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3M HIS Prospective Dashboard User Guide

Overview

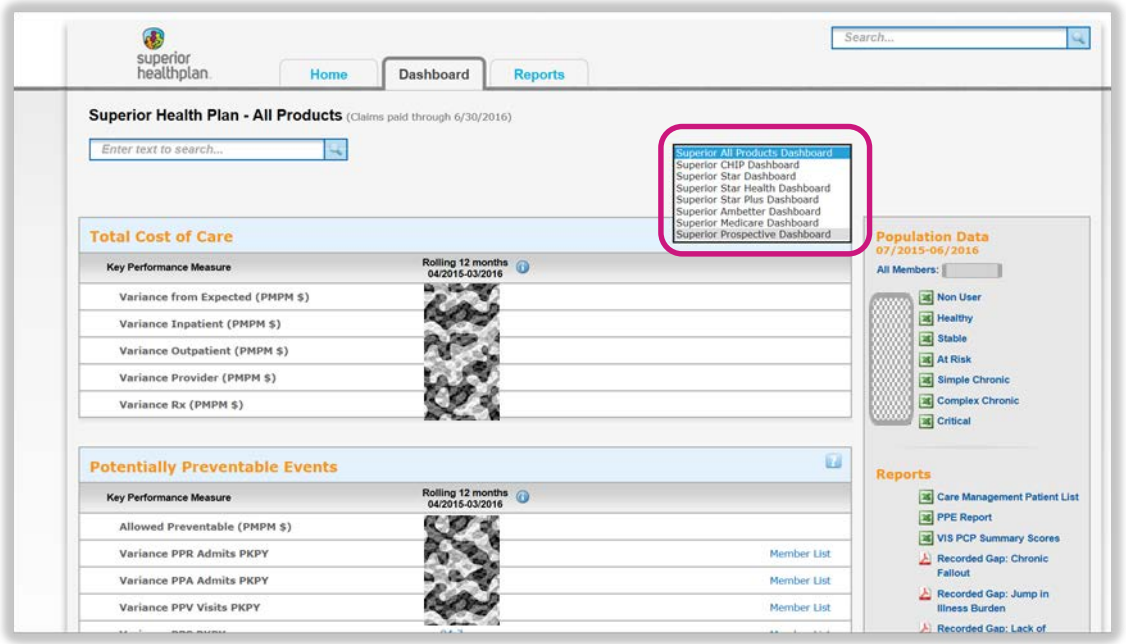
- Superior utilizes the 3M Health Information System (HIS), to offer select providers and provider networks a value-based incentive program.
- Providers may access specialized 3M dashboards to monitor performance and identify specific opportunities for improvement.
- The following training will provide guidance on the basics of the **3M HIS Prospective Dashboard**, as well as how to use the tools available to improve quality of care, Value Index Scores (VIS) and increase savings.
- The training is divided into 3 sections for easy reference:
  - Section One: 3M HIS Dashboard Guide - Page 3
  - Section Two: VIS Improvement Guide - Page 33
  - Section Three: Appendix - Page 75

3M HIS
Dashboard Guide

Section One

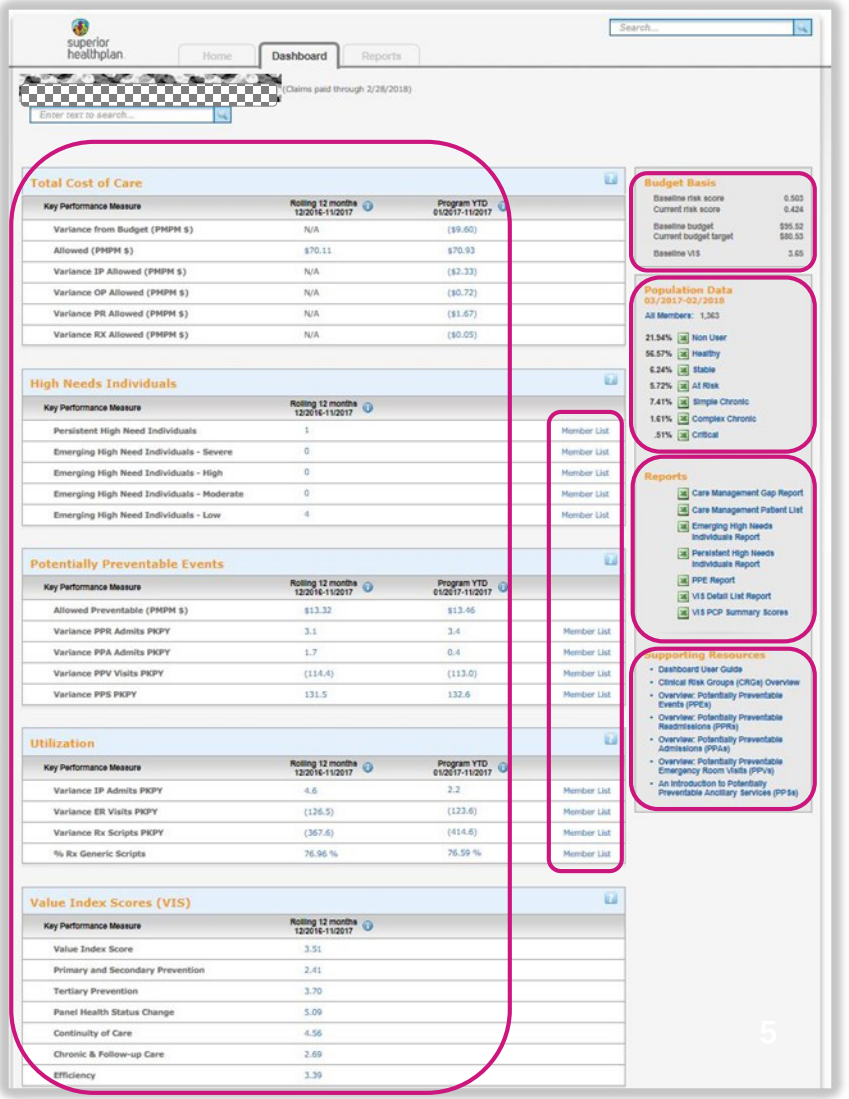
Prospective Dashboard

- This user guide will review the Superior Prospective Dashboard.
- This dashboard has been tailored to provide information necessary for the shared savings program.
- A drop down menu is shown after clicking the arrow in the menu bar.
- Memberships accounted for this dashboard are from the following products:
  - STAR
  - STAR+PLUS (non-duals, non-Medicare-Medicaid Plan [MMP])
  - CHIP
  - Ambetter from Superior HealthPlan
  - Medicare (non-MMP)



Prospective Dashboard Overview

- The Prospective Dashboard gives providers an overview of their group.
- Take note of the following sections to retrieve useful information:
  - Prospective Dashboard
    - Budget Basis
    - Population Data
    - Reports and Supporting Resources
  - Key Performance Measures
    - Total Cost of Care
    - Potentially Preventable Events (PPE)
    - High Needs Individuals
    - Utilization
    - Value Index Score (VIS)
    - Network/Group Level
    - Provider Level
  - Member Data
    - Member List
    - Patient Profile
- These sections will assist the provider in identifying areas for improvement.



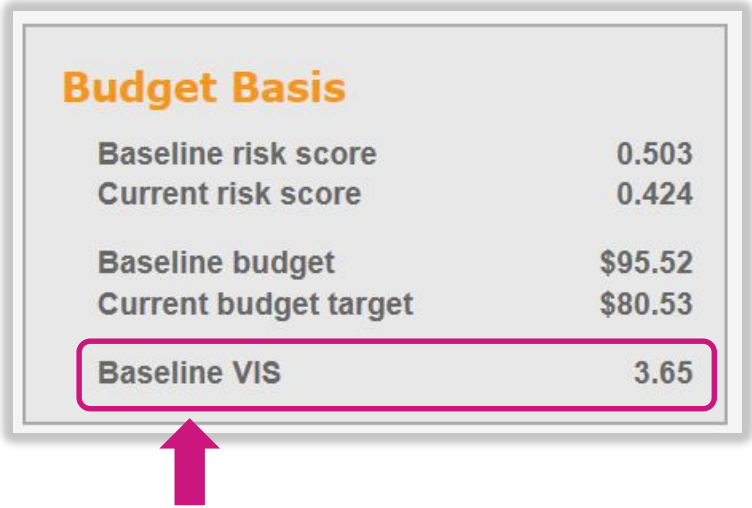
Prospective Dashboard: Budget Basis

- The **Budget Basis** section provides specific information about the incentive program.
- The **Baseline risk score** and **Baseline budget** show the Clinical Risk Group (CRG) weight and Per Member/Per Month (PMPM) budget, respectively, for the previous fiscal year. The baseline budget is used to project the current budget target.
- The **Current risk score** and the **Current budget target** show the CRG weight and PMPM budget, respectively, for the most recent program data available.

Please note: Savings are achieved when the Actual PMPM amount is less than the Current Budget Target.

Prospective Dashboard: Budget Basis

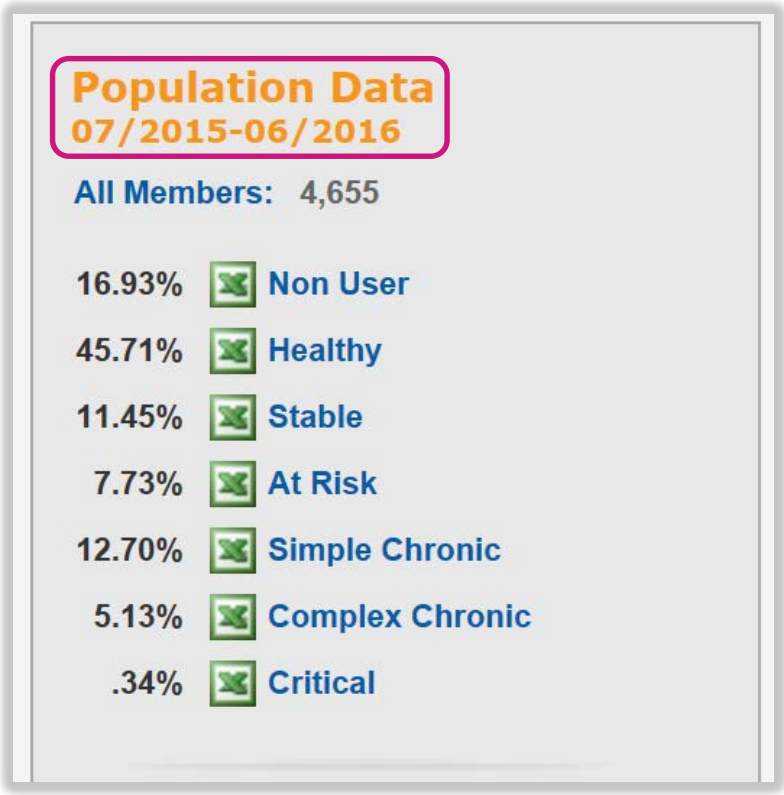
- The **Baseline VIS** is a value generated at the beginning of the VIS scoring period. This value gives you an idea of where you started out. This is a baseline value only and is not the value used to determine what percentage of savings was achieved.
- It is important to note that if patient acuity changes during the measurement period, targets will adjust to reflect these changes.



*Please note: **DO NOT** use the Baseline VIS for shared savings VIS monitoring.*

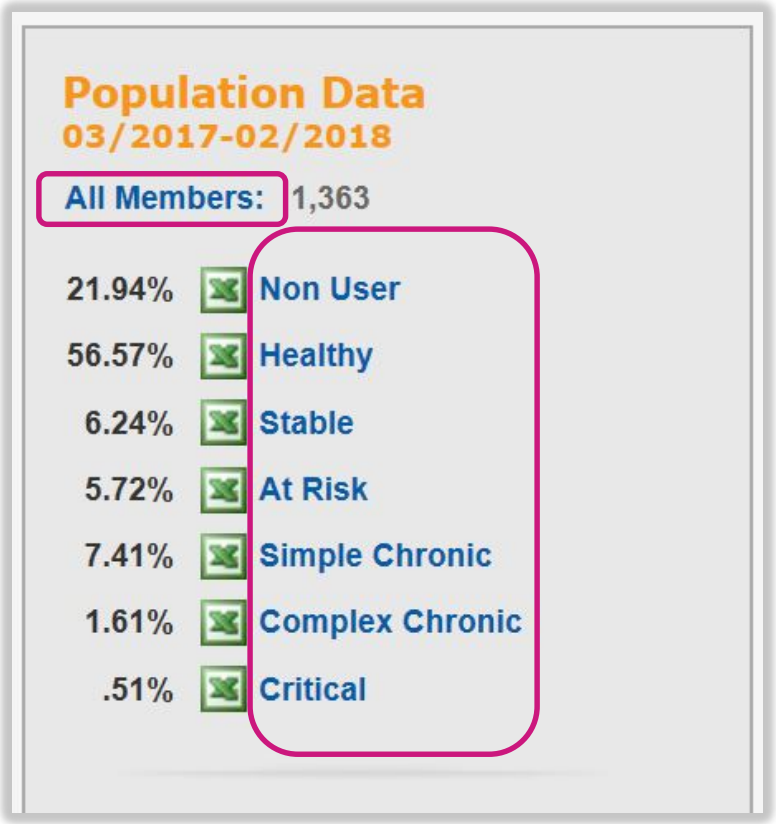
Prospective Dashboard: Population Data

- **Population Data** details how many members are a part of the network in a specified rolling 12-month measurement period.
- This section also displays where members are distributed in the population health segment groups (refer to pg. 92).
  - Providers can note what percentage of their patients are healthy, stable, at risk, etc. to focus on a particular group, if needed.
  - These numbers are helpful to gauge the health of the population to the program group.



Population Data

- Click **All Members** to view the entire member population and detailed member information.
- To look at members in a particular health segment, click any one of the health segment names in blue to retrieve a list of members within that group, as well as their information.

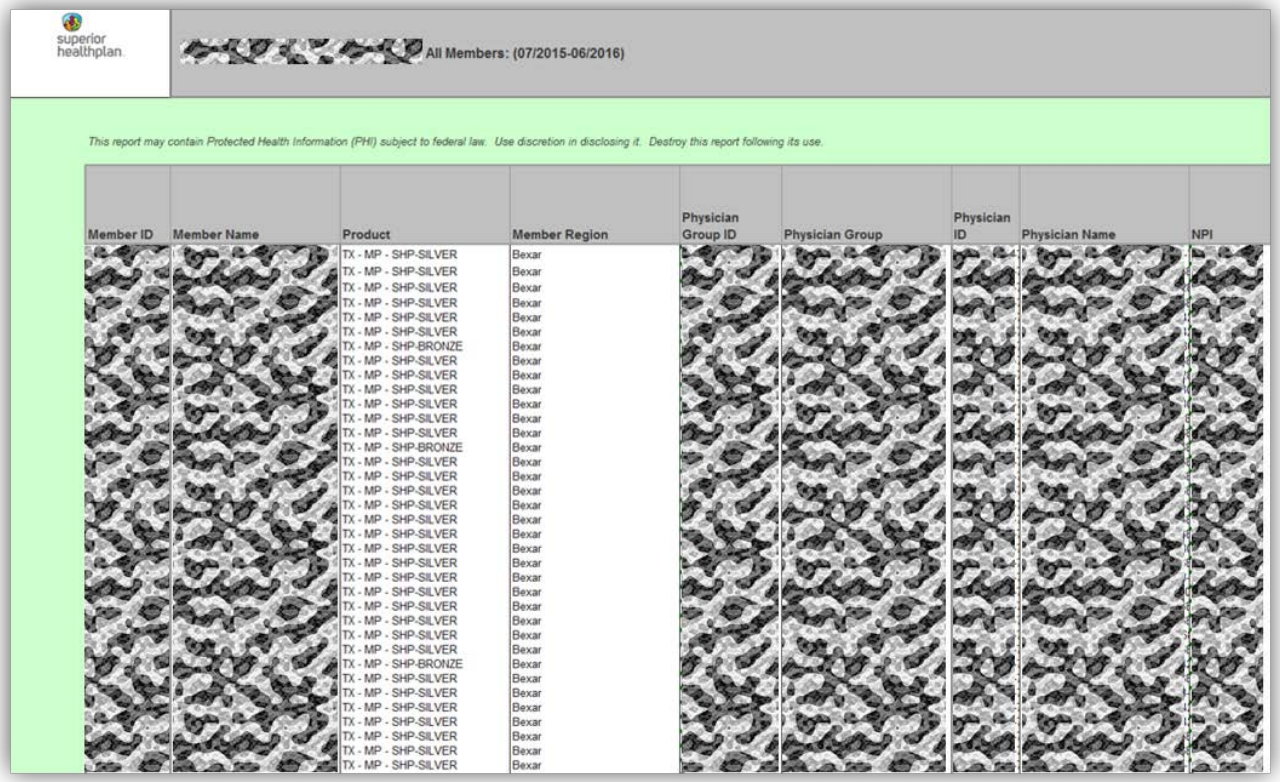


Population Data

- Once the link for **All Members** has been clicked, the following 3 dialog boxes will pop up:
  - Generating Report
  - Generated Report
    - Click **All Members: (Please click here to retrieve the report.)**
  - Select **Open/Save/Save As**
    - Choose if you would like to open or save the excel document.

Population Data

- Once you have generated the report, an Excel spreadsheet will open and display member data, including Clinical Risk Group (CRG) weight, health segment group and cost of care.



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All Members: (07/2015-06/2016)

This report may contain Protected Health Information (PHI) subject to federal law. Use discretion in disclosing it. Destroy this report following its use.

Member ID	Member Name	Product	Member Region	Physician Group ID	Physician Group	Physician ID	Physician Name	NPI
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-BRONZE	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-BRONZE	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
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		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-BRONZE	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					
		TX - MP - SHP-SILVER	Bexar					

Population Data

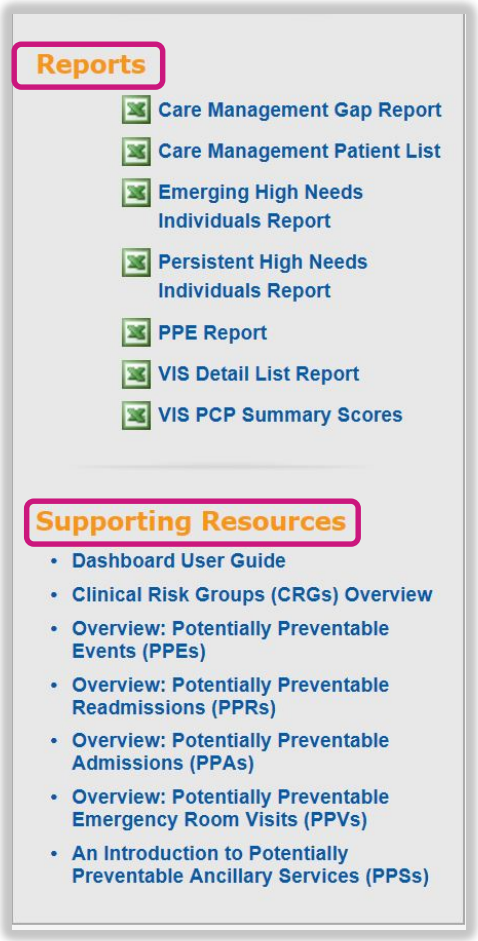
- Scrolling to the right of the window reveals more information on the member, including number of and paid amounts for different types of visits.
- The **Budget Exclusion Reason** column indicates if a member was counted towards the current budget.

ACRG3 Base	ACRG3 Description	Condition Description	CRG Weight	Member Months	Active Member	Total Paid	Total Paid PMPM	PPE Allowed	Total Preventable Paid	Total Preventable Paid PMPM	Inpatient Admits	Inpatient Paid	Inpatient PPAs	Inpatient PPAs Paid	Inpatient PPRs	Inpatient PPRs Paid	Outpatient Visits	Outpatient Paid	Outpa ER Vi
60	Pairs - Multiple Dominant	Diabetes	0.871	6	N	$2,546	$424	$131	$131	$22	0	$0	0	$0	0	$0	0	$0	
60	Pairs - Multiple Dominant	Diabetes	5.107	6	Y	$308	$51	$0	$0	$0	0	$0	0	$0	0	$0	0	$0	
50	Single Dominant or Mode	Diabetes	1.384	6	Y	$1,527	$254	$12	$12	$2	0	$0	0	$0	0	$0	0	$0	
60	Pairs - Multiple Dominant	Diabetes	3.525	6	Y	$1,505	$251	$151	$151	$25	0	$0	0	$0	0	$0	0	$0	
50	Single Dominant or Mode	Diabetes	3.047	6	Y	$351	$59	$66	$66	$11	0	$0	0	$0	0	$0	0	$0	
60	Pairs - Multiple Dominant	Diabetes	1.805	5	Y	$1,656	$331	$267	$267	$53	0	$0	0	$0	0	$0	0	$0	
60	Pairs - Multiple Dominant	Diabetes	3.426	8	N	$14,113	$1,764	$9,722	$9,722	$1,215	2	$8,376	2	$8,376	0	$0	1	$260	
			2.792	43		$22,005	$512	$10,349	$10,349	$241	2	$8,376	2	$8,376	0	$0	1	$260	

t	Outpatient ER Visits	Outpatient ER Paid	Outpatient PPV Visits	Outpatient PPV Paid	Professional Visits	Professional Paid	Professional Preventable Services	Professional Preventable Paid	RX Scripts	RX Paid	In Budget	Budget Exclusion Reason
$0	0	$0	0	$0	6	$517	6	$131	14	$2,029	Y	Person In Budget
$0	0	$0	0	$0	2	$211	0	$0	9	$96	Y	Person In Budget
$0	0	$0	0	$0	2	$137	3	$12	3	$1,390	Y	Person In Budget
$0	0	$0	0	$0	7	$1,402	7	$151	11	$102	Y	Person In Budget
$0	0	$0	0	$0	4	$295	6	$66	5	$56	Y	Person In Budget
$0	0	$0	0	$0	10	$1,005	24	$267	15	$651	N	Minimum member month threshold not met
60	1	$260	0	$0	48	$3,425	14	$268	20	$2,052	Y	Person In Budget
60	1	$260	0	$0	79	$6,992	60	$896	77	$6,377		

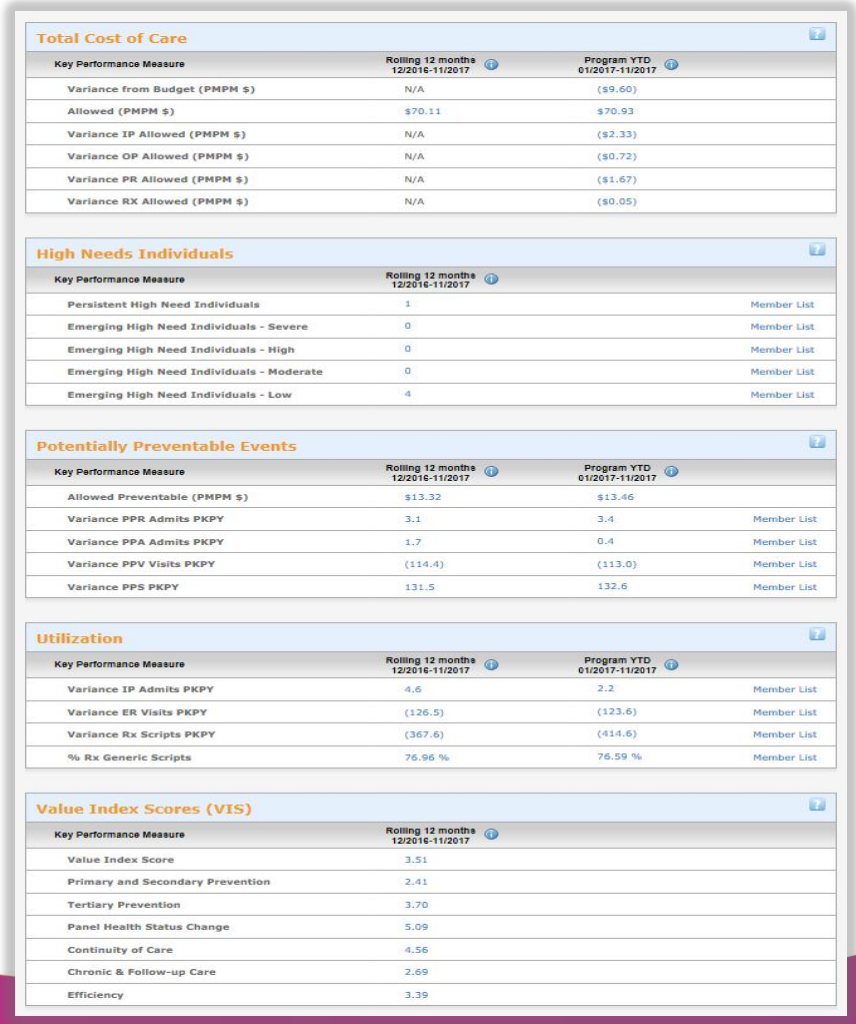
Prospective Dashboard: Reports and Supporting Resources

- The **Reports** found in this section are useful in identifying areas of improvement for providing quality care and increasing the VIS. Section three (pg. 75) of the guide goes into further detail about these reports.
- The **Supporting Resources** section provides information that can be referenced for more generalized information about the dashboard, CRGs and PPEs.



Key Performance Measures

- There are five main sections that have Key Performance Measures (KPM) to assist a provider in identifying other savings opportunities:
  - Total Cost of Care
  - High Needs Individuals
  - Potentially Preventable Events (PPE)
  - Utilization
  - Value Index Scores (VIS)



Total Cost of Care

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017
Variance from Budget (PMPM $)	N/A	($9.60)
Allowed (PMPM $)	$70.11	$70.93
Variance IP Allowed (PMPM $)	N/A	($2.33)
Variance OP Allowed (PMPM $)	N/A	($0.72)
Variance PR Allowed (PMPM $)	N/A	($1.67)
Variance RX Allowed (PMPM $)	N/A	($0.05)

High Needs Individuals

Key Performance Measure	Rolling 12 months 12/2016-11/2017	
Persistent High Need Individuals	1	Member List
Emerging High Need Individuals - Severe	0	Member List
Emerging High Need Individuals - High	0	Member List
Emerging High Need Individuals - Moderate	0	Member List
Emerging High Need Individuals - Low	4	Member List

Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$13.32	$13.46	
Variance PPR Admits PKPY	3.1	3.4	Member List
Variance PPA Admits PKPY	1.7	0.4	Member List
Variance PPV Visits PKPY	(114.4)	(113.0)	Member List
Variance PPS PKPY	131.5	132.6	Member List

Utilization

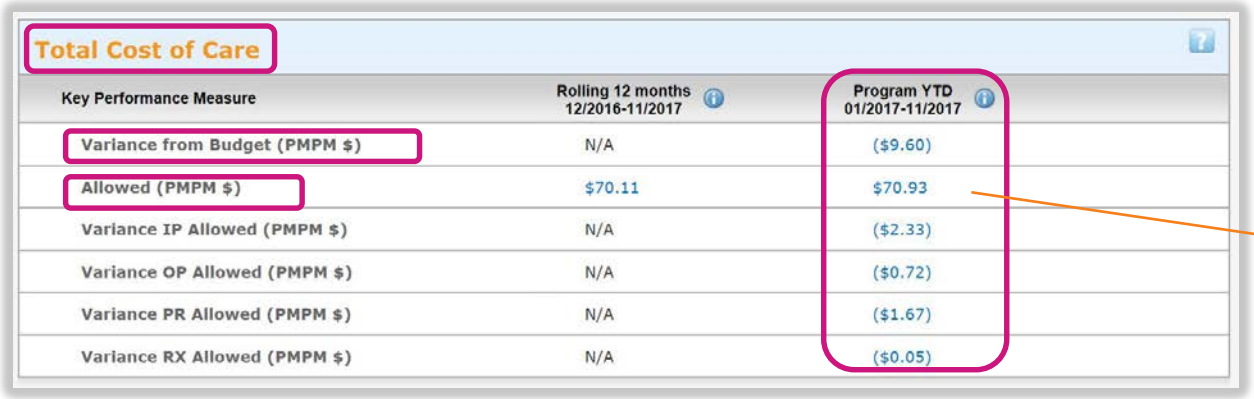
Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Variance IP Admits PKPY	4.6	2.2	Member List
Variance ER Visits PKPY	(126.5)	(123.6)	Member List
Variance Rx Scripts PKPY	(367.6)	(414.6)	Member List
% Rx Generic Scripts	76.96 %	76.59 %	Member List

Value Index Scores (VIS)

Key Performance Measure	Rolling 12 months 12/2016-11/2017
Value Index Score	3.51
Primary and Secondary Prevention	2.41
Tertiary Prevention	3.70
Panel Health Status Change	5.09
Continuity of Care	4.56
Chronic & Follow-up Care	2.69
Efficiency	3.39

KPM: Total Cost of Care

- The **Total Cost of Care** section is an overview of population data PMPM for a specific provider network or provider.
- The second column provides information on performance for the **Program Year To Date (YTD)** for which data is available.
  - The **Allowed** row under this column is your actual budget (what is being spent), and is used to compare to the current budget target (refer to pg. 6). If this amount is over that of the current budget target (shown as the **Variance from Budget**), no savings has been achieved and no incentive will be earned. Amounts shown in parentheses reflect a savings.
  - In this example screenshot, the provider is under budget by $9.60.



Total Cost of Care

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017
Variance from Budget (PMPM $)	N/A	($9.60)
Allowed (PMPM $)	$70.11	$70.93
Variance IP Allowed (PMPM $)	N/A	($2.33)
Variance OP Allowed (PMPM $)	N/A	($0.72)
Variance PR Allowed (PMPM $)	N/A	($1.67)
Variance RX Allowed (PMPM $)	N/A	($0.05)

Budget Basis

Baseline risk score	0.503
Current risk score	0.424
Baseline budget	$95.52
Current budget target	$80.53
Baseline VIS	3.65

KPM: PPE, High Needs Individuals and Utilization

- These three sections are valuable in decreasing cost and managing care.
  - The **High Needs Individuals** section refers to members who may need more attention due to their history of increased costs and utilization.
  - The **Potentially Preventable Events (PPE)** section is described in further detail in section two (pg. 33) of the presentation.
  - The **Utilization** section provides an overview of population data per thousand per year (PKPY).

High Needs Individuals

Key Performance Measure	Rolling 12 months 12/2016-11/2017	
Persistent High Need Individuals	1	Member List
Emerging High Need Individuals - Severe	0	Member List
Emerging High Need Individuals - High	0	Member List
Emerging High Need Individuals - Moderate	0	Member List
Emerging High Need Individuals - Low	4	Member List

Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$13.32	$13.46	
Variance PPR Admits PKPY	3.1	3.4	Member List
Variance PPA Admits PKPY	1.7	0.4	Member List
Variance PPV Visits PKPY	(114.4)	(113.0)	Member List
Variance PPS PKPY	131.5	132.6	Member List

Utilization

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Variance IP Admits PKPY	4.6	2.2	Member List
Variance ER Visits PKPY	(126.5)	(123.6)	Member List
Variance Rx Scripts PKPY	(367.6)	(414.6)	Member List
% Rx Generic Scripts	76.96 %	76.59 %	Member List

KPM: Value Index Score

- The **Value Index Score (VIS)** is a single score that quantifies the quality of care incorporating risk adjustment. VIS quality measures exist in six domains (shown below) with 15 components that are discussed in detail in section two (pg. 33).
- The overall VIS value highlighted here is used to determine savings percentage. This is the value that should be monitored monthly to gauge a provider's performance and the values below make up the overall score.

Value Index Scores (VIS)

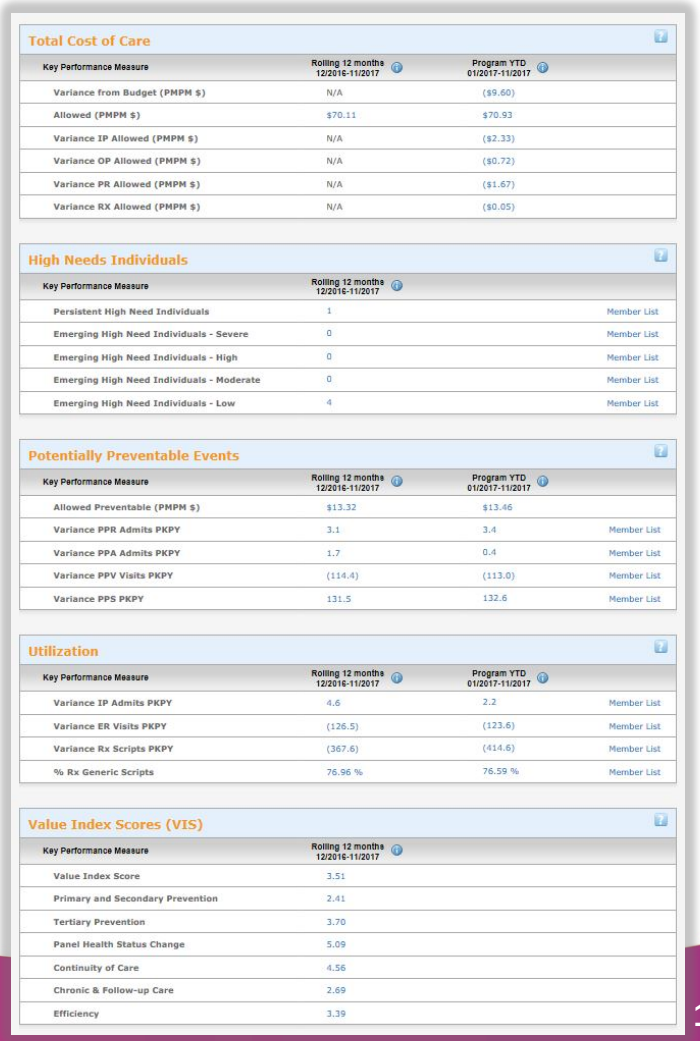
Key Performance Measure	Rolling 12 months 12/2016-11/2017
Value Index Score	3.51
Primary and Secondary Prevention	2.41
Tertiary Prevention	3.70
Panel Health Status Change	5.09
Continuity of Care	4.56
Chronic & Follow-up Care	2.69
Efficiency	3.39

KPM: Drilling Down

- Any data in blue font may be clicked on to drill down and retrieve more information about the selected key performance measure.

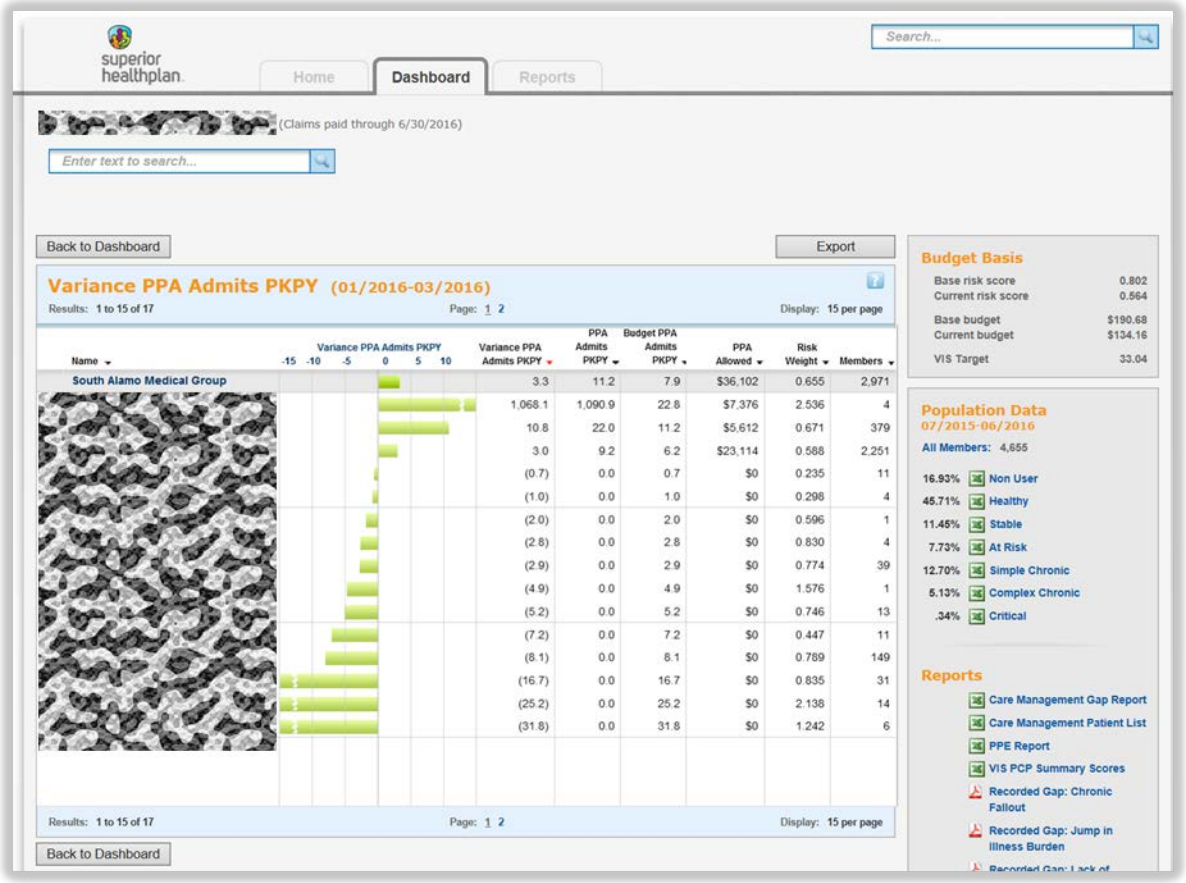
Total Cost of Care

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017
Variance from Budget (PMPM $)	N/A	($9.60)
Allowed (PMPM $)	$70.11	$70.93
Variance IP Allowed (PMPM $)	N/A	($2.33)
Variance OP Allowed (PMPM $)	N/A	($0.72)
Variance PR Allowed (PMPM $)	N/A	($1.67)
Variance RX Allowed (PMPM $)	N/A	($0.05)



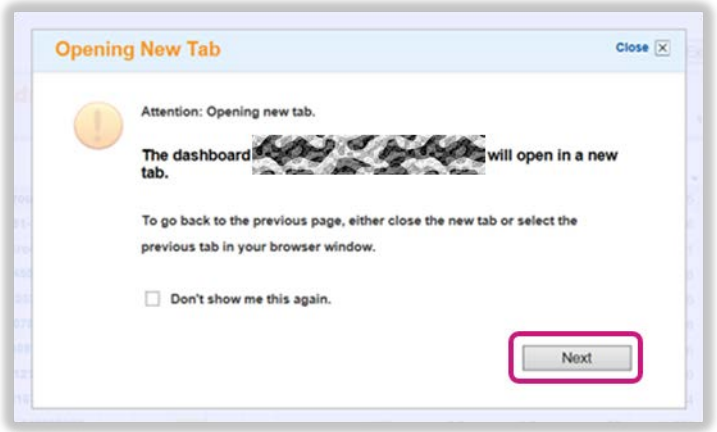
KPM: Network/Group Level

- A more detailed report corresponding to the value clicked on the summary dashboard page will open and display a list of providers in the group.
- The graph arranges the list of providers within the group in order from high to low rank, relevant to the key performance measure chosen (e.g. variance, dollars, etc).
- To retrieve more information on a particular provider, click on a provider's name.



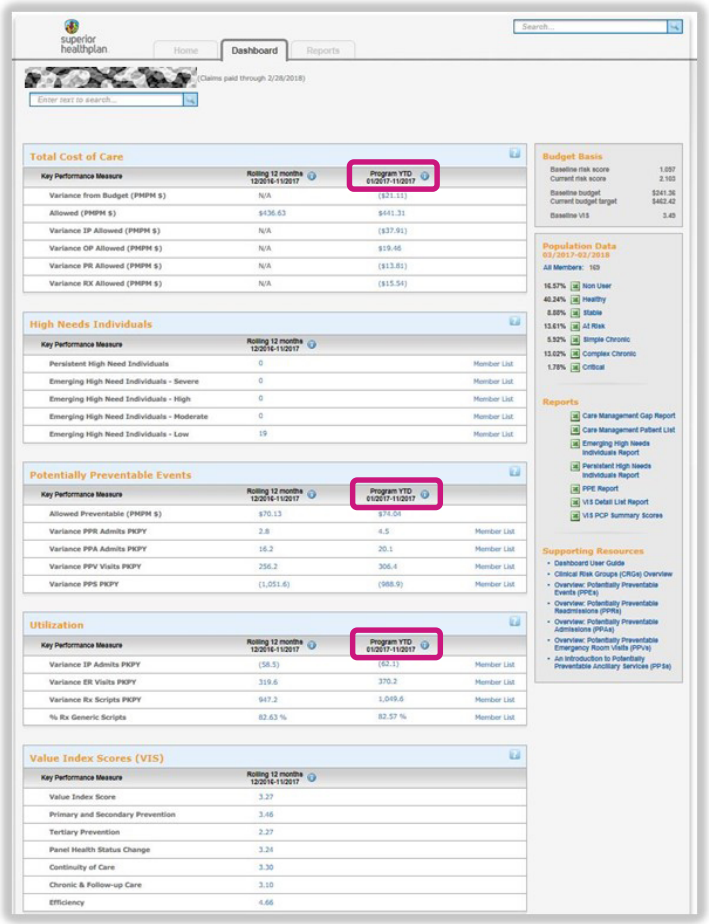
KPM: Provider Level

- A dialog box displays to notify the provider that a report will be opened in a new tab.
- Click **Next** to proceed.



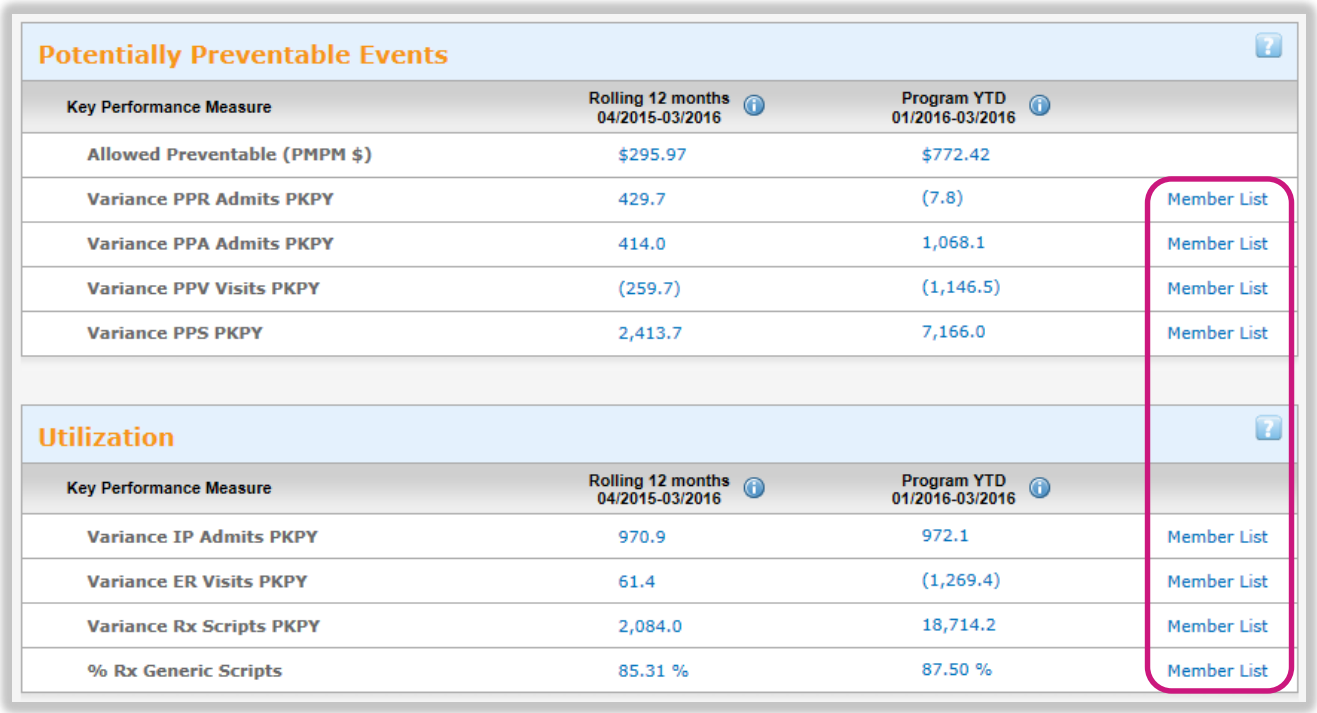
KPM: Provider Level

- Another prospective dashboard, similar to the dashboard shown at the group level, is now displayed for the selected individual provider.
- The same information can be obtained for any of the providers within the network by clicking on their name in the previous window.
- Any of the blue font values in the **Program YTD** column can be clicked on to display the data of where the member population falls.
- A provider may review member details by following the steps demonstrated in the next few pages.



Member List

- Click on any of the **Member List** links to open up a new window showing member information with regard to the corresponding key performance measure.



Potentially Preventable Events

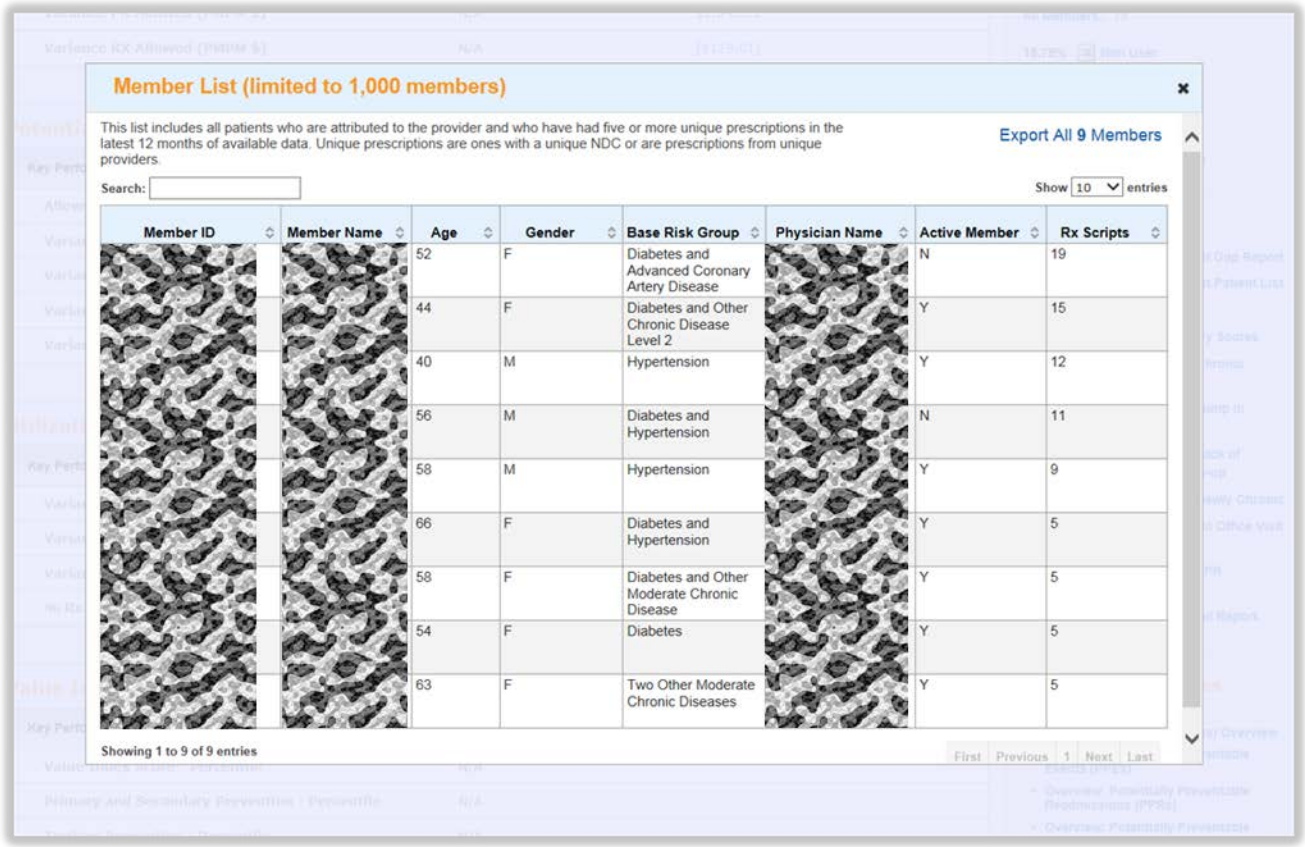
Key Performance Measure	Rolling 12 months 04/2015-03/2016	Program YTD 01/2016-03/2016	
Allowed Preventable (PMPM $)	$295.97	$772.42	
Variance PPR Admits PKPY	429.7	(7.8)	Member List
Variance PPA Admits PKPY	414.0	1,068.1	Member List
Variance PPV Visits PKPY	(259.7)	(1,146.5)	Member List
Variance PPS PKPY	2,413.7	7,166.0	Member List

Utilization

Key Performance Measure	Rolling 12 months 04/2015-03/2016	Program YTD 01/2016-03/2016	
Variance IP Admits PKPY	970.9	972.1	Member List
Variance ER Visits PKPY	61.4	(1,269.4)	Member List
Variance Rx Scripts PKPY	2,084.0	18,714.2	Member List
% Rx Generic Scripts	85.31 %	87.50 %	Member List

Member List

- Providers can see which members are listed in a particular key performance measure, such as PPE and prescription usage.
- To see more information on a patient, click on the Member's name to open a Patient Profile.



Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have had five or more unique prescriptions in the latest 12 months of available data. Unique prescriptions are ones with a unique NDC or are prescriptions from unique providers.

Export All 9 Members

Search:

Show 10 entries

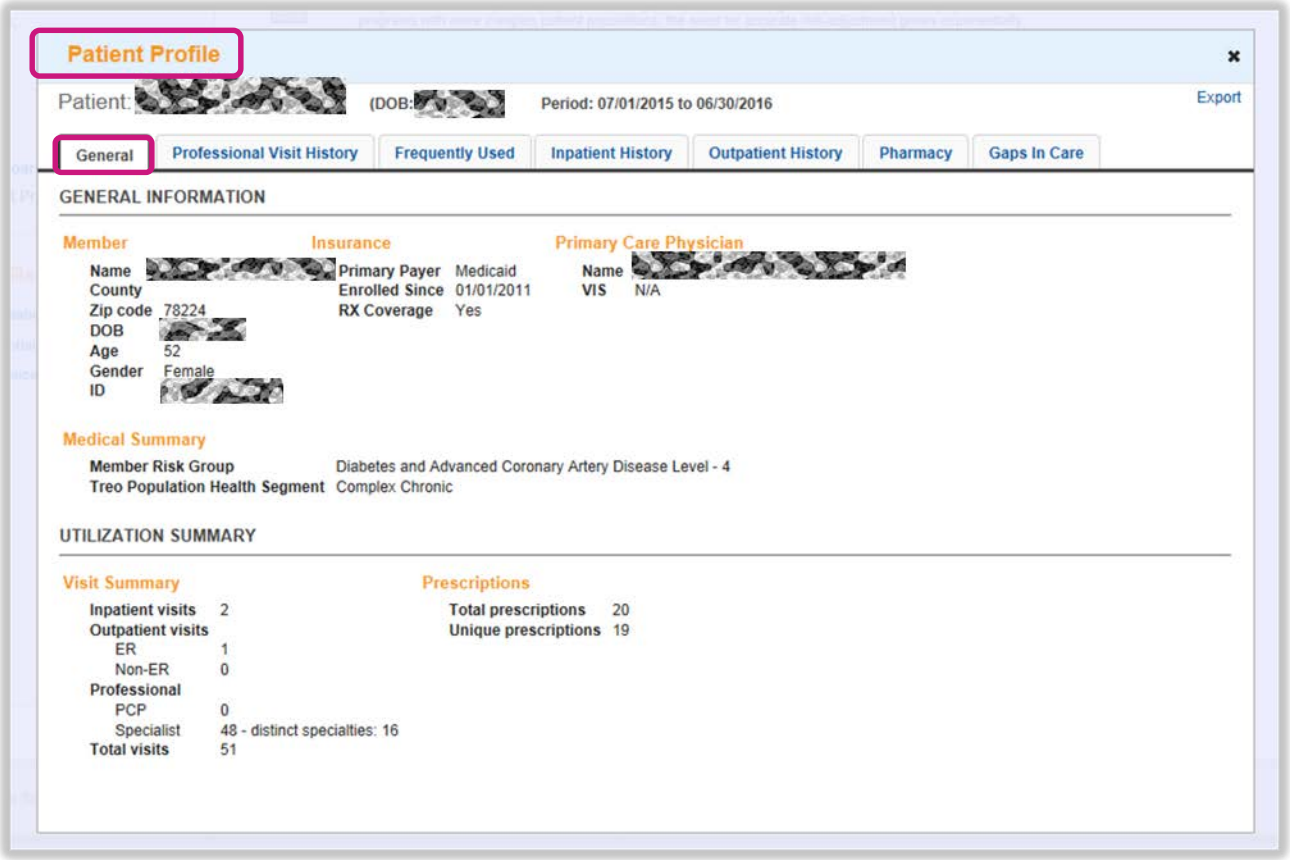
Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	Active Member	Rx Scripts
		52	F	Diabetes and Advanced Coronary Artery Disease		N	19
		44	F	Diabetes and Other Chronic Disease Level 2		Y	15
		40	M	Hypertension		Y	12
		56	M	Diabetes and Hypertension		N	11
		58	M	Hypertension		Y	9
		66	F	Diabetes and Hypertension		Y	5
		58	F	Diabetes and Other Moderate Chronic Disease		Y	5
		54	F	Diabetes		Y	5
		63	F	Two Other Moderate Chronic Diseases		Y	5

Showing 1 to 9 of 9 entries

First Previous 1 Next Last

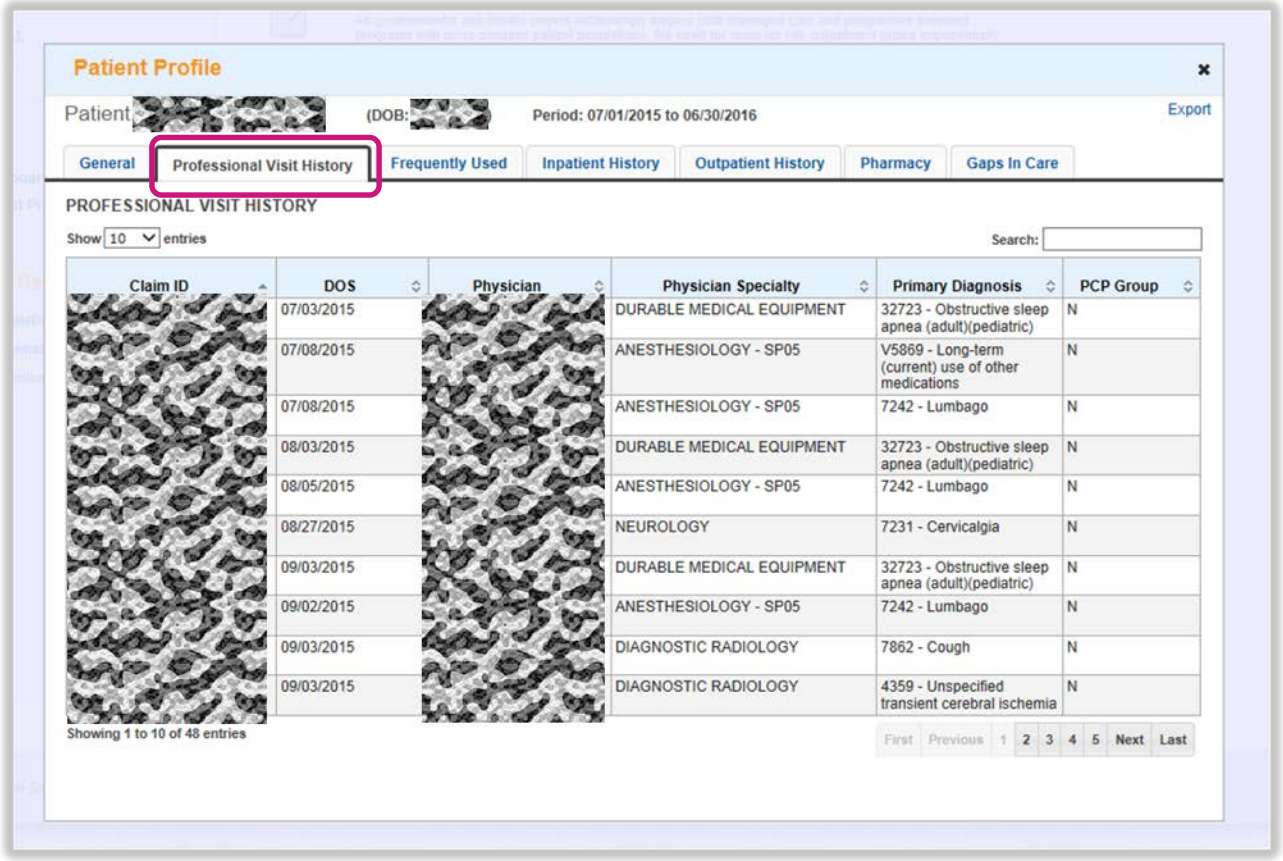
Patient Profile

- A **Patient Profile** window opens with several tabs for the physician to view specific information about a member.
- The **General** tab shows member demographics, medical, visit and prescription summary.



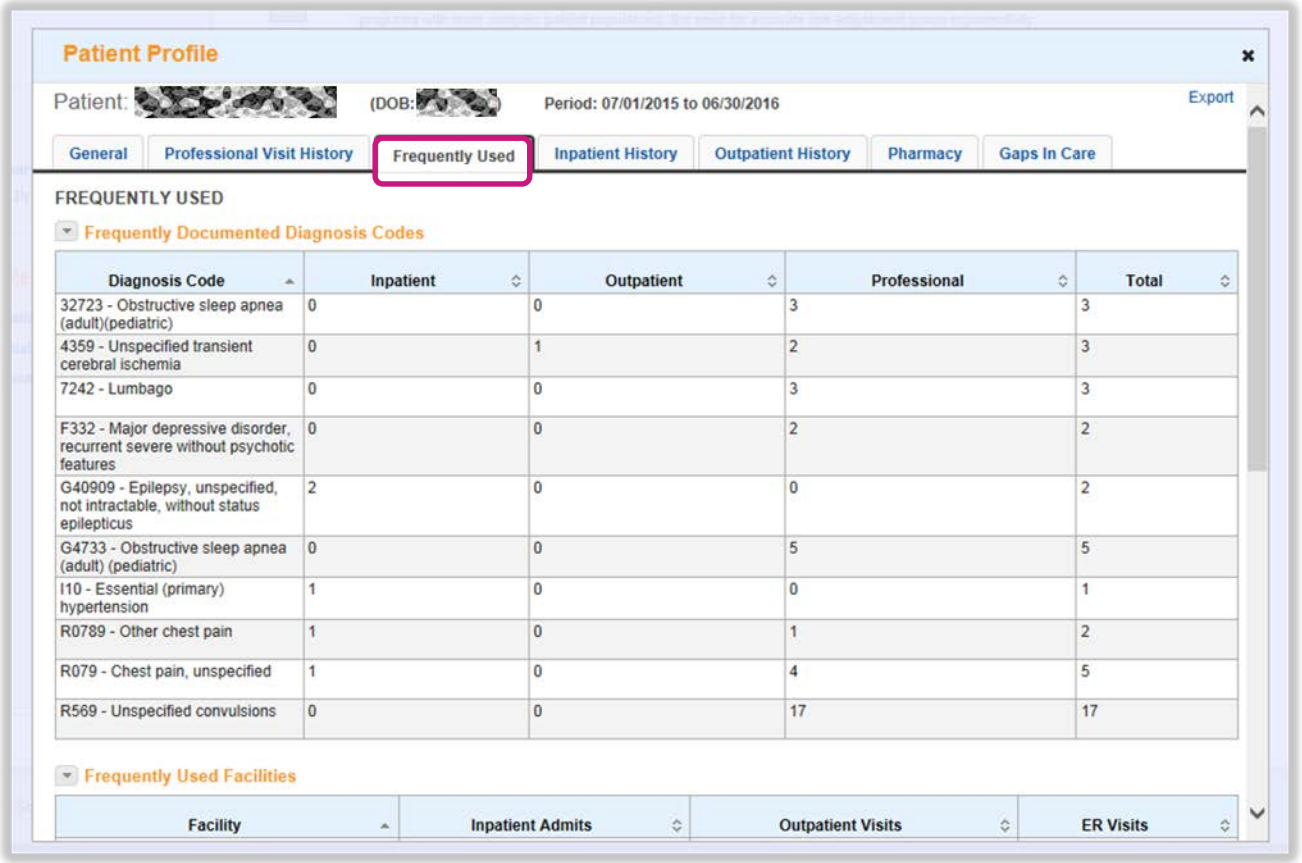
Patient Profile

- The **Professional Visit History** tab displays a quick summary of the member's visits within the measurement period.



Patient Profile

- The **Frequently Used** tab gives a summary of diagnosis codes, facilities and providers most commonly used.



Patient Profile

Patient: [redacted] (DOB: [redacted]) Period: 07/01/2015 to 06/30/2016 Export

General | Professional Visit History | Frequently Used | Inpatient History | Outpatient History | Pharmacy | Gaps In Care

FREQUENTLY USED

Frequently Documented Diagnosis Codes

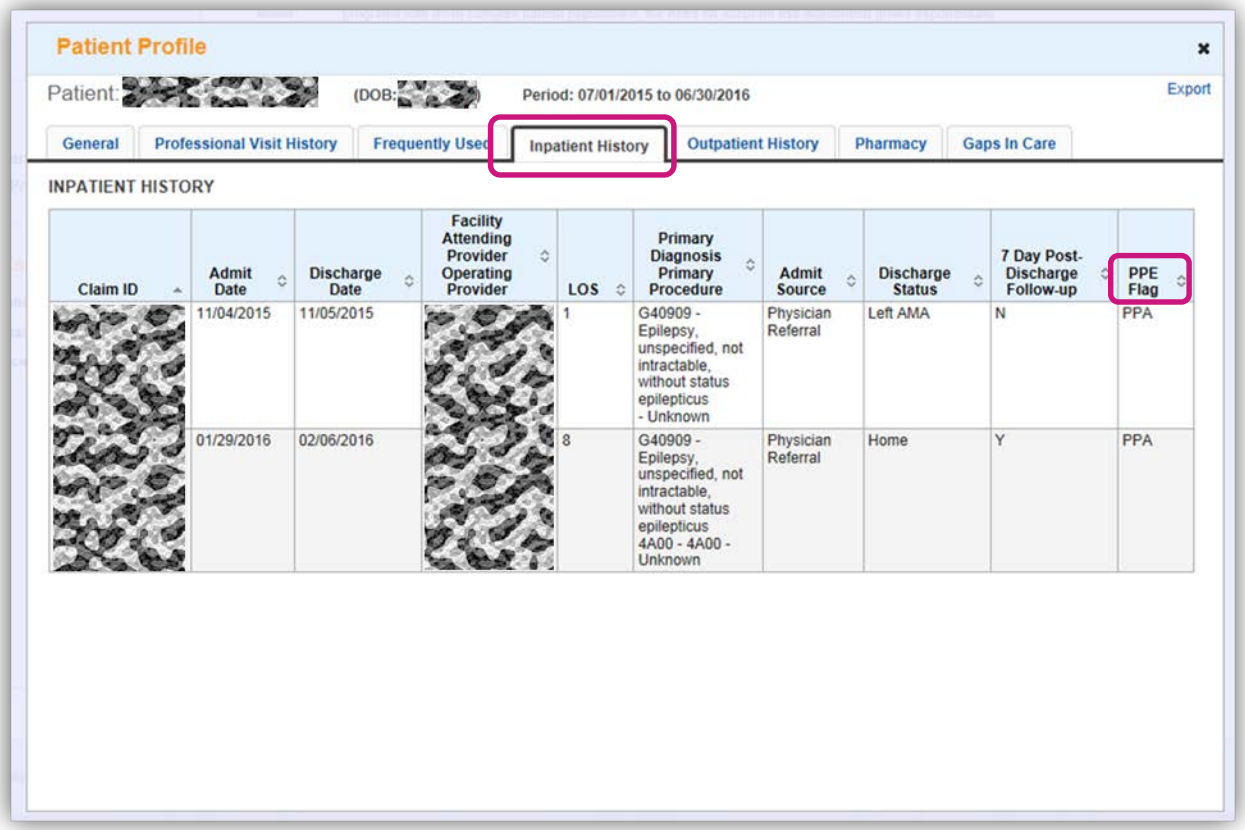
Diagnosis Code	Inpatient	Outpatient	Professional	Total
32723 - Obstructive sleep apnea (adult)(pediatric)	0	0	3	3
4359 - Unspecified transient cerebral ischemia	0	1	2	3
7242 - Lumbago	0	0	3	3
F332 - Major depressive disorder, recurrent severe without psychotic features	0	0	2	2
G40909 - Epilepsy, unspecified, not intractable, without status epilepticus	2	0	0	2
G4733 - Obstructive sleep apnea (adult) (pediatric)	0	0	5	5
I10 - Essential (primary) hypertension	1	0	0	1
R0789 - Other chest pain	1	0	1	2
R079 - Chest pain, unspecified	1	0	4	5
R569 - Unspecified convulsions	0	0	17	17

Frequently Used Facilities

Facility	Inpatient Admits	Outpatient Visits	ER Visits

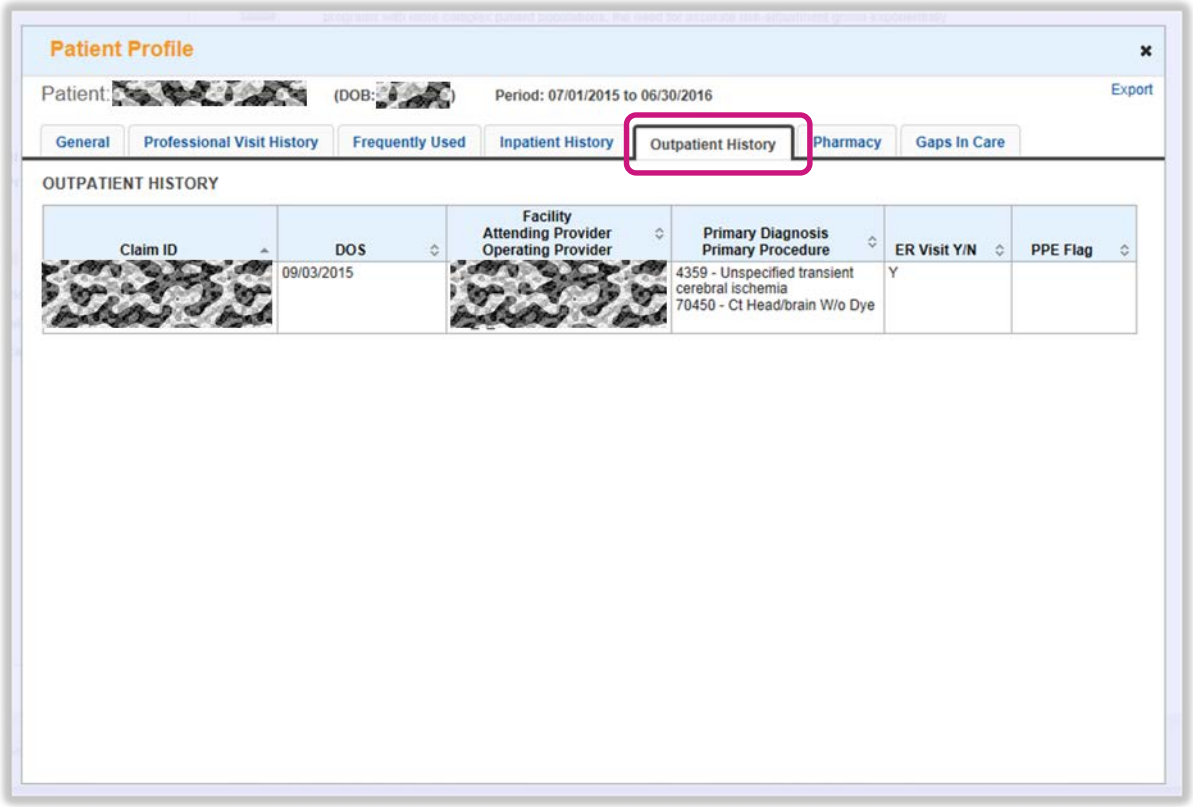
Patient Profile

- The **Inpatient History** tab allows the provider to see if the member has recently been admitted to a facility during the measurement period and for what reason.
- The last column (**PPE Flag**) shows if the admit was considered a PPE.



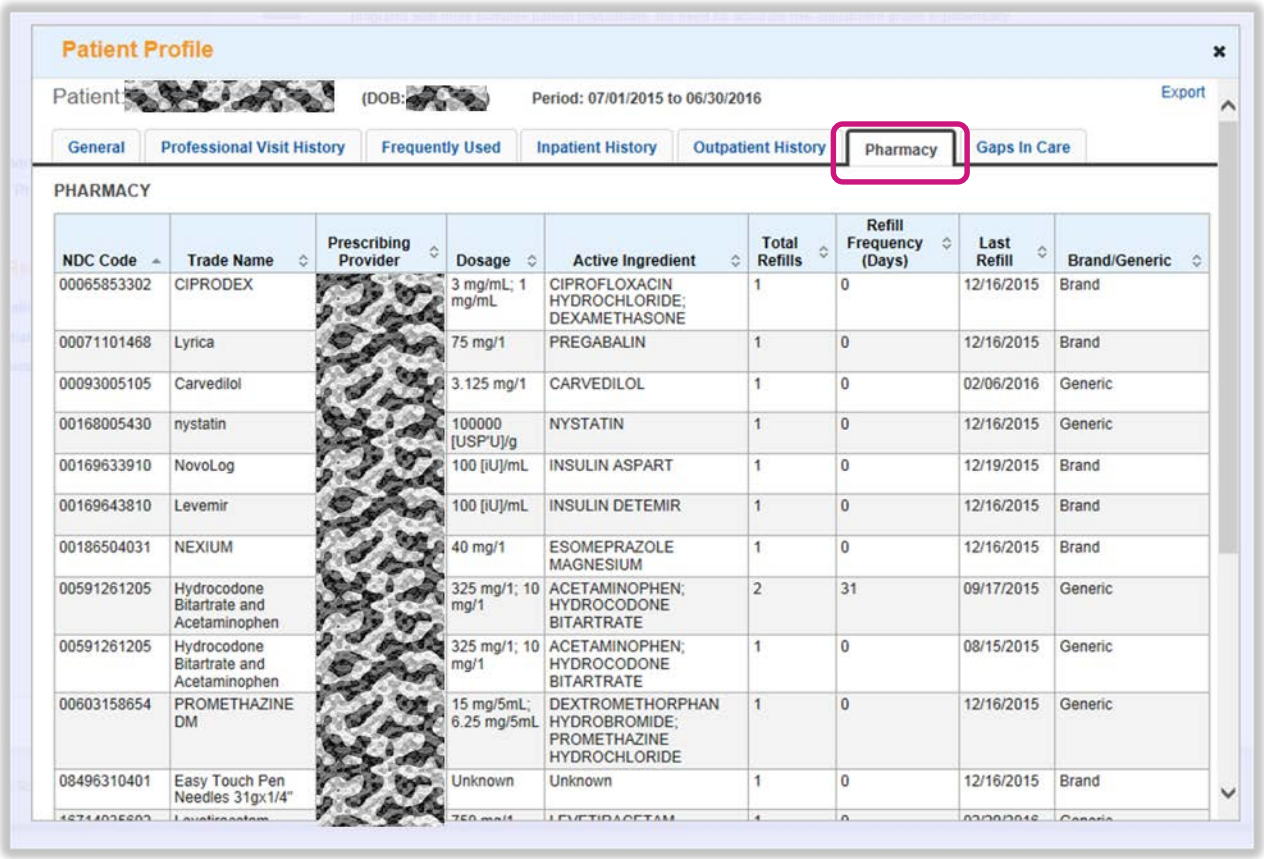
Patient Profile

- The **Outpatient History** tab details any outpatient visits and reasons for the visits within the measurement period.
- It also shows if the visit was in the ER and if it is considered a PPE.



Patient Profile

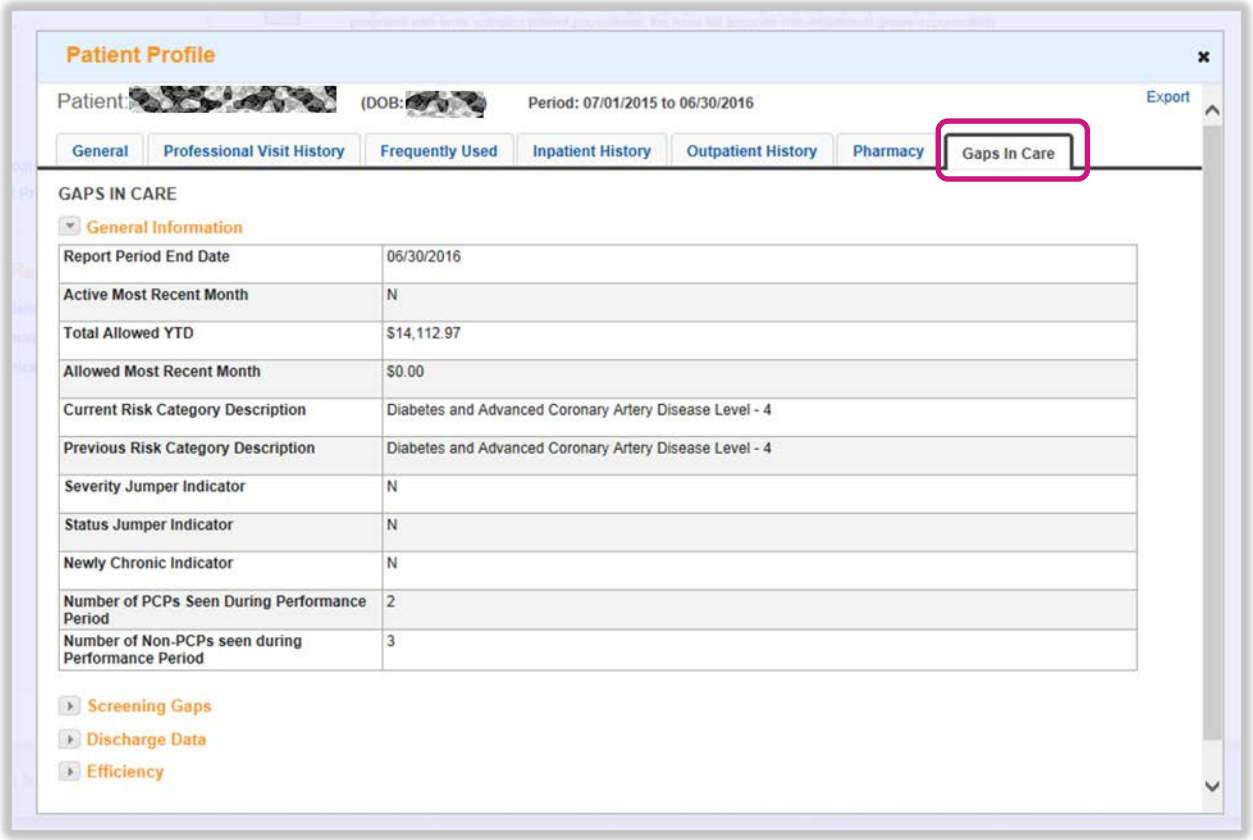
- The **Pharmacy** tab displays a detailed list of all the member's prescriptions within the measurement period.



NDC Code	Trade Name	Prescribing Provider	Dosage	Active Ingredient	Total Refills	Refill Frequency (Days)	Last Refill	Brand/Generic
00065853302	CIPRODEX	[redacted]	3 mg/mL; 1 mg/mL	CIPROFLOXACIN HYDROCHLORIDE; DEXAMETHASONE	1	0	12/16/2015	Brand
00071101468	Lyrica		75 mg/1	PREGABALIN	1	0	12/16/2015	Brand
00093005105	Carvedilol		3.125 mg/1	CARVEDILOL	1	0	02/06/2016	Generic
00168005430	nystatin		100000 [USP'U]/g	NYSTATIN	1	0	12/16/2015	Generic
00169633910	NovoLog		100 [iU]/mL	INSULIN ASPART	1	0	12/19/2015	Brand
00169643810	Levemir		100 [iU]/mL	INSULIN DETEMIR	1	0	12/16/2015	Brand
00186504031	NEXIUM		40 mg/1	ESOMEPRAZOLE MAGNESIUM	1	0	12/16/2015	Brand
00591261205	Hydrocodone Bitartrate and Acetaminophen		325 mg/1; 10 mg/1	ACETAMINOPHEN; HYDROCODONE BITARTRATE	2	31	09/17/2015	Generic
00591261205	Hydrocodone Bitartrate and Acetaminophen		325 mg/1; 10 mg/1	ACETAMINOPHEN; HYDROCODONE BITARTRATE	1	0	08/15/2015	Generic
00603158654	PROMETHAZINE DM		15 mg/5mL; 6.25 mg/5mL	DEXTROMETHORPHAN HYDROBROMIDE; PROMETHAZINE HYDROCHLORIDE	1	0	12/16/2015	Generic
08496310401	Easy Touch Pen Needles 31gx1/4"		Unknown	Unknown	1	0	12/16/2015	Brand

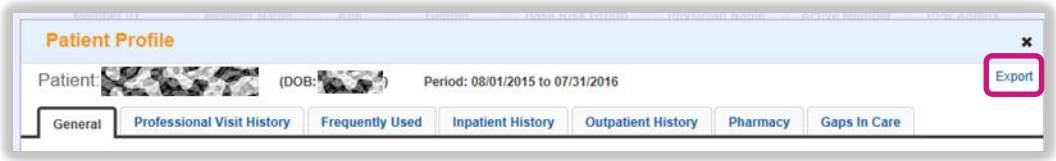
Patient Profile

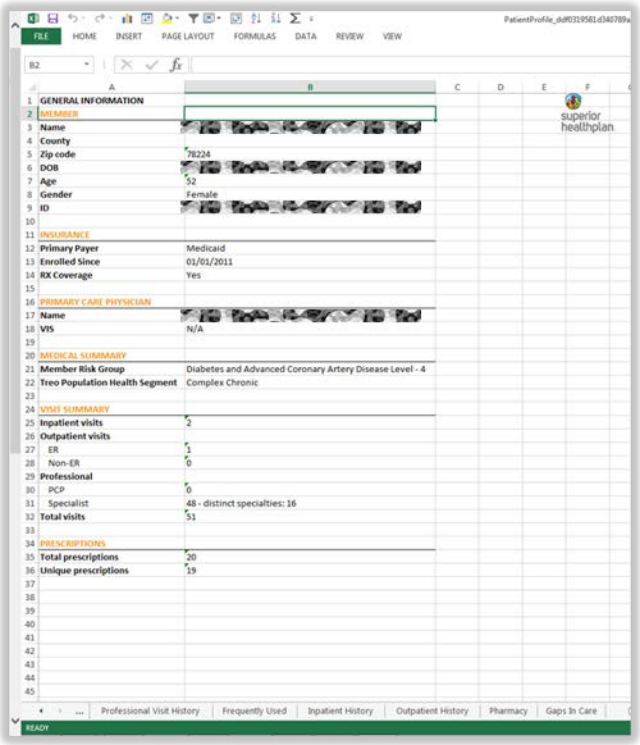
- The **Gaps In Care** tab allows the provider to view information that may point to any areas of care prompting outreach to the member.



Patient Profile

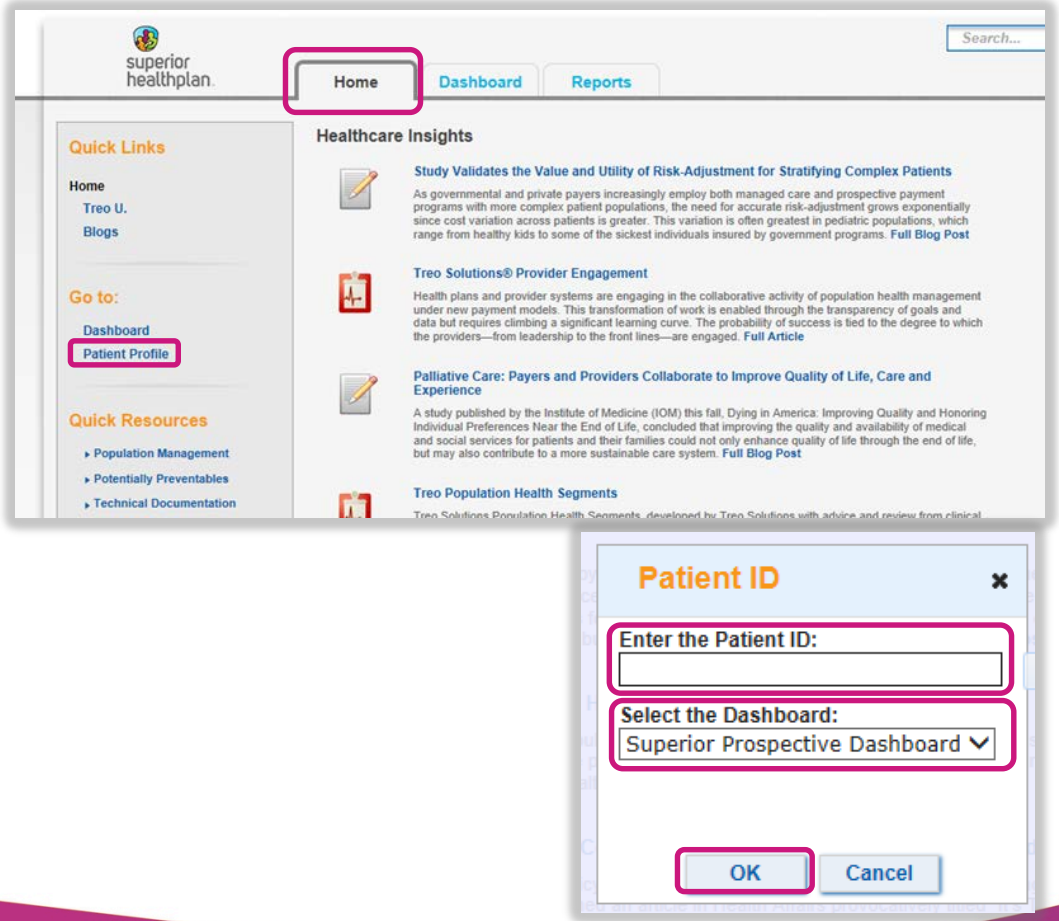
- If at any time, while viewing the patient profile, a provider needs to save a copy of this information, they may click **Export** in the top right-hand corner of the window.
- The program will generate a report and prompt the provider to open or save the Excel document.





Patient Profile

- Another way to retrieve a patient profile is by using the **Patient Profile** link on the **Home** tab.
- Enter the **Patient ID/Code** in the new pop-up window and be sure to select the **Prospective Dashboard**.
- Click **OK** and the patient profile window will open.



VIS Improvement Guide

Section Two

Purpose

- This guide is intended for PCPs and their staff to increase their VIS on the 3M HIS dashboard.
- This guide demonstrates how to use the dashboard to identify patients that affect the scores for each metric.
- Concepts and technical definitions of each metric are provided.
- Strategies for score improvement are offered.

Please note:

- *This guide was created using de-identified patient and provider data.*
- *The following definitions and technical documentation provided by 3M VIS Comprehensive Guide version 2.0 are copyrighted products of the 3M Corporation:*
  - *Potentially Preventable Readmissions (PPR),*
  - *Potentially Preventable Admissions (PPA),*
  - *Potentially Preventable Visits (PPV),*
  - *Potentially Preventable Services (PPS) and*
  - *Clinical Risk Groups (CRG)*

VIS Improvement Guide Overview

Domain 1: Primary and Secondary Prevention
- Breast Cancer Screening
- Colorectal Cancer Screening
- Well-Child Visits for Infants (0-15 months)
- Well-Child Visits for Children (3-6 years)

Domain 2: Tertiary Prevention
- Potentially Preventable Admissions (PPA)
- Potentially Preventable ER Visits (PPV)

Domain 3: Panel Health Status Change
- Status Jumpers
- Severity Jumpers

Domain 4: Continuity of Care
- PCP Visit
- Continuity of Care Index

Domain 5: Chronic and Follow Up Care
- 3 Chronic Care Visits
- Potentially Preventable Readmissions (PPR)
- 30-Day Discharge Visit

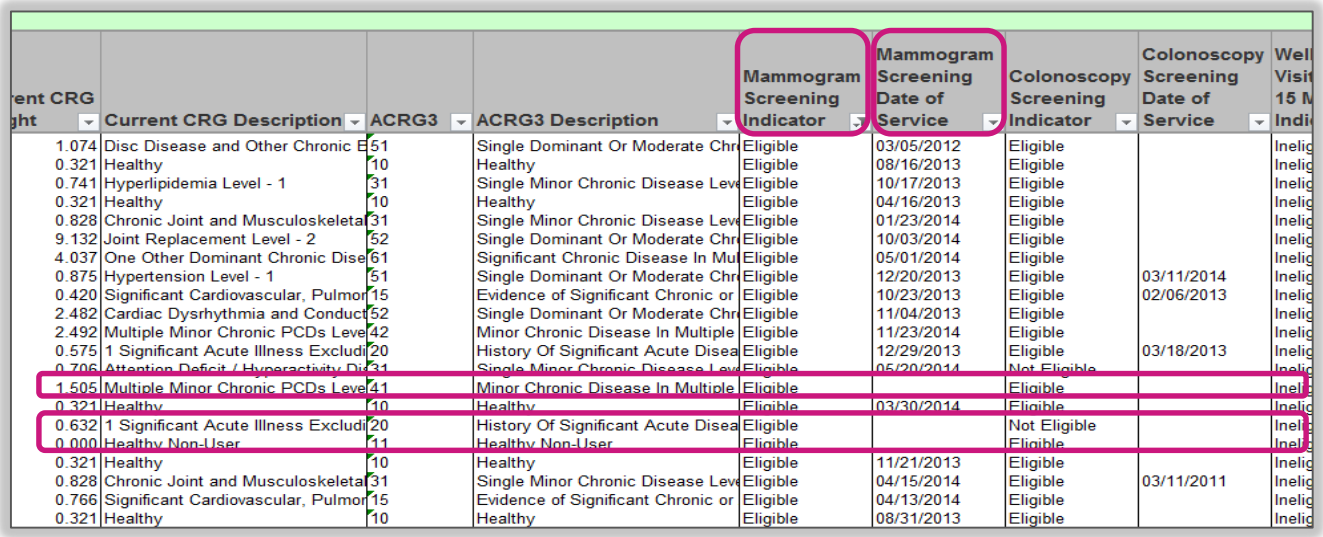
Domain 6: Efficiency
- Potentially Preventable Services (PPS)
- Generic Prescribing

Domain 1: Primary and Secondary Prevention

- **Measure: Breast Cancer Screening**
  - The denominator for breast cancer screening is the number of attributed women 52–74 years old who have not had a bilateral or two separate unilateral mastectomies, absence of both right and left breasts and are not in hospice. The numerator is the number of eligible members who have had a mammogram in the past 27 months.
  - This measure is identified with the following codes:
    - G0202, G0204, G0206, 77055, 77056, 77057, 77061, 77062, 77063, 77065, 77066, 77067, 87.36, 87.37, and revenue codes 0401, 0403.
  - To find patients in need of this procedure, open the **Care Management Gap Report**.

Domain 1: Primary and Secondary Prevention

- **Measure: Breast Cancer Screening**
  - Filter the spreadsheet by **Mammogram Screening Indicator** to find members that are eligible for a Mammogram screening.
  - The **Mammogram Screening Date of Service** shows the date of the last claim received for a Mammogram.
    - In this example, the highlighted members do not have a claim history of a Mammogram in the past 27 months.



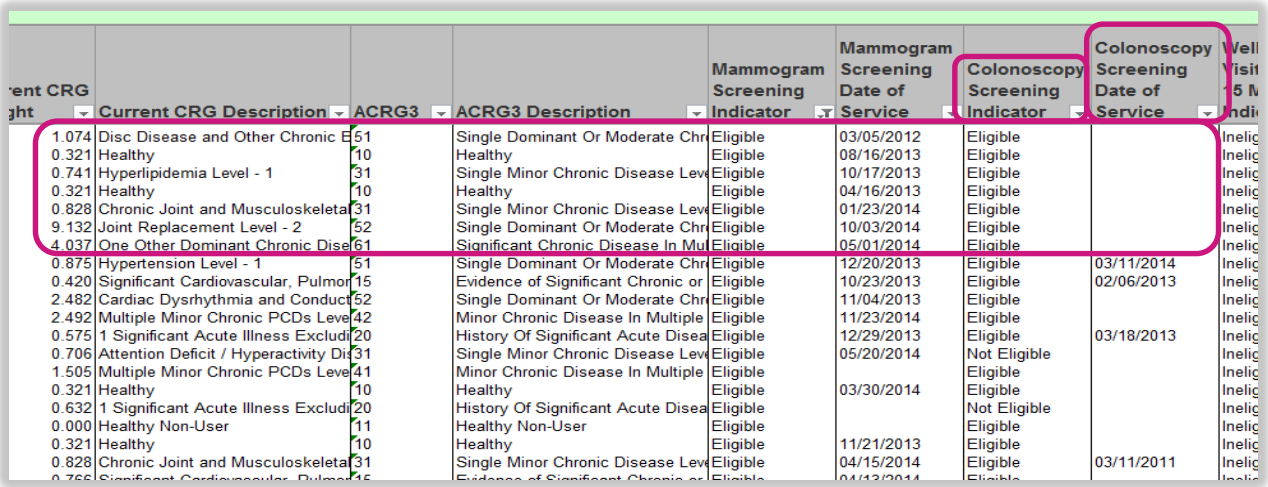
ent CRG ght	Current CRG Description	ACRG3	ACRG3 Description	Mammogram Screening Indicator	Mammogram Screening Date of Service	Colonoscopy Screening Indicator	Colonoscopy Screening Date of Service	Well Visit 15 M Indi
1.074	Disc Disease and Other Chronic E	51	Single Dominant Or Moderate Chr	Eligible	03/05/2012	Eligible		Inelig
0.321	Healthy	10	Healthy	Eligible	08/16/2013	Eligible		Inelig
0.741	Hyperlipidemia Level - 1	31	Single Minor Chronic Disease Lev	Eligible	10/17/2013	Eligible		Inelig
0.321	Healthy	10	Healthy	Eligible	04/16/2013	Eligible		Inelig
0.828	Chronic Joint and Musculoskeleta	31	Single Minor Chronic Disease Lev	Eligible	01/23/2014	Eligible		Inelig
9.132	Joint Replacement Level - 2	52	Single Dominant Or Moderate Chr	Eligible	10/03/2014	Eligible		Inelig
4.037	One Other Dominant Chronic Dise	61	Significant Chronic Disease In Mul	Eligible	05/01/2014	Eligible		Inelig
0.875	Hypertension Level - 1	51	Single Dominant Or Moderate Chr	Eligible	12/20/2013	Eligible	03/11/2014	Inelig
0.420	Significant Cardiovascular, Pulmor	15	Evidence of Significant Chronic or	Eligible	10/23/2013	Eligible	02/06/2013	Inelig
2.482	Cardiac Dysrhythmia and Conduct	52	Single Dominant Or Moderate Chr	Eligible	11/04/2013	Eligible		Inelig
2.492	Multiple Minor Chronic PCDs Leve	42	Minor Chronic Disease In Multiple	Eligible	11/23/2014	Eligible		Inelig
0.575	1 Significant Acute Illness Excludi	20	History Of Significant Acute Disea	Eligible	12/29/2013	Eligible	03/18/2013	Inelig
0.706	Attention Deficit / Hyperactivity Di	31	Single Minor Chronic Disease Lev	Eligible	05/20/2014	Not Eligible		Inelig
1.505	Multiple Minor Chronic PCDs Leve	41	Minor Chronic Disease In Multiple	Eligible		Eligible		Inel
0.321	Healthy	10	Healthy	Eligible	03/30/2014	Eligible		Inelig
0.632	1 Significant Acute Illness Excludi	20	History Of Significant Acute Disea	Eligible		Not Eligible		Inel
0.000	Healthy Non-User	11	Healthy Non-User	Eligible		Eligible		Inel
0.321	Healthy	10	Healthy	Eligible	11/21/2013	Eligible		Inelig
0.828	Chronic Joint and Musculoskeleta	31	Single Minor Chronic Disease Lev	Eligible	04/15/2014	Eligible	03/11/2011	Inelig
0.766	Significant Cardiovascular, Pulmor	15	Evidence of Significant Chronic or	Eligible	04/13/2014	Eligible		Inelig
0.321	Healthy	10	Healthy	Eligible	08/31/2013	Eligible		Inelig

Domain 1: Primary and Secondary Prevention

- **Measure: Colorectal Cancer Screening**
  - An index based on the number of members 51–75 years of age who had screening for colorectal cancer within the measurement year. Current screening guidelines expect colonoscopy once every 10 years, sigmoidoscopy once every 5 years, FIT-DNA every 3 years, and Fecal Occult Blood Testing (FOBT) every year.
    - (Exclusions: Members who have had a total colectomy, have colorectal cancer or are in hospice).
  - This measure is identified with the following codes:
    - 82270, 82274, G0328 (10%—FOBT)
    - G0464, 81528 (30%—FIT-DNA)
    - 45330–45335, 45337–45342, 45345, 45346, 45347, 45349, 45350, G0104. 45.24, 74261–74263 (50%—sigmoidoscopy)
    - 44388–44394, 44397, 44401–44408,45355, 45378–45393, 45398, G0105, G0121, 45.22, 45.23, 45.25, 45.42, 45.43 (100%—colonoscopy)
  - To find patients in need of this procedure, open the **Care Management Gap Report**.

Domain 1: Primary and Secondary Prevention

- **Measure: Colorectal Cancer Screening**
  - Filter the spreadsheet by the **Colonoscopy Screening Indicator** to find members that are eligible for a Colonoscopy screening.
  - The **Colonoscopy Screening Date of Service** shows the date of the last claim received for a Colonoscopy.
    - In this example, the highlighted members are eligible but do not have a claim history of a Colonoscopy in the measurement period.



ent CRG ght	Current CRG Description	ACRG3	ACRG3 Description	Mammogram Screening Indicator	Mammogram Screening Date of Service	Colonoscopy Screening Indicator	Colonoscopy Screening Date of Service	Well Visit 5 M Indi
1.074	Disc Disease and Other Chronic E	51	Single Dominant Or Moderate Chr	Eligible	03/05/2012	Eligible		Ineli
0.321	Healthy	10	Healthy	Eligible	08/16/2013	Eligible		Ineli
0.741	Hyperlipidemia Level - 1	31	Single Minor Chronic Disease Leve	Eligible	10/17/2013	Eligible		Ineli
0.321	Healthy	10	Healthy	Eligible	04/16/2013	Eligible		Ineli
0.828	Chronic Joint and Musculoskeletal	31	Single Minor Chronic Disease Leve	Eligible	01/23/2014	Eligible		Ineli
9.132	Joint Replacement Level - 2	52	Single Dominant Or Moderate Chr	Eligible	10/03/2014	Eligible		Ineli
4.037	One Other Dominant Chronic Disea	61	Significant Chronic Disease In Mul	Eligible	05/01/2014	Eligible		Ineli
0.875	Hypertension Level - 1	51	Single Dominant Or Moderate Chr	Eligible	12/20/2013	Eligible	03/11/2014	Ineli
0.420	Significant Cardiovascular, Pulmor	15	Evidence of Significant Chronic or	Eligible	10/23/2013	Eligible	02/06/2013	Ineli
2.482	Cardiac Dysrhythmia and Conduct	52	Single Dominant Or Moderate Chr	Eligible	11/04/2013	Eligible		Ineli
2.492	Multiple Minor Chronic PCDs Leve	42	Minor Chronic Disease In Multiple	Eligible	11/23/2014	Eligible		Ineli
0.575	1 Significant Acute Illness Excludi	20	History Of Significant Acute Disea	Eligible	12/29/2013	Eligible	03/18/2013	Ineli
0.706	Attention Deficit / Hyperactivity Di	31	Single Minor Chronic Disease Leve	Eligible	05/20/2014	Not Eligible		Ineli
1.505	Multiple Minor Chronic PCDs Leve	41	Minor Chronic Disease In Multiple	Eligible		Eligible		Ineli
0.321	Healthy	10	Healthy	Eligible	03/30/2014	Eligible		Ineli
0.632	1 Significant Acute Illness Excludi	20	History Of Significant Acute Disea	Eligible		Not Eligible		Ineli
0.000	Healthy Non-User	11	Healthy Non-User	Eligible		Eligible		Ineli
0.321	Healthy	10	Healthy	Eligible	11/21/2013	Eligible		Ineli
0.828	Chronic Joint and Musculoskeletal	31	Single Minor Chronic Disease Leve	Eligible	04/15/2014	Eligible	03/11/2011	Ineli

Domain 1: Primary and Secondary Prevention

- **Measure: Well-Child Visits for Infants (0-15 months)**
  - This metric tracks the percentage of attributed members who had plan eligibility from 31 days to 15 months old, who turned 15 months old during the evaluation period and had the recommended six well-visits with a PCP during their first 15 months of life.
  - This measure is identified with the following codes:
    - 99381, 99382, 99391, 99392, 99461, G0438, G0439, V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 or ICD10 Dx Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.8, Z02.2, Z02.6, Z02.71, Z02.79, Z02.82, Z02.83, Z02.89, and Z02.9.
  - To review the history and progress of well-child visits for patients in need of these exams, open the **Care Management Gap Report**.

Domain 1: Primary and Secondary Prevention

- **Measure: Well-Child Visits for Infants (0-15 months)**
  - This spreadsheet displays eligibility information for this measure, as well as the claims history of each required well-child visit within the measurement period.
  - Patients in need of additional visits to meet the requirements can be identified with this report.
  - The highlighted example indicates a child who is eligible and is in need of 2 more exams to get credit for the metric.

Well Child Visit Birth to 15 Months Indicator	Well Child Visit Birth to 15 Months Date of Service 1	Well Child Visit Birth to 15 Months Date of Service 2	Well Child Visit Birth to 15 Months Date of Service 3	Well Child Visit Birth to 15 Months Date of Service 4	Well Child Visit Birth to 15 Months Date of Service 5	Well Child Visit Birth to 15 Months Date of Service 6
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Eligible and 6 well visit requirement not met						
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Not eligible (too young) and 6 well visit requiren	09/01/2014	06/28/2014	05/11/2014			
Not eligible (too young) and 6 well visit requiren	09/09/2014	07/04/2014	05/22/2014			
Eligible and 6 well visit requirement not met	04/04/2014	01/31/2014	11/10/2013	10/06/2013		
Ineligible due to age (too old)						
Not eligible (too young) and 6 well visit requiren	08/14/2014	04/20/2014	01/13/2014	12/02/2013		
Not eligible (too young) and 6 well visit requiren	10/19/2014	06/23/2014				
Ineligible due to age (too old)						
Ineligible due to age (too old)						
Eligible and 6 well visit requirement not met	06/02/2013					
Eligible and 6 well visit requirement not met	03/11/2014	01/08/2014	09/28/2013	06/19/2013		
Ineligible due to age (too old)						

Domain 1: Primary and Secondary Prevention

- **Measure: Well-Child Visits for Children (3-6 years)**
  - This metric tracks the percentage of attributed members 3–6 years of age at the end of the evaluation period, who had one or more well-child visits with a PCP during the evaluation period.
  - This measure is identified with the following codes:
    - 99382, 99383, 99392, 99393, G0438, G0439, V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9, or ICD10 Dx Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.2, Z02.5, Z02.6, Z02.71, Z02.79, Z02.82, Z02.83, Z02.89, and Z02.9
  - To review the history and progress of well-child visits for patients in need of these exams, open the **Care Management Gap Report**.

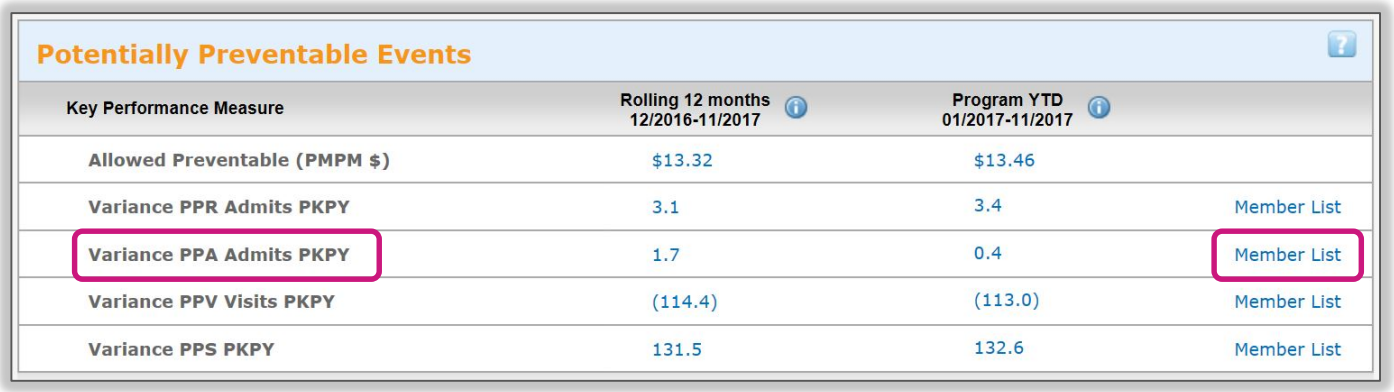
Domain 1: Primary and Secondary Prevention

- **Measure: Well-Child Visits for Children (3-6 years)**
  - This spreadsheet displays eligibility information for this measure, as well as the claim history of the last well-child visit on file.
    - Patients in need of a visit to meet the requirement can be identified with this report.
  - This report has been filtered to show children who are eligible and in need of the required exam to get credit for the metric. They have either not had a well-child claim between 3-6 years of age, or their last well-child visit occurred prior to them turning 3 years of age.
    - This demo data period runs from 10/1/2013 - 9/30/2014

it	Well Child Visit Birth to 15 Months Date of Service 6	Well Child Visit 3-6 Years Indicator	Well Child Visit 3-6 Years Date of Service	30 Day Discharge Indicator	Date Disch with n Follov
		Eligible and 1 well visit requirement not met	10/29/2012	Ineligible due to	
		Eligible and 1 well visit requirement not met	08/24/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	08/11/2012	Ineligible due to	
		Eligible and 1 well visit requirement not met	06/19/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	08/25/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	10/20/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met		Ineligible due to	
		Eligible and 1 well visit requirement not met	11/19/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	09/13/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	12/21/2012	Ineligible due to	
		Eligible and 1 well visit requirement not met	12/13/2012	Ineligible due to	
		Eligible and 1 well visit requirement not met	11/22/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	03/21/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	04/21/2013	Ineligible due to	
		Eligible and 1 well visit requirement not met	06/13/2011	Ineligible due to	
		Eligible and 1 well visit requirement not met		Ineligible due to	
		Eligible and 1 well visit requirement not met		Ineligible due to	
		Eligible and 1 well visit requirement not met	01/28/2013	Ineligible due to	

Domain 2: Tertiary Prevention

- **Measure: Potentially Preventable Admissions (PPA)**
  - This metric measures the rate of potentially preventable initial hospital admissions, compared with the expected rate based off 3M's clinical risk grouping, age group, gender and line of business.
  - If the discharge data includes Mental Health/Chemical Dependency (MH/CD) diagnoses, the PPR expected rate is modified to reflect the increased probability of readmission associated with these conditions.
  - To review the patients that have had an admission flagged as a PPA, click on the **Member List** link associated with **Variance PPA Visits**.

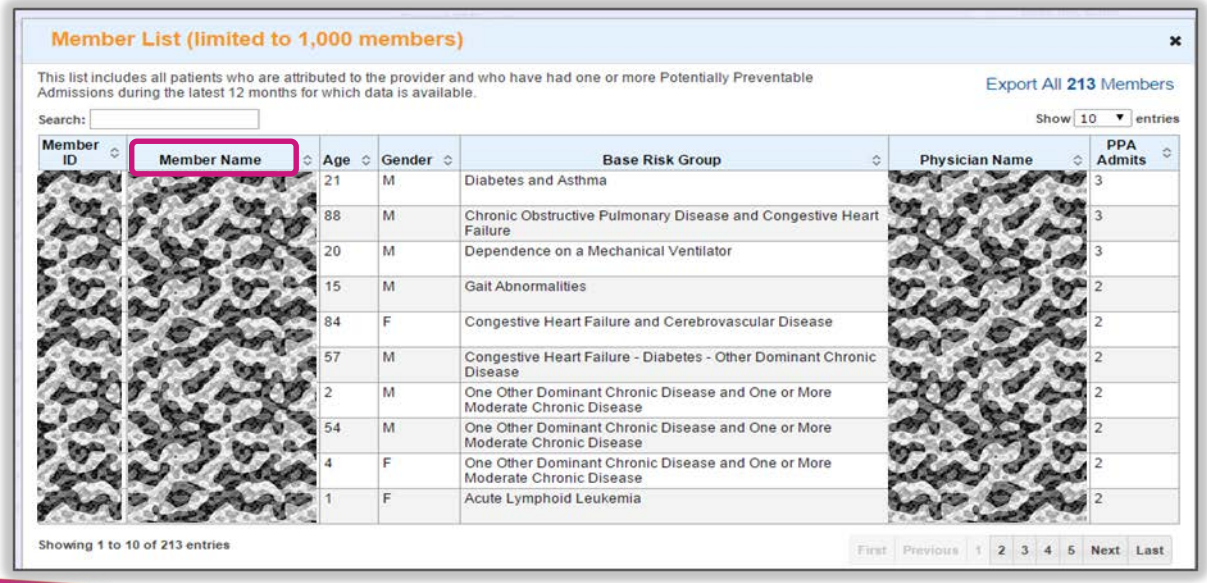


Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$13.32	$13.46	
Variance PPR Admits PKPY	3.1	3.4	Member List
Variance PPA Admits PKPY	1.7	0.4	Member List
Variance PPV Visits PKPY	(114.4)	(113.0)	Member List
Variance PPS PKPY	131.5	132.6	Member List

Domain 2: Tertiary Prevention

- **Measure: PPA**
  - This report shows members that have had a PPA in the measurement period.
  - This report is useful in identifying patients that have been repeatedly hospitalized and could benefit from more focused primary care intervention.
  - Click on the **Member Name** to view detailed health-care utilization information.



Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have had one or more Potentially Preventable Admissions during the latest 12 months for which data is available.

Export All 213 Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	PPA Admits
		21	M	Diabetes and Asthma		3
		88	M	Chronic Obstructive Pulmonary Disease and Congestive Heart Failure		3
		20	M	Dependence on a Mechanical Ventilator		3
		15	M	Gait Abnormalities		2
		84	F	Congestive Heart Failure and Cerebrovascular Disease		2
		57	M	Congestive Heart Failure - Diabetes - Other Dominant Chronic Disease		2
		2	M	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease		2
		54	M	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease		2
		4	F	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease		2
		1	F	Acute Lymphoid Leukemia		2

Showing 1 to 10 of 213 entries

First Previous 1 2 3 4 5 Next Last

Domain 2: Tertiary Prevention

- **Measure: Potentially Preventable ER Visits (PPV)**
  - This metric measures the rate of PPV, compared with the expected rate based off 3M's clinical risk grouping, age group, gender and line of business.
  - A PPV is an ER visit that could have been more appropriately treated in a primary care setting.
    - Offering after hours care, heightened monitoring of known high utilizing patients or creating initiatives to improve patient understanding and when to seek treatment may help to reduce this score.
  - To review the patients that have had one or more ER visits flagged as a PPV, click on the **Member List** link associated with **Variance PPV Visits**.

Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$13.32	$13.46	
Variance PPR Admits PKPY	3.1	3.4	Member List
Variance PPA Admits PKPY	1.7	0.4	Member List
Variance PPV Visits PKPY	(114.4)	(113.0)	Member List
Variance PPS PKPY	131.5	132.6	Member List

Domain 2: Tertiary Prevention

- **Measure: PPV**
  - The member list displays patients with one or more PPVs in the measurement period.
    - These are the high ER utilizers that may benefit from education and outreach.
  - Click on a **Member Name** to review more in-depth utilization data.

Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have had one or more Potentially Preventable Emergency Room Visits during the latest 12 months for which data is available.

Export All 2,769 Members

Search:

Show 10 entries

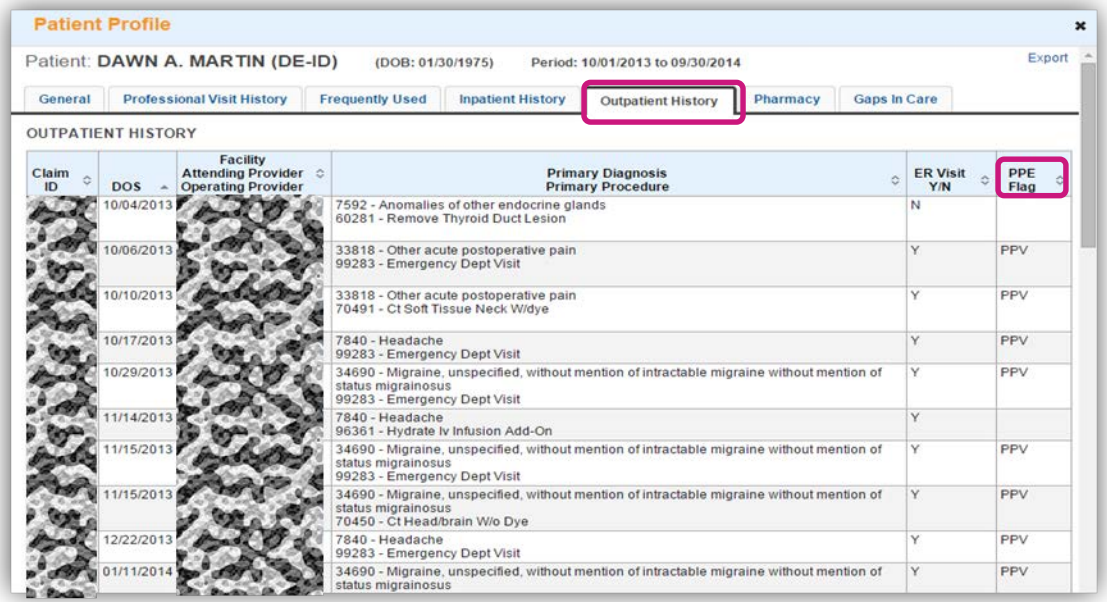
Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	PPV Visits
[redacted]	[redacted]	39	F	Diabetes and Other Moderate Chronic Disease	[redacted]	33
		20	F	Two Other Dominant Chronic Diseases		16
		56	F	Diabetes and Other Moderate Chronic Disease		16
		43	F	Moderate Chronic Substance Abuse and Other Moderate Chronic Disease		14
		32	F	Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease		13
		35	F	Two Other Moderate Chronic Diseases		11
		35	F	Two Other Moderate Chronic Diseases		10
		42	F	Moderate Chronic Substance Abuse and Other Moderate Chronic Disease		9
		47	F	Two Other Moderate Chronic Diseases		9
		34	F	Diabetes and Other Moderate Chronic Disease		9

Showing 1 to 10 of first 1,000 entries

First Previous 1 2 3 4 5 Next Last

Domain 2: Tertiary Prevention

- **Measure: PPV**
  - The **Outpatient History** tab from the Patient Profile Report shows the patient's outpatient history. If a hospital was flagged as a PPV, it is noted under **PPE Flag**.



Patient Profile

Patient: DAWN A. MARTIN (DE-ID) (DOB: 01/30/1975) Period: 10/01/2013 to 09/30/2014 Export

General | Professional Visit History | Frequently Used | Inpatient History | Outpatient History | Pharmacy | Gaps In Care

OUTPATIENT HISTORY

Claim ID	DOS	Facility Attending Provider Operating Provider	Primary Diagnosis Primary Procedure	ER Visit Y/N	PPE Flag
	10/04/2013		7592 - Anomalies of other endocrine glands 60281 - Remove Thyroid Duct Lesion	N	
	10/06/2013		33818 - Other acute postoperative pain 99283 - Emergency Dept Visit	Y	PPV
	10/10/2013		33818 - Other acute postoperative pain 70491 - Ct Soft Tissue Neck W/dye	Y	PPV
	10/17/2013		7840 - Headache 99283 - Emergency Dept Visit	Y	PPV
	10/29/2013		34690 - Migraine, unspecified, without mention of intractable migraine without mention of status migrainosus 99283 - Emergency Dept Visit	Y	PPV
	11/14/2013		7840 - Headache 96361 - Hydrate Iv Infusion Add-On	Y	
	11/15/2013		34690 - Migraine, unspecified, without mention of intractable migraine without mention of status migrainosus 99283 - Emergency Dept Visit	Y	PPV
	11/15/2013		34690 - Migraine, unspecified, without mention of intractable migraine without mention of status migrainosus 70450 - Ct Head/brain W/o Dye	Y	PPV
	12/22/2013		7840 - Headache 99283 - Emergency Dept Visit	Y	PPV
	01/11/2014		34690 - Migraine, unspecified, without mention of intractable migraine without mention of status migrainosus	Y	PPV

Domain 2: Tertiary Prevention

- **Measures: PPAs and PPVs**
  - Another helpful resource for identifying members who have had Potentially Preventable Events (PPEs) is the **PPE Report**. This report shows all types of PPEs, not just PPAs and PPVs.
  - Once these members have been identified, a more in depth look at their profile may be useful in determining next steps of care by looking them up using the Patient Profile link on the home tab of the prospective dashboard (refer to page 32).

Active Member	PPVs	PPV Most Recent Visit	PPV Most Recent Type	PPRs	PPR Most Recent Visit	PPR Most Recent Type	PPAs	PPA Most Recent Visit	PPA Most Recent Type	PPSs
Y	1	05/18/2017	Chest Pain	0			0			60
N	0	01/24/2017	CAT Scan - Other	0			0			5
Y	0			0			0			6
N	0			0			0			5
Y	0			0			0			85
N	0			0			0			2
Y	0			0			0			16
N	0			0			0			4
Y	1	12/14/2017	CAT Scan - Brain	0			0			13
Y	0			0			0			1
Y	0			0			0			5
Y	3	06/20/2017	Level I Cardiac Arrhythmia & Conduction D	0			0			32
N	0			0			0			10
N	0			0			0			4
Y	0			0			0			5
N	0			0			0			5
N	0			0			0			9
N	0			0			0			4
Y	0	02/11/2017	Conjunctivitis	0			0			4
Y	0			0			0			20
N	0			0			0			10
N	0			0			0			3
Y	0	07/27/2014	Dental & Oral Diseases & Injuries	0	12/28/2011	Schizophrenia	0			24
N	4	10/10/2017	CAT Scan Back	0			0			70
Y	1	10/26/2017	CAT Scan - Abdomen	0			0			4
N	0			0			0			11
Y	0	01/26/2017	Level II Other Musculoskeletal System & C	0			0			2
Y	1	11/07/2017	Infections of Upper Respiratory Tract & Oti	0			0			1
Y	3	12/04/2017	Infections of Upper Respiratory Tract & Oti	0			0			5
Y	1	10/25/2017	Level II Other Musculoskeletal System & C	0			0			6

Domain 3: Panel Health Status Change

- **Measure: Status Jumpers**
  - This metric accounts for the risk-adjusted percent difference of attributed members who do not acquire additional chronic conditions.
  - This rate is calculated by taking into account members who previously had a dominant chronic condition the previous year, and then acquired an additional dominant condition during the following year. This rate is compared to the expected rate and then adjusted for clinical risk group, age and gender.
  - To identify members that have acquired an additional chronic condition, open either the **Care Management Gap Report** or the **Care Management Patient List** report on the dashboard.

Domain 3: Panel Health Status Change

superior healthplan™

- **Measure: Status Jumpers**
  - The **Care Management Gap Report** and **Care Management Patient List** show members that have acquired a new chronic condition in the performance period.
  - These reports target members who have experienced significant clinical deterioration in the measurement period.
  - These members may benefit from a detailed review to attempt to prevent further clinical decline and future cost.

Care Management Gap Report

Allowed	Chronic Severity Jumper	Chronic Status Jumper	Chronic Fall Out	Newly Chronic
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N
$0	N	N	N	N

Care Management Patient List

Active Member	Population Health Segment	Fall Out Report	Jumpers Report	Newly Chronic	N V 6
Y	Simple Chronic			Y	
Y	Healthy				
Y	Stable				
Y	Simple Chronic				Y
Y	Stable				
Y	Complex Chronic				
Y	Healthy				
Y	Complex Chronic		Y		
Y	Stable				
Y	Stable				
Y	Simple Chronic				Y
Y	Simple Chronic				Y
Y	Complex Chronic			Y	
Y	Simple Chronic			Y	
Y	Complex Chronic		Y		
Y	Simple Chronic				Y
Y	Simple Chronic			Y	
Y	Stable				
Y	Complex Chronic				
Y	Healthy				
Y	Simple Chronic				Y
Y	Complex Chronic				
Y	Healthy				
Y	Complex Chronic		Y		
Y	Simple Chronic				Y
Y	Simple Chronic				Y
Y	Stable				
Y	Simple Chronic			Y	
Y	Simple Chronic			Y	
Y	Stable				
Y	Simple Chronic				Y
Y	Simple Chronic			Y	

Domain 3: Panel Health Status Change

- **Measure: Severity Jumpers**
  - This metric is the risk-adjusted percent difference of attributed members with a dominant chronic condition and whose condition does not increase in severity.
  - This is the rate of members with a dominant chronic condition in the previous measurement period whose severity of disease increased in the current period, compared with the expected rate and adjusted for clinical risk group, age and gender.
  - The numerator is attributed members with chronic conditions whose severity moves two or more levels, as measured by 3M's clinical risk group methodology (ACRG3) in the evaluation period. The denominator is all members with chronic conditions, eligible to jump two or more severity levels.
  - To review the patients that have experienced an increase in the severity of their chronic condition(s), open the **Care Management Gap Report** on the dashboard.

Domain 3: Panel Health Status Change

- **Measure: Severity Jumpers**
  - This 3M predictive model shows patients who have clinically deteriorated since the last measurement period.
  - Providers can use the report to identify these patients and design appropriate intervention to attempt to prevent future costs and increased illness burden.

Allowed	Chronic Severity Jumper	Chronic Status Jumper	Chronic Fall Out	Newly Chronic	Total Number of Seen During the Prospective Peri
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	
$0	N	N	N	N	

Domain 4: Continuity of Care

- **Measure: PCP Visit**
  - This metric tracks the number of visits that a patient has with a PCP in the measurement period.
    - Without at least one PCP visit in the measurement period, it is difficult to determine how primary care is occurring.
  - The denominator is all attributed members and the numerator is the number of attributed members with at least 1 visit to a PCP in a qualified service location.
  - To identify members that lack a PCP visit, open the **Care Management Gap Report** from the dashboard.

Domain 4: Continuity of Care

- **Measure: PCP Visit**
  - This part of the report indicates the **Total Number of PCPs Seen During the Prospective Period**.
  - Sort the report to reveal the patients with zero PCPs seen.
    - This is the group of patients that are affecting this metric score.

Chronic Status Jumper	Chronic Fall Out	Newly Chronic	Total Number of PCPs Seen During the Prospective Period	Number of PPAs	Date of Most Recent PPA	Type of Most Recent PPA	P D f
N	N	N	0	0			
N	N	N	0	0			
N	N	N	1	0			
N	N	N	1	0			
N	N	N	1	0			
N	N	N	2	0			
N	N	N	2	0	05/02/2013	Kidney & Urinary Tract Infe	
N	N	N	1	0			
N	N	N	1	0			
N	N	N	1	0			
N	N	N	1	0			
N	N	N	1	0			
N	N	N	0	0			
N	N	N	0	0			
N	N	N	0	0			
N	N	N	0	0			
N	N	N	1	0			
N	N	N	1	0			
N	N	N	0	0			
N	N	N	0	0			
N	N	N	0	0			
N	N	N	1	0			
N	N	N	1	0			

Domain 4: Continuity of Care

- **Measure: Continuity of Care Index**
  - This metric is an index of the number of visits in the reporting period between members of the provider's panel and any qualified provider.
  - The index is scored on a range from 0-1.
  - A score of 0 indicates that the patient has not seen their PCP in the measurement period, and is receiving the entirety of their primary care elsewhere.
  - A score of 1 would indicate the patient is receiving all of their primary care from their attributed PCP.
  - All attributed members that have had at least 4 visits to either a physician or the ER are eligible. Scores for each patient are a formula that measures care dispersion.
  - If an attributed member sees another PCP in the same practice, that visit is counted as a separate provider.
  - Members in the malignancy and catastrophic 3M Clinical Risk Groups are excluded.

Domain 4: Continuity of Care

- **Measure: Continuity of Care Index**
  - PPVs that did not result in admission are treated as a visit from a different provider of a different group.
  - Risk adjustment is used to account for the known decrease in continuity of care that accompanies panels with high numbers of chronic patients.
  - To identify members that have seen multiple PCPs and are experiencing a dispersion of care, open the **Care Management Gap Report** from the dashboard.

Domain 4: Continuity of Care

- **Measure: Continuity of Care Index**
  - This report indicates the **Total Number of PCPs Seen During the Prospective Period**.
  - The patients with the higher number of PCP visits are decreasing the Continuity of Care Index Score.
  - Reviewing the patients' PCP selection or discussing with them their primary care options may help to reduce these outside visits.

Chronic Status Jumper	Chronic Fall Out	Newly Chronic	Total Number of PCPs Seen During the Prospective Period	Number of PPAs	Date of Most Recent PPA	Type of Most Recent PPA
N	N	N	0	0		
N	N	N	0	0		
N	N	N	1	0		
N	N	N	1	0		
N	N	N	1	0		
N	N	N	2	0		
N	N	N	2	0	05/02/2013	Kidney & Urinary Tract Infe
N	N	N	1	0		
N	N	N	1	0		
N	N	N	1	0		
N	N	N	1	0		
N	N	N	1	0		
N	N	N	0	0		
N	N	N	0	0		
N	N	N	0	0		

Domain 5: Chronic and Follow-up Care

- **Measure: 3 Chronic Care Visits**
  - The dashboard tracks chronically ill patients as a cohort that requires three provider visits within the measurement period.
    - These patients are identified in the dashboard as having an ACRG3 base between 50 - 79.
  - Use the **Care Management Gap Report** to identify chronically ill patients that have not yet met the criteria for this metric.
  - Bringing these patients in for the recommended 3 visits will help increase the score for this metric.

Domain 5: Chronic and Follow-up Care

- **Measure: 3 Chronic Care Visits**
  - The resulting report can be filtered to show which patients are eligible for this measure.
  - From this example, the report lists the dates of their three visits within the measurement period.
  - Patients that require additional visits can be identified using this information.

ber of s without a Date	3 Chronic Visits Indicator	Chronic Visit Date of Service 1	Chronic Visit Date of Service 2	Chronic Visit Date of Service 3	Severity Jumper
	Eligible and had 3 visits	12/21/2014	09/01/2014	07/13/2014	N
	Eligible and had 3 visits	10/31/2014	10/24/2014	10/13/2014	N
	Eligible and had 3 visits	11/10/2014	11/03/2014	10/29/2014	N
	Eligible and had 3 visits	10/07/2014	10/03/2014	09/03/2014	N
0	Eligible and had 3 visits	08/21/2014	08/12/2014	07/29/2014	N
	Eligible and had 3 visits	08/26/2014	08/04/2014	07/29/2014	N
	Eligible and had 3 visits	10/05/2014	09/13/2014	09/10/2014	N
	Eligible and had 3 visits	03/01/2014	01/11/2014	01/04/2014	N
	Eligible and had 3 visits	08/02/2014	07/14/2014	06/21/2014	N
	Eligible and did not have 3 visi	03/12/2014			N
	Eligible and had 3 visits	05/05/2014	03/06/2014	02/21/2014	N
	Eligible and had 3 visits	08/25/2014	08/06/2014	07/28/2014	N
	Eligible and had 3 visits	09/09/2014	03/12/2014	01/18/2014	N
	Eligible and had 3 visits	07/23/2014	06/18/2014	06/07/2014	N
0	Eligible and had 3 visits	04/09/2014	03/15/2014	02/06/2014	N
	Eligible and had 3 visits	07/26/2014	06/13/2014	05/19/2014	N
	Eligible and did not have 3 visi	03/22/2014	01/02/2014		N

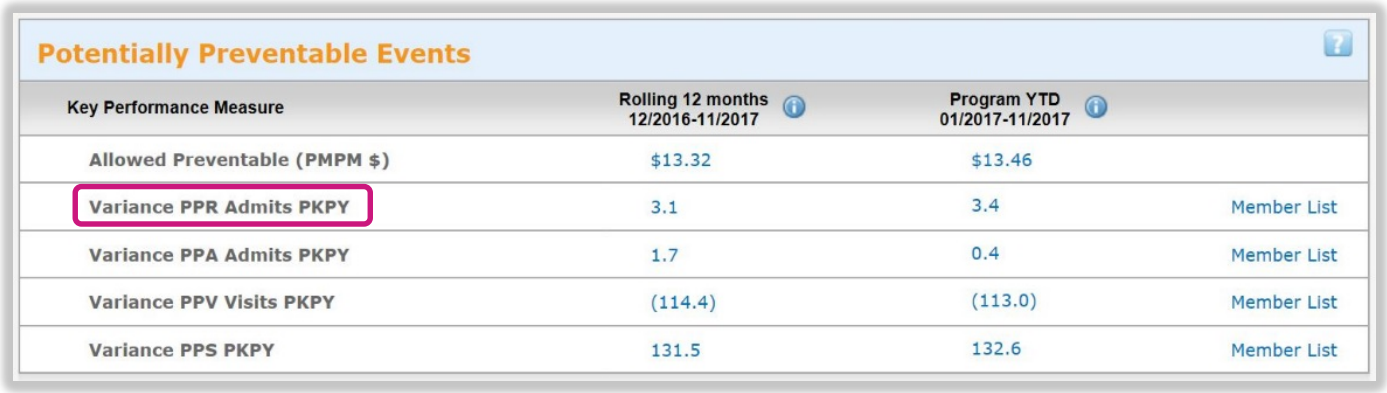
Domain 5: Chronic and Follow-up Care

- **Measure: 3 Chronic Care Visits**
  - Patients with a **ACRG3** base description between 50-79 are eligible and being tracked for the 3 Chronic Visit metric.
  - See the Appendix (pages 77-79) for a full list of conditions and diseases that are included in these risk groups.

urrent CRG Description	ACRG3	ACRG3 Description	Mammo Screen Indicat
cquired Hemiplegia Level - 2	52	Single Dominant Or Moderate Chr	Not Eligi
epressive and Other Psychoses	52	Single Dominant Or Moderate Chr	Not Eligi
xtrapyramidal Diagnoses Level -	51	Single Dominant Or Moderate Chr	Not Eligi
ypertension Level - 1	51	Single Dominant Or Moderate Chr	Eligible
ydrocephalus and Other Brain Ar	51	Single Dominant Or Moderate Chr	Not Eligi
heumatoid Arthritis Level - 2	52	Single Dominant Or Moderate Chr	Eligible
isc Disease and Other Chronic E	51	Single Dominant Or Moderate Chr	Eligible
epressive and Other Psychoses	51	Single Dominant Or Moderate Chr	Not Eligi
ervasive Development Disorder L	51	Single Dominant Or Moderate Chr	Not Eligi
rug Abuse - Cannabis/NOS/NEC	51	Single Dominant Or Moderate Chr	Not Eligi
ypertension Level - 2	51	Single Dominant Or Moderate Chr	Not Eligi
hronic Alcohol Abuse Level - 1	51	Single Dominant Or Moderate Chr	Not Eligi
sthma Level - 2	52	Single Dominant Or Moderate Chr	Not Eligi
isc Disease and Other Chronic E	51	Single Dominant Or Moderate Chr	Not Eligi
wo Other Dominant Chronic Dise	62	Significant Chronic Disease In Mu	Not Eligi

Domain 5: Chronic and Follow-up Care

- **Measure: Potentially Preventable Readmissions (PPR)**
  - The prospective dashboard tracks clinically related hospital readmissions within 30 days of initial discharge as Potentially Preventable Readmissions (PPR).
  - On a risk adjusted basis, the underlying reason for readmission could plausibly be related to the care rendered during or immediately following a prior hospital admission.
  - Pulling the list of members affecting this score identifies patients that have had one or more PPR and can be useful for outreach or enhanced monitoring of their care.
  - To review the number of patients that have had one or more PPR, click on the Member List link associated with **Variance PPR Admits**.

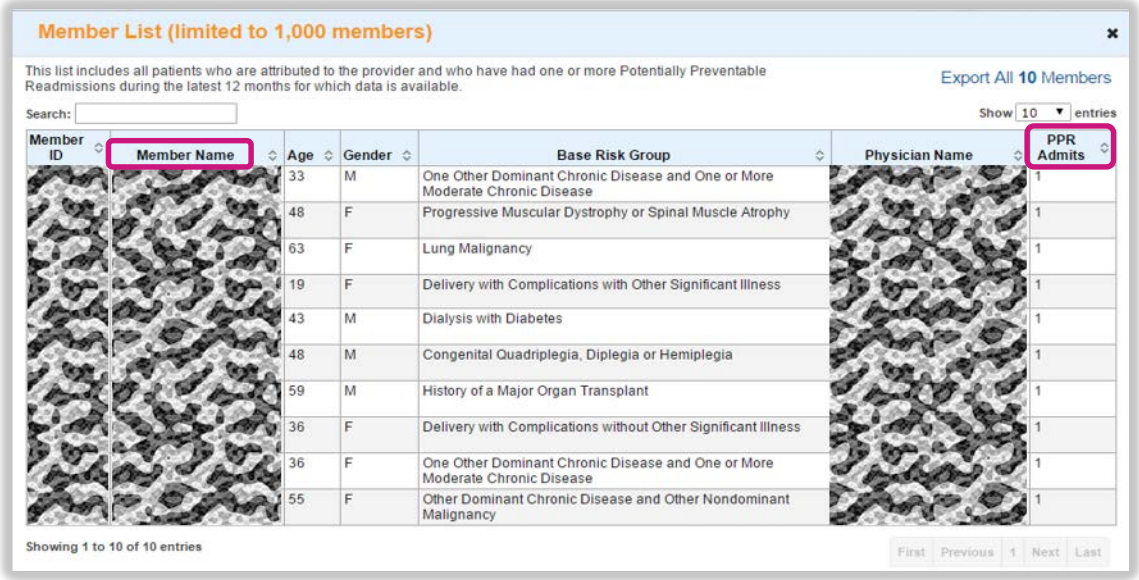


Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$13.32	$13.46	
Variance PPR Admits PKPY	3.1	3.4	Member List
Variance PPA Admits PKPY	1.7	0.4	Member List
Variance PPV Visits PKPY	(114.4)	(113.0)	Member List
Variance PPS PKPY	131.5	132.6	Member List

Domain 5: Chronic and Follow-up Care

- **Measure: PPR**
  - The member list displays all of the eligible patients affecting this measure.
  - Clicking a **Member Name** will reveal more detailed information is available regarding their utilization and hospitalization history.



Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have had one or more Potentially Preventable Readmissions during the latest 12 months for which data is available.

Export All 10 Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	PPR Admits
		33	M	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease		1
		48	F	Progressive Muscular Dystrophy or Spinal Muscle Atrophy		1
		63	F	Lung Malignancy		1
		19	F	Delivery with Complications with Other Significant Illness		1
		43	M	Dialysis with Diabetes		1
		48	M	Congenital Quadriplegia, Diplegia or Hemiplegia		1
		59	M	History of a Major Organ Transplant		1
		36	F	Delivery with Complications without Other Significant Illness		1
		36	F	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease		1
		55	F	Other Dominant Chronic Disease and Other Nondominant Malignancy		1

Showing 1 to 10 of 10 entries

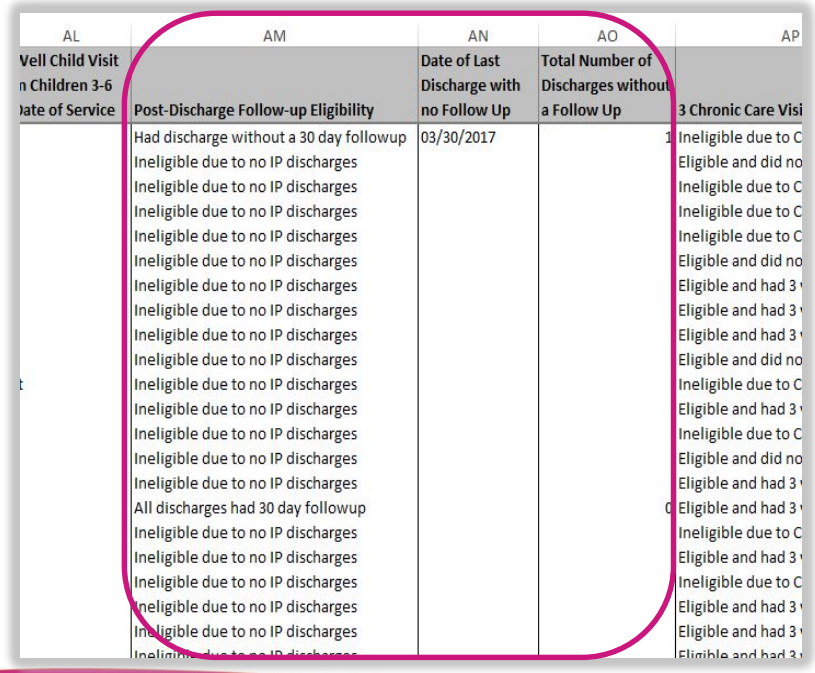
First Previous 1 Next Last

Domain 5: Chronic and Follow-up Care

- **Measure: 30-Day Discharge Visit**
  - The prospective dashboard reports members who had a PCP visit within 30 days after an acute care hospitalization discharge.
  - Both the **Care Management Gap Report** and the **Care Management Patient List** show the members affecting this score and identifies patients that have had a hospitalization without a 30-day follow up visit with their PCP.
    - This can be useful for outreach, better post-discharge coordination with hospitals or enhanced monitoring of their care.

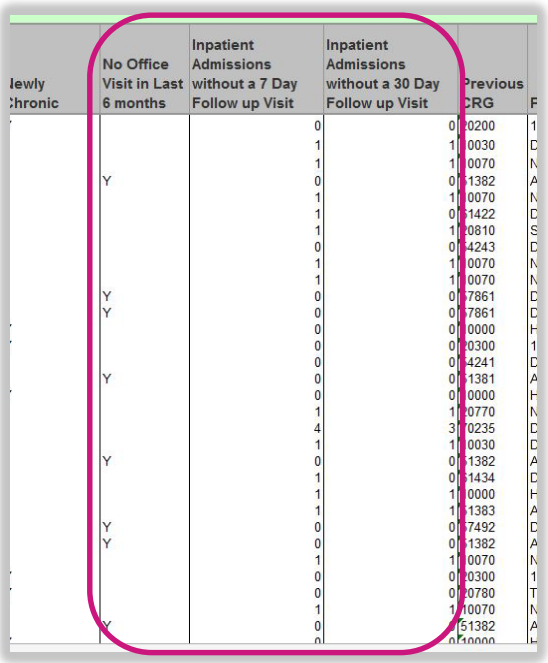
Domain 5: Chronic and Follow-up Care

- **Measure: 30-Day Discharge Visit**
  - The **Care Management Gap Report** below shows the dates and number of total discharges without a follow up.



AL	AM	AN	AO	AP
Vell Child Visit n Children 3-6 Date of Service	Post-Discharge Follow-up Eligibility	Date of Last Discharge with no Follow Up	Total Number of Discharges without a Follow Up	3 Chronic Care Visi
	Had discharge without a 30 day followup	03/30/2017	1	Ineligible due to C
	Ineligible due to no IP discharges			Eligible and did no
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Eligible and did no
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Eligible and did no
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Eligible and did no
	Ineligible due to no IP discharges			Eligible and had 3
	All discharges had 30 day followup		0	Eligible and had 3
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Ineligible due to C
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Eligible and had 3
	Ineligible due to no IP discharges			Eligible and had 3

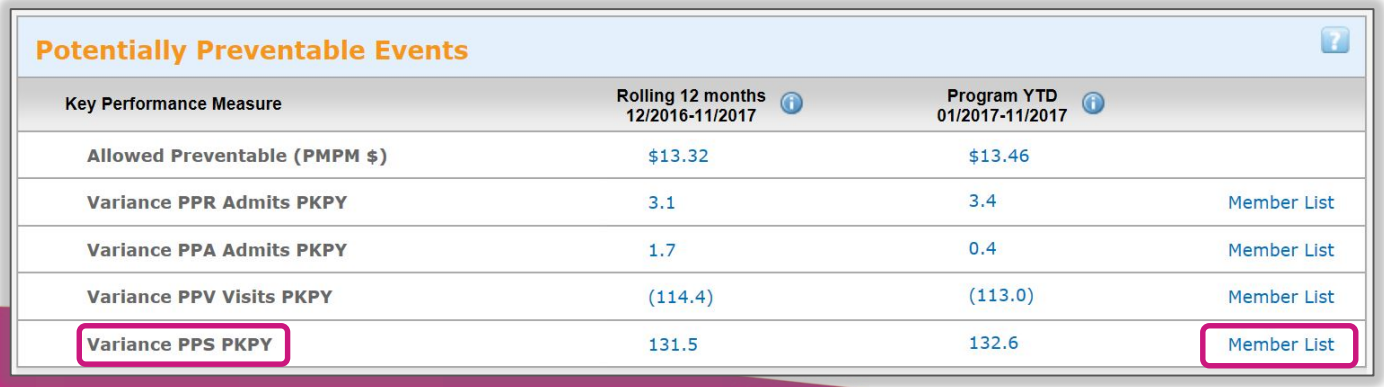
  - The **Care Management Patient List** below shows the number of inpatient admissions without a 7 or 30 day follow up.



lewly Chronic	No Office Visit in Last 6 months	Inpatient Admissions without a 7 Day Follow up Visit	Inpatient Admissions without a 30 Day Follow up Visit	Previous CRG	F
		0	0	0200	1
		1	1	0030	D
		1	1	0070	N
	Y	0	0	1382	A
		1	1	0070	N
		1	0	1422	D
		1	1	0810	S
		0	0	4243	D
		1	1	0070	N
		1	1	0070	N
	Y	0	0	7861	D
	Y	0	0	7861	D
		0	0	0000	H
		0	0	0300	1
		0	0	4241	D
	Y	0	0	1381	A
		0	0	0000	H
		1	1	0770	N
		4	3	0235	D
		1	1	0030	D
	Y	0	0	1382	A
		1	0	1434	D
		1	1	0000	H
		1	1	1383	A
	Y	0	0	7492	D
	Y	0	0	1382	A
		1	1	0070	N
		0	0	0300	1
		0	0	0780	T
		1	1	0070	N
	Y	0	0	1382	A

Domain 6: Efficiency

- **Measure: Potentially Preventable Services (PPS)**
  - This metric shows the allowed amount of qualifying services that are designated as potentially preventable, compared with the expected amount.
    - Adjusted for clinical risk group, age group and gender.
  - PPS are ancillary services such as procedures, treatments and other interventions ordered by PCPs or specialists in ambulatory care settings, which may not provide useful information for diagnosis and treatment (e.g., ordering an MRI for every patient with back pain).
  - PPS only include ancillary services performed outside of an inpatient hospital setting.
  - To review the number of PPS attributed to high utilization members, click on the Member List link associated with **Variance PPS Member List**.



Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$13.32	$13.46	
Variance PPR Admits PKPY	3.1	3.4	Member List
Variance PPA Admits PKPY	1.7	0.4	Member List
Variance PPV Visits PKPY	(114.4)	(113.0)	Member List
Variance PPS PKPY	131.5	132.6	Member List

Domain 6: Efficiency

- **Measure: Potentially Preventable Services (PPS)**
  - This report reveals the patients with the highest number of **PPS Services** allowed in the measurement period.
  - This will reveal opportunities to review their plan of care and make possible adjustments to reduce these costs.
  - Drilling down to individual members will show detailed utilization information.

Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and who have utilized one or more Potentially Preventable Services during the latest 12 months for which data is available.

Export All 2,860 Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	PPS Services
		20	F	Psychiatric Disease (Except Schizophrenia) and Other Moderate Chronic Disease		306
		60	F	Lung Malignancy		211
		57	F	Schizophrenia and Other Moderate Chronic Disease		209
		54	F	Two Other Moderate Chronic Diseases		179
		27	F	Chronic Neuromuscular/Other Neurological Diagnoses - Moderate		162
		63	M	Congestive Heart Failure and Other Moderate Chronic Disease		152
		50	F	Joint Replacement		130
		84	F	Diabetes - 2 or More Other Dominant Chronic Diseases		129
		59	F	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease		113
		29	F	Chronic Neuromuscular/Other Neurological Diagnoses - Moderate		109

Showing 1 to 10 of first 1,000 entries

First Previous 1 2 3 4 5 Next Last

Domain 6: Efficiency

- **Measure: Potentially Preventable Services (PPS)**
  - The procedures listed below account for over 75% of 3M's PPS:
    - Angioplasty and Transcatheter Procedures
    - Cardiogram
    - Cat Scan – Abdomen
    - Cat Scan - Other
    - Class IV Pharmacotherapy
    - Class V Pharmacotherapy
    - Diagnostic Ultrasound Except Obstetrical and Vascular of Lower Extremities
    - Diagnostic Upper GI Endoscopy or Intubation
    - Echocardiography
    - Exercise Tolerance Tests
    - Hysteroscopy
    - Individual Comprehensive Psychotherapy
    - Level I Arthroscopy
    - Level I Chemistry Tests
    - Level I Endoscopy of the Upper Airway
    - Level I Immunology Tests
    - Level II Immunology Tests
    - Level II Microbiology Tests
    - Level III Diagnostic Nuclear Medicine
    - Minor Cardiac and Vascular Tests
    - MRI- Back
    - MRI- Brain
    - MRI- Joints
    - Nerve and Muscle Tests
    - Obstetrical Ultrasound
    - Organ or Disease Oriented Panels
    - Pet Scans
    - Plain Film
    - Sleep Studies

Domain 6: Efficiency

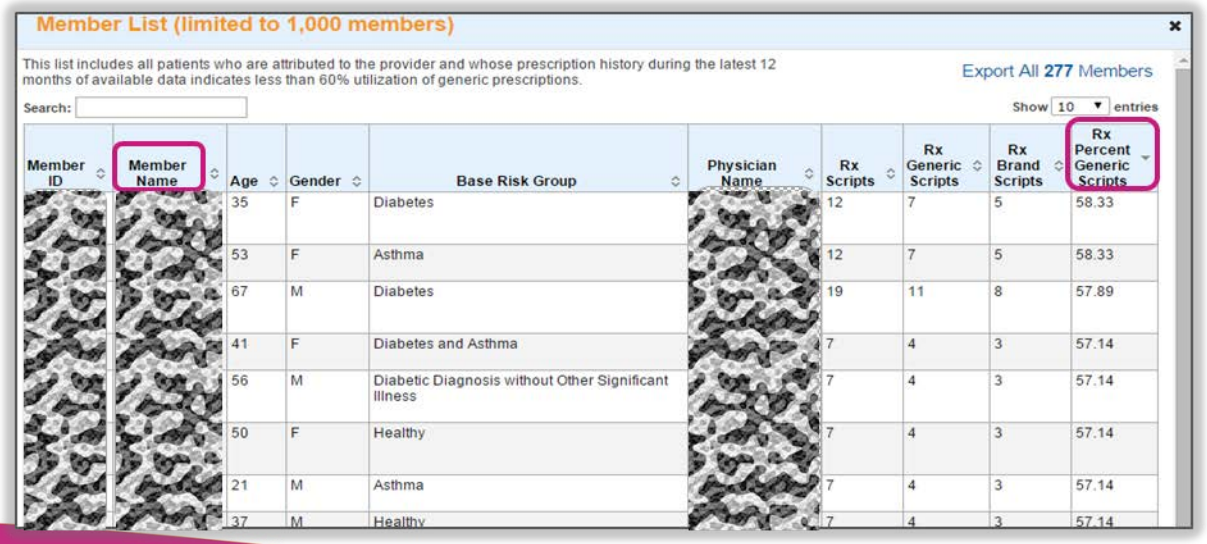
- **Measure: Generic Prescribing**
  - This metric reports the percent of prescriptions that are filled with generic drugs, according to 3M's formulary.
  - The numerator for generic prescribing rate is the number of generic prescriptions. The denominator is the total panel members' prescriptions. This is then compared to the expected rate based upon the health status of the panel.
  - To review the members with low percentages of generic medications, select the **Member List** associated with **% Rx Generic Scripts**.

Utilization

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Variance IP Admits PKPY	4.6	2.2	Member List
Variance ER Visits PKPY	(126.5)	(123.6)	Member List
Variance Rx Scripts PKPY	(367.6)	(414.6)	Member List
% Rx Generic Scripts	76.96 %	76.59 %	Member List

Domain 6: Efficiency

- **Measure: Generic Prescribing**
  - To review members who are attributed to the provider and whose prescription history during the latest 12 months of available data indicates less than 60% utilization of generic prescriptions, select **Rx Percent Generic Scripts**.
  - Opportunities to review the patients' pharmacy data and make any possible adjustments are available when drilling down on an **Member Name**.



Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider and whose prescription history during the latest 12 months of available data indicates less than 60% utilization of generic prescriptions.

Export All 277 Members

Search:

Show 10 entries

Member ID	Member Name	Age	Gender	Base Risk Group	Physician Name	Rx Scripts	Rx Generic Scripts	Rx Brand Scripts	Rx Percent Generic Scripts
		35	F	Diabetes		12	7	5	58.33
		53	F	Asthma		12	7	5	58.33
		67	M	Diabetes		19	11	8	57.89
		41	F	Diabetes and Asthma		7	4	3	57.14
		56	M	Diabetic Diagnosis without Other Significant Illness		7	4	3	57.14
		50	F	Healthy		7	4	3	57.14
		21	M	Asthma		7	4	3	57.14
		37	M	Healthy		7	4	3	57.14

Additional Reports

- 3M's High Needs Individuals predictive model uses information from the most recent 24 months to identify members as having opportunity to receive additional care management.
- The **Emerging High Needs Individuals Report** and **Persistent High Needs Individuals Report** should be reviewed to determine what course of action should be taken to improve these members' care.

Additional Reports – Emerging High Needs Individuals Report

- Emerging High Needs Individuals (EHNI) are members who are at high risk of becoming Persistent High Needs Individuals (PHNI).
- These members are identified as trending towards becoming a patient with increased costs and utilization of health-care services and are stratified into 4 risk categories ranging from low to severe.
- The provider can reach out to these members early on in order to reduce their risk of excessive resource utilization and prevent them from getting into a pattern of persistent high needs or high cost.

Base CRG (Year 1)	Base CRG Description (Year 1)	CRG Severity (Year 1)	Base CRG (Year 2)	Base CRG Description (Year 2)	CRG Severity (Year 2)	Pain Cluster (Year 1)	Pain Cluster (Year 2)
7031	Chronic Obstructive Pulmonary Disease - 2 or More Other Dominant Chronic Diseases	3	6122	Chronic Obstructive Pulmonary Disease and Other Dominant Chronic Disease	6	Yes	Yes
6190	Two Other Dominant Chronic Diseases	5	7016	Congestive Heart Failure - 2 or More Other Dominant Chronic Diseases	6	Yes	Yes
7013	Congestive Heart Failure - Chronic Obstructive Pulmonary Disease - Other Dominant C	4	7010	Congestive Heart Failure - Diabetes - Chronic Obstructive Pulmonary Disease	5	Yes	Yes
7031	Chronic Obstructive Pulmonary Disease - 2 or More Other Dominant Chronic Diseases	5	7031	Chronic Obstructive Pulmonary Disease - 2 or More Other Dominant Chronic Diseases	3	Yes	Yes
6141	Diabetes and Other Dominant Chronic Disease	4	7023	Diabetes - 2 or More Other Dominant Chronic Diseases	4	Yes	Yes
6150	Advanced Coronary Artery Disease and Other Dominant Chronic Disease	6	6100	Chronic Renal Failure and Other Dominant or Moderate Chronic Disease	6	Yes	Yes
7001	Chronic Renal Failure - Diabetes - Other Dominant Chronic Disease	5	7001	Chronic Renal Failure - Diabetes - Other Dominant Chronic Disease	6	Yes	Yes
6140	Diabetes and Advanced Coronary Artery Disease	6	7012	Congestive Heart Failure - Diabetes - Other Dominant Chronic Disease	6	Yes	Yes
6100	Chronic Renal Failure and Other Dominant or Moderate Chronic Disease	6	6100	Chronic Renal Failure and Other Dominant or Moderate Chronic Disease	6	Yes	Yes
7022	Diabetes - Chronic Obstructive Pulmonary Disease - Other Dominant Chronic Disease	5	7022	Diabetes - Chronic Obstructive Pulmonary Disease - Other Dominant Chronic Disease	5	Yes	Yes
7030	Chronic Obstructive Pulmonary Disease - Advanced Coronary Artery Disease - Other	5	7010	Congestive Heart Failure - Diabetes - Chronic Obstructive Pulmonary Disease	6	Yes	Yes
7071	Diabetes - Hypertension - Other Dominant Chronic Disease	3	7071	Diabetes - Hypertension - Other Dominant Chronic Disease	4	Yes	Yes
5743	Schizophrenia	1	7023	Diabetes - 2 or More Other Dominant Chronic Diseases	5	No	Yes
7010	Congestive Heart Failure - Diabetes - Chronic Obstructive Pulmonary Disease	6	7013	Congestive Heart Failure - Chronic Obstructive Pulmonary Disease - Other Dominant C	5	Yes	Yes
6170	Schizophrenia and Other Dominant Chronic Disease	4	6170	Schizophrenia and Other Dominant Chronic Disease	4	Yes	Yes
6171	Schizophrenia and Other Moderate Chronic Disease	5	7041	Advanced Coronary Artery Disease - 2 or More Other Dominant Chronic Diseases	6	Yes	Yes
6171	Schizophrenia and Other Moderate Chronic Disease	4	6141	Diabetes and Other Dominant Chronic Disease	4	Yes	Yes
5424	Diabetes	3	7001	Chronic Renal Failure - Diabetes - Other Dominant Chronic Disease	6	No	Yes

Additional Reports – Persistent High Needs Individuals Report

- PHNI Individuals are members who fall into the top tier of members with a high need of care.
- These members are identified as having a strong history of high resource utilization including hospital admissions, test, pharmaceuticals, etc.
- This provider can use this report to identify, target and educate members who are good candidates for care management intervention.

Member ID	Member Last Name	Member First Name	Member Age	Gender	Date of Birth	Base CRG	Base CRG Description
[redacted]	[redacted]	[redacted]	4	F	[redacted]	6190	Two Other Dominant Chronic Diseases
			4	F		6261	One Other Dominant Chronic Disease and Other Chronic Disease Level 2
			64	M		7010	Congestive Heart Failure - Diabetes - Chronic Obstructive Pulmonary Disease
			4	F		6160	Dementing Disease and Other Dominant Chronic Disease
			9	M		6190	Two Other Dominant Chronic Diseases
			4	M		6260	One Other Dominant Chronic Disease and One or More Moderate Chronic Disease
			5	M		6190	Two Other Dominant Chronic Diseases
			13	F		7060	3 or More Other Dominant Chronic Diseases
			17	M		6190	Two Other Dominant Chronic Diseases
			4	F		6240	Other Dominant Chronic Disease and Asthma
			24	F		6190	Two Other Dominant Chronic Diseases
			4	M		6170	Schizophrenia and Other Dominant Chronic Disease
			14	M		7060	3 or More Other Dominant Chronic Diseases
			50	M		7001	Chronic Renal Failure - Diabetes - Other Dominant Chronic Disease
			55	F		7010	Congestive Heart Failure - Diabetes - Chronic Obstructive Pulmonary Disease
			11	M		7060	3 or More Other Dominant Chronic Diseases

Additional Reports: VIS Reports

- Two reports are available that show the provider and/or provider network's overall VIS as well as the domains that make up the overall VIS.
- The **VIS Detail List Report** lists the providers within a group or network and their panel sizes and raw scoring (percentages or rates) within each domain.
- The **VIS PCP Summary Scores** lists the providers within a group or network, their panel size, VIS Target, VIS and the scores of each component that make up the overall VIS.

VIS Detail List Report

			Primary and Secondary Prevention				Tertiary Prevention				
	Total Panel	VIS Panel	Breast Cancer Screening Rate	Colorectal Cancer Screening Index Rate	Well Child Visit for Infants Rate	Well Child Visit for 3 to 6 Years Old Rate	Potentially Preventable Admissions	Expected	Potentially Preventable ER Visits	Expected	C
	5	2	N/A	N/A	N/A	N/A	0	0.002	0	0.3	
	13	3	N/A	50.00%	N/A	N/A	1	0.721	7	2.6	
er El	552	401	N/A	N/A	29.41%	93.94%	7	5.970	162	175.5	
	1		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	17		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	1		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
	51	33	11.11%	13.13%	N/A	N/A	0	0.440	2	4.5	
	18	13	20.00%	20.00%	N/A	N/A	0	0.192	3	2.0	
	10	8	0.00%	0.00%	N/A	N/A	0	0.003	0	0.4	
	27	10	N/A	N/A	0.00%	0.00%	0	0.025	1	4.3	
	4	4	100.00%	0.00%	N/A	N/A	0	0.008	2	0.4	
	114	52	N/A	N/A	50.00%	75.00%	0	1.358	21	23.8	
366	4		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
as Pa	14	5	N/A	N/A	N/A	N/A	0	0.003	0	1.2	

VIS PCP Summary Scores

Panel Size	VIS Target	VIS	Breast Cancer Screening	Colorectal Cancer Screening Index	Well Child Visits Birth to 15 Months	Well Child Visits 3-6 Years of Age	Primary and Secondary Prevention Domain	Pote Prev Admi
104	3.72	4.19				4.07	4.07	
111	3.42	3.14				2.76	2.76	
319	3.48	3.13				2.71	2.71	
754	3.11	2.95	0.50	4.34	2.67	3.31	2.09	
375	3.79	3.99				4.23	4.23	
1651	3.53	3.18			3.66	4.93	4.25	
300	3.79	3.57			5.13	3.60	4.29	
980	3.46	3.86			1.42	4.51	2.53	
726	3.82	2.98				1.82	1.82	
5638	3.86	3.80			2.75	4.29	3.43	
132	3.35	4.04				4.00	4.00	
424	3.84	2.93			4.86	4.02	4.42	
100	4.40	3.77						

Appendix

Section Three

Appendix: Overview

- Chronic Conditions (pages 77- 79)
- Glossary of Terms (page 80-81)
- Clinical Risk Groups (page 82)
- VIS Scoring Methodology (page 83)
- Common Set of Expected Values (pages 84-85)
- 3M VIS Measures (pages 86-91)
- Health Segments (page 92)
- Frequently Asked Questions (page 93-95)
- General Information (page 96)

Appendix: Chronic Conditions

- Acquired Hemiplegia
- Acquired Quadriplegia and Persistent Vegetative State
- Acute Lymphoid Leukemia
- Acute Non-Lymphoid Leukemia
- Alcoholic Liver Disease
- Alzheimer's Disease and Other Dementias
- Amputation and Bone Disease
- Angina and Ischemic Heart Disease
- Anomalies of Kidney or Urinary Tract
- Anomaly Skull and Facial Bones
- Asthma
- Atrial Fibrillation
- Bi-Polar Disorder
- Blindness, Visual Loss, and Chronic Eye Diagnoses - Major / Moderate
- Brain and Central Nervous System Malignancies
- Breast Malignancy
- Burns - Extreme
- Cardiac Device Status
- Cardiac Dysrhythmia and Conduction Disorders
- Cerebral Palsy NOS
- Cerebrovascular Disease with Infarction or Intracranial Hemorrhage
- Cerebrovascular Disease without Infarction
- Chromosomal Anomalies and Syndromes Except Down's
- Chronic Alcohol Abuse
- Chronic Disorders of Arteries and Veins - Major
- Chronic Endocrine, Nutritional, Fluid, Electrolyte and Immune Diagnoses - Moderate
- Chronic Gastrointestinal Diagnoses - Moderate
- Chronic Genitourinary Diagnoses
- Chronic Hematological and Immune Diagnoses - Moderate
- Chronic Infections Except Tuberculosis
- Chronic Lymphoid Leukemia
- Chronic Mental Health Diagnoses - Moderate
- Chronic Metabolic and Endocrine Diagnoses - Major
- Chronic Neuromuscular/Other Neurological Diagnoses - Moderate
- Chronic Non-Lymphoid Leukemia
- Chronic Obstructive Pulmonary Disease and Bronchiectasis
- Chronic Pancreatic and Liver Disorders - Moderate
- Chronic Renal Failure
- Chronic Skin Ulcer
- Cleft Lip and Palate
- Coagulation Disorders
- Cocaine Abuse

Appendix: Chronic Conditions

- Colon Malignancy
- Complex Cyanotic and Major Cardiac Septal Anomalies
- Conduct, Impulse Control, and Other Disruptive Behavior Disorders
- Congenital Hemiplegia and Diplegia
- Congenital Quadriplegia
- Congestive Heart Failure
- Connective Tissue Disease and Vasculitis
- Coronary Atherosclerosis
- Crystal Arthropathy
- Curvature or Anomaly of the Spine
- Cystic Fibrosis
- Depressive and Other Psychoses
- Developmental Delay NOS / NEC / Mixed
- Diabetes
- Digestive Malignancy
- Disc Disease and Other Chronic Back Diagnoses
- Down's Syndrome
- Drug Abuse - Cannabis/NOS/NEC
- Eating Disorder
- Epilepsy
- Extrapyramidal Diagnoses
- Gastrointestinal Anomalies
- Genitourinary Malignancy
- Heart Transplant Status
- History of Coronary Artery Bypass Graft
- History of Hip Fracture Age > 64 Years
- History of Myocardial Infarction
- History of Percutaneous Transluminal Coronary Angioplasty
- History of Transient Ischemic Attack
- HIV Disease
- Hodgkin's Lymphoma
- Hydrocephalus, Encephalopathy, and Other Brain Anomalies
- Hypertension
- Immune and Leukocyte Disorders
- Inflammatory Bowel Disease
- Joint Replacement
- Kidney Malignancy
- Kidney Transplant Status
- Leg Varicosities with Ulcers or Inflammation
- Liver Transplant Status
- Lung Malignancy
- Lung Transplant Status

Appendix: Chronic Conditions

- Macular Degeneration
- Major Anomalies of the Kidney and Urinary Tract
- Major Congenital Bone, Cartilage, and Muscle Diagnoses
- Major Liver Disease except Alcoholic
- Major Personality Disorders
- Major Respiratory Anomalies
- Malignancy NOS/NEC
- Mild / Moderate Mental Retardation
- Multiple Myeloma
- Multiple Sclerosis and Other Progressive Neurological Diagnoses
- Nephritis
- Neurodegenerative Diagnoses Except Multiple Sclerosis and Parkinson's
- Non-Hodgkin's Lymphoma
- Obesity
- Opioid Abuse
- Osteoporosis
- Other Cardiovascular Diagnoses - Major
- Other Major Chronic Pulmonary Diagnoses
- Other Major Congenital Heart Diagnoses Except Valvular
- Other Malignancies
- Other Significant Drug Abuse
- Ovarian Malignancy
- Pancreas Transplant Status
- Pancreatic Malignancy
- Pelvis, Hip, and Femur Deformities
- Peripheral Vascular Disease
- Pervasive Development Disorder
- Plasma Protein Malignancy
- Progressive Muscular Dystrophy and Spinal Muscular Atrophy
- Prostate Malignancy
- Rheumatoid Arthritis
- Schizophrenia
- Secondary Malignancy
- Secondary Tuberculosis
- Severe / Profound Mental Retardation
- Sickle Cell Anemia
- Significant Skin and Subcutaneous Tissue Diagnoses
- Spina Bifida
- Spinal Stenosis
- Spondyloarthropathy and Other Inflammatory Arthropathies
- Valvular Disorders

Appendix: Glossary of Terms

- **Base budget** – baseline budget for a population determined by the previous fiscal year's performance.
- **Base risk score** – baseline risk score for a population established by previous fiscal year's performance.
- **Clinical Risk Group (CRG)** – a population classification system developed by 3M that places members into a health category based on their needs and health status. This classification helps to predict the amount and type of health-care services individuals should have used in the past or can be expected to use in the future to manage financial risk and deliver quality health care.
- **Current budget** – budget for a population at this time, based on current risk scores.
- **Current risk score** – risk score for a population during the present period.
- **Emerging High Needs Individuals (EHNI)** - members who exhibit signs of and are at substantial risk for becoming persistent high needs individuals.
- **Persistent High Needs Individuals (PHNI)** - members who have a strong history of high resource utilization including hospital admissions, tests, pharmaceuticals, etc. and may be identified as good candidates for care management intervention.
- **Potentially Preventable Admission (PPA)** – hospital admissions that could have been avoided by the member accessing services from their primary care provider.

Appendix: Glossary of Terms

- **Potentially Preventable Event (PPE)** – any event or service that could have been avoided by the member and provider through comprehensive care efforts. These events include hospital admissions, readmissions, ER visits, and ancillary services.
- **Potentially Preventable Readmission (PPR)** – subsequent hospital admission that may be a result of inadequate care or treatment during a previous hospital stay or from inadequate post-discharge follow-up.
- **Potentially Preventable Service (PPS)** – Ancillary services ordered by providers that may not have delivered useful information for diagnosis and treatment, such as procedures, treatments, and other interventions ordered by a PCP or specialist in ambulatory care settings. PPSs only include ancillary services performed outside of an inpatient hospital setting.
- **Potentially Preventable Visit (PPV)** – Emergency room (ER) visits that possibly could have been avoided by the member contacting their Superior Primary Care Provider (PCP) or Superior's Nurse Advice Line.
- **Provider Network** – refers to a group of providers within an organizational entity, such as an IPA or PHO.
- **Total cost of care** – overview of population data Per Member Per Month (PMPM) for a specific facility or provider.
- **Utilization** – overview of population data Per Thousand Per Year (PKPY).
- **Value Index Score (VIS)** – a single score that quantifies the quality of care incorporating risk adjustment.

Appendix: Clinical Risk Groups

- Clinical Risk Groups (CRGs) – groupings of clinically similar individuals.
- Provide the basis for a comparison. Grouped by:
  - Severity
  - Treatment
  - Best practice patterns
  - Disease management strategies
- Includes inpatient, outpatient, professional and pharmacy claims.
- CRGs are created using data to:
  - Build a member profile.
  - Identify and rank a member's most significant chronic illness.
  - Assign a member to a risk group (CRG) with a severity level.
  - Include a member in an aggregated risk group.

Appendix: VIS Scoring Methodology

- To determine a comprehensive VIS, a PCP must have domain scores available for at least 5 of the 6 domains.
  - The scores are based on a scale of 0.5 – 5.5.
  - These scores are breakpoints that measure the provider's performance against national thresholds and compared with differences from expected rates.
- Once measure scores are available on the scale between 0.5 and 5.5, measures within a domain are combined to form the domain score, and then the domains are combined to form the overall 3M VIS.
- The geometric mean of all measure scores within a domain is calculated to find the domain score. If some measures are not scored due to insufficient data, the domain is calculated from the available measures.
  - A minimum of one measure must be scored in a domain to receive a score for that domain. All measures are equally-weighted within the domain.
- The 3M VIS is calculated as the geometric mean of the domain scores.
  - A PCP must have scores for at least 5 domains in order to receive a 3M VIS.
- The geometric mean is used because it provides more meaningful differentiation among PCP performance. The table shows a hypothetical example of 2 PCPs who are being scored on two measures:

Provider	Score for Measure 1	Score for Measure 2	Arithmetic Mean	Geometric Mean
PCP 1	3	3	3.000	3.000
PCP 2	1	5	3.000	2.236

Appendix: Common Set of Expected Values - Risk Adjustment

- A subset of the measures used in 3M VIS are risk adjusted. This means that the results for a given person are dependent upon the health of that person.
- For example, people with a heavier illness burden tend to use more PPS than those who are healthy. For these measures, 3M VIS uses a set of expected values as the basis for comparison, and computes a percent difference from the expected value across a population (for instance a PCP's panel). These expected values are built from multiple plans resulting in a robust and reliable set of expected values.
- As the same set of values are used for all clients within a line of business (commercial or Medicaid), we refer to these as a set of common expected values.

Appendix: Common Set of Expected Values - Defined by 3M

- The Medicaid process relaxed the member-month requirement from the 12 months of eligibility for commercial members to 10 months of eligibility for Medicaid members, due to the more transient nature of this population. As many Medicaid clients submit clinic-based claims that 3M processing classifies as outpatient, certain measure calculations were extended to use claims submitted by these identified facilities to credit activity.
- In building out the set of common expected values and establishing the thresholds for 3M VIS scoring, a benchmark set of data was used that covered a variety of plans in the commercial and Medicaid lines of business. Data was included only from plans who had agreed to this use of their data. We cannot specifically disclose the named payers, but we can disclose that the benchmark included membership from these states for each line of business:
  - New York, South Carolina, Michigan, Louisiana, Texas, and Pennsylvania.
- The business rules for the risk-adjusted measures were then applied to these populations to generate the 3M VIS person pool per client.
  - This process gathers, by client, all of the relevant member information and health-care service utilization tied to the 3M VIS risk-adjusted measures.
  - This pool of claims was consolidated across clients into a single data source tagged for commercial or Medicaid membership.

Appendix: 3M VIS - Primary and Secondary Prevention Measures

For Breast Cancer Screening – anyone scoring a 40% or less completion rate will receive a score of 0.50. If an entity has a completion rate between 2 of the threshold values, the score will be proportionally assigned between the identified scores. For example, a completion rate of 70% receives a score of 4.00.

Primary and Secondary Prevention Measures Scoring

Breast Cancer Screening		Colorectal Cancer Screening		Well Visit for Infant		Well Visit for Child 3 to 6 years of age	
Score	**Rate**	**Score**	**Rate**	**Score**	**Rate**	**Score**	**Rate**
5.50	84%	5.50	12%	5.50	86%	5.50	93%
4.50	75%	4.50	10%	4.50	78%	4.50	86%
3.50	68%	3.50	8%	3.50	71%	3.50	80%
2.50	62%	2.50	6%	2.50	63%	2.50	74%
1.50	55%	1.50	4%	1.50	56%	1.50	67%
0.50	45%	0.50	2%	0.50	44%	0.50	55%

Appendix: 3M VIS - Tertiary Prevention Measures

These measures are risk adjusted so the input is a percent difference from the common expected. The measures are designed so that positive rates are "good." For example, if a provider for PPAs scored 35% above the expected, the score would be a 4.20. A poor performer would score 40% below the expected for PPVs, receiving a score of 2.17.

Tertiary Prevention Measures Scoring			
PPAs		PPVs	
Score	Rate	Score	Rate
5.50	100%	5.50	68%
4.50	73%	4.50	38%
3.50	46%	3.50	18%
2.50	7%	2.50	-1%
1.50	-41%	1.50	-24%
0.50	-132%	0.50	-61%

Appendix: 3M VIS - Panel Health Status Change Measures

superior healthplan

Panel Health Status Change Measures Scoring			
Status Jumpers		**Severity Jumpers**	
Score	**Rate**	**Score**	**Rate**
5.50	10%	5.50	6%
4.50	5%	4.50	3%
3.50	2%	3.50	1%
2.50	-1%	2.50	0%
1.50	-3%	1.50	-2%
0.50	-7%	0.50	-5%
Risk adjusted percent difference of attributed members who do not acquire new chronic conditions.		Risk adjusted percent difference of attributed members with a dominant chronic condition whose condition does not increase in severity.	

Appendix: 3M VIS - Chronic and Follow-up Measures

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Chronic and Follow-up Measures Scoring					
PPR		Post-Discharge Follow-up		Chronic Care Visits	
Score	**Rate**	**Score**	**Rate**	**Score**	**Rate**
5.50	100%	5.50	86%	5.50	98%
4.50	48%	4.50	79%	4.50	95%
3.50	22%	3.50	74%	3.50	92%
2.50	-2%	2.50	69%	2.50	89%
1.50	-30%	1.50	63%	1.50	85%
0.50	-76%	0.50	52%	0.50	76%
Risk adjusted percent difference in PPRs.		Percent of attributed members w/ hospital discharge visits w/in 30 days of discharge.		Percent of attributed members with chronic disease with at least 3 provider visits.	

Appendix: 3M VIS - Continuity of Care Measures

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Continuity of Care Measures Scoring			
PCP Visit		Continuity of Care Index	
Score	**Rate**	**Score**	**Rate**
5.50	95%	5.50	55%
4.50	90%	4.50	25%
3.50	87%	3.50	3%
2.50	83%	2.50	-15%
1.50	77%	1.50	-29%
0.50	66%	0.50	-46%
Percent of attributed members with a PCP visit.		Index of number of visits between member's assigned provider and unassigned provider.	

Appendix: 3M VIS - Efficiency Measures

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Efficiency Measures Scoring			
Generic Rx		PPSs	
Score	**Rate**	**Score**	**Rate**
5.50	12%	5.50	44%
4.50	6%	4.50	27%
3.50	3%	3.50	14%
2.50	0%	2.50	2%
1.50	-4%	1.50	-13%
0.50	-11%	0.50	-40%
Percent of Rx filled w/ generic drugs compared with expected.		Risk adjusted percent difference in PPS.	

Appendix: Health Segments

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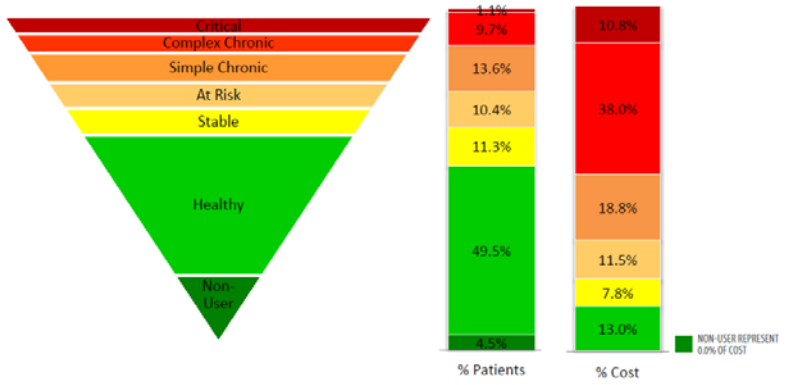
SEGMENT	DEFINITION	METHODOLOGY
NON-USER	*No use of services*	Patients within this segment have not had any health system encounters, there is no cost associated with them and their illness burden is unknown.
HEALTHY	*No or temporary illness burden; low use of services primarily related to prevention, well care, and minor acute services*	Patients within this segment have a low use of healthcare services and do not have a recent history of significant event(s) that would indicate a chronic illness.
STABLE	*Low illness burden; modest use of services including well care and occasional acute care services*	Patients in the Stable segment have occasionally used healthcare services for acute events that have not manifested into any evidence of chronic illness.
AT-RISK	*Modest illness burden but with clear potential for deterioration; increasing, inconsistent use of well care, specialty, and acute care services*	Patients within this segment have used healthcare services, are showing early indications of chronic illness, and are at risk of higher utilization of services. This population is considered unstable and at-risk given the inconsistent use of services during the past year.
SIMPLE CHRONIC	*Medium illness burden; consistent use of services to treat a chronic condition*	Patients in the Simple Chronic segment have used healthcare services that are clearly targeted for treatment of a single, moderate chronic illness.
COMPLEX CHRONIC	*Medium to high illness burden; consistent use of services to treat severe or multiple chronic conditions*	Patients within this segment utilize healthcare services for the management and control of co-morbid, chronic illnesses that tend to be life-long conditions.
CRITICAL	*High illness burden; consistent use of services for life threatening illnesses*	Patients within the Critical segment use healthcare services that are clearly targeted for treatment of a chronic illness.

As shown in the graphic (below), the Healthy segment has a low illness burden, makes up the largest portion of the population, and incurs the lowest total cost. The Critical segment has the highest burden of illness and the smallest population, but has the highest relative share of cost.

TREO POPULATION HEALTH SEGMENTS



Appendix: Frequently Asked Questions

- What is 3M Health Information Systems (HIS)?
  - HIS is a health-care analytics suite that gives providers access to data about the quality and access to care within their practice. HIS features a user-friendly dashboard that will help improve performance, manage costs and promote quality of care.
- When did this service begin?
  - Superior started using HIS in July, 2015.
- Do I need a special login?
  - Yes. To request access, please contact your Account Manager or Clinical Nurse Liaison.
- Can multiple staff in my office have their own accounts?
  - Yes. Each staff member will need to request their own login. To do so, please contact your Account Manager.
- How often do I need to log in?
  - Each person will need to log into HIS within 5 days of the notice that access has been granted. From there, you must access your account every 90 days or will be locked out.
- What do I do if I get locked out?
  - Please use the ‘Forgot Password’ link located on the HIS login page.

Appendix: Frequently Asked Questions

- How is the information in HIS gathered?
  - Superior sends paid claims information to HIS each month. This information is then analyzed and updated on the dashboard by HIS's analyst team.
- What is the range of claim data used?
  - The information on the dashboard displays a rolling 12 month period.
- How can I use the information in HIS?
  - Providers can use information from HIS to receive a Value Index Score (VIS) and to monitor their own patients' ER visits, receive reports on total cost of care, potentially preventable events and utilization.
- How will Superior be using the information from HIS?
  - Superior will use the data in HIS to analyze provider performance and create incentive-based programs.
- What is the Value Index Score (VIS)?
  - The VIS is a single composite score that quantifies the provider's overall quality and efficiency of care.
- Why do some providers have a VIS or Domain Score listed, while others do not?
  - To be considered for scoring on an individual measure, a PCP panel must meet a minimum sample size threshold. For most measures, the PCP must have at least 19 members eligible for that measure in order to receive a score.

Appendix: Frequently Asked Questions

- Are there exceptions to the minimum sample size threshold?
  - Yes. When a PCP is part of a group practice and has fewer than 19 eligible members but at least 10 members, the score is imputed as the average of that PCP's score for that measure, plus the combined score for the PCP's group practice.
  - Two measures are also exceptions to the sample size rule: 30 day post discharge visits and potentially preventable readmissions. These require a minimum of 10 eligible cases (not members), and a minimum of 6 cases to have a score imputed from the group practice.
- In a group practice, do visits with different doctors within the practice have a negative effect on the Continuity of Care score?
  - Yes, if an attributed member sees another PCP in the same practice, that visit is counted as a separate provider.

Appendix: General Information

- Support Contact Information
  - Clinical Nurse Liaisons:
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