, these reports could be used to identify patients who meet clinical criteria and may also benefit from Transition Care Management.

While the below table presumes that most patients will be identified through a retrospective review of the practice’s current patients (see step 1 above), the same rules can be applied to patients that newly meet the criteria (see steps 2 and 3 above).

<table>
<thead>
<tr>
<th>Patient Identification and Stratification</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify patients with targeted diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Create patient registry</td>
<td>Using practice management and EMR data, identify all patients that qualify as having targeted disease state.</td>
<td>Use of CPT codes and/or diagnostic codes and/or lab values</td>
</tr>
<tr>
<td>Stratify patients on severity of disease and other parameters (e.g., patients regularly seen and under care)</td>
<td>Using practice management and EMR data, identify patients with targeted disease, stratifying them based upon a variety of factors that can deliver on chosen measures. Considerations are based upon the disease process. (see below)</td>
<td>Use of CPT codes and/or diagnostic codes and/or lab values. Decide upon which patients will most benefit from intervention and investment of resources.</td>
</tr>
</tbody>
</table>
| DM considerations                        | 1. Does patient have a recorded HbA1c?  
2. Time since last HbA1c  
3. Value of most recent HbA1c (use measures for guidance on significance of value) | Other factors per POD |
| CAD considerations                        | 1. Does patient have a recorded LDL- C?  
2. Value of most recent LDL- C (use measures for guidance on significance of value) | Other factors per POD |
| HTN considerations                        | 1. Does patient have a recorded BP reading?  
2. Value of most recent BP reading (use measures for guidance on significance of value) | Other factors per POD |
| Ped – Prevention considerations           | 1. Has patient received all immunizations per measures? |          |
| Ped – Obesity considerations              | 1. Has patient and family received obesity education?  
2. Change in BMI  
3. Comparing 2 most recent HbA1c values (use measures for guidance on significance of value) | Other factors per POD |
| Ped – Asthma considerations               | 1. Patient with hospital admission for asthma  
2. Date of last hospital admission for asthma  
3. Frequency of hospital admissions for asthma over time period (e.g., 12 months)  
4. Patient with an ER visit for asthma over time period (e.g., 12 months)  
5. Date of last patient ER visit for asthma  
6. Number of patient ER visits for asthma over time period (e.g., 12 months) | Other factors per POD |
Questions and considerations presented to each POD include:

1. Describe in detail how patients will be identified and stratified for interventions for inclusion in a disease specific patient registry.

2. Be sure to detail each of the steps taken, the resources utilized, and the frequency of the activity.

3. Do not forget to detail how patients will be stratified and the reasons for choosing such a stratification strategy. Considerations may include availability of local resources, clinical factors, ongoing clinical projects, and expertise of the practice. Please pay close attention to the considerations noted in the patient identification and stratification table (See Table 2.) and address them as specifically as possible.

4. The information provided here will form a detailed road map on how care will be provided to the targeted population to achieve the project’s clinical and financial goals.

**Technical Considerations**

In order to effectively coordinate the process for identification and stratification, as mentioned above, the functionality of a patient registry would be required. However, this functionality can be accomplished through different mechanisms, and as such, each POD may find that their approach will be somewhat unique. For example, in Hudson Headwater, where all docs share one EMR, the EMR will initially serve the purpose of the registry, assuming that it can provide the necessary reporting capabilities. However, in the Plattsburg POD and in the Adirondack Medical Center POD, given that there are multiple EMRs involved, there must be a Health Information Exchange involved to centralize the data sharing. As this is not currently in place, the registry function will be provided at each practice out of their EMR. However, as not all EMRs have the same functionality when it comes to reporting, some of the practices might have less ability to manage their patients using these tools. However, even if the practice has all of the registry functions in their EMR, they would most likely not have access to the patient’s complete medical record, including hospitalizations, ER visits, and information about visits at other physicians, such as specialists. However, with the integration of the practice’s EMR into HIXSNY, this information could be available at each practice location.
An HIE (health information exchange) could also perform registry functions or the HIE could feed the registry, partly depending on whether the community wanted a federated or centralized approach to data sharing. Other issues to consider are that whatever tool is used for the registry function, it must have access to lab data, including not only hospital labs but also reference labs if they are prevalent in that community. The registry should have access to hospital discharge (inpatient and ER) reports – this is especially important to manage asthmatic patients (see Table 2) and as mentioned above, the hospital personnel should have access to the registry as well. Lastly, while it is feasible to have multiple registries, one per different condition, it would be best to have one system that shared clinical information on all patients, as this would more easily enable co-morbid patients that fit the requirements for more than one condition.

**Patient Outreach**

Once patients have been identified and stratified, an efficient and effective process must be utilized to contact these patients and engage them in an evidence-based longitudinal care process. It is expected that a number of patients will decline participation in this proactive care delivery effort and will only seek care on an emergency basis, a result consistent with previous disease management efforts. However, it is critical to not exclude patients from this project just because they have not shown compliant behavior in the past. Lack of compliance is oftentimes misinterpreted as lack of desire or interest in properly caring for themselves or their family. However, this might not be accurate. As such, it is important to understand the patient’s motivation for their behavior.

For example, a male head of household that is holding down two jobs in order to stay off public assistance might resist seeing a physician on a regular basis due to the inability to easily take time off from work. This is especially true for routine care driven by an asymptomatic, chronic disease such as hypertension. However, if properly educated on the ramifications of leaving the disease untreated, he might be better motivated to obtain regular routine check-ups and proper medication therapy to reduce the probability of his getting seriously ill where he is then unable to properly care for his family. By addressing the key reason a patient is not seeking care; it is very possible to transform a non-compliant patient into a compliant one.

For those patients willing and able to participate in a project that can improve their overall health and quality of life, outreach to these patients must be broad-based, consistent, and effective in achieving regular participation. Such participation includes scheduling and completion of necessary clinical visits (e.g., physicians, educators, therapists, pharmacists) to create, deliver, monitor, and adjust the prescribed therapeutic plan. Such a plan encompasses evaluation, education, and specific therapies (e.g., pharmaceuticals, diet, and exercise).
Effective outreach, whether using outbound calling, email, text messaging, etc. delivers high levels of appointment completion consistent with frequency dictated by evidence-based guidelines of the realities of the patient’s clinical condition. (See Table 3) Each plan is also developing a community based communication plan to raise the awareness of the project and its benefits to those who participate.

**Methods of communication**

There will be three primary components to the communication strategy for this program: 1) Automated outbound communication; 2) Inbound communication; and 3) Easy access to Patient Education.

The automated outbound communications could take the form of email, telephone call, text message, or even postal mail. The choice should be decided primarily by the urgency of the communication and the likelihood that the patient (or family) will respond in the desired manner, providing that the system selected supports this level of variability. The other factor that must be considered is the feasibility of such communication – if a patient does not currently have phone service at home due to financial constraints, then outbound calling would not be appropriate. As such, one communication approach may work exceptionally well for one patient whereas another communication approach will work much better for another patient. Alternatively, the POD may decide it is best to take a standardized approach, such as phone calls three days apart for one week, then emails three days apart for one week, then send a letter or postcard if still no response.

A centralized call center can be most beneficial to deal with after-hours patient support, such as help in scheduling appointments or requesting refills or referrals. Of course, this will require access to at least a centralized scheduling system and preferably the office’s EMR. The primary value in having the call center solution is that often patients respond to the outbound communication after normal office hours and there is little value in reaching out to a patient to schedule an appointment if the patient is unable to easily accomplish that goal when responding from home in the evening. Alternatively, the POD could offer a patient portal which could provide for most of these functions but depending on the population, this might not be pragmatic.

When creating the outreach strategic, one must consider the availability of resources in the population and how the community can support those patients that do not have readily available options, such as internet access. In many cases, patients in these populations will not have computer access from home and many that are working will not be able to access a computer from work. However, many communities do provide alternatives, such as computers in libraries or in other accessible locations. As part of the outreach process, it should be
identified for each patient or caregiver for pediatric patients, what methods of communications are available to them. The following seven questions are designed to determine this, and depending on these answers, what alternatives might exist in the community.

1. Do you have a phone at home that can be used for inbound calls?
   a. Do you have an answering system that is checked regularly?
2. Do you have a cell phone and if so, can you receive text messages?
3. Do you have a phone at work that can be used for inbound calls?
   a. Is it feasible to leave a message for you?
4. What times can you be called, at home or at work?
5. Do you have access to a computer and the internet at home or at work?
6. If not, can you utilize a computer at a family member, friend, or in the community?
7. If more than one option is available, what is your preferred method of outbound communication?

Lastly, the POD should be able to prescribe easy accessed educational information. In general, the best solution would be to provide this through a patient portal so the patient, or their family, can access from a home, work, or community based computer, such as one in a library. However, if computer access is limited, another alternative is to deliver the education through postal mail, although this is much harder to track compliance this way. It is also important that all patient education be readily available during an office visit, so the patient can leave the office with the printed materials in hand. Lastly, as much of the education could be related to medication management, community pharmacists and hospital discharge planners should also have access to deliver the same educational information to the patients. This is especially important when discharging a patient from a hospital on a new medicine.

Questions and considerations presented to each POD are outlined below.

1. Describe in detail the communication plan applied to patients identified and stratified per each targeted disease.

2. Be sure to include detail on how patients will be contacted, the frequency of outreach (e.g., number and modality of attempts to contact patients), the escalation process if no response is received, and what resources will be utilized to complete these activities.

3. This section requires a detailed description of activities, including, but not limited to:
   
   a. Establishing and staffing a call/communication center,
b. How to ensure reliable communication among communication center, practices, community resources, and patients.

c. An accounting of the technologies and personnel resources that will be utilized in patient outreach.

d. An approach to measuring the effectiveness of the communication strategies with the goal of continuous improvement. If, for example, response rates from each type of communication approach should gathered and evaluated as it may be determined that some of these are not effective and should be discontinued while others should be enhanced.

4. These details form the roadmap, including governance, of the patient outreach activity.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Patient Outreach</td>
<td>Contact patients identified and stratified to engage them in care delivery</td>
<td></td>
</tr>
<tr>
<td>❖ Develop patient outreach methodology</td>
<td>Specify, in detail, processes used to contact patients and schedule them for needed office visits and testing (e.g., lab, imaging). Develop a detailed flow chart of processes including decision points, staffing, and governance (e.g., rules followed during contact activity) 1. What modalities will be used to contact patients? (Phone, email, mail, text messages) 2. How will those modalities be used to contact patients? In what order? How often? 3. Will the approach be standardized for all patients, by disease type, or based on patient preference? 4. What entity will contact patients? (Practices, call center, Pod) 5. Who, within entities, will contact patients? (Physician, nurse, case manager, social worker, pharmacist, etc.) 6. What are the rules that govern how patients are contacted including frequency, effort made to contact them, tracking of those refusing treatment, accommodation of patient requirements for contact modality, etc? 7. What information can be shared either on a telephone message or with another family member or co-worker, if the patient is not immediately available?</td>
<td>Patient outreach requires a detailed analysis of how patients are contacted and consideration of all potential decision points of the process. Careful consideration of available resources is important in setting these rules. Clinical considerations must also drive rules development. Without detailed rules, variability of care will appear due to the differences between those contacting patients as well as differences among practices. Standardization of processes ensures more consistent outcomes while allowing for improvement of processes in an effort to deliver enhanced levels of care. Evaluation of the rules should be completed on a periodic basis to determine if improvements can be accomplished.</td>
</tr>
<tr>
<td>• DM considerations</td>
<td>1. Frequency of lab testing due to guidelines and lab values (e.g., HbA1c) 2. Patient education (e.g., in-office and community services) 3. Patient monitoring and follow-up</td>
<td>Factors such as date or value of last lab test will impact the frequency of patient outreach and the types of outreach required (e.g., education)</td>
</tr>
<tr>
<td>• CAD considerations</td>
<td>1. Frequency of patient monitoring</td>
<td>Not expected to require large</td>
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### Table 3

#### Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Comments</th>
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<tbody>
<tr>
<td>2. Medication education</td>
<td>Investment in outreach due to few factors requiring intervention</td>
<td></td>
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</tbody>
</table>
| • HTN considerations      | 1. Frequency of patient monitoring  
2. Medication education | Not expected to require large investment in outreach due to few factors requiring intervention |
| • Ped – Prevention considerations | 1. Family education and follow-up | Not expected to require significant outreach due to already existing efforts to immunize children |
| • Ped – Obesity considerations | 1. Patient and family education (e.g., in-office and community services)  
2. Patient monitoring and follow-up | Requires repetitive “touches” due to complexity of disease risk factors (e.g., family involvement) |
| • Ped – Asthma considerations | 1. Patient and family education  
2. Medication management, including issues of compliance | Outreach will be determined by how well the patient is being managed on current medication |

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**Care Delivery and Coordination**

Care delivery and coordination encompasses all clinical activities including those provided by physicians, nurses, pharmacists, social workers, nutritionists, educators, and others. For clarity, activities provided by non-physicians are described separately from those of physicians. Nevertheless, all clinical interventions are included and described in this section as they represent activities that work toward improving and maintaining patient health while offering a comprehensive, holistic view of the patient and the interventions required to keep the patient well. This represents a team approach to disease management rather than a disconnected, episodic approach to correcting acute problems.

**Coordination/Structure of Care Interventions**

There are multiple touch points to ensure care is coordinated across the continuum. True coordination has rarely occurred in traditional care delivery. In the “gold standard” coordination occurs within the hospital setting AND continues as patients seek care in the home or outpatient setting as appropriate. The major activities for each function are listed below.

**Hospital Case Management Role**

- Identify patients conduct patient visits in preparation for discharge.
- Interface with hospital provider and promote scheduling of post-hospital visit prior to discharge.
- Initiate home care referral where appropriate
- Submit a daily fax (or other suitable mean of notice) to the Care Manager of the patients who meet the criteria for inclusion in the Care Management
Program, and where possible identify patients that have been referred to Public Health.

**Hospital Provider Role:** It is strongly felt that patients will be more engaged with the program if the provider counsels them about the program.

- Reinforce Care Management Program as a Standard of Care
- Assure an appointment is scheduled with the PCP's team within 5-7 days of discharge (14 days at most).
- Pay careful attention to the details of medication reconciliation.
- Order other specific education that would be helpful to keep the patient stable after discharge. (Hospital Nursing is responsible for education at discharge.)

**Home Care Role**

- Conducts home visits and complete goals
- Interact with Care Manager as needed
- Refer patients to Care Management where appropriate

**Care Manager Role**

- Monitor daily admission reports to identify patients who meet care management criteria and track hospital course on hospital electronic record system or through phone contact with hospital Case Manager
- Interact with hospital provider as needed to coordinate initial patient contact
- Make telephone contact with patient/care giver within 24-72 hours post-discharge.
- Facilitate scheduling of post-hospital appointment, if not already done, and re-enforce need to keep appointment.
- Conducts 3-4 phone calls post-discharge to complete outlined program goals (additional calls can be made based upon patient need)
- Document patient interaction in EMR or registry as appropriate
- Communicate with primary care provider as needed
- Attend post hospital office visit where deemed beneficial

**Office Provider Role**

- Review medication reconciliation and clarify discrepancies as needed
- Review order set in EMR
- Interact with patient and Care Manager as needed
The team approach to care coordination is a markedly different approach that what is provided in a traditional episodic treatment approach to care. While many of the same activities might happen in the traditional office setting, in an office dedicated to care coordination, it is imperative that specific roles and responsibilities are identified in advance to make sure that the patient’s care is managed throughout the treatment of his/her condition. As such, it is important to identify specific individuals in the team and the roles that they will be playing. Detailed information on each of these key roles is provided.

**Provider**

The provider’s role in the Care Management program has three primary functions. First, he/she diagnoses patients thereby determining if they meet the criteria for inclusion in the disease management program. Second, he/she develops an individualized treatment plan for each patient in the program based on clinical findings. This treatment plan is then be used by the Care Manager and the other Care Coordination team members to provide services as appropriate to the patient. Lastly, the provider monitors and adjusts the patient’s treatment plan as appropriate based on any new clinical findings.

It is important to note that one of the key requirements for care coordination is medication management, including medication reconciliation and medication compliance review. Having a complete medication history is critical to properly perform that function. As such, one of the many tools that will be used to ensure the best possible care coordination is the use of electronic prescribing. In an effort to make best use of this technology and to provide the best management of a patient’s medication, the use of a Clinical Pharmacist is recommended.

**Clinical Pharmacist**

Clinical Pharmacists will provide comprehensive medication management as follows:

The common elements of two definitions can be used to describe this service in the medical home—the definition offered by the American Medical Association (AMA) when it provided current procedural terminology (CPT) payment codes for the delivery of medication management services and the definition provided by legislation for Minnesota Medicaid recipients. These definitions have the following five elements in common relevant to the needs of patients being cared for in the medical home:

1. The service (medication management) needs to be delivered directly to a specific patient.
2. The service must include an assessment of the specific patient’s medication-related needs to determine if the patient is experiencing any drug therapy problems. A care plan is developed to resolve the problems, establish specific therapy goals, implement personalized interventions and education, and follow up to determine the actual outcomes the patient experienced from taking the medications.
3. The care must be comprehensive because medications impact all other medications and all medical conditions.
4. The work of pharmacists and medication therapy practitioners needs to be coordinated with other team members in the PCMH.
5. The service is expected to add unique value to the care of the patient.

The Clinical Pharmacists performing comprehensive medication management services will perform the following activities in a systematic manner.
1. Assess the patient’s medication-related needs.
2. Identify the patient’s medication-related problems, outlining:
   a. Appropriateness of the medication
   b. Effectiveness of the medication
   c. Safety of the medication
   d. Adherence to the medication
3. Develop a care plan with individualized therapy goals and personalized interventions.
4. Follow-up evaluation to determine actual patient outcomes.

The comprehensive medication management services provided by the clinical pharmacists at CVPH Medical Center (acting as a model for the other Pods) will produce the following tools that can be used by the other clinicians on the team.
1. A description of the patient’s medication experience.
   a. Includes a description of how the patient makes decisions about the medications he she takes in a cultural and holistic context
   b. Provides a complete medication history and current medication record, complete with how the patient actually takes the medications.
   c. The complete medication record is provided to both the patient and the prescribing providers so everyone is aware of all the medications and how they are taken.
2. A list of medication related problems that need to be addressed.
3. Care plan goals of therapy individualized to the patient
4. Measurable outcome parameters personalized for each patient
5. Interventions personalized for each patient (education, tools etc.).
6. Routine follow-up evaluation of actual outcomes related to medication use.

Other Care Coordination Roles
As mentioned above, care coordination involves hospital, community, and office personnel. In addition to those highlighted and outlined in more detail above, there are two other critical roles which should be further defined – the clinical social worker and the office based care manager.
Clinical Social Worker
The Clinical Social Worker will serve an assessment, coordination, education, and counseling role for the Care Management program.

Assessment - The social worker will work with the care manager to assess the patient and their family, as appropriate, to determine if they are an appropriate candidate for inclusion in this program. Most important, the social worker will work to best understand any barriers to a patient’s participation in the program including understanding the importance of therapeutic compliance (see hypertension example above). If any barriers are identified, the Social Worker, in coordination with the Care Manager, may work towards educating the patient and family in an attempt to remove such barriers.

Coordination – As part of the care plan for a patient, many external resources may be utilized to best ensure that a patient is meeting the goals of his care plan. These external resources could include: smoking cessation, weight loss, disease condition educational classes, and exercise programs. The social worker can assist the Care Manager in coordinating these resources for the patient and his/her family.

Education – In some cases, external resources may not exist in a community for programs such as smoking cessation (e.g., NYS Smokers Quit line) or weight loss. In this case, the Social Worker might be best suited amongst the care coordination team to run these classes on behalf of the POD.

Counseling – Changing behavior is a very difficult process for many people and the patients that will be included in this program already have many social and economic difficulties they are dealing with. As such, the Social Worker will create support groups to provide the additional emotional support to help keep the patients engaged in the program. In addition, the Social Worker should also be available on an as needed basis to provide individualized support to the patients in the program.

Care Manager
Care delivery can occur at the hospital, at both the primary care and specialist’s offices, in the community, or at the pharmacy. As these services can be provided by multiple different people in multiple locations, it is critical that one person is responsible for the care plan for each patient. This is the role of the Care Manager who must not only create the care plan, in collaboration with the patient’s primary care physician, but also must coordinate all care provided by community resources. As such, one of primary roles of the Care Manager is to gain familiarity with the patient’s medical plan of care in its entirety so they may seek to intervene early to maintain or improve the patient’s health status using multiple interventions.
Once a patient has been identified and accepted for Care Management services, the Care Manager will assume responsibility for assessment, coordination and intervention, communication, education and ongoing monitoring and evaluation. However, it is important to understand that while in some cases the Care Manager may provide some of these services, the primary role of the Care Manager is to coordinate the care provided on behalf of the patient, regardless of who is providing the care and where it is delivered.

Although the sequence of Care Management activities is generally the same, the plan for each care-managed patient is unique to the particular circumstances of the individual patient. Thus, the individualized plan of care for patients with the same diagnosis or condition can vary widely based on variations in support systems, geographic areas, provider and community resource availability and psychosocial elements.

Once a patient has been identified as meeting the guidelines via the process outlined above, a Care Manager will assume responsibility for gathering information necessary to accurately assess the patient’s needs. Information, obtained from the patient, electronic medical records, and any providers, is then analyzed by the Care Manager. The Care Manager utilizes an assessment tool to determine the patient’s readiness for the care management program. As discussed in the stratification section above, one of the initial goals of care management is to identify patient readiness as well as any barriers, problems, or issues the patient or family may have in self-managing the condition. Another goal of Care Management is the development of an individualized patient-centered plan of care based on risk and patient goals.

Following a patient’s enrollment, the Care Manager explores the various options available to meet the patient’s individual needs. Input from the patient and all providers is essential in the development of an effective and successful individualized plan of care. It is important that in developing this plan, the Care Manager leverages information from multiple sources of clinical data while not just focusing on information known to the PCP’s office. This should include information from the hospital to determine if the patient is a “frequent flyer,” and information from the pharmacy to determine if the patient has been compliant with medications. In the ideal world, this information is readily available in the patient’s electronic chart.

The Care Manager will work with the patient and/or caregivers to identify the areas for intervention. Interventions typically include:

1. Self-Management Education;
2. Skills Review;
3. Symptom Monitoring;
4. Medication Management;
5. Condition Monitoring – i.e., annual dilated eye exam; annual foot exam; etc;
6. Individualized Plan of Care;

During planning each problem area is tied to a corresponding expected outcome (goal) and a patient-centered individualized plan of care is developed. The individualized plan of care may include both short term and long-term goals; time frames for follow-up and evaluation, resources to be utilized, collaborative approaches, rationale for closure for anticipated outcomes. The individualized plan of care is created with the patient for the purpose of promoting self-management of the patient’s disease.

The Care Manager is responsible for determining whether a Clinical Social Worker and/or Clinical Pharmacist could be beneficial in assisting in the development and delivery of the individualized plan of care.

After an individual individualized plan of care is established, the Care Manager assumes a lead role in communicating the plan to the appropriate parties. The Care Manager is also responsible for coordinating additional resources including but not limited to:

1. Referral to Self-Management Support Service (such as a Certified Diabetes Educator)
2. Contact with the Clinical Social Worker assigned to Care Management
3. Interaction with the Clinical Pharmacist related to medication regimes, etc.
4. Referral to other community resources for self-management support or additional care management services

Care Management is a dynamic process, and once implemented, requires careful monitoring and adjustment of the individualized care plan by the Care Manager as needed. Assessment of the overall effectiveness of the plan in progressing the patient toward established goals, providing quality outcomes, and containing costs is ongoing. Plans deemed ineffective are revised as needed to maintain continual progress, establish new goals and maintain quality.

Given the extent of the Care Manager’s role and the importance of this individual to the care coordination team, a sample job description is included below.

**Care Manager’s Job Description**

I. **Qualifications:**
   A. Current New York State R.N. license required.
   B. B.S. Degree preferred.
   C. CPHQ required within two years.
   D. Minimum five years of broad current clinical nursing experience, to include specialty units
   E. Quality assurance/risk management occurrence investigation experience required.
   F. A high level of interpersonal skills and professional poise to interact with Medical Staff, other department staff, and Medical Center management is required.
G. Assessment and goal setting skills, project/time management skills, and problem solving skills are required.

H. Knowledge of Department of Health, JCAHO, Medicare, and Long Term Care regulations is required.

I. Knowledgeable in managed care processes is required.

J. Computer skills required.

K. Good writing skills.

L. Working knowledge of statistical tools.

M. Performance Improvement teaching skills required (able to teach PI to hospital staff).

N. Utilization review and discharge planning experience preferred.

O. Knowledge of the prospective payment system and current insurers payment methodologies, coding and sequencing, and data collection and analysis.

P. Education and presentation experience preferred.

As applicable, the individual has training/competency in attending to the special needs and/or behaviors appropriate to the age of the patients for which care is being provided.

II. Job Description:

The Care Manager will monitor and analyze data and identify where care coordination is needed in the specific patient populations identified for this program. The Care Manager will also work with physicians, hospital discharge planners, social workers, pharmacists, and others as appropriate, to develop and monitor the care plan for each patient based on the guidelines of this program.

The Care Manager utilizes his/her skills to coordinate internal and external resources to facilitate appropriate resource management of an age specific patient population which spans from newborns to geriatrics, identifying opportunities for process improvement, high risk cases and sentinel events, to the achievement of an acceptable outcome.

Questions and considerations presented to each POD are outlined below:

1. Describe in detail the clinical process adopted by the Pod to achieve care coordination, after careful consideration of the disease specific clinical guidelines, that will work to deliver the targeted clinical and financial outcomes.

2. These care coordination processes must reflect the available technologies, ongoing clinical initiatives, and available community resources.

3. In development of these clinical processes, consideration of existing best practices must be taken into account. This will form a road map of the best practice clinical processes for the Pod.

Table 4 details the considerations taken by each POD in delivering an expansive list of clinical interventions provided by a diverse team of professionals to achieve targeted clinical and financial outcomes.
Clinical Encounter

Utilizing the guidelines for each disease while considering the resources available in each practice, describe the clinical activities that will be applied to achieve clinical and financial targets.

- **Clinical factors and interventions**
  1. Develop a list of standardized clinical services provided to patients based upon current disease state and guideline requirements
  2. Inventory community resources available for use in improving outcomes for each targeted disease
  3. Identify processes that can enhance the probability of achieving improved outcomes (e.g., removing shoes and socks of all DM patients by office staff before physician visit)

- **DM considerations**
  1. HbA1c testing and follow-up per guidelines
  2. LDL-C and lipid monitoring per guidelines
  3. Nephropathy assessment per guidelines (e.g., modified based upon set protocol for each practice/Pod – microalbumin/creatinine ration vs. 24 hour urine for microalbuminuria)
  4. Eye exam per guidelines
  5. Foot exam per guidelines
  6. BP and screening for HTN
  7. Smoking cessation per guidelines
  8. Formulary compliance

- **CAD considerations**
  1. LDL-C monitoring (per guidelines)
  2. Formulary compliance
  3. Medication education (e.g., in-office and community based)
  4. Nutritional education (e.g., HTN and obesity)

- **HTN considerations**
  1. HTN monitoring (per guidelines)
  2. Obesity screening
  3. Medication education (e.g., in-office and community based)
  4. Nutritional education (e.g., HTN and obesity)
  5. Formulary compliance

- **Ped – Prevention considerations**
  1. Immunizations per guidelines

- **Ped – Obesity considerations**
  1. Patient and family nutrition education
  2. Lab values (per guidelines and practice preferences – e.g., LDL-C, glucose, HbA1c)

- **Ped – Asthma considerations**
  1. Appropriate medication use
  2. Formulary compliance

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<tr>
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<tbody>
<tr>
<td>Clinical Encounter</td>
<td>Utilizing the guidelines for each disease while considering the resources available in each practice, describe the clinical activities that will be applied to achieve clinical and financial targets.</td>
<td>Detailed and comprehensive description of services to be provided to each patient for each targeted disease. Includes the clinical and other resources provided to deliver the services.</td>
</tr>
<tr>
<td><strong>Clinical factors and interventions</strong></td>
<td>1. Develop a list of standardized clinical services provided to patients based upon current disease state and guideline requirements&lt;br&gt;2. Inventory community resources available for use in improving outcomes for each targeted disease&lt;br&gt;3. Identify processes that can enhance the probability of achieving improved outcomes (e.g., removing shoes and socks of all DM patients by office staff before physician visit)</td>
<td>Each pod will determine what the allocation of resources to each of these measures. Availability of community resources will impact the effort applied to achieve specific outcomes.</td>
</tr>
<tr>
<td><strong>DM considerations</strong></td>
<td>1. HbA1c testing and follow-up per guidelines&lt;br&gt;2. LDL-C and lipid monitoring per guidelines&lt;br&gt;3. Nephropathy assessment per guidelines (e.g., modified based upon set protocol for each practice/Pod – microalbumin/creatinine ration vs. 24 hour urine for microalbuminuria)&lt;br&gt;4. Eye exam per guidelines&lt;br&gt;5. Foot exam per guidelines&lt;br&gt;6. BP and screening for HTN&lt;br&gt;7. Smoking cessation per guidelines&lt;br&gt;8. Formulary compliance</td>
<td>Inventory and utilize available community resources</td>
</tr>
<tr>
<td><strong>CAD considerations</strong></td>
<td>1. LDL-C monitoring (per guidelines)&lt;br&gt;2. Formulary compliance&lt;br&gt;3. Medication education (e.g., in-office and community based)&lt;br&gt;4. Nutritional education (e.g., HTN and obesity)</td>
<td>Inventory and utilize available community resources</td>
</tr>
<tr>
<td><strong>HTN considerations</strong></td>
<td>1. HTN monitoring (per guidelines)&lt;br&gt;2. Obesity screening&lt;br&gt;3. Medication education (e.g., in-office and community based)&lt;br&gt;4. Nutritional education (e.g., HTN and obesity)&lt;br&gt;5. Formulary compliance</td>
<td>Inventory and utilize available community resources</td>
</tr>
<tr>
<td><strong>Ped – Prevention considerations</strong></td>
<td>1. Immunizations per guidelines</td>
<td>Inventory and utilize available community resources</td>
</tr>
<tr>
<td><strong>Ped – Obesity considerations</strong></td>
<td>1. Patient and family nutrition education&lt;br&gt;2. Lab values (per guidelines and practice preferences – e.g., LDL-C, glucose, HbA1c)</td>
<td>Inventory and utilize available community resources</td>
</tr>
<tr>
<td><strong>Ped – Asthma considerations</strong></td>
<td>1. Appropriate medication use&lt;br&gt;2. Formulary compliance</td>
<td>Inventory and utilize available community resources</td>
</tr>
</tbody>
</table>

Table 4

Patient Monitoring and Follow-up – Acute Phase

After patients receive care through clinical encounters, the results of those interventions require monitoring and follow-up as appropriate. There are two phases of this follow up, an
acute phase and a longitudinal monitoring phase. The goal of the acute phase is to get the patient to a treatment plan that is stable whereas the goal of the longitudinal phase is to continue evaluating the patient’s status on a periodic basis, such as every 6 months, and adjust the plan as necessary.

During the acute phase, frequent monitoring must occur until a stable care plan can be established. As such, this process can be iterative. During this phase, results include laboratory tests, completion of referral visits (e.g., podiatrist, diabetes educator, pharmacist, social worker) and participation in community-based programs (e.g., diet program, exercise classes) will be evaluated. Only through follow-up of results will patients be more likely to complete the necessary treatment program prescribed by their physician. These activities assist patients in managing their chronic disease, an often difficult burden for anyone irrespective of their socioeconomic status. This phase will continue until meds, if appropriate, are no longer being adjusted and tests are no longer being ordered on a routine basis.

Table 5 describes some of the consideration each POD evaluating in their development of processes and workflows to achieve specific outcomes. Questions and considerations presented to each POD are outlined below.

1. Describe in detail the follow-up steps to be prescribed to ensure continuity of care for the patient after each clinical encounter.

2. Consider the factors noted in the below table for “Patient Follow-up” and develop detailed processes to achieve targeted clinical and financial outcomes.
   a. Of significant important is the clinical decision support that staff will follow to direct patients to their next clinical encounter or referral to clinical services.
   b. This clinical decision support must reflect best clinical practice and availability of resources. In addition, its detail must be robust enough to ensure a low level of variability among personnel providing this service.
   c. Both available Pod (e.g., pharmacist, nurse, social worker, clinics) and community resources must be reflected in the clinical decision support algorithms provided.

| Patient Monitoring and Follow-up – Acute Phase | Follow-up on clinical patient visits (ambulatory and hospital), patient appointments for testing, education, etc. Monitor lab results and utilize these results in decisions on follow-up (e.g., repeat office visit, further testing, prescribed medication or intervention) | Each clinical encounter generates a follow-up activity. These include the need to schedule another office visit or a longer list of required services. Each prescribed intervention requires monitoring of results and a clinical decision to be made on next steps in treatment. |
Specific, explicit criteria are required to govern the clinical decision process during this phase of patient management.

<table>
<thead>
<tr>
<th>Develop patient follow-up methodology</th>
<th>Create flow chart of each clinical activity requiring follow-up and assigning the appropriate resource to that activity. At each decision point, clinical rules, where appropriate, must be assigned to direct consistent care.</th>
</tr>
</thead>
</table>
| **DM considerations**                 | 1. HbA1c testing and follow-up per guidelines (if not done before clinical visit)  
2. LDL-C and lipid monitoring per guidelines (if not done before clinical visit)  
3. Nephropathy assessment per guidelines (e.g., modified based upon set protocol for each practice/Pod – microalbumin/creatinine ration vs. 24 hour urine for microalbuminuria) (If not done before clinical visit)  
4. Eye exam per guidelines (includes scheduling and reporting results)  
5. Foot exam follow-up (e.g., podiatrist care)  
6. HTN nutritional education (e.g., education, enrollment)  
7. Smoking cessation education (e.g., education enrollment, coordinate community resources)  
8. Medication compliance (e.g., prescription filled, education) |
| **CAD considerations**                | 1. LDL-C testing and monitoring per guidelines (if not done before clinical visit)  
2. Medication education and compliance (e.g., in-office and community based)  
3. Nutritional education (e.g., HTN and obesity, enrollment, coordinate community resources) |
| **HTN considerations**                | 1. Medication education and compliance (e.g., in-office and community based)  
2. Nutritional education (e.g., HTN and obesity, enrollment) |
| **Ped – Prevention considerations**   | 1. Coordinate community resources to achieve measures (e.g., scheduling, education) |
| **Ped – Obesity considerations**      | 1. Patient and family nutrition education (e.g., enrollment, coordinate community resources)  
2. Follow-up of lab values (per guidelines and Pod preferences – e.g., LDL-C, glucose, HbA1c) leading to appropriate clinical interventions (e.g., medications) |
| **Ped – Asthma considerations**       | 1. Appropriate medication use  
2. Medication compliance  
3. Medication reconciliation upon ER or hospital discharge  
4. Patient follow-up upon ER or hospital discharge |

*Table 5*

**Care Delivery Monitoring – Longitudinal**

Upon completion of care delivery and follow up of results, patients require longitudinal monitoring to ensure they receive the proper interventions at the required intervals. Examples
of such interventions include regular blood pressure testing for patients with hypertension, HbA1c testing at guideline prescribed intervals for diabetics; and regular weigh-ins and review of food diaries of patients struggling with obesity. Such interventions are described in detail in clinical treatment guidelines which can be found later in this document. Table 6 describes some of the consideration presented to each POD in their development of their processes and workflows.

Additionally, during this phase of the program, patients are monitored for continued behavior that should be decreased if the interventions are working properly, such as:

- Frequent preventable hospital admissions
- Frequent use of the hospital Emergency Department
- Poor medication compliance
- Missed lab tests
- Missed appointments
- Lab tests trending in the wrong direction

While the goal is to monitor the patient’s progress towards healthier behavior and better management of their chronic condition, it is necessary to realize that some patients will slide back into their old habits and others will find compliance with their prescribed treatment too difficult. For others who are compliant, the treatment will be deemed ineffective. Therefore, it is important to not only look for progress, but to monitor for problems and concerns so these can be addressed immediately.

In addition, standard, actionable reports are required to monitor the impact of the delivered interventions for each disease so that the program can be modified if deemed to be falling short of targeted outcomes. Physicians and other clinical care providers must be given a summary report of the effectiveness of their interventions in an effort to encourage the continuation of effective practices or the modification of less satisfactory ones. Each POD should develop a communication strategy, including the formulation of required reports, to engage clinical team members in a process of continuous improvement of processes and workflows that can deliver targeted outcomes.

The reporting methodology should be as follows:

- Quality care and evaluation program to be developed
  - Data Collection
    - What types of information to be included?
      - Disease type
      - Intervention(s)
• Age
• Clinical results
  o Weight
  o Lab results
• Medications
• Subjective assessment
  o Business intelligence tool to be developed
    ▪ Standard actionable reports available on a weekly and monthly basis
    ▪ Ad-hoc reporting capability
  o Population Health Management reports
    ▪ Ability to trend changes in overall population based on disease state and intervention approach
    ▪ Identification of protocols that worked vs. those that need enhancement
• Who are reports to be shared with?
  o All PCPs in POD
  o Hospital personnel
  o Specialists in POD
  o Other members of the care coordination team
• Distribution approach for reports
  o All reports to be available via centralized reporting tool – preferably via the web
  o For those individuals not able to access the reporting tool (or if this is not yet in place), reports to be faxed on an periodic basis
    ▪ Timeline for reports to be created

Questions and considerations presented to each POD are outlined below.

1. Describe in detail the processes, including decision points that will be used to monitor patients in an effort to identify those that will require outreach and a “re-entering” of the care delivery cycle.

2. Emphasis should be on the proactive measures that help ensure practices are following targeted disease guidelines in their effort to satisfy agreed to clinical and financial outcome metrics.
   a. This activity helps ensure that patients remain within the disease management road map for each disease.

<table>
<thead>
<tr>
<th>Patient Monitoring – Longitudinal</th>
<th>Monitor patients per guidelines and refer to patient outreach as required</th>
<th>Using guidelines, determine when patients require clinical interventions and engage patient outreach to return them to clinical care flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient registry</td>
<td>Track patients on their continuum of care, proactively</td>
<td>Emphasis is on proactive</td>
</tr>
</tbody>
</table>
referring them to patient outreach to help ensure compliance with disease guidelines. interventions that promote continuity of care, preventive services and monitoring and treatment compliance with disease guidelines

- DM considerations
- CAD considerations
- HTN considerations
- Ped – Prevention considerations
- Ped – Obesity considerations
- Ped – Asthma considerations

| Table 6 |
|---------------------------------|-------------------------------------------------|
| Quality Of Care Programs        | In addition to utilizing a standardized process to guide activities, all three PODS will be utilizing the same evidence-based guidelines to provide care to those participating in the program. The guidelines are discussed below. |
| Obesity Screening and Management in Pediatric Patients | This evidence-based treatment plan is based on clinical guidelines from the following: Prevention and Treatment of Pediatric Obesity: An Endocrine Society Clinical Practice Guideline Based on Expert Opinion; Gilbert P. August, Sonia Caprio, Ilene Fennoy, Michael Freemark, Francine R. Kaufman, Robert H. Lustig, Janet H. Silverstein, Phyllis W. Speiser, Dennis M. Styne, and Victor M. Montori. This was originally published in the *Journal of Clinical Endocrinology and Metabolism* 2008 93:4576-4599 and originally published online Sep 9, 2008;, doi: 10.1210/jc.2007-2458. |
| Obesity is known to occur in up to 18% of children in the United States and is also considered a worldwide epidemic. Obesity in children increases the risk of early onset insulin dependent diabetes, hypertension, non-alcoholic fatty liver and elevated lipid levels in the blood stream. Along with significant psychological and social impact the epidemic of obesity has multiple long term effects in children. Children as young as two years old with a BMI of >95 have an increased risk for adult obesity and the subsequent health problems associated including early morbidity and mortality. Although BMI may identify some “false positive” obese children who have a high muscle mass, those patients should be identified by the PCP and be excluded from the obesity interventions. By screening in a systematic fashion and intervening in a consistent and community wide manner, childhood obesity may be treated and adult obesity may be prevented. Patients will be diagnosed with obesity and included for treatment in this program after considering the following: |
1. Children between 2 and 18 years old will have height, weight and BMI calculated at all preventive care visits. CDC-derived normative percentiles are the preferred method for the diagnosis of the overweight or obese child.

2. Children will be diagnosed as overweight if the BMI is at least in the 85th percentile but < the 95th percentile and obese if the BMI is at least in the 95th percentile for age and sex.

3. Unless the child’s height velocity, assessed in relation to stage of puberty and family background, is attenuated recommend against a routine laboratory evaluation for endocrine causes of obesity.

4. Consider referral to a geneticist for children whose obesity has a syndromic etiology, especially in the presence of neurodevelopmental abnormalities. Parents of children who have inexorably gained weight from early infancy and have risen above the 97th percentile for weight by 3 yr of age be informed of the availability of MC4R genetic testing. However, the test is positive in only 2%–4% of such patients who are above the 97th percentile for weight and currently will not alter treatment.

The goals of treating this population of patients include:

1. Identify and categorize patients at risk and with obesity
2. Decrease the percentage of children entering categories of at risk for obesity, obese, and severely obese.

The standardized treatment plan for all pediatric patients identified with asthma is as follows:

A. Prescribe and support intensive lifestyle (dietary, physical activity, and behavioral) modification to the entire family and to the patient, in an age-appropriate manner, for all overweight and obesity treatments for children and adolescents.

B. Prescribe and support healthy eating habits such as:
   • Avoiding the consumption of calorie-dense, nutrient-poor foods (e.g. sweetened beverages, sports drinks, fruit drinks and juices, most “fast food,” and calorie-dense snacks).
   • Controlling caloric intake through portion control in accordance with the Guidelines of the American Academy of Pediatrics
   • Reducing saturated dietary fat intake for children older than 2 yr of age.
   • Increasing the intake of dietary fiber, fruits, and vegetables.
   • Eating timely, regular meals, particularly breakfast, and avoiding constant “grazing” during the day, especially after school.

C. Prescribe and support 60 min of daily moderate to vigorous physical activity and a decrease in time spent in sedentary activities, such as watching television, playing
video games, or using computers for recreation. Screen time should be limited to 1–2 h per day, according to the American Academy of Pediatrics.

D. Educate parents about the need for healthy rearing patterns related to diet and activity. Examples include parental modeling of healthy habits, avoidance of overly strict dieting, setting limits of acceptable behaviors, and avoidance of using food as a reward or punishment and probe for and diagnose unhealthy intrafamily communication patterns and support rearing patterns that seek to enhance the child’s self-esteem.

E. Consider pharmacotherapy (in combination with lifestyle modification) if a formal program of intensive lifestyle modification has failed to limit weight gain or to mollify comorbidities in obese children. Overweight children should not be treated with pharmacotherapeutic agents unless significant, severe comorbidities persist despite intensive lifestyle modification. In these children, a strong family history of T2DM or cardiovascular risk factors strengthens the case for pharmacotherapy. Pharmacotherapy will only be offered by clinicians who are experienced in the use of anti-obesity agents and are aware of the potential for adverse reactions.

In addition to the treatments followed above, all participating providers will work to prevent the onset of childhood obesity. These include:

A. Encourage breast-feeding for a minimum of 6 months.

B. Promote and participate in efforts to educate children and parents by means of ongoing anticipatory guidance about healthy dietary and activity habits and, further, that clinicians encourage school systems to provide adequate health education courses promoting healthy eating habits.

C. Promote and participate in efforts to educate the community about healthy dietary and activity habits.

D. Clinicians advocate for regulatory policies designed to decrease the exposure of children and adolescents to the promotion of unhealthy food choices in the community (e.g. by media advertisements targeting children and adolescents).

E. Clinicians advocate that school districts ensure that only nutritionally sound food and drinks are available to children in the school environment, including the school cafeteria and alternative sources of food such as vending machines.

F. Advocate for parental participation in the design of school-based dietary or physical activity programs and that schools educate parents about the rationale for these programs to ensure their understanding and cooperation.

G. Advocate for other community and policymaker plans, programs and incentives.
Participating providers will be aware of and work to overcome social barriers through the following efforts:

1. Advocate for regulatory policies designed to decrease exposure of children and adolescents to the promotion of unhealthy food choices in the community (e.g. by media advertisements targeting children and adolescents.)
2. Clinicians advocate that school districts ensure that only nutritionally sound food and drinks are available to children in the school environment, including the school cafeteria and alternative sources of food such as vending machines.
3. Advocate for parental participation in the design of school-based dietary or physical activity programs and that schools educate parents about the rationale for these programs to ensure their understanding and cooperation.
4. Advocate for other community and policymaker plans, programs, and incentives.

Each participating practice will evaluate and report the following measures:

1. All children starting at 24 months and continuing through 18 years of age will have BMI measurements taken at each preventative visit or at a minimum of once per year.
2. Patients with a BMI at the 85th percentile or higher will be evaluated for overweight/obesity associated co-morbidities (metabolic syndrome) which includes lipid profile, fasting glucose, HbA1c, and blood pressure testing at least once per year.
3. Patients with a BMI at the 85th percentile or higher will have themselves and their families prescribed, in an age appropriate manner, intensive lifestyle (dietary, physical activity, behavioral) modifications.

Asthma Management in Pediatric Patients

This evidence-based treatment plan is based on clinical guidelines from the following:

Asthma is the most common chronic illness in children. These guidelines were created to ensure national standards of asthma care are applied to pediatric patients in the Adirondack Medical Home Pilot.

Children known to have greater than two courses of systemic steroids in a six month period and children with hospitalizations and emergency department visits caused by asthma exacerbations are at risk for more acute exacerbations as well as impairment of quality of life. The methods of care and recommendations focus on reducing those risk factors.
Each participating practice across all PODs will identify, treat, and standardize care for all children diagnosed with asthma will receive standard treatment plan to ensure optimized care. Patients with asthma will be diagnosed by history and direct assessment. The direct assessment may include tools such as a physical exam, peak flow meter assessment, and pulmonary function tests. Pediatric patients between 5 and 18 years old with a diagnosis of asthma will be identified on an annual basis.

The goals of treating this population of patients include:

1. Reduce hospitalizations caused by acute asthma exacerbations
2. Reduce emergency department visits caused by acute asthma exacerbations
3. Decrease use of systemic steroids in children with asthma

The standardized treatment plan for all pediatric patients identified with asthma is as follows:

Patients who experience symptoms that suggest the diagnosis of asthma will be assessed for the diagnosis.

Patients diagnosed with asthma will:

A. be assessed and monitored for severity using both impairment and risk domains
B. have a spirometry measurement (FEV, FVC, FEV,/FVC) in all patients ≥ 5 years old before and after the patient inhales a SABA
C. be assessed for self-management skills, including medication administration technique
D. be prescribed appropriate pharmacological therapy and peak flow meters based on severity assessment
E. have a seasonal influenza vaccination annually
F. have a quarterly visit with their primary care provider
G. have a written Asthma Management Plan that is developed in conjunction with the patient’s caregiver(s) and ongoing education as needed;
H. have environmental factors and co-morbid conditions assessed and counseling provided to control/reduce exposure; and
I. be monitored at least at 2-6 week intervals until control is achieved
J. have an annual asthma control test once control is achieved

Each participating practice will monitor and report to their respective POD the following measures:

1. The number of emergency department visits of patients with a diagnosis of asthma and a discharge diagnosis of asthma during the measurement period
2. The number of emergency department visits of patients with a diagnosis of asthma and a discharge diagnosis of asthma during the measurement period compared to the previous number (trend)
3. The number of admissions of patients with diagnosis of asthma and a discharge diagnosis of asthma during the measurement period
4. The number of admissions of patients with diagnosis of asthma and a discharge diagnosis of asthma during the measurement period compared to the previous number (trend)
5. The use of appropriate medication in the treatment of asthma, i.e. the percentage of in patients ages 5 - 18 years identified with asthma who received Rx for long term control of asthma (inhaled corticosteroids, cromolyn sodium, nedocromil, leukotriene modifiers, methylxanthines)
6. The number of patients with diagnosis of asthma that received an influenza vaccination annually
7. The number of patients with a diagnosis of chronic asthma that received a quarterly visit with their primary care provider during each twelve month period

Preventive Care in Pediatric Patients
This evidence-based treatment plan is based on clinical guidelines outlined in the MMWR January 8, 2010 / 58(51&52); 1-4,
http://aapredbook.aappublications.org/resources/lZSchedule0-6yrs.pdf
http://www.health.state.ny.us/publications/2378.pdf

Preventive care guidelines in pediatrics encompass a broad range of healthcare topics. For purposes of this program, focus will be on the following areas:

1. Immunizations
2. Obesity screening
3. Lead and anemia testing

Each participating pediatric patients across all PODs will receive preventive care as recommended by the American Academy of Pediatrics, the ACIP, and the New York State Department of Health.

The standardized treatment plan to ensure pediatric patients receive preventative services includes:

A. Childhood Immunizations—(series must be completed by age 2)
   a. 4 DTaP/DT (none prior to 42 days of age)
   b. 3 IPV (none prior to 42 days of age)
   c. 1 MMR
d. 3 HIB (none prior to 42 days of age)
e. 3 hepatitis B
f. 2 hepatitis A
g. 1 VZV, or documented chicken pox disease (or positive serology) occurring prior to 2nd birthday
h. 4 pneumococcal conjugate
i. 2-3 rotavirus
j. 2 influenza

B. Obesity:
   a. Children between 2 and 18 will have BMI assessments completed at preventive visits
   b. Children between 16 and 18 will also have a lipid profile and fasting glucose completed annually

C. Lead screening:
   a. Children at age 2 will have had at least one lead screening test, and one anemia screening test

Each POD will determine the appropriate goal for compliance for their participating practices. However, each practice will monitor and report to their respective POD the following measures:
1. Percentage of pediatric patients 2-18 years old with height and weight measured who have BMI calculated
2. Percentage of pediatric patients 16-18 years old with an annual lipid profile and glucose screening completed
3. Percentage of children who have had at least one lead test by age two
4. Percentage of children receiving recommended immunizations by age two:
   a. 4 DTaP/DT (none prior to 42 days of age)
   b. 3 IPV (none prior to 42 days of age)
   c. 1 MMR
d. 3 HIB (none prior to 42 days of age)
e. 3 hepatitis B
f. 2 hepatitis A
g. 1 VZV, or documented chicken pox disease (or positive serology) occurring prior to 2nd birthday
h. 4 pneumococcal conjugate
i. 2-3 rotavirus
j. 2 influenza
Hypertension Management in Adult Patients

This evidence-based treatment plan is based on clinical guidelines from the following: Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), the US Department of Health and Human Services, National Institute of Health and National Heart, Lung and Blood Institute. For more information and updates visit www.nhlbi.nih.gov.

High blood pressure (hypertension) is prevalent, results in costly intervention and/or death if not treated and managed; however, high blood pressure is easily detected and usually controllable. About 74.5 million people in the United States age 20 and older have high blood pressure, which translates to roughly one in three adults. Of those people with high blood pressure, 77.6 percent were aware of their condition. Of those aware of their condition, 67.9 percent were under current treatment; 44.1 percent had it under control, and 55.9 percent did not have it controlled. In addition, those with the highest rates of hypertension are more likely to be middle aged or older, less educated, overweight or obese, physically inactive, and to have diabetes.

Each participating practice across all PODs will identify and report standardized measures for all adults diagnosed with chronic, stable coronary artery disease. When determined appropriate by the treating physician, patients will receive standard treatment plan to ensure optimized care. Patients with hypertension will be diagnosed by history and direct assessment.

For inclusion in the measurement aspect of this guideline the patient must meet all of the following criteria:

1. Patient is age 35 or older;
2. Patient must have had a history of hypertension for at least 12 months; and
3. Patient must have been under the care of the physician or physician group for at least 12 months.

The goals of treating these patients include:

1. Blood Pressure Control
   - 75% of patients will have blood pressure < 140/90 mm Hg on their most current reading
2. Lipid Control
   - 80% of patients will have a complete lipid profile completed annually
   - At least 50% of patients have an LDL < 100 mg/dl
3. Lifestyle modification
   - At least 80% of patients have documentation of weight and BMI and appropriate counseling if BMI > 25 kg/m²
At least 80% of patients have documentation of their smoking status and receive cessation advice or treatment if they are a smoker.

The standardized treatment plan for all patients with hypertension is as follows:

A. Be seen at least twice a year at the PCP office to monitor and manage symptoms and assess risk factors.
B. Have a blood pressure reading, weight and BMI at every visit.
C. Have a complete lipid profile annually (includes total cholesterol, high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C) and triglycerides.)
D. Have an electrocardiogram obtained as part of diagnostic work-up.
E. Have smoking status determined at least annually and receive smoking cessation counseling and intervention were recommended.
F. Receive information/counseling on lifestyle modification such as weight reduction, DASH eating plan, dietary sodium reduction, aerobic physical activity and moderation of alcohol consumption, if appropriate.
G. Be prescribed appropriate medications to treat their hypertension, initial drug choices as follows:
   a. Without Compelling Indications
      i. Stage 1 Hypertension (SBP 140-159 or DBP 90-99 mmHg): Thiazide-type diuretics for most. May consider ACEI, ARB, BB, CCB, or combination
      ii. Stage 2 Hypertension (SBP ≥ 160 or DBP ≥ 100 mmHg): 2-drug combination for most (usually thiazide-type diuretic and ACEI, ARB, BB or CCB)
   b. With Compelling Indications:

Each participating practice will monitor and report to their respective POD the following measures:

1. Blood Pressure Control
   a. Percentage of patients with blood pressure < 140/90 mm Hg
2. Complete lipid profile
   a. Percentage of patients with having an annual complete lipid profile
   b. Percentage of patients with LDL < 100 mg/dl
3. Smoking Status and Cessation Advice
   a. Percentage of patients with of patients with documentation of their smoking status and receive cessation advice or treatment if they are a smoker
4. BMI
a. Percentage of patients with documentation of weight and BMI and appropriate counseling if BMI $\geq 25$ kg/m$^2$

*Diabetes Management in Adult Patients*

This evidence-based treatment plan is based on clinical guidelines outlined in “Randomized Trial of a telephone Care-Mangement Strategy” conducted by David E. Wennberg, M.D., M.P.H., Amy Marr, PhD., Lance Lang, M.D., Stephen O’ Mailley, M. Sc., George Bennett, PhD and “Management of Blood Glucose in Type 2 Diabetes Mellitus” by Cynthia M. Ripsin, MD, MS, MPH; Helen Kang, MD; and Randall J. Urban, MD, University of Texas Medical Branch, Galveston, Texas published in *Am Fam Physician*. 2009 Jan 1;79(1):29-36.

Adult diabetic patients are the focus, so only patients with a diagnosis of Diabetes – 250.xx or Glucose intolerance (fasting glucose above 110) – 290.71 and over the age of 18 will be included. This criteria specifically attempts to identify those patients not yet carrying the diagnosis code 250.xx but who are becoming insulin resistant and thus at risk of developing DM. They will require further testing and clinical evaluation.

The goals of treating these patients include:

1) Reduction in number of hospital admissions related to DM
2) Reduction in number of ER visits related to DM
3) Reduction in number of lower extremity amputations (e.g., toes, foot, lower leg)
4) Reduction in incidence of patients with diabetic retinopathy
5) Reduction in incidence of patients with diabetes related coronary artery disease (e.g., myocardial infarction)
6) Reduction in incidence of patients with diabetes related nephropathy

Patients identified for inclusion will be stratified into the following three categories:

1. Low risk: At least 2 HGBA1C$< 8$ in the last 12 months
2. Moderate risk: At least one HGBA1C above 8 but less than 9 in the past 12 months.
3. High risk: At least one HGBA1C over 9 in past 12 months.

Some providers can measure HGBA1C in their office. This information may not be part of formal lab reports and thus, not readily accessible by the POD for stratification. Those providers will have to work with their EMR vendors and the POD to ensure that office based HGBA1C data is readily captured in the patient’s EMR. That will ensures patients are properly stratified.

There should be a mechanism to capture those diabetics who continue to visit an endocrinologist. Specialty visits can certainly count as a medical visit if received and reviewed by the PCP office.
The standardized treatment plan for these patients will include:

A. Patient Outreach

Once patients are identified and stratified by the POD, that list will be sent to the PCP for verification. From that point on, the PCP should review the list and confirm that all his/her diabetics/glucose intolerant patients are listed and properly stratified. If not, he/she should make the appropriate deletion/additions/corrections and share those with the POD.

From the corrected list, and using the above stratification criteria, the POD would provide support in between clinical encounters. Understandably, low risk patient will not get as intense POD follow-up as higher risk patients. A protocol will specifically describe to POD personnel the intensity of service to provide each strata of patients. The POD will function as a bridge to ensure patients remain compliant with prescribed treatments and reinforce basic self-management skills. Most importantly, the POD might play a pivotal role in ensuring patient comply with daily monitoring and recording of fingersticks. Daily glucose monitoring allow patients to assess their control in real time and aid providers in adjusting therapies at follow-up visits.

Protocol:

Low risk patients: Monthly phone call querying degree of compliance with glucose monitoring, diet. Average phone call may only last 5 to 10 minutes. Brief review of need for annual eye exam and flu shot, routine medical visit.

Moderate risk patients: Same as above but phone call will be made twice a month. More attention will be placed on frequency of testing and actual FS values. Inquiries will also to be made about compliance with therapeutic regimen and perceived obstacle to adherence to treatment.

High risk patients: Same as moderate risk patients but phone calls may be weekly and may last much longer. More details to be obtained about perceived obstacle to therapeutic compliance and strategy to be offered to patient to overcome them. Ideally, the educator contacting these patients will have handy medication list and basic labs to set up specific goals to be achieved. Each week, the educator will review progress and if appropriate, set new goals. Educators will remain in close communication with PCP.

A number of studies suggest that regular phone follow-up, perhaps weekly, can improve compliance with glycemic monitoring. Initially, the POD might focus its resources on the highest risk patients.
At this stage, the POD functions will include:

- Producing accurate list of names and other demographic information of all diabetic patients in our area;
- Stratifying this list based on criteria set by the Quality Committee;
- Hiring and training qualified staff that will carry out patient intervention; this approach, although proven successful, is labor intensive. It will require certified diabetic educators, RN, dieticians to contact patients on a regular basis.
- Providing all IT and other logistical support necessary for patient outreach;
- Developing and maintaining documentation system to be used by educators;
- Alerting PCP if recurrent hyper or hypoglycemia is detected.

Other uses of the POD might include:

- Building close relationships with local gyms and negotiating preferential rates for our diabetic patients to encourage them to exercise more regularly;
- Expanding existing diabetic education in our area to make them more accessible to our diabetics;
- Building a website dedicated to diabetic patients in the North Country. This website would list local resources available to our patients and include links to national and state organizations dedicated to Diabetes.
- Enlisting support from local eateries to provide healthier menus for our patients. Those who do could be featured on the Website.

B. Clinical Encounter/Patient follow-up:

These are grouped together as they complement each other. With each patient contact, the PCP needs to review recent clinical data (i.e. relevant blood work, glycemic journal, consult note) and reinforce basic principle of good diabetic care. Every attempt should be made by the office to ensure the following actions are taken:

1. Provide DM clinical visits at least twice a year at the PCP office to monitor and manage symptoms.
2. Have a comprehensive history and physical exam to include a blood pressure, weight and BMI at every visit;
3. Document annual comprehensive foot exam, annual dilated eye exam; and annual dental referral.
4. Order appropriate labwork including: A1c every 3-6 months; fasting lipid profile/cholesterol, urine microalbumin/creatinine ratio annually and serum creatinine at least annually.
5. Update flu and pneumovax if appropriate.
6. Provide counseling on tobacco use, psychosocial adjustment, sexual functioning, preconception/pregnancy,
7. Review need for aspirin therapy and ACE Inhibitor/ARB therapy, when appropriate.
8. Encourage self-management skills such as physical activity, nutrition, self monitoring blood glucose and self inspection of feet.

Here again the PCP office will need to collaborate with the EMR vendor to determine the best way to capture information not generated at his office (dilated eye exam, dental exam...)

Each participating practice will monitor and report to their respective POD the following measures:

1. Glycated Hemoglobin (HbA1c) Control
   a. % of patients with a HbA1c value > 9.0%
   b. % of patients with a HbA1c value < 8.0 %
   c. % of patients with a HbA1c value < 7.0 %
2. Blood Pressure Control
   a. % of patients with blood pressure > 130/80 mm Hg
   b. % of patients with blood pressure < 130/80 mm Hg
3. Eye Examination
   a. % of patients with having an annual retinal screening with documentation of date (or an exam 12 months prior to reporting year if exam was done and screening was negative for retinopathy.)
4. Smoking Status and Cessation Advice
   a. % of patients with documentation of their smoking status and receive cessation advice or treatment if they are a smoker
5. Lipid Control
   a. % of patients with an LDL > 130 mg/dl
   b. % of patients with an LDL < 100 mg/dl
6. Nephropathy Assessment
   a. % of patients having microalbuminuria testing or positive urinalysis or medical attention for nephropathy with documentation of date
7. Foot Exam
a. % of patients having a foot examination, with shoes and socks removed, with documentation of date. Documentation of a podiatry visit within the last year counts as it is assumed that the visit included a foot examination, with shoes and socks removed.

**Chronic, Stable Coronary Artery Disease (CAD)**

This evidence-based treatment plan is based on clinical guidelines from the following:
American College of Cardiology (ACC)/American Heart Association (AHA)
Physician Consortium for Performance Improvement (The Consortium)
For more information and updates visit The Consortium’s Web site [www.ama-assn.org/go/quality](http://www.ama-assn.org/go/quality)

Each participating practice across all PODs will **identify, treat, and standardize care** for all adults diagnosed with coronary artery disease and will deliver standard treatment plans to ensure optimized care. Patients with CAD will be diagnosed by history and direct assessment.

For inclusion in the measurement aspect of this guideline the patient must meet all of the following criteria:

1. Patient is age 35 or older;
2. Patient must have had a history of coronary artery disease for at least 12 months; and the patient must have been under the care of the physician or physician group for at least 12 months.

Chronic stable coronary artery disease (CAD) is the leading cause of mortality in the United States, accounting for almost 1 in 5 deaths. There are approximately one million Americans living with CAD. In the past two decades, the number of short-stay hospital discharges for individuals with CAD increased by almost 18%. The total cost of CAD in the United States is approximately $130 billion.

For individuals with CAD, the risk of another heart attack, stroke, and other serious complication is substantial.

Despite potential risks and established clinical guidelines, recent data suggest that some patients are not being managed optimally for this disease including less than optimal numbers of patients being prescribed beta-blockers and angiotensin-converting enzyme (ACE) inhibitor therapy post hospitalization for acute myocardial infarction (AMI) and failure to provide smoking cessation counseling post hospitalization for AMI

The goals of treating these patients include:

1. **Blood Pressure Control:** 75% of patients will have blood pressure < 140/90 mm Hg on their most current reading
2. **Lipid Control:**
80% of patients will have a complete lipid profile completed annually
At least 50% of patients have an LDL < 100 mg/dl

3. Use of Aspirin or other Antithrombotic: 80% of patients will be prescribed antiplatelet therapy (patients are excluded from this goal if antiplatelet therapy is contraindicated)

4. Smoking Status and Cessation Advice
   a. At least 80% of patients have documentation of their smoking status and receive cessation advice or treatment if they are a smoker

The standardized treatment plan for all patients with coronary artery disease is as follows:
1. Be seen at least twice a year at the PCP office to assess for anginal symptoms and manage symptoms.
2. Have a blood pressure reading, weight and BMI at every visit.
3. Have a complete lipid profile annually (includes total cholesterol, high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C) and triglycerides.)
4. Have smoking status determined at least annually and receive smoking cessation counseling and intervention were recommended.
5. Be prescribed aspirin or another antithrombin in the absence of contraindication.
6. Be prescribed drug therapy to lower LDL-cholesterol if their LDL-C > 130 md/dl simultaneously with therapeutic lifestyle changes and control of non-lipid factors.
7. Be prescribed Beta-blocker therapy if they have had a myocardial infarction in the absence of contraindications.
8. Be prescribed ACE inhibitor therapy if they have also been diagnosed with diabetes and/or left ventricular systolic dysfunction (LVSD).
9. Be screened for diabetes (typically by fasting blood glucose or 2 hour glucose tolerance testing). Screening is considered at 3-year intervals.

Each participating practice will monitor and report to their respective POD the following measures:
1. Blood Pressure Control
2. Percentage of patients with blood pressure < 140/90 mm Hg
3. Complete lipid profile
4. Percentage of patients with having an annual complete lipid profile
5. Percentage of patients with LDL < 100 mg/dl
6. Use of Aspirin or Another Antithrombic
7. Percentage of patients prescribed aspirin or another antithrombic
8. Smoking Status and Cessation Advice
9. Percentage of patients with documentation of their smoking status and receive cessation advice or treatment if they are a smoker

**Quality Measures**

Solely improving clinical measures is not sufficient to obtain the full potential benefits from implementing a medical home and associated disease management practices in a primary care practice. Additional benefit must come from cost savings generated from the efforts of the medical home. These benefits are evaluated in the following ways:

- Utilization of professional services
- Utilization of services provided by medical facilities
- Utilization of appropriate pharmaceuticals

To appropriately measure these savings, clinical outcomes must remain at baseline or higher levels to ensure that savings are not due to the withholding of necessary clinical services.

To choose the measures to be used by participating practices within all PODs, the following criteria was used:

- **Importance**
  - Relevance to stakeholders
  - Health importance
  - Applicable to measuring care distribution among various population strata
  - Potential for improvement
  - Susceptibility to influence by health care system

- **Scientific soundness**
  - Clinical
  - Explicitness of evidence
  - Strength of evidence
  - Measurement
  - Reliability
  - Validity
  - Allowance for stratification/case–mix adjustment
  - Comprehensible

- **Feasibility**
  - Explicit specification of numerator and denominator
  - Explicit description of inclusion & exclusion criteria
  - Data availability
  - Accessibility, timeliness, costs
• **Face validity** - An adequate quality indicator must have sound clinical or empirical rationale for its use. It should measure an important aspect of quality that is subject to provider or health care system control.

• **Precision** - An adequate quality indicator should have relatively large variation among providers or areas that is not due to random variation or patient characteristics. This criterion measures the impact of chance on apparent provider or community health system performance.

• **Minimum bias** - The indicator should not be affected by systematic differences in patient case-mix, including disease severity and comorbidity. In cases where such systematic differences exist, an adequate risk adjustment system should be possible using available data.

• **Construct validity** - The indicator should be related to other indicators or measures intended to measure the same or related aspects of quality. For example, improved performance on measures of inpatient care (such as adherence to specific evidence-based treatment guidelines) ought to be associated with reduced patient complication rates.

• **Fosters real quality improvement** - The indicator should be robust to possible provider manipulation of the system. In other words, the indicator should be insulated from perverse incentives for providers to improve their reported performance by avoiding difficult or complex cases, or by other responses that do not improve quality of care.

• **Application** - The indicator should have been used in the past or have high potential for working well with other indicators. Sometimes looking at groups of indicators together is likely to provide a more complete picture of quality.


Measure selection and implementation is driven by a focus on enhancing the probability of a successful project. Deploying all chosen measures at the start of the project would significantly delay the actual start of the project by greatly adding to its complexity at an early stage. Rather than overburden practices with an overabundance of new processes and complex data reporting responsibilities, criteria that provides meaningful value in measuring care for the targeted diseases but were relatively easy to deploy were chosen to be part of Phase 1 data collection.

During Phase 1, practices will learn to efficiently collect and send data to the data warehouse. At the same time, project managers will study the best practices for the collection and reporting of data. After approximately a year of data collection, the Phase 2 measures will be
re-evaluated. After re-evaluation, only those measures that will efficiently fit into the data collection processes will be deployed. It is expected that all Phase 2 measures will be deployed, but we reserve the option to modify based upon the realities of the project.

Additionally, comparative baselines will be constructed to provide evaluation of the effect of the project on both measures and the diseases targeted. As most practices are not currently designated as medical homes nor do they have the health information technology in place to efficiently collect comparative baseline data, a comparative baseline will be developed utilizing a sampling process that leverages effective processes already utilized in the collection of HEDIS measures. A comparative baseline will not be collected for all measures due to the difficulty (i.e., expense, inaccessibility) of a particular measure. This approach only applies to clinical measures. Comparative databases for both utilization and cost measures will be developed initially as the data is already available from existing data collection activities.

Once all practices have achieved medical home status and the health information technology is in place, a comparative baseline database will be constructed that includes all the clinical measures. This baseline database will be used to track trends over time for the physicians, practices, and pods. Trending of the clinical, utilization, and cost measures will be reported on a regular basis to provide feedback to project participants.

Performance regarding care provided for the following diseases will be submitted by each participating practice regardless of POD affiliation:

- Adult
  - Diabetes Mellitus
  - Hypertension
  - Coronary Artery Disease
- Pediatrics
  - Prevention
  - Obesity
  - Asthma

Comparative baselines will be constructed to provide evaluation of the effect of the project on both measures and the diseases targeted. Comparative databases for both utilization and cost measures will be developed initially as the data is already available from existing data collection activities. This baseline database will be used to track trends over time for the physicians, practices, and pods. Trending of the clinical, utilization, and cost measures will be reported on a regular basis to provide feedback to project participants. Detailed information is provided for each Phase in the remainder of the section.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
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| **Hemoglobin A1c (HbA1c)** - Percent of patients receiving one or more HbA1c test, measurement period | HbA1c is a recognized and proven measure of average patient blood sugar levels over a period of time, and therefore is used to evaluate the degree a patient’s diabetes mellitus is under control. NCQA uses this measure in evaluating health plans. When combined with the other measures in this table, it helps give an indication of how well a physician is managing diabetic patients. This measure was chosen for the following characteristics:  
  - **Importance** – major DM monitor  
  - **Scientific soundness** – Proven quality measure  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – process measure but often used to indicate level of care delivery  
  - **Precision** – high as process measure  
  - **Minimum bias** – not affected by case-mix, selection bias  
  - **Construct validity** – precedes HbA1c values  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
| **Data Source** - EHR | **Measure Result Source** – QDC |

| **Hemoglobin A1c (HbA1c)** - Percent of patients with most recent HbA1c level >9.0%, measurement period | Patients with a HbA1c level above 9% do not have their DM under proper control and therefore may indicate poor. Although some patients may not follow their prescribed care regimen, it is not expected that selection bias would deliver skewed results from the norm. This measure was chosen for the following characteristics:  
  - **Importance** – major DM monitor  
  - **Scientific soundness** – Proven quality measure  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – clinical outcome measure  
  - **Precision** – highly accepted outcome measure  
  - **Minimum bias** – minimally affected by demographic factors  
  - **Construct validity** – tightly tied to other quality measures  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
| **Data Source** - EHR | **Measure Result Source** – QDC |

| **Hemoglobin A1c (HbA1c)** - Percent of patients with most recent HbA1c level <=8%, measurement period | In some populations, patients with a HbA1c level below 8% are assumed to have their DM under proper control. Although 7% is the usual standard there is some evidence that a level below 8% in some populations is acceptable. Therefore we decided to collect data for both quality standards. This measure was chosen for the following characteristics:  
  - **Importance** – major DM monitor  
  - **Scientific soundness** – Proven quality measure  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – clinical outcome measure  
  - **Precision** – highly accepted outcome measure  
  - **Minimum bias** – minimally affected by demographic factors  
  - **Construct validity** – tightly tied to other quality measures  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
<p>| <strong>Data Source</strong> - EHR | <strong>Measure Result Source</strong> – QDC |</p>
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<th>Measure</th>
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| **Hemoglobin A1c (HbA1c)** - Percent of patients with most recent HbA1c level <=7%, measurement period | In some populations, patients with a HbA1c level below 7% are assumed to have their DM under proper control (See 8% standard elsewhere in this table). This measure was chosen for the following characteristics:  
  - **Importance** – major DM monitor  
  - **Scientific soundness** – Proven quality measure  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – clinical outcome measure  
  - **Precision** – highly accepted outcome measure  
  - **Minimum bias** – minimally affected by demographic factors  
  - **Construct validity** – tightly tied to other quality measures  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
| **Lipid** – Percentage of patients receiving at least one low-density lipoprotein cholesterol (LDL-C) test, measurement period | LDL-C is a recognized and proven measure of lipid levels that are tied to risk of CAD. As patients with DM are at a higher risk of CAD, use of this respected CAD measure is appropriate as management of CAD should be a part of any overarching management of a patient with DM. This measure was chosen for the following characteristics:  
  - **Importance** – major DM and CAD monitor  
  - **Scientific soundness** – Proven quality measure for CAD  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – process measure but often used to indicate level of care delivery  
  - **Precision** – high as process measure  
  - **Minimum bias** – not affected by case-mix, selection bias  
  - **Construct validity** – precedes LDL-C values  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
| **Lipid** – Percent of patients with Dx of DM with LDL-C < 100 mg/dl from last test done, over measurement period | LDL-C level under 100 mg/dl is a recognized indicator of lipid levels under control. As patients with DM are at a higher risk of CAD, use of this respected CAD measure is appropriate as management of CAD should be a part of any overarching management of a patient with DM. This measure was chosen for the following characteristics:  
  - **Importance** – major DM and CAD monitor  
  - **Scientific soundness** – Proven quality measure for CAD  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – clinical outcome measure  
  - **Precision** – highly accepted outcome measure  
  - **Minimum bias** – minimally affected by demographic factors  
  - **Construct validity** – tightly tied to other quality measures  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
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<tr>
<td><strong>Lipid</strong> – Percent of patients with DM with LDL-C &gt;= 130 mg/dl from last test done, over measurement period</td>
<td>LDL-C level over 130 mg/dl is a recognized indicator of lipid levels not under adequate control. As patients with DM are at a higher risk of CAD, use of this respected CAD measure is appropriate as management of CAD should be a part of any overarching management of a patient with DM. This measure was chosen for the following characteristics:</td>
</tr>
<tr>
<td>Measure Result Source – QDC</td>
<td>• Importance – major DM and CAD monitor</td>
</tr>
<tr>
<td>Data Source - EHR</td>
<td>• Scientific soundness – Proven quality measure for CAD</td>
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<td>• Feasibility – available in EMRs; ease of electronic data exchange</td>
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<td></td>
<td>• Application – used in HEDIS and other measurement efforts</td>
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<tr>
<td><strong>Urine Profile</strong> – Percentage of patients receiving at least one nephropathy assessment (microalbumin/creatinine ratio, a 24 hour urine for microalbuminuria, timed urine for or spot urine for microalbuminuria or positive urinalysis for protein) during the measurement period</td>
<td>Due to the impact of elevated blood glucose levels on the kidney through its nephrotoxicity or manifestations as CAD nephropathy should be monitored to allow for appropriate care that can mitigate the insult to the kidney. Test values are not included in this measure due to the added complexity of collecting such a value when weighed against the benefits. This measure was chosen for the following characteristics:</td>
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<tr>
<td>Measure Result Source – QDC</td>
<td>• Importance – major DM and CAD monitor</td>
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<tr>
<td>Data Source - EHR</td>
<td>• Scientific soundness – Proven quality measure for DM</td>
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<tr>
<td></td>
<td>• Feasibility – available in EMRs; ease of electronic data exchange</td>
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<tr>
<td></td>
<td>• Face validity – process measure but often used to indicate level of care delivery</td>
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<td>• Precision – high as process measure</td>
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<td></td>
<td>• Minimum bias – not affected by case-mix, selection bias</td>
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<td></td>
<td>• Construct validity – screening measure</td>
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<td>• Fosters real quality improvement – actionable measure</td>
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<td>• Application – used in HEDIS and other measurement efforts</td>
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<tr>
<td><strong>Hypertension Control</strong> – Percent of patients with most recent systolic blood pressure &lt;130 mm/Hg AND diastolic blood pressure &lt;80 mm/Hg, measurement period</td>
<td>As DM patients are at a higher risk for CAD, properly controlling blood pressure is an important part of an adequate care plan. Blood pressure with a systolic pressure &lt;130 mm/Hg and a diastolic pressure &lt;80 mm/Hg is indicative of being under control for care. This measure was chosen for the following characteristics:</td>
</tr>
<tr>
<td>Measure Result Source - QDC</td>
<td>• Importance – major DM and CAD monitor</td>
</tr>
<tr>
<td>Data Source - EHR</td>
<td>• Scientific soundness – Proven quality measure for CAD</td>
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<td>• Feasibility – available in EMRs; ease of electronic data exchange</td>
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<td>• Face validity – clinical outcome measure</td>
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<td>Rationale</td>
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| **Hyper tension Control** – Percent of patients with most recent systolic blood pressure >= 140 mm/Hg OR diastolic blood pressure >= 90 mm/Hg, measurement period | As DM patients are at a higher risk for CAD, properly controlling blood pressure is an important part of an adequate care plan. Blood pressure with a systolic pressure <130 mm/Hg and a diastolic pressure <80 mm/Hg is indicative of being under control for care. This measure was chosen for the following characteristics:  
  - **Importance** – major DM and CAD monitor  
  - **Scientific soundness** – Proven quality measure for CAD  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – clinical outcome measure  
  - **Precision** – highly accepted outcome measure  
  - **Minimum bias** – minimally affected by demographic factors  
  - **Construct validity** – tightly tied to other quality measures  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used in HEDIS and other measurement efforts |
<p>| Measure Result Source - QDC | |
| Data Source - EHR | |
| <strong>ER Visits</strong> - Number of ER visits of patients with Dx of DM and discharge Dx diabetes related during measurement period | Appropriate care for patients with diabetes mellitus should virtually eliminate the need for these patients to seek care in the ER through the prevention of morbidity associated with hyperglycemia (e.g., diabetic ketoacidosis, severe dehydration). Regular practice/clinic based care should prove less expensive than ER based care. Therefore, tracking of this measure is a good surrogate for cost savings as well as quality. Analysis is compiled from a utilization data warehouse and reported on a physician, practice and regional level. |
| Measure Result Source – TBD | |
| Data Source – Hospital Data (Treo) | |
| <strong>ER Visits (Trend)</strong> - Number of ER visits of patients with DX of DM and discharge Dx diabetes related during measurement period and previous period (trend) | See above (ER Visits). This will trend utilization. |
| Measure Result Source – TBD | |
| Data Source – Hospital Data (Treo) | |
| <strong>Admissions</strong> - Number of admissions of patients with DX of DM and discharge Dx diabetes related during measurement period | Appropriate care for patients with diabetes mellitus should virtually eliminate the need for these patients to require admission solely due to hyperglycemia (e.g., diabetic ketoacidosis). Regular practice/clinic based care should prove less expensive than hospital admissions. Therefore, tracking of this measure is a good surrogate for cost savings as well as quality. Analysis is compiled from a utilization data warehouse and reported on a physician, practice and regional level. |
| Measure Result Source – TBD | |
| Data Source – Hospital Data (Treo) | |</p>
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<td><strong>Admissions (Trend)</strong> - Number of admissions of patients with DX of DM and discharge Dx diabetes related during measurement period and previous period (trend)</td>
<td>See above (Admissions). This will trend utilization.</td>
</tr>
<tr>
<td>Measure Result Source – TBD</td>
<td>Data Source – Hospital Data (Treo)</td>
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<tr>
<td><strong>Cost of Admission</strong> - Median cost of admission of patients with DX of DM and discharge Dx diabetes related during measurement period</td>
<td>Appropriate care for patients with diabetes mellitus should virtually eliminate the need for these patients to require admission solely due to hyperglycemia (e.g., diabetic ketoacidosis). Regular practice/clinic based care should prove less expensive than hospital admissions. Therefore, tracking of this measure is a good measure of cost savings as well as quality. Analysis is compiled from a payor data warehouse and reported on a physician, practice and regional level.</td>
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<tr>
<td>Measure Result Source – TBD</td>
<td>Data Source – Payor Data</td>
</tr>
<tr>
<td><strong>Cost of Admission (Trend)</strong> - Median cost of admission of patients with DX of DM and discharge Dx diabetes related during measurement period and previous period (trend)</td>
<td>See above (Cost of Admissions). This will trend costs.</td>
</tr>
<tr>
<td>Measure Result Source – TBD</td>
<td>Data Source – Payor Data</td>
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<tr>
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<td>Rationale</td>
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</table>
| **Eye Exam** – Percent of patients who received a dilated eye exam or evaluation of retinal photographs by an optometrist or ophthalmologist within the measurement period | Eye exams are an important part of a comprehensive program to manage patients with diabetes mellitus. NCQA uses this measure in evaluating health plans. When combined with the other measures in this table, it helps give an indication of how well a physician is managing diabetic patients. Efficient data collection of this measure requires an electronic process to avoid the high cost of record review. Efficient data collection will only come after the implementation of medical homes in each of the practices and effective implementation and use of EMRs. As other diabetes measures provide a good, initial surrogate for diabetes care, this measure is assigned to a second phase in the project when it can become part of a more robust, efficient data collection process. This measure was chosen for the following characteristics:  
- **Importance** – major DM monitor  
- **Scientific soundness** – Proven quality measure  
- **Feasibility** – available in EMRs; ease of electronic data exchange  
- **Face validity** – process measure but often used to indicate level of care delivery  
- **Precision** – high as process measure  
- **Minimum bias** – not affected by case-mix, selection bias  
- **Construct validity** – important screening measure due to DM associated morbidity  
- **Fosters real quality improvement** – actionable measure  
- **Application** – used in HEDIS and other measurement efforts |
| **Foot Exam** – Percent eligible patients (defined as those without bilateral amputations) receiving at least one foot exam, defined in any manner, measurement period | Foot exams are an important part of a comprehensive program to manage patients with diabetes mellitus. NCQA uses this measure in evaluating health plans. When combined with the other measures in this table, it helps give an indication of how well a physician is managing diabetic patients. Efficient data collection of this measure requires an electronic process to avoid the high cost of record review. Efficient data collection will only come after the implementation of medical homes in each of the practices and effective implementation and use of EMRs. As other diabetes measures provide a good, initial surrogate for diabetes care, this measure is assigned to a second phase in the project when it can become part of a more robust, efficient data collection process. This measure was chosen for the following characteristics:  
- **Importance** – major DM monitor  
- **Scientific soundness** – Proven quality measure  
- **Feasibility** – available in EMRs; ease of electronic data exchange  
- **Face validity** – process measure but often used to indicate level of care delivery  
- **Precision** – high as process measure  
- **Minimum bias** – not affected by case-mix, selection bias  
- **Construct validity** – important screening measure due to DM associated morbidity  
- **Fosters real quality improvement** – actionable measure  
- **Application** – used in HEDIS and other measurement efforts |
<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Hypertension Control** – Percent of patients with most recent systolic blood pressure <130 mm/Hg AND diastolic blood pressure <80 mm/Hg, measurement period | Blood pressure with a systolic pressure <130 mm/Hg and a diastolic pressure <80 mm/Hg is indicative of being under control for care. This measure was chosen for the following characteristics:  
- **Importance** – major measurement of care  
- **Scientific soundness** – Proven quality measure for HTN  
- **Feasibility** – available in EMRs; ease of electronic data exchange  
- **Face validity** – clinical outcome measure  
- **Precision** – highly accepted outcome measure  
- **Minimum bias** – minimally affected by demographic factors  
- **Construct validity** – tightly tied to other quality measures  
- **Fosters real quality improvement** – actionable measure  
- **Application** – used in HEDIS and other measurement efforts |
| Measure Result Source - QDC | |
| Data Source - EHR | |

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Hyper tension Control** – Percent of patients with most recent systolic blood pressure >= 140 mm/Hg OR diastolic blood pressure >= 90 mm/Hg, measurement period | Blood pressure with a systolic pressure <130 mm/Hg and a diastolic pressure <80 mm/Hg is indicative of being under control for care. This measure was chosen for the following characteristics:  
- **Importance** – major measurement of care  
- **Scientific soundness** – Proven quality measure for HTN  
- **Feasibility** – available in EMRs; ease of electronic data exchange  
- **Face validity** – clinical outcome measure  
- **Precision** – highly accepted outcome measure  
- **Minimum bias** – minimally affected by demographic factors  
- **Construct validity** – tightly tied to other quality measures  
- **Fosters real quality improvement** – actionable measure  
- **Application** – used in HEDIS and other measurement efforts |
| Measure Result Source - QDC | |
| Data Source - EHR | |
### Adult – Hypertension, Patients 18-85 Years of Age – Phase 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients who have had a diagnosis of hypertension and who had a BMI greater than or equal to 95th percentile who are receiving treatment (dietary and activity counseling/education), measurement period</td>
<td>Obesity is clinically tied to hypertension. Reduction in BMI has a positive impact on hypertension and is considered a treatment modality. When combined with the other measures in this table, it helps give an indication of how well a physician is managing hypertensive patients. Further work is needed to define “receiving treatment.” In addition, efficient data collection of this measure requires an electronic process to avoid the high cost of record review. Efficient data collection will only come after the implementation of medical homes in each of the practices and effective implementation and use of EMRs. As other hypertension measures provide a good, initial surrogate for hypertension, this measure is assigned to a second phase in the project when it can become part of a more robust efficient data collection process. This measure was chosen for the following characteristics:</td>
</tr>
</tbody>
</table>
| Measure Result Source – TBD | • Importance – hypertension treatment modality  
• Scientific soundness – Proven treatment modality  
• Feasibility – available in EMRs; ease of electronic data exchange  
• Face validity – process measure but can be used to indicate level of care delivery when combined with other measures  
• Precision – high as process measure  
• Minimum bias – not affected by case-mix, selection bias  
• Construct validity – important treatment measure  
• Fosters real quality improvement – actionable measure  
• Application – effective treatment modality |
| Data Source - TBD | Obesity Treatment - percentage of patients who have had a diagnosis of hypertension and who had a BMI greater than 85th percentile but less than the 95th percentile who are receiving treatment (dietary and activity counseling/education), measurement period |
| Measure Result Source – TBD | Obesity is clinically tied to hypertension. Reduction in BMI has a positive impact on hypertension and is considered a treatment modality. When combined with the other measures in this table, it helps give an indication of how well a physician is managing hypertensive patients. Further work is needed to define “receiving treatment.” In addition, efficient data collection of this measure requires an electronic process to avoid the high cost of record review. Efficient data collection will only come after the implementation of medical homes in each of the practices and effective implementation and use of EMRs. As other hypertension measures provide a good, initial surrogate for hypertension, this measure is assigned to a second phase in the project when it can become part of a more robust efficient data collection process. The measure is similar to the other BMI measure in this table and was added to provide an additional reporting option. This measure was chosen for the following characteristics: |
| Data Source - TBD | • Importance – hypertension treatment modality  
• Scientific soundness – Proven treatment modality  
• Feasibility – available in EMRs; ease of electronic data exchange  
• Face validity – process measure but can be used to indicate level of care delivery when combined with other measures  
• Precision – high as process measure  
• Minimum bias – not affected by case-mix, selection bias  
• Construct validity – important treatment measure  
• Fosters real quality improvement – actionable measure  
• Application – effective treatment modality |
**Adult – Coronary Artery Disease (CAD), Patients 18-85 Years of Age – Phase 1**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Lipid** – Percentage of patients with a Dx of CAD and receiving at least one low-density lipoprotein cholesterol (LDL-C) test, measurement period | LDL-C is a recognized and proven measure of lipid levels that are tied to risk of CAD. As patients with DM are at a higher risk of CAD, use of this respected CAD measure is appropriate as management of CAD should be a part of any overarching management of a patient with DM. This measure was chosen for the following characteristics:  
- Importance – major DM and CAD monitor  
- Scientific soundness – Proven quality measure for CAD  
- Feasibility – available in EMRs; ease of electronic data exchange  
- Face validity – process measure but often used to indicate level of care delivery  
- Precision – high as process measure  
- Minimum bias – not affected by case-mix, selection bias  
- Construct validity – precedes LDL-C values  
- Fosters real quality improvement – actionable measure  
- Application – used in HEDIS and other measurement efforts |
| Measure Result Source - QDC | Data Source - EHR |
| **Lipid** – Percent of patients with Dx of CAD with LDL-C < 100 mg/dl from last test done, over measurement period | LDL-C level under 100 mg/dl is a recognized indicator of lipid levels under control. As patients with DM are at a higher risk of CAD, use of this respected CAD measure is appropriate as management of CAD should be a part of any overarching management of a patient with DM. This measure was chosen for the following characteristics:  
- Importance – major DM and CAD monitor  
- Scientific soundness – Proven quality measure for CAD  
- Feasibility – available in EMRs; ease of electronic data exchange  
- Face validity – clinical outcome measure  
- Precision – highly accepted outcome measure  
- Minimum bias – minimally affected by demographic factors  
- Construct validity – tightly tied to other quality measures  
- Fosters real quality improvement – actionable measure  
- Application – used in HEDIS and other measurement efforts |
| Measure Result Source - QDC | Data Source - EHR |
| **Hypertension Control** – Percent of patients with most recent systolic blood pressure <130 mm/Hg AND diastolic blood pressure <80 mm/Hg, measurement period | Blood pressure with a systolic pressure <130 mm/Hg and a diastolic pressure <80 mm/Hg is indicative of being under control for care. This measure was chosen for the following characteristics:  
- Importance – major measurement of care  
- Scientific soundness – Proven quality measure for HTN  
- Feasibility – available in EMRs; ease of electronic data exchange  
- Face validity – clinical outcome measure  
- Precision – highly accepted outcome measure  
- Minimum bias – minimally affected by demographic factors  
- Construct validity – tightly tied to other quality measures  
- Fosters real quality improvement – actionable measure  
- Application – used in HEDIS and other measurement efforts |
| Measure Result Source - QDC | Data Source - EHR |
| **Hypertension Control** – percentage of patients who had a diagnosis of CAD with most recent systolic blood pressure >= 140 mm/Hg OR diastolic blood pressure >= 90 mm/Hg, current | Blood pressure with a systolic pressure <130 mm/Hg and a diastolic pressure <80 mm/Hg is indicative of being under control for care. This measure was chosen for the following characteristics:  
- Importance – major measurement of care  
- Scientific soundness – Proven quality measure for HTN  
- Feasibility – available in EMRs; ease of electronic data exchange  
- Face validity – clinical outcome measure  
- Precision – highly accepted outcome measure  
- Minimum bias – minimally affected by demographic factors |
<p>| Measure Result Source - QDC | Data Source - EHR |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Obesity Treatment** - percentage of patients with a Dx of CAD who had a BMI greater than or equal to the 95th percentile who are receiving treatment (dietary and activity counseling/education) | Obesity is clinically tied to CAD. Reduction in BMI has a positive impact on CAD (e.g., hypertension) and is considered a treatment modality. When combined with the other measures in this table, it helps give an indication of how well a physician is managing CAD patients. Further work is needed to define “receiving treatment.” In addition, efficient data collection of this measure requires an electronic process to avoid the high cost of record review. Efficient data collection will only come after the implementation of medical homes in each of the practices and effective implementation and use of EMRs. As other CAD measures provide a good, initial surrogate for hypertension, this measure is assigned to a second phase in the project when it can become part of a more robust efficient data collection process. This measure was chosen for the following characteristics:  
  - **Importance** – CAD treatment modality  
  - **Scientific soundness** – Proven treatment modality  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – process measure but can be used to indicate level of care delivery when combined with other measures  
  - **Precision** – high as process measure  
  - **Minimum bias** – not affected by case-mix, selection bias  
  - **Construct validity** – important treatment measure  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – effective treatment modality |
| **Obesity Treatment** - percentage of patients with a Dx of CAD who had a BMI greater than 85th percentile but less than the 95th percentile who are receiving treatment (dietary and activity counseling/education) | Obesity is clinically tied to CAD. Reduction in BMI has a positive impact on CAD (e.g., hypertension) and is considered a treatment modality. When combined with the other measures in this table, it helps give an indication of how well a physician is managing CAD patients. Further work is needed to define “receiving treatment.” In addition, efficient data collection of this measure requires an electronic process to avoid the high cost of record review. Efficient data collection will only come after the implementation of medical homes in each of the practices and effective implementation and use of EMRs. As other CAD measures provide a good, initial surrogate for hypertension, this measure is assigned to a second phase in the project when it can become part of a more robust efficient data collection process. This measure is similar to the other BMI measure in this table and was added to provide an additional reporting option. This measure was chosen for the following characteristics:  
  - **Importance** – CAD treatment modality  
  - **Scientific soundness** – Proven treatment modality  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – process measure but can be used to indicate level of care delivery when combined with other measures  
  - **Precision** – high as process measure  
  - **Minimum bias** – not affected by case-mix, selection bias  
  - **Construct validity** – important treatment measure  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – effective treatment modality |
# Pediatrics – Prevention – Phase 1

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Lead Screening** - Percentage of patients with at least one blood lead screening test at 24 months of age | Lead screening of children by the second birthday is a major public health initiative of the NYS Department of Health ([http://www.health.state.ny.us/publications/2378.pdf](http://www.health.state.ny.us/publications/2378.pdf)).  
  - Importance – major preventive care measure  
  - Scientific soundness – Proven quality measure for pediatric prevention  
  - Feasibility – available in EMRs; ease of electronic data exchange  
  - Face validity – process measure  
  - Precision – high as process measure  
  - Minimum bias – not affected by case-mix, selection bias  
  - Construct validity – recognized measure  
  - Fosters real quality improvement – actionable measure  
  - Application – NYS DOH measure |
| **Obesity** - Percentage of children over 2 years of age and less than 18 years of age who have had at least one (1) height and weight taken upon visit with BMI calculated during measurement period | Obesity screening is consistent with AAP preventive guidelines ([http://aapredbook.aappublications.org/resources/IZSchedule0-6yrs.pdf](http://aapredbook.aappublications.org/resources/IZSchedule0-6yrs.pdf)).  
  - Importance – major preventive care measure  
  - Scientific soundness – Proven quality measure for pediatric prevention  
  - Feasibility – available in EMRs; ease of electronic data exchange  
  - Face validity – process measure  
  - Precision – highly accepted process measure  
  - Minimum bias – minimally affected by demographic factors  
  - Construct validity – recognized measure  
  - Fosters real quality improvement – actionable measure  
  - Application – used to identify patients requiring obesity counseling |

# Pediatrics – Prevention – Phase 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Immunizations** - Percentage of patients with complete childhood immunization status by age 2 - four DtaP/DT, three IPV, 1 MMR, 3 H influenza, type B, 1 chicken pox (VZV), 4 pneumococcal conugate, | Immunizations are a widely recognized prevention measure. Collection of accurate immunization records is difficult due to the lack of medical record interoperability among immunization point of care sites. Accurate data collection requires a well-run immunization registry. The implementation of medical homes in practices will assist in improving the accuracy of records. Therefore, this measure is being implemented in Phase II to allow for the establishment of medical homes in practices and improvement on interoperability. It is recognized that implementation of these steps does not correct errors due to their absence in the past, it is expected that records will become more accurate over time and therefore should be considered as a quality measure.  
  - Importance – major preventive care measure  
  - Scientific soundness – Proven quality measure for pediatric prevention  
  - Feasibility – available in EMRs; ease of electronic data exchange recognizing gaps in this exchange  
  - Face validity – outcome measure  
  - Precision – high as outcome measure  
  - Minimum bias – not affected by case-mix, selection bias  
  - Construct validity – recognized measure  
  - Fosters real quality improvement – actionable measure  
  - Application – CDC (ACIP) measure; legal requirement |
| Data Source - TBD | Measure Result Source - TBD |
## Pediatrics – Obesity – Phase 1

<table>
<thead>
<tr>
<th><strong>Measure</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity Screening</strong> - percentage of patients who had height and weight taken upon visit with BMI calculated during yearly measurement period</td>
<td>Obesity screening is consistent with AAP preventive guidelines (<a href="http://aapredbook.aappublications.org/resources/IZSchedule0-6yrs.pdf">http://aapredbook.aappublications.org/resources/IZSchedule0-6yrs.pdf</a>).</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td><strong>Rationale</strong></td>
</tr>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients receiving medical evaluation if BMI greater than or equal to 85th percentile; Testing - blood pressure measurement, HbA1c, lipid profile, fasting glucose.</td>
<td>Obesity treatment evaluation is based upon obtaining basic laboratory values to identify early-stage clinical problems. The actual treatment of childhood obesity is multidimensional and difficult to measure using simple methods. Therefore, focus is on simple screening tests that indirectly indicate a focus by the physician on health problems that are associated with the disease.</td>
</tr>
<tr>
<td><strong>Measure Result Source</strong> – QDC</td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong> - EHR</td>
<td><strong>Feasibility</strong> – available in EMRs; ease of electronic data exchange</td>
</tr>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients who had a BMI greater than or equal to 85th percentile who, with their families, are receiving diet counseling and activity counseling/education</td>
<td><strong>Face validity</strong> – process measure</td>
</tr>
<tr>
<td><strong>Measure Result Source</strong> – TBD</td>
<td><strong>Precision</strong> – highly accepted process measure</td>
</tr>
<tr>
<td><strong>Data Source</strong> - TBD</td>
<td><strong>Minimum bias</strong> – minimally affected by demographic factors</td>
</tr>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients who had a BMI greater than or equal to 85th percentile who, with their families, are receiving diet counseling and activity counseling/education</td>
<td><strong>Construct validity</strong> – recognized measure</td>
</tr>
<tr>
<td><strong>Measure Result Source</strong> – TBD</td>
<td><strong>Fosters real quality improvement</strong> – actionable measure</td>
</tr>
<tr>
<td><strong>Data Source</strong> - TBD</td>
<td><strong>Application</strong> – used to identify patients requiring obesity counseling</td>
</tr>
</tbody>
</table>

## Pediatrics – Obesity – Phase 2

<table>
<thead>
<tr>
<th><strong>Measure</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients who had a BMI greater than or equal to 85th percentile who, with their families, are receiving diet counseling and activity counseling/education</td>
<td>The actual treatment of childhood obesity is multidimensional and difficult to measure using simple methods. Obesity treatment includes counseling, education and other activities that are not easily captured in an EMR. Therefore, this measure will be evaluated for inclusion in a Phase II revision of measures.</td>
</tr>
<tr>
<td><strong>Measure Result Source</strong> – TBD</td>
<td><strong>Scientific soundness</strong> – Proven treatment modality</td>
</tr>
<tr>
<td><strong>Data Source</strong> - TBD</td>
<td><strong>Feasibility</strong> – available in EMRs after some modification; ease of electronic data exchange</td>
</tr>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients who had a BMI greater than or equal to 85th percentile who, with their families, are receiving diet counseling and activity counseling/education</td>
<td><strong>Face validity</strong> – process measure</td>
</tr>
<tr>
<td><strong>Measure Result Source</strong> – TBD</td>
<td><strong>Precision</strong> – accepted process measure</td>
</tr>
<tr>
<td><strong>Data Source</strong> - TBD</td>
<td><strong>Minimum bias</strong> – minimally affected by demographic factors</td>
</tr>
<tr>
<td><strong>Obesity Treatment</strong> - percentage of patients who had a BMI greater than or equal to 85th percentile who, with their families, are receiving diet counseling and activity counseling/education</td>
<td><strong>Construct validity</strong> – recognized measure</td>
</tr>
<tr>
<td><strong>Measure Result Source</strong> – TBD</td>
<td><strong>Fosters real quality improvement</strong> – actionable measure</td>
</tr>
<tr>
<td><strong>Data Source</strong> - TBD</td>
<td><strong>Application</strong> – treatment modality</td>
</tr>
</tbody>
</table>
### Pediatrics – Asthma – Phase 1

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **Appropriate Medications** - Percentage of patients ages 5 - 18 years who have asthma who are on appropriate medication (inhaled corticosteroids or Singulair) | Appropriate care for patients with asthma should virtually eliminate the need for these patients to seek care in the ER through the prevention of morbidity associated with disease (e.g., Status asthmaticus). Regular practice/clinic based care should prove less expensive than ER based care. Therefore, tracking of this measure is a good surrogate for cost savings as well as quality. Analysis is compiled from a utilization data warehouse and reported on a physician, practice and regional level.  
  - **Scientific soundness** – Proven quality measure for pediatric prevention  
  - **Feasibility** – available in EMRs; ease of electronic data exchange  
  - **Face validity** – process measure  
  - **Precision** – highly accepted process measure  
  - **Minimum bias** – minimally affected by demographic factors  
  - **Construct validity** – recognized measure  
  - **Fosters real quality improvement** – actionable measure  
  - **Application** – used to identify patients requiring obesity counseling and closer medical supervision |
| Measure Result Source – QDC                 |                                                                                                                                                                                                          |
| Data Source - EHR                           |                                                                                                                                                                                                          |

### Pediatrics – Asthma – Phase 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| **ER Visits** - Number of ER visits of patients with DX of asthma and Discharge Dx asthma related during measurement period | Appropriate care for patients with asthma should virtually eliminate the need for these patients to seek care in the ER through the prevention of morbidity associated with disease (e.g., Status asthmaticus). Regular practice/clinic based care should prove less expensive than ER based care. Therefore, tracking of this measure is a good surrogate for cost savings as well as quality. Analysis is compiled from a utilization data warehouse and reported on a physician, practice and regional level.  
  - See above (ER Visits). This will trend utilization.                                                      |
| Measure Result Source – TBD                 |                                                                                                                                                                                                          |
| Data Source – Hospital Data (Treo)          |                                                                                                                                                                                                          |
| **ER Visits (Trend)** - Number of ER visits of patients with DX of asthma and Discharge Dx asthma related during measurement period and previous period (trend) |                                                                                                                                                                                                          |
| Measure Result Source – TBD                 |                                                                                                                                                                                                          |
| Data Source – Hospital Data (Treo)          |                                                                                                                                                                                                          |
| **Admissions** - Number of admissions of patients with DX of asthma and Discharge Dx asthma related during measurement period | Appropriate care for patients with asthma should virtually eliminate the need for these patients to require hospital admission (e.g., Status asthmaticus). Regular practice/clinic based care should prove less expensive than hospital admissions. Therefore, tracking of this measure is a good surrogate for cost savings as well as quality. Analysis is compiled from a utilization data warehouse and reported on a physician, practice and regional level. |
| Measure Result Source – TBD                 |                                                                                                                                                                                                          |
| Data Source – Hospital Data (Treo)          |                                                                                                                                                                                                          |
### Pediatrics – Asthma – Phase 2

<table>
<thead>
<tr>
<th>Measure</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admissions (Trend)</strong> - Number of admissions of patients with DX of asthma and discharge Dx asthma related during measurement period and previous period (trend)</td>
<td>See above (Admissions). This will trend utilization.</td>
</tr>
<tr>
<td>Measure Result Source – TBD</td>
<td></td>
</tr>
<tr>
<td>Data Source – Hospital Data (Treo)</td>
<td></td>
</tr>
</tbody>
</table>

| **Cost of Admission** - Median cost of admission of patients with DX of asthma and discharge Dx asthma related during measurement period | Appropriate care for patients with asthma should virtually eliminate the need for these patients to require hospital admission (e.g., Status asthmaticus). Regular practice/clinic based care should prove less expensive than hospital admissions. Therefore, tracking of this measure is a good measure of cost savings as well as quality. Analysis is compiled from a payor data warehouse and reported on a physician, practice and regional level. |
| Measure Result Source – TBD | |
| Data Source – Payor Data | |

| **Cost of Admission (Trend)** - Median cost of admission of patients with DX of asthma and discharge Dx asthma related during measurement period and previous period (trend) | See above (Cost of Admissions). This will trend costs. |
| Measure Result Source – TBD | |
| Data Source – Payor Data | |

### Performance Reporting

The Adirondack project requires physicians, practices, and pods to achieve advances in clinical and financial outcomes, and Level II Medical Home status, in return for a payment of $7 PMPM. Clinical and financial measures were developed for the following adult diseases – diabetes, hypertension, CAD – and the following pediatric diseases – prevention, obesity, asthma. Simply recording and monitoring trends in these metrics is not enough to achieve a level of change that justifies the additional PMPM payment. Therefore, an overarching clinical strategy is needed to guide the physicians, practices, and pods in their effort to achieve these clinical and financial outcomes improvements. In addition, a comprehensive work plan is required to offer the various providers a roadmap for change. The work plan requires the following:

1. Clinical measures
   a. Description
   b. Meaning
c. Explanation of trending
   i) Summary of reporting

d. Impact on clinical outcomes for the disease

e. Impact on financial outcomes for the disease

f. Relationship to other clinical outcomes

g. Explanation on how the clinical measure can be improved
   i) Process
   ii) Workflow

2. Financial measures
   a. Description
   b. Meaning
   c. Explanation of trending
      i) Summary of reporting

d. Impact on clinical outcomes for the disease

e. Impact on financial outcomes for the disease

f. Relationship to other clinical outcomes

g. Explanation on how the financial measure can be improved
   i) Process
   ii) Workflow

3. Impacting measures - process and workflow
   a. Identify best practices in impacting clinical and financial measures
      i) Describe in detail as per targeted diseases
   b. Inventory of available resources
      i) Clinicians – pharmacists, home health aides, nutritionists, etc.
   c. Evaluate available resources with those required for best practices
   d. Develop possible “interventions” that can impact clinical and financial outcomes
      i) Create multiple paths to accommodate varied capabilities of practices
          (1) Prioritize these paths

4. Develop comprehensive project plan for improving clinical and financial outcomes
   a. Link activities to specific outcomes
   b. Create timeline for implementation
      i) Include milestones, points of evaluation
          (1) Plan for interventions for “course corrections”
   c. Include disease management principles
      i) Activities done by practices and/or pods
   d. Create simple reporting mechanism for practices/pods to signal their process changes
   e. Create process for practices to obtain assistance with change management
As was reported in Deliverable 2, there are significant areas for improvement across most participating practices in establishing the data collection and reporting processes to enable them to meet these requirements. In May, only 9% of the participating practices met the “Must Pass” criteria. Only one practice reported compliance with all quality improvement criteria, and the overall average score was 28% of the possible points. Given the importance of performance improvement to both obtaining NCQA PCMH certification and meeting one of the primary goals of the pilot program, each POD has requested additional assistance from EastPoint Health. We have spent the past two months working with the practices within each POD to begin the data collection process and focusing on establishing common reporting frameworks. We have developed one for pediatric performance measures and one for adult performance measures. Examples of one POD’s initial pediatric practice data is provided at Attachment F, while the initial adult data is provided as Attachment G.

Ultimately, all three PODs will feed quality improvement and clinical data into HIXNY. Clinical data will be housed into a data warehouse. Financial data will be fed from participating payors into a separate data warehouse, which will allow practices to identify patients that are responsible for high resource utilization. Each POD will then be able to obtain patient-level clinical quality data and associated financial data from each payor. The tracking and reporting of data will ultimately flow seamlessly. Unfortunately, each of these data repositories will not be available until late 2011. Until that time, each POD will be using substitutions to identify high resource utilizing patients.

Initial review reveals that within the sample POD, there are substantial opportunities for improvement in many reporting areas. Most practices have not yet begun to submit data on pediatrics preventative measures and there are also adult measures that are not consistently reported. However, each practice is in the first few months of reporting and this is to be expected. This will be a continuing focus area.
ATTACHMENT A: POD 1 DRAFT SERVICES CONTRACT

EMPLOYEE LEASE AGREEMENT

THIS EMPLOYEE LEASE AGREEMENT ("Agreement") is made as of this __ day of _______________, 2011, by and between ADIRONDACK MEDICAL CENTER ("AMC"), located at 2223 State Route 86, Saranac Lake, New York 12983, and ____________________________ ("Practice"), located at ________________________________ (the "Office").

WITNESSETH:

WHEREAS, AMC and Practice are participants in the Adirondack Medical Home Multipayor Demonstration Program (the "Program"), the purpose of which is to promote improved quality of and access to health care services and to promote improved clinical outcomes and efficiency through patient care continuity and coordination of health care services; and

WHEREAS, Practice operates an office practice in which certain physicians who are employed by Practice conduct their office practices; and

WHEREAS, as part of the Program, Practice is in need of employees to provide certain services to it and its patients in its Office in order to promote the continuity of patient care and the coordination of health care services;

WHEREAS, AMC employs individuals who are qualified and capable of providing the services needed by Practice ("Staff"); and

WHEREAS, Practice desires to lease Staff from AMC, and AMC desires to furnish Staff to Practice, on the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the foregoing and the mutual promises set forth in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, hereby agree as follows:

1. **Duties and Responsibilities of AMC**
   
   1.1 AMC agrees to lease Staff to Practice to perform the following services: (i) Pharmacist/Pharm D Medication Management Services, (ii) Nutritional Services; (iii) Case Management Services; (iv) Social Services; and (v) Information Systems Services (collectively, the “Services”). The Directors of the appropriate Departments at AMC shall be responsible for determining which Staff shall perform the Services. Staff leased to Practice are subject to change, as determined by the applicable Department Director in his/her sole discretion. The applicable Department Director and Practice shall mutually determine whether the Services should be performed in the Office or if such Services can be performed remotely. AMC shall provide the appropriate Staff person to perform the Services as soon as practicable after receiving a request from Practice. Practice shall direct all such requests to the appropriate Department Director.

   1.2 AMC shall enter into the HIPAA Business Associate Agreement with Practice, which is attached hereto as Exhibit A.

2. **Duties and Responsibilities of Practice.** Practice is solely responsible for:

   2.1 Supervising the performance of Staff, including supervision of both the services accomplished and also the details and means by which the services are accomplished.
2.2 Ensuring that services provided by Staff are provided in accordance with all applicable professional standards, the standards of Practice, Federal, State and local laws, regulations and guidelines.

2.3 Directing Staff to operate in accordance with Practice’s policies and procedures. At Practice’s direction, Staff will: (i) attend Practice’s staff conferences and (ii) participate in select on-site educational programs. Providing all equipment and supplies necessary for Staff to provide services hereunder, provided, however, that Staff shall be responsible for advising Practice as to the inadequacy, disrepair or need for replacement or reorder of such supplies and equipment.

2.4 Directing all requests for Staff to the appropriate Department Director.

3. **Hiring and Firing of Staff.** AMC shall have the responsibility to procure qualified persons to serve as Staff hereunder and make such persons available to Practice. In the event Practice is dissatisfied with the performance or conduct of any Staff person, Practice shall communicate its concerns to the appropriate Department Director, who shall work with the Staff person to implement corrective action. AMC agrees to terminate the assignment of any Staff person under this Agreement upon the Practice’s reasonable request. AMC shall not terminate the employment of a Staff person without the prior consent of Practice, which consent shall not be unreasonably withheld. In the event a particular Staff person resigns his or her employment with AMC, AMC shall have the responsibility to procure qualified replacement candidates as soon as reasonably possible.

4. **Fees.**

4.1 For the Staff leased by AMC hereunder, Practice agrees to pay AMC the fees specified in Exhibit B on a monthly basis. AMC shall bill Practice monthly and Practice shall issue a check within thirty (30) days of receiving such invoice.

4.2 The provisions of this Section 4 shall survive termination of this Agreement.

5. **Term and Termination.**

5.1 Unless earlier terminated as hereinafter provided: The term of this Agreement shall commence on January 1, 2011 and shall continue in full force and effect until December 31, 2011; following the initial term, this Agreement shall be automatically renewed for successive one-year terms.

5.2 This Agreement may be terminated by either party, without cause, at any time upon not less than sixty (60) days prior written notice given to the other party.

5.3 In the event of material breach of this Agreement by either party, the non-defaulting party may terminate this Agreement by giving the breaching party ten (10) days prior written notice to cure, provided that, upon receipt of such notice, the breaching party shall have ten (10) days to cure such breach.

5.4 Termination of this Agreement shall not affect the rights and obligations of the parties arising prior to the effective date of such termination. In the event, for any reason, this Agreement is terminated prior to the expiration of the first year of the Agreement, the parties agree not to re-enter any Agreement with each other for the provision of leased employees until a date of at least one year following the date of this Agreement.

6. **Independent Contractor.** This Agreement shall not create a joint venture, partnership or other joint business relationship between AMC and Practice. AMC is not exclusively limited to providing employees to Practice, and is entitled to provide employees and/or services to other providers. In performing services hereunder, Staff are acting as leased employees of Practice. Staff are not limited in the provision of services to third parties at times other than the time they are required to provide services to Practice under this Agreement.

7. **Insurance.**
7.1 At all times during the term of this Agreement, Practice and AMC each agree to maintain in full force and effect sufficient general liability insurance in minimum amounts of $1,000,000 per occurrence and $2,000,000 aggregate amount covering Practice and Practice’s employees, and AMC and AMC’s Staff, respectively, in the performance of Services.

7.2 At all times during the term of this Agreement, Practice agrees to maintain in full force and effect sufficient professional liability insurance in minimum amounts of $1,300,000 per occurrence and $3,900,000 aggregate amount covering Practice and Practice’s employees and the Staff, as the case may be, in the performance of patient services hereunder.

8. **Indemnification.**

8.1 Practice shall indemnify and hold harmless AMC and its agents, representatives, officers and employees, and each of them, from and against any and all claims, penalties, demands, causes of actions, damages, losses, liabilities, costs, expenses, including reasonable attorney's fees, in law or in equity, of any kind or nature whatsoever, directly or indirectly arising out of the breach by Practice of this Agreement. This provision shall survive termination of this Agreement.

8.2 AMC shall indemnify and hold harmless Practice and its agents, representatives, officers and employees, and each of them, from and against any and all claims, penalties, demands, causes of actions, damages, losses, liabilities, costs, expenses, including reasonable attorney's fees, in law or in equity, of any kind or nature whatsoever, directly or indirectly arising out of the breach by AMC of this Agreement. This provision shall survive termination of this Agreement.

9. **Civil Rights.** Practice and AMC agree to comply with the Civil Rights Act of 1964 which prohibits discrimination based on race, sex, national origin, color or handicap, as amended, and all Federal, State and local laws related to employment.

10. **Notices.** Except as otherwise provided herein, any notice, request, demand, consent, approval of other communication required or permitted under this Agreement shall be in writing and shall be deemed to have been given (i) upon actual delivery, if delivery is by hand, or (ii) the first business day following delivery to any nationally recognized overnight delivery service, or (iii) five days after it is deposited in the United States mail, postage prepaid, certified or registered mail, return receipt requested. Each such notice shall be sent to the respective parties at the addresses indicated below.

    * **If to AMC:** Adirondack Medical Center  
    2223 State Route 86  
    Sarnarc Lake, New York 12983  
    Attn: President/CEO

    * **If to Practice:** ________________
    ________________
    ________________
    ________________

Any party may change its address for purposes of this Section by giving the other parties ten (10) days prior written notice in accordance with this Section.

11. **Confidentiality.** The parties hereby covenant and agree to comply with all applicable laws relating to the confidentiality of patient information including, but not limited to, the Health Information Portability and Accountability Act
(“HIPAA”). By virtue of this Agreement, each party may obtain access to or come into possession of confidential business information of the other party. Each party shall keep all such information to which it has access or of which it has obtained custody, confidential. Notwithstanding anything herein to the contrary, each party may disclose such confidential information when required to do so by law. Without prejudice to the rights and remedies otherwise available to it, each Party shall be entitled to seek equitable relief by way of injunction if the other party breaches or threatens to breach this Section.

12. **Access to Books and Records.** Pursuant to Section 1395x(v)(1)(I) of Title 42 of the United States Code and applicable rules and regulations thereunder, until the expiration of four years after the termination of this Agreement, AMC shall make available, upon appropriate written request by the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States General Accounting Office, or the applicable state agencies or departments, or any of their duly authorized representatives a copy of this Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the services provided by AMC under this Agreement. AMC further agrees that in the event it carries out any of its duties under this Agreement through a subcontract with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12) month period, such subcontract shall contain a clause identical to that contained in the first sentence of this Section.

13. **Nonwaiver of Subsequent Defaults.** Any failure of a party to enforce any provision of this Agreement, or to demand strict compliance therewith, upon any default by the other party shall not be construed as modifying the terms of this Agreement or as a waiver of such party’s right to terminate this Agreement as herein provided or otherwise to enforce the provisions hereof upon any subsequent default by the other party, unless such modification or waiver is in writing and signed by each party.

14. **Survival Benefit.** The covenants contained herein, if applicable, shall survive the expiration or termination of this Agreement. Such covenants shall bind and inure to the benefit of the respective successors and permitted assigns of the parties hereto.

15. **Interpretation.** Unless the context requires otherwise, the singular shall be construed to include the plural and vice versa. The Section headings used herein are for convenience only and are not to be used in interpreting or construing the terms of this Agreement. Any reference herein to “days” shall mean calendar days unless “business days” are expressly provided. Except as otherwise specified, references to Sections contained in this Agreement shall be to the correspondingly numbered Sections as set forth in this Agreement. This Agreement shall be governed by and construed in accordance with the laws of the State of New York. If any term, covenant, or condition of this Agreement or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Agreement, or the application of such term, covenant, or condition to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby, and each and every term, covenant, and condition of this Agreement shall be valid and be enforced to the fullest extent permitted by law.

16. **Venue.** The parties to this Agreement agree that jurisdiction and venue shall properly lie in a State court in and for Essex or Franklin County, New York, or in the United States District Circuit Court for the Northern District of New York, with respect to any legal proceedings arising from this Agreement. The parties further agree to bring all legal proceedings arising under this Agreement only in the courts listed above.

17. **Fair Market Value.** The amounts to be paid by Practice to AMC hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor shall it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by Practice to AMC, or by AMC to Practice, or for the recommending or arranging of the purchase, lease or order of any item or service. In addition, no amount paid or advanced hereunder includes any discount, rebate, kickback or other reduction in charge. For purposes of this Section, AMC and Practice shall include each such entity and any affiliate thereof.
18. **Program Representations.** AMC and Practice hereby represent, warrant and covenant to each other that as of the date of this Agreement, and for the entire term and any renewal hereof, with respect to any federal health care program as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(f)) or any state health care program as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(h)) (collectively, the “Programs”): neither (a) the representing party; (b) any individual with a direct or indirect ownership or central interest of five percent or more of the representing party; nor (c) any director, officer, agent or employee of the representing party; has ever been debarred, suspended or excluded from any Program. Each party covenants to immediately notify the other in writing if this representation is no longer true, or if such party is sanctioned or has a civil monetary penalty levied under any Program.

19. **Responsibility Under Laws and Regulations.** In accordance with 10 NYCRR Section 400.4, notwithstanding any other provision in this Agreement, Hospital remains responsible for ensuring that any services provided hereunder comply with all pertinent provisions of federal, state and local statutes, rules and regulations.

20. **Change in Law.** Notwithstanding anything to the contrary contained in this Agreement, in the event that any Medicare and/or Medicaid law, rule, regulation or payment policy, or any law, rule or regulation relating to AMC’s income tax exempt status, or any other applicable law or regulation, or any interpretation thereof, at any time, is modified, implemented, threatened to be implemented, or determined to prohibit, restrict or in any way materially change the terms of this Agreement, or by virtue of the existence of this Agreement has or will have a material adverse affect on either party, then AMC and Practice agree to negotiate in good faith to amend this Agreement in a manner consistent with such change and the intent of the parties.

**IN WITNESS WHEREOF,** the parties hereto, intending to be legally bound, have duly executed this Agreement as of the day and year first written above.

<table>
<thead>
<tr>
<th>Adirondack Medical Center</th>
<th>___________________________________________________________________________</th>
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<tr>
<td>By:______________________</td>
<td>By:______________________________</td>
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**EXHIBIT A**

**Business Associate Agreement**

**EXHIBIT B**

**Fees for Leased Staff**

The following fees apply to time spent performing Services and any travel time involved:

- Pharmacist/Pharm D Medication Management Services: $XX.XX/hr
- Nutritional Services: $XX.XX/hr
- Case Management Services: $XX.XX/hr
- Social Services: $XX.XX/hr
- Information System Services: $XX.XX/hr
ATTACHMENT B: AHI to POD DRAFT SERVICES CONTRACT

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<tr>
<th>CENTRAL SERVICES AGREEMENT</th>
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<tr>
<td>This Central Services Agreement is made as of the ___ day of ______ 2010 by and between Champlain Valley Physicians Hospital Medical Center, a New York not-for-profit corporation with an address of 75 Beekman Street, Plattsburgh, New York 12901 (hereinafter “CVPH” or “POD”) and Upper Hudson Primary Care Consortium, Inc. [Note: this will be changed to Adirondack Health Institute once name change has been approved] a New York not-for-profit corporation with an address of 9 Carey Road, Queensbury, New York 12804 (hereinafter “UHPCC”).</td>
</tr>
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WHEREAS, Hudson Headwaters Health Network Inc (“HHHN”) has been awarded grant funding under Phase 10 of the Healthcare Efficiency and Affordability of the New Yorkers capital grant program (“HEAL NY”) to develop and implement patient centered medical homes supported by an interoperable health information exchange infrastructure in the Adirondack region which has been developed as the Adirondack Medical Home Pilot Program (“AMHPP” or the “Medical Home Pilot”); and

WHEREAS, HHHN is a federally qualified health center that operates clinical sites in the Adirondacks/Lake George/Glens Falls area in New York State and receives various federal grant funds to provide full spectrum of primary and preventative health care services to medically underserved populations; and

WHEREAS, UHPCC is an Article 28 Central Services facility incorporated under New York’s not-for-profit corporation law which supports the provision of comprehensive health care services to residents of those areas in which the Medical Home Pilot is being developed and operated; and

WHEREAS, HHHN has engaged UHPCC to manage the operation of AMHPP which includes coordinating the efforts of the POD which will vary based on the need of each POD participating in the AMHPP and such services shall include setting standards, contracting, development activities and contracting with various vendors as needed, to develop a central data repository for the clinical data of each patient and assimilating that data with payor claims; and

WHEREAS, the POD and the primary care providers and certain specialty care providers participating in the Medical Home Pilot, have entered into certain services agreements whereby the POD is providing necessary administrative and clinical services and the POD desires to obtain the services set forth in this Agreement from UHPCC, in order to carry out its responsibilities and obligations under those service agreements.

NOW THEREFORE, in consideration of the mutual covenants and agreements contained, the parties agree as follows:

1. **Services of UHPCC.**
   1.1 UHPCC agrees to provide to the POD the services described on Exhibit A, annexed hereto and made a part hereof (the “Services”) to this Agreement, subject to the terms and conditions as set forth in this Agreement.
   1.2 The Services shall be performed by qualified personnel and such Services shall be performed in a professional manner. UHPCC shall provide all compensation to all personnel who perform the Services and pay all payroll costs associated with such personnel.

2. **Fees for Services.**
   2.1 During the term of this Agreement and in consideration for the services provided by UHPCC to the POD, the POD shall pay to UHPCC a monthly amount at the rate set forth on Exhibit B annexed hereto and made a part hereof (the “Service Fees”). UHPCC shall invoice the POD for such amounts on a monthly basis.

3. **Nature of Relationship.**
   3.1 Independent Contractor. In the performance of the work, duties and obligations devolving upon the parties under this Agreement, it is mutually understood and agreed that the parties are at all times acting and performing as an independent contractor. No joint venture, partnership, or employment agreement relationship is created by this Agreement.

4. **Access Books and Records.**
   4.1 Pursuant to Section 1395x(v)(1)(I) of Title 42 of the United States Code and applicable rules and regulations thereunder, until the expiration of our (4) years after the termination of this Agreement, UHPCC shall
make available, upon appropriate written request by the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States General Accounting Office, or the applicable state agencies or departments, or any of their duly authorized representatives a copy of this Agreement and such books documents and records as are necessary to certify the nature and extent of the costs of the services provided by UHPCC under this Agreement. UHPCC further agrees that in the event it carries out any of its duties under this Agreement through a subcontract with a value or cost of Ten Thousand and NO/100 ($10,000.00) Dollars or more over a twelve (12) month period, such subcontract shall contain a clause identical to that contained in the first sentence of this Section.

5. **Fair Market Value.**

5.1 The amounts to be paid by POD to UHPCC hereunder have been determined by the parties through good faith and arms-length bargaining to be the fair market value of the services to be rendered hereunder. No amount paid or to be paid hereunder is intended to be, nor shall it be construed as, an offer, inducement or payment, whether directly or indirectly, overtly or covertly, for the referral of patients by POD to UHPCC, or by UHPCC to POD, or for the recommending or arranging of the purchase, lease or order of any item or service. In addition, no amount paid or advanced hereunder includes any discount, rebate, kickback or other reduction in charge. For purposes of this Section, UHPCC and the POD shall include each such entity and any affiliate thereof.

6. **Term of Agreement.**

6.1 **Term.** This Agreement shall be effective as of January 1, 2010 and shall continue for five (5) years, terminating on December 31, 2014 (the “Term”) unless earlier terminated in accordance with this Agreement.

7. **Compliance.** Either party may terminate this Agreement in the event of a material breach by the other, provided that the breaching party shall be given written notice of said breach and thirty (30) days to cure said breach.

7.2 **Legal Deficiency.** In the event that any federal, state or local law is amended, enacted, or interpreted by a court of competent jurisdiction in such manner as would make any substantial term of this Agreement unlawful, such unlawful term shall be deemed severed and the Agreement shall in all other respects remain in effect, and the parties shall forthwith apply diligent efforts to renegotiate the terms of this Agreement to conform with applicable law.

7.3 **Rights Upon Termination.** The termination of this Agreement shall not release or discharge either party from any obligation, debt or liability which shall have previously accrued and remains to be performed as of the date of termination.

8. **Notices.** All notices, requests, demands or other communications hereunder shall be in writing and shall be deemed to have been duly delivered if delivered in person or if sent by registered or certified mail, postage prepaid to the following addresses:

- **If to UHPCC:**
  
  Upper Hudson Primary Care Consortium, Inc.
  
  [Note: this will be changed to Adirondack Health Institute once name change has been approved]
  
  9 Carey Road
  
  Queensbury, New York 12804
  
  Attn:

- **If to POD:**

  Champlain Valley Physicians Hospital
  
  Medical Center
  
  75 Beekman Street
  
  Plattsburgh, New York 12901
  
  Attn:

  Any of the undersigned may, from time to time, change their address by written notice to the other party as above provided.

9. **Compliance with Laws.** The POD and UHPCC are committed to complying with all applicable federal and state laws and regulations. Each party hereby certified on behalf of itself and its directors and officers that it has never been excluded, disbarred, suspended or otherwise determined to be ineligible from participation in any
federally or state funded health care program and no proceedings are pending or have been threatened which might result in disbarment, exclusion or determination of ineligibility. Further, UHPCC and the POD hereby represent, warrant and covenant to each other that as of the date of this Agreement, and for the entire term and any renewal hereof, with respect to any federal health care program as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(f)) or any state health care program as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(h)) (collectively, the "Programs"): neither (a) the representing party; (b) any individual with a direct or indirect ownership or central interest of five (5%) percent or more of the representing party; nor (c) any director, officer, agent or employee of the representing party; has ever been debarred, suspended or excluded from any Program. Each party covenants to immediately notify the other in writing if this representation is not longer true, or if such party is sanctioned or has a civil monetary penalty levied under any Program.

Each party shall comply during the term of this Agreement with the privacy and security standards promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended from time to time. The Business Associate Agreement is attached hereto as Exhibit C and is incorporated into this Agreement.

10. Material Changes in the Law. If this Agreement, in the written opinion of counsel for either party, constitutes a material violation of any applicable statute, law, rule or regulation, including, but not limited to, the antitrust laws of the United States or the State of New York due to a material change in such statute, law, rule or regulations, then the parties shall, in good faith, amend this Agreement in a manner to correct such violation. If this Agreement is not amended within thirty (30) days after written notice to the other party of the violation, this Agreement may be terminated upon thirty (30) days prior to written notice.

11. Indemnification.

11.1 Notwithstanding any insurance carried by either party pursuant to this Agreement or otherwise, each party agrees to indemnify, defend and hold harmless the other from all claims, loss, damage or injury of any kind or character, including, without limitation, each party’s reasonable attorney’s fees and expenses, to any person or property arising from any act or omission of the other or the other’s in the performance of services pursuant to this Agreement.

11.2 In the event that either party becomes aware of any claim arising out of or under this Agreement, each party agrees to give the other written notice containing sufficient particulars to identify the name and address of the allegedly inured person, the time, place and circumstances of the alleged incident, and the names of any available witnesses.

11.3 Each party agrees to cooperate with the other in the defense of claims in enforcing any right of contribution or indemnification against any person or organization who may be liable to either party, including, but not limited to, assisting in securing evidence, obtaining the attendance of witnesses, and attending trials or hearings upon request.

12. Confidentiality.

12.1 Confidential Information. In the course of providing services under this Agreement, UHPCC may obtain access to confidential information concerning the POD. UHPCC agrees to keep such information confidential. With respect to information which the POD discloses to UHPCC and identifies as proprietary, strategic and confidential financial information that is material and non-public, UHPCC agrees not to disclose such information to any third party without the prior consent of the POD, except as required by law or in the course of healthcare operations required for the HEAL NY funding of the Medical Home Pilot.


13.1 This Agreement represents the entire agreement and understanding between the Parties with respect to the subject matter; it may not be amended or modified except by written consent of both parties. A waiver of any right or obligation under this Agreement must be in writing signed by the Party waiving such right or obligation.

13.2 This Agreement shall be governed by and construed in accordance with the laws of the State of New York, without reference to principles of conflicts of law and any action or proceeding shall be exclusively venued in a court of competent jurisdiction in , New York.

13.3 This Agreement is not intended and shall not be construed to confer any benefit on any person who is not a party hereto.
Neither Party shall assign or transfer its rights, duties or obligations under this Agreement without the other Party’s prior written consent.

In the event that any provision of this Agreement is found to be void and unenforceable, the remaining provisions of this Agreement shall nevertheless be binding upon the Parties hereto with the same effect as though the void or unenforceable party had been severed and deleted.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement the dates set forth below.

Dated: ______________, 2010  
UPPER HUDSON PRIMARY CARE CONSORTIUM, INC.  
By: ______________________________

Dated: ______________, 2010  
CHAMPLAIN VALLEY PHYSICIANS HOSPITAL MEDICAL CENTER  
By: ______________________________

EXHIBIT ‘A’

SCOPE OF SERVICES

AHI agrees to:

1. Provide assurance of anti-trust protection to the degree permitted by law, as a designated Rural Health Network.
2. Leverage the reimbursement model with on-going negotiation regarding medical home with payors participating in the Pilot.
   a. Need to consider negotiations with ASO’s
   b. Need to consider negotiations with plans not currently included in the Pilot
   c. Need to be sure to identify what is AHI, pod, and/or practice functions to be sure to maintain/not over-reach the anti-trust protections
3. Support the interoperable health IT infrastructure thru maintenance of the data warehouse and funding of the capitalized asset following the completion of HEAL 10.
   a. Issues to be sure to address: EMR data warehouse, payor data warehouse, interoperability, other business intelligence and clinical decision support tools, depreciation
4. Develop and monitor evidence-based quality measures.
5. Evaluate, analyze and summarize the ability of the Medical Home Pilot to attract providers to the underserved region through the reimbursement model.
6. Provide grant writing resources and administration in support of Medical Home Pilot activities.
7. Purchase and utilize communication methods (i.e. web site, brochures, and surveys) to effectively convey the mission of the Medical Home Pilot.
8. Coordinate educational resources for participating providers.
9. Support the AHI infrastructure through purchased legal and independent audit services to maintain the comprehensive governance & organization structure and compliance with applicable audit and government standards.
10. Research, benchmarking, and publication
11. Develop collaborative business relationships – Pfizer, Merck, American Cancer Society, Universities, etc.

EXHIBIT ‘B’

COMPENSATION

Compensation model will be outlined by Cathy and Dennis with consideration for remittance terms (monthly, quarterly, etc.) based on how the payors are currently reimbursing the PODS with consideration for reconciliation process.
ATTACHMENT C: COMMON BUSINESS ASSOCIATES AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the “Business Associate Agreement” or the “Agreement”) is made as of the date set forth on the signature page hereof (the “Effective Date”) by and between EastPoint Health LLC, a Kansas limited liability company (“EastPoint”), the Massachusetts eHealth Collaborative, Inc. (“MaeHC”), the Healthcare Information Exchange of New York (“HIXNY”) and the physician practice listed on the signature page hereof (the “Practice”). All capitalized terms not defined herein shall have the meanings given to them in the Standards for Privacy of Individually Identifiable Health Information under the Health Insurance Portability and Accountability Act of 1996 (hereinafter, the “HIPAA Regulations”) or the Health Information Technology for Economic and Clinical Health Act of 2009 (hereinafter, “HITECH”).

1. PURPOSE

The Practice is participating in the Adirondack Health Care Home Multipayer Demonstration Program (also known as the Adirondack Medical Home Demonstration (AMHD)) (the “Project”). EastPoint and MaeHC (each, a “Business Associate”) will be providing certain services to the Practice in connection with the Project, and in the course of providing those services, will have access to PHI of the Practice.

2. PERMITTED USES AND DISCLOSURES OF PHI

2.1 Permitted Uses and Disclosures by the Business Associates. Except as otherwise specified herein, a Business Associate may make any and all uses and disclosures of PHI necessary to perform its obligations under the Project, provided that such uses or disclosures would not violate the HIPAA Regulations if made by the Practice, which may include disclosure of PHI (i) to its employees, subcontractors and agents, as set forth below, (ii) as directed by the Practice, or (iii) as otherwise permitted by the terms of this Business Associate Agreement. All other uses and disclosures of PHI are prohibited. Unless otherwise limited herein, each Business Associate may use PHI of the Practice for the following purposes:

(a) Disclosure for Management, Administration. The Business Associate may use or disclose PHI for proper management and administration of the Business Associate as set forth in 45 C.F.R. § 164.504(e)(4). The Business Associate shall take appropriate corrective action in the event any of its employees or workforce members uses or discloses PHI in contravention of this Business Associate Agreement.

(b) Disclosure to Third Parties for Performance of Agreement. The Business Associate may use or disclose the PHI in its possession to third parties for the purpose of performing its duties in connection with the Project and under this Business Associate Agreement. The third party shall provide written assurances of its confidential handling of such PHI, which shall include the same restrictions and conditions on use and disclosure as apply to the Business Associate herein.

(c) As Required by Law/Legal Process. The Business Associate may use or disclose PHI to fulfill any present or future legal responsibilities of the Business Associate would not violate the HIPAA Regulations if made by the Practice, which may include disclosure of PHI (i) to its employees, subcontractors and agents, as set forth below, (ii) as directed by the Practice, or (iii) as otherwise permitted by the terms of this Business Associate Agreement. All other uses and disclosures of PHI are prohibited. Unless otherwise limited herein, each Business Associate may use PHI of the Practice for the following purposes:

(d) Aggregation of Data. The Business Associate may aggregate the PHI in its possession with the PHI of other covered entities and provide the Practice with data analyses relating to the Health Care Operations of the Practice in accordance with 45 C.F.R. § 164.504(e)(2)(ii)(B). Under no circumstances may the Business Associate disclose PHI of the Practice to any other party or covered entity without the explicit authorization of the Practice.

(e) Use of De-identified Data. The Business Associate may de-identify PHI and utilize de-identified PHI for purposes other than research, provided that the Business Associate (i) de-identifies the PHI pursuant to the HIPAA requirements set out in 45 C.F.R. § 164.514(b) and (ii) provides the Practice with appropriate documentation if required by 45 C.F.R. § 164.514 (b)(1)(ii). De-identified information does not constitute PHI and, with the exception of section 2.1(f) below, is not subject to the terms of this Business Associate Agreement.
(f) Use of Data for Research Purposes. The Business Associate agrees that it will obtain prior approval by the Practice for the use or disclosure of PHI or de-identified PHI for research purposes. Use or disclosure for research purposes that has not been approved by the Practice is strictly prohibited.

3. RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PHI

3.1 Responsibilities of the Business Associate. With regard to the uses or disclosures of PHI permitted by this Business Associate Agreement, each Business Associate hereby agrees to the following:

(a) Report Unauthorized Use. The Business Associate agrees to report to the Practice any unauthorized use or disclosure of PHI by such Business Associate or its third party agents of which the Business Associate becomes aware, and any remedial action to be taken by the Business Associate with respect to such unauthorized use or disclosure. The Business Associate shall make said report to the designated Privacy Officer of the Practice, in writing, within 5 days of having been made aware of the unauthorized use or disclosure.

(b) Safeguard PHI. The Business Associate agrees to use commercially reasonable efforts to maintain the confidentiality and security of PHI regardless of media (including written, oral, and electronic) and to prevent unauthorized use or disclosure of such PHI by implementing and maintaining appropriate protection policies and procedures.

(c) Mitigate. The Business Associate agrees to mitigate, to the extent possible, any deleterious effects from any unauthorized use or disclosure of PHI by the Business Associate or its third party agents.

(d) Bind Subcontractors and Agents. The Business Associate agrees to require all of its subcontractors and agents that receive, use, or have access to PHI under this Business Associate Agreement to agree, in writing, to adhere to the same restrictions and conditions on the use or disclosure of PHI that apply to the Business Associate pursuant to this Business Associate Agreement.

(e) Minimum Necessary Disclosure. The Business Associate agrees to disclose to its subcontractors, agents, or other third parties, and request from the Practice, only the minimum PHI necessary to perform or fulfill a specific function required or permitted hereunder.

(f) Return or Destroy. Subject to Section 4.3 below, within 30 days of the termination of this Agreement, the Business Associate agrees, if feasible, to return to the Practice or destroy the PHI in its possession and retain no copies (which for purposes of this Agreement shall mean destruction of all backup tapes or other media). If the Business Associate reasonably determines that such return or destruction is not feasible, it shall extend the protections of this Business Associate Agreement to such information and limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

(g) Implement Safeguards. The Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Practice.

(h) Bind Subcontractors and Agents. The Business Associate agrees to require all of its subcontractors and agents to which it provides electronic PHI to agree, in writing, to implement reasonable and appropriate safeguards to protect such PHI.

(i) Report Security Incident. The Business Associate agrees to report to the Practice any security incident involving PHI experienced by the Business Associate or its subcontractors and agents of which the Business Associate becomes aware, and any remedial or other action to be taken by the Business Associate with respect to such incident. The Business Associate shall make said report to the designated Privacy Officer of the Practice, in writing, within 5 days of having been made aware of the security incident.

(j) Access for Viewing, Inspection, and Copying by Individual Subject of PHI. The Business Associate agrees to make PHI maintained by the Business Associate in a Designated Record Set, if any, available to the Practice for subsequent inspection and copying by the Individual subject thereof in accordance with applicable law (including, but not limited to, the HIPAA Regulations, 45 C.F.R. § 164.524).
(k) Amendment by Subject of PHI. Upon 10 days’ written notice by the Practice, Business Associate agrees to make PHI maintained by the Business Associate in a Designated Record Set, if any, available to the Practice for subsequent amendment by the Individual subject thereof and incorporate any amendments to PHI in accordance with applicable law (including, but not limited to, the HIPAA Regulations, 45 C.F.R. § 164.526). The Business Associate shall create a process to permit and document such amendments.

(l) Access by the U.S. Department of Health and Human Services (HHS). Subject to attorney-client and any other applicable legal privileges, and pursuant to 45 C.F.R. § 164.504(e)(2)(ii)(H), the Business Associate agrees to make available to the Secretary of HHS all records, books, agreements, policies, and procedures relating to the use or disclosure of PHI so that HHS may determine the Practice’s compliance with the HIPAA Regulations. The Business Associate shall immediately notify the Practice upon receipt of any request for access by HHS and shall provide the Practice with a copy of the HHS request for access and all materials to be disclosed pursuant thereto.

(m) Access for Accounting Purposes. The Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for the Practice to respond to a request by an Individual for an accounting of disclosures of PHI. The Business Associate agrees to provide to the Practice, within 10 days of receiving a request in writing therefor, such information as is requested by the Practice to permit the Practice to respond to a request by an Individual for an accounting of the disclosures of the Individual’s PHI in accordance with 45 C.F.R. § 164.528.

(n) Notification of Breach. The Business Associate shall notify the Practice of any Breach involving Unsecured Protected Health Information maintained, used or disclosed by the Business Associate on the Practice’s behalf without unreasonable delay but in no event more than fourteen (14) days after the Business Associate’s discovery of the Breach. The Business Associate’s notification to the Practice shall include the identity of each individual whose Unsecured Protected Health Information has been, or is reasonably believed to have been accessed, acquired or disclosed in connection with the Breach, and, if known, the specific data elements disclosed for each individual. The Business Associate shall reasonably cooperate with the Practice in investigating and mitigating the harmful effects of any Breach. The Business Associate shall assume responsibility for preparing and sending Breach notification letters to individuals without unreasonable delay but in no event more than sixty (60) days after the Business Associate’s discovery of the Breach; provided, however, that the content of any notification shall be subject to the prior written approval of the Practice.

(o) Acknowledgement of Application of HITECH. The Business Associate acknowledges and agrees that the requirements of HITECH that relate to privacy or security are applicable to the Business Associate in the same manner that such requirements are applicable to the Practice. All such requirements are incorporated by reference into this Business Associate Agreement.

3.2 Responsibilities of the Practice. With regard to the use or disclosure of PHI by a Business Associate, the Practice hereby agrees as follows:

(a) Inform the Business Associate of Changes in Privacy Notice. Upon request, the Practice agrees to furnish the Business Associate with a copy of the Notice of Privacy Practices that the Practice provides to Individuals pursuant to 45 C.F.R. § 164.520 and to inform the Business Associate of any subsequent changes thereto, if such changes affect the Business Associate’s permitted or required uses and disclosures of PHI.

(b) Inform the Business Associate of Changes in Authorizations. The Practice agrees to inform the Business Associate of any changes in, or withdrawal of, any authorizations provided to the Practice by Individuals in accordance with 45 C.F.R. § 164.508 and pursuant to which the Practice has disclosed PHI to the Business Associate, if such changes affect the Business Associate’s permitted or required uses and disclosures of PHI.

(c) Inform the Business Associate of Opt-out Election. The Practice agrees to inform the Business Associate of any opt-outs exercised by any Individual from marketing or fundraising activities of the Practice pursuant to 45 C.F.R. § 164.514(f), if such opt-outs affect the Business Associate’s permitted or required uses or disclosures of PHI.

(d) Notify the Business Associate of Additional Limitations. The Practice agrees to notify the Business Associate, in writing and in a timely manner, of any arrangements permitted or required of the Practice under 45 C.F.R. parts 160 and 164 that may affect in any manner the use or disclosure of PHI by the Business Associate under this Business
4. TERM AND TERMINATION

4.1 Term. This Agreement shall become effective on the Effective Date and shall continue in effect until all obligations of the Parties have been met, unless terminated as provided in this Section 4. In addition, the provisions and requirements of Section 4.3 and Section 3.1 (solely with respect to PHI the Business Associate retains in accordance with Section 4.3) of this Agreement shall survive its expiration or other termination.

4.2 Termination by the Practice. Each Business Associate hereby acknowledges and agrees that in the event the Practice receives a complaint that includes, or the Practice otherwise has or obtains, substantial and credible evidence that such Business Associate has violated a material term of this Business Associate Agreement, the Practice shall have the right to investigate such violation, and the Business Associate shall cooperate fully with the Practice with respect to such investigation. As provided for under 45 C.F.R. §§ 164.314 (a)(2)(i)(D) & 164.504(e)(2)(iii), the Practice may immediately terminate this Business Associate Agreement with respect to a Business Associate, and terminate such Business Associate’s access to PHI of the Practice, without penalty or recourse to the Practice if the Practice reasonably determines that the Business Associate has breached a material term of this Business Associate Agreement. Alternatively, the Practice may choose to: (i) provide the Business Associate with written notice of the existence of a material breach; and (ii) afford the Business Associate an opportunity to cure said material breach, to the satisfaction of the Practice, within 30 days of receipt of the Practice’s written notice. Failure to cure is grounds for the immediate termination of this Business Associate Agreement with respect to such Business Associate. Each Business Associate further acknowledges that where the Practice determines in its reasonable discretion that such Business Associate has violated any material term of this Business Associate Agreement and that it is not feasible to terminate this Business Associate Agreement, the Practice will report such violation to HHS and to any other governmental agency as may be required by applicable law. Termination of this Business Associate Agreement by the Practice under either alternative shall be in writing. Notwithstanding termination of this Business Associate Agreement with respect to one of the Business Associates, this Business Associate Agreement shall remain in effect with respect to the other Business Associate unless and until the Practice expressly terminates this Agreement with respect to such other Business Associate as well.

4.3 Effect of Termination. Upon the event of termination of this Agreement with respect to a Business Associate pursuant to this Section 4, such Business Associate agrees to return or destroy all PHI pursuant to 45 C.F.R. § 164.504(e)(2)(ii), if it is feasible to do so. Prior to doing so, the Business Associate further agrees to recover any PHI in the possession of its subcontractors or agents. If it is not feasible for the Business Associate to return or destroy said PHI, the Business Associate will notify the Practice in writing within 10 days of the termination of this Business Associate Agreement. Said notification shall include: (i) a statement that the Business Associate has determined that it is infeasible to return or destroy the PHI in its possession, and (ii) the specific reasons for such determination. The Business Associate further agrees to extend any and all protections, limitations, and restrictions contained in this Agreement to the Business Associate’s use or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses or disclosures to the purposes that make the return or destruction of the PHI infeasible. If it is not feasible for the Business Associate to obtain from subcontractors or agents any PHI in the possession of subcontractors or agents, the Business Associate shall provide a written explanation to the Practice and require subcontractors and agents to agree to extend any and all protections, limitations, and restrictions contained in this Business Associate Agreement to subcontractors’ or agents’ use or disclosure of any PHI retained after termination of this Business Associate Agreement, and to limit any further uses or disclosures to the purposes that make return or destruction of the PHI infeasible.

5. MISCELLANEOUS

5.1 Successors and Assigns. The terms and conditions of this Business Associate Agreement shall inure to the benefit of and be binding upon the respective successors and assigns of the parties, provided that this Agreement may not be assigned by either party without the prior written consent of the other. Nothing in this Agreement, express or implied, is intended to confer upon any party other than the parties hereto or their respective successors and assigns any rights, remedies, obligations, or liabilities under or by reason of this Agreement.

5.2 Severability. If one or more provisions of this Agreement are held to be unenforceable under applicable law, the parties agree to renegotiate such provision(s) in good faith. In the event that the parties cannot reach a mutually
agreeable and enforceable replacement for such provision, then (a) such provision shall be excluded from this Agreement, (b) the balance of the Agreement shall be interpreted as if such provision were so excluded and (c) the balance of the Agreement shall be enforceable in accordance with its terms.

5.3 Amendment and Waiver. Any term of this Agreement may be amended only with the written consent of the parties. Any amendment or waiver effected in accordance with this Section shall be binding upon the parties and their respective successors and assigns. Failure to enforce any provision of this Agreement by a party shall not constitute a waiver of any term hereof by such party. If HIPAA, the HIPAA Regulations or HITECH are amended or interpreted in any manner that renders this Agreement inconsistent therewith, the Practice may, on thirty (30) days written notice to the Business Associates (or any shorter notice period necessary to comply with such amendment or interpretation), amend this Agreement to the extent necessary to comply with such amendments or interpretations.

5.4 Counterparts. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original and all of which together shall constitute one instrument.

5.5 Entire Agreement. This Agreement is the product of both of the parties hereto, and constitutes the entire agreement between such parties pertaining to the subject matter hereof, and merges all prior negotiations and drafts of the parties with regard to the transactions contemplated herein. Any and all other written or oral agreements existing between the parties hereto regarding such transactions are expressly canceled.

5.6 Notice. All requests, reports, approvals and notices required or permitted to be given under this Agreement shall be in writing and, unless specifically provided otherwise in this Agreement, shall be deemed to have been given when sent if personally delivered, faxed (with receipt confirmed) or mailed by registered or certified air mail, return receipt requested, or by overnight mail with receipt confirmed, postage prepaid, to the party concerned, at its address or addresses as set forth on the signature page hereof or as designated from time to time by notice in writing.

The parties have executed this Business Associate Agreement as of the date first above written.

EastPoint Health, LLC  
P.O. Box 25506  
Overland Park, Kansas 66221  
Name: Dennis Weaver, Chief Executive Officer

Massachusetts eHealth Collaborative, Inc.  
860 Winter Street  
Waltham, MA 02451  
Name: Micky Tripathi, Chief Executive Officer

Healthcare Information Xchange of New York  
855 State Route 146  
Clifton Park, NY, 12065  
Name: Dominick Bizzarro, Chief Executive Officer
ATTACHMENT D: COMMON ATTESTATION STATEMENT

ATTESTATION STATEMENT

Practice Name:____________________________________

Practice Address:___________________

Practice City:_____________________________________

Practice State:______________________  ZIP:__________

I certify that I have reviewed each NCQA Medical Home Recognition requirements in the attached document, and attest that (practice name)

_________________________________________________

is working toward compliance with the applicable requirements.

_________________________________________________

Signature:

_________________________________________________

Printed Name:

Title:___________________________________________

Date:___________________________________________
## ATTACHMENT E: ACCESS & COMMUNICATION MEASURES

*Element PPC1B: Access & Communication Results (Items 1, 2, 3, 5) Cumulative data*

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>Practice Standards</th>
<th>Month 1/Year</th>
<th>Month 2/Year</th>
<th>Month 3/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1. (Meets standard 1A1) % of patients assigned to a personal clinician</td>
<td>90%</td>
<td>N=133</td>
<td>N=116</td>
<td>N=133</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Item 1. (Meets standard 1A1) % of patient visits w/ assigned personal clinician (measured during 1 week)</td>
<td>90%</td>
<td>N=133</td>
<td>N=116</td>
<td>N=133</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Item 2. (Meets standard 1A3-6) % of same day appointments for urgent requests (measured during 1 week)</td>
<td>90%</td>
<td>N=11</td>
<td>N=10</td>
<td>N=6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>91%</td>
<td>80%</td>
<td>83%</td>
</tr>
<tr>
<td>Item 3. (Meets standard 1A7) % of telephone requests returned within 4 hours – daytime (measured during 1 week)</td>
<td>90%</td>
<td>N=142</td>
<td>N=107</td>
<td>N=44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td></td>
<td>4 Hours</td>
<td>1.6</td>
<td>1.9</td>
<td>.9</td>
</tr>
<tr>
<td>Item 3 (Meets standard 1A8) % of urgent telephone requests returned within 1 hour – after hours (measured during 1 week)</td>
<td>90%</td>
<td>N=0</td>
<td>N=2</td>
<td>N=1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>1 Hour</td>
<td>0</td>
<td>.1</td>
<td>.1</td>
</tr>
<tr>
<td>Item 4. (Meets standard 1A9) % of email requests returned within 8 hours (measured during 1 week)</td>
<td>90%</td>
<td>N=</td>
<td>N=</td>
<td>N=</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>0%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>8 Hours</td>
<td>Average # of hours</td>
<td>Average # of hours</td>
<td>Average # of hours</td>
</tr>
<tr>
<td>Item 4. (Meets standard 1A10) % of web requests returned within 24 hours (measured during 1 week)</td>
<td>90%</td>
<td>N=</td>
<td>N=</td>
<td>N=</td>
</tr>
<tr>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>24 Hours</td>
<td>Average # of hours</td>
<td>Average # of hours</td>
<td>Average # of hours</td>
</tr>
<tr>
<td>Item 5. (Meets standard 1A11) Number of times language services utilized (measured during 1 week)</td>
<td></td>
<td>N=0</td>
<td>N=0</td>
<td>N=0</td>
</tr>
</tbody>
</table>
# Attachment F: Pediatric Quality Measures

## Pediatric Prevention

<table>
<thead>
<tr>
<th>POD Patients</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of patients documented per month:</td>
<td>2429</td>
</tr>
</tbody>
</table>

### Process: Patients with 4 DtaP/DT
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 30%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 30%

### Process: Patients with 3 IPV
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 56%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 56%

### Process: Patients with 1 MMR
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 40%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 40%

### Process: Patients with 4 pneumococcal conugate
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 39%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 39%

### Process: Patients with documented BMI
- 92%
- 27%
- 90%
- 79%
- 93%
- 72%
- 69%
- 63%
- 53%
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- 93%
- 73%

### Outcome: Patients with documented Lead Test before age 2
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 39%
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- 56%
- 48%

## Asthma

### Process: Patients 5-18 yrs old with Asthma
- No data
- No data
- Unknown
- Unknown
- No data
- No data
- No data
- 11%
- 6%
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- 19%
- 12%

### Outcome: Of these chronic asthma patients, number on certain meds*
- 69%
- 44%
- 74%
- 58%
- 67%
- 66%
- 47%
- 85%
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- 52%
- 62%

## Obesity

### Process: All patients whose blood pressure was recorded
- 37%
- 8%
- 28%
- 29%
- 25%
- 23%
- 22%
- 15%
- 35%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 14%
- 24%

### Outcome: Of these, patients with BP >= 140/90 mm Hg
- 6%
- 8%
- 2%
- 13%
- 4%
- 8%
- 5%
- 6%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 1%
- 6%

### Process: Patients whose weight was recorded (BMI)
- 92%
- 27%
- 84%
- 79%
- 93%
- 72%
- 69%
- 5%
- 53%
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- 93%
- 67%

### Outcome: Of these, patients whose BMI was recorded (BMI >= 85th %ile)
- 42%
- 30%
- 40%
- 37%
- 30%
- 32%
- 33%
- 100%
- 41%
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- Incomplete
- 33%
- 42%

### Process: Of these, patients with blood pressure was recorded
- 89%
- 85%
- 80%
- 93%
- 80%
- 88%
- 92%
- 90%
- 89%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 45%
- 83%

### Outcome: Of these, patients with BP >= 140/90 mm Hg
- 6%
- 5%
- 2%
- 14%
- 4%
- 7%
- 5%
- 6%
- No data
- No data
- No data
- No data
- No data
- No data
- No data
- 1%
- 6%
<table>
<thead>
<tr>
<th>Clinical Process and Outcome Measures: Adults, 2010</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
<th>M</th>
<th>N</th>
<th>TOTAL PATIENTS</th>
<th>AVERAGE SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with Dx of Hypertension ( ttl patients documented)</td>
<td>1026</td>
<td>511</td>
<td>1192</td>
<td>260</td>
<td>2890</td>
<td>2371</td>
<td>232</td>
<td>369</td>
<td>1334</td>
<td>403</td>
<td>1297</td>
<td>273</td>
<td>1013</td>
<td>600</td>
<td>13771</td>
<td></td>
</tr>
<tr>
<td>1. Process: Patients with documentation of BMI</td>
<td>40%</td>
<td>25%</td>
<td>57%</td>
<td>69%</td>
<td>52%</td>
<td>90%</td>
<td>49%</td>
<td>61%</td>
<td>74%</td>
<td>91%</td>
<td>89%</td>
<td>49%</td>
<td>62%</td>
<td>45%</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>2. Process: Patients with documentation of weight</td>
<td>66%</td>
<td>No data</td>
<td>No data</td>
<td>72%</td>
<td>No data</td>
<td>98%</td>
<td>98%</td>
<td>No data</td>
<td>76%</td>
<td>96%</td>
<td>92%</td>
<td>49%</td>
<td>87%</td>
<td>46%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>3. Process: Patients having an annual complete lipid profile</td>
<td>33%</td>
<td>51%</td>
<td>No data</td>
<td>17%</td>
<td>No data</td>
<td>65%</td>
<td>82%</td>
<td>98%</td>
<td>34%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>70%</td>
<td>7%</td>
<td>51%</td>
</tr>
<tr>
<td>4. Process: Patients with documentation of their smoking status</td>
<td>1%</td>
<td>0%</td>
<td>34%</td>
<td>No data</td>
<td>8%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>51%</td>
<td>4%</td>
<td>26%</td>
<td>11%</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Outcome: Patients with BP =&gt; 140/90 mm Hg</td>
<td>12%</td>
<td>26%</td>
<td>49%</td>
<td>27%</td>
<td>27%</td>
<td>44%</td>
<td>No data</td>
<td>18%</td>
<td>24%</td>
<td>18%</td>
<td>8%</td>
<td>3%</td>
<td>38%</td>
<td>9%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>2. Outcome: Patients with LDL &lt; 100 mg/dl</td>
<td>No data</td>
<td>63%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>38%</td>
<td>72%</td>
<td>No data</td>
<td>40%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>47%</td>
<td>38%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>3. Outcome: Patients who smoke who received cessation advice or treatment</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>58%</td>
<td>No data</td>
<td>No data</td>
<td>58%</td>
</tr>
<tr>
<td>Patients with Dx of Diabetes ( ttl patients documented)</td>
<td>277</td>
<td>110</td>
<td>494</td>
<td>123</td>
<td>1237</td>
<td>713</td>
<td>77</td>
<td>369</td>
<td>475</td>
<td>219</td>
<td>655</td>
<td>75</td>
<td>342</td>
<td>215</td>
<td>5381</td>
<td></td>
</tr>
<tr>
<td>1. Process: Eligible patients receiving at least one foot exam</td>
<td>No data</td>
<td>0%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>37%</td>
<td>1%</td>
<td>No data</td>
<td>No data</td>
<td>13%</td>
</tr>
<tr>
<td>1. Outcome: Patients with most recent HbA1C &lt;= 9.0%, measurement pd (3)</td>
<td>7%</td>
<td>14%</td>
<td>No data</td>
<td>8%</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
<td>19%</td>
<td>9%</td>
<td>No data</td>
<td>4%</td>
<td>15%</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>2. Outcome: Patients with most recent HbA1C &lt;= 8.0%, measurement pd (3)</td>
<td>83%</td>
<td>76%</td>
<td>No data</td>
<td>89%</td>
<td>92%</td>
<td>85%</td>
<td>81%</td>
<td>No data</td>
<td>70%</td>
<td>82%</td>
<td>No data</td>
<td>38%</td>
<td>74%</td>
<td>88%</td>
<td>73%</td>
<td>78%</td>
</tr>
<tr>
<td>3. Outcome: Patients with most recent HbA1C &lt;= 7.0%, measurement pd (3)</td>
<td>56%</td>
<td>46%</td>
<td>No data</td>
<td>67%</td>
<td>74%</td>
<td>59%</td>
<td>40%</td>
<td>48%</td>
<td>57%</td>
<td>No data</td>
<td>31%</td>
<td>48%</td>
<td>66%</td>
<td>57%</td>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>2a. Outcome: Patients with BP =&gt; 140/90 mm Hg</td>
<td>8%</td>
<td>16%</td>
<td>33%</td>
<td>15%</td>
<td>29%</td>
<td>29%</td>
<td>8%</td>
<td>No data</td>
<td>23%</td>
<td>1%</td>
<td>4%</td>
<td>2%</td>
<td>34%</td>
<td>3%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>2b. Outcome: Patients with BP &lt;= 130/80 mm Hg</td>
<td>9%</td>
<td>52%</td>
<td>16%</td>
<td>71%</td>
<td>45%</td>
<td>54%</td>
<td>42%</td>
<td>No data</td>
<td>47%</td>
<td>35%</td>
<td>48%</td>
<td>54%</td>
<td>39%</td>
<td>38%</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>2c. Outcome: Patients with an LDL &lt; 130 mg/dl</td>
<td>No data</td>
<td>12%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>15%</td>
<td>20%</td>
<td>15%</td>
<td>No data</td>
<td>19%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>13%</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>2d. Outcome: Patients with an LDL &lt; 100 mg/dl</td>
<td>No data</td>
<td>75%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>61%</td>
<td>53%</td>
<td>68%</td>
<td>No data</td>
<td>51%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>65%</td>
<td>40%</td>
<td>59%</td>
</tr>
<tr>
<td>4. Outcome: Patients who smoke who received cessation advice or treatment</td>
<td>No data</td>
<td>0%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
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<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>0%</td>
</tr>
<tr>
<td>Patients with Dx of CAD ( ttl patients documented)</td>
<td>168</td>
<td>87</td>
<td>295</td>
<td>65</td>
<td>677</td>
<td>503</td>
<td>49</td>
<td>246</td>
<td>No data</td>
<td>150</td>
<td>303</td>
<td>39</td>
<td>164</td>
<td>13</td>
<td>2759</td>
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</tr>
<tr>
<td>1. Process: Patients with documentation of weight</td>
<td>71%</td>
<td>Data suspect</td>
<td>No data</td>
<td>77%</td>
<td>No data</td>
<td>98%</td>
<td>100%</td>
<td>46%</td>
<td>No data</td>
<td>99%</td>
<td>91%</td>
<td>62%</td>
<td>81%</td>
<td>38%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>2. Process: Patients with documentation of BMI</td>
<td>38%</td>
<td>Data suspect</td>
<td>No data</td>
<td>41%</td>
<td>77%</td>
<td>No data</td>
<td>92%</td>
<td>57%</td>
<td>47%</td>
<td>No data</td>
<td>97%</td>
<td>86%</td>
<td>49%</td>
<td>57%</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>3. Process: Patients having an annual complete lipid profile</td>
<td>27%</td>
<td>Data suspect</td>
<td>No data</td>
<td>15%</td>
<td>39%</td>
<td>0%</td>
<td>73%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>28%</td>
<td>75%</td>
<td>0%</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>4. Process: Patients with documentation of their smoking status</td>
<td>1%</td>
<td>Data suspect</td>
<td>No data</td>
<td>8%</td>
<td>41%</td>
<td>10%</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>42%</td>
<td>No data</td>
<td>27%</td>
<td>No data</td>
<td>22%</td>
</tr>
<tr>
<td>1. Outcome: Patients with BP =&gt; 140/90 mm Hg</td>
<td>10%</td>
<td>Data suspect</td>
<td>42%</td>
<td>15%</td>
<td>No data</td>
<td>25%</td>
<td>4%</td>
<td>17%</td>
<td>No data</td>
<td>6%</td>
<td>8%</td>
<td>10%</td>
<td>35%</td>
<td>0%</td>
<td>16%</td>
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</tr>
<tr>
<td>2. Outcome: Patients with LDL &lt; 100 mg/dl</td>
<td>64%</td>
<td>Data suspect</td>
<td>No data</td>
<td>No data</td>
<td>No data</td>
<td>69%</td>
<td>49%</td>
<td>75%</td>
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<td>82%</td>
<td>71%</td>
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<td>59%</td>
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<tr>
<td>3. Outcome: Patients who smoke who received cessation advice or treatment</td>
<td>No data</td>
<td>No data</td>
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</tr>
<tr>
<td><strong>ATTACHMENT G: ADULT QUALITY MEASURES</strong></td>
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</tbody>
</table>