



**DATA COLLECTION GUIDE
FOR CERTIFIED HEALTH CARE HOMES
Optimal Vascular Care
2010 Dates of Service**





2011 Health Care Homes Optimal Vascular Care Measure Specifications

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About Health Care Home Direct Data Submission

The Health Care Home direct data submission (DDS) submission process is slightly different from the DDS reporting that is part of the Statewide Quality Reporting and Measurement System (SQRMS). Whenever possible, efforts have been made to align reporting done under the two programs, however, because the goals are different for each program modifications were necessary to accommodate for the specific information needed for health care home recertification and program evaluation. Listed in the bullets below are some of the key differences between Health Care Home Direct Data Submission and SQRMS

- Health Care Homes (HCH) data will not be publicly reported
- HCH data will be used by MDH as a component of the annual HCH recertification process
- HCH data will be analyzed according to the level of certification (i.e. individual, clinic, health system)
- HCH results will be displayed at the provider level within the HCH portal
- New HCH specific data elements have been added to the end of the current Optimal Vascular and Asthma Care measure specifications.

In regards to HCH data submissions in 2011, certified health care homes are required to submit data for their HCH providers who qualified for the 2010 MNMCM Optimal Vascular Care measure and the 2011 Optimal Asthma Care measure. The data will be submitted to a separate HCH specific data portal that is linked to the current MNMCM Data Portal. MNMCM is currently building a single sign-on function that will allow users to access to both the health care home's data portal and the SQRMS portal from the same location. Thus, if you have a current user account in the MNMCM Data Portal you will be able to use the same login credentials and have access to the HCH Portal through the current DDS portal.

The first required measure for HCH data submission is the Optimal Vascular Care measure. In efforts to align with the current OVC measure the population identification MNMCM and MDH have agreed allow for same population identification for the vascular measure. Thus, if your medical group or clinic already submitted full population data for the 2010 Optimal Vascular Care measure to MNMCM you will be able to use that file to begin the process of submitting data on behalf of your health care home providers. If your medical group/clinic submitted a sample of vascular patients or if you have never submitted data to MNMCM before please contact hch-support@mncm.org to discuss the HCH data submission options.

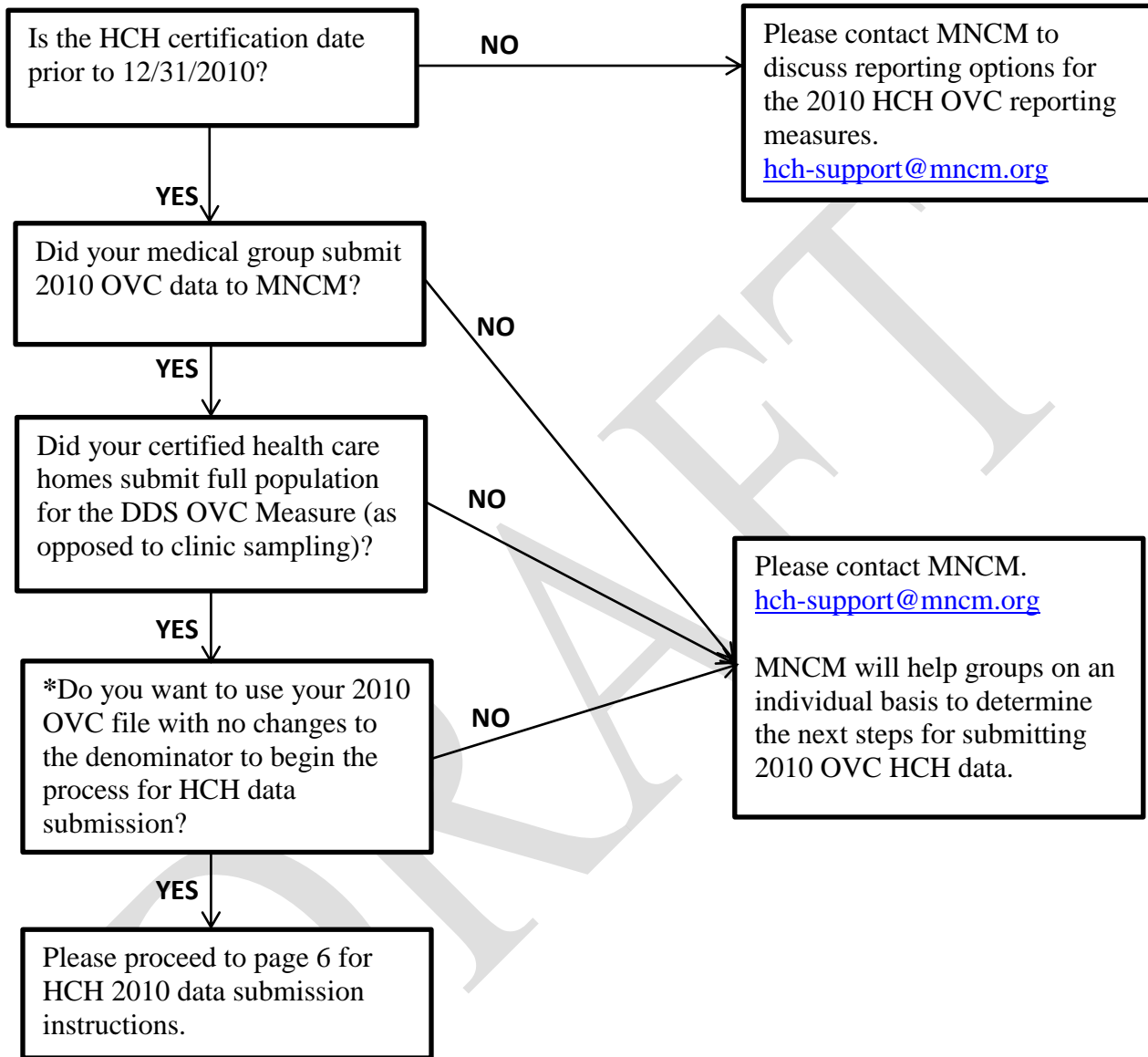
What is new for Health Care Home's Optimal Vascular Care measure?

- I) **Additional data elements (see pg. 7 for definitions)**
 - a. Patient's assigned Health Care Home Risk Tier level
 - b. Patient's assigned Health Care Home Primary Care Provider
 - c. Is the patient enrolled in care coordination (accepted/refused)?
 - d. Date patient started receiving Health Care Home Care Coordination
 - e. Mental health modifier

FOR THE 2010 OVC MEASURE THESE FIELDS WILL BE OPTOINAL. THESE FIELDS WILL BE REQUIRED IN FUTURE HCH QUALITY MEASUREMENT REPORTING PERIODS.
- II) **National Provider Identification (NPI) is now a required field** (this replaces the provider ID column from the 2010 OVC specifications)
- III) **All HCH data will be submitted to a separate HCH data portal**
- IV) **Health Care Homes have the option to use data submitted for the Statewide Quality Reporting and Measurement System OR submit data from the date of HCH certification through Dec. 31st, 2010.**
- V) **Health Care Homes are required to submit data according to the level of health care homes certification**

The data submission process for health care homes will vary depending on the level of participation in the Statewide Quality Reporting and Measurement System. The decision tree on the next page is intended to help certified health care homes decide the best process for submitting HCH data for the 2010 Optimal Vascular Care measure.

Decision Tree for Health Care Homes 2010 Optimal Vascular Care Data Submission



*The denominator specifications for the HCH Optimal Vascular Care measure are the same as the 2010 Optimal Vascular Care measure. However, medical groups have the option of submitting data from the date of certification (DOC) through the end of 2010 (DOC-12/31/10). Certified health care homes also have the option to submit data according to the level of certification (i.e. clinician level, clinic level, or medical group level). For example, if 5 out of 25 clinics within a medical are certified only those 5 clinics need to submit data. If you chose to use your 2010 OVC file, MNCM will accept data for non-certified clinics but the results will not be displayed in the HCH portal.

Health Care Homes Optimal Vascular Care Measure Data Submission

These data submission instructions are intended for medical groups that are currently registered in the main MNMCM Data Portal and plan to use their 2010 Optimal Vascular Care file previously submitted to MNMCM. If you are unsure whether or not your group qualifies for this data submission process please email hch-support@mncm.org.

Step 1: Sign on to the HCH Data Portal & Verify your HCH providers

You will be able to access the Health Care Home Data portal from the below listed location:

- *The HCH data portal: <http://hch-data.org/login> (This link will go live 5/15/11 for HCH data portal users, MNMCM will contact you if changes to this timeline occur).*

** Please note: MNMCM is working on a single-sign-on process that would allow access the HCH portal and MNMCM portal using a single unified login. MNMCM will share those details when that process is ready for use.*

Instructions: Login to the HCH portal and verify HCH providers.

- 1) MNMCM will provide login credentials to your HCH's data portal user
- 2) Login to the HCH portal
- 3) Click on my health care home
- 4) Verify the name and National Provider Identification (NPI) of each certified health care home provider for your medical group. There is an option to "Download HCH providers" so you can verify the information using your own preferred method.
- 5) If there are **NO** errors click on "verify/submit" providers and move on to the next step
- 6) If you find errors with either a name or NPI click on the "Corrections Needed" button. This will allow you to edit each provider's information by clicking on the "Edit" button next to each provider. Please make the appropriate correction and when you are finished click on the "Submit Changes to MNMCM/MDH."
- 7) MNMCM will review the changes and within 1-2 business days approve or decline the changes depending on the result of researching the discrepancies between the MDH Health Care Homes list and the changes submitted.
- 8) If the changes are approved start you will need to complete process steps 3-4 above to "verify/submit" your providers.
- 9) If changes are declined MNMCM will contact you individually to resolve the outstanding issues.



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*Please note you will not be able to continue with data submission until you have verified and submitted your providers.

Step 2: Data Narrative Description-HCH Data Elements

Since you have indicated there are no changes to your original denominator MNCM will use the denominator certification uploaded for the 2010 DDS OVC measure.

For this step please upload a narrative description of how your medical group plans to update the 2010 OVC file with the new Health Care Home specific data elements. Steps 3-6 of this guide provide an outline for inserting the HCH data elements into your 2010 OVC file. The HCH Data Narrative Description should reflect deviations from the process or any unique steps that were involved in updating your 2010 OVC data file.

HCH Data Elements Definitions:

Health Care Home Field	Definition
Patient Health Care Home Tier level	Please see the Minnesota Department of Health's <i>Care Coordination Tier Assignment Tool, Version 1.0</i> for directions on how to assign a complexity tier to each patient in your HCH OVC file. See appendix C. or following the link below: http://www.health.state.mn.us/healthreform/homes/payment/HCHComplexityTierTool_March2010.pdf
Health Care Home Care Coordination	Care coordination is a team approach that engages the participant, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the participant's well-being by organizing timely access to resources and necessary care that results in continuity of care and builds trust. (The MDH & DHS adopted rule related to health care homes adopted on January 11, 2010).

<p>Mental Health modifier</p>	<p>This means the patient has an active diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder. The Minnesota Department of Health's <i>Care Coordination Tier Assignment Tool, Version 1.0</i> provides instruction for determining whether or not a patient qualifies for a mental health modifier. The definition of mental health modifier comes from <i>Minnesota Statute 245.462, subdivision 20</i>. See appendix D.</p>
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Instructions: Upload HCH Data Narrative Description

1. Login to the HCH Data Portal and click on the HCH Narrative link to download the Narrative Template form.
2. Complete the form and save the form on your network directory.
3. Login to the HCH Data Portal, click on HCH Narrative link tab, and upload the HCH Narrative description.
4. MNMCM will review the method and respond within 1-2 business days.

Step 3: Retrieve your 2010 OVC file

Instructions: Retrieve and copy your 2010 OVC final Excel (.xls) file and insert new HCH columns at the end of the file

- 1) In your network directory find the final 2010 OVC DDS EXCEL (.xls) file that used prior to the saving the file as a .csv file for DDS submission. Right click on the file, click copy, then right again and paste the copy into the same folder.
Please note: **You will want to use the final .xls final because if you open the .csv file in Excel the formatting of your file will be changed. If you don't have access to your final file or are not sure which file to use please contact hch-support@mncm.org and we can retrieve your final 2010 OVC for you.**
- 2) Once you have the Excel file open please add the header labels to the columns at the end of the file. As you insert the new columns be sure to include the appropriate formatting. To change the formatting in excel highlight an entire column, right click and select the appropriate category for each column (i.e. number, text, or date). The Excel formatting default is "General" which will not work for HCH data submission.

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Column Identification	Header Label	Excel Format	Field Notes
AE	Patient Health Care Home Tier level	Number	Appendix B: (See pg. 24)
AF	Patient assigned Health Care Home Primary Care Provider	Number	See pg. 24
AG	Patient accepted/refused Health Care Home Care Coordination?	Number	See pg. 24
AH	Date patient started Health Care Home care coordination	Date (mm/dd/yyyy)	See pg. 25
AI	Mental Health modifier for Health Care Home patients	Number	See pg. 25

Step 4: Add HCH specific data to the 2010 OVC file

Collecting and submitting the patient-specific Health Care Home data elements are necessary for program evaluation and certification/re-certification. You can pull this data from any source that you use to track Health Care Home information, including:

- An electronic medical record (or EMR)
- Health Care Home registries maintained outside of an EMR (such as an excel spreadsheet)
- Other sources (paper tracked registries, etc.)

Instructions: Insert HCH specific data for each patient in the 2010 OVC file.

1) **Additional data elements (See page 24 and 25 for field specifications)**

- a. Patient's assigned Health Care Home Risk Tier level
- b. Patient's assigned Health Care Home Primary Care Provider
- c. Patient accepted/refused Health Care Home Care Coordination?
- d. Date patient started receiving Health Care Home Care Coordination
- e. Mental health modifier

FOR THE FIRST DATA COLLECTION PERIOD, THESE FIELDS WILL BE OPTOINAL. THESE FIELDS WILL BE REQUIRED IN FUTURE HCH QUALITY MEASUREMENT REPORTING PERIODS.

- 2) Replace provider ID (column "O") with National Provider Identification (NPI). If NPI was used in column "O" of the original submission no action is needed for this step.

Step 5: HCH Data Quality Checks

Since your data was previously data to MNCM it is not necessary to go through the same quality checks, however, there are 7 new quality checks that will need to be performed to ensure the new HCH data fields are accepted by the portal. The table below shows the column number that needs to be checked before submitting the HCH Optimal Vascular Care file.

Instructions: Perform quality checks on the new HCH fields listed below and save as a CSV.

Column Letter	Field Name	Quality Check
O	Provider ID	Verify that each cell has data (no cell should be blank). Verify that you are submitting the 10-digit NPI number for your health care home certified providers.
AE	Patient Health Care Home Tier level	Verify that all values are either blank or 0-4. Look to see that a selection of "blank" patients truly do not have an assigned health care home tier.
AF	Patient assigned Health Care Home Primary Care Provider	Verify that all of the values in this field are either blank or are a 10-digit NPI number.
AH	Patient accepted/refused Health Care Home Care Coordination?	Use the filter to view this field and verify that all of the values are either blank, 1 or 0
AH	Date patient started Health Care Home care coordination	Use the filter to view this field and verify that all of the dates are prior to January 1, 2011
AI	Mental Health modifier for Health Care Home patients	Use the filter to view this field and verify that all of the values are either blank, 1 or 0

Instructions for Saving File as a .csv file:

For Excel 2003 Users	For Excel 2007 Users
1. Open the original Excel file (.xls) and do the following:	
2. Click Edit or right-click the tab of the spreadsheet you wish to save (near the bottom of the screen)	2. Right-click the tab of the spreadsheet you wish to save (near the bottom of the screen)
3. Select Move or Copy Sheet	3. Select Move or Copy Sheet
4. To book (new book) – this is a drop-down selection	4. To book (new book) – this is a drop-down selection
5. Create Copy (check this box)	5. Create a Copy (check this box)
6. In this new book, click File, Save As	6. In this new book, click the Office Button (upper left-hand corner of screen); Select Save As
7. Select the folder and file name of your choice.	
8. At the very bottom you'll see Save as type ; choose from the drop-down menu, CSV (comma delimited) .	
9. Click Save . When you save the CSV file, the following warning will appear: "...may contain features that	

are not compatible with CSV. Do you want to keep the workbook in this format?" Click **Yes**.

10. Now you can close the file; a message will appear: "Do you want to save this file...?" Click either yes or no. Your CSV file is now ready for upload to the MNCM Data Portal. Do NOT open the CSV file in Excel. If the file is mistakenly opened, simply resave a new CSV file.

Step 6: Upload Data to the HCH Data Portal

The next step is to upload the CSV file to the HCH Data Portal. Login to the HCH Data Portal and go to the Home Page. Click on Data Submission and complete the next series of screens.

- 1) **Enter Denominator:** Enter the following information for each clinic row:
 - **Number of Patients That Meet Inclusion Criteria (Less Exclusions):** Enter the number of patients who are eligible or met the inclusion criteria for the measure (based on diagnosis codes, age, visit criteria, etc.).
 - Do NOT include patients who met an accepted exclusion (e.g., deceased, etc.). Including excluded patients in this count will decrease the final rate, so remember to subtract these patients from the total population.
 - If submitting a sample, this number must be higher than the number entered in the next field (Number of Patients Submitting).
 - **Number of Patients Submitting:** Enter the number of patients in the clinic that are being submitted.
 - For total population submission, enter the same number as what was entered in the *Number of Patients That Meet Inclusion Criteria* category.
 - For a sample submission, enter the number of patients being submitted for the sample.
 - **Not Reporting:** Check this box if a clinic is not reporting for this cycle of HCH data collection.
- 2) **Review & Save:** Verify the numbers entered and click **Save and Continue**, or click **Back to Step 1** to re-enter.
- 3) **Upload Data:** Click **Browse** to search for the CSV file and click **Upload CSV and Continue**.
- 4) **Review & Submit:** The portal will now scan the CSV file to identify possible errors. "Preliminary Rates" will also be listed for each clinic. You can download the data from the portal to see which patients were optimal (1) and which did not meet the optimal target (0) by viewing the additional columns added by the portal to the right of the document. Please review this information and determine if the file is ready to submit to MNCM. Follow these steps:
 - a. **Errors:** Corrections must be made and a new file uploaded (example: portal finds a date of birth that is out-of-range). Proceed to instructions 3 or 4 below.
 - b. **Warnings:** Review *possible* errors and decide whether corrections are needed (example: portal finds an LDL like 1000 that should be 100). If corrections are needed, proceed to instructions 3 or 4 below.
 - c. **Corrections to the data file:** Click **Save as Draft**. This holds the file but does not submit the file to MNCM. **IMPORTANT: Make corrections in the original Excel file and save; then save a new CSV file to upload. Do NOT make corrections in CSV file as this will destroy the format and alter the data.** Go back to the portal submission page and click **Re-Upload Data File**. Begin again with **Step 3 Upload Data**.
 - d. **Clear & Start Over button:** Only click this button to start the process completely over from **Step 1 Enter Denominator**. NOTE: all number entries and a new file upload will be necessary.

When the data file is ready to submit to MNCM: Click **Submit Data to MNCM** and proceed to **Step 5 Done**.



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Step 5 Done: The data file has been successfully submitted. MNCM will send an e-mail that the data has been received.

Step 7: Review your results

Once your data has been uploaded to the portal you will have the opportunity to review your results.

Step 8: Audit and Validation of HCH data

As an independent auditor, MNCM validates the data for accuracy, calculates the HCH specific rates from the validated data, and will submit your data to the Minnesota Department of Health to be used for Health Care Homes re-certification, and program evaluation.

Instructions: Minnesota Community Measurement will contact you via email if your medical group is selected for an audit of your health care home data.

Overview of the Process and Timeline

Process Step	Timeline
<p>Create a Health Care Home Data Portal User Account and verify health care home providers</p> <p><i>WHAT YOU WILL NEED / RESOURCES:</i> http://hch-data.org/login</p>	<p>May 15th, 2011</p>
<p>Health Care Home Data Narrative</p> <p><i>Medical group submits a document outlining the method for identifying the HCH patient specific data to the HCH Data Portal. MNCM reviews and approves the process.</i></p> <p><i>WHAT YOU WILL NEED / RESOURCES:</i> download from HCH Data Portal the HCH Data Narrative form.</p>	<ul style="list-style-type: none"> • HCH narrative can be submitted after all HCH providers have been verified. • MNCM responds within 1-2 business days
<p>Data Collection and Submission</p> <p><i>Medical group creates a copy of their 2010 DDS OVC Excel (xls) file and inserts new columns and appropriate patient level data.</i></p> <p><i>Medical groups update the provider ID column to ensure the ten digits National Provider Identification (NPI) is used in column "O".</i></p> <p><i>Medical group prepares Excel file and saves as .csv format before submitting to the HCH portal.</i></p> <p><i>WHAT YOU WILL NEED / RESOURCES:</i> A copy of your 2010 OVC Excel file.</p>	<ul style="list-style-type: none"> • MNCM Data Portal opens: May 15th, 2011
<p>Data Validation</p> <p><i>MNCM auditor conducts audit to validate that the submitted data matches the source data in the patient medical record.</i></p> <p><i>WHAT YOU WILL NEED / RESOURCES:</i> HCH data narrative, data collection forms/spreadsheet with notes, staff to participate in validation audit.</p>	<p>After the data file is successfully uploaded onto the HCH Data Portal, an MNCM auditor will contact the medical group to schedule the validation audit.</p>

Confidentiality and HIPAA for Direct Data Submission

Our legal firm, Lindquist & Vennum P.L.L.P., has assured us that direct data submission fits within the scope of lawful compliance with HIPAA and MN statute as long as we have a signed Business Associate Agreement (BAA) with the medical group. This document can be electronically signed on the MNCM Data Portal, or MNCM would be open to signing a medical group's standard BAA document version. The BAA is signed annually and remains in effect for all direct data submissions for the year. Thus, if your medical group already signed a BAA with MNCM for direct data submission you will not need to sign a new one.

Health Insurance Portability and Accountability Act (HIPAA) Law:

- This activity is considered within the scope of "health care operations" associated with the medical group quality improvement efforts.
- The federal HIPAA law specifically allows release of individually identifiable health information - without the consent or authorization of the individual - for treatment, payment and health care operations of, or for, the provider.

Minnesota Statute:

- The primary governing Minnesota statute is MN Stat. Section 144.335.
- Subd. 3a. entitled "Patient consent to release of records; liability" states: (a) A provider, or a person who receives health records from a provider, may not release a patient's health records to a person without a signed and dated consent from the patient or the patient's legally authorized representative authorizing the release, unless the release is specifically authorized by law.
- However, the statute does not restrict release (without patient authorization) to only those circumstances authorized by state law.
- Legal opinion assures us that it is reasonable to conclude that the HIPAA privacy regulation does specifically address authorization for release of such information. The appropriate method for a covered entity to allow such release and to make sure the release is for a certain, narrow purpose, is either via a data confidentiality agreement or, if the auditor or other entity to whom the information is released will be maintaining any individually identifiable health information, a business associate agreement.

American Recovery and Reinvestment Act of 2009: At the release of this guide, MNCM is reviewing policies, procedures, and practices to ensure HIPAA compliance with the new ARRA provisions.

Appendix A: Optimal Vascular Care 2011 (2010 Dates of Service) Measure Specifications

Measurement Period	Measurement period will be a fixed 12 month period: 01/01/2010 to 12/31/2010																																		
Denominator	<p>Established patient who meets each of the following criteria is included in the population (denominator):</p> <ul style="list-style-type: none"> • Patient was age 18 to 75 during the measurement period (date of birth was 01/01/1935 to 12/31/1992). • Patient was seen by an eligible provider in an eligible specialty face-to-face at least 2 times during the last 2 years (01/01/2009 to 12/31/2010) with visits coded with an IVD ICD-9 code (in any position, not only primary). Use this date of service range when querying the practice management or EMR system to allow a count of the visits within this time frame. • Patient was seen by an eligible provider in an eligible specialty face-to-face at least 1 time during the last 12 months (01/01/2010 to 12/31/2010) for any reason. This may or may not include one of the face-to-face IVD visits. <p><u>Eligible specialties:</u> Family Medicine, Internal Medicine, Geriatric Medicine, Cardiology.</p> <p>* <i>NOTE: Clinics whose adult patient population (18 or older) is less than 10% of the clinic's total population are not expected to submit data for this measure.</i></p> <p><u>Eligible providers:</u> Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP).</p> <p><u>Ischemic Vascular Disease ICD-9 codes:</u></p> <table style="width: 100%; border: none;"> <tr><td style="width: 15%;">410 – 410.92</td><td>Acute Myocardial Infarction (AMI)</td></tr> <tr><td>411 – 411.89</td><td>Post Myocardial Infarction Syndrome</td></tr> <tr><td>412</td><td>Old AMI</td></tr> <tr><td>413 – 413.9</td><td>Angina Pectoris</td></tr> <tr><td>414.0 – 414.07</td><td>Coronary Artherosclerosis</td></tr> <tr><td>414.2</td><td>Chronic Total Occlusion of Coronary Artery</td></tr> <tr><td>414.3</td><td>Atherosclerosis due to lipid rich plaque (NEW CODE)</td></tr> <tr><td>414.8</td><td>Other Chronic Ischemic Heart Disease (IHD)</td></tr> <tr><td>414.9</td><td>Chronic IHD</td></tr> <tr><td>429.2</td><td>Cardiovascular (CV) disease, unspecified</td></tr> <tr><td>433 – 433.91</td><td>Occlusion and stenosis of pre-cerebral arteries</td></tr> <tr><td>434 – 434.91</td><td>Occlusion of cerebral arteries</td></tr> <tr><td>440.1</td><td>Atherosclerosis of renal artery</td></tr> <tr><td>440.2 – 440.29</td><td>Atherosclerosis of native arteries of the extremities, unspecified</td></tr> <tr><td>440.4</td><td>Chronic Total Occlusion of Artery of the Extremities</td></tr> <tr><td>444 – 444.9</td><td>Arterial embolism and thrombosis</td></tr> <tr><td>445 - 445.8</td><td>Atheroembolism</td></tr> </table>	410 – 410.92	Acute Myocardial Infarction (AMI)	411 – 411.89	Post Myocardial Infarction Syndrome	412	Old AMI	413 – 413.9	Angina Pectoris	414.0 – 414.07	Coronary Artherosclerosis	414.2	Chronic Total Occlusion of Coronary Artery	414.3	Atherosclerosis due to lipid rich plaque (NEW CODE)	414.8	Other Chronic Ischemic Heart Disease (IHD)	414.9	Chronic IHD	429.2	Cardiovascular (CV) disease, unspecified	433 – 433.91	Occlusion and stenosis of pre-cerebral arteries	434 – 434.91	Occlusion of cerebral arteries	440.1	Atherosclerosis of renal artery	440.2 – 440.29	Atherosclerosis of native arteries of the extremities, unspecified	440.4	Chronic Total Occlusion of Artery of the Extremities	444 – 444.9	Arterial embolism and thrombosis	445 - 445.8	Atheroembolism
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Allowable Exclusions	<ul style="list-style-type: none"> • Patient was a permanent nursing home resident home during the measurement period • Patient was in hospice at any time during the measurement period • Patient died prior to the end of the measurement period • Documentation that diagnosis was coded in error 																																		



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Numerator Components	<p>Percentage of IVD patients age 18-75 in the measurement period (01/01/2010-12/31/2010) who met <u>all</u> of the following targets:</p> <ul style="list-style-type: none">• The most recent LDL test in the measurement period (<u>10/01/2009</u>-12/31/2010) has a value <100.• The most recent Blood Pressure in the measurement period (01/01/2010-12/31/2010), two targets will be calculated:<ul style="list-style-type: none">○ Systolic value of <140 and diastolic value of <90 for patients with IVD <u>and</u> diabetes (both values must be less than)○ Systolic value of <130 and diastolic value of <80 for all other patients with IVD (both values must be less than)• There is documentation in the chart that the patient is currently a non-tobacco user• There is documentation in the measurement period (01/01/2010-12/31/2010) that the patient is on daily aspirin or there is documentation of an accepted contraindication (any date).
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2011 Optimal Vascular Care Data Elements and Field Specifications

Appendix B: Health Care Homes Optimal Vascular Care 2011 (2010 Dates of Service) Data Elements and Field Specifications. **New HCH Fields start of page 24.*

Field Name	Notes	Excel Format	Example
Clinic ID	Enter the MNCM clinic ID for every patient/row submitted. MNCM assigns the clinic ID at the time of registration for the Statewide Quality Reporting and Measurement System. If you are not sure what your clinic ID is please email hch-support@mncm.org .	Text	9999
Patient ID	Enter a unique patient ID that will identify each patient. Options: <ul style="list-style-type: none"> Enter "1" through the total number of patient records that will be submitted for the medical group. Keep a "crosswalk" between the patient ID and the patient name and DOB to help clinic staff locate the record for the validation audit, or Enter clinic-assigned ID (e.g., MRN, account number). Do NOT enter social security numbers. 	Text	1 or other patient ID identifiable to the clinic
Patient's Date of Birth	Enter the patient's date of birth. Patient must be ages 18–75 in the measurement period with a birth date from 01/01/1935 to 12/31/1992.	Date (mm/dd/yyyy)	05/08/1985
Patient's Gender	Enter the patient's gender: Female = F; Male = M; Unknown = U	Text	F
Patient's Zip Code, Primary Residence	Enter the patient's 5-digit zip code of primary residence at the most recent encounter on or prior to 12/31/2010. <ul style="list-style-type: none"> If EMR query extracts a 9-digit number, submit the 9-digit number (the portal will remove the last 4 digits automatically). 	Text	55111



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
<p>Race and Ethnicity Code Up to five possible categories:</p> <ul style="list-style-type: none"> • Race1 • Race2 • Race3 • Race4 • Race5 <p>FYI: Your clinic may collect <u>more specific</u> Race, Ethnicity, Language, and Country of Origin that is relevant to your patient population. For the purposes of data submission, please map your clinic's specific categories to one of the MNMCM categories provided in this guide or select the "other" category if none of the MNMCM categories apply.</p>	<p>Enter the patient-reported race/ethnicity using the codes listed below. Enter one race or up to five races for patients that report multi-racial status.</p> <p>1 = <u>American Indian or Alaska Native</u> (a person having origins in any of the original peoples of North and South America [including Central America], and who maintains tribal affiliation or community attachment)</p> <p>2 = <u>Asian</u> (a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)</p> <p>3 = <u>Black or African American</u> (a person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American")</p> <p>4 = <u>Hispanic or Latino</u> (a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin. The term "Spanish origin" can be used in addition to "Hispanic or Latino")</p> <p>5 = <u>Native Hawaiian/Other Pacific Islander</u> (a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)</p> <p>6 = <u>White</u> (a person having origins in any of the original peoples of Europe, the Middle East, or North Africa)</p> <p>97 = <u>Chose not to disclose/declined</u></p> <p>98 = <u>Unknown</u></p> <p>Enter 97 if the patient chooses not to disclose race/ethnicity. Enter 98 if the patient reports race/ethnicity is unknown. If race/ethnicity data is incomplete, leave blank.</p>	Number	Race1 = 1 (up to 5 fields available)
Patient's Country of Origin Code	<p>Enter the patient-reported country of origin (birth country) using one of the codes listed on page 18. Enter 997 if the patient does not disclose country.</p> <p>Enter 998 if the patient reports country is unknown.</p> <p>Enter 999 if the country does not match one of the codes listed and enter the country in the next field.</p> <p>If country of origin data is incomplete, leave blank.</p>	Number	1
Patient's Country of Origin "Other" Description	<p>If Patient's Country of Origin Code is 999, enter a description here. If Patient's Country of Origin Code is not 999, leave blank.</p>	Text	Country XYZ



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
Patient's Primary Language Code	<p>Enter the patient-reported specific language preference using one of the codes listed on page 19.</p> <p>Enter 97 if the patient does not disclose language.</p> <p>Enter 98 <u>if the patient reports</u> language is unknown.</p> <p>Enter 99 if the language does not match one of the codes listed and enter the language in the next field.</p> <p>If language data is incomplete, leave blank.</p>	Number	1
Patient's Primary Language "Other" Description	If <i>Patient's Primary Language Code</i> is 99, enter a description here. If <i>Patient's Primary Language Code</i> is not 99, leave blank.	Text	Language XYZ
Provider ID	For health care home data submission, you must use the individual provider's National Provider Identification (NPI) if that provider is a health care home certified provider. For all other providers, you can use either the NPI number or a unique provider ID.	Text	16895
Provider Specialty Code	<p>Enter the specialty code of the physician (see codes below). If the provider is not a physician, enter the code that best describes the clinic's specialty.</p> <p>Family Medicine = 1 Geriatric Medicine = 5 Internal Medicine = 2 Cardiology = 6</p>	Number	1
Insurance Coverage Code	<u>This field is required.</u> Enter one of the codes from page 16 that corresponds with the patient's insurance coverage at the most recent encounter on or prior to 12/31/2010. Look at the patient's insurance card and note the name and logo of the payer. If "Other" (99) code is entered, you must enter the name of the insurance payer in the next field.	Number	1
Insurance Coverage "Other" Description	<u>This field is required if "Other" (99) code was entered:</u> Enter the name of the insurance payer. If <i>Insurance Coverage Code</i> is not 99, leave blank.	Text	<i>Assurant Health</i>
Health Plan/Insurance Plan Member ID	<p><u>This is a required field.</u> Enter the patient's Health Plan/Insurance Plan Member ID.</p> <ul style="list-style-type: none"> • <i>Format field as TEXT in the Excel spreadsheet.</i> • <i>Include leading zeros (e.g., 000123456789)</i> • <i>Do not enter hyphens or spaces.</i> • <i>If the member ID is a SSN (e.g., Medicare Fee-for-Service product), leave blank.</i> • <i>If the patient does not use or have insurance (self-pay or uninsured), leave blank.</i> 	Text	<i>FBOXZ7926998</i>



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
Patient Has Diabetes? (as a co-morbidity)	<p>This is a <u>required field</u>. Enter 1 (Yes) or 0 (No) if the patient has a diagnosis of diabetes that can be confirmed upon validation audit (e.g., ICD-9 codes 250-250.93).</p> <p>This field is subject to audit because it now determines which blood pressure target applies (patients with IVD <u>and</u> diabetes <140/90; all other patients with IVD <130/80). The MNMCM auditor will look for a diagnosis of diabetes in the measurement year and the year prior. Use all of the following sources to identify the diagnosis:</p> <ul style="list-style-type: none"> • Patient’s problem list • Documentation in patient’s record (progress notes, etc.), AND • ICD-9 codes (EMR or practice management system) 	Number	0
NEW: Patient Has Depression? (as a co-morbidity)	<p>This is a <u>required field</u>. Enter 1 (Yes) or 0 (No) if the patient has a diagnosis of depression that can be confirmed upon validation audit. Use all sources to identify a depression diagnosis (see section above for list of sources). Look for a diagnosis of Depression in the measurement period and the year prior. Use the following codes to identify patients with Depression:</p> <ul style="list-style-type: none"> • 296.2x Major depressive disorder, single episode • 296.3x Major depressive disorder, recurrent episode • 300.4 Dysthymic disorder • 311 Depressive disorder, not elsewhere classified <p>(NOTE: The 311 code is not used for the purpose of identifying patients for MNMCM’s Depression Measures denominator, however, please include the 311 code for identifying a depression co-morbidity for this measure.)</p>	Number	0
LDL Date IVD target: at least one test in the measurement period (last 15 months, <u>10/01/2009-12/31/2010</u>) FYI, Optimal Diabetes Care measurement period is different; for this component see ODC specifications	<p>Enter the date of the most recent LDL test on or prior to 12/31/2010.</p> <ul style="list-style-type: none"> • <i>If an LDL was never performed, leave the date and value fields blank.</i> • <i>Do NOT enter test date that occurred in 2011.</i> • <i>Test from an outside referring provider or specialist is acceptable (not required) but only if documented in the primary clinic’s record and is more recent than the primary clinic’s test.</i> • <i><u>Elevated Triglyceride</u>: If LDL is “too high to calculate,” enter the LDL date field and leave the LDL value field blank.</i> 	Date (mm/dd/yyyy)	07/22/2010



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
LDL Value Target <100	Enter the value of the most recent LDL test on or prior to 12/31/2010 .	Number	68
Blood Pressure Date Target: at least one BP in the measurement period (01/01/2010-12/31/2010)	Enter the date of the most recent Blood Pressure (BP) test on or prior to 12/31/2010 . Other considerations: <ul style="list-style-type: none"> • <i>If a BP was never performed, leave the date and value fields blank.</i> • <i>For multiple BPs on the same date, it is acceptable (not required) to use the lowest systolic value and lowest diastolic value from any of the readings on that date. The systolic and diastolic results do not need to be from the same reading.</i> • <i>Do NOT enter BP date that occurred in 2011.</i> • <i>BP from any outside referring provider or specialist is acceptable (not required) but only if documented in the primary clinic's record and is more recent than the primary clinic's reading.</i> • <i>Nurse-only BP checks in the clinic may be used.</i> • <i>Do not enter a BP that is associated with a surgical procedure, inpatient or ER visit, diagnostic testing or a diagnosis that is associated with acute pain.</i> • <i>Do not enter BP reported by or taken by the patient.</i> 	Date (mm/dd/yyyy)	07/22/2010
BP Systolic Target <140 (patients with IVD and diabetes) Target <130 (all other patients with IVD)	Enter the "systolic" value according to the rules above for selecting the correct BP date. The systolic BP is the <u>upper</u> number. For example, the systolic value for a BP 124/72 is "124."	Number	124
BP Diastolic Target <90 (patients with IVD and diabetes) Target <80 (all other patients with IVD)	Enter the "diastolic" value according to the rules above for selecting the correct BP date. The diastolic BP is the <u>lower</u> number. For example, the diastolic value for a BP 124/72 is "72." <i>NOTE: if there is no diastolic value, the patient is considered not controlled and therefore misses the diastolic target.</i>	Number	72



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
<p>Aspirin (ASA) Date</p> <p>Target: Patient has documented daily ASA or anti-platelet use <u>anytime</u> during the measurement period (01/01/2010-12/31/2010), or valid contraindication date (see below).</p> <p><i>Each patient should have only one date entry in either the aspirin date field or the contraindication date field, NOT both date fields.</i></p>	<p>Enter the date of documented ASA or anti-platelet during the past 12 months (01/01/2010-12/31/2010). Any documented date of ASA or an anti-platelet is acceptable during 2010; the date does not need to be the most recent date in 2010.</p> <p>The following are accepted ASA or anti-platelet medications (please see page 17 for a list of ASA-containing products):</p> <ul style="list-style-type: none"> • Aspirin (ASA) • Plavix (clopidogrel) • Ticlid (ticlopidine) • Aggrenox (aspirin/dipyridamole) • Low dose enteric-coated 81 mg ASA (Ecotrin or Bayer) <p>NOTE:</p> <ul style="list-style-type: none"> • Enter the date in which ASA (or other accepted anti-platelet) was documented as a current medication (e.g., med reconciliation date). • <i>If there is no documentation of daily ASA or anti-platelet, leave this date field blank.</i> • <i>Do NOT enter a 2011 date.</i> • <i>If the patient is NOT taking ASA and has a contraindication to ASA, leave ASA date field blank and enter the contraindication date in the next field.</i> • <i>Do not count an ASA/narcotic combo medication for the “daily aspirin use” component of the measure whether it is used for temporary or chronic pain.</i> 	Date (mm/dd/yyyy)	07/22/2010



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
Aspirin (ASA) Contraindication Date	<p>If patient has a documented contraindication to ASA, enter the date of the contraindication. <u>Any</u> valid contraindication date (2010 date or prior) will be given credit. MNCM auditor must be able to validate this date.</p> <p>Accepted contraindications:</p> <ul style="list-style-type: none"> • Anticoagulant use, Lovenox (Enoxaparin) or Coumadin (Warfarin) • Any history of gastrointestinal (GI)* or intracranial bleed (ICB) • Allergy to ASA <p><i>*Gastroesophageal reflux disease (GERD) is not automatically considered a contraindication but may be included if specifically documented as a contraindication by the physician.</i></p> <p>The following may be exclusions if <u>specifically documented by the physician</u>:</p> <ul style="list-style-type: none"> • Use of non-steroidal anti-inflammatory agents • Documented risk for drug interaction • Uncontrolled hypertension defined as >180 systolic, >110 diastolic • Other provider documented reason for not being on ASA therapy <p>NOTE:</p> <ul style="list-style-type: none"> • <i>If ASA Date field is completed (patient is taking ASA), leave the ASA Contraindication Date field blank (this field is only needed for patients <u>not</u> taking daily ASA with a documented contraindication to ASA). For patients taking Coumadin or Lovenox AND ASA, enter the ASA date and NOT the contraindication date.</i> • <i>Contraindication date does <u>not</u> need to be in the measurement period. If only the month and year is known (e.g., GI Bleed- June 2008), enter a valid date to indicate the time, (e.g., 6/01/2008). Look back at least 3 years (dates of service in 2010, 2009 or 2008) for contraindication date. Looking back 4 years or more is optional. The MNCM auditor must be able to validate this date.</i> • <i>If the patient is on an anticoagulant, enter the most recent date.</i> • <i>If the ASA has been discontinued prior to a surgical procedure, do <u>not</u> count this as a contraindication, rather document this patient as taking ASA during the measurement period. NOTE: do not assume that a pre-op standing order like, "Do not take ASA seven days prior to the procedure," means that a patient is taking ASA every day; there must be other documentation in the record that the patient is taking daily ASA.</i> • <i>If there is <u>no</u> documentation of taking ASA, anti-platelets or a contraindication, leave <u>both</u> date fields blank.</i> 	Date (mm/dd/yyyy)	06/01/2008



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Field Name	Notes	Excel Format	Example
Tobacco Status Documentation Date	<p>Enter the most recent date the patient's tobacco status was documented. This date can be in 2010, 2009 or prior, as long as it is the most recent documented status. The MN CM auditor must be able to validate the date and status, and validate that the date and status are the most recent.</p> <ul style="list-style-type: none"> If the patient was not asked or there is no associated date with the patient's tobacco status, leave the tobacco date field blank and enter 2 (No Documentation) for the Tobacco Status. Do NOT enter any 2011 tobacco status date. 	Date (mm/dd/yyyy)	07/22/2010
Tobacco Status Target: Tobacco Free Status	<p>Enter the tobacco status. Tobacco includes any amount of cigarettes, cigars, pipes, or "chew."</p> <p>1 = Tobacco Free (patient does not use tobacco) 2 = No Documentation 3 = Current Tobacco User</p>	Number	1
NEW HCH FIELD Patient Health Care Home Tier level	<p>Look up the patient to see if they have a health care home assigned risk tier level. If no tier is assigned to the patient, leave blank.</p> <p>Enter the code that correspond to the appropriate tier level:</p> <p>0 (zero) = Tier 0 1 = Tier 1 2 = Tier 2 3 = Tier 3 4 = Tier 4 Blank = Unassigned or data not available</p>	Number	0
NEW HCH FIELD Patient assigned Health Care Home Primary Care Provider	<p>Look up the patient, if the patient has an assigned health care home primary care provider provide the NPI for the provider. If the patient is not in the health care home registry or not assigned to a primary care provider, leave blank.</p>	Number	1999999999
NEW HCH FIELD Care Coordination (accepted/refused)	<p>Provide a 1 if the patient has accepted care coordination or a 0 (NO) if the patient refused care coordination (1 = Accepted care coordination; 0 = Refused care coordination). If no data is available, leave blank. Blank=patient has not been offered care coordination or no data is available.</p> <p><i>Note: Do not supply a "0 = No" if the patient has NOT YET been offered care coordination services. Only supply a "0 = No" if the patient has been offered care coordination and refused participation.</i></p>	Number	0



2011 Optimal Vascular Care Data Elements and Field Specifications

Field Name	Notes	Excel Format	Example
<p>*NEW HCH FIELD*</p> <p>Date patient started HCH care coordination</p>	<p>Provide the date when the patient started or initiated Health Care Home Care Coordination services. If no data is available, leave blank.</p> <p><i>Note: This file will error if you supply a date for care coordination but show the patient has either not been offered care coordination or has refused care coordination.</i></p>	Date (mm/dd/yyyy)	07/22/2010
<p>*NEW HCH FIELD*</p> <p>Mental Health modifier for Health Care Home patients</p>	<p>Provide a 1 if they patient if the patient qualifies under the MDH/DHS definition of mental health modifier. Provide a 0 if the patient does not have a condition that qualifies under the MDH/DHS definition of the mental health modifier (1=Yes, patient has a mental health modifier. 0=No patient does not qualify for mental health modifier.</p> <p><i>Minnesota Statute 245.462, subdivision 20. Defines mental illness as:</i></p> <p>Mental illness means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0-302.99</p> <p>For information regarding the definition of mental health modifier see the Minnesota Department of Health Complexity Tool</p> <p>Click the link below for an overview of the MDH/DHS complexity tiers and payment methodology: HCH Payment Methodology</p> <p>306.0- 316.0</p>	Number	1



2011 Optimal Vascular Care Data Elements and Field Specifications

Insurance Coverage Codes (listed alphabetically)

The insurance coverage code and member ID are required for Direct Data Submission. MNCM shares this information with the corresponding health plan who then maps the member ID to the appropriate insurance product category (e.g., Commercial, Medicare, Minnesota Health Care Programs). The product categories are then used for risk adjustment of the data.

Directions: Enter one of the codes below in the *Insurance Coverage Code* field that corresponds with the patient’s insurance coverage at the most recent encounter on or prior to 12/31/2010. The insurance code must reflect the **name of the payer as seen on the patient’s insurance card**. Below are some examples:

- *If the patient’s insurance card has the Blue Cross Blue Shield of Minnesota name and logo on the front of the card, enter 1 for BCBS of MN.*
- *If the patient’s insurance card has Medicare Health Insurance on the front of the card, enter 8 for Medicare FFS.*
- *If the patient’s insurance card has MN Department of Human Services on the front of the card, enter 13 (MN Department of Human Services, Medicaid FFS).*
- *If the patient does not use or have insurance, enter 16 (self-pay) or 29 (uninsured).*
- *If the patient’s insurance does not match one of the listed codes, enter 99 (Other) and enter the name of the insurance payer in the Insurance Coverage “Other” Description field.*

GAMC (General Assistance Medical Care): Beginning June 1, 2010, GAMC patients were given the option to enroll in GAMC or MinnesotaCare. Patients who have chosen GAMC may choose to receive care at a designated coordinated care delivery system (CCDS). Four Twin Cities metro-area hospitals established CCDSs: Hennepin County Medical Center, North Memorial Medical Center, Regions Hospital and University of Minnesota Medical Center-Fairview. Patients who have chosen MinnesotaCare are covered by a health plan’s MinnesotaCare program.

- *For patients enrolled in GAMC and who receive care at a designated CCDS, enter code 35 MN Department of Human Services – GAMC/CCDS.*
- *For patients enrolled in GAMC but who do not receive care at a designated CCDS, enter code 29 Uninsured.*
- *For GAMC patients who chose to enroll in MinnesotaCare, enter the code of the payer who provides the MinnesotaCare coverage (e.g., BCBS of MN, HealthPartners, Medica, etc.)*

18	Aetna	21	Indian Health Services	25	Prudential
33	Allina Partners Care	11	Itasca Medical Care (including but not limited to PMAP, MinnesotaCare, MSHO, Medicare managed care products)	34	Security Health Plan
27	America’s PPO	4	Medica (including but not limited to Patient Choice, Definity Health, Elect, Essential, Insights, LaborCare, Medica Choice, Premier, Primary, Select Care, PMAP, MinnesotaCare, MSHO, Medicare managed care products)	16	Self-pay



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22	American Family	20	Medicaid (<u>not</u> Minnesota)	9	South Country Health Alliance (SCHA) (including but not limited to PMAP, MinnesotaCare, MSHO)
15	Blue Cross Blue Shield (<u>not</u> of Minnesota; Anthem, etc.)	35	Minnesota Department of Human Services <u>GAMC – General Assistance Medical Care, receiving care at a CCDS – Coordinated Care Delivery System</u> <i>NOTE: Only those entities with established CCDSs use this code. The following four Twin Cities metro-area hospitals established CCDSs: Hennepin County Medical Center, North Memorial Medical Center, Regions Hospital and University of Minnesota Medical Center-Fairview. See GAMC instructions above for more information.</i>	24	State Farm
1	Blue Cross Blue Shield of Minnesota (including but not limited to Aware Gold, Blue Plus, Options Blue, Preferred Gold, Simply Blue, PMAP, MinnesotaCare, MSHO, Medicare managed care products) <i>NOTE: Member IDs are typically 15 digits, commercial member IDs start with “XZ”, public program member IDs are all numeric starting with “8” or “9”, federal employee member IDs start with “R”</i>	13	Minnesota Department of Human Services <u>Medicaid Fee-for-Service</u>	26	Travelers Insurance
17	Cigna (including but not limited to Great West, etc.)	8	Medicare Fee-for-Service and supplemental plans (such as Pyramid Life, Tricare/CHAMPUS, Unicare, ZMedicare) <i>NOTE: Member IDs are typically SSNs, therefore enter the code (8) but leave the Member ID field blank.</i>	7	Ucare (including but not limited to PMAP, MinnesotaCare, MSHO, Medicare managed care products) <i>NOTE: Member ID format is typically “000#####00” where the # is a numeric digit.</i>
23	Comprehensive Care Services	5	Metropolitan Health Plan (MHP) (including but not limited to PMAP, MinnesotaCare, MSHO, Medicare managed care products)	28	UMR (formerly Wausau)
2	FirstPlan Minnesota (including but not limited to PMAP, MinnesotaCare, MSHO, Medicare managed care products)	30	MMSI (Mayo Management Services Inc.)	29	Uninsured
32	HealthEOS	6	Preferred One <i>NOTE: Member IDs are typically 11 digits, starting with “801”</i>	31	United Health Care
3	HealthPartners (including but not limited to individual or group plans, PMAP, MinnesotaCare, MSHO, Medicare managed care products)	10	PrimeWest (including but not limited to PMAP, MinnesotaCare, MSHO, Medicare managed care products)	19	Veterans Administration (VA) (CHAMPVA)
14	Humana	12	Sanford Health Plan	99	Other (enter description in Insurance Coverage “Other” Description field)

Enter the code of the payer who provides the coverage for the programs listed here. For example, (1) for BCBS of MN or (3) for HealthPartners, (4) for Medica, etc.

- MinnesotaCare
- Medicare managed care products
- PMAP (Prepaid Medical Assistance Program)
- MSHO (Minnesota Senior Health Options)

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Aspirin and Anti-Platelet Medications (not a comprehensive list)

Products Containing Aspirin		
1/2HALFPRIN TAB 162MG EC	Aspirin Buff (Ca Carb-Mg Carb-Mg Ox)	GENACOTE TAB 325MG EC
ADLT ASA LOW TAB 81MG EC	ASPIRIN CHLD CHW 81MG	HCA ASPIRIN TAB 325MG
ANACIN TAB 400-30MG	ASPIRIN EC TAB 325MG	HCA ASPIRIN TAB 325MG EC
ASA LO-DOSE TAB 81MG EC	ASPIR-LOW TAB 81MG EC	HCA ASPIRIN TAB 81MG
ASA LOW DOSE TAB 81MG EC	BAYER ASA TAB 325MG	LO-DOSE ASA TAB 81MG EC
ASPIR-81 TAB 81MG EC	BUFFERED ASA TAB 325MG	SM ASA CHLD CHW 81MG
ASPIRIN	CHILD ASA CHW 81MG	SM ASPIRIN CHW 81MG
ASPIRIN CHW 81MG	CVS ASPIRIN TAB 325MG	SM ASPIRIN TAB 325MG
ASPIRIN TAB 325MG	CVS ASPIRIN TAB 325MG EC	SM ASPIRIN TAB 325MG EC
ASPIRIN TAB 325MG EC	CVS ASPIRIN TAB 81MG EC	SM ASPIRIN TAB 81MG EC
ASPIRIN TAB 81MG E/C	EC ASPIRIN TAB 325MG	ZORPRIN
ASPIRIN TAB 81MG EC	ECOTRIN LOW TAB 81MG EC	
ASPIRIN BUFF TAB 325MG	ECPIRIN TAB 325MG EC	
ASPIRIN BUFFERED	EXCEDRIN TAB EX STR	

Oral Anti-Platelet Medications		
Aspirin and Dipyridamole; Aggrenox®	Clopidogrel; Plavix®	Prasugrel; Effient®
Cilostazol; Pletal®	Dipyridamole; Persantine®	Ticlopidine; Ticlid®

This list was compiled by a pharmacy expert at one of the MN health plans. This is not a comprehensive list. Do not count an ASA/narcotic combo med for the “daily aspirin use” component of the measure whether it is used for temporary or chronic pain.



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Codes for Patient Country of Origin

2	Afghanistan	52	Ecuador	102	Malawi	152	Solomon Islands
3	Albania	53	Egypt	103	Malaysia	153	Somalia
4	Algeria	54	El Salvador	104	Maldives	154	South Africa
5	American Samoa	55	Equatorial Guinea	105	Mali	155	South Korea
6	Angola	56	Eritrea	106	Malta	156	Spain
7	Argentina	57	Estonia	107	Marshall Islands	157	Sri Lanka
8	Armenia	58	Ethiopia	108	Mauritania	158	Sudan
9	Australia	59	Fiji	109	Mauritius	159	Suriname
10	Austria	60	Finland	110	Mexico	160	Swaziland
11	Azerbaijan	61	France	111	Micronesia	161	Sweden
12	Bahamas	62	Gabon	112	Moldova	162	Switzerland
13	Bahrain	63	Gambia	113	Mongolia	163	Syria
14	Bangladesh	64	Georgia	114	Montenegro	164	Taiwan
15	Barbados	65	Germany	115	Morocco	165	Tajikistan
16	Belarus	66	Ghana	116	Mozambique	166	Tanzania
17	Belgium	67	Greece	117	Namibia	167	Thailand
18	Belize	68	Grenada	118	Nepal	168	Togo
19	Benin	69	Guam	119	Netherlands	169	Tonga
20	Bhutan	70	Guatemala	120	New Zealand	170	Trinidad and Tobago
21	Bolivia	71	Guinea	121	Nicaragua	171	Tunisia
22	Bosnia Herzegovina	72	Guinea-Bissau	122	Niger	172	Turkey
23	Botswana	73	Guyana	123	Nigeria	173	Turkmenistan
24	Brazil	74	Haiti	124	North Korea	174	Uganda
25	Brunei	75	Honduras	125	Norway	175	Ukraine
26	Bulgaria	76	Hungary	126	Oman	176	United Arab Emirates
27	Burma	77	Iceland	127	Pakistan	177	United Kingdom
28	Burkina Faso	78	India	128	Palestinian State (proposed)	1	United States
29	Burundi	79	Indonesia	129	Panama	178	Uruguay
30	Cambodia	80	Iran	130	Papua New Guinea	179	Uzbekistan
31	Cameroon	81	Iraq	131	Paraguay	180	Vanuatu
32	Canada	82	Ireland	132	Peru	181	Venezuela
33	Cape Verde	83	Israel	133	Philippines	182	Virgin Islands, U.S.
34	Central African Republican	84	Italy	134	Poland	183	Vietnam
35	Chad	85	Jamaica	135	Portugal	184	Western Sahara
36	Chile	86	Japan	136	Puerto Rico	185	Yemen
37	China	87	Jordan	137	Qatar	186	Yugoslavia (former)
38	Colombia	88	Kazakhstan	138	Romania	187	Zambia
39	Comoros	89	Kenya	139	Russia	188	Zimbabwe



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40	Congo, Democratic Republic of	90	Kuwait	140	Rwanda	997	Chose not to disclose/declined
41	Congo, Republic of	91	Kyrgyzstan	141	Saint Lucia	998	Unknown
42	Costa Rica	92	Laos	142	Saint Vincent & the Grenadines	999	Other
43	Cote D'Ivoire	93	Latvia	143	Samoa		
44	Croatia	94	Lebanon	144	Sao Tome and Principe		
45	Cuba	95	Lesotho	145	Saudi Arabia		
46	Cyprus	96	Liberia	146	Senegal		
47	Czech Republic	97	Libya	147	Serbia		
48	Denmark	98	Lithuania	148	Sierra Leone		
49	Djibouti	99	Luxembourg	149	Singapore		
50	Dominican Republic	100	Macedonia	150	Slovakia		
51	East Timor	101	Madagascar	151	Slovenia		

From the *Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups*, www.mncm.org

2011 Optimal Vascular Care Data Elements and Field Specifications

Codes for Patient Language Preference

1	Amharic	9	French	17	Laotian	25	Spanish	33	Yoruba
2	Arabic	10	German	18	Mandarin	26	Swahili	97	Chose not to disclose/declined
3	Bosnia	11	Hearing Impaired	19	Oromo	27	Tagalog	98	Unknown
4	Burmese	12	Hindi	20	Polish	28	Thai	99	Other
5	Cambodian	13	Hmong	21	Romanian	29	Tibetan		
6	Cantonese	14	Japanese	22	Russian	30	Tigrinya		
7	Chinese	15	Karen	23	Sign Language	31	Urdu		
8	English	16	Korean	24	Somali	32	Vietnamese		

From the *Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups*, www.mncm.org



Appendix C: Care Coordination Tier Assignment Tool

See next page.

DRAFT

Care Coordination Tier Assignment Tool, Version 1.0

Health Care Home Initiative

PURPOSE OF THE TOOL:

This tool is intended to assess the overall complexity of patients by grouping them into “complexity tiers” based on the number of major chronic condition categories that apply to them. By relying on practices to assess complexity, a more complete picture of complexity is obtained because we are not limited by diagnosis codes that have been billed on a claim in the past. This understanding of your own practice population will not only ensure more accurate payment through the use of complexity to approximate the time and work of care coordination, but can also help to shape your programs and care coordination agendas.

Please review the instructions below for the Tier Assignment Tool and review the patient’s problem list and the supporting information in the patient’s medical record.

DIRECTIONS FOR TIER ASSIGNMENT:

1. Sort the patient’s diagnoses and problems into condition groups outlined on the form, such as allergy, cardiovascular, mental health, etc. You may use conditions contained in the patient’s problem list or diagnoses in the treatment plan or obtained during a patient history, past medical history, care plan, or in a guideline or protocol such as anticipatory guidance.
2. First, identify those conditions that are likely to be “chronic.” **Chronic conditions** are those that:
 - have lasted at least six months;
 - can reasonably be expected to continue for at least six months; or
 - are likely to recur.

Check the box in the “condition is chronic” column for each condition group. Please note that there may be several diagnoses listed in one condition group. Conditions are counted by condition group and not by individual diagnoses. The box is checked for the entire group if there is one condition that meets the definition of chronic.

3. Second, consider the severity of the conditions that you listed and identify those conditions that are “severe” for this patient. **Severe conditions** are defined as major and potentially unstable conditions that without optimal care are likely to worsen and lead to more serious problems that may result in severe illness, impairment or death. Check the box in the “condition is severe” column if the patient meets these criteria.
4. For those patients that have both boxes checked (a condition group is both chronic and severe), consider whether this **condition requires a care team** to coordinate services in order to attain or maintain the patient’s stability or to reach his or her optimal goals. This would include coordination of preventive care services or disease management to prevent the patient’s condition from becoming worse, deteriorating or resulting in gaps in care for the patient.

Some points to consider when considering the care team requirement:

- While every patient will require some type of care team, “care team” here is defined as a group of health care professionals who plan and deliver patient care in a coordinated way through a health care home in collaboration with a patient. The care team includes at least a personal clinician and the care coordinator and may include other health professionals based on the patient’s needs.
- Some patients will have severe chronic conditions that are stable, such as a patient who has hypothyroidism or hypertension, is taking his or her medications, following his or her clinical plan and

may or may not be seeing a specialist. The patient is stable and does not need additional care coordination. In this case the box would not be checked.

- There may be patients who are only receiving referrals to a specialist and may not require additional coordination by the health care team and may not meet these criteria.

If the patient meets the criteria, check the box in the “condition requires a care team” column and continue with the next steps to add up the patient’s total number of condition groups.

5. Total the score for each patient and list in the column provided for sum count and tier. This is a simple conversion of SUM COUNT using the table shown below with one point for each condition group:

SUM COUNT	TIER
0	0
1-3	1
4-6	2
7-9	3
10 or more	4

(For example, a patient with five condition categories meeting all three of the attributes {chronic, severe and requiring a care team} would have a **SUM COUNT of 5** and be placed in **TIER 2**)

Please note the patient’s score will only total “one” for each condition group if all three criteria are met: the patient’s condition is chronic, severe and requires a care team. As noted above, each condition group may have more than one chronic disease diagnosis in the group.

SUPPLEMENTAL FACTORS:

After totaling the sum count and tier, identify if either of the non-medical condition elements listed at the bottom of the tool apply (non-English speaking or active major mental illness).

If the patient’s primary language or mental health boxes are checked, they will be used to modify the basic tier structure to account for the increased care coordination efforts these situations represent. There will be a percentage increase in the rate for each tier for patients who:

1. **Need to communicate about their health care in a non-English primary language.** This means that the patient’s English skill levels are not sufficient to discuss and create complicated care plans, complex care choices and options, etc.
 - This also includes those patients who are hearing impaired and require a sign language interpreter. Please consider whether the language barrier is significant enough to prevent a discussion with a patient’s care team for care coordination services for patients with severe chronic conditions. If so, check the box.
 - This extra designation for non-English speaking patients is in addition to any billing that is done for interpreter services for interpretation. This designation is for the extra work of care coordination.
2. **Have a serious and persistent mental illness diagnosis.** This means the patient has an active diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder. This may apply to the patient or to a caregiver of a dependent patient. Checking this box implies that some level of functional impairment is observed. This definition was derived from *Minnesota Statute 245.462, subdivision 20*.

- This designation is in addition to the mental health diagnosis that is checked as part of a condition group. This designation is for those patients who are experiencing significant mental health conditions that impact the intensity of the care coordination by the health care team. This includes those defined mental health conditions for the dependent patient’s caregiver that are noted in the patient’s medical record.

CODING FOR CLAIMS SUBMISSION:

The billing process is based on existing claims systems. The health care home will use the procedure codes and modifiers recommended by the Administrative Uniformity Committee (AUC) as follows:

HCPCS Codes				
S0280	medical home program, comprehensive care coordination and planning, initial plan			
S0281	medical home program, comprehensive care coordination and planning, maintenance			
Modifiers				
Tier	Patient Complexity Level		Primary Language Non-English	Severe and Persistent Mental Illness
0	Low	(no modifier)	U3	U4
1	Basic	U1	U3	U4
2	Intermediate	TF	U3	U4
3	Extended	U2	U3	U4
4	Complex	TG	U3	U4

Care Coordination Tier Assignment Tool, Version 1.0

Health Care Home Initiative

Patient ID: _____

Date: ____/____/____
month day year

Does this patient present with these conditions.....	Condition Is Chronic	Condition Is Severe	Condition Requires A Care Team	SCORE
<input type="checkbox"/> Allergy, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ear, Nose, and Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Female Reproductive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gastrointestinal/Hepatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Genetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Malignancies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Health/Psychosocial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rheumatologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Toxic Effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check either of the boxes below if they apply

(These factors are not added to the sum count):

The patient or caregiver of a dependent patient must use a non-English primary language to communicate about their health care.

The patient or caregiver of a dependent patient has a serious and persistent mental illness.



SUM COUNT **TIER**

Derive patient Tier assignments using the table shown below:	
SUM COUNT	TIER
0	0
1-3	1
4-6	2
7-9	3
10 or more	4

Appendix D: 2010 Minnesota Statutes

245.462 DEFINITIONS.

Subdivision 20 .Mental illness.

(a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section [245.4871, subdivision 6](#); and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.