



## CTC Nurse Care Management (NCM) Measure Specifications

### Table of Contents

CTC Nurse Care Management (NCM) Measure Specifications .....	1
NCM Measure Definitions .....	2
Practice Patient Specific Report to Each Health Plan on the Health Plan Referred Complex/High Cost Patients.....	3
NCMReporting.....	6
 <u>For Reference Purposes:</u>	
Category 1a – ED High Utilizers: Percentage of Emergency Department High Utilizers who had a Nurse Care Management Activity (Phase 1) .....	7
Category 1b – Hospital High Utilizers: Percentage of Hospital High Utilizers who had a Nurse Care Management Activity (Phase 1: .....	8
Category 2 – Co-morbid Conditions: Percentage of Patients who are Poorly Controlled and/or have Comorbid Conditions who had a Nurse Care Management Activity (Phase 1).....	9
Category 3 – Complex/High Cost: Percentage of Complex/High Cost Patients who had a Nurse Care Management Activity(Phase 1).....	12
Percentage of Total High Risk Patients who had a Nurse Care Management Activity (Phase 1) .....	13
Percentage of Non-High Risk Patients who had a Nurse Care Management Activity (Phase 1) .....	14



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

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

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

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

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

### Definitions:

Term	Definition
Active Patient 18+	<i>Any patient age 18 and older as of the last day of the reporting period</i>
Active Patient	<i>All patients age 18+ years that were identified as being a high risk complex patient through the most recent reports from the insurers</i>
Engagement as defined by the health plans and CTC	Practices provide patient specific report to health plans (BCBSRI, Tufts and NHPRI) on NCM engagement activity with health plan identified high risk patients and an aggregated summary report to CTC; engagement information is identified as: <ol style="list-style-type: none"> <li>1) Engagement Status: Active</li> <li>2) Reason not engaged</li> </ol> NCM may provide oversight of other team members interventions with complex patients; When such NCM oversight is provided (i.e. patients referred to CHT for added intervention; patients referred for behavioral health intervention as part of complex/care team meetings), NCM may document on this engagement activity as part of follow up intervention.
Full time equivalent (FTE)	Full time equivalent is calculated as 40 hours per week.
Practice Identified High risk patients	Using information from a variety of sources including payer and practice clinicians, method practice uses for identifying patients at high risk for future avoidable high cost services. Risk assessment methodology includes at a minimum consideration of the following factors: <ol style="list-style-type: none"> <li>a) Assessment of patient based on co-morbidities</li> </ol>



For reference purposes:

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



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

<p><b>Health Plan Referred Complex/ High cost Patients</b></p>	<p>Each health plan uses its own predictive modeling methodology to identify complex/high cost patients based on cost, utilization and/or chronic conditions. Health plans provide CTC practices with patient specific complex/high cost information on at least a quarterly basis.</p> <p>The below criteria must be used to identify complex/high cost patients referred from the health plans:</p> <ol style="list-style-type: none"> <li>1. <u>For Blue Cross and Blue Shield of Rhode Island:</u> <ol style="list-style-type: none"> <li>a. Patients are highlighted in Red and Orange on the monthly panel reports are distributed on the last week of the calendar month.</li> <li>b. Blue Cross Blue Shield may also provide transition of care reports; it is expected that high risk patients on this lists would receive timely follow up;</li> <li>c. Practice identified high risk: Indicates if a patient who was not identified as high risk by BCBSRI, has been identified by the practice as high risk. <u>Note:</u> Engagement with these members will count in the calculation of a practice engagement rate.</li> </ol> </li> <li>2. <u>Neighborhood Health Plan of Rhode Island (NHPRI):</u> <ol style="list-style-type: none"> <li>a. Distributes list to practices that have 200 attributed patient lives the 22<sup>nd</sup> of each month.</li> <li>b. NHPRI provides a list of identified high risk patients. All patients on this file must be included.</li> </ol> </li> <li>3. <u>Tufts:</u> <ol style="list-style-type: none"> <li>a. Distributes list the end of the month for each quarter (January, April, July and October).</li> <li>b. Tufts provide a list of identified high risk patients. All patients on this file must be included.</li> </ol> </li> <li>4. <u>United Medicaid:</u> <ol style="list-style-type: none"> <li>a. Distributes a prioritized list of patients on a quarterly basis (January, April, July and October) and calls the practices when a Top 5% member who is on their panel is in the hospital</li> <li>b. Practice must use the quarterly report and provide information on patients that are in the highest, higher and high priority category and those members on the top 5% report that the health plan has contacted the NCM to report a hospital admission.</li> </ol> </li> <li>5. <u>United Commercial:</u></li> </ol>
<p><b>NCM Case load Reconciliation</b></p>	<p>Nurse care manager case load for each full time staff is expected to be 150 active patients; it is anticipated that NCM will outreach to patients on the high risk lists and successfully engage (inclusive of care plan) with 45% (for practices not in a system of care ) and 50% (for practices in system of care) of patients high risk patients on the high risk lists</p>
<p><b>Practice Report to the health plan</b></p>	<p>Practices are responsible for providing each health plans with a list of identified complex/high cost patients based on the above criteria with the identified fields below on a monthly basis (BCBSRI requires quarterly reporting per the 2018 BCBSRI Advanced Primary Care Policies) . <i>The practice uses the health plan report from the previous 30 day period. For example, the April report would be based on health plan list received by the end of February. Practices are advised to send any patient information through a secure email account that is HIPPA compliant. Practices may ask health plans to send information through a secure email and then respond back to the health plan through that same secure email process.</i></p> <p>Practices are responsible for providing a list of identified complex/high cost patients with the following columns:</p> <ol style="list-style-type: none"> <li>1) <u>Demographic Data:</u> Patient Name, DOB, Insurance</li> <li>2) <u>Practice Information:</u> NCM Name, Practice Name</li> <li>3) <u>Engagement Status:</u> Indicate if the patient is actively engaged</li> </ol>



	<p>5) <u>Reason not engaged*</u>:</p> <ul style="list-style-type: none"> <li>a) Discharged from practice (i.e. patient transferred care to another provider; patient has re-located to long term care (SNF) as permanent location )</li> <li>b) Patient expired</li> <li>c) Goals met</li> <li>d) Patient refused</li> <li>e) Patient is followed for complex care management due to pregnancy</li> <li>f) Unable to reach patient after three attempts and there has been consultation with health plan around locating patient.</li> </ul> <p>For each health plan: number of patients on NCM caseload  <u>*BCBSRI defines "Reason Not Engaged" as: Declined, Expired, Not a patient of this practice, or LTC Resident.</u></p>
<p><b>Notes</b></p>	<p>Practice site is responsible for assigning responsibility to a non-clinical practice resource to obtain the health plan referred complex/high cost patient list per health plan posting mechanism and providing NCM with the patient data so NCM can work to outreach and engage complex high cost patients                  Health plans are expected to provide practices with actionable mechanism for removing complex/high cost patients from the health plan list based on patient status (deceased, discharged).                  Blue Cross and Blue Shield of Rhode Island require monthly reporting.</p>
<p><b>Practice report to health plan</b></p>	<p>Practice provides health plan with patient specific report generated from electronic health record and/or through reporting mechanism identified by health plan. <u>Practices provide all health plans with patient specific data quarterly.</u></p> <ul style="list-style-type: none"> <li>• Tufts: Secure email to: Michele Wolfsberg - <a href="mailto:michele_wolfsberg@tufts-health.com">michele_wolfsberg@tufts-health.com</a> (617 972 9400 x 59747)</li> <li>• <b>BCBSRI</b>: Establish a Secure File Transfer Portal (SFTP) connection or via the PCMH email inbox below. File communication should be the same mechanism as received by the practice. If submitting via secure email, submit according to organizational requirements for exchanging PHI to <a href="mailto:PCMH@bcsri.org">PCMH@bcsri.org</a> with the email subject line in the same format as the file name (file format: <i>Contracted Group_Practice Site_NCM Engagement MMYYYY</i>) and for any clinical questions call 401-459-CARE (2273).</li> <li>• United Commercial: Secure email to: <a href="mailto:ctcincmreportsc-uhc@uhc.com">ctcincmreportsc-uhc@uhc.com</a> For questions on portal, contact Amy Larochelle <a href="mailto:Amy.larochelle@uhc.com">Amy.larochelle@uhc.com</a> 952-406-5674</li> <li>• United Medicaid: Secure email to: <a href="mailto:mcaidreports@uhc.com">mcaidreports@uhc.com</a></li> <li>• NHPRI: Secure email to: Yvonne Heredia <a href="mailto:yheredia@nhpri.org">yheredia@nhpri.org</a></li> <li>• 401-459-6186</li> </ul>
<p><b>Data Source</b></p>	<p>Health Plan generated high risk patient lists;                  Nurse Care Manager engagement information: Practice generates from EHR or through other mechanism such as NCM reporting on share point site. When NCM provides oversight of other team member high risk intervention, (i.e. referral and conferencing with Community Health Team, behavioral health complex care conferencing), NCM may document on this activity as part of the engagement report.</p>
<p><b>Measure/ Domain Type</b></p>	<p>Process</p>
<p><b>Measure/ Domain</b></p>	<p>Process</p>

CTC Summary Report on Engagement with High Risk Patients

A	B	C	D	F	G	H	I	J	K	L	N	O	P	Q	R
1	Primary care practice: _____ Date: _____ (Due when quality metrics are submitted via portal CTC-RI.org)														
2	)														
3															
4	Nurse care manager engagement report : Practice provides summary information based on a) health plan identified high risk patients and NCM engagement with those high risk patients and b) practice identified high risk patients and patient engagement			<b>Comments</b>											
5															
6	<b>1 Does the practice have a High Risk Registry, including Inpatient Utilization, ED Utilization and co-morbidity as required by OHIC?</b>														
7															
8	<b>2 Does the practice have a defined methodology for identifying patients at high risk? (please include)</b>														
9															
10	<b>3 What is the NCM FTE this quarter? (Assume 40 hour work week)</b>														
12	<b>a. Are there any vacant position(s) or months when an NCM position was not staffed in the reporting period?</b>														
13															
14															
16	<b>EXAMPLE</b>														
17															
18	<b>4 What is the % of engaged High Risk Patients?</b>		<i>Overall, and by Payer</i>	<b>Payor Specific Reporting</b>					<i>Overall, and by Payer</i>	<b>Payor Specific Reporting</b>					
				Blue Cross*	Tufts	NHPRI	United Medicaid**	Overall Totals		Blue Cross*	Tufts	NHPRI	United Medicaid**	Overall Totals	
19	Definition of engagement: 1) NCM last Encounter Date: (which would be the date of NCM most current assessment) 2) Patient Intervention: Type is based on nurse care manager assessment of frequency of intervention is offered as a general guideline with the NCM making the final determination of intensity based on patient assessment : a) High Intensity/Complex: Nurse Care Manager activity more than once a week over a 60-90day time period b) Moderate intensity: Nurse Care Manager activity once a week for 30-60 day time period c) Low Intensity/Short Term : Nurse Care Manager activity for less than a 30 day time period		<b># of High Risk identified by the Health Plan (D)</b>					0	<b># of High Risk identified by the Health Plan (D)</b>	50	150	500	100	800	
20			<b># Engaged (N)</b>							<b># Engaged (N)</b>	20	100	200	50	
21			<b>% Engagement</b>						0	<b>% Engagement</b>					0
22			<b>Payor Agnostic Reporting (Practice high risk patients identified from patient panel using practice methodology)</b>					<b>Payor Agnostic Reporting (Practice high risk patients identified from practice panel using practice methodology)</b>							
23			<b># of High Risk identified by the Practice (using methodology in #2)</b>	0	This category is not mutually exclusive from payor-based reporting. A patient may appear in both categories.				<b># of High Risk identified by the Practice (using methodology in #2)</b>	0	This category is not mutually exclusive from payor-based reporting. A patient may appear in both categories.				
24			<b># Engaged (N)</b>						<b># Engaged (N)</b>						
25			<b>% Engagement</b>	0					<b>% Engagement</b>	0					
26															
27															
28	*Use the NCM active caseload for high risk patients from your most recent														
29															
30	**United Medicaid continues to send practices the list of high risk patients and expects practices to engage with these patients but does not require practices to provide patient specific report on engagement with high risk patients to United														
31															



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

<b>Definition</b>	Percentage of patients age 18+ who had 3 or more Emergency Department (ED) visits during the 6 months prior to one month before the last day of the quarter, and who had a Nurse Care Manager activity during the past 7 months.
<b>Numerator 1</b>	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the past 7 months (7 month look back is to allow for time for the NCMs to outreach to the patients seen near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30.
<b>Numerator 2</b>	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 7 months (7 month look back is to allow for time for the NCMs to outreach to the patients that visit the ED near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30. <i>Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.</i>
<b>Denominator</b>	Patients age 18+ years who were identified as part of the PCMH practice and who had 3 or more Emergency Department visits in the most recent 6 months ending 1 month prior to the last day of the quarter. i.e. if quarter ends on 9/30 then denominator is 3/1 – 8/31. You <i>may</i> include patients that visited the ED and were subsequently admitted as an inpatient. Do <i>not</i> include patients that visited Urgent Care.
<b>Exclusions</b>	Patients who have left the practice by the end of the reporting period, as determined by: <ul style="list-style-type: none"> <li>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice</li> <li>• Patient has passed away</li> <li>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person*</li> <li>• Patient has been discharged</li> <li>• Urgent Care visits should not be counted as an ED visit</li> </ul>
<b>Notes</b>	<p>Practice site is responsible for creating a structured way to document and track:</p> <ol style="list-style-type: none"> <li>1. Types of nurse care manager activity and encounter type</li> <li>2. Patients who had an ED event <ul style="list-style-type: none"> <li>• When practice receives notification of patient being seen in the ED via CurrentCare Direct Alert, fax from hospital, direct access into hospital portal, or via insurance report, each event must be documented in the practice’s EMR in a trackable, reportable manner.</li> <li>• <i>All patients identified on the lists from the insurers as attributed to your practice must be included in the report unless an exclusion applies.</i></li> </ul> </li> </ol> <p>* If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient</p> <p>3. NCQA 2014 Guidelines: 4.1: Care Management and Support</p> <p>Practices establish a systematic process for identifying patients who may benefit from care management support (such as patients who are high cost/high utilizers, poorly controlled or complex conditions, referred by outside organizations). The care team and patient/family collaborate at relevant visits to develop and update an individual care plan that includes the following features:</p> <ul style="list-style-type: none"> <li>• Incorporates patient preferences and functional lifestyle goals</li> <li>• Identified treatment goals</li> <li>• Assesses and addresses potential barriers to meeting goals</li> <li>• Includes a self-management plan</li> <li>• Is provided to the patient/family/caregiver</li> </ul> <p>Practices will want to consider these NCQA standards and elements with the development of the documentation system for clinical staff, including the NCM.</p>
<b>Data Source</b>	All data must be extracted from practice’s EMR or a practice based registry

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

<b>Definition</b>	Percentage of patients age 18+ who had 3 or more hospital visits during the 6 months prior to one month before the last day of the quarter, and who had a Nurse Care Manager activity during the past 7 months.
<b>Numerator 1</b>	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the past 7 months. (7 month look back is to allow for time for the NCMs to outreach to the patients seen near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30.
<b>Numerator 2</b>	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 7 months. (7 month look back is to allow for time for the NCMs to outreach to the patients that are hospitalized near the end of the quarter). i.e. if quarter ends on 9/30 then numerator is 3/1 – 9/30. <i>Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.</i>
<b>Denominator</b>	Patients age 18+ years who were identified as part of the PCMH practice and who had 3 or more hospitalizations in the most recent 6 months ending 1 month prior to the last day of the quarter. i.e. if quarter ends on 9/30 then denominator is 3/1 – 8/31. You <i>may</i> include patients that visited the ED and were subsequently admitted as an inpatient. Do <i>not</i> include patients that visited Urgent Care.
<b>Exclusions</b>	Patients who have left the practice by the end of the reporting period, as determined by: <ul style="list-style-type: none"> <li>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice</li> <li>• Patient has passed away</li> <li>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person*</li> <li>• Patient has been discharged</li> <li>• Urgent Care visits should not be counted as an ED visit</li> </ul>
<b>Notes</b>	Practice site is responsible for creating a structured way to document and track: <ol style="list-style-type: none"> <li>1. Types of nurse care manager activity and encounter type</li> <li>2. Patients who had a hospital/inpatient event <ul style="list-style-type: none"> <li>• When practice receives notification of patient being seen in the hospital for an inpatient stay via CurrentCare Direct Alert, fax from hospital, direct access into hospital portal, or via insurance report, each event must be documented in the practice's EMR in a trackable, reportable manner.</li> <li>• <i>All patients identified on the lists from the insurers as attributed to your practice must be included in the report unless an exclusion applies.</i></li> </ul> </li> </ol> <p>* If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient</p>
<b>Data Source</b>	All data must be extracted from practice's EMR or a practice based registry
<b>Measure Domain/ Type</b>	Process





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

<b>Definition</b>	Percentage of active* patients age 18+ who have 3 or more comorbid/poorly controlled conditions and who had a Nurse Care Manager activity during the past 6 months.
<b>*Active Patient 18+</b>	<p>Any patient age 18 and older as of the last day of the reporting period, and seen by a primary care clinician of the PCMH anytime within the measurement year or year prior. Definition of primary care clinician includes the following: MD/DO, Physician’s Assistant (PA) and Certified Nurse Practitioner (CNP).</p> <p>Exclusions:</p> <p>Patients who have left the practice by the end of the measurement year, as determined by:</p> <ul style="list-style-type: none"> <li>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice</li> <li>• Patient has passed away</li> <li>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person*</li> <li>• Patient has been discharged</li> </ul>
<b>Numerator 1</b>	Active Patients ages 18+ in the denominator who had any Nurse Care Manager activity documented within the EMR during the past 6 months.
<b>Numerator 2</b>	<p>Active Patients ages 18+ in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 6 months.</p> <p><i>Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.</i></p>
<b>Denominator</b>	<p>Active patients ages 18+ at any time in the last 24 months who were seen by a primary care clinician of the PCMH during the past 24 months and who has <b>3 or more of the below conditions</b> as of the last day of the quarter:</p> <ol style="list-style-type: none"> <li>1. Poorly Controlled Diabetes (&gt;9.0) <ul style="list-style-type: none"> <li>• <b>Active patients</b> between the ages of 18-75 years at any time during the past 24 months who are listed in the registry or problem list as diabetic or diagnosed as diabetic via the following codes: <ul style="list-style-type: none"> <li>• <b>ICD9 Code Groups: 250.xx, 357.2, 362.0x, 366.41, 648.0</b></li> <li>• <b>ICD10 codes: See excel spreadsheet, Tab2 - Diabetes</b></li> </ul> </li> <li>• <b>AND</b> their most recent A1C HcA1c level &gt;9.0% in the past 12 months.</li> <li>• <b>Exclusions:</b> Patients with gestational diabetes, steroid–induced diabetes, or polycystic ovary syndrome during the last 12 months, as identified by one of the following: <ul style="list-style-type: none"> <li>• ICD–9 codes: <ul style="list-style-type: none"> <li>• Steroid induced diabetes: 249.xx, 251.8x, 962.0x</li> <li>• Gestational diabetes: 648.8x</li> <li>• PCOS: 256.4x</li> </ul> </li> <li>• ICD–10 codes: <ul style="list-style-type: none"> <li>• <b>See excel spreadsheet, Tab3 – DM Exceptions</b></li> </ul> </li> </ul> </li> </ul> </li> <li>2. Asthma <ul style="list-style-type: none"> <li>• Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as asthmatic via the following codes: <ul style="list-style-type: none"> <li>• <b>ICD9 Code Groups: 493.0, 493.22, 493.80-493.82, 493.90-493.92</b></li> <li>• <b>ICD10 codes: See excel spreadsheet, Tab9 - Asthma</b></li> </ul> </li> </ul> </li> </ol>

3. COPD
- Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having COPD via the following codes:
    - ICD9 Code Groups: 492.xx, 494.xx, 496.xx**
    - ICD10 codes: See excel spreadsheet, Tab10 - COPD**
4. CHF
- Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having CHF via the following codes:
    - ICD9 Code Groups: 425.x, 428.x**
    - ICD10 codes: See excel spreadsheet, Tab11 - CHF**
5. Depression
- Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having depression via the following codes:
    - ICD-9 codes: 296.20-296.25, 296.30-296.35, 298.0x, 311.xx**
    - ICD-10 codes: See excel spreadsheet: Tab 6 – Depression**
6. Hypertension BP Uncontrolled
- Active patients** ages 18-85 at any time during the past 24 months and who are listed in the registry or problem list as having hypertension via the following codes:
    - ICD9 Code Groups: 401.0, 401.1, 401.9**
    - ICD10 codes: See excel spreadsheet, Tab3 - Hypertension**
  - AND** their most recent blood pressure (both systolic and diastolic) is uncontrolled in the past 12 months defined by:
    - Members 18–59 years of age as of the last day of the reporting period whose BP was >140/90 mm Hg.
    - Members 60–85 years of age as of the last day of the reporting period and diagnosed with diabetes (ICD 9 Code groups for diabetes: 250.xx, 357.2x, 362.0x, 366.41, 648.0x ) whose BP was >140/90 mm Hg.
    - Members 60–85 years of age as of the last day of the reporting period and flagged as not having a diagnosis of diabetes whose BP was >150/90 mm Hg.
  - Exclusions:** Patients who are pregnant or are diagnosed with ESRD, as identified by one of the following:
    - ICD–9 codes:
      - Pregnant: 630.xx-679.xx, V22.xx, V23.xx, V28.xx
      - ESRD: 585.6x
    - ICD–10 codes:
      - See excel spreadsheet, Tab1 – Pregnancy, Tab5 - ESRD**
7. Schizophrenia or Bi-Polar Disorder
- Active patients ages 18+ at any time during the past 24 months who are listed in the registry or problem list as having schizophrenia via the following codes:
    - ICD9 Code Groups: 295.xx**
    - ICD10 codes: See excel spreadsheet, Tab12 - Schizophrenia**
  - OR** who have bi-polar disorder via the following codes:
    - ICD9 Code Groups: 296.0x, 296.1x, 296.4x, 296.5x, 296.6x, 296.7**



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

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

<b>Definition</b>	Percentage of complex/high cost patients age 18+ identified by health insurance companies based on risk status and who had a Nurse Care Manager activity during the last 6 months.
<b>Numerator 1</b>	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the last 6 months.
<b>Numerator 2</b>	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 6 months. <i>Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.</i>
<b>Denominator</b>	Patients age 18+ years who were identified as part of the PCMH practice and who are identified as being a high risk/complex patient through the most recent reports from the insurers (details in notes on identifying patients). Note: Health plan provides timeframe for the identified patient list.
<b>Exclusions</b>	Patients who have left the practice by the end of the reporting period, as determined by: <ul style="list-style-type: none"> <li>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice</li> <li>• Patient has passed away</li> <li>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person*</li> <li>• Patient has been discharged</li> </ul>
<b>Notes</b>	Practice site is responsible for creating a structured way to document and track: <ol style="list-style-type: none"> <li>1. Types of nurse care manager activity and encounter type</li> <li>2. Patients who are identified as complex from health insurance plans: <ul style="list-style-type: none"> <li>• Blue Cross: Patients identified in red and orange on panel listing</li> <li>• United Commercial: Top 5% of patients identified as having the highest prospective risk score</li> <li>• United Medicaid: All patients on high-risk patient list</li> <li>• Tufts: All patients on high-risk patient list</li> <li>• NHPRI: All patients on high-risk patient list</li> </ul> </li> </ol> <p>* If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient</p>
<b>Data Source</b>	All data must be extracted from practice's EMR or a practice based registry
<b>Measure Domain/ Type</b>	Process

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

<b>Definition</b>	Percentage of unduplicated high risk patients who had any Nurse Care Manager activity during the last 6 months.
<b>Numerator :</b> <i>Any type of NCM Activity</i>	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the time specified for the given measure.
<b>Denominator</b>	Unduplicated patients who were identified as part of the PCMH practice (for timeframe see definition of active patient) and who are identified as being a high risk patient by meeting any of the denominators for the below measures: <ul style="list-style-type: none"> <li>• ED High Utilizer</li> <li>• Hospital High Utilizer</li> <li>• Patients who are Poorly Controlled and/or have comorbid conditions</li> <li>• Complex/High Cost Patients from Insurers</li> </ul>
<b>Exclusions</b>	Patients who have left the practice by the end of the reporting period, as determined by: <ul style="list-style-type: none"> <li>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice</li> <li>• Patient has passed away</li> <li>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person*</li> <li>• Patient has been discharged</li> </ul>
<b>Notes</b>	Practice site is responsible for creating a structured way to document and track: Types of nurse care manager activity and encounter type * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
<b>Data Source</b>	All data must be extracted from practice's EMR or a practice based registry
<b>Measure Domain/ Type</b>	Process

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

<b>Definition</b>	Total numbers of non-high risk patients who had any Nurse Care Manager activity during the last 6 months Total Patient Panel minus the number of high risk patients)
<b>Total Encounter Numbers</b>	Total number of NCM encounters, during the last 6 months •
<b>Numerator 1:</b> <i>Any type of NCM Activity</i>	Patients in the denominator who had any Nurse Care Manager activity documented within the EMR during the last 6 months.
<b>Numerator 2:</b> <i>Face-to-Face NCM Activity</i>	Patients in the denominator who had a face-to-face encounter with the Nurse Care Manager documented within the EMR during the past 6 months. <i>Face-to-face encounters may include any office visit and/or home visit the NCM has with the patient.</i>
<b>Denominator</b>	Patients age 18+ years (for timeframe, see definition of active patient) who were identified as part of the PCMH practice and who are <u>not</u> identified as being a high risk patient by meeting any of the denominators for the below measures: <ul style="list-style-type: none"> <li>• ED High Utilizer</li> <li>• Hospital High Utilizer</li> <li>• Patients who are Poorly Controlled and/or have comorbid conditions</li> <li>• Complex/High Cost Patients from Insurers</li> </ul>
<b>Exclusions</b>	Patients who have left the practice by the end of the reporting period, as determined by: <ul style="list-style-type: none"> <li>• Patient has asked for records to be transferred or otherwise indicated that they are leaving the practice</li> <li>• Patient has passed away</li> <li>• Patient cannot be reached on 3 consecutive occasions via phone or emergency contact person*</li> <li>• Patient has been discharged</li> </ul>
<b>Notes</b>	Practice site is responsible for creating a structured way to document and track: Types of nurse care manager activity and encounter type * If the patient has an exclusion based on unable to reach, it is recommended that the NCM outreach to the health plan (if the patient has insurance) to see if the resources of the health plan can be utilized to engage the patient
<b>Data Source</b>	All data must be extracted from practice's EMR or a practice based registry
<b>Measure Domain/ Type</b>	Process