Clinical Integration Information and Enrollment Packet

North State
Quality Care Network
A Dignity Health Member

Mission Statement

The mission of the North State Quality Care Network is for its physician members, in collaboration with their hospital partners, to improve the health of the community through the efficiency and effectiveness of the care they deliver, monitoring outcomes across the health care continuum, and focusing on improvement of processes and appropriate utilization to ensure quality.

A physician-driven initiative of the medical staff at Dignity Health's North State hospitals.

Dear Colleague:

We are very pleased to invite you to join our collaborative team of North State physicians serving Shasta, Siskiyou and Tehama counties and surrounding area. In a clinically integrated network such as North State Quality Care Network (NSQCN), physicians strive to improve the quality of care they provide while decreasing their costs and increasing their reimbursement from health plans, based on their ability to achieve quality standards.

Organized for the specific purpose to help local physicians overcome the challenges of health care reform, NSQCN is physician-controlled and physician-led. Participating physicians in NSQCN can provide their patients with better quality care while increasing the efficiency of their practices and reducing costs. In addition, physicians may have access to financial rewards for attaining certain quality goals. In similar programs throughout the country, physicians receive increased reimbursement for achieving quality benchmarks.

As team members in this clinically integrated network of individuals and hospitals committed to improving quality and patient outcomes, physicians negotiate jointly with commercial payers and self-insured employers while demonstrating their ability to achieve the quality benchmarks set by local member physicians and hospitals. NSQCN includes members of the medical staff at Dignity Health North State hospitals (Mercy Medical Center Redding, Mercy Medical Center Mt. Shasta and St. Elizabeth Community Hospital).

There is no enrollment fee or ongoing participation cost. Once you have decided to take part in this opportunity, simply complete and sign the enrollment materials and contact:

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I.

North State Quality Care Network (NSQCN)

What's in it for You?

Frequently Asked Questions

What's in it for You?

Clinical integration (CI): a proven method

Clinical integration (CI) is an innovative, proven method that enhances the quality of health care while controlling costs. Better health outcomes result for the community from physician leadership, greater clinical collaboration and shared accountability among physicians and hospitals.

North State Quality Care Network (NSQCN) is a collective network of independent physicians serving Shasta, Siskiyou and Tehama Counties and surrounding area who are committed to improving quality of care and patient outcomes, as well as the efficiency and cost of the care provided.

NSQCN physicians collectively negotiate with health plans while demonstrating their ability to achieve certain quality benchmarks. The network includes members of the medical staff at Dignity Health North State hospitals (Mercy Medical Center Redding, Mercy Medical Center Mt. Shasta and St. Elizabeth Community Hospital).

Other physicians in clinical integration programs throughout the country also are earning financial rewards for achieving their quality goals.

What clinical integration is not

Clinical Integration is not capitation or physician employment, and it will not put your individual fees at risk. There is no cost to enroll. It is not led by the hospitals. They provide the organizational development and operational funds, but the Board of Managers is physician-dominated and the committees are physician-led.

Hospitals do not support the program to control physician practices. They enlist physician support for quality initiatives through clinical integration and gain an advantage in the market based on quality.

What are the benefits of joining?

A CI network such as NSQCN provides a support system for private-practice physicians facing the many challenges in health care today. Most importantly, network participation allows you to practice within a more "integrated and multidisciplinary" practice model while maintaining your independent medical practice.

NSQCN provides tools and resources to help manage your more complex patients, enabling you to drive both quality and efficiency in your practice. This will benefit your patients' care and outcomes, as well as your practice.

NSQCN allows you to be part of a community physician network focused on improving pathways of care and clinical quality. The network also provides a vehicle for you to engage in joint contracting with fee-for-service payers for their commercial patients.

What is expected of those who join?

As a participating physician in NSQCN, you agree to:

- Sign a Physician Participation Agreement
- Practice evidence-based medicine
- Uphold regulatory, quality and safety goals
- Report quality data
- Attend meetings and performance feedback sessions
- Accept decisions by peer physicians in the network
- Collaborate and communicate with colleagues, case managers and hospitals

What is the cost?

Participation costs nothing. There are no enrollment fees and no ongoing participation fees.

How do I sign up?

Complete and submit all enrollment materials to:

Rosa Soito, RN, Executive Director
North State Quality Care Network, LLC
rosa.soito@dignityhealth.org
530.225.6151

Participating Providers

For a current list of NSQCN participating providers, please visit our website at NSQCN.org. Click on the "About Us" tab and then the "Participants" link.

Frequently Asked Questions

Q: What is a clinically integrated network?

A: Clinically integrated (CI) networks are integrated systems of hospitals, physicians and other medical facilities that collaborate to improve quality and efficiency of care. The structure of these networks encourages a team-based approach to care delivery and allows for greater sharing of patient data and best practices. CI networks are able to leverage the unique strengths of independent physician practices and share resources—such as technology, care management programs and infrastructure investments.

Q: What are the characteristics of an effective clinically integrated program?

A: Clinical integration fosters interdependence among providers who, by working together on the quality initiatives they select for the program, are able to achieve higher quality and greater cost-effectiveness than they likely could accomplish on their own.

Q: What does a clinically integrated network of independent physicians look like?

A: In most instances, clinical integration involves a hospital and physicians on its medical staff who create committees and management capabilities to:

- Identify and adopt clinical protocols for the treatment of particular disease states
- Develop systems to monitor compliance with the adopted protocols on both an inpatient and outpatient basis
- Contract with fee-for-service health plans and local employer self-insured plans in a way that financially recognizes the physicians' efforts to improve healthcare quality and efficiency

Q: Does clinical integration require me to place my fees at risk in a "withhold" or capitation model?

A: While clinical integration uses many of the same quality improvement and medical management techniques that would allow for effective management of capitation, it currently does not require the use of withholds or capitation.

As healthcare reimbursement models change in the future, members of the network may opt to participate in contracts that have downside risks.

Q: Will I be able to negotiate with other doctors in the program for better fee-for-service rates from the health plans?

A: In successful clinical integration programs, value-based contracts with fee-for-service health plans can include incentives that recognize the value of the higher quality and greater efficiency furnished through the clinical integration program.

Q: Can we participate in just the contracts that we choose?

A: The clinical integration program agreement requires physicians to participate in each clinically integrated payer contract negotiated by the network. Participation in the Bundled Payment for Care Improvement (BPCI) or Medicare Shared Savings Program (MSSP) is voluntary.

Q: Do all members of the group have to participate if we sign up under a group agreement?

A: The participation agreement stipulates that all members in a group must participate.

Q: Will this affect my referral patterns?

A: Participation in a clinically integrated network does not mandate any change in referral patterns. NSQCN is not an HMO or an IPA.

Q: Does participating affect my other payer contracts?

A: Membership is non-exclusive and does not limit a physician's ability to contract with other health plans independently or through another independent practice association (IPA), physician organization (PO) or physician hospital organization (PHO).

Q: My staff cannot take on more work. How will this affect my practice?

A: Joining a CI network will provide additional resources. The goal is to not add more work to office staff. Provider feedback indicates the required claims uploading process only takes a few minutes.

Q: What role do Dignity Health and the hospitals have in making decisions for the network?

A: NSQCN is physician-led. Its board of managers is composed entirely of physicians with one hospital representative.

Q: Why can't care management support all of my patients?

A: NSQCN's care management team currently supports patients who are part of the CI network's contracts and can assist with providing information on community resources for other patients.

Q: Do the CI network's quality metrics replace PQRS?

A: Federal Trade Commission (FTC) regulations require a CI program to measure and report on the quality of the care provided within the network. These measures have been designed to overlap with PQRS; however, they are not a replacement.

Q: Is a CI network an ACO? Is it an IPA?

A: A CI network is neither an ACO nor an IPA. A CI program can involve independent and employed physicians working with a hospital or health system who contract collectively with fee-for-service health plans without violating anti-trust laws.

Q: What benefit will Mercy Medical Center Redding, Mercy Medical Center Mt. Shasta and St. Elizabeth Community Hospital provide in developing a clinical integration program?

A: Partnering with a hospital or health system can provide distinct advantages to a network of independent physicians in the development of clinical integration. In instances where the hospital shares the same quality vision as the physicians, as is the case at Mercy Medical Center Redding, Mercy Medical Center Mt. Shasta and St. Elizabeth Community Hospital, are a powerful ally in program development by:

- Collaborating with the physicians in developing clinical integration initiatives based on existing inpatient quality measures
- Lending financial assistance and personnel in implementing inpatient and outpatient initiatives that provide true community benefit and are not tied to the referral volume or value

Q: Why are physicians across the country engaging in clinical integration?

A: Physicians have several motivations for participating in clinically integrated networks, including:

- Enhancing the quality of the care provided to patients
- Legitimately negotiating with payers as a network
- Developing their own alternatives to health plan "report cards" and other initiatives that may not accurately assess physicians
- Providing access to technological and quality improvement infrastructure
- Allowing networks of physicians and hospitals to market themselves based on quality

Q: Why do so many physicians view clinical integration as a good business and healthcare strategy?

A: Doctors and hospitals nationwide are implementing clinical integration programs because they believe in its value proposition:

1. Clinical integration allows physicians to:
   - Demonstrate their quality to current and future patients
   - Choose the clinical measures against which they will be evaluated
   - Share in appropriate care management, care coordination and technology tools that allow the physicians to participate in the health system in a more integrated way

2. Clinical integration gives hospitals the ability to:
   - Develop a better, more collaborative relationship with their medical staff
   - Demonstrate their quality to current and future patients
   - Enlist physician support for hospital initiatives, including compliance with "core measures," clinical pathways, standardized order sets and supply chain management initiatives

3. Clinical integration provides patients with:
   - Greater stability in their relationships with their doctors and hospitals and less likelihood that they will need to choose new healthcare providers every year
   - A better value for their healthcare dollar
   - More effective care management and outreach from a trusted source—their physician
   - More reliable information to support their choice of health plans, physicians and hospitals
   - More accurate and meaningful provider ratings

4. Clinical integration gives employers:
   - Allows employers to provide a more integrated model of care for their employees that focuses on quality outcomes and efficiency in healthcare
   - Increased employee productivity and reduced absenteeism through better management of chronic disease
   - The ability to more effectively manage the healthcare costs of employees and their dependents through the purchase of better, more efficient healthcare
   - Lower healthcare costs over the long term through the reduction of variation in physician practice patterns
   - More reliable information to support conversion to consumer-driven health insurance products

II.

Program Details

Contracts and Initiatives

Health Information Exchange

Data Security Fact Sheet

Quality Data Reporting Frequently Asked Questions

Contracts and Initiatives

Our current contracts are listed below. For the most current list, please visit nsqcn.org.

1. Blue Shield PPO ACO

Dignity Health and Blue Shield entered into an agreement to form an Accountable Care Organization for management of members enrolled in the Blue Shield of California IFP/PPO/ACO insurance plan. This is a collaborative agreement to help improve member quality of care, while reducing cost of care.

The population enrolled in Blue Shield's Individual and Family Plan (IFP) products, including plans offered both on and off the California Exchange, are covered by the program.

There is no financial risk to participating physicians. Physicians will be paid according to the existing direct fee-for-service agreements with Blue Shield. Claims are submitted by the physician office to Blue Shield of California.

Members are not required to select a PCP and may be seen by any physician. Members have access to any facility or specialist. Referrals to specialists do not require pre-approval. The referral process is the same as the current Blue Shield PPO contract.

2. Bundled Payment for Care Improvement (BPCI) Model 2

Mercy Medical Center Redding and St. Elizabeth Community Hospital are participating in the Bundled Payment for Care Improvement (BPCI) initiative, a model within the Center for Medicare and Medicaid Innovation (CMMI). BPCI is an innovative payment model designed to increase efficiencies of care, improve quality and enhance patient satisfaction across the care continuum.

We are partnering with naviHealth, the CMS "awardee convener," to participate in Model 2, a three-year initiative which focuses on acute care hospital stays and 90 days post-acute care. This model seeks to foster collaboration among hospitals, physicians and post-acute providers in improving care coordination for Medicare fee-for-service patients through care redesign, aligned financial incentives and enhanced communication processes. This in turn can improve the patient's experience of care during a hospital stay and in their post-discharge recovery.

We are working collaboratively with CMMI to gain experience while this model is still under development. As a result, we will have a significant hand in shaping the process going forward.

This proactive approach to testing innovative payment and service delivery models will seek to re-engineer and provide greater value in care delivery and better prepare us to thrive in an era of health care reform. You as physician leaders are instrumental to the success of the project, and we hope to be working closely with you to test the efficacy of this new delivery model in our community.

You would only be responsible for the metrics within your specialty.

Gainsharing
CMMI has provided specific guidance to the bundling program participants to manage the distribution of savings pools created from this program. Physicians will be reimbursed their standard CMS fee-for-service reimbursement.

There is no downside risk to a physician in this model; however, for physicians to achieve a portion of the savings, they must have executed a contract/amendment to comply with CMS guidelines, have rendered services to patients in the selected episodes and collaboratively achieved the identified quality measures.

Physicians (working in collaboration) must meet quality measures to be eligible to receive gainsharing payments from the savings pools. Quality measures consist of inpatient (e.g., hospital core measures) and outpatient metrics (e.g., readmissions).

For each clinical area, payouts are determined based on having achieved quality ratings within the physicians' scope of work. Gainsharing payments are based on collective and aggregate performance within these clinical areas.

Bundled Payment for Care Improvement (BPCI) FAQs

In addition to the FAQs below, we will continue to provide program updates as necessary to help answer any questions.

Q: What comprises a bundled payment?

A: A bundled payment, as defined by Model 2 of this project, is an episode that encompasses a family of related MS-DRGs with various co-morbidities; this includes all non-hospice Parts A and B services provided during the initial inpatient stay and a post-acute period of 90 days.

Q: Which patients are included in this program?

A: The BPCI program is applicable to all Medicare fee-for-service patients (both Parts A and B), where Medicare is the primary payer and services fall within the clinical episodes. It is NOT applicable to Medicare Advantage (i.e., "Medicare HMO") patients or end stage renal disease (ESRD) patients. In addition, Medicaid patients are only included if Medicare is the primary payer with Medicaid being secondary.

Q: How does BPCI work from a physician's standpoint?

A: Physicians will bill and collect per their prevailing Medicare fee schedule. In the BPCI program, physicians have the opportunity to participate in gainsharing if savings are achieved and quality goals are met.

Q: Will participation in BPCI result in my receiving reduced reimbursement?

A: Physicians will bill and get reimbursed at the prevailing Medicare fee schedule. Current billing, collecting processes (with regard to patient copays, secondary payers, etc.) and policies still apply.

Q: How do physicians become eligible for gainsharing?

A: Participation in gainsharing is voluntary, and quality metrics must be achieved before any cost savings are distributed. Physicians do not have any downside risk in participating in this program. To be eligible for gainshare distribution from the BPCI Savings pool, hospitals and physicians must implement written agreements that meet CMS requirements.

The gainsharing distribution is subject to meeting all CMS, naviHealth-Dignity Health Agreement and Model 2 Physician Gainsharing Agreement requirements. The quality measures must be met by physicians to be eligible to receive incentive payments.

In addition, CMS imposes an annual cap on shared savings based on the provider's reimbursement, not to exceed 50 percent of the Medicare fee-for-service schedule. CMS has the authority to determine eligibility of each physician to participate in gainsharing. CMS is provided a roster of eligible physicians and notified of any updates as needed.

Q: How does BPCI gainsharing distribution work?

A: CMS will quarterly reconcile the total amount of actual fee-for-service expenditures for items and services against the target price for each episode. This target price is determined by taking a 2% discount off the baseline price that CMS established based on three-year historical claims data and trended forward to current pricing structures.

If the actual expenditures are below the amount in the target price for both acute and post-acute care, a portion will be contributed to the BPCI savings pool for gainsharing distribution. The amount of savings will be aggregated for each physician gainsharing pool, which is grouped by relevant episodes and distributed as according to performance on quality goals.

Q: Are there any financial risks for physicians participating in this program?

A: Physicians have no downside risk in participating in the bundled payment gainsharing program, as the participating hospitals and naviHealth will take on the downside risks of participation as well as program costs.

Q: Will we partner with any other organizations in these efforts?

A: We will be working with naviHealth, a post-acute management company, and the BPCI awardee convener. Based out of Nashville, naviHealth specializes in managing post-acute services and transitions of care nationally.

Q: How will physicians collaborate with naviHealth?

A: NaviHealth uses a patient assessment survey tool, LiveSafe™, to help drive appropriate post-acute care placement and outcomes. NaviHealth will use this tool to stratify and assess patients for appropriate levels of post-acute settings. Then, based upon the level of intervention needed, naviHealth may follow the patient for the next 90 days and work with physicians to manage the patient's progress. As a part of this process, naviHealth will provide care coordinators to work alongside physicians, hospital case management, discharge planners and other staff.

Clinical Integration Quality Measures

North State Quality Care Network (NSQCN) is physician-driven, with physicians determining which quality measures will be used to improve overall quality of care.

Purpose

1. Promote greater accountability for quality, effectiveness and efficacy of health care services to patients.
2. Ensure that NSQCN and all of its stakeholders demonstrate a consistent endeavor to deliver safe, effective and optimal patient care and services.

Scope of activities

1. NSQCN's Quality Committee designs, measures and assesses specific quality measures to:
   - Inform and drive quality improvement projects.
   - Assess and re-evaluate performance improvement activities to continually improve.

Goals

1. Continually and systematically plan, design, measure, assess and improve performance of priority focus areas.
2. Improve health care outcomes through data-driven quality measures and accountabilities and clinical quality projects across the patient-care continuum.
3. Promote effectiveness and efficiency of health care services.
4. Continuously improve processes related to:
   - Safety
   - Effectiveness
   - Patient-centeredness
   - Timeliness
   - Efficiency

Based on the mission and vision of Dignity Health, NSQCN is committed to fostering an environment that encourages performance assessment and improvement related to clinical care and quality. Clinical integration administrative leaders, the NSQCN Board of Managers, physicians, other providers and quality staff leaders agree to work mutually toward those goals.

Quality Measures Phase I Common Scorecard

Metrics	Metric definition	Metric ID	Level of Reporting	Data Source	Benchmark	Scoring	Weighting
Citizenship							**25%**
Billing data	Adequate submission of billing data (pre-adjudicated claims) each month when deemed technically able to do so		Physician/ practice	IT Department	> =92%	0, 1	30%
CIN meeting participation	Attend >50% of CIN meetings per year		Physician	Sign-in sheets	> 50% of meetings	0, 1	15%
Resolve care management issues	% of issues resolved within 2 business days; score is 0 if does not engage with CM; measure removed if no CM offered		Physician	CM/UM team	75%	0, 1	15%
EHR	Attestation to stage II meaningful use		Physician/ practice	Complete survey evaluation of 10 or more network colleagues every 6 months. (Measure calculated June 15 and Dec. 15)	yes	0, 1	15%
Review metrics results	Access dashboard or review performance with quality nurse once a quarter		Physician	IT Dept, CIN team	yes	0, 1	10%
Physician-to-physician survey every 6 months (NSQCN measure only)	Complete a survey evaluation of 10 or more network colleagues every 6 months		Physician	Complete survey evaluation of 10 or more network colleagues every 6 months. (measure calculated June 15 and Dec. 15)	yes	0,1	15%

Quality Measures Phase I Common Scorecard (continued)

Metrics	Metric definition	Metric ID	Level of Reporting	Data Source	Benchmark	Scoring	Weighting
Quality							**25%**
Appropriate testing for children with pharyngitis (CWP)	% of children 2-18 years diagnosed with pharyngitis, dispensed an antibiotic and received group A streptococcus (strep) test for the episode	NQF 2	Physician	Adjudicated claims or payer report		0, 1	Average of metrics
	% of children 3 months-18 years who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic	NQF 65	Physician	Adjudicated claims or payer report		0, 1	Average of metrics
Avoidance of antibiotic treatment in adults with acute bronchitis	% of adults 18-64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription	NQF 58	Physician	Adjudicated claims or payer report		0, 1	Equally weighted
Comprehensive diabetes care: medical attention for nephropathy	% of members 18-75 years of age with diabetes (type 1 and type 2) who had medical attention for nephropathy in the last	NQF 62	Physician	Adjudicated claims or payer report	Mean =	0, 1	Equally weighted
Well-child visits in 3-6 years of life (W34)	% of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year	NQF 1516	Physician	Adjudicated claims or payer report		0, 1	Equally weighted
Well-child visits in first 15 months of life (W15)	% of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life	NQF 1392	Physician	Adjudicated claims or payer report		0, 1	Equally weighted
Good glycemic control	% of members with diabetes who have an A1C<8%	ACO 22 (retired) NQF 575	Physician	Billing + chart abstraction		0, 1	Equally weighted
Hypertension: controlling high blood pressure	% of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period	ACO 28	Physician	Billing + chart abstraction	Mean = 72.43% St Dev = 17.04%	0, 1	Equally weighted

Quality Measures Phase I Common Scorecard (continued)

Metrics	Metric definition	Metric ID	Level of Reporting	Data Source	Benchmark	Scoring	Weighting
Patient experience							**25%**
Same-day access	Agree to offer same day access for emergent/stat appointments or consults with the requested physician or designated covering physician		Practice	Survey	100%	0, 1	20%
Participate in an alternative hours program for routine care	Agree to offer alternative hours (evenings and weekends) for routine visits as a practice or part of a larger group		Practice	Survey	100%	0, 1	40%
CG-CAHPS	Overall performance on CG-CAHPS survey		CIN	Survey			40%
Efficiency – network-level measures							**25%**
Readmissions	% of index admissions with a readmission within 30 days	PQRS 356	CIN	Adjudicated claims or payer report	Mean = 15.94% St. Dev = 1.39%		40%
ED visits	ED visits per 1000 members		CIN	Adjudicated claims or payer report			20%
Admissions	Admissions per 1000 members		CIN	Adjudicated claims or payer report			20%
High-tech imaging	MRI/CT/PET scan events per 1000 members		CIN	Adjudicated claims or payer report			20%

ACO Quality Metrics

ACO metric	Metric description	PY2014 mean pioneer performance	Level of reporting	Data source	PY2014 mean MSSP performance
Patient/ caregiver experience					
ACO 1	CAHPS: Getting timely care, appointments and information	80.47%	Provider	CG CAHPS survey	80.13%
ACO 2	CAHPS: How well your providers communicate	92.45%	Provider	CG CAHPS survey	92.39%
ACO 3	CAHPS: Patients' rating of provider	91.88%	Provider	CG CAHPS survey	91.58%
ACO 4	CAHPS: Access to specialists	83.93%	Provider	CG CAHPS survey	83.97%
ACO 5	CAHPS: Health promotion and education	58.86%	Provider	CG CAHPS survey	58.29%
ACO 6	CAHPS: Shared decision-making	72.59%	Provider	CG CAHPS survey	74.60%
ACO 7	CAHPS: Health status/functional status	71.20%	Provider	CG CAHPS survey	71.10%
ACO 34	CAHPS: Stewardship of patient resources		Provider	CG CAHPS survey	
Care coordination / patient safety					
ACO 8	Risk standardized all condition readmission	15.70%	Provider	Adj claims	15.15%
ACO 9*	ASCA: COPD or asthma in older adults	1.11%	Provider	Adj claims	1.08%
ACO 10**	ASCA: Heart failure	1.13%	Provider	Adj claims	1.19%
ACO 11	% of PCP who successfully meet MU requirements	76.81%	Provider	CMS report	76.71%
ACO 13	Falls: screening for future fall risk	74.85%	Provider	Manual abstraction	83.55%
ACO 35	SNF 30-day all cause readmission		Provider	Adj claims	
ACO 36	All-cause unplanned admissions for patients with diabetes		Provider	Adj claims	
ACO 37	All-cause unplanned admissions for patients with HF		Provider	Adj claims	
ACO 38	Documentation of current medications in the medical record		Provider	Manual abstraction	
ACO 39	All-cause unplanned admissions for patients with MCC		Provider	Adj claims	

All discharges with Dx of COPD or asthma for patients 40 or older

**All discharges with Dx of HF for patients 40 or older

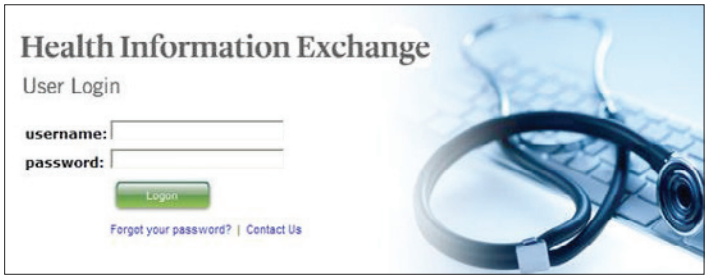
ACO Quality Metrics (continued)

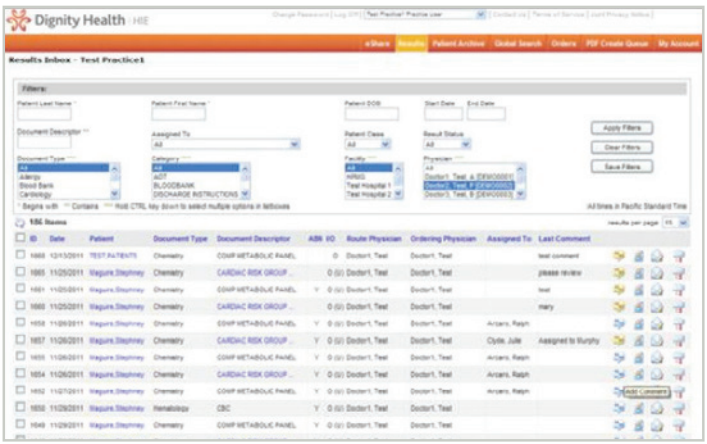
ACO metric	Metric description	PY2014 mean pioneer performance	Level of reporting	Data source	PY2014 mean MSSP performance
Preventive health					
ACO 14	Influenza immunization	61.29%	Provider	Adj claims	57.74%
ACO 15	Pneumococcal vaccination status for older adults	68.13%	Provider	Adj claims	55.22%
ACO 16	Body mass index screening and follow-up	62.57%	Provider	Manual abstraction	67.01%
ACO 17	Tobacco use: screening and cessation intervention	90.33%	Provider	Manual abstraction	87.04%
ACO 18	Screening for clinical depression and follow-up plan	46.61%	Provider	Manual abstraction	39.37%
ACO 19	Colorectal cancer screening	70.84%	Provider	Adj claims	56.16%
ACO 20	Breast cancer screening	70.87%	Provider	Adj claims	61.42%
ACO 21	Screening for high blood pressure and follow-up documented	57.37%	Provider	Manual abstraction	60.36%
ACO 42	Statin therapy for prevention and treatment of cardiovascular disease		Provider	Manual abstraction	
At-risk population					
Diabetes composite					
ACO 27 (DM-2)	Diabetes: hemoglobin A1c poor control	18.83%	Provider	Manual abstraction	20.32%
DM-41 (DM-7)	Diabetes: eye exam		Provider	Adj claims	
ACO 28	Hypertension: controlling high blood pressure	72.88%	Provider	Manual abstraction	67.96%
ACO 30	IVD: use of aspirin or another antithrombotic	82.38%	Provider	Manual abstraction	80.84%
ACO 31	HF: beta-blocker therapy for LVSD	90.44%	Provider	Adj claims – RX	84.32%
ACO 33	CAD: ACE-I or ARB therapy in patients with diabetes or LVSD	79.09%	Provider	Adj claims – RX	75.25%
ACO 40	Depression: remission at 12 months		Provider	Adj claims	

North State Health Information Exchange (HIE)

Participating NSQCN physicians and their staff have access to a free service that helps to improve workflow and accelerate delivery of lab results and reports, saving time and money.

The North State Health Information Exchange (HIE) is accessible from any computer with an internet connection. HIE participation allows physicians to access important patient information from St. Elizabeth Community Hospital, Mercy Medical Center Redding and Mercy Medical Center Mt. Shasta via a secure web-based results inbox and share information with other enrolled practices.

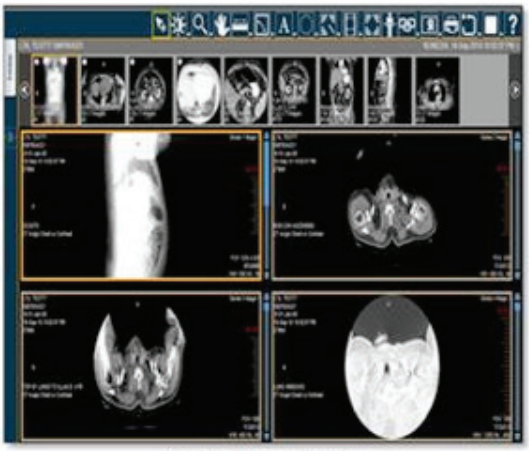




Other HIE features include:

- Information specifically designed for physician practices.
- Patient lab results and transcribed and radiology reports delivered to practice inbox.
- Access to patients' historical results prior to treatment relationship.
- Access to patients' face sheets for viewing or printing.
- Information printable locally to any printer.
- Primary care physician notifications for ED/inpatient admissions and discharges.

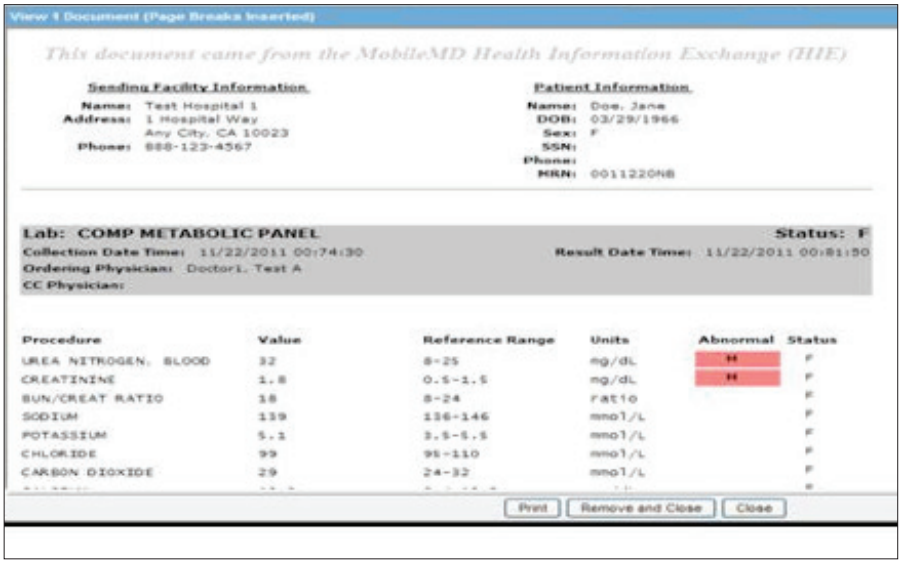
Rad Report with Image Hyperlink



iConnect Image Viewer

HIE also features role-based results routing to:

- Admitting
- Attending
- Dictating
- Ordering
- Primary care physicians
- CC physicians



Smartphone and tablet access:

- Enhanced view of results and reports on smartphones and tablets

Patient ED/admit/discharge notification:

- Notifications via email or text
- Run reports on patient admitting and discharge events

Video tutorials and quick reference guides are available on the HIE portal website. To have hospital results and reports sent directly to a practice's EMR, contact NorthStateHIE@DignityHealth.org. Your EMR vendor might charge a fee for this service.

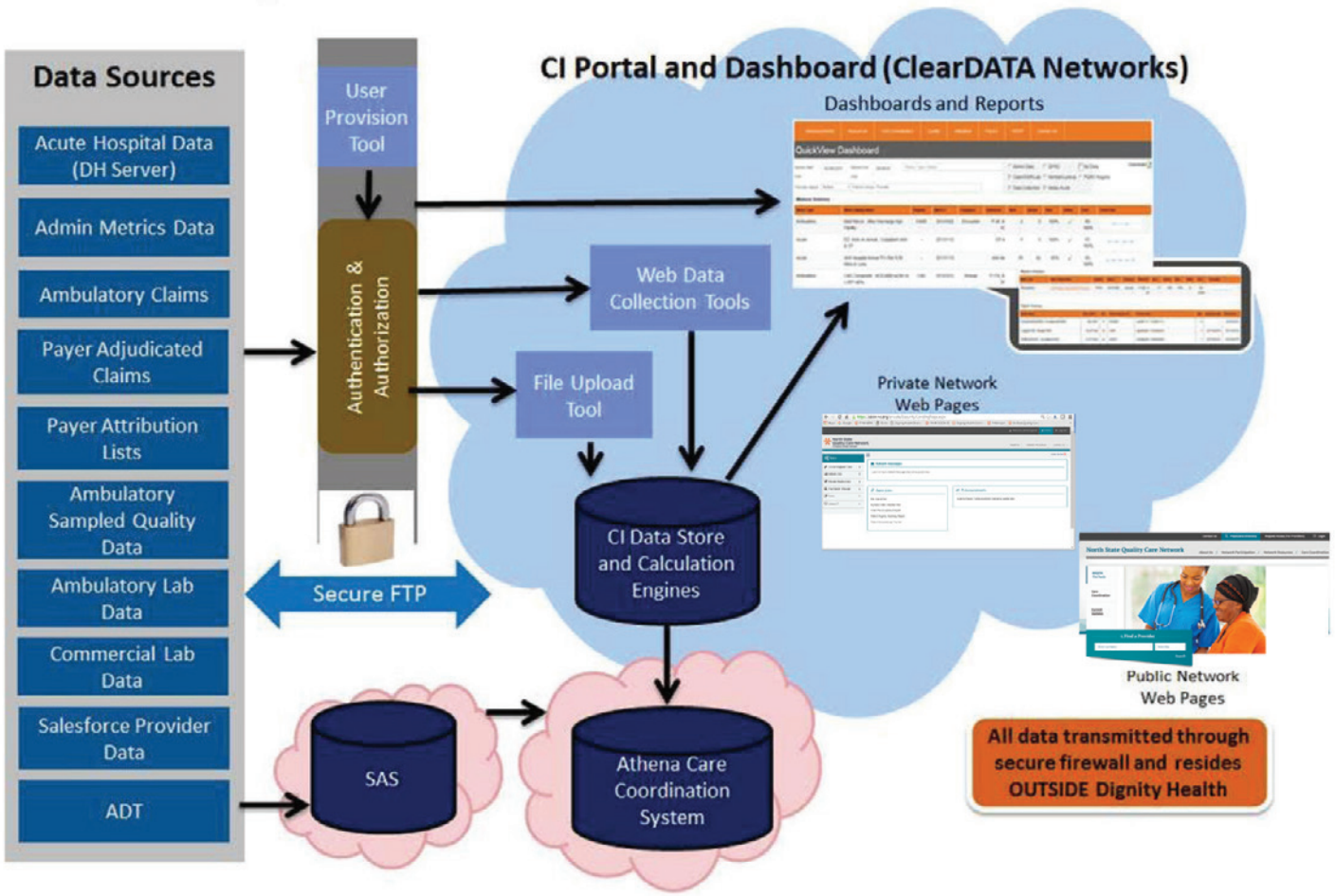
To sign up for a free Dignity Health HIE account, visit www.hie.org/NorthState and click on "Request Account."

Population Health Management:
Clinical Integration/Accountable Care Organization Data Management

Security and Privacy Assurance

The clinical integration (CI) website supports CI network participating practice groups to upload claims data for the purposes of quality reporting and analysis. The portal allows physicians and their assigned staff to view their quality data through the CI Quality Dashboard. This Quality Dashboard displays physician progress against the CI network quality measures that support CI initiatives. Access to the dashboard requires user ID and password.

Security of Data: Clinical Integration Portal



Assurance of HIPAA Compliance

The CI portal is hosted by a third-party vendor that specializes in secure, cloud-based health care data management systems, also referred to as "environments." The CIN environment is an SSAE No. 16 certified data center.

This certification means that an extensive process has been developed, thoroughly reviewed and audited to ensure that data is backed up, secured and managed according to strict specifications that comply with HIPAA and HITECH requirements.

Protection of Patient Data within the Clinical Integration Program

Patient-level data originating from the practice groups are stored at the HIPAA-certified, CIN-managed, hosted environment. This minimizes points of vulnerability and ensures that the data is used for only intended purposes.

All data is securely transmitted (with encryption) through secure websites, firewalls and secure file transfer methods.

Only authorized user administrators who closely manage the setup have access rights for users of the system. User IDs and role-based access are configured as directed on a signed, role-based access control form completed by the practice group.

Role-based access is an approach to restricting system access to authorized users based on job function. Every approved user is required to change his or her password in the system and answer a security question for future reset of passwords.

Check and Double-Check Access

Processes are in place to ensure:

- A double check (two-factor authentication) when adding new users.
- Users are disabled from accessing the system if the practice group exits the CI program or the user leaves the practice group.
- Each user can access only that information that is appropriate, based on the user's role.
- No patient-level detail is combined or aggregated across separate CI networks. Users with access to data on one network are not able to view or access any data associated with another network.

Audit of CI Dashboard Viewing

Every time a user views data on the CI quality dashboard, this access is logged into a database. Network quality managers or compliance resources are assigned to complete audit log report reviews to audit use by user, patient and by dashboard report. In addition, operational reports are provided with the system to spotlight unauthorized access.

Additional Safeguards Include:

- Encryption Technology and Security Services: Provides data encryption at rest and in motion as required by HIPAA. There is no one-size-fits-all approach.
- Secure Data Access Controls: Tools, policies and procedures restrict, track and monitor who accesses what data, where, when and for how long in a cloud environment.
- Audit Logging: Utilizes procedural audit mechanisms through every component of the application and data storage solutions.
- Multi-tier Authentication: Security and privacy architecture supports authentication and role-based access for secure cloud environments.
- Firewall Management: Secure authentication and identification management, provides dedicated firewall management in the cloud.
- Intrusion Detections Systems and Virus Scanning: Robust and best-of-breed solutions expertly managed to keep your cloud environment secure and safe.
- Vulnerability Scanning: Constant scanning of over 10,000 elements to ensure that your applications and cloud systems are safeguarded and high-performing.
- Physical Security Environment: Provides protection from physical breach by multiple superior physical security elements, including video surveillance, 24x7 armed guards, 3-factor authentication, mantraps, and biometric access—iris and vein/vascular scans.
- Inventory PHI: Tracks and inventories all PHI-created, received, maintained or transmitted for auditability in the “chain of custody”.

For additional information or questions
Please contact Population Health Management support at PHM_Portalsupport@DignityHealth.org or the Clinical Integration Network Help Desk at: 855-782-5638.

Quality Data Reporting Frequently Asked Questions

Q: Why am I being asked to submit claims for all my patients?

A: NSQCN is a clinical integration (CI) network. The network's success will depend upon the program's robust and multi-specialty quality improvement program. The only way to measure this is through claims data that participating providers have agreed to submit when signing the NSQCN Participation Agreement.

We believe that physicians who submit claims information for all of their patients will benefit the most from the CI network's quality program because they will be able to determine how they are doing across their entire panel of patients as opposed to just a subset of patients.

Sharing quality information on patients is permissible as long as the Notice of Privacy Practices (NPP) contains standard wording permitting the use of protected health information (PHI) for treatment, payment and health care operations. Reporting on quality to improve patients' care is covered under "health care operations."

NSQCN members need to add the following disclaimer to their NPP:
This practice and its physicians are members of a clinically integrated network known as North State Quality Care Network (NSQCN). The members of NSQCN may share patient health information for treatment, population health and joint quality activities.

Q: What are the ways we can report quality data to NSQCN?

A: Consistent with quality data reporting for the Centers for Medicare and Medicaid Services, quality data can only be reported to NSQCN as:

1. Claims-based reporting (CPT4 and diagnosis) or
2. Registry reporting, if available. Contact Population Health Management (PHM) IT for required file formats.

Q: What information is used from my claims?

A: NSQCN only uses rendering provider information (NPI and Tax ID), patient demographics, date and place of service, diagnosis and procedure code information from the claims you submit. We will not extract your billed charges from the claims you will upload to our secure web portal.

Q: How will the claims file upload process work if we use a billing company?

A: Your billing company currently submits claims files either directly to a payer or through a claims clearinghouse. The same file submitted to payers/clearinghouses can be uploaded to our secure web portal.

Q: If I have to submit all claims for all of my patients, will this consume significant resources in my practice?

A: We have tested this process; and from testimonials we have received, it should only take a few minutes for practice staff to submit the same billing file created for submission to other payers to our secure website. Please contact your physician practice liaison to assist your staff with the claims file uploading process.

Q: Can the claims upload process be automated?

A: You would need to have this conversation with your billing office or your IT consultant. It may be possible for a vendor to create a script or an interface to handle this functionality and process. PHM-IT can create a secure FTP connection to automate the claims upload process.

Q: What are acceptable file formats for claims uploads?

A: 1. 837P and 8371 (any file extension).
2. Alternative claim file format –.txt. (Contact the physician practice liaison for more details.)

Q: NSQCN staff is asking providers to upload claims files to a secure website. My office uses an EHR, so why do we need to send our claims?

A: 1. To aggregate claims from multiple providers for a specific patient, NSQCN needs to match the patient's data using demographic and other information (name, date of birth, address, insurance, etc.), which is not often contained in the EHR.

2. Claims data contains information not always available in the EHR that is required to measure compliance, such as diagnosis and procedure codes for a specific date of service, as well as rendering provider information. This information will be linked to the EHR data, including laboratory values and pharmacy information.

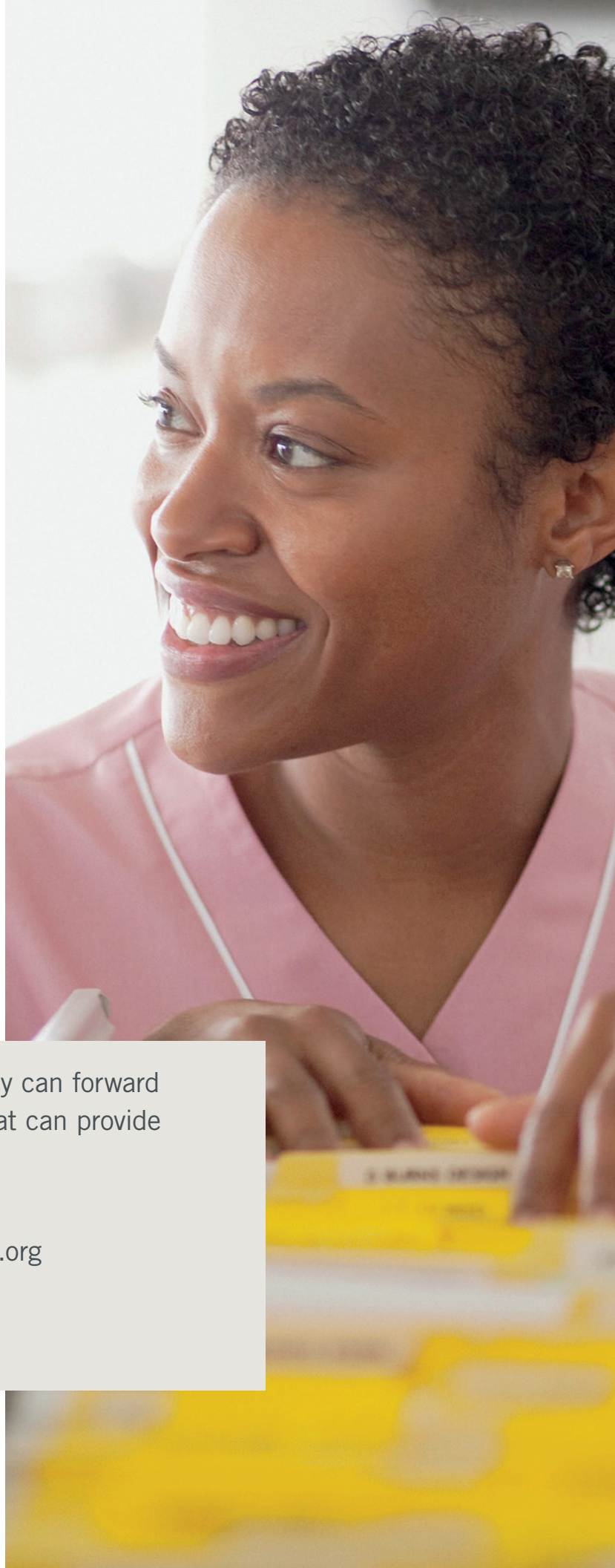
3. The measure specifications require CPT 4/HCPCS codes, diagnosis codes, place of service, date of service and patient demographics to determine the patient attribution for each measure. In addition, NSQCN will need the rendering provider of service NPI and Tax ID. If all this information can be included in the EHR data extract, then claims would not be needed.

4. To satisfy the Federal Trade Commission's (FTC) regulatory requirements for a CI program, NSQCN must measure and report on the quality of the care provided within the network. NSQCN needs claims files to report on quality.

Q: Do you have any clearinghouses that automatically submit files to your secured website?

A: Yes, but only those practices using Office Ally as their clearinghouse. NSQCN has an agreement with Office Ally to automate this process at no cost to the participating practice.

If you have any questions, please contact:
Rosa Soito, RN, Executive Director
North State Quality Care Network, LLC
rosa.soito@dignityhealth.org
530.225.6151



You can also contact the help desk and they can forward your request to the appropriate resource that can provide more detailed information.

1-855-QUALNET (1-855-782-5638) or
by email at CI/ACOHelpDesk@dignityhealth.org

III.

Care Management Program

Overview of the NSQCN Care Management Program

Care Management Referral Form

Care Management Program Overview

The Comprehensive Care Management Program is designed to improve quality of care and clinical outcomes for patients with complex, chronic diseases. High-risk and rising-risk patients are identified by the RN care coordinator, and physicians can refer patients into the program.

The RN care coordinator addresses obstacles to care, coordinates transitions of care, assists with management of complex medications and identifies resources related to psychosocial support.

Outreach to high-risk members may take place in a clinical setting or through home visits by professionals based on the patient's specific needs.

A typical care management program enrollment period is 12 weeks but could be extended if needed. Physicians are kept informed of the patient's progress by the RN care coordinator.

A copy of the referral form is on the next page, and a loose form that you can duplicate is also included in this packet.

Care Management Referral Form

Rosa Soito, RN, Executive Director
North State Quality Care Network, LLC
rosa.soito@dignityhealth.org
530.225.6151

Date of referral: _____

Referring source: _____

Patient name: _____

DOB: _____

Best #(s) to reach patient: _____

Patient email: _____

Health plan: _____

PCP: _____

RISK

Reason for referral: _____

Is this a patient you are concerned may end up in the hospital in the next 3 months? [ ] Yes [ ] No

SYMPTOM RECOGNITION/DISEASE MANAGEMENT

1. Is this patient able to manage and recognize symptoms of their disease(s)? [ ] Yes [ ] No

Briefly explain: _____

2. Does the patient have a treatment plan that he/she is not adhering to? [ ] Yes [ ] No

Briefly explain: _____

HOME SAFETY

1. Any functional concerns that impair the patient from managing their care at home? (i.e., lack of assistive devices, unable to complete ADLs) [ ] Yes [ ] No

Briefly explain: _____

2. Needing higher level of care or lack of caregiver support in home? [ ] Yes [ ] No

Briefly explain: _____

MEDS

1. Any medication management concerns? [ ] Yes [ ] No

Briefly explain: _____

NEXT UPCOMING APPOINTMENTS

Date(s): _____

Provider name(s): _____

Specialties: _____

North State Quality Care Network
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nsqcn.org