NEW PROVIDER ONBOARDING GUIDE

McLaren
MEDICAL GROUP

DOING WHAT'S BEST.

MM-376 (10.19)

McLaren
HEALTH CARE

MISSION STATEMENT

McLaren Health Care Corporation,
through its subsidiaries,
will be the best value in healthcare
as defined by
quality outcomes and cost.

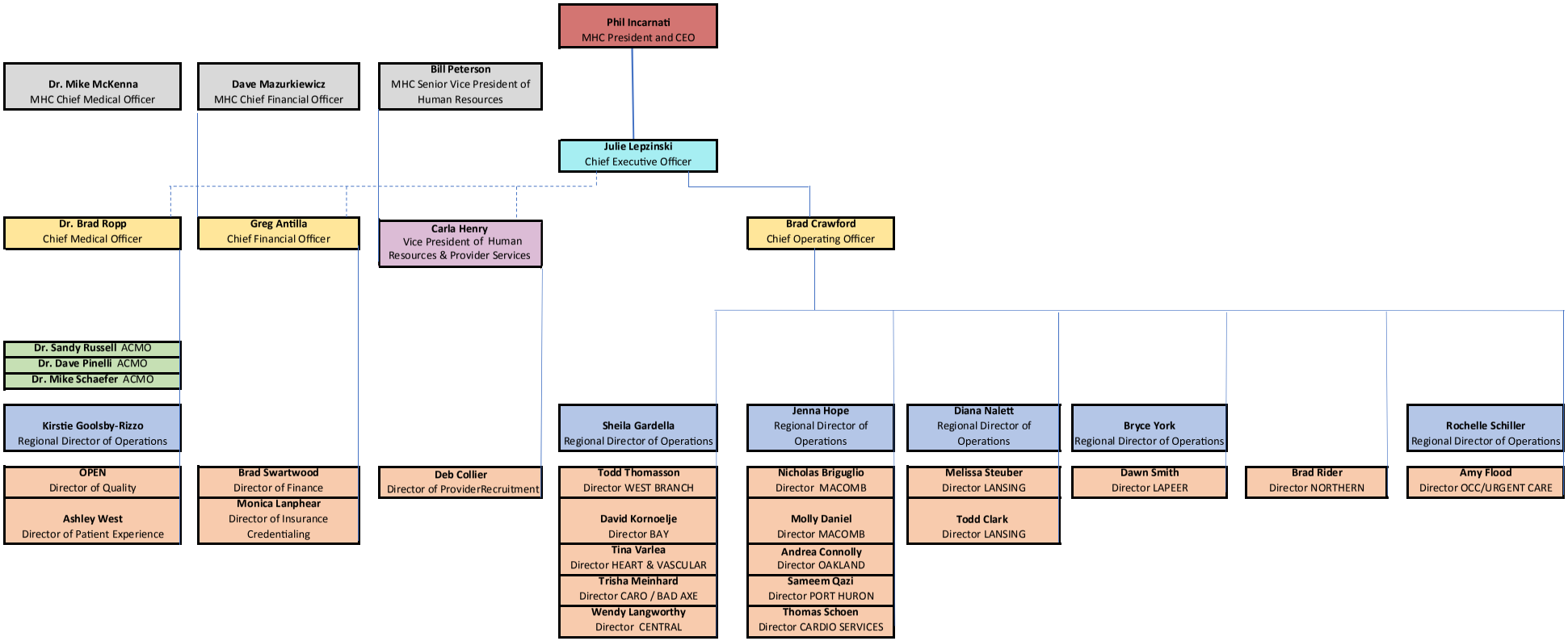
McLaren
MEDICAL GROUP

VISION STATEMENT

McLaren Medical Group, will establish
and promote, on behalf of McLaren
Health Care, an integrated health care
delivery system that provides increased
access and quality health care services
in a cost effective manner.

TAB 1

McLaren MEDICAL GROUP



McLaren

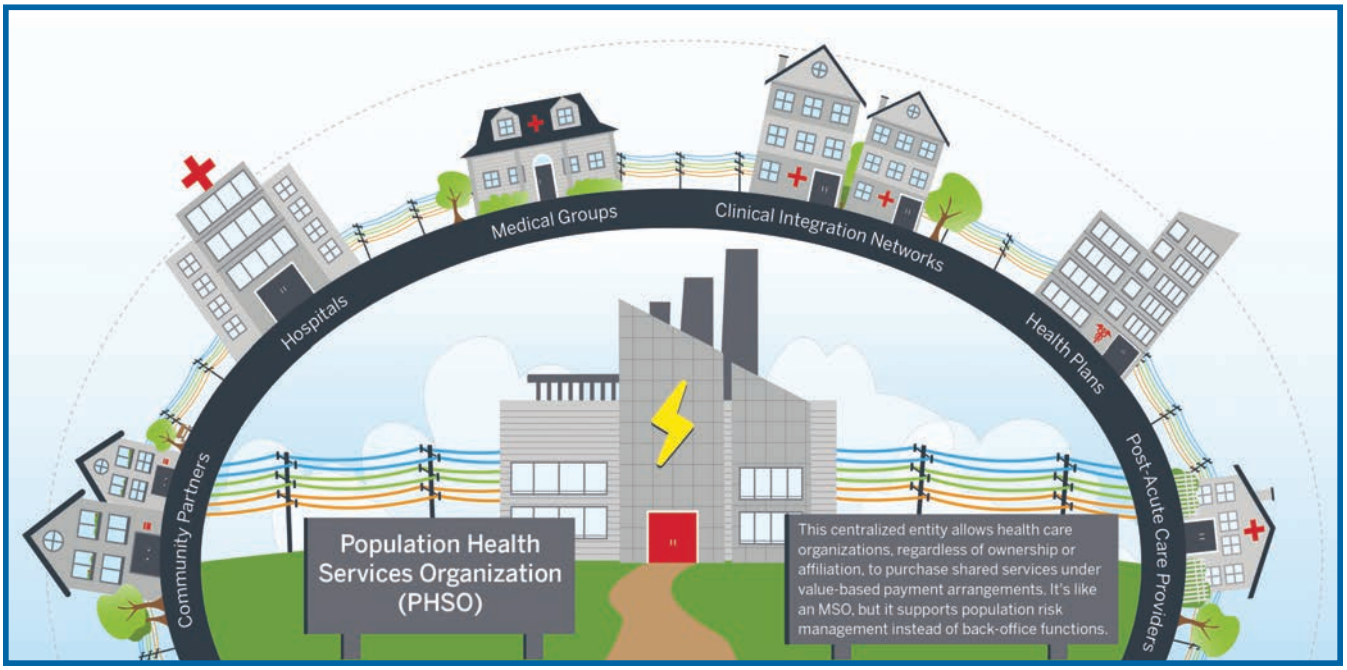
PHYSICIAN PARTNERS

2019 Top Ten Quality Metrics Quick Reference Guide

— POWER OUR —

Population Health Strategy

Population Health Services Organization (PHSO)—an optimized, physician-partnered operations entity that powers a system to improve health outcomes, promote economies of scale and coordination, and reduce variation across the continuum.



"Power Your Population Health Strategy," Consulting and Management, The Advisory Board Company, Copyright 2015

McLaren Physician Partners through its members will be the best value in health care as defined by quality outcomes and cost.

McLaren
PHYSICIAN PARTNERS

Dear McLaren Physician Partners Member,

MPP strives to provide the highest value care to our patients. One of the ways we do this is through success in Population Health Management. Our ultimate goal is to improve the quality of care while reducing costs.

Essential components of our strategy include:

- Continuously improving performance on HEDIS Quality metrics
- Providing Patient-Centric care consistent with the Patient-Centered Medical Home (PCMH, PCMH-N) model
- Adoption and use of evidence-based guidelines
- Resource Stewardship

To assist with performance on HEDIS metrics we are pleased to present the 2019 updates to the MPP Top Ten Guide. The Top Ten Quality Metrics for 2019 remain unchanged from the prior year. Providers will continue to be rewarded on performance in these metrics through the MPP Clinical Integration (CI) Program and MPP Payment Distribution Methodology. Success in payer incentive plans will also be realized with high performance on these ten metrics.

We have identified three main activities that are common among MPP top performing providers and ensure success with Top Ten metric performance and other incentive metrics. These activities include:

- Pre-visit planning
- Use of a point of care tool to identify patient care gaps (i.e. registry patient care summary)
- Applying evidence-based screening guidelines at all visit types, not just those designated for health maintenance

One common comment we receive is the variation of recommendations among differing medical/surgical societies. MPP endorses Choosing Wisely and USPSTF. Throughout this guide you will find that the HEDIS metrics do not always reflect current cancer screening or professional organization guidelines in terms of age groups or frequency of testing. We have provided you with the HEDIS specifications needed to meet the measure requirements. We have also provided you with the professional societal recommendations so that you can make the best choices for your patients.

If you have any questions regarding the content of this guide, please feel free to contact any one of us. Your MPP Quality Performance Specialist and Practice Coach (field team) are also available to assist you with practice transformation to ensure success in this year's program.

Sincerely,

Michael Ziccardi, Jr., D.O.
Chief Medical Officer

Lawrence J. Cowsill, D.O., F.A.C.O.I.
Senior Medical Director

Preston Thomas, M.D.
Associate Medical Director

Sara Liter-Kuester, D.O., F.A.C.O.I.
Chairperson, Quality & CI Subcommittee

MPP Top Ten Quality Metrics - 2019

Category	Measure Title	Specifications
Utilization Measure	Imaging for Low Back Pain	Percentage of patients ages 18 and older (not including hospice) with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT Scan) within 28 days of the diagnosis
Screening Measures	Adolescent Well Child Visit	Patients 12-21 years of age who had a comprehensive Well-Care visit with PCP, Pediatrician or OB/GYN in 2019
	Breast Cancer Screening	Women 50-74 years of age who had one or more mammograms any time during current or prior year (October 1, 2017– December 31, 2019) Exclusion: Bilateral mastectomy
	Chlamydia Screening in Women	Women 16-24 years identified as sexually active who had at least one chlamydia test during 2019
	Colorectal Cancer Screening	Patients ages 50-75 with one of the following: • FOBT during current year (must not be digital rectal exam specimen)(2019) • Flexible sigmoidoscopy in last 5 years (2015-2019) • Colonoscopy in the last 10 years (2010-2019) • CT Colonography in last 5 years (2015-2019) • FIT-DNA (Cologuard) in last 3 years (2017, 2018, 2019) Exclusion: colorectal cancer, total colectomy
	Cervical Cancer Screening	Women 21-64 years who were screened for cervical cancer using either of the following: • 21-64 who had a pap smear in the last 3 years (2017 - 2019) • 30-64 who had PAP and HPV co-testing during the last 5 years (2015 - 2019). (HPV reflex testing results do not count) Exclusion: Hysterectomy with no residual cervix. Document: Total, complete, or radical abdominal or vaginal hysterectomy.
Comprehensive Diabetes Care	Diabetes Care: Hemoglobin A1C (HbA1C) Testing	Patients age 18-75 who had A1C test completed in current year (2019)
	Diabetes Care: Retinal Eye Exam	Diabetic retinal eye exam in current year (may be 2 years if negative)
	Diabetes Care: Hemoglobin A1C (HbA1C) Control < 8.0%	Patients age 18-75 who had A1C test results less than 8.0% in current year (2019)
	Diabetes Care: Medical attention for Nephropathy	Age 18-75 who had either (1) a urine test: 24-hour urine for albumin, protein or total protein; timed urine for albumin or protein; spot urine for albumin or protein, urine for albumin/creatinine ratio, or random urine for protein/creatinine ratio, (2) visit with nephrologist, or (3) ACE/ARB dispensed in current year

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HEDIS QUICK REFERENCE 2019

ADOLESCENT WELL CARE VISIT

HEDIS Measure description:

- Percentage of patients ages 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN during 2019.
- NOTE: Services specific to the assessment or treatment of an acute or chronic condition do not count towards this measure

Documentation:

Documentation in the medical record must include a note indicating a visit to a PCP, Pediatrician or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following: (elements may be combined from multiple visits)

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance
- Depression screening

Description	Codes for Well Care Visits
Well-care Visits	HCPCS: G0438, G0439
	CPT: 99381-5, 99461
	ICD-10: Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0-Z02.6, Z02.71, Z02.82, Z02.89

Ways to improve Adolescent Well Care Visit rates:

Avoid missed opportunities by taking advantage of every office visit (including sick visits) to provide a Well Care Visit, immunizations, and BMI value/ percentile calculations.

Use previsit planning to ensure correct well care visit template document is used.

Convert sports/day care physicals into well-care visits by performing the required services and submitting appropriate codes.

Use standardized templates in charts and in EMRs that allow checkboxes for standard counseling activities.

A sick visit and well-child visit can be performed on the same day by adding a modifier 25 to the sick visit, and billing for the appropriate preventive visit.

Utilize MPP Web Reporting to identify patients with gaps.

IMAGING FOR LOW BACK PAIN

HEDIS Measure description:

- Percentage of patients ages 18 and older (not including hospice) with a primary diagnosis of low back pain (LBP) who did not have an imaging study (plain X-ray, MRI, CT Scan) within 28 days of the diagnosis. (NOTE: Denied claims not included in measure.) Includes the following visit types:
  - Outpatient or Telehealth visit with primary diagnosis of uncomplicated low back pain
  - ED or Observation visit with primary diagnosis of uncomplicated LBP that did not result in an inpatient stay
  - Chiropractic / Osteopathic / Physical Therapy visit with a primary diagnosis of LBP
- EXCLUSIONS: (imaging is considered appropriate)
  - Cancer in patient's history through 28 days after initial low back pain diagnosis
  - Trauma anytime from 90 days prior to initial diagnosis through 28 days after initial diagnosis
  - Intravenous drug use any time from 12 months prior to initial diagnosis through 28 days after initial diagnosis
  - Neurologic impairment any time from 12 months prior to initial diagnosis though 28 days after initial diagnosis
  - IV drug abuse any time during the 12 months prior to initial diagnosis through 28 days after initial diagnosis
  - HIV anytime in patient's history through 28 days after initial diagnosis
  - Spinal infection any time from 12 months prior to initial diagnosis through 28 days after initial diagnosis
  - Major organ transplant any time in patient's history through 28 days after initial diagnosis
  - Prolonged use of corticosteroids for 90 consecutive days any time in the past 12 months including day of initial diagnosis

STRATEGIES TO IMPROVE IMAGING FOR LOW BACK PAIN RATES

The NIH states that backache is usually self limited, resolving in 4 to 6 weeks. 90% of all cases of back pain with trauma resolve within 6 weeks without treatment.

The following tips are recommended conversation strategies with patients experiencing low back pain:

- Instruct patients that exercise is the best way to relieve low back pain and prevent future attacks
- Instruct patients to get up and move every 30 minutes
- Use heat to ease discomfort
- Use over-the-counter pain relievers, NSAIDs, and muscle relaxants
- Patients may place a pillow between their legs when sleeping on their side or a pillow under their knees when sleeping on their back to reduce back discomfort
- Imaging tests, such as x-ray, CT or MRI, done less than four weeks from the onset of low back pain rarely improves pain and outcomes
- Early access to physical therapy (within 30 days) by patients with LBP actually improved patient outcomes

Pharmacological Treatment of Acute Uncomplicated LBP:

- No difference between acetaminophen and placebo
- NSAIDS were associated with a small improvement in pain intensity compared with placebo and one NSAID versus another showed no differences in pain relief
- Muscle relaxers improved short-term pain relief compared with placebo after 2 to 7 days
- Evidence showed no difference in pain OR function between a single intramuscular injection of methylprednisolone or a 5-day course of prednisolone compared with placebo

Non-Pharmacological Treatment of Acute Uncomplicated LBP:

- A heat wrap moderately improved pain relief (at 5 days) and disability (at 4 days) compared with placebo
- Evidence showed no clear differences between different exercise regimens
- Acupuncture resulted in a small decrease in pain intensity compared with sham acupuncture with non-penetrating needles, but there were no clear effects on function
- Evidence showed no difference between spinal manipulation and other active interventions for pain relief at 1 week through 1 year for function
- Massage improves short-term pain relief and function compared with other interventions but effects were small

BREAST CANCER SCREENING

HEDIS Measure description:

- Percentage of Women ages 50 to 74 who had a mammogram between October 1, 2017 and December 31, 2019. All types and methods of mammograms (screening, diagnostic, film, digital or digital breast tomosynthesis) will qualify.

- EXCLUSIONS:
  - Bilateral mastectomy
  - Patients age 66 and older living in skilled nursing facility
  - Advanced illness and frailty (see pages 28-29)

Screening Recommendations

Breast cancer screening recommendations for women at average risk		
American Cancer Society	**Barbara Ann Karmanos Cancer Institute, Wayne State University — National Comprehensive Cancer Network**	**U.S. Preventive Services Task Force**
Annual screening for women 45-54 (women should have the opportunity to begin annual screening between 40 – 44) Every 2 years (or every year if a woman chooses to do so) starting at age 55, for as long as a woman is in good health	Every year starting at age 40, for as long as a woman is in good health	Every 2 years ages 50-74

Ways to improve breast cancer screening rates:

Educate female patients about the importance of early detection and screening.

Breast Cancer Awareness activities during the month of October.

Utilize MPP Web Reporting to identify patients with Breast Cancer Screening gaps.

Utilize test tracking methods to ensure compliance.

Use standing orders for mammograms.

Partner with McLaren Regional Breast Centers, which offer free or discounted screening and other services such as transportation and reminder programs.

Document date of mastectomy in the medical record and code history of bilateral mastectomy (Z90.13).

Forward exclusion documentation to the health plan.

CHLAMYDIA SCREENING

Ways to improve Chlamydia screening rates:

Utilize MPP Web Reporting to identify patients with chlamydia screening gaps.

Perform chlamydia urine test for patients aged 16-24 when they present for pregnancy testing, dysuria, or birth control prescription/refill.

Utilize test tracking methods to ensure compliance.

Forward exclusion documentation to the health plan.

HEDIS Measure description:

- Percentage of women ages 16-24 who were identified as sexually active (through claims for birth control pills, STD testing, or pregnancy testing) who had at least one Chlamydia test during 2019.
  NOTE: screening may be performed by swab or urine.

- EXCLUSIONS: Women who were included in the measure based on pregnancy test alone and the member had a prescription for Isotretinoin or an X-ray on the date of the pregnancy test or the 6 days after the pregnancy test.

McLaren PHYSICIAN PARTNERS

HEDIS QUICK REFERENCE 2019

CERVICAL CANCER SCREENING

HEDIS Measure description:

- Women aged 21-64 years who were screened for cervical cancer using either of the following:
  - 21-64 who had a pap smear in the last 3 years (2017, 2018, 2019)
  - 30-64 who had PAP and HPV co-testing during the last 5 years (2015, 2016, 2017, 2018, 2019)

  NOTE: HPV reflex testing results do not satisfy the measure for 5 years

- EXCLUSION: Hysterectomy with no residual cervix. Document: Total, Complete, or Radical abdominal or vaginal hysterectomy and the year of the surgery.

  Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening will also meet this measure.

For additional information, please see a video on this topic at:

iphone: open camera and hover
Android: use QR code reader app

Ways to improve Cervical cancer screening rates:

For Pap and HPV co-testing, do not order "Reflex" testing as the lab will only run the HPV test if the PAP test is abnormal.

Educate female patients about the importance of early detection and screening.

Utilize MPP Web Reporting to identify patients with Cervical Cancer Screening gaps.

For patients who have testing done by their OB/GYN, request a copy of the test results from the specialist's office (see OB/GYN Services Referral Form).

Document date of hysterectomy in the medical record and code absense of cervix and uterus (Z90.710).

Forward exclusion documentation to the health plan.

OB/GYN Services

Patient Information

Patient Name: _____ DOB: _____

Date of Exam: _____ Health Plan ID: _____

Primary Care Physician Information

Physician: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: MI Zip: _____

FINDINGS

	Date of service	Result
Cervical Cancer Screening	_____	_____
HPV Co-Testing	_____	_____
Chlamydia Screening	_____	_____
Breast Cancer Screening	_____	_____

Please check any that apply:

□ Hysterectomy with no residual cervix

Date of procedure: _____

□ Pregnancy Test performed in current measurement year to screen for pregnancy before X-ray or Isotretinoin prescription

□ Bilateral Mastectomy

Date of procedure: _____

Please return with a copy of the test results/reports to the fax number above

OB/Gyn Signature _____

OB/Gyn Printed Name Office Name:_____

Date: _____

COLORECTAL CANCER SCREENING

HEDIS Measure description:

- Percentage of patients ages 50-75 with one of the following:
  - FOBT during 2019
  - Flexible sigmoidoscopy between 2015 through 2019
  - Colonoscopy between 2010 through 2019
  - CT colonography between 2015 through 2019
  - FIT-DNA (Cologuard) between 2017-2019

- EXCLUSIONS:
  - Colon Cancer or Total Colectomy
  - Patients age 66 and older living in skilled nursing facility
  - Advanced illness and frailty (see pages 28-29)

NOTE: Tests performed on a sample collected via a digital rectal exam <u>do not</u> meet criteria.

Test Kit Selection

Product	Sensitivity/ Specificity	Process
Seracult - Triple slide 	Sensitivity is 0.38mg of hemoglobin per 100ml of water Requires dietary and medicinal modifications	Three patient samples collected at home, returned and processed at office
FOBT/FIT Test 	Specificity is 97% No restrictions to diet or medications required	Single patient sample collected at home, processed at office or regional hospital
FIT-DNA (Cologuard) 	CRC Specificity is 92.3% No restrictions to diet or medications	Provider orders test kit for patient through Cologuard. Kit is sent to patient, completed specimen is returned to Cologuard, result sent to provider

Ways to improve Colorectal cancer screening rates:

Encourage patients resistant to having a colonoscopy to complete a FOBT or FIT-DNA test at home.

Utilize MPP Web Reporting to identify patients with Colorectal Cancer Screening gaps. Utilize test and specialist referral tracking methods to ensure compliance.

On the patient problem list in the medical record, document test/surgical history and include date.

A pathology report that indicates the type of screening (e.g., colonoscopy) and the date when the screening was performed meets criteria.

For pathology reports that do not indicate the type of screening and for incomplete procedures, evidence that the scope advanced beyond the splenic flexure meets criteria for a completed colonoscopy.

Document the date of total colectomy in the medical record.

Forward exclusion documentation to the health plan.

COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1C TESTING

Ways to improve A1C testing rates:

Review diabetic services at each visit.

Utilize MPP Web Reporting to identify patients with A1C testing gaps.

Order lab testing prior to office visit or use standing orders.

Utilize Diabetic or Chronic Care Flow sheets to document testing.

Utilize test tracking methods to ensure patient compliance and that lab reports are received.

Review hospital medical records for lab results.

For waived testing at the office, ensure that the testing is documented in the medical record and CPT II codes are included on the claim.

Forward exclusion documentation to the health plan.

HEDIS Measure description:

- Percentage of diabetic patients ages 18-75 who have had an A1C test during 2019.
- EXCLUSIONS:
  - Gestational diabetes or steroid induced diabetes in 2018 or 2019.
  - Patients age 66 and older living in skilled nursing facility.
  - Advanced illness and frailty (see pages 28-29)

The American Diabetes Association (2019) Clinical Practice Recommendations: Perform A1C test at least 2 times a year in patients who are meeting treatment goals. Perform A1C quarterly in patients whose therapy has changed or who are not meeting glycemic goals.

Diabetes Care 2019;42(Suppl. 1):S1–S186

COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1C <8%

HEDIS Measure description:

- Percentage of diabetic patients ages 18-75 whose A1C is < 8% during 2019.
- EXCLUSIONS:
  - Gestational diabetes or steroid-induced diabetes in 2018 or 2019.
  - Patients age 66 and older living in skilled nursing facility.
  - Advanced illness and frailty (see pages 28-29)

Description	CPT II Code for A1C Testing:
A1C < 7%	3044F
A1C 7-9%	3045F
A1C > 9%	3046F

Ways to improve A1C < 8% rates:

Utilize MPP Web Reporting to identify patients with A1C < 8% gaps.

Ensure diabetes medication compliance.

Refer patients for Self-Management or Nutritional Counseling.

Utilize Diabetic or Chronic Care Flow sheets to document testing.

Utilize test tracking methods to ensure patient compliance and that lab reports are received.

For waived testing at the office, ensure testing is documented in the medical record and CPT II codes are included on the claim.

Review hospital medical records for lab results.

Forward exclusion documentation to the health plan.

COMPREHENSIVE DIABETES CARE: MEDICAL ATTENTION FOR NEPHROPATHY

HEDIS Measure description:

- Percentage of diabetic patients ages 18-75 who had a nephropathy screening or monitoring test or evidence of nephropathy during 2019.
- EXCLUSIONS:
  - Gestational diabetes or steroid induced diabetes in 2018 or 2019.
  - Patients age 66 and older living in skilled nursing facility.
  - Advanced illness and frailty (see pages 28-29)

Any of the following meet criteria for a nephropathy screening or monitoring test for evidence of nephropathy:

- A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding.

  Any of the following meet the criteria:
  - 24-hour urine for albumin or protein.
  - Timed urine for albumin or protein.
  - Spot urine (e.g., urine dipstick or test strip) for albumin or protein. (Note: a result with protein valued as positive/ negative does not meet the measure.)
  - Urine for albumin/creatinine ratio.
  - 24-hour urine for total protein.
  - Random urine for protein/creatinine ratio.
- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of diagnosis or treatment for any of the following:
  Diabetic nephropathy, ESRD, chronic renal failure (CRF), chronic kidney disease (CKD), renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure (ARF), or dialysis, hemodialysis or peritoneal dialysis.
- Evidence of ACE inhibitor/ARB therapy during the measurement year. Any of the following meet criteria:
  Documentation that a prescription for an ACE inhibitor/ ARB was written, filled or taken during the measurement year.

For additional information, please see a video on this topic at:

iphone: open camera and hover
Android: use QR code reader app

Ways to improve Nephropathy screening rates:

Utilize MPP Web Reporting to identify patients with nephropathy screening gaps.

Utilize Diabetic or Chronic Care Flow sheets to document testing.

Utilize Test Tracking Process to ensure patient completed testing and lab reports are received.

For waived testing at the office, ensure testing is documented in the medical record and coded on the claim.

Review hospital medical records for lab results.

Forward exclusion documentation to the health plan.

COMPREHENSIVE DIABETES CARE: MEDICAL ATTENTION FOR NEPHROPATHY

HEDIS Abstractors: The following are ACE/ARB medications that meet this measure

ACE Inhibitor/ARB Medications

Description	Prescription
Angiotensin converting enzyme inhibitors	• Benazepril • Enalapril • Lisinopril • Perindopril • Ramipril • Captopril • Fosinopril • Moexipril • Quinapril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Eprosartan • Losartan • Telmisartan • Candesartan • Irbesartan • Olmesartan • Valsartan
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan • Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil

Description	CPT II Code
Documentation of treatment for nephropathy (patient receiving dialysis, patient being treated for ESRD, CKD, ARF, or renal insufficiency, any visit to a nephrologist)	3066F
ACE inhibitor or ARB therapy	4010F

COMPREHENSIVE DIABETES CARE: RETINAL EYE EXAM

HEDIS Measure description:

- Percentage of diabetic patients ages 18-75 who had a retinal or dilated eye exam during 2019 or a negative retinal eye exam in 2018.
- EXCLUSIONS:
  - Bilateral eye enucleation.
  - Gestational diabetes or steroid induced diabetes in 2018 or 2019.
  - Patients age 66 and older living in skilled nursing facility.
  - Advanced illness and frailty (see pages 28-29)

Description	CPT II Code:
No evidence of retinopathy in the prior year. (Must have documentation of the date, name of provider who performed the exam, and the result.)	3072F

Ways to improve Retinal Eye Exam rates:

Remind patients that retinal eye exams are covered under their medical insurance.

Utilize a retinal eye exam referral form.

Utilize MPP Web Reporting to identify patients with retinal eye exam gaps.

Utilize Diabetic or Chronic Care Flow sheets to document exam results.

Partner with PCMH-Neighborhood eye care specialists to enhance communication.

Utilize referral tracking methods to ensure patient compliance and that specialist reports are received.

Forward exclusion documentation to the health plan.

Diabetic Retinopathy Evaluation

Patient Instructions: Please take this form to your eye care professional and have them complete and return. *Diabetic Eye exams are covered under medical insurance and may be subject to your specialist co-pay and/or deductible.*

Patient Name: _____ DOB: _____

Date of Exam: _____ Health Plan ID: _____

Primary Care Physician Information

Physician: _____ Fax: _____

Address: _____ Phone: _____

City: _____ State: MI Zip: _____

FINDINGS

- ❑ No diabetic retinopathy is found in either eye. OR
- ❑ RETINAL EXAM ABNORMALITIES DETECTED, AS FOLLOWS:
  - ❑ Background changes noted in:
    - ❑ Right *(Circle Grade)* Mild Moderate Severe
      Clinically significant diabetic macular edema? Yes No
    - ❑ Left *(Circle Grade)* Mild Moderate Severe
      Clinically significant diabetic macular edema? Yes No
  - ❑ Proliferative changes noted in:
    - ❑ Right *(Circle Grade)* Active Regressed/Stable
    - ❑ Left *(Circle Grade)* Active Regressed/Stable

FOLLOW UP

- ❑ Routine follow-up exam is recommended in one year. OR
- ❑ Follow-up of abnormalities in my office is recommended in _____ (timeframe).
- ❑ Referral to Dr._____ is recommended in _____(timeframe).
- ❑ Cataracts or Glaucoma detected OR laser treatment is needed. Letter to follow.

Codes to Indicate HEDIS Compliance:

92004 – Ophthalmological services: Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient, one or more visits.

92014 – Ophthalmological services: Medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.

2022F – Dilated eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

2024F – Seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed.

2026F – Eye imaging validated to match diagnosis from seven (7) standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed.

3072F – Low risk for retinopathy (no evidence of retinopathy in the prior year)

_____ Eye Care Professional Signature

_____ Eye Care Professional Printed Last Name

Office Name: _____

ADDITIONAL HEDIS MEASURES AT A GLANCE

Category	Measure Title	Specifications
Transition of Care	Post Hospital Follow-up	Post hospital follow-up visit within 7 or 14 calendar days of discharge.
Pediatric Immunizations and Well Child Visits	Childhood Immunization Status	Children 2 years of age who had the following vaccines on or before their second birthday: (4) DTaP; (3) IPV ; (1) MMR; (3) HiB; (3) Hep B; (1) VZV; (4) PCV; (1) Hep A; (2 or 3) RV; (2) Influenza Exclusion: documented anaphylactic reaction to the vaccine or its components.
	Immunizations for Adolescents	Children 13 years of age who received the following vaccine on or before the 13th birthday: (1) meningococcal, (1) Tdap, and have completed the HPV vaccine series (males and females). Exclusion: documented anaphylactic reaction to the vaccine or its components.
	Well-Child Visits in the First 15 months of Life	6 or more visits by the time the child reached 15 months of age (does not include inpatient or ED visit types).
	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Patients 3 – 6 years of age who had at least one well-child visit with a PCP during 2019.
	Weight assessment for children/adolescents	Patients aged 3-17 who had weight and BMI percentile documented during 2019.
	Counseling for Nutrition	Patients aged 3 – 17 who have had counseling for nutrition during 2019. Documentation must include a note indicating the date and at least one of the following: discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors), checklist indicating nutrition was addressed, counseling or referral for nutrition education, patient received educational materials on nutrition during a face-to-face visit, anticipatory guidance for nutrition, weight or obesity counseling. **CODE: Z71.3 Dietary Surveillance and Counseling**
	Counseling for Physical Activity	Patients aged 3 – 17 who have had counseling for physical activity during 2019. Documentation must include a note indicating the date and at least one of the following: discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation), checklist indicating physical activity was addressed, counseling or referral for physical activity, member received educational materials on physical activity during a face-to-face visit, anticipatory guidance specific to the child's physical activity, weight or obesity counseling. **CODE: Z71.82 Exercise Counseling or Z02.5 Sports Physical**

ADDITIONAL HEDIS MEASURES AT A GLANCE

Category	Measure Title	Specifications
Respiratory Condition	Appropriate Testing for Children with Pharyngitis	Patients ages 3-18 diagnosed with pharyngitis and dispensed an antibiotic should have received a strep test within 3 days prior to diagnosis through 3 days after diagnosis.
	Appropriate Treatment for Children with Upper Respiratory Infection	Patients ages 3 months to 18 years of age diagnosed with URI who were NOT dispensed an antibiotic 30 days prior through 3 days after the diagnosis.
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Patients ages 18-64 diagnosed with acute bronchitis who were **NOT** dispensed an antibiotic.
	Medication management for people with Asthma	Patients 5-64 years of age, dispensed controller medication and remained on for at least 50% during 2019.
Behavioral Health	Antidepressant Medication Management: Acute Phase	Patients age 18 and older diagnosed with new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks).
	Antidepressant Medication Management: Continuation Phase	Patients age 18 and older diagnosed with new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 180 days (6 months).
	Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase (6-12 years)	Patients newly prescribed ADHD medication who had one follow-up visit within 30 days of first ADHD medication prescription.
	Follow-up Care for Children Prescribed ADHD Medication: Continuation and Maintenance (C&M) Phase (6-12 years)	Patients newly prescribed ADHD medication who remained on the medication for at least 210 days and who in addition to the visit in the initiation phase, had at least 2 follow-up visits within 270 days (9 months) after the initiation phase ended.
	Depression Screening and follow-up for Adolescents and Adults	All patients 12 years and older are screened for depression using a standardized tool. If positive screen (PHQ-9 score of 5 or greater) receive follow-up care within 30 days.
Prevention/ Screening	Medical assistance with smoking cessation	Patients 18 years and older who are screened and are identified to use tobacco; receive face-to-face cessation advice, information on medication and strategies to help them quit.

Interpreting PHQ-9 Scores

Minimal depression	0-4
Mild depression	5-9
Moderate depression	10-14
Moderately severe depression	15-19
Severe depression	20-27

Actions Based on PH9 Score

Score	Action
< 4	The score suggests the patient may not need depression treatment
> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

BMI ASSESSMENT

- Weight and BMI percentile documented in 2018 or 2019. This may occur in any outpatient visit type (PCP or Specialist).
- Patients from ages 3 to 20 should have a BMI percentile documented annually (either numeric or plotted on a growth chart).
- Documentation in the medical record must indicate the height, weight and BMI value.
- Place BMI Assessment Z-code on the claim.

Description	ICD-10 Code for ages 21 years and older (use BMI percentile if less than 21)
BMI 19 or less	Z68.10
BMI 20.0-20.9	Z68.20
BMI 21.0-21.9	Z68.21
BMI 22.0-22.9	Z68.22
BMI 23.0-23.9	Z68.23
BMI 24.0-24.9	Z68.24
BMI 25.0-25.9	Z68.25
BMI 26.0-26.9	Z68.26
BMI 27.0-27.9	Z68.27
BMI 28.0-28.9	Z68.28
BMI 29.0-29.9	Z68.29
BMI 30.0-30.9	Z68.30
BMI 31.0-31.9	Z68.31
BMI 32.0-32.9	Z68.32
BMI 33.0-33.9	Z68.33
BMI 34.0-34.9	Z68.34
BMI 35.0-35.9	Z68.35
BMI 36.0-36.9	Z68.36
BMI 37.0-37.9	Z68.37
BMI 38.0-38.9	Z68.38
BMI 39.0-39.9	Z68.39
BMI 40.0-44.9	Z68.41
BMI 45.0-49.9	Z68.42
BMI 50.0-59.9	Z68.43
BMI 60.0-69.9	Z68.44
BMI >=70	Z68.45

BMI Percentile	
Description	**ICD 10 Code**
BMI less than 5th percentile for age	Z68.51
BMI 5th to less than 85th percentile for age	Z68.52
BMI 85th to less than 95th percentile for age	Z68.53
BMI greater than 95th percentile for age	Z68.54

Physician – Dr. Primary Care

Region

MPP Clinical Integration Score
Primary Care Physician 2019

		Possible Points	Metrics	Your Score	Metric Parameters
25%	Membership Metrics	10	Participate in PGIP with MPP	0	Master Membership document must have a signed PGIP Agreement: Yes or No
		5	Disease Registry	0	A Disease Registry is in use: Yes or No
		10	Physician Education	0	Completion of 2 (two) Physician Education offerings posted on MPP website **per payment period (Jan-Jun, Jul-Dec)**
75%	Quality/Efficiency Metrics	20	Quality Metric Composite Score: **Calendar Year End 2018**	0	Your score XXX a. 1 point for each Top Ten metric between NCQA 75th and 89th percentile b. 2 points for every Top Ten metric at or above the NCQA 90th percentile Source: MPP Web reporting
		15	Patient Centered Medical Home (PCMH)	0	Level of PCMH participation (Source: by approved accreditation body) • 15 points for PCMH Designation • 10 points for PCMH Nomination • 5 points for practices with > 30 capability points
		15	Care Coordination - Post acute care visits (TOC)	0	Percent of Post-Acute Care (TOC) visits within 14 days of hospital discharge: • 77% in 14 days = 15 points • 73% in 14 days = 10 points • 70% in 14 days = 5 points (Source: submission of appointments/practice management system; 12-month rolling average)
		10	Medicare Annual Wellness Visits	0	10 points = 20 % of AWV Visits completed 5 points = 13% of AWV Visits completed 3 points = 10% of AWV Visits completed (Source: MHPN data: 12-month rolling average)
		15	Hierarchical Condition Category (HCC) Coding	0	15 points = 5 % increased HCC score 10 points = 3 % increased HCC sore 5 points = 1% increased HCC score (Source: MHPN data: 12-month rolling average)
		Watch Metric	MPP/MHPN Out of Network Utilization	N/A	Percentage of MPP/MHPN Out of Network Utilization (Source: MPP/MHPN data)
		100		**0**	

McLaren HEALTH CARE		**Policy Title:**	Controlled Substance Compliance
Effective Date:	July 17, 2014	**Policy Number:**	MHC_CC0135
Review Date:		**Section:**	Compliance
Revised Date:	March 12, 2018	**Oversight Level:**	Corporate Compliance
Administrative Responsibility:	Vice President of Compliance, Executive VP and Chief Medical Officer		

1. Purpose

1.1. To comply with applicable state and federal laws regarding Prescribing, Administering, Dispensing, storage and disposal of Controlled Substances and to promote patient safety.

2. Scope

2.1. McLaren Health Care Corporation ("MHC"), its subsidiaries, any other entity or organization in which MHC or an MHC subsidiary owns a direct or indirect equity interest of 50% or more, provided that organization has agreed to adopt MHC policies; and MHC's workforce members, including employees and contracted agents, physicians, volunteers, vendors/suppliers, and other business partners. Note – this policy does not apply to Controlled Substances utilized for the provision of Hospice care.

3. Definitions

3.1. **Acute Pain** means pain that is the normal, predicted physiological response to a noxious chemical or thermal or mechanical stimulus and is typically associated with invasive procedures, trauma and disease and usually lasts for a limited amount of time.

3.2. **Administer** means the direct application of a Controlled Substance to the body of a patient or research subject by 1) a Practitioner or (in his/her presence) by an authorized agent, or 2) the patient or research subject at the direction and in the presence of the Practitioner, whether such application is by injection, inhalation, ingestion, or any other means.

3.3. **Advance Practice Registered Nurse (APRN)** means a Nurse Practitioner, Clinical Nurse Specialist or Nurse Midwife.

3.4. **Bona Fide Prescriber-Patient Relationship** means a treatment or counseling relationship between a prescriber and a patient in which:

3.4.1. The prescriber has reviewed the patient's relevant medical/clinical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant medical evaluation of the patient conducted in person or via telehealth; and

3.4.2. The prescriber has created and maintained records of the patient's condition in accordance with medically accepted standards.

3.5. **Controlled Substance** means a drug, substance, or immediate precursor included in schedules II to V in the Public Health Code Act 368 of 1978.

3.6. **Dispense** means to deliver a Controlled Substance to an ultimate user or research subject by, or pursuant to the lawful order of, a Practitioner, including the Prescribing and Administering of a Controlled Substance and the packaging, labeling, or other compounding necessary to prepare the substance for such delivery.

3.7. **Inventory** means all stocks in finished form of a Controlled Substance that is manufactured or otherwise acquired by a licensee, whether in bulk or commercial containers or contained in pharmaceutical preparations in the possession of the licensee.

3.8. **Local Pharmacy** means a McLaren Health Care pharmacy.

3.9. **Practitioner** means a physician, dentist, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted to distribute, Dispense, conduct research with respect to, Administer, or use in teaching or chemical analysis, a Controlled Substance in the course of professional practice or research.

3.10. **Prescriber** means a licensed dentist, a licensed doctor of medicine, a licensed doctor of osteopathic medicine and surgery, a licensed doctor of podiatric medicine and surgery, a licensed physician's assistant acting under a practice agreement, a licensed optometrist certified to administer and prescribe therapeutic pharmaceutical agents, or another licensed health professional acting under the delegation and using, recording, or otherwise indicating the name of the delegating licensed doctor of medicine or licensed doctor of osteopathic medicine and surgery.

3.11. **Prescribe or Prescription** means an order for medication which is Dispensed to or for an ultimate user. This does not include orders for immediate Administration to the patient.

4. Policy

4.1. Licensing

4.1.1. MHC Practitioners are required to obtain and maintain Controlled Substance licenses to Prescribe, Administer, and Dispense Controlled Substances for medical use, as required by state and federal law.

4.1.2. *Michigan License*

4.1.2.1. A Practitioner who Prescribes, Administers and/or Dispenses Controlled Substances is required to obtain and maintain a valid **Michigan Controlled Substances License** from the Michigan Board of Pharmacy.

4.1.2.1.1. A Practitioner may *Prescribe* Controlled Substances at more than one location with a valid **Michigan Controlled Substances License**.

4.1.2.1.2. A **Michigan Controlled Substance License** is required for each business location at which a Practitioner *Dispenses* Controlled Substances.

4.1.2.2. A Practitioner who Prescribes, Administers or Dispenses Controlled Substances to treat narcotic addiction is required to obtain and maintain a valid **Michigan Substance Abuse License** from the Michigan Substance Abuse Program.

4.1.3. *Federal*

4.1.3.1. A Practitioner who Prescribes, Administers and/or Dispenses Controlled Substances must obtain the required **Federal DEA Registration** from the Drug Enforcement Administration (DEA).

4.1.3.2. The **DEA Certificate of Registration** must be maintained at the registered location in a readily retrievable manner and kept available for official inspection.

4.1.3.3. A separate **DEA Registration** is required for each principal place of business or professional practice where Controlled Substances are manufactured, distributed, or Dispensed.

4.1.3.4. If a Practitioner maintains supplies of Controlled Substances, Administers, or directly Dispenses Controlled Substances at separate locations the Practitioner is required to obtain and maintain a separate **DEA Registration** at each applicable location.

4.1.3.5. A Practitioner who moves to a new physical location must request a modification of **DEA Registration** prior to Prescribing, Administering, Dispensing, and/or storing Controlled Substances at the new physical location.

4.1.3.6. Practitioners (e.g., intern, resident, staff physician, mid-level Practitioner) who are agents or employees of a hospital or other institution may, when acting in the usual course of business or employment, Administer, Dispense, or Prescribe Controlled Substances under the **DEA Registration** of the hospital or other institution in which they are employed, provided that:

4.1.3.6.1. The Dispensing, Administering, or Prescribing is in the usual course of professional practice;

4.1.3.6.2. Practitioners are authorized to do so by the state in which they practice;

4.1.3.6.3. The hospital or institution has verified that the Practitioner is permitted to Dispense, Administer or Prescribe Controlled Substances within the state;

4.1.3.6.4. The Practitioner acts only within the scope of employment in the hospital or institution;

4.1.3.6.5. The hospital or institution authorizes the Practitioner to Dispense or Prescribe under its DEA Registration and assigns a specific internal code number for each Practitioner so authorized.

4.1.3.7. Practitioners are required to renew the DEA Registration every three years.

4.2. Practitioner Responsibilities

4.2.1. A Practitioner is responsible for ensuring that he/she acts within the scope of his/her practice when Prescribing, Administering, and/or Dispensing Controlled Substances.

4.2.2. A Practitioner is responsible for ensuring that Controlled Substances are Prescribed, Administered, and/or Dispensed in good faith, and for a legitimate and professionally recognized purpose.

4.2.3. A Practitioner is obligated to take reasonable measures to prevent diversion.

4.3. Delegation Authority

4.3.1. A supervising physician may delegate *Prescribing* authority of schedules 2 to 5 Controlled Substances to an Advance Practice Registered Nurse (APRN).

4.3.1.1. *Identification*. The APRN's name and the supervising physician's name shall be used, recorded, or otherwise indicated in connection with each individual Prescription so that the individual who Dispenses or Administers the Prescription knows under whose delegated authority the APRN is Prescribing.

4.3.1.2. *License*. The APRN's and supervising physician's DEA Registration numbers shall be used, recorded, or otherwise indicated in connection with each individual Prescription.

4.4. Medical Record Documentation Requirements

4.4.1. MHC Practitioners shall abide by state and federal requirements for documenting the clinical need for the Prescription, Administration, or Dispensing of a Controlled Substance to a patient.

4.5. Valid Prescription Requirements

4.5.1. MHC and its Practitioners will adhere to the state and federal requirements for valid Prescriptions of Controlled Substances.

4.5.2. A Prescription for a Controlled Substance is not valid unless it is issued for a legitimate medical purpose by a Practitioner acting in good faith, in the usual course of professional practice, for a legitimate and professionally recognized therapeutic, scientific, or industrial purpose.

4.6. Physician Practice and Clinic Procurement of Controlled Substances

4.6.1. All Controlled Substances will be procured from a McLaren pharmacy, unless the patient's insurance requires the patient to obtain the Controlled Substance through an approved retail pharmacy.

4.7. Prescribing Guidelines and Safeguards

4.7.1. MHC and its Practitioners will implement safeguards to ensure safe and effective medication use and to prevent diversion.

4.8. Storage and Security

4.8.1. MHC and its practitioners will adhere to state and federal requirements for the storage of Controlled Substances and for notification to appropriate authorities of theft or loss of controlled substances..

4.8.2. *Employment/Agent Restrictions*. MHC shall not employ as an agent or employee who has access to Controlled Substances:

4.8.2.1. Any person who has been convicted of a felony offense related to Controlled Substances;

4.8.2.2. Any person who has been denied a DEA Registration;

4.8.2.3. An person who has had a DEA Registration revoked; and,

4.8.2.4. Any person who has surrendered a DEA Registration for cause.

4.9. Recordkeeping, Tracking, and Inventory Requirements

4.9.1. *Recordkeeping*

4.9.1.1. Records of Controlled Substances must be maintained as required by state and federal law.

4.9.1.2. Inventories of Controlled Substances must be conducted and reported as required by state and federal law.

4.10. Reporting Requirements

4.10.1. *Electronic Reporting*. MHC Pharmacists shall submit a daily report of Dispensed Controlled Substances to the Michigan Department of Health and Human Services in the required format and containing the requisite content.

4.10.2. Reporting is not required when:

4.10.2.1. A Controlled Substance is *Administered* directly to a patient.

4.10.2.2. A Controlled Substance is *Dispensed* from a health facility or agency by a Dispensing Practitioner in a quantity adequate to treat a patient for not more than 48 hours.

4.11. Administration and Waste of Controlled Substances

4.11.1. *Administration*. Controlled Substances will be Administered according to facility Medication Administration policies and procedures unless otherwise specified by clinical protocol.

4.11.2. *Waste*. If a partial Controlled Substance dose remains and cannot be returned for future use, it must be destroyed and documented as waste. Waste of Controlled Substance must be physically witnessed by a licensed professional and a co-signature of the witness is required.

4.12. Outdated and Unwanted Controlled Substances

4.12.1. All out-of-date, damaged, or otherwise unusable or unwanted Controlled Substances must be returned according to state and federal law.

4.13. Record Retention

4.13.1. Records will be retained in compliance with the McLaren Health Care Record Retention Schedule (see MHC_CC0110 Record Retention Policy).

5. Procedure

5.1. Licensing

5.1.1. MHC subsidiary Medical Staff Offices and the McLaren Medical Group (MMG) Contract Coordinator will confirm physicians and allied health professionals maintain a valid Michigan Controlled Substance License and DEA Registration, and a Michigan Substance Abuse License as applicable, during the credentialing and privileging processes.

5.1.2. *Michigan Controlled Substance License*. A Practitioner's license can be verified online on the Department of Licensing and Regulatory Affairs (LARA) website.

5.1.3. *Hospital DEA License.* A hospital DEA license allows the hospital to purchase and store Controlled Substances for hospital patients.

5.1.3.1. Practitioners with a DEA Registration do not use the hospital DEA Registration number to Dispense or Prescribe Controlled Substances.

5.1.3.2. Practitioners such as interns and residents, who do not have a DEA Registration may Dispense or Prescribe Controlled Substances using the hospital DEA Registration number. Facility policy and procedure shall be followed regarding the maintenance and distribution of a list of internal codes to identify applicable Practitioners.

5.1.4. *License Verification*. The Paragon Provider Master, Cerner, Allscripts Enterprise and other similar applications limit access to Prescribing Controlled Substances based on the Practitioner's license restrictions. Licensing information is entered into these systems by the Medical Staff Office at each facility and by the MMG EMR Team.

5.2. Delegation Authority

5.2.1. *Documentation of Authorization*. MHC subsidiary Medical Staff Offices and McLaren Medical Group (MMG) will document authorization of supervising physician delegation of authority to APRNs. Delegation authorization documentation will include the following:

5.2.1.1. The name, license number, and signature of the delegating physician;

5.2.1.2. The name, license number, and signature of the APRN;

5.2.1.3. The limitations or exceptions to the delegation;

5.2.1.4. The effective date of the delegation.

5.2.2. *Retention*. Written authorization shall be maintained in each facility where delegation occurs.

5.2.3. *Review of Authorization*. Delegation authorization will be reviewed at least annually for appropriateness.

5.3. Medical Record Documentation Requirements

5.3.1. *Documentation of Dispensing*. A Dispensing Practitioner shall include in a patient's chart or clinical record a complete record, including Prescription drug names, dosages, and quantities, of all prescription drugs Dispensed directly by the Dispensing Practitioner, or indirectly under his or her delegation authority.

5.3.1.1. If a Controlled Substance is Dispensed under the Practitioner's delegatory authority, the delegate who Dispenses the Controlled Substance shall initial the patient's chart, clinical record, or log of Controlled Substances Dispensed (see Section 4.3).

5.3.1.2. In a patient's chart or clinical record, a Dispensing Practitioner shall distinguish between Controlled Substances *Dispensed* to the patient, and Controlled Substances *Prescribed* to the patient.

5.3.2. *Documentation of Administering*. Administration of any Controlled Substance will be recorded in the patient's medical record including the date, time, dose, route of

Administration, patient's response to the Controlled Substance, and patient education provided.

5.3.2.1. Certain Controlled Substances require the patient to wait for the Practitioner to monitor the patient's response after Administration. In these cases the patient's response to the Controlled Substance shall be documented after the patient has waited the required amount of time.

5.4. Valid Prescription Requirements

5.4.1. *Documentation Requirements*. The following must be included and documented legibly in ink, indelible pencil, or electronic print-out (Schedule II-V Controlled Substances only), to create a valid prescription for a Controlled Substance:

5.4.1.1. Dated and signed on the date issued;

5.4.1.2. Patient's full name and address;

5.4.1.3. Practitioner's full name, address, and DEA Registration number, and professional designation;

5.4.1.4. Drug name;

5.4.1.5. Strength;

5.4.1.6. Dosage form;

5.4.1.7. Quantity Prescribed in written and numerical terms (i.e. "thirty (30)") or with a pre-printed check box with the appropriate number checked by the prescriber;

5.4.1.8. Directions for use; and,

5.4.1.9. Number of refills authorized (if any)

5.4.1.9.1. Refills of a Prescription for a Controlled Substance listed in Schedule II are prohibited. A new Prescription must be completed each time.

5.4.1.9.2. A maximum of five refills of a prescription for a Controlled Substance listed in Schedules III, IV, and V are permitted.

5.4.2. A Prescription for a Controlled Substance cannot be post-dated.

5.4.3. *ePrescribing.* ePrescribing of Schedule II through V Controlled Substances is permissible with the patient's consent.

5.4.3.1. In addition to the requirements above, an ePrescription requires:

5.4.3.1.1. An electronic signature or other identifier that specifically identifies and authenticates the Prescriber or the Prescriber's authorized agent;

5.4.3.1.2. The time and date of transmission;

5.4.3.1.3. The identity of the pharmacy intended to receive the transmission; and

5.4.3.1.4. Prescriber telephone number.

5.4.3.2. MHC will adhere to the state and federal transmission security requirements for ePrescribing.

5.5. Prescribing Guidelines and Safeguards

5.5.1. The following safeguards should be implemented by Practitioners, to the extent possible:

5.5.1.1. Keep all prescription blanks locked in a safe place where they cannot be stolen;

5.5.1.2. Minimize the number of prescription pads in use;

5.5.1.3. Use prescription blanks only for writing a prescription order and not for notes;

5.5.1.4. Do not sign prescription blanks in advance;

5.5.1.5. Assist the pharmacist when necessary to verify information about a prescription order;

5.5.1.6. Use tamper-resistant prescription pads or tamper resistant paper to print the prescription on;

5.5.1.7. Do not pre-print Practitioner DEA Registration on prescription blanks;

5.5.1.8. Register to Michigan Automated Prescription System ("MAPS") online to request prescription data on patients and perform MAPS queries regularly to identify and prevent abuse and diversion (see the McLaren Medical Group Recommended Best Practices: Use of Controlled Medicines for further guidance);

5.5.1.9. In the physician practice and clinic settings, execute a Controlled Medicines Agreement with patients at the time of Prescribing Controlled Substances and annually. Retain a copy of this Agreement in the patient's medical record;

5.5.1.10. Practitioners should contact the local DEA Field Office, as well as the Compliance Officer and/or the Local Pharmacy to report suspicious Prescribing activity.

5.6. Bona Fide Prescriber-Patient Relationship

5.6.1. A prescriber cannot prescribe a schedule 2-5 controlled substance unless the prescriber is in a "Bona Fide Prescriber-Patient Relationship" with the patient (see definitions).

5.6.2. Before prescribing or dispensing a controlled substance to a patient, the prescriber must ask the patient about other controlled substances the patient may be using and record the patient's response in the patient's medical/clinical record.

5.6.3. If a schedule 2-5 controlled substance is prescribed, the prescriber must provide follow up care to the patient to monitor the effectiveness of the controlled substance as a treatment of the patient's medical condition.

5.6.4. If the prescriber is unable to provide follow up care, he/she shall refer the patient to the patient's PCP for follow up care, or, if no PCP, he/she shall refer to another licensed prescriber who is geographically accessible to the patient for follow up care.

5.6.5.

5.7. Physician Practice and Clinic Procurement of Controlled Substances

5.7.1. *Ordering*. Orders for Controlled Substances may be placed by telephone, fax, or mail through the Local Pharmacy. Orders for schedule II Controlled Substances must be placed using DEA Form 222.

5.7.1.1. Controlled Substances will be ordered in unit dose packaging whenever possible.

5.7.2. *Transportation of Controlled Substances*. Controlled Substances should be transported in secure medication transport cases.

5.7.3. *Receipt of Controlled Substances*. Upon receipt of the Controlled Substance order, the office staff will:

5.7.3.1. Examine the transport box for tampering;

5.7.3.2. Verify that the proper item, size, strength, and quantity were received,

5.7.3.3. Have the licensee sign the receipt and place in the transport box for return to the pharmacy.

5.7.4. *Rejecting Receipt*. If the order appears to be tampered with in any way, such as a broken seal on the box, staff should not accept the order and should notify the pharmacy immediately.

5.7.5. *Authorized Signer*. The Controlled Substance licensee for each office will sign for and accept Controlled Substance orders from the courier.

5.7.6. *Logging Receipt of Controlled Substances*. Upon receipt of a Controlled Substance from the pharmacy, a Controlled Substance Log form will be initiated, including the following information about the medication:

5.7.6.1. Name of medication

5.7.6.2. Strength

5.7.6.3. Quantity received

5.7.6.4. Lot number

5.7.6.5. Expiration date

5.7.6.6. Received by (staff member checking-in the medication)

5.7.6.7. Site (practice/clinic)

5.8. Storage and Security

5.8.1. Schedule I Controlled Substances must be stored in a securely locked, substantially constructed cabinet that is anchored to a wall or to the floor.

5.8.2. Schedule II – V Controlled Substances must be stored in a securely locked, substantially constructed cabinet, room or cart.

5.8.3. Parenteral Schedule III Controlled Substances required to be refrigerated must be stored according to federal regulations.

5.8.4. *Notification of Theft or Loss*.

5.8.4.1. Within one business day of discovery of any theft or significant loss of Controlled Substances, the DEA Registrant must notify the DEA Field Office directly and submit DEA Theft/Loss Form 106 to the DEA.

5.8.4.2. Within ten (10) days following the discovery of any theft or loss of any Controlled Substance, the Controlled Substance licensee shall submit DEA Theft and Loss Report Form 106 to the Michigan Board of Pharmacy, regardless of whether the Controlled Substance is subsequently recovered or the responsible party is identified, and regardless of whether the theft/loss was reported to the DEA.

5.8.4.3. Practitioners will also notify the local Compliance Officer and the Local Pharmacy, upon discovery, of any thefts or significant losses of Controlled Substances.

5.9. Recordkeeping, Tracking, and Inventory Requirements

5.9.1. *Recordkeeping*

5.9.1.1. All records for Controlled Substances, including invoices and other acquisition records, must be maintained and readily retrievable within 48 hours.

5.9.1.1.1. Invoices and acquisition records of all schedule I and II Controlled Substances shall be maintained in a file separate from schedules III to V.

5.9.1.2. Except in medical institutions, patients' original prescriptions for Controlled Substances shall be sequentially numbered and maintained in chronological order with separate files maintained for schedule II and for schedules III to V.

5.9.2. *Tracking*

5.9.2.1. Physician Practice and Clinic Settings. Controlled Substances will be counted daily by two appropriately trained staff, at least one of whom is licensed, and documented in the Daily Controlled Substance Verification Sheets (a separate Verification Sheet is required for Schedule II). The sheet should indicate the dates when the office was not open and therefore, the Controlled Substances were not counted.

5.9.2.1.1. A Log will be maintained for each Controlled Substance administered to patients in physician practice or office settings. The log will be used to conduct daily inventories. The log must include:

5.9.2.1.1.1. Date

5.9.2.1.1.2. Time

5.9.2.1.1.3. Patient name

5.9.2.1.1.4. Medication name

5.9.2.1.1.5. Dosage

5.9.2.1.1.6. Amount wasted (if applicable)

5.9.2.1.1.7. Physician Prescribing medication

5.9.2.1.1.8. Person Administering medication

5.9.2.1.1.9. Co-signature of witness

5.9.2.1.1.10. Quantity of drug remaining

5.9.2.2. Hospital Settings. Controlled Substances will be tracked in accordance with facility Pharmacy procedure.

5.9.3. *Annual Inventory*

5.9.3.1. Annual Inventory of all Controlled Substances in the possession or control of a licensee must be taken at each licensed location and the record of the inventory must be maintained at the licensee's location. The inventory must be dated and signed by the responsible licensee. Schedule II Controlled Substance records must be kept separate from Schedules III to V.

5.9.3.2. Each inventory must contain the following information:

5.9.3.2.1. Whether the inventory was conducted at the beginning or close of business;

5.9.3.2.2. Names of the Controlled Substances;

5.9.3.2.3. Each finished form of the substances (e.g., 100 milligram tablet);

5.9.3.2.4. The number of dosage units of each finished form in the commercial container (e.g., 100 tablet bottle);

5.9.3.2.5. The number of commercial containers of each finished form (e.g., four 100 tablet bottles);

5.9.3.2.6. Disposition of the Controlled Substances; and

5.9.3.2.7. Licensee's name, address and DEA number.

5.9.3.3. Practitioners are required to include in their inventories Controlled Substance samples provided by pharmaceutical companies.

5.10. Reporting Requirements

5.10.1. *Electronic Reporting*. Pharmacists and Dispensing Prescribers are required to report online daily to the Michigan Department of Community Health, the following information when *Dispensing* Controlled Substances:

5.10.1.1. The patient identifier;

5.10.1.2. The name of the Controlled Substance Dispensed;

5.10.1.3. The metric quantity of the Controlled Substance Dispensed;

5.10.1.4. The national drug code number (NDC) of the Controlled Substance Dispensed;

5.10.1.5. The date of issue of the Prescription;

5.10.1.6. The date of Dispensing;

5.10.1.7. The estimated days of supply of the Controlled Substance Dispensed;

5.10.1.8. The prescription number assigned by the Dispenser;

5.10.1.9. The DEA Registration number of the Prescriber and the Dispensing pharmacy; and,

5.10.1.10. The Michigan license number of the dispensing pharmacy.

5.11. Administration and Waste of Controlled Substances

5.11.1. *Administration*. The following licensed professionals may Administer Controlled Substances:

5.11.1.1. Physician

5.11.1.2. Physician Assistant (PA)

5.11.1.3. Certified Registered Nurse Anesthetists (CRNA's)

5.11.1.4. Advance Practice Registered Nurse (APRN)

5.11.1.5. Registered Nurse (RN)

5.11.1.6. Licensed Practical Nurse (LPN)

5.11.2. *Waste*. Facility policies and procedures regarding medication waste should be followed.

5.12. Outdated and Unwanted Controlled Substances

5.12.1. Non-hospital based physician practices may dispose of out-of-date, damaged or otherwise unusable or unwanted Controlled Substances by transferring them to a DEA registrant who is authorized to receive such materials (referred to as a 'reverse distributor'). Schedule II Controlled Substances should be transferred via DEA Form 222. Schedule III through V compounds are transferred via invoice. The invoice must contain the name and address of both the sending and receiving DEA registrant and the DEA numbers of both. Practitioners must maintain copies of the records documenting the transfer and disposal of Controlled Substances in compliance with the MHC Record Retention Schedule (see MHC_CC0110 Record Retention Policy).

5.12.2. MHC clinics and physician offices shall keep their outdated or unwanted Controlled Substances secured (per Section 5.7 above) until returned to the Local Pharmacy from which the substances were ordered.

5.13. Automated Dispensing Devices

5.13.1. MHC may operate an Automated Dispensing Device ("automated device") at a location affiliated with a hospital that is not located at the same physical address as the pharmacy. The hospital shall notify the Michigan Department of Health and Human Services of the location of the automated device. A separate Controlled Substance license is required when the automated device is not located at the same address as the pharmacy responsible for the device.

5.13.2. The off-site automated device must be under the control and supervision of the pharmacist in charge for the pharmacy. The pharmacist in charge may delegate the stocking of the automated device, the removal of medication from the automated device, the

maintenance of the automated device and other tasks related to the operation of the automated device, but he/she is not required to be immediately physically present to supervise a delegated task. The operation of the automated device is limited to licensed health professionals.

5.14. Opioid Prescriptions for Minors

5.14.1. Before a prescriber issues the first opioid prescription in a single course of treatment to a minor (under 18), the prescriber shall:

5.14.1.1. Discuss the following with the minor and with the minor's parents/guardian or with 'another adult authorized, in writing, to consent to the minor's medical treatment'*:

5.14.1.1.1. The risks of addiction and overdose associated with the opioid;

5.14.1.1.2. The increased risk of addiction to an opioid for an individual suffering from mental and substance abuse disorders;

5.14.1.1.3. The danger of taking an opioid with a benzodiazepine, alcohol, or other central nervous system depressant; and

5.14.1.1.4. Any other information in the patient counseling information section of the label that is required under federal law.

5.14.1.2. *NOTE that when the consent is signed by another adult authorized to consent in writing by the minor's parents, the prescriber shall not prescribe more than a 72 hour supply of the controlled substance.

5.14.2. Obtain parent's/guardian's/other authorized adult's* signature on a ***Start Talking Consent Form*** and include the Form in the medical record. The Form must include:

5.14.2.1. Opioid name, quantity and amount of initial dose;

5.14.2.2. Statement that a controlled substance is a drug or other substance that the DEA has identified as having a potential for abuse;

5.14.2.3. Statement certifying that the prescriber discussed the risks of addiction, etc, with the minor and the minor's parent/guardian or another adult authorized to consent to the minor's medical treatment;

5.14.2.4. The number of refills, if any, authorized by the prescription*; and

5.14.2.5. Signature of the parent/guardian/authorized adult and the date.

5.14.2.6. *NOTE that when the Consent is signed by 'another adult authorized to consent in writing by the minor's parents', the prescriber shall not prescribe more than a 72 hour supply of the controlled substance.

5.14.3. Parental consent is not required when:

5.14.3.1. The treatment is associated with a medical emergency or surgery;

5.14.3.2. Obtaining consent would be detrimental to the minor's health/safety;

5.14.3.3. The treatment is rendered in a hospice or upon discharge from a hospice;

5.14.3.4. Consent from parents is not required for the minor to obtain the treatment.

5.15. Opioid Education for Adults

5.15.1. Before an opioid is prescribed to a patient, the prescriber or another health professional shall inform the patient or his/her representative of the following and obtain the patient's signature on the required State of Michigan Form which shall be included in the patient's medical record:

5.15.1.1. The danger of opioid addiction;

5.15.1.2. How to properly dispose of expired, unused or unwanted opioid;

5.15.1.3. Delivery (diversion) of a controlled substance is a felony under Michigan law; and

5.15.1.4. For pregnant patients or female patients of reproductive age - the short and long term effects of exposing a fetus to a controlled substance, including but not limited to neonatal abstinence syndrome.

5.15.2. Education requirements do not apply to inpatients.

5.16. MAPS Reports

5.16.1. Before prescribing or dispensing a controlled substance to a patient, a licensed prescriber must register with MAPS.

5.16.2. Before prescribing or dispensing a controlled substance to a patient in a quantity that exceeds a 3-day supply, the licensed prescriber shall obtain and *review* a MAPS report on the patient.

5.16.3. Exception: If the dispensing occurs in a hospital or freestanding surgical outpatient facility and the controlled substance is administered to the patient in that hospital/facility.

5.16.4. The dispensing of a controlled substance to hospital inpatients is exempt from MAPS *reporting.*

5.16.5. Controlled substances dispensed by a dispensing prescriber in a health facility in a quantity adequate to treat the patient for not more than 48 hours is exempt from MAPS *reporting*.

5.16.6. Before dispensing or prescribing buprenorphine, or a drug containing buprenorphine or methadone, to a patient in a substance use disorder program, the prescriber shall obtain and *review* MAPS data.

5.16.7. A prescriber dispensing buprenorphine, or a drug containing buprenorphine or methadone to a patient in a substance abuse disorder program shall also *report* the data to MAPS (if federal law does not prohibit the reporting of such data)

5.17. Opioids for Acute Pain

5.17.1. If a prescriber is treating a patient for Acute Pain, the prescriber shall not prescribe more than a seven (7) day supply of an opioid within a 7 day period.

5.18. Post-Opioid Overdose Education

5.18.1. A health professional licensee or registrant who treats a patient for an opioid-related overdose must provide information to the patient on substance use disorder prevention or treatment services.

5.19. Audits of Compliance

5.19.1. Subsidiary pharmacies will conduct an annual audit of all provider based practices to verify compliance with the requirements of this policy.

5.19.2. McLaren Medical Group will conduct an annual audit of all non-provider based physician offices/clinics to verify compliance with the requirements of this policy.

5.19.3. McLaren Homecare Group will conduct annual audits of all long term care and retail sites to verify compliance with the requirements of this policy.

6. References

6.1. Michigan Public Health Code Act 368 of 1978, MCL 333.1101 et seq.

6.1.1. MCL 333.17744

6.1.2. MCL 333.17754

6.1.3. MCL 333.7333

6.1.4. MCL 333.17211

6.1.5. MCL 333.17760

6.1.6. MCL 333.177601

6.1.7. MCL 333.177601c

6.1.8. MCL 333.177601a

6.1.9. MCL 3 333.7333a

6.1.10. MCL . 333.7333(3)

6.1.11. MCL . 333.7333b

6.1.12. MCL . 333.16282

6.1.13. Start Talking Consent Form

6.1.14. State of Michigan Opioid Education Form

6.2. Mich. Admin. Code R. 338.31

6.3. Federal Controlled Substances Act – 21 USCA §801 *et seq.*

6.4. 21 CFR §1306.04

6.5. 21 U.S.C. §829

6.6. DEA Practitioner's Manual – An Informational Outline of the Controlled Substances Act

6.7. DEA Rule Electronic Prescriptions for Controlled Substances

6.8. McLaren Medical Group Recommended Best Practices: Use of Controlled Substances

Previous Revisions: July 17, 2014

Supersedes Policy: Not Applicable

Approvals:

Corporate Compliance Committee: July 17, 2014, March 12, 2018

March 12, 2018

Michael McKenna, M.D.
Executive VP and CMO

Date

McLaren MEDICAL GROUP		**Policy Title:**	Delinquent Medical Records
Effective Date:	10/96	**Policy Number:**	6310
Review Date:		**Category:**	Medical Records/HIPAA
Revised Date:	2/21/2018	**Oversight Level:**	2
Administrative Responsibility:	Operations Managers, Regional Operations Directors, Regional Medical Directors, Chief Medical Officer, Vice President of Operations, Vice President of Human Resources, Chief Financial Officer, Chief Executive Officer		
Interpretation:	Compliance Officer, Regional Medical Directors, Vice President of Operations		

1. Purpose

1.1. To facilitate patient care, treatment, and services with complete and timely medical record documentation.

2. Scope

2.1. All employees of McLaren Medical Group (MMG) and/or employees working at a MMG managed site.

3. Definitions

3.1. Delinquent medical records include medical records that are not completed within three business days of a patient encounter and include providers who have more than 100 medical records not completed.

4. Policy

4.1. Providers will timely document patient visits and review diagnostic testing.
4.2. In order to ensure the integrity, confidentiality, and availability of patient information, paper medical records must remain on site in order to complete documentation.
4.3. Failure to follow this policy will result in corrective action, up to and including termination of the provider.

5. Procedure

5.1. To ensure this policy is being followed:
5.1.1. Billing will run a weekly report identifying delinquent medical records by provider and will provide this report to the Operations Manager and Regional Operations Director.
5.1.2. The Operations Manager will notify the provider of delinquent medical records and will document that the provider was notified.
5.1.3. The provider is responsible to complete the delinquent medical record(s).

5.2. Delinquent medical records not completed within three business days of an encounter.

5.2.1. Any medical record not completed within three business days of an encounter will result in elimination of the work RVU's associated with the encounter.

5.2.2. Charge entry personnel are directed to bill any medical record greater than three business days delinquent with an internal modifier code which will remove the work RVU value.

5.2.3. The Operations Manager and the Regional Operations Director will assist the provider in becoming compliant with this policy. Escalation will follow 5.3.

5.2.4. If the Regional Operations Director deems the provider's actions to correct the delinquent medical records ineffective, despite the provider's efforts, the delinquency is reported to administrative representatives, including but not limited to, the Compliance Officer, Vice President of Operations, Vice President of Human Resources, Chief Medical Officer, Chief Financial Officer, and Chief Executive Officer.

5.3. Delinquent medical records for providers who have more than 100 medical records not completed.

5.3.1. In the first week of non-compliance, notice is given to the provider by the Operations Manager and the Regional Operations Director.

5.3.2. In the second week of non-compliance, the provider will have their schedule reduced by 25%. The Regional Operations Director will notify the Regional Medical Director of the non-compliance.

5.3.3. In the third week of non-compliance, the provider will have their schedule reduced by 50%. The provider must also meet with the Regional Medical Director and an administrative representative(s), including, but not limited to, the Compliance Officer, Vice President of Operations, Vice President of Human Resources, Chief Medical Officer, Chief Financial Officer, and Chief Executive Officer.

5.4. Delinquent medical records for providers who have more than 200 medical records not completed.

5.4.1. The provider is immediately removed from the patient schedule and will not see patients in the office.

5.4.2. The provider will have eight hours of Paid Time Off reduced from their bank for each day that the provider is removed from the patient schedule until all of the medical records are completed, meaning no delinquent medical records remain.

5.4.3. If the provider's Paid Time Off bank is in or will run into arrears, then the Paid Time Off bank will run into a negative balance.

5.5. Dictation/Transcription of Reports

5.5.1. Reports dictated to a designated transcription vendor will be completed within 48 hours of date of service; all dictated reports will be transcribed within 72 hours following physician dictation.

5.5.1.1. Office staff will highlight the appointment on the schedule until the transcribed report is returned.

5.5.1.2. The provider will review and sign, date, and time the transcribed report.

5.5.1.3. The signed report will be placed or scanned into the patient's medical record.

5.4.2 Reports dictated within the electronic medical record will be completed within the same business day.

5.4.3 Date dictated, date transcribed, provider's signature, and time and date of review by the provider is noted on the report.

6. Exceptions

None

7. References

None

8. Appendix

None

9. Approvals

William Hardimon	***2/26/2018***
(Original signed policy on file in MMG Practice Management)	
William Hardimon President/Chief Executive Officer	Date
Brad Ropp, MD	***2/21/2018***
(Original signed policy on file in MMG Practice Management)	
Brad Ropp, MD Chief Medical Officer	Date

Ambulatory Quality Improvement Committee approval: 2/21/2018

Previous Revision Dates/Supercedes Policy:
11-25-2016 / 9-2015 / 8-7-2012 / 6-01 / 8.14/ 9.15

Risk-Stratified Care Management and Coordination

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Table 1: Examples of Potentially Significant Risk Factors

Clinical Diagnoses, Behavioral Health, Special Needs	Potential Physical Limitations	Social Determinants	Utilization/Claims Data	Clinician Input (Personal Knowledge)
- Any chronic disease, particularly one that is not in control or at desired goal - Chronic pain - Substance abuse (alcohol/drug/tobacco) - Terminal illness - Advanced age with frailty - Multiple co-morbidities - Pre-term delivery of newborn - Child, youth, or adult with special needs - Anxiety, schizophrenia, bipolar, depression, or other behavior affecting health - Dental health - Dementia/Alzheimer's disease	- Non-ambulatory - Needs Assistance with Activities of Daily Living (ADLs) - Severely diminished functional status - Declining eyesight - Extreme weakness or fatigue - At risk for falls	- Lack of financial or family support that impacts care - Unemployed - No health insurance - Low health literacy - Unsafe home environment - Homeless - Lives alone and needs assistance with ADLs - Transportation for health care appointments is difficult - Language barriers	- Frequent hospitalizations (particularly heart failure, GI disorders, and pneumonia) - Frequent office, ER, or urgent care visits - Multiple providers - Hospital readmission within 30 days - Major procedure in last year - Chronic kidney disease - Brain trauma - Expensive medications	- Polypharmacy – Patient is taking several medications that may not all be needed and/or could have potential for interactions - High-risk medications - Non-compliant with treatment plan - Confusion with medications or following the treatment plan - Recent move to long-term facility or other transition of care - Spouse (who was the caregiver) recently deceased - Lack of engagement in care plan - Low confidence or ability for self-management - Answer to the question: Is this patient at higher risk for dying within the next year?

Table 2: Risk Categories and Levels using Diabetes Example Case

CATEGORY	PRIMARY PREVENTION (Low Resource Use) GOAL: To prevent onset of disease		SECONDARY PREVENTION (Moderate Resource Use) GOAL: To treat a disease and avoid serious complications		TERTIARY (High Resource Use) GOAL: To treat the late or final stages of a disease and minimize disability	CATASTROPHIC/COMPLEX (Extremely High Resource Use) GOAL: May range from restoring health to only providing comfort care
Stage	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
	No known diagnoses or complex treatments	No known diagnoses but demonstrates warning signs or potentially significant risk factors	Has diagnosis, but stabilized or in control; potentially significant risk factors	Has diagnosis and/or complex treatment, and at higher risk for complications or potentially significant risk factors	Has diagnosis, complex treatment, and complications or potentially significant risk factors– goal is to prevent further complications	• Very severe illness or condition and potentially significant risk factors • End-of-life care • Premature baby (May have high costs with limited or no opportunity for improvement, stabilization, or cost control)
Example of using uncontrolled progression of diabetes	• Healthy	• Blood glucose and lipids rising, but still within desired parameters • BMI elevated • Smoker	• Diagnosed with type 2 diabetes, blood sugar, and lipids brought within desired parameters • Married, family involved	• Blood sugar and lipids not within desired parameters, and financial situation impacting negatively • Lives alone • One ER visit and one hospitalization in past year	• Has diabetes with early renal disease, coronary artery disease, failing eyesight, and lives alone • Three ER visits and two hospitalizations in past year • Dual eligible Medicaid/Medicare • Needs Assistance with Activities of Daily Living (ADLs)	• Diagnosed with lung cancer • Recent myocardial infarction • Progression to ESRD with renal dialysis • Amputation of one leg • Blind • Lives in nursing home
Example of Care Plan Considerations for patient with uncontrolled progression of diabetes	✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring for warning signs ✓ Health risk assessment (annual) ✓ Care plan that includes smoking cessation counseling and program offered		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (semi-annual) ✓ Care plan with smoking cessation counseling and program offered ✓ Team/planned care ✓ Group visits ✓ Health coach ✓ Referrals as appropriate, such as social services ✓ Community resources ✓ Home self-monitoring		✓ Preventive screenings and immunizations ✓ Patient education and engagement ✓ Appropriate monitoring ✓ Health risk assessment (quarterly) ✓ Intensive care management plan and resources ✓ Smoking cessation ✓ Group visits ✓ Health coach ✓ Home health	✓ Hospitalization ✓ Rehabilitation ✓ Long-term care ✓ Hospice ✓ Home health ✓ Individualized intensive care management and coordination ✓ May or may not conduct preventive screenings ✓ Health risk assessment, as appropriate

Identifying Disease Burden and Determining Health Risk Status

Is the patient healthy, with no chronic disease, or *significant risk factors?*	Is the patient healthy, but at risk for a chronic disease, or has other *significant risk factors?*	Does the patient have one or more chronic diseases, with *significant risk factors,* but is stable or at desired treatment goals?	Does the patient have one or more chronic diseases, with *significant risk factors,* and is unstable or not at treatment goal(s)?	Does the patient have multiple chronic diseases, *significant risk factors,* complications, and/or complex treatment(s)?	Does the patient have a catastrophic or complex condition in which his/her health may or may not be able to be restored?
Level 1 PRIMARY PREVENTION	**Level 2 PRIMARY PREVENTION**	**Level 3 SECONDARY PREVENTION**	**Level 4 SECONDARY PREVENTION**	**Level 5 TERTIARY PREVENTION**	**Level 6 CATASTROPHIC CARE**
GOAL: To prevent onset of disease (Low Resource Use)	**GOAL: To prevent onset of disease (Low Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: To treat a disease and avoid serious complications (Moderate Resource Use)**	**GOAL: Treat the late or final stages of a disease and minimize disability (High Resource Use)**	**GOAL: May range from restoring health to only providing comfort care (Extremely High Resource Use)**
CARE PLAN SUGGESTIONS - Preventive screenings and immunizations - Patient education - Health risk assessment (annual) - Appropriate monitoring for warning signs	**CARE PLAN SUGGESTIONS** - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (annual) - Appropriate monitoring for warning signs - Interventions for unhealthy lifestyle/habits - Links to community resources to enhance patient education, self-management skills, or special facilities	**CARE PLAN SUGGESTIONS** - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (semi-annual) - Appropriate monitoring for warning signs - Interventions for unhealthy lifestyle/habits - Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** - Group visits - Home self-monitoring - Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings	**CARE PLAN SUGGESTIONS** - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (semi-annual) - Appropriate monitoring for warning signs - Interventions for unhealthy lifestyle/habits - Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** - Group visits - Home self-monitoring - Links to the medical neighborhood for care management, coordination of care, treatments, communication, and exchange of information with other providers and health care settings - Health coach - Referrals, as appropriate	**CARE PLAN SUGGESTIONS** - Preventive screenings and immunizations - Patient education and engagement - Health risk assessment (quarterly) - Appropriate monitoring for warning signs - Interventions for unhealthy lifestyle/habits - Links to community resources to enhance patient education, self-management skills, or special facilities **TEAM/PLANNED CARE** - Group visits - Home self-monitoring - Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings - Health coach/personalized care plan/management and resources - Referrals, as appropriate - Home health	**CARE PLAN SUGGESTIONS** - Hospitalization - Rehabilitation - Long-term care - Hospice/palliative care **TEAM/PLANNED CARE** - Support groups - Links to the medical neighborhood for coordination of care, treatments, communication, and exchange of information with other providers and health care settings - Health coach/care management - Referrals, as appropriate - Home health - Personalized intensive care plan/management and resources

McLaren

MEDICAL GROUP

MEDICAL PRACTICE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Was this your first visit here? ..... ○ Yes ○ No

2. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room? ☐☐☐ minutes

3. How many **minutes** did you wait in the exam room **before** you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife? ..... ☐☐☐ minutes

INSTRUCTIONS: Please rate the services you received from our practice. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of scheduling your appointment	○	○	○	○	○
2. Ease of contacting (e.g., email, phone, web portal) the clinic	○	○	○	○	○
3. Courtesy of staff in the registration area	○	○	○	○	○

Comments (describe good or bad experience): _____

MOVING THROUGH YOUR VISIT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Degree to which you were informed about any delays	○	○	○	○	○
2. Wait time at clinic (from arriving to leaving)	○	○	○	○	○

Comments (describe good or bad experience): _____

NURSE/ASSISTANT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the nurse/assistant listened to you	○	○	○	○	○

this section continued on next page...

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NURSE/ASSISTANT (...continued)

	very poor 1	poor 2	fair 3	good 4	very good 5
2. Concern the nurse/assistant showed for your problem	○	○	○	○	○

Comments (describe good or bad experience):_____

CARE PROVIDER

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Concern the care provider showed for your questions or worries	○	○	○	○	○
2. Explanations the care provider gave you about your problem or condition	○	○	○	○	○
3. Care provider's efforts to include you in decisions about your care	○	○	○	○	○
4. Care provider's discussion of any proposed treatment (options, risks, benefits, etc.)	○	○	○	○	○
5. Likelihood of your recommending this care provider to others	○	○	○	○	○

Comments (describe good or bad experience):_____

PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Our concern for your privacy	○	○	○	○	○
2. How well the staff protected your safety (by washing hands, wearing ID, etc.)	○	○	○	○	○

Comments (describe good or bad experience):_____

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for you	○	○	○	○	○
2. Likelihood of your recommending our practice to others	○	○	○	○	○

Comments (describe good or bad experience):_____

Patient's Name: (optional)_____

Telephone Number: (optional)_____

PRESS GANEY®

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MEMORANDUM

DATE: March 27, 2018

TO: All MMG Physicians, Physician Assistants, and Nurse Practitioners

FROM: Brad Ropp, MD, Chief Medical Officer

SUBJECT: Updated Best Practices in Controlled Substance Prescribing

The MMG Medical Directors Committee has completed a review of our Best Practices in Controlled Substance Prescribing and Documentation. The attached document outlines the recent updates to the Committee's recommendations. These recommendations are intended for use with controlled substance prescribing. They are evidence-based as well as in alignment with the State of Michigan Pain Management Guidelines and the CDC Guideline for Prescribing Opioids for Chronic Pain. It is the expectation that the Best Practices are followed.

Please note that the State of Michigan has instituted new law regarding controlled substance prescribing. There is a corporate compliance policy (MHC_CC0135 Controlled Substance Compliance) that addresses those laws. **This Best Practice also includes the State of Michigan requirements in bold print.**

This update packet includes:

- 2018 Best Practices in Controlled Substance Prescribing and Documentation
- For providers not yet registered for MAPS, registration is done online at: https://michigan.pmpaware.net/login. Click on **Create an Account** to complete registration.
- LARA MAPS Poster
- Form MM-21, Controlled Medicines Agreement
- Form MM-170, Parent Controlled Medicines Agreement
- CDC Guideline for Prescribing Opioids for Chronic Pain
- CDC Opioid Prescribing Guideline Mobile App
- CDC Why Guidelines for Primary Care Providers?
- CDC Calculating Total Daily Dose of Opioids for Safer Dosage
- CDC Assessing Benefits and Harms of Opioid Therapy
- CDC Non-opioid Treatments for Chronic Pain
- CDC Checklist for prescribing opioids for chronic pain
- Turn the Tide Prescribing Opioids for Chronic Pain
- Michigan Guidelines for the use of Controlled Substances for the treatment of Pain

McLaren MEDICAL GROUP

Recommended Best Practices – Use of Controlled Medicines

Recommendations	Action
Controlled Medicines Agreement	Initially signed by provider and patient. Reviewed annually and signed by any clinical staff member. A copy is provided to the patient. For pediatric patients, the parent/guardian should sign and this is also reviewed annually.
Frequency of Visit	Monthly x 3 months and then every 3 months to evaluate the need for continuation of drug.
MAPS	**State of Michigan law requires all providers who prescribe controlled substances to be registered for MAPS. Before a prescription exceeding a three-day supply is written, MAPS is reviewed. MAPS is not part of the permanent medical record.** If printed it is maintained in a secure, locked, and retrievable location (administrative file)
Documentation	a. **State of Michigan law requires for adult patients, before being prescribed an opioid, education must occur and both the patient and provider sign the DHHS form. For pediatric patients, before being prescribed an opioid, education is given and the parent/guardian and provider sign the Start Talking Consent form. If the pediatric patient has an authorized adult (not the parent/guardian) sign, then the provider cannot prescribe more than a 72-hour supply.** b. Documentation for all patients, includes a comprehensive assessment of the patient's physical condition, general medical condition, psychological history, psychiatric status, substance use and abuse history of the patient and family be obtained. Document medical necessity of initial prescribing and maintenance of all controlled substances. c. Each visit: assess pain level, functional level/score, document side effects aberrant substance-related behaviors, affect or mood and educate on driving under the influence. d. **State of Michigan law requires that a bona fide patient relationship must exist before a provider can prescribe any controlled substance to a patient. This means that the provider has reviewed relevant medical records, completed a full assessment of the patient's medical history and current medical condition, and the provider has created a medical record. The provider must ask the patient about other controlled substances the patient may be using and record the patient's response in the patient's medical record.** e. Routinely document the time the patient last took their controlled substance medication. The answer may warrant drug testing. f. **State of Michigan law requires any provider who treats a**
Laboratory-based compliance monitoring	UDS at discretion of provider for pediatric patients. For adults, initially and random based on red flags. Use serum testing to confirm any potentially false negatives. When ordering, use expanded panel test and indicate specific drug you are testing for on the request. Before UDS, ask the patient what drugs (legal & illicit) were used in the past week.

Recommendations	Action
	If you have a UDS that is negative for a prescribed controlled medicine, repeat patient testing and specify to the lab the drug you are testing for. Low risk every 1-2 years, medium risk every 6-12 months, high risk every 3-6 months. All drug testing is done before the prescription is written. With abnormal test results, discuss with patient before re-testing and/or discharge. This discussion should be documented in the medical record.
Prescription	**Providers treating a patient for acute pain shall not prescribe more than seven-day supply of an opioid in a seven-day period.** All medications are entered into the patient's Medication list. EMR prescriptions are printed on security paper. Prescription pads should be in the duplicate, numbered format. Prescriptions with refills should indicate "DO NOT REFILL PRIOR TO (DATE). Do NOT pre- date the prescription. Use caution when cross-covering another physician and asked to refill a controlled substance. It is recommended to not prescribe benzodiazepines and opioids together.
Consults	Consider Pain Management Consult for patients not meeting pain management goals, if a covered benefit. For low and medium risk patients, if an aberrant behavior is demonstrated, the recommendation is counseling to address the behavior. For a high-risk patient with an aberrant behavior, the recommendation is weaning. Patients with a hx of substance abuse or mental illness may need referral to pain, psych, or addiction specialist.
Non-Compliance	Periodic pill counting is recommended. Non-compliance or early re-fills should be reviewed with the patient and documented in the medical record. Physicians may choose to discharge a patient for non-compliance with the controlled medicines agreement under the Discharge Policy. Discuss with patient and document. Refer for counseling and/or wean off controlled substances. Red flags would include – early requests for refills, multiple reports of lost or stolen rxs, obtaining controlled medicines from multiple sources w/o provider's knowledge, intoxication/impairment, pressuring/threatening behaviors, presence of illicit/un-prescribed drugs in UDS, unsanctioned dose escalations, deteriorating function, and failure to comply with the tx plan.
Medical Marijuana	Marijuana is still illegal under federal law, even though there is a Michigan law for medical use. It is recommended to avoid prescribing any controlled substance while a patient is taking an illicit drug, including medical marijuana.

References:
American Society of Interventional Pain Physicians (2017). *Responsible, safe, and effective prescription of opioids for chronic non-cancer pain: American Society of Interventional Pain Physicians Guidelines.* Pain Physician, 20: S3-S92..
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Legislative Council, State of Michigan, (2010). *Public Health Code (Excerpt) Act 368 of 1978,* State of Michigan: Retrieved from www.legislature.mi.gov.
Michigan Bureau of Health Services. (2003). Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain.
Morbidity and Mortality Weekly Report. (2016, March 15). *CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016.* Retrieved from http://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1-ebook.pdf

Effective 4/5/2011; revised 3/5/2013, 5/6/14, 6/2/15, 4/20/2016, 2/14/2017, 3/22/2018.

MAPS

This facility utilizes the Michigan Automated Prescription System

In partnership with the state of Michigan

to assist in the prevention of prescription

drug abuse, diversion, overprescribing, and

overdispensing of controlled substances, and to

ensure the health and safety of our community.

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing – Michigan Automated Prescription System

LARA | michigan.gov/mimapsinfo

McLaren Medical Group

CONTROLLED MEDICINES AGREEMENT

The purpose of this Agreement is to prevent any misunderstandings about certain medicines that you will be taking. This is to assist both you and your doctor in complying with the law regarding controlled medicines.

TERMS OF THE AGREEMENT:

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my doctor will stop prescribing controlled medicines.

I understand that this agreement includes all controlled medicines scheduled II-V as categorized by the U.S. Federal regulations. This may include, but is not limited to, drugs referred to as Narcotics, ADD/ADHD Medications, Sleep Medications, Benzodiazepines, etc.

I will communicate fully with my doctor about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping to relieve the symptoms.

I will not use any illegal controlled substances, including marijuana, cocaine, etc., or prescription drugs not prescribed to me, and agree that I will submit to a random blood or urine test if requested by a provider to determine compliance with my program of controlled medication management.

I will not share, sell or trade my medicine with anyone.

I will not attempt to obtain any controlled substances, including opioid medicines, controlled stimulants, or anti-anxiety medicines, from any other doctor without coordination of care between doctors.

I will safeguard my medicine from loss or theft. I understand my doctor may not replace my lost, misplaced, or stolen medicines. If I have trouble with safeguarding my medicine, I understand my doctor will discuss this with me and may elect to remove me from drug therapy, if medically appropriate, or otherwise take additional control measures regarding my supply of controlled medicines. I agree to these additional controls, which I understand include limitations on my supply of controlled medicines.

I agree that refills of my prescriptions for controlled medicines will be made only at the time of an office visit or during regular office hours because an evaluation of my circumstance or condition must be made. No refills will be available outside of normal business hours.

I agree to use _____ Pharmacy, located at _____, for filling prescriptions for all of my controlled medicines.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medicine for a period of time.

I understand that I am required to see my healthcare provider in a face-to-face appointment at least _____ times per year.

I understand that any provisions not followed in this Agreement could be grounds for discharge from care.

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding these medicines have been adequately answered. A copy of this Agreement has been given to me.

All controlled substances carry the risk of addiction.

This Agreement is entered into on this _____ day of _____, _____. _____

Patient: _____ Provider: _____

Authorized Representative: _____ Relationship: _____

Witness: _____

PATIENT
NAME:

DATE OF BIRTH:

McLaren Ambulatory Care Center
PARENT CONTROLLED MEDICINES AGREEMENT

The purpose of this Agreement is to prevent any misunderstandings about certain medications that your child will be taking. This is to assist both you and your doctor in complying with the law regarding controlled medicines.

TERMS OF AGREEMENT:

I understand that my child's doctor is bound by certain state and federal laws when prescribing controlled medicines. While these laws seem inconvenient to me, I understand that they are ultimately intended to protect my child's safety, health, and privacy.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my child's doctor will stop prescribing controlled medicines for my child.

I understand that this agreement includes all controlled medicines scheduled II-V as categorized by the U.S. Federal regulations. This may include, but is not limited to, drugs referred to as Narcotics, ADD/ADHD Medications, Sleep Medications, Benzodiazepines, etc.

I will communicate with my child's doctor about the character and intensity of my child's symptoms, the effect of the symptoms on my child's daily life, and how well the medicine is helping to control the symptoms.

I will be vigilant in assuring that my child does not use any illegal controlled substances, including marijuana, cocaine, etc., or prescription drugs not prescribed to my child, and agree that my child may be tested for use of controlled substances at any time.

I will not use, share, sell, or trade my child's medication at any time.

I agree that I will administer the medication exactly as the doctor prescribed it and make no changes to the dose, nor discontinue the medication, without instruction from my child's doctor.

I will not attempt to obtain any controlled medications for my child from any other doctor without coordination of care between doctors.

I will safeguard my child's prescription and my child's medication from loss or theft. I understand that my child's doctor may not replace lost, misplaced, or stolen medicines. If I have trouble with safeguarding my child's medicine, I understand my doctor will discuss this with me and may elect to remove my child from therapy with controlled medicines.

I understand that refills of my child's medication will be made only at the times of office visits, or during regular office hours if I call 5 business days ahead of time with a refill request. I understand that after I have called for a refill request, I should call the office the day I plan to pick it up to be sure that the physician has had the opportunity to write the prescription. I understand that refills are NOT available after office hours, on weekends, or through an on-call physician.

I understand that I may be asked for photo ID when picking up my child's prescription. I understand that I may leave written permission for some other adult designee (over age 18) to pick up my child's prescription and that the designee may be asked to provide photo ID when picking up my child's prescription.

I understand that my child is required to see the healthcare provicer in a face-to-face apointment at least _ times each year.

I understand that any provisions not followed in this Agreement could be grounds for discharge from care.

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding these medicines have been adequately answered. A copy of this Agreement has been given to me.

This Agreement is entered into on this _ day of _ , .

Patient: _ Physician: _

Parent/Guardian: _ Relationship: _

Witness: _

Patient Name:

Date of Birth:

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

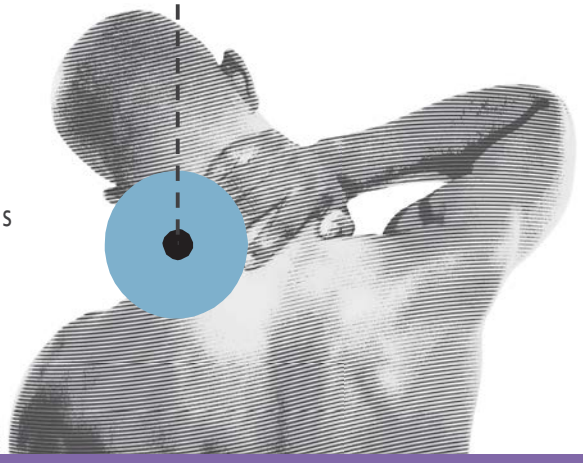
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



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LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

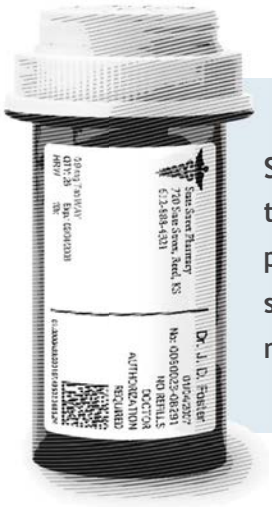
LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC OPIOID PRESCRIBING GUIDELINE MOBILE APP

Safer Opioid Prescribing at Your Fingertips

THE OPIOID GUIDE APP

Opioids can have serious risks and side effects, and CDC developed the CDC Guideline for Prescribing Opioids for Chronic Pain to encourage safer, more effective chronic pain management. CDC's new Opioid Guide App makes it easier to apply the recommendations into clinical practice by putting the entire guideline, tools, and resources in the palm of your hand.



Since 1999, the amount of prescription opioids sold in the U.S. has nearly quadrupled.

FEATURES INCLUDE:

MME Calculator

Patients prescribed higher opioid dosages are at higher risk of overdose death. Use the app to quickly calculate the total daily opioid dose (MME) to identify patients who may need closer monitoring, tapering, or other measures to reduce risk.

Prescribing Guidance

Access summaries of key recommendations or link to the full Guideline to make informed clinical decisions and protect your patients.

Motivational Interviwing (MI)

To provide safer, more effective pain management, talk to your patients about the risks and benefits of opioids and work together towards treatment goals. Use the interactive MI feature to practice effective communication skills and prescribe with confidence.

MANAGING CHRONIC PAIN IS COMPLEX, BUT ACCESSING PRESCRIBING GUIDANCE HAS NEVER BEEN EASIER.

Download the free Opioid Guide App today!

https://www.cdc.gov/drugoverdose/prescribing/app.html.

Available on the App Store

ANDROID APP ON Google play

This App, including the calculator, is not intended to replace clinical judgment. Always consider the individual clinical circumstances of each patient.

U.S. Department of Health and Human Services
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LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

providers
roximately
%
n opioids
sed

Nearly
2 million
Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chroni
- Primary care providers are concerned about patient addiction and rep insufficient training in prescribing opioids

MYTH VS TRUTH

ioids are effective long-term
atments for chronic pain

While evidence supports short-term effectiveness of opioids, there is insufficient evide opioids control chronic pain effectively over the long term, and there is evidence that o treatments can be effective with less harm.

ere is no unsafe dose of opioids as
g as opioids are titrated slowly

Daily opioid dosages close to or greater than 90 MME/day are associated with significa and lower dosages are safer.

e risk of addiction is minimal

Up to one quarter of patients receiving prescription opioids long term in a primary care struggles with addiction. Certain risk factors increase susceptibility to opioid-associat harms: history of overdose, history of substance use disorder, higher opioid dosages, o concurrent benzodiazepine use.

WHAT CAN PROVIDERS DO?

First, **do no harm**. Long-term opioid use has uncertain benefits but known, serious risks. CDC's ***Guideline for Prescribing Opioids for Chronic Pain*** wi support informed clinical decision making, improved communication betwe patients and providers, and appropriate prescribing.

PRACTICES AND ACTIONS

USE NONOPIOID TREATMENT

Opioids are not first-line or routine therapy for chronic pain *(Recommendation #1)*

In a systematic review, opioids did not differ from nonopioid medication in pain reduction, and nonopioid medications were better tolerated, with greater improvements in physical function.

START LOW AND GO SLOW

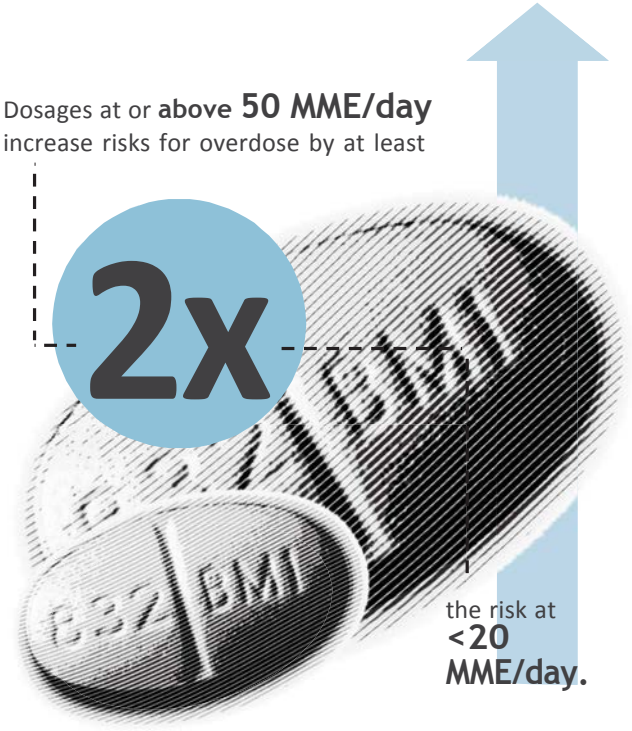
When opioids are started, prescribe lowest effective dose *(Recommend*

Studies show that high dosages (≥100 MM are associated with 2 to 9 times the risk o compared to <20 MME/day.

CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

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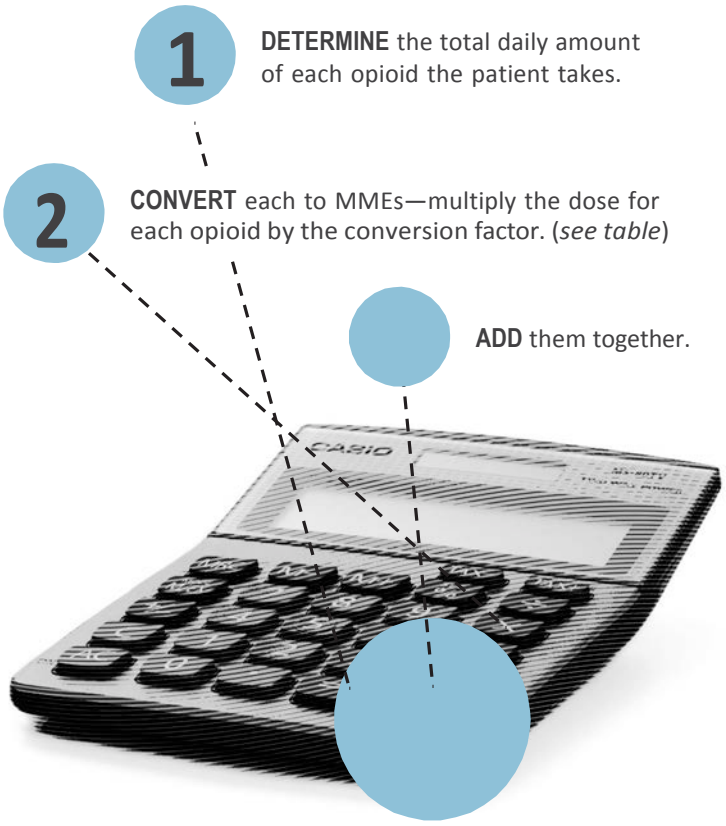
HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- **Methadone:** the conversion factor increases at higher doses
- **Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe t h
- Use extra precautions when increasing to ≥50 MME per day* such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.*

* These dosage thresholds are based on overdose risk when opioids are prescribed for pain and should not guide dosing of medication-assisted treatment for opioid use disorder.

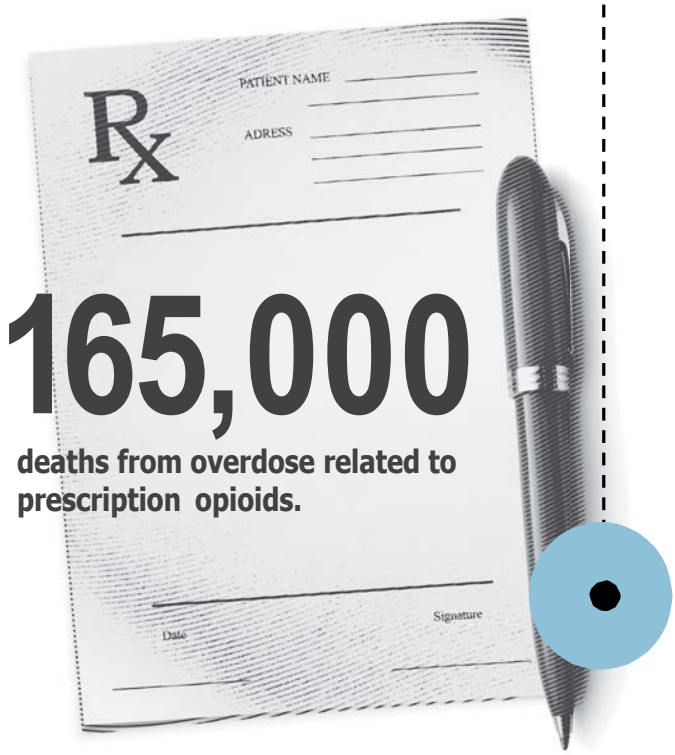
ASSESSING BENEFITS AND HARMS OF OPIOID THERAPY

THE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdose deaths, which killed more than 14,000 people in 2014 alone.

Since 1999, sales of prescription opioids—and related overdose deaths—have quadrupled.

Since 1999, there have been more than



165,000

deaths from overdose related to prescription opioids.

GUIDANCE FOR OPIOID PRESCRIBING

The *CDC Guideline for Prescribing Opioids for Chronic Pain*[1] provides up-to-date guidance on prescribing and weighing the risks and benefits of opioids.

- Before starting and periodically during opioid therapy, discuss the known risks and realistic benefits of opioids.
- Also discuss provider and patient responsibilities for managing therapy.
- Within 1-4 weeks of starting opioid therapy, and at least every 3 months, evaluate benefits and harms with the patient.

ASSESS BENEFITS OF OPIOID THERAPY

Assess your patient's pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and assess pain using validated instruments such as the 3-item (PEG) Assessment Scale:

1. **What number best describes your pain on average in the past week?** (from 0=no pain to 10=pain as bad as you can imagine)
2. **What number best describes how, during the past week, pain has interfered with your enjoyment of life?** (from 0=does not interfere to 10=completely interferes)
3. **What number best describes how, during the past week, pain has interfered with your general activity?** (from 0=does not interfere to 10=completely interferes)

If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids. Continue opioids only as a careful decision by you and your patient when improvements in both pain and function outweigh the harms.

[1]**Recommendations do not apply to pain management in the context of active cancer treatment, palliative care, and end-of-life care.**

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ASSESS HARMS OF OPIOID THERAPY

Long-term opioid therapy can cause harms ranging in severity from constipation and nausea to opioid use disorder and overdose death. Certain factors can increase these risks, and it is important to assess and follow-up regularly to reduce potential harms.

1 **ASSESS.** Evaluate for factors that could increase your patient's risk for harm from opioid therapy such as:

- Personal or family history of substance use disorder
- Anxiety or depression
- Pregnancy
- Age 65 or older
- COPD or other underlying respiratory conditions
- Renal or hepatic insufficiency

2 **CHECK.** Consider urine drug testing for other prescription or illicit drugs and check your state's prescription drug monitoring program (PDMP) for:

- Possible drug interactions (such as benzodiazepines)
- High opioid dosage (≥50 MME/day)
- Obtaining opioids from multiple providers

3 **DISCUSS.** Ask your patient about concerns and determine any harms they may be experiencing such as:

- Nausea or constipation
- Feeling sedated or confused
- Breathing interruptions during sleep
- Taking or craving more opioids than prescribed or difficulty controlling use

4 **OBSERVE.** Look for early warning signs for overdose risk such as:

- Confusion
- Sedation
- Slurred speech
- Abnormal gait

If harms outweigh any experienced benefits, work with your patient to reduce dose, or taper and discontinue opioids and optimize nonopioid approaches to pain management.

TAPERING AND DISCONTINUING OPIOID THERAPY

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:

1 Go Slow

To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).

2 Consult

Work with appropriate specialists as needed—especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.

3 Support

During the taper, ensure patients receive psychosocial support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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CS263451 April 27, 2016

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First-line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

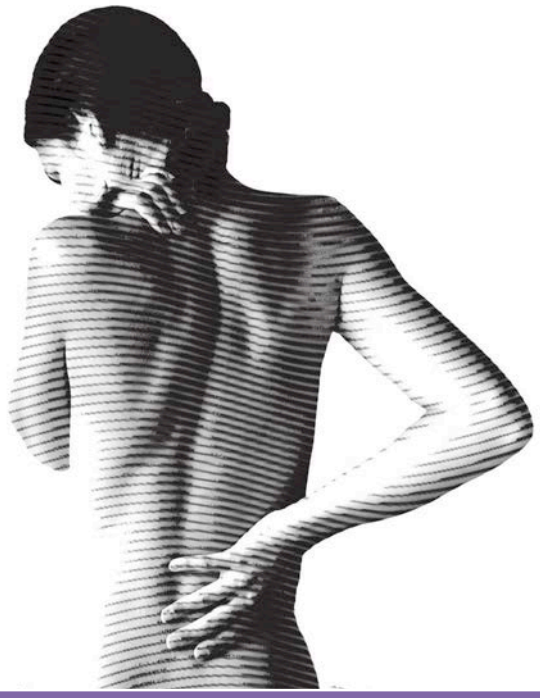
Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin



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Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confi clinically meaningful improvements in pain and function without signifi risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, diffi controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefi of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefi small to moderate for pain; inconsistent for function.*
- *Insuffi evidence for long-term benefi in low back pain, headache, and fi*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confi presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (**PDMP**): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0-10 best describes your **pain** in the past week?*
0 = "no pain", 10 = "worst you can imagine"

Q2: *What number from 0-10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0 = "not at all", 10 = "complete interference"

Q3: *What number from 0-10 describes how, during the past week, pain has interfered with your **general activity**?*
0 = "not at all", 10 = "complete interference"

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March 2016

TURN THE TIDE

PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = "no pain", 10 = "worst you can imagine")

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = "not at all", 10 = "complete interference")

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = "not at all", 10 = "complete interference")

2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calulator, go to TurnTheTideRx.org/treatment.

50 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

90 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:
www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: go.cms.gov/pecos
Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

JOIN THE MOVEMENT

of health care practitioners committed to ending the opioid crisis at TurnTheTideRx.org.

TURN THE TIDE

The Office of the Surgeon General

CDC

Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The Michigan Boards of Medicine and Osteopathic Medicine & Surgery recognize that principles of quality medical practice dictate that the people of the State of Michigan have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Boards' position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Boards recognize that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the *U.S. Agency for Health Care and Research Clinical Practice Guidelines* for a sound approach to the management of acute[1] and cancer-related pain[2]. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Boards are obligated under the laws of the State of Michigan to protect the public health and safety. The Boards recognize that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

1. Acute Pain Management Guideline Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. *Clinical Practice Guideline*. AHCPR Publication No. 92-0032. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. February 1992.

2. Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain. *Clinical Practice Guideline No. 9*. AHCPR Publication No. 94-0592. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. March 1994.

Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain will be evaluated on an individual basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs—including any improvement in functioning—and recognizing that some types of pain cannot be completely relieved.

The Boards will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Boards consider to be within the boundaries of professional practice.

Section II: Guidelines

The Boards have adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

   A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

   The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

   The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

   - o urine/serum medication levels screening when requested;
   - o number and frequency of all prescription refills; and
   - o reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. Periodic Review

   At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation

   The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. Medical Records

   The physician should keep accurate and complete records to include

   - o the medical history and physical examination;
   - o diagnostic, therapeutic and laboratory results;
   - o evaluations and consultations;
   - o treatment objectives;
   - o discussion of risks and benefits;
   - o treatments;
   - o medications (including date, type, dosage and quantity prescribed);
   - o instructions and agreements; and
   - o periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance With Controlled Substances Laws and Regulations

   To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction

Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Analgesic Tolerance

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic Pain

A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence

Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction

Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Substance Abuse

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

ASSESS HARMS OF OPIOID THERAPY

Long-term opioid therapy can cause harms ranging in severity from constipation and nausea to opioid use disorder and overdose death. Certain factors can increase these risks, and it is important to assess and follow-up regularly to reduce potential harms.

1 **ASSESS.** Evaluate for factors that could increase your patient's risk for harm from opioid therapy such as:

- Personal or family history of substance use disorder
- Anxiety or depression
- Pregnancy
- Age 65 or older
- COPD or other underlying respiratory conditions
- Renal or hepatic insufficiency

2 **CHECK.** Consider urine drug testing for other prescription or illicit drugs and check your state's prescription drug monitoring program (PDMP) for:

- Possible drug interactions (such as benzodiazepines)
- High opioid dosage (≥50 MME/day)
- Obtaining opioids from multiple providers

3 **DISCUSS.** Ask your patient about concerns and determine any harms they may be experiencing such as:

- Nausea or constipation
- Feeling sedated or confused
- Breathing interruptions during sleep
- Taking or craving more opioids than prescribed or difficulty controlling use

4 **OBSERVE.** Look for early warning signs for overdose risk such as:

- Confusion
- Sedation
- Slurred speech
- Abnormal gait

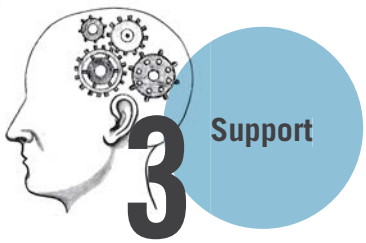
If harms outweigh any experienced benefits, work with your patient to reduce dose, or taper and discontinue opioids and optimize nonopioid approaches to pain management.

TAPERING AND DISCONTINUING OPIOID THERAPY

Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:

To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).

Work with appropriate specialists as needed—especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.



During the taper, ensure patients receive psychosocial support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

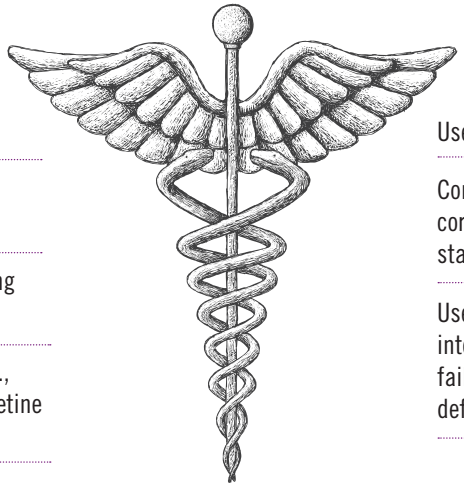
Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:



- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

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CS263451 April 27, 2016

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First-line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

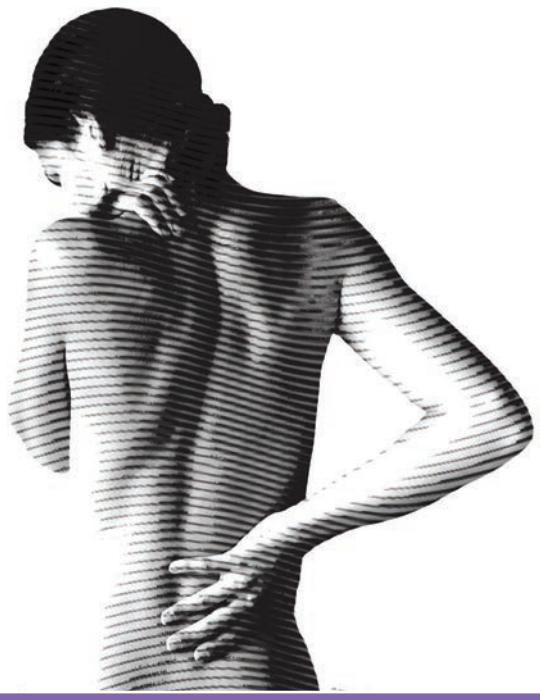
Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin



LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (**PDMP**): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TO LEARN MORE
WWW.CDC.GOV/DRUGOVERDOSE/PRESCRIBING/GUIDELINE

March 2016

TURN THE TIDE

PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = "no pain", 10 = "worst you can imagine")

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = "not at all", 10 = "complete interference")

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = "not at all", 10 = "complete interference")

2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calulator, go to TurnTheTideRx.org/treatment.

50 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

90 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:
www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: go.cms.gov/pecos
Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

JOIN THE MOVEMENT

of health care practitioners committed to ending the opioid crisis at TurnTheTideRx.org.

TURN THE TIDE

The Office of the Surgeon General

CDC

STANDARDS OF CONDUCT

Rev. October 2017 | A Guide to Ethics and Compliance

McLaren HEALTH CARE

Contents

McLaren HEALTH CARE

Mission Statement

McLaren Health Care, through its subsidiaries, will be the best value in healthcare as defined by quality outcomes and cost.

Corporate Compliance Statement of Purpose:

The Corporate Compliance Program of McLaren Health Care will provide guidance and evaluation of systems and processes to facilitate and promote ethical and legal conduct.

A Message from the President and CEO...

Dear McLaren Health Care Colleague:

Accepting the responsibility of providing health care to the communities we serve requires us to continuously evaluate how we can improve to best meet that important obligation. As a system, McLaren Health Care is committed to utilizing resources in a manner that will enhance the public's trust, confidence, and respect.

McLaren Health Care and its subsidiaries bring together distinct histories, cultures, and traditions. We draw the best from our historical foundations to preserve the highest ethical and legal standards. This is achieved through our individual and corporate commitment to excellence in service of our Mission, Visions, and Goals.

Our system culture is strengthened by an understanding of the principles that guide our behaviors. The following guidelines direct our actions and decisions as we represent our dynamic organization to the patients, physicians, employees, volunteers, members, and payers of our communities.

Philip Incarnati

President and Chief Executive Officer

McLaren Health Care

McLaren expects each of us:

1. to commit to excellence through continuously improving the quality of service delivered and to be responsive to patients, physicians, employees, and our communities;
2. to be system team members who think of patients first and have broad vision beyond our individually assigned areas of responsibility;
3. to work as a member of a team that builds a system of which we can be proud and of which people can depend on;
4. to be good listeners and to respect each other's point of view;
5. to work toward the accomplishment of the system's Mission and Goals, and to commit to system achievement and success;
6. to be advocates and representatives of McLaren Health Care to the public;
7. to address persons directly about issues of style or decisions that we feel are not consistent with organizational culture or with the system's Mission and Goals;
8. to honor the dignity and worth of each person with whom we work;
9. to build relationships within McLaren based on fairness, truthfulness, and trustworthiness;
10. to commit to providing quality health care with empathy and understanding.

McLaren HEALTH CARE

Mission Statement

McLaren Health Care, through its subsidiaries, will be the best value in healthcare as defined by quality outcomes and cost.

Our Values

T **TRUST** – Portrays confidence in and reliance on good qualities, especially fairness, truth, honor and ability.

E **EXCELLENCE** – Performs overall job responsibilities at a very high quality or standard.

A **ACCOUNTABILITY** – Is responsible for their own actions and ensures that others are held accountable for their actions, as appropriate.

M **MOTIVATION** – Displays a feeling of interest and enthusiasm in the work that is performed. Energizes and encourages other staff.

W **WELCOMING** – Expresses a friendly or courteous greeting to all medical staff, patients, visitors and staff.

O **ORGANIZATION** – Conducts work in a systematic and efficient manner. Works cooperatively with coworkers to conduct business.

R **RESPECT** – Shows consideration and appreciation to all medical staff, patients, visitors and staff. Maintains patient confidentiality and respects the right of patients.

K **KINDNESS** – Is considerate, and demonstrates a caring and compassionate attitude when interacting with others.

Purpose of our Standards of Conduct

Health care is a highly regulated business, and the laws and regulations that govern health care practices are numerous and complex. McLaren Health Care's (MHC) reputation for excellence, in both clinical practice and compliance with legal and accreditation requirements, is critical to maintaining the confidence of our patients and the public. **To this end, McLaren Health Care is committed to:**

- Ensuring that our employees, physicians, governing boards, volunteers, suppliers, and other contracted agents understand and take responsibility for compliance with all applicable laws and regulations;
- Avoiding conflicts of interest and conducting business with the highest degree of integrity and honesty; and
- Treating our customers with dignity and respect.

This document communicates MHC's standards of business ethics to all levels of MHC's workforce. These commitments apply to relationships with patients, physicians, contractors, vendors, third party payers, consultants, and each other. By upholding these Standards of Conduct, employees will preserve the integrity of individuals, the reputation of McLaren, and the trust and confidence of the public.

Governing Board

The Governing Boards are ultimately responsible for ensuring MHC has an active and effective Compliance Program. The Boards demonstrate support for the Compliance Program through commitment of financial resources to support the program, review of compliance activities, and annual evaluation of the Compliance Program's effectiveness.

Leadership

While all employees of MHC are responsible for adhering to the Standards of Conduct, leadership within the organization is expected to be the model for all employees. Leadership is charged with ensuring a culture that promotes high standards of ethics and compliance and with selecting future employees who embody these characteristics.

Leadership is responsible for:

- Assessing areas of responsibility to determine areas of high risk
- Maintaining current knowledge of laws that affect his/her areas of responsibility
- Implementing effective internal controls to provide reasonable assurance that processes comply with all applicable laws and regulations
- Ensuring that potential/real violations are reported and changes are implemented to prevent future violations
- Reporting compliance related activities to the Compliance Officer
- Supporting and ensuring employee participation in both annual and special topic compliance training relating to the laws and regulations within their roles
- Creating an ethical culture that allows employees to raise appropriate questions of potential violations of standards without fear of retaliation
- Annually completing the Attestation of Business Integrity and Conflict of Interest Disclosure forms
- Management is also responsible to assure employees leaving the organization have turned in all keys, identification badges, or any other items that may compromise company or patient security

Employees and Volunteers

Employees and volunteers are responsible for:

- Adhering to the requirements outlined in the Human Resources Policy and Procedure Manual and Standards of Conduct
- Knowing and following established policies and procedures, and laws related to compliance and their department
- Participating in compliance training
- Reporting concerns or suspected violations promptly to their supervisor, Compliance Officer or Compliance HOTLINE

Providers

Providers are responsible for:

- Knowing and complying with applicable laws and the policies and procedures of the organization
- Disclosing, as requested, any and all financial interests in and relationships with suppliers, including but not limited to pharmaceutical and medical device manufacturers, suppliers, hospitals, and other health care providers
- Annually completing the Provider Conflict of Interest Disclosure forms

Vendors and Contracted Agents

Vendors and contracted agents are responsible for:

- Complying with MHC's credentialing, certification and education requirements, policies and procedures, and applicable laws

Education provides a key component to an effective compliance program within MHC. The organization is committed to education at the time of hire, as well as

annually, and ongoing specific to the roles and situations required of its workforce, and in adherence to its policies and procedures. The contents of the Standards of Conduct may not address the complexity of issues encountered for every situation, but provide the framework of MHC's ethical culture and outlines behaviors expected of employees, providers, contractors, vendors, third party payers, and volunteers.

A Commitment to Providing Patient Care

McLaren Health Care strives to provide excellent results in every situation and expects its workforce to treat all patients and their family members with care, respect, and dignity. This commitment to excellence includes the physical, emotional, psychological, and spiritual care of each person. MHC's philosophy for successful patient care stems from vigorous dedication to evidence-based care, constantly evaluating outcomes, and building successful protocols around effective practices to ensure appropriate and necessary care.

The organization and its workforce are committed as a team to achieve quality and patient safety. McLaren Health Care has consistently been recognized locally and nationally for its quality outcomes. Our "Patient Safety Dashboard," measures system-wide quality outcomes and compares MHC hospitals to system and national best practice. MHC expects employee involvement in departmental initiatives for quality and safety to ensure continuous improvement in patient care. When a MHC employee questions if quality or safety concerns are being met, he or she is obligated to raise the concern through appropriate channels.

Patients will not be denied appropriate care on the basis of race, religion, color, culture, language, national origin, ethnic background, sex, sexual orientation, gender identity or expression, age, disability, marital status or source of payment. Upon admission, each patient will receive detailed Patient Rights and Responsibilities. It is the responsibility of each MHC workforce member to ensure patients know who is responsible for and providing their direct care. MHC will ensure that patients have the right to make informed decisions for the proposed course or choices of treatment based on information about their medical conditions provided by the appropriate individuals, and presented in a manner that the patient can easily understand. Patients are entitled to refuse treatment to the extent provided by law and to be informed of the consequences of that refusal. In addition, patients are entitled to receive information about designating another person to make decisions about their medical care (Advance Directive) in the event they are not capable of making decisions on their own. Patients may formulate advance directives, and the medical staff will comply with the provisions of the directives within the guidelines of the law and medical ethics.

McLaren Health Care and its workforce are also committed to monitoring services and assuring the most customer-friendly services are provided. **The workforce is expected to create a proper atmosphere for patients and visitors through:**

- Attention to both facility and personal appearance
- Individual professionalism – being responsible for your actions and taking pride in your work
- Effective communication – using plain language, making eye contact, using proper phone etiquette, smiling and greeting patients and family members
- Exceeding the expectations of patients, patient family members, and co-workers

Patients will receive information upon admission on how to raise any concerns about their care directly to the organization or a regulating body. In the event a patient or family member express concern about the care received at one of the MHC facilities, workforce members are individually responsible to address the issue or refer it to the appropriate person within the organization.

A Commitment to Our Community

McLaren Health Care is committed to improving the quality of life in every community it serves. MHC and its employees are involved in numerous community activities such as outreach and education programs, community foundations, health screenings, support

groups, transportation services, food and blood drives, scholarship programs, and career mentoring. It is the responsibility of each employee, physician, and volunteer to consider their role in improving the health status of the community at large.

Under the oversight of the Internal Revenue Service, McLaren Health Care operates as a 501(c) (3) tax-exempt organization, providing millions of dollars in charity or reduced fee care and community benefit each year. Employees are required to understand charity care policies and procedures within their work areas, enabling effective assistance to patients and accurate recognition of this expense.

Acting as a representative of MHC, employees will not participate or intervene in any political campaign on behalf of (or in opposition to) any candidate for public office. Examples of participation include publishing or distributing statements, or contributing money, property, or the services of any employee at the expense of MHC. Any attempt to influence the decision making process of a government representative by an improper offer of any benefit is absolutely prohibited, and any request by a government representative for any improper benefit should be reported. Where MHC's understanding may assist in governmental issues, it may publicly offer recommendations or positions concerning legislation or regulations being considered which impact the operations of the organization. Employees may personally participate in political processes using their own time and financial resources, but may not represent their personal point of view as that of the corporation.

A Commitment to Environmental Health and Safety

A variety of organizations guide our requirements to maintain a safe environment for our patients and staff. Some of these organizations include: Occupational Safety and Health Administration (OSHA), National Fire Protection Agency (NFPA), Food and Drug Administration (FDA), Centers for Disease Control (CDC), and the Department of Transportation (DOT). Keeping the workplace clean and safe helps everyone. It is essential everyone knows and understands the safety laws, regulations, and MHC policies pertaining to their roles. To ensure current knowledge on safety issues and regulations, employees are required to complete yearly education sessions and some departments may have additional requirements based on job duties. It is each employee's responsibility to complete this education. **Although the list is not exhaustive of all potential situations and responsibilities, employees are required to:**

- Follow all employee health guidelines
- Adhere to standard precautions, sterile environments, and environmental controls to reduce the risk of disease transmission
- Properly report infections
- Maintain refrigeration at required temperatures
- Wear safety equipment when using machines or personal protective equipment as required
- Follow manufacturers' equipment handling guidelines
- Adhere to proper handling of hazardous waste and alert leadership and appropriate departments of improper handling or disposal of waste
- Know their respective departmental role for emergency preparedness to protect our community

McLaren Health Care is committed to the safety and security of all employees and visitors. Maintaining a safe and secure environment requires cooperation and communication between workforce members and management. Intimidating and disruptive behaviors whether overt or passive may jeopardize patient care and other work, and will not be tolerated. Examples of unacceptable behavior include: verbal outbursts and physical threats; refusing to perform assigned tasks, answer questions, or return phone calls or pages; and condescending language or voice intonation.

Workforce members will:

- Wear appropriately displayed name badges at all times and be familiar with others that work in their areas
- Report suspicious persons or situations immediately
- Remain calm, listen, and diffuse verbally hostile situations

Only authorized individuals should have access to controlled substances, prescription drugs, and other medical supplies. These substances are provided under the order of a physician and must always be administered by the appropriate individual in accordance with organizational policies and procedures. If you become aware of inappropriate use or other violation related to drugs or supplies, you are to report the occurrence immediately.

A Commitment to Proper Employment Practices

McLaren Health Care is a federal contractor and thus takes reasonable precautions to ensure the work environment is free of discrimination or harassment in compliance with federal and state laws. All employees and staff are to be treated fairly, without regard to race, age, color, sex, religion, national origin, height, weight, marital status, or disability. This applies to all employment decisions, including but not limited to hiring, promotion, transfer, discipline, layoff, termination, compensation, and terms and conditions of employment.

Each person has the right to work in an atmosphere free from discriminatory practices and unlawful harassment. Any employee who believes he/she has been a

subject of discrimination or harassment, or any employee who witnesses such conduct, should immediately report it to management or Human Resources.

To ensure the highest level of patient care and to provide for the safety and welfare of patients, visitors, and employees, the workplace must be free of the health and safety hazards caused by inappropriate use or abuse of alcohol or drugs. Individuals who observe a colleague appearing to be impaired in the performance of his or her job must immediately consult with management or Human Resources.

MHC and its subsidiaries will not knowingly hire or employ any individual who is excluded from participating as a provider in a federal health care program. Consistent with this policy, MHC will conduct background checks of prospective employees and will screen all prospective employees and physicians who seek clinical privileges. Workforce members associated with MHC are individually responsible to maintain credentials, licenses, and certifications necessary to perform their job functions.

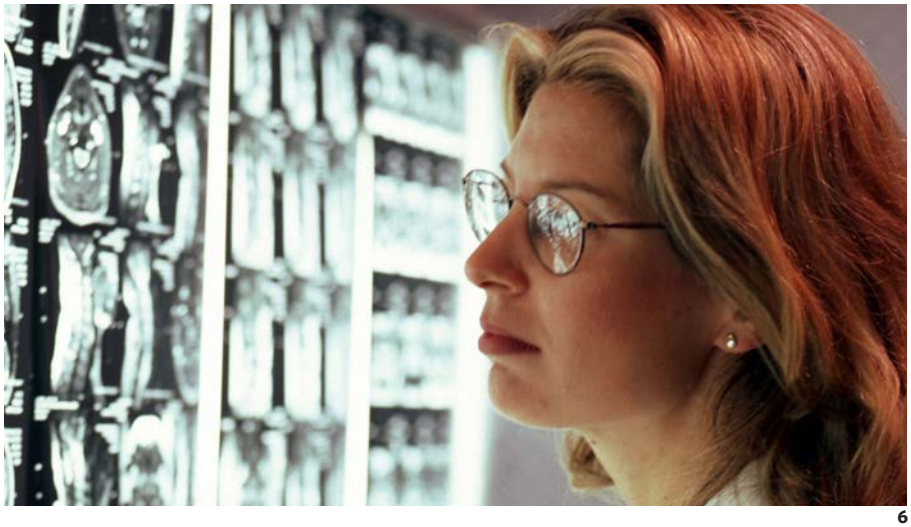
A Commitment to Ethical Business Conduct

To maintain public trust, employees are expected to act in MHC's best interest and conduct all activities on behalf of McLaren in good faith, being careful to avoid the appearance of a conflict of interest. **A conflict of interest can exist in any instance where an individual's actions or activities on behalf of the organization result in personal gain. Specifically:**

- Employees may not solicit or accept anything of more than de minimus value, including a loan, reward, material or property, from a patient or a patient's family, visitor, contractor, supplier or competitor. Accepting cash or a cash equivalent, like a gift certificate, is strictly forbidden. However, it is recognized that situations sometimes arise where refusal of a small token of appreciation from a patient, such as candy or cookies, would be awkward and embarrassing. In these situations, acceptance of such small items is permissible. Employees should direct patients or family members wanting to make donations or provide gifts to MHC's local health care foundation.
- MHC employees who sit on boards of directors or advisory boards of outside organizations must disclose this information to MHC. In addition, they may not be involved in decisions that impact the outside organization and MHC. The use of official position and influence to further personal gain or that of family members or associates is considered to be unacceptable behavior.
- Employees may not use their employment, or any information received through MHC, to obtain financial gain (direct or indirect) for themselves, a member of their family or a business with which they or a member of their family, is associated.
- Outside employment or business activities must be limited to off-work time. During work hours, employees are expected to devote their best and full time efforts to job responsibilities.
- Employees will report to their subsidiary Human Resources executive any situation that may be considered a conflict of interest that arises during their employment with MHC or any of its subsidiaries. The Human Resources executive will consult with the subsidiary compliance officer and department director and will respond to the employee who discloses a potential conflict. Failure to abide by the foregoing provisions may result in discipline up to and including termination.

Managing conflicts of interest is essential to ensuring integrity in business decisions and maintaining public trust. Members of the governing boards, leadership, contracted providers (physicians and allied health), and other designated individuals are required to complete a Business Integrity Attestation and a Conflict of Interest Disclosure on an annual basis (refer to Policies MHC_CC0109, MHC_CC0137 and MHC_GB0001).

In order to protect the safety of our patients, minimize work interruptions, and ensure subsidiaries conduct business with the highest ethical standards, MHC requires vendors to adhere to a certification process and complete the necessary education (refer to Policy MHC_SC0110). Vendors include companies that provide medical devices, supplies, pharmaceuticals, services, and equipment. Admittance to any MHC subsidiary is a privilege and not a right, requiring appropriate appointments and identification by the vendor. All workforce members are responsible for assuring vendors comply with the policy. Failure to comply should be reported to the Compliance



Officer or Supply Chain Management. Repeated and flagrant violations can result in indefinite suspension of privileges for the individual vendor and its representatives.

Staff and physicians may not share pricing information, internal reports, communications, procedure schedules, volumes or pricing unless approved by Supply Chain Management. Supplier-sponsored entertainment activities and gifts may not be accepted under circumstances that could have the effect of influencing business decisions that are not in the best interest of the organization. If a correlation is found between a supplier-sponsored event or gift and an unsound business decision on the part of an employee, the employee will be subject to discipline, up to and including termination.

A Commitment to MHC Assets and Financial Transactions

Employees must report and record all information honestly, completely, and accurately. Resources, including equipment, supplies, and paid work time, belong to MHC and should be protected from theft and waste. **MHC employees, physicians, volunteers, and contractors must remain committed to protecting assets, including but not limited to:**

- Appropriately representing productivity
- Accurately recording travel expenses and mileage
- Securing money, equipment, or supplies from theft
- Complying with business expense reimbursement policies
- Purchasing goods and services for organizational use only

MHC expects honest, accurate, and complete reporting of financial transactions, including information provided to third party payers, cost reports, IRS forms, and financial statements. Internal and external controls are maintained to provide assurance that transactions are completed in accordance with management's authorization and in accordance to applicable rules and guidelines. Federal and State laws require the submission of operating cost and statistical reports, and these reports are subjected to internal and external review.

A Commitment to Accurate Coding and Billing Transactions

Providers and employees must make certain that codes submitted for billing transactions accurately reflect the patient's diagnoses and services provided. Employees, physicians, and subcontractors will follow applicable laws, policies and procedures to ensure accurate coding, billing, and collection activities to governmental payers, commercial insurances, and patients. When billing questions and issues arise, employees will resolve matters in a professional and courteous manner. **Employees, physicians, and contractors must remain committed to accurate business practices, including:**

- Providing and billing only for services that were reasonable and necessary
- Billing for services at levels that are supported by medical record documentation
- Waiving of co-pays or deductibles only in accordance with policy and procedure
- Bundling or unbundling charges appropriately
- Attempting to collect outstanding balances from a Medicare or Medicaid patients only when Advance Beneficiary Notices were provided prior to service
- Preventing duplicate billing
- Ensuring the accuracy of diagnostic and procedure codes

Any subcontractors engaged to perform coding and billing functions are expected to have the necessary competencies, processes and systems to ensure accurate, timely, and complete billing. These organizations are required to have their own compliance programs and codes of conduct, or to adopt those of MHC.

A Commitment to Physician Relations

For physicians who practice in our facilities or use the services of McLaren Health Care, the organization is committed to providing an excellent work environment focused on high quality, innovative facilities, and equipment. The organization will maintain positive working relationships and respect the legal rights of physicians. MHC provides a uniformly-applied privileging process that is fair, prompt and reasonable, without discrimination on the basis of race, color, national origin, sex, marital status, religion, and age or other protected category as defined by law. In addition, MHC demonstrates its pledge to the medical community through its teaching facilities and practices to assist in advancing the field of medicine.

Federal and State laws and regulations govern relationships between physicians and health care organizations. Two of these laws in particular are the Anti-Kickback and Stark statutes. An overview of these laws is provided in the section entitled, "Our Commitment to Laws and Regulations." All agreements involving payments or other forms of compensation from MHC or one of its subsidiaries to physicians (employed or non-employed) are required to be in writing and approved through the Contract Review Authorization and Management Process (refer to Policy MHC_CC 0139). **The contract review process provides an assurance that:**

- Contracts and agreements meet documentation requirements
- Compensation for services provided is consistent with fair market value
- Leased property and equipment are clearly identified and payment is

consistent with fair market value
- Community need is documented, when applicable

- Joint venture relationships and payments are established
- Contracts are authorized by appropriate individuals

MHC will adhere to laws and regulations pertaining to providing special treatment, money, favors, gifts, services, or anything of value in exchange for referrals. Inappropriate solicitation of favors of gifts should be reported to the Compliance Department. Physicians who work with MHC may not accept payments or gifts in exchange for referrals.

A Commitment to Confidentiality and Electronic Security

Patient Information

The Health Insurance Portability and Accountability Act (HIPAA) established requirements for the handling, processing, and storage of a patient's health information. These regulations, governed by the Office of Civil Rights, do not replace existing confidentiality policies but further support and strengthen the commitment to keep patient information secure. The Privacy and Security Rules affect every health care worker, volunteer, and physician no matter where they work in the health care delivery system. Patients provide us with sensitive protected health information (PHI) on a constant basis so MHC employees can appropriately care for them. PHI refers to any information, whether oral or recorded in any form, that is created or received by a health care provider and relates to a past, present or future medical condition or payment for services of an individual. The Privacy Rules give guidance on how, when and with whom PHI can be shared. The Security Rules give us guidance on administrative, physical, and technical safeguards for protecting PHI when storing or communicating electronically. **It is the responsibility of every employee, physician, volunteer, and contractor or vendor to adhere to regulations, policies/procedures, and patient rights for privacy including:**

- Right to confidential communication of PHI
- Right to receive a notice of uses/disclosures of PHI
- Right to access or receive a copy of their medical records
- Right to request a restriction to how PHI is used
- Right to request changes (amendments) to their records
- Right to receive a listing (accounting of disclosures) if requested, of PHI disclosures during the prior six-year period

MHC workforce members may use or disclose PHI for treatment, payment, and operations or as required by law, but must abide by the "need to know" and "minimum necessary" standards outlined in the Privacy Rule. Release of PHI for other reasons requires patient authorization or a court order.

All MHC subsidiaries provide initial (new hire) and ongoing training on privacy and security policy and procedures. Each subsidiary has designated an individual (HIPAA Privacy/Security Officer) to oversee compliance with HIPAA policies and regulations. Suspected or actual violations should be reported to the HIPPA Privacy or Security Officer or to the Compliance Hotline.

Business Information

Workforce members may be exposed to many types of confidential business information including information related to strategies, financial information, trade secrets, and other commercially sensitive information. Many of the same safeguards used to protect confidential patient information should be used to protect our business and financial information. All work product of the employee, including but not limited to ideas, refinements, alterations of equipment, procedures, technology, and all records and files concerning the MHC's operations, belong to and remain the property of MHC or its subsidiaries. Work product, records or files, should not be removed from MHC's premises except in the ordinary course of performance of service. All work products, records, and files shall remain with MHC upon termination of the employee. Trade secrets and proprietary or confidential information may not be disclosed to other organizations that are in direct competition with MHC or any of its subsidiaries. Electronic media (i.e. phone, email, voice mail, text messages, internet access, etc.) used to facilitate business operations remains the property of MHC, and MHC maintains the right to monitor and retrieve all communications as necessary.

Retention and Destruction of Documents and Electronic Media

Laws and regulations specify how long many business and clinical records must be retained, and in some cases how they must be destroyed. These retention periods and/or MHC's requirements are compiled in the Record Retention Schedule (MHC_CC0110 Appendix 7.1). Each department is responsible for ensuring that records are retained and destroyed in accordance with the Retention Schedule and the Record

Retention and Destruction Policy (MHC_CC0110). Paper and electronic media (e.g., disks, CDs, USB flash drives keys, etc.) containing PHI or other confidential business information should be placed into one of the locked shredding bins or sent to the authorized contractor for destruction.

A Commitment to Laws and Regulations

The laws surrounding health care are numerous and complex. The following does not intend to cover all applicable laws related to the services provided by McLaren Health Care, but provides an overview of a few key laws that can impact our business. MHC expects all workforce members to be familiar with laws applicable to their specific roles.

The Anti-Kickback Statute

The Anti-Kickback Statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward the referral of business reimbursable under any federal health care program. The types of remuneration prohibited, without limitation, include kickbacks, bribes, and rebates, whether made directly or indirectly, overtly or covertly, in cash or in kind. Prohibited conduct includes not only the payment of remuneration intended to induce or reward referrals of patients, but also the payment of remuneration intended to induce or reward the purchasing, leasing, or ordering of, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item reimbursable by any federal health care program. The Anti-Kickback Statute is violated even if inducing or rewarding the referral of business is only one of several reasons for the remuneration. That is, the referral of business does not need to be the sole reason for the remuneration to violate the Anti-Kickback Statute.

The Anti-Kickback Statute and its implementing regulations provide for certain "safe harbors," which give guidelines about arrangements that avoid a violation. While an arrangement need not meet all of the parameters of a safe harbor, the further an arrangement strays from the parameters, the more likely the arrangement is to violate the Statute.

Anti-Kickback violations are classified as felonies and are punishable by fines of up to $25,000 and/or imprisonment for up to five years. Additional penalties include exclusion from federally funded programs, other financial liabilities under the False Claims Act or civil monetary penalties.

Stark Laws (Physician Self-Referral Law)

Stark Laws prohibit a physician from making referrals for Designated Health Services payable by Medicare or Medicaid to an entity with which the physician (or an immediate family member) has a financial relationship, unless a specific exception applies. Stark also prohibits the entity from submitting claims to Medicare or billing the beneficiary or third party payer for such referred services, unless an exception applies. Under Stark, a "financial relationship," which gives rise to a Stark violation includes both direct and indirect ownership and investment interests and compensation arrangements.

Stark regulations provide exceptions that describe arrangements not defined as "financial relationships." Unlike the Anti-Kickback Safe Harbors, under Stark an arrangement must precisely meet all of the requirements of an exception or the arrangement is deemed a "financial relationship" that can give rise to a violation.

The Federal Stark Laws also outline non-monetary compensation and incidental benefits (allowed while physicians are on campus). Employees providing these benefits or physicians of MHC will ensure:

- Non-monetary compensation will not exceed limits established annually by the Centers for Medicare and Medicaid Services (CMS)."
- Incidental on-campus benefits are limited to $33 per source
- Compensation may not be determined in any manner that takes into account the volume or value of the referrals or other business generated by the physician
- Compensation may not be solicited by the physician or the physician's practice (including employees and staff members)
- Non-monetary compensation arrangements do not violate the Anti-Kickback Statute or any Federal or State Law or regulation governing billing or claims submission

Non-monetary Compensation for Referral Sources (MHC-CC0107) provides detailed guidance to employees on providing and tracking non-monetary compensation and other courtesies.

Violations of the Stark Laws can result in denial and refund of payments, civil monetary penalties up to $15,000 per referral, a $100,000 fine for circumvention, and exclusion from federally funded programs. The regulations under both Stark and the Anti-Kickback Statute state that a violation of one of these statutes creates a violation of the other statute. The Stark exceptions and the Anti-Kickback safe harbors are not precisely identical, so it could be possible to violate the terms of one of the statutes without violating the terms of the other statute and still be held in violation of both. Violation of Stark or the Anti-Kickback Statute also implicates the False Claims Act, 31 U.S.C. §3729-33 and subjects parties to civil monetary penalties, which are potentially three times the amount of the initial claims involved.

Federal False Claims Act

The primary function of the False Claims Act (FCA) is to prevent an entity or individual from submitting a false or fraudulent claim to the United States Government. Claims to Medicare and Medicaid for payment make up the majority of health care claims paid by the U.S. Government. **This law defines a false claim to the U.S. Government as follows:**

- Knowingly presenting a false or fraudulent claim for payment or approval
- Knowingly making or using a false record or statement to get a false or fraudulent claim paid or approved
- Conspiring with another to get a false or fraudulent claim paid or approved
- Knowingly making or using a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property

There is no requirement that there be intent to defraud. The requirement of doing something in a knowing manner is met by showing either (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.

False claims may take on a variety of forms, including:

- Classic False Claim: Billing for services not provided, billing for unnecessary services, upcoding, and double billing, including non-reimbursable items on a submitted cost report
- Standard of Care False Claim: Knowingly submitting a claim for provider services which fall below the quality of care standard (CMS treats these as if care was never provided)
- Tainted False Claim: FCA liability resulting from violation of another law (i.e. Stark, Anti-Kickback)

Violations of the Federal FCA can result in civil monetary penalties of not less than $10,700 and not more than $21,500 per claim (subject to inflationary increases), plus three times the amount of damages that the government sustains. Under a second regulation addressing health care fraud (Chapter 38 of Title 31 of the United States Code), the Department of Health and Human Services may impose on a person who submits certain claims to the government of the United States additional monetary penalties, plus twice the amount of the false claim.

A private person ("Qui Tam Relator") may bring a civil action for any false claim (itemized above) in the name of the US Government. The federal government gets an opportunity to review the complaint and the disclosure of all the material evidence and information the person possesses to decide whether to intervene. If the federal government decides to intervene, then it has the primary responsibility for prosecuting the action for the false claims, and the person who originally brought the action (the Qui Tam Relator), may receive a portion of the proceeds of the action or settlement of the claim.

State False Claims Act

Michigan's Medicaid False Claims Act establishes liability for the submission of false or fraudulent claims to the State's Medicaid program. The Act imposes prison terms of up to four (4) years and fines of up to $50,000 for:

- Knowingly making a false statement or false representation of a material fact in any application for Medicaid benefits or for use in determining rights to a Medicaid benefit
- Soliciting, offering or receiving kickbacks or bribes for referrals to another for Medicaid-funded services (fine up to $30,000)
- Entering into an agreement with another to defraud Medicaid through a false claim
- Making or presenting to the State of Michigan a false claim for payment

Similar to the Federal FCA, any person (Qui Tam Relator) may bring a civil action on behalf of the State of Michigan to recover losses that the State suffered from a person violating the Michigan Medicaid False Claims Act, and the Michigan Attorney General is to be notified and has an opportunity to appear and intervene in the action brought on behalf of the State of Michigan.

Both the federal and state laws protect individuals who investigate or report possible false claims made by their employer against discharge or employment discrimination because of such investigation. Whistleblowers who experience these types of retaliation may sue in court for damages. MHC's Non-retaliation policy (MHC_CC 0114) protects from retaliatory actions, individuals who report in good faith a suspected or known violation.

EMTALA (Emergency Medical Treatment and Active Labor Act)

MHC hospitals must comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) (Section 1867 of the Social Security Act; 42 USC 1395dd. EMTALA requires a hospital with an emergency department to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits a hospital with an emergency department from refusing to examine or treat individuals with emergency medical conditions regardless of their ability to pay. A hospital must provide necessary stabilizing treatment within its capacity and provide an appropriate transfer as necessary and according to the standards. The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. McLaren Health Care hospitals will follow and ensure enforcement of the regulations and expects all workforce members involved in

emergent care to understand the law and their responsibilities.

A Commitment to Ongoing Monitoring

McLaren Health Care is committed to ensuring the effectiveness of its compliance program and Standards of Conduct. One monitoring mechanism includes voluntary or mandatory surveys from regulatory agencies. Some examples of these agencies include The Joint Commission, Centers for Disease Control (CDC), and the Food and Drug Administration (FDA). In addition, various federal, state or local agencies may request information for investigative purposes. These agencies may include the Department of Justice (DOJ), Office of the Inspector General (OIG), Office of Civil Rights (OCR), Center for Medicare and Medicaid Services (CMS), and Federal or State Attorneys General (AG), as well as local courts and law enforcement agencies. Information or documents may be requested by letter, telephone call, or scheduled or unannounced visit by the investigating agent(s). For mailed and telephone requests, promptly and prior to releasing any information, notify the Compliance Officer for assistance in determining the purpose of the request and expediting the response. If an investigating agent appears for an unannounced visit, MHC staff is expected to obtain the individual's name, credentials, and purpose of visit, then immediately contact their supervisor and the Compliance Officer and follow the procedures outlined in the Responding to Government Official Visits – Search Warrant Policy (MHC_CC0104).

A second commitment to ongoing monitoring includes program evaluation through independent internal and external audits. The use of audits evaluates internal controls and promotes adherence to applicable laws and regulations. These audits are completed as part of the annual plan or risk assessment, ongoing financial business processes or by identified need. Audit/review follow-up is an integral part of good management and an effective compliance program, and it is a shared responsibility of management, auditors/reviewers, and all applicable department members. MHC has a variety of policies pertaining to auditing and monitoring for employees to follow, and specifically include: Auditing/Monitoring (MHC_CC0105) and Audit, Investigation, Response, Follow-up and Resolution (MHC_CC0108).

All workforce members are expected to work with regulatory agencies and internal/external auditors in a direct, open, and honest manner and without actions taken that could mislead. Documents must never be concealed, damaged or altered. In addition, all MHC employees are expected to take an active role in their departments' actions to assure the prompt and proper resolution and implementation of audit or review recommendations.

A Commitment to Responsible and Ethical Conduct of Research

McLaren Health Care Corporation is committed to the goal of conducting research responsibly and ethically. Further, McLaren Health Care is committed to conducting research in full compliance with all applicable federal and state laws, regulations and guidelines, as well as our own policies and procedures.

All members of the McLaren Health Care Corporation community engaged in research are expected to conduct their research with integrity and intellectual honesty at all times and with appropriate regard for human subjects. To protect the rights of human subjects, all research involving human subjects is to be reviewed by appropriate scientific review committees and designated institutional review board(s). Additionally, McLaren Health Care expects all investigators who conduct research activities at any McLaren Health Care facility to comply with all applicable McLaren Research policies and procedures.

McLaren Health Care Corporation prohibits research misconduct. Members of the McLaren community engaged in research are not to: fabricate data or results; change or knowingly omit data or results to misrepresent results in the research record; or intentionally misappropriate the ideas, writings, research, or findings of others. All those engaged in research are expected to pursue the advancement of knowledge while meeting the highest standards of honesty, accuracy, and objectivity. They are also expected to demonstrate accountability for sponsors' funds and to comply with specific terms and conditions of contracts and grants.

Research compliance is essential to protect the health and safety of research subjects, ensure the scientific integrity of the research, ensure research billing compliance and safeguard funds provided from all sources that support research activities.

Compliance Program and Resources

To assist management in communicating and implementing the Standards of Conduct, McLaren Health Care Corporation maintains a Corporate Compliance Program. The Board of Trustees of each subsidiary and the Board of Directors of McLaren Health Care are committed to maintaining an organizational culture that encourages ethical behavior as well as the prevention, detection, and resolution of instances of conduct that do not conform to the laws, standards, and payer requirements of the health care industry.

The MHC compliance program and each subsidiary compliance program were developed in collaboration and articulate the Corporation's dedication to operating in a manner that demonstrates integrity, ethical standards and compliance with the federal, state, and local laws that govern operations. The Board is ultimately responsible for ensuring that McLaren Health Care has an active and effective compliance program. The Board also has final authority and responsibility for actions taken on identified issues, concerns, and recommendations.

The Compliance Officer is responsible for the day-to-day oversight and operation of the compliance program. The Compliance Officer has the authority to review all documents and other information that are relevant to compliance activities. He/she may also investigate the contracts and arrangements McLaren Health Care has with other parties.

The MHC Corporate Compliance Committee oversees the implementation of the compliance programs and collaborates on compliance initiatives, including the review of policies and procedures and annual compliance plans and reports. In addition, the Committee oversees audits and reviews the effectiveness of the compliance program. **MHC Compliance Departments accomplish this purpose through several tools including:**

- Standards of Conduct
- Annual Business Integrity Attestations and Conflict of Interest Disclosures for leadership, providers, and governing boards
- Assignment of Compliance Officer and teams at each MHC subsidiary
- A Compliance Hotline for reporting of actual or suspected violations without fear of retaliation
- Development of compliance policies and procedures which provide standardization of operational activities
- New hire and annual education programs, newsletters, and regulatory updates for all workforce members, as well as specialized education for leadership and employees in high risk positions
- Internal and external auditing and monitoring programs with action plans when applicable
- Organizational enforcement of compliance related issues
- Screening mechanisms for assurance of qualified employees, vendors, and contractor relationships
- Annually developed compliance plans addressing areas of focus within specific departments or divisions
- Quarterly compliance reports to MHC and at least semiannual reports to subsidiary boards

Compliance Reporting

As a MHC employee, if you become aware of any situation that could lead you or others to engage in actions that could result or have resulted in a compliance violation, you should consult your immediate supervisor. If the problem involves your supervisor, or if you do not feel comfortable talking to your supervisor, contact the Compliance Officer. As a responsible employee, you have an obligation to identify and report any internal problems to the appropriate people so that they may be corrected. You are responsible to report identified issues to your subsidiary Compliance Officer (consult the subsidiary telephone directory for the number) or you may contact the MHC Compliance Office at 1-866-MHC-COMPLY. You will be asked to leave a voice mail message explaining the situation. You may leave your message anonymously, or you may leave your name and a contact number for the Compliance Officer to reach you. All reports will be investigated, and it may be necessary to contact you for additional information to complete the investigation. Anything you report to the Compliance Officer is strictly confidential and will not result in retaliation of any kind.

MHC COMPLIANCE TOLL FREE HOTLINE:

1-866-MHC-COMPLY

(1-866-642-2667)

REPORTING A COMPLIANCE VIOLATION IN GOOD FAITH WILL NOT RESULT IN RETALIATION!

Final Points to Remember

The contents of the Standards of Conduct may not anticipate every situation encountered by employees, physicians, volunteers, contractors or vendors. While written policies are in place in a number of significant areas to assist employees in fulfilling their responsibilities, the purpose of this booklet is to address some of the more common business ethics issues employees might experience at McLaren Health Care. MHC workforce members are responsible to be aware of policies and procedures pertaining to their work areas and should consult with their leadership, the compliance department or human resources on areas of uncertainty.

Any employee who violates the McLaren Health Care Standards of Conduct, compliance laws, regulations, policies or procedures is subject to human resources policies governing disciplinary action, which can include oral or written reprimand, suspension, or termination of employment. Prohibited actions may also violate criminal laws, resulting in personal criminal prosecution and, upon conviction, fines and imprisonment.

Board members, medical staff members, employees, volunteers, vendors, and contractors are required to sign an acknowledgement confirming that they have received, and are required to comply with the purpose and provisions of McLaren Health Care Standards of Conduct. The Standards of Conduct are also posted on all MHC websites.

Ethical behavior depends on self-discipline and maintaining respect for yourself, your customers, your co-workers, and your working environment. Upholding these standards of conduct will preserve the integrity of individuals, the reputation of our system, and the trust and confidence of the public, allowing us to accomplish our purpose, "To improve the quality of life in every community we service."

McLaren HEALTH CARE

Organization Copy

Sign and send to
HR or Compliance.

(9/17)

Standards of Conduct Acknowledgement

I have received and read the Standards of Conduct adopted by McLaren Health Care and its subsidiary organizations. I understand that they represent policies of McLaren Health Care.

If I have a concern about a known or suspected violation, I understand that I am to report the concern to my supervisor or the Compliance Officer. I understand that I can report this information anonymously and cannot be retaliated against for making any kind of report under this program.

I will fully cooperate with members of the compliance team during any investigative process. If I have questions concerning the Standards of Conduct, I understand that I may consult my supervisor or the Compliance Officer.

Signature _____ Printed Name _____

Department/Company (if applicable) _____ Date _____

Badge Number (if applicable) _____

TAB 2

Keystone's turnkey approach to providing benefit solutions in this niche market is the difference. Between Keystone and its partner organizations, all of the market-leading resources are in one place.

Every benefit plan Keystone designs is supported with our turnkey approach and methodologies. With Keystone, it is not necessary for employers to navigate between their plan consultants, product providers, and plan administrators. Keystone provides our clients with a one-stop resource for all services that are needed for plan and participant success. Our services include:

- **Comprehensive Enrollment Processes** - Group and individual meetings can be arranged as needed with expert, licensed personnel who are knowledgeable about your organization's basic, voluntary, and supplemental benefit programs.
- **Development of Web-based Enrollment Interface** - We pride ourselves in arranging solutions that fit with your existing systems. These solutions are designed to reflect your organization, not ours or our technology partners.
- **Benefit Plan Administration Services** - Non-qualified supplemental benefit plans have unique support needs. We partner with your organization to determine the appropriate level of support for your organization.

Our dedicated and knowledgeable client service team has the expertise to keep your plan operating efficiently. When you choose Keystone Benefit Group as your partner in delivering supplemental benefits to your physicians, you are choosing the industry leader in experience and innovation.

Keystone Benefit Group

4353 Tilly Mill Road • Suite 125
Atlanta, GA 30360
(404) 907-1882
www.KeystoneBenefit.com

MCLAREN CAPITAL ACCUMULATION PROGRAM (MCAP)

A Capital Accumulation Plan for Healthcare Professionals

McLaren

Finding an acceptable tax-effective method to create capital accumulation that allows voluntary contributions by healthcare professionals is a very challenging exercise for potential plan sponsors and participants.

Healthcare professionals in today's challenging environment have had to face many obstacles to maintaining their practice and adapting to the current healthcare and Medicare environment. Many of these professionals have opted in recent years to become employees of tax-exempt healthcare organizations in order to accomplish certain objectives which have become increasingly difficult in today's marketplace while remaining in a private practice. The opportunity to transition to or become part of a healthcare system-based practice has solved many issues, but professionals who have become employees of tax-exempt healthcare organizations now experience a challenge that they did not prepare for. Limited to only basic healthcare system retirement savings plans, healthcare professionals are unable to accumulate on a pre-tax basis sufficient post-employment capital in order to accomplish post-employment goals and objectives for them and their families.

This challenge is caused by the very restrictive tax rules that govern deferred compensation plans sponsored by tax-exempt organizations, including hospitals and healthcare systems. These limitations require the physician to be completely unvested in plan benefits to avoid taxation, whether the contributions are made by the organization or the physician. Ultimately, the accumulated plan benefit must be taxed on a lump sum basis when they become vested, not when they receive benefit payments. Keystone Benefit Group has created a benefit solution that avoids these seemingly impossible provisions and provides a capital accumulation platform that has the flexibility and performance to assist the physician with accumulating the significant tax-advantaged savings needed to achieve their own financial security.

The MCAP can be used by employed physicians as an extremely tax-effective capital accumulation vehicle, providing them with opportunities similar to what their peers have in private practice.

Tax and retirement planning are two of the most important financial considerations for physicians. For physicians that are employees of healthcare organizations, the standard employer-provided retirement plans will not allow for adequate contributions or savings for the future. Qualified deferral plans and Section 457(b) plans are terrific programs, but they have modest limits on how much income can be set aside on a pre-tax basis.

The MCAP concept allows physicians and executives to fill the needed gap by offering a plan that, structured properly, allows unlimited amounts to be contributed on a voluntary basis. Contributions to the plan are flexible and can be contributed on monthly, quarterly or annual basis.

While the plan design of the MCAP provides a unique framework that maximizes the benefits received, Keystone provides an array of attractive investment choices and products in connection with the MCAP that appeal to all levels of investment experience and risk tolerance. From the most simplified insurance and annuity products to more complex financial securities, Keystone and the MCAP make your dream of a secure financial future a reality.

Imagine the ability to create your own financial security while gaining the benefits of working within a stable healthcare practice environment. With the MCAP, you create your own road map towards financial success.

Our ability to provide creative, customized benefit solutions is our trademark.

Known industry-wide for our technical competence and creativity, our clients expect customized solutions for their benefit needs and we deliver. From the most traditional benefit arrangements to those proprietary solutions that define our organization, we are able to exceed client expectations by consistently delivering results that exceed expectations. Our staff is comprised of talented professionals with legal, actuarial, and financial services experience that is unmatched in the marketplace.

We assist non-profits and their higher compensated executive and physician employees with tax planning strategies that provide the needed tools to retain, reward, and recruit the highest level talent.

Our proprietary solutions and concepts allow the higher-compensated employee or health professional to achieve their tax planning and financial goals by implementing supplemental capital accumulation programs that allow the individual to create ultimate financial security.

The unique plan design of the MCAP combines the favorable features of qualified and non-qualified benefit plans while eliminating their disadvantages.

McLaren Capital Accumulation Program (MCAP) is a third generation supplemental capital accumulation program that complies with all applicable Treasury regulations and IRS tax guidance and, in a conservative design and concept, provides healthcare professionals with the ability to contribute on a voluntary basis towards their post-employment benefits. Designed to be a supplement to existing qualified benefit plans and the limited non-qualified plans, the MCAP avoids the restrictive and unattractive aspects of traditional non-qualified benefit plans sponsored by tax-exempt organizations. This plan delivers flexibility and value like no other program or concept.

The superior tax and other quantitative and qualitative advantages of the MCAP provide the employer, executive, and physician with the ultimate solutions to their capital accumulation benefit challenges. With a variety of investment and product choices, the flexibility of the MCAP overcomes the typical limitations of other programs and is effective for employees at all stages of their careers, regardless of age, duration of employment, or proximity to termination of employment.

KEY FEATURES AND BENEFITS:

- **VOLUNTARY CONTRIBUTIONS**
- **NO LEGISLATIVE LIMIT ON ANNUAL CONTRIBUTIONS**
- **SUPERIOR TAX-FAVORED BENEFITS**
- **IMMEDIATELY VESTED BENEFITS**
- **PLAN BENEFITS SECURE FROM EMPLOYER CREDITORS**
- **VARIETY OF INVESTMENT CHOICES AND PRODUCTS**
- **FINANCIALLY NEUTRAL ON EMPLOYER FINANCIAL STATEMENTS**

Keystone has designed a proprietary, non-qualified concept that avoids the limitations that plague traditional arrangements.

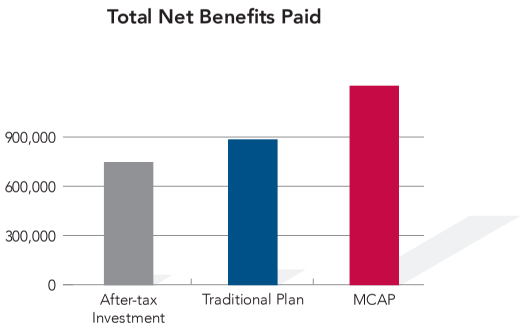


Chart results above based on the following assumptions: Participant, age 50, contribution of $50,000 per year for 10 years accumulated for 15 years with benefits payable annually for 20 years beginning at age 65. Assumed investment rate of 6% for indexed products and alternatives, assumed federal and state combined ordinary income tax rate of 42.5%, assumed tax rate on after tax investment earnings of 30%. All benefits illustrated are expressed after all plan administrative costs, taxes, expenses, and fees.

The IRS recently went so far as to essentially eliminate all "traditional" deferred compensation plans sponsored by tax-exempt organizations when used as a pre-tax deferral plan (for compensation purposes, this is still shown in the chart as an alternative). In related guidance, the plan design of the MCAP was recently confirmed as being generally exempt from these restrictive rules and limitations that apply to deferred compensation plans. Accordingly, the MCAP provides a benefit that is, on average, 40% to 100% higher with respect to net benefits received by participants through after-tax investment or alternative plans. Moreover, all benefits can be fully vested from the inception of the plan without taxation and are totally secure from employer creditors as well. Certain financial products are required to be utilized in order to be exempt from the IRS rules relating to deferred compensation plans. Accordingly, specialized annuity and life insurance products can be utilized under the MCAP, providing the maximum tax advantages to the participant with the most efficient financial results possible.

The IRS and Treasury have provided tax guidance in recent years that further restricts traditional methods of providing deferred compensation. Related guidance has confirmed that the MCAP is generally not subject to these rules.

McLaren Capital Accumulation Program (MCAP)

Representative Contact Information

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Lyons Kitzrow Capital Group
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mitch@lyonskitzrow.com

A guide for using PeopleSoft (PS) for reimbursement

- **Dates** - enter the date the expense was incurred - not the current date you are creating the request.
    - Requests for reimbursement should be submitted on a monthly basis.
- **Mileage** – should be entered on a monthly basis. Submissions older than six (6) months may not be reimbursed. The Expense Description for mileage must indicate the "From ___ and To ___" location. Indicate roundtrip if applicable. All mileage on same date should be entered on the same line. Provide purpose of the trip.
    - You can submit mileage individually listing each trip/date traveled as a separate Expense Line item, or
    - One line stating a total number of miles traveled monthly, or periodically, with all miles listed on one line.
        - If total miles are how the expense line reads, a detailed list of each trip must be included as an attachment (i.e. old paper form; a calendar copy with locations and miles indicated; an excel spreadsheet; or other detailed listing).
- **Attachments** - Detailed receipts are required for all purchases. Attachments can be added individually, or all as one scan. Credit card signature/summary slips must also include the associated itemized receipt. Make sure receipt amounts and scanned copies match the amount of the request. Do not attach paperwork for items not listed in the Expense Line Items.
    - If receipt includes other items not claimed, identify the items applicable to the provider requesting reimbursement.
- **Hotels** – attach the hotel folio – the check-out sheet showing room fees, taxes, other room charges and/or fees, listed individually by day. Separate out any parking fees or other reimbursable costs (i.e. room service, food purchases) and enter on line item separate from hotel costs.
    - Room service, restaurant costs, must be accompanied by an itemized receipt – alcohol cannot be reimbursed.
    - Reimbursement cannot be made from a credit card statement or reservation confirmation. Itemized breakdown is required.
    - If reservation is made through an internet site, such as Expedia, Orbitz, etc., and hotel cannot provide an itemized receipt, a printed receipt from site is acceptable.
- **Conferences** – McLaren Travel & Expense Policy SCM-107 provides comprehensive directions
    - Pre-approval is required. A "Conference Request" form must be submitted and approved prior to attendance and must be attached to the PeopleSoft Reimbursement report. In addition, the Travel Authorization component in PeopleSoft should be completed to estimate costs and link to the reimbursement movement.
    - Reimbursement can only be processed when proof of attendance is provided, not at the time the registration and/or travel arrangements are made.
    - All costs for reimbursement should be included in the same expense report. Something showing conference name, dates and location is required. *(Note: At this time, information entered into the Travel Authorization does not show on the reimbursement request, therefore requiring the information to be provided again.)*

- **Meals** - Business Meals vs. Physician Meals
    - **Cost** – McLaren limits reimbursement to $70 per day (including taxes & tips)
    - **Identify items** – if multiple items are listed on the receipt, items for the provider must be identified
    - **Tips** are reimbursable up to 20% of the meal cost, for the provider only, before tax
    - **Business Meals** – use for all business-related meal reimbursements, including when physician is requesting reimbursement for meals paid for themselves, i.e. CME, travel etc., and for meals purchased during the regular work day if outside home office service area. If requesting reimbursement for meal/food provided at a meeting, include a list of persons attending and name/location of meeting
    - **Physician Meals** – this designation is generally never used. It is when you or someone else (not physician) is requesting reimbursement for a meal purchased for a physician. In this case, the employee is being reimbursed but the physician has essentially received something for free. This requires compliance review and approval.
- **Cell Phone costs**
    - Cell phone reimbursement is processed through corporate policy MHC_IT0002, *(attached)* you cannot simply provide receipts for payment. A stipend of either $40 or $85 per month can be requested by following the policy and submitting the required forms for approval. *(rms are attached.)* Payment will not be paid retroactively and is paid directly through payroll.

The following are items that are **not** acceptable to submit for reimbursement**.**

- Alcohol
- Office lunches, birthday celebrations/cakes, office dinners, etc., which have not been pre-approved by Senior Leadership. (*Approval must be included with the reimbursement request.)*
- Gift cards of any kind
- Bereavement, birthday or celebratory flowers, plants or arrangements.
    - *As an individual, or as a department, you can take up a collection to send such items, but MMG will not reimburse for them.*
- Employee appreciation gifts. i.e.: candy, plants, smoothies, pizza, etc.
- Bottled water
- Tangible assets
    - Cell phones, iPads, lab coats, stethoscopes, laptops, - items that belong to the provider

McLAREN
HEALTH CARE
FLINT, MICHIGAN

CONFERENCE REQUEST

Date: _____

TO:

FROM:

SUBJECT: **REQUEST FOR PERMISSION TO ATTEND THE FOLLOWING CONFERENCE**

1. Name of Conference _____
2. Date _____
3. Place _____
4. Name and Department of Person(s) to attend _____

   _____

   _____
5. Estimated Cost -

   All Travel Arrangements, including air and ground transportation and hotel accommodations, must be made through Conlin Travel. Employees making their own arrangements or using other agencies will not be reimbursed. Please consult the McLaren Travel Policy for more details.

   Transportation _____

   Registration _____

   Hotel _____

   Meals _____

   Miscellaneous _____

   TOTAL _____
6. Remarks _____

   _____

APPROVED BY: _____ DATE: _____

(Department Director to Approve Staff)
(Vice President to Approve Department Director)

Upon approval this form should be sent to Accounting at least 14 days prior to conference.

M-142 Rev. (6/02)

McLaren HEALTH CARE		Policy Title:	Mobile Device Network Access and Reimbursement
Effective Date:	April 1, 2015	**Policy Number:**	MHC_IT0002
Review Date:		**Section:**	Information Technology
Revised Date:		**Oversight Level:**	Corporate
Administrative Responsibility:	Chief Information Officer		

1. **Purpose**

1.1. McLaren Health Care Corporation ("MHC") recognizes that the performance of certain job responsibilities may require the use of a Mobile Device (see definition below). MHC will either provide MHC managed Mobile Devices or Reimbursement to qualified Workforce Members for Mobile Device use.

2. **Scope**

2.1. McLaren Health Care Corporation ("MHC"), its subsidiaries, any other entity or organization in which MHC or an MHC subsidiary owns a direct or indirect equity interest of 50% or more, provided that organization has agreed to adopt MHC policies; and MHC's workforce members.

2.2. Mobile Devices. The provisions of this policy apply when the "Users" access or store Confidential/Proprietary Information or Email on Mobile Devices that are MHC-provided, MHC-subsidized, or personally owned.

2.3. This policy applies immediately to all new requests for Mobile Devices and email or network access for Mobile Devices. Individuals with company provided Mobile Devices on current contracts will be offered the option to convert to personally owned Mobile Devices with stipend at the conclusion of their contract period.

3. **Definitions**

3.1. **IT Services** means Anthelio Healthcare Solutions, Inc., or other information technology partners serving McLaren Health Care Corporation and its subsidiaries.

3.2. **Mobile Device or Device** means a mobile device which is personally owned, or provided or subsidized by MHC, and allowed to access MHC IT systems. Device's covered under this policy include:

3.2.1. **Smartphone** - A mobile phone which includes features such as internet connection, WiFi, e-mail access, applications and a web browser. The MHC IT Services will support email synchronization on Apple iOS and Android devices only.

3.2.2. **Standard Wireless Phone** - a mobile phone that does not include internet

access, WiFi or email access.

3.2.3. **Tablet** - Mobile Devices usually consisting of a large (6"+) touch screen, internet connectivity and other smart features. This does not include Tablet PCs, running full versions of desktop operating systems, or laptops which can be converted to a tablet mode.

3.2.4. **Mobile Hot-spot** - A Device that creates a local WiFi network using the carrier's wireless telephone network.

3.3. **Policy** means this Mobile Device Network Access and Reimbursement policy, including all attachments.

3.4. **Reimbursement** means a fixed rate monthly allowance, designated to offset costs associated with use of a personally owned Mobile Device for MHC business.

3.5. **Supported Devices** means MHC's IT Services will only support email synchronization on Mobile Devices with designated versions of Apple iOS and Android operating systems, to ensure the Device can support MHC's security requirements.

3.6. **Workforce Member or "User"** for purposes of this policy generally means an employee, but may in some instances refer to a contracted provider who meets work condition criteria and need for a Mobile Device.

4. Policy

4.1. **Eligibility Requirements** include frequent need for a Mobile Device for work-related purposes. Qualified Users may receive a MHC provided Mobile Device or Reimbursement, in the form of a monthly allowance, to cover business-related costs associated with use of a personally purchased/leased Device.

4.1.1. Smartphone. A User is eligible for a MHC provided Smartphone or allowance for a personal Device if at least one of the following criteria is met:

4.1.1.1. The job function of the User requires considerable time outside of his/her assigned office or work area and it is important to MHC that he/she is accessible during those times (EXAMPLE: User who travels frequently between facilities or is regularly away from the office in meetings and must be accessible);

4.1.1.2. The job function of the User requires him/her to be accessible outside of scheduled or normal working hours (EXAMPLE: User or provider required to be "on call" during or after work hours. Limited availability required - on call periodically; High level - continuous availability required.);

4.1.1.3. The job function of the User requires him/her to have wireless data and internet access (EXAMPLE: User needs email or network access to promptly respond when out of the office); and/or

4.1.1.4. The User is designated as a "first responder" to emergencies on campus.

4.1.2. Tablets and/or mobile hot-spots. Personally owned/leased Devices may be provided network access, but do NOT qualify for Reimbursement. In addition to the above phone requirements, the individual must demonstrate that the specific Device type and/or functionality of the tablet (e.g. larger screen) or mobile computing Device (e.g. connectivity while commuting) is crucial to that User's ability to perform the needed service or job function.

4.1.3. Laptops. Personal laptops do NOT qualify for Reimbursement.

4.1.4. MHC provided Devices. Smart Phones, tablets and hot spots provided by MHC require approval of the department Director (or Vice President), the subsidiary CFO and the Corporate CIO. A list of options for MHC provided Devices will be maintained by IT Services.

4.1.4.1. MHC provided Devices may be approved for certain individuals and services when remote access to the network is required to provide services, e.g., home care nurses.

4.2. **Mobile Device Request Form (Appendix 7.1)**

4.2.1. MHC's Mobile Device Request Form will be used to:

4.2.1.1. Request MHC email and calendar, and network access for personally owned Mobile Devices, and

4.2.1.2. Request purchase, replacement or upgrade of a MHC provided Mobile Device.

4.3. **Reimbursement**

4.3.1. Requests. Users meeting the eligibility requirements outlined above may request Reimbursement using the Mobile Device Reimbursement Request Form (Appendix 7.2). Reimbursement requests may be submitted any time during the fiscal year.

4.3.2. Oversight, Approval, & Funding. Mobile Device Reimbursement Request Form will be submitted to the appropriate Department Director, CFO and Corporate CIO for approval. Approved forms will be forwarded to Payroll.

4.3.2.1. Department Directors are responsible for:

4.3.2.1.1. Identifying Users who meet the eligibility requirements for business use of a Mobile Device;

4.3.2.1.2. Annually reviewing the need for Reimbursement to determine if existing Reimbursement should be continued as-is, changed, or discontinued.

4.3.2.2. Each request will be evaluated to determine whether a Mobile Device is necessary or a less costly alternative means of communication could be used, e.g., landlines, pagers, and mobile radios.

4.3.2.3. Reimbursements are funded by the department submitting the request.

4.3.3. Method of Payment.

4.3.3.1. Employed Users. The Reimbursement amount will be added to the employee's regular pay. In accordance with guidance in IRS Notices 2011-72 and 2011-93, this reimbursement will not be taxed.

4.3.3.1.1. The Reimbursement does not constitute an increase to base pay, and will not be included in the calculation of percentage increases to base pay due to annual raises, job upgrades, bonuses, benefits based on a percentage of salary, etc.

4.3.3.1.2. The Reimbursement will be paid as a fixed rate distributed pro-rata over 24 pay periods. MHC will pay only the agreed upon amount, even if monthly costs exceed that amount.

4.3.3.2. Contractors. Reimbursement for independent contractors who meet work condition criteria and demonstrate they maintain appropriate wireless phone services will be paid monthly through Accounts Payable.

4.3.3.2.1. Contract agreement must specify work condition requiring Mobile Device use, and amount to be paid (not to exceed the Reimbursement levels established in this policy). Mobile Device Reimbursement must be calculated into Fair Market Value of compensation.

4.3.4. Reimbursement Amount. The Reimbursement amounts will be determined on an annual basis by the Chief Information Officer taking into consideration the average cost of service for MHC provided Mobile Phones. MHC will not provide Reimbursement for more than one Device per person, and **Reimbursement must not exceed costs of the personal plan**.

4.3.4.1. Two Reimbursement levels will be established.

4.3.4.1.1. A lower rate (e.g., $40) will apply to Users with Standard Wireless Phones, limited plans, or who have less frequent work related use (EXAMPLE: Provider who is on call periodically, not 24/7).

4.3.4.1.2. A higher rate (e.g., $85) to off-set costs of Smartphones with data services, and/or extensive use requirements (EXAMPLE: Continuous availability required.)

4.3.4.2. The Reimbursement rates will be evaluated, and if appropriate, adjusted annually to align with current market rates.

4.3.4.3. The Reimbursement allowance is neither permanent nor guaranteed. MHC reserves the right to remove a User from this plan and/or cancel the plan if there is insufficient budget to meet the plan costs.

4.4. **User Rights & Responsibilities for Personally Owned Devices.**

4.4.1. Device Selection, Service Contracts and Payments. The User is responsible for purchasing a Mobile Device and establishing a service contract with the provider of his/her choice. The contract is in the name of the User, who is solely responsible for all payments to the service provider. The User purchases service and equipment; determines plan choices, service levels, calling areas, service and features; and accepts termination clauses and payment terms.

4.4.2. Device Use. The User owns/leases the Mobile Device and may use the

phone for both business and personal purposes, as needed.

4.4.2.1. Extra services or equipment features may be added at the User's own expense. If there are problems with service, the User is expected to work directly with the carrier for resolution. Support from MHC's IT Services is limited to connecting a personally-owned Mobile Device to designated MHC networks and applications, including email, calendar, contacts and required security applications.

4.4.3. Verifying Service Plans and Use. A User receiving Reimbursement must be able to show, if requested by his/her supervisor, a copy of the monthly access plan charges and business related use to ensure the amount of MHC compensation is appropriate.

4.4.4. Terminating Service Plans. If the User terminates the wireless contract at any point, he/she must notify his/her supervisor within 5 business days to terminate the Reimbursement.

4.5. **Liability.** MHC does not accept any liability for claims, charges or disputes between the service provider and the User. Use of the Mobile Device in any manner contrary to local, state, or federal laws will constitute misuse, and will result in immediate termination of the Reimbursement.

4.6. **MHC Policies and Security Requirements.** Devices covered by this policy are used in part to conduct MHC business and/or to create, receive, send, or store MHC data. As a result, information contained on Devices covered by this policy are also subject to Federal and State data maintenance and protection laws as well as all MHC policies, including those pertaining to data security, acceptable computing use, and email.

4.6.1. Compliance with Laws. A User provided network access or receiving Reimbursement from MHC must comply with Federal, State, and MHC requirements, and assist MHC in providing access to information about or contained on the Device covered by this policy in response to requests for such data or information by third parties as required by Federal and/or State law.

4.6.2. Mobile Device Security. Any Mobile Device that has data capabilities must be secured in accordance with current MHC security standards including use of MHC's Mobile Device Management software, password or PIN protection and encryption.

4.6.2.1. If a Device with data capabilities is stolen or missing, it must be reported to the User's supervisor, the IT Service Desk, and the wireless Device service provider as soon as possible.

4.6.2.2. Users with a MHC provided Mobile Device or requesting network access for their Device will sign the User Agreement section of the Mobile Device Request Form including but not limited to the following provisions:

4.6.2.2.1. Agree to follow MHC security policies, including if required, Device encryption.

4.6.2.2.2. Allow MHC to wipe all MHC data from the Device when their employment with MHC is severed, except when required to maintain that data in

compliance with litigation hold notices.

4.6.2.2.3. Allow MHC to wipe all MHC data from the Device before servicing, upgrading or selling the Device.

4.6.2.3. If a User does not download and activate Airwatch within seven (7) calendar days, network and email access will be disabled by IT.

4.7. **Other Reimbursement for Business Calls.** If User's job duties do not meet the business related use criteria, the User is not eligible for Reimbursement. Such individuals may request reimbursement for the actual extra expenses of business use on their phone. Reimbursement for per-minute "air time" charges for voice service is limited to the total overage charge shown on the invoice; expenses for minutes included in the plan will not be reimbursed. Similarly, reimbursement for data overages applies to the total overages shown on the invoice for that section. The User should make personal payment to the provider, and then should submit a request for reimbursement. Reimbursement documentation should identify the business purpose.

4.8. **Cancellation of Reimbursement.** It is the Director's responsibility to immediately notify payroll to cancel Reimbursement in the following circumstances:

4.8.1. Terminations. Reimbursement will be immediately cancelled if an employed or contracted User receiving Mobile Device Reimbursement terminates employment or contractual arrangement with MHC.

4.8.2. Job Transfers. Reimbursement will also be cancelled if an employed User changes job positions. A new Mobile Device Request Form and Mobile Device Reimbursement Form must be submitted to establish the continued business need for a Mobile Device.

4.8.3. Misconduct. If, prior to the end of the Mobile Device contract, a personal decision by the User, User misconduct, or misuse of the phone results in the need to end or change the Mobile Device contract, the User will bear the cost of any fees associated with that change or cancellation. EXAMPLE: The User quits, and no longer wants to retain the current Mobile Device contract for personal purposes.

4.8.4. Department Decision to Cancel. If, prior to the end of the Mobile Device contract period, a department decision (unrelated to User misconduct) results in the need to end or change the Mobile Device contract, the department will bear the cost of any fees associated with that change or cancellation. The original billing statement indicating the early termination charge billed must be submitted in order to be reimbursed in these circumstances. (EXAMPLES: The User's Director has changed the User's duties, and the Reimbursement is no longer needed. The User does not want to retain the current Mobile Device contract for personal purposes.

4.9. **Miscellaneous**

4.9.1. Other Applicable Policies. In their use of the Technology Resources, Users must observe and comply with all other policies and guidelines of MHC including the Acceptable Use of Technology Resources Policy (MHC_CC0106), Email Policy (MHC_CC0124) and Human Resource policies on Communication Devices.

4.9.2. Amendments and Revisions. This Policy may be amended or revised by MHC from time to time as deemed necessary. Users will be advised of changes/revisions consistent with MHC policy and practice.

4.9.3. No Additional Rights. This Policy is not intended to, and does not, grant Users any contractual rights.

5. Procedure

5.1. **Mobile Device Request Form.** The form will be completed by appropriate Directors and Users and submitted to the IT service desk, and if a Reimbursement is to be paid, to the Payroll Department.

5.1.1. Signature of the Director (or their authorized designee) is required for system access;

5.1.2. Signatures of Director (or their authorized designee), CFO and Corporate CIO are required for MHC provided Devices.

5.1.3. User agreement must be signed by User in order to activate access, Reimbursement or provide a MHC managed Device.

5.2. Upon notice from IT Services that email/network access has been enabled, User will download the Airwatch application from iTunes store or Google Playstore and follow activation procedures.

5.2.1. If a password or pin was not previously established for the phone, create a password/pin to unlock Device. Enabling Device encryption is also strongly recommended.

5.3. **Mobile Phone Reimbursement Form.** The request for Reimbursement will be completed by employed and contracted Users, authorized by Director/VP, the CFO, and Corporate CIO and submitted to the Payroll Department with documents listed below.

5.3.1. A copy of the User's most recent cellular billing statement must be provided to verify the level of services and current cost of the plan.

5.3.2. If the User's cellular service costs are lower than the current fixed Reimbursement rate, the User will not qualify for Reimbursement.

6. References

6.1. MHC_HR0160_Use of Personal Communication Devices Policy

6.2. MHC_CC0106_Acceptable Use of Technology Resources Policy

6.3. MHC_CC0121_User Access Termination Policy

6.4. MHC_CC0124_Email Use Policy

6.5. IRS Notices 2011-72 and 2011-93 - Guidance on Tax Treatment of Cell Phones

6.5. IRS Notices 2011-72 and 2011-93 - Guidance on Tax Treatment of Cell Phones

6.6. Airwatch Standard Operating Procedure

7. Appendix

7.1. Mobile Device Request Form

7.2. Mobile Phone Reimbursement Request Form

Previous Revisions: Not applicable

Supersedes Policy: HR 0133 and the Network Services Cellular Request Form

Approvals:

IT Security Committee: October 25, 2014
Corporate Compliance Committee: January 15, 2015

Ron Strachan
Chief Information Officer

3/24/2015
Date

McLaren HEALTH CARE

MOBILE DEVICE REQUEST FORM

EMPLOYEE NAME:	DATE OF REQUEST:
EMPLOYEE ID#:	POB CASE #:
E-MAIL ADDRESS:	COMPANY#/COST CENTER #:
CONTACT PHONE #:	SUBSIDIARY/LOCATION:

COMPANY PROVIDED DEVICE REQUEST

Only designated executives and employees requiring mobile device for their job are eligible to receive MHC provided devices.

☐ NEW ACTIVATION ☐ TRANSFER TO NEW EMPLOYEE ☐ ACCESSORIES REQUEST ONLY
☐ LOST PHONE ☐ DISCONTINUE SERVICE ☐ NETWORK ACCESS
☐ PORT # TO BUSINESS ACCT ☐ BROKEN/REPLACEMENT PHONE ☐ EMAIL and CALENDAR ACCESS

SPRINT ☐ Acct. # _____ **VERIZON** ☐ Acct. # _____ **AT&T** ☐ Acct. # _____

New cellular number_____ **Upgrade current cellular number**_____

Port number to business account_____ **Release number to private account**_____

NOTE: *In order to complete a number port, we require the front sheet of the current bill that the phone number is being transferred to or from*

TYPE OF DEVICE

☐ SMART PHONE (With Text/Data Connectivity)
☐ TABLET
☐ HOT SPOT

NOTE: Lead-time for all new activation is 5 to 7 business days.

ACCESSORIES & ADDITIONAL FEATURES *(if needed)*

☐ CAR CHARGER
☐ PHONE CASE/HOLSTER
☐ DATA PLAN

MAILING ADDRESS If requesting a cellular phone be sent to your home, please provide mailing address:

PERSONALLY OWNED DEVICE REQUEST FOR ACCESS (check all that apply)

☐ EMAIL and CALENDAR ACCESS ☐ NETWORK ACCESS | ☐ SMART PHONE ☐ TABLET

USER AGREEMENT (required for email/network access, reimbursement AND company provided Mobile Device)

I have read and agree to comply with MHC's Email, Mobile Device, and Acceptable Use of Technology Resources policies. I agree to install and maintain the security application, Airwatch, on my phone and understand that all MHC data will be wiped from the device if the device is stolen or lost. I will use a password to lock the phone, enable the encryption feature, if required, and will IMMEDIATELY report to the IT Service Desk if my phone is lost or stolen. If my Mobile Device has been provided by MHC (or one of its subsidiaries), I will return to my Director all equipment that is issued, upon separating employment or contract with MHC, or if I have a change in job status that no longer justifies the use of the equipment.

USER Signature: _____ Date: _____

MANAGEMENT AUTHORIZATION

I authorize network access, email/calendar access or issuance of an MHC provided Mobile Device as specified above. I will ensure surrender of company owned equipment and notify IT Services upon termination or job status change for the above listed employee.

DIRECTOR/VP Signature Required for network or email access on (new activation and equipment upgrade) and MHC provided devices (new and upgrades)	
CFO Signature Required for all MHC provided devices (new and upgrades)	
MHC CIO Signature Required all MHC provided devices (new and upgrades)	

Questions: Contact the Service Desk at 888-424-8516 or servicedesk@antheliohealth.com, or KCI Helpdesk at 313-576-9400

FORM WILL NOT BE PROCESSED UNTIL COMPLETE. EMAIL SIGNED COPIES TO appropriate IT Service Desk.

Rev. 05-08-15

McLaren
HEALTH CARE

Mobile Phone Reimbursement Request Form

EMPLOYEE INFORMATION

Date of Request: _____

Name: _____

Employee ID: _____

Unit/Dept: _____

Company# and Cost Center#: _____

Work Telephone: _____

Covered Cellular Phone Number: _____

BUSINESS JUSTIFICATION / ELIGIBILITY CRITERIA

Describe job responsibilities which warrant payment of a wireless device allowance

REIMBURSEMENT LEVEL

☐ $40 - Standard wireless device or limited use work conditions

☐ $85 - Smart phone and service plan with required capabilities and/or significant business use required

ACKNOWLEDGEMENT

I acknowledge that I am receiving reimbursement from McLaren to cover business use of my personal cell phone. In return for receiving this reimbursement, I will make my phone number available to McLaren management team, will comply with McLaren's security requirements, and IMMEDIATELY report to the IT Service Desk a lost or stolen device, and change in my phone number.

Undersigned employee has read, understands and accepts the provisions of the McLaren's Mobile Device Network Access and Reimbursement Policy.

_____		_____	
Employee	Date	Director/VP	Date
_____		_____	
CFO	Date	Corporate CIO	Date

McLaren HEALTH CARE

Mobile Device Request Process MHC_IT0002.8.2

Your Own Device
Phones or Tablets

Device new, upgraded, replacement?

NO → Using own device with expense reimbursement?

YES

YES

Need MHC Network Access, Email or Calendar

NO

YES

Complete Mobile Device Network Access Request Form

Qualify for Reimbursement?

NO

YES

Complete Mobile Phone Access Request Form

Required Authorizations Obtained?

NO

YES

Send Request Form to IT and/or Payroll

Install AirWatch Application

Company Provided Device

Need new, upgraded, or replacement device?

YES

Complete Mobile Device Network Access Request Form

Required Authorizations Obtained?

NO

YES

Send Request Form to IT and/or Payroll

Install AirWatch Application

1. **Question:** I am required to be on call and use my personal mobile phone regularly for business calls, but I don't want my work email pushed to my personal phone. Do I still qualify for reimbursement?
   Answer: If your Director verifies that your on-call coverage requirements constitute a qualifying work condition, as defined in the policy, you would qualify for reimbursement. The level of reimbursement ($40 or $85), is determined based on the frequency of call coverage requirements, need for network access for calendar and email, and the plan you have with your existing carrier. This scenario would typically qualify for $40 level of reimbursement since you do not need network access.

2. **Question:** I have a standard cell phone (e.g., it doesn't have internet capabilities) and will not be accessing the network on my phone, but I am frequently required to be on call. Do I qualify for reimbursement?
   Answer: If your Director verifies that your on-call coverage requirements constitute a qualifying work condition as defined in the policy, you would qualify for reimbursement. This scenario would typically qualify for $40 level of reimbursement since you do not need network access.

3. **Question:** I'm a new department director and am required to be available by phone and respond to email after hours. My VP says I qualify for a company-provided phone. Do I have to use two phones (company and personal) or can I get reimbursement and use my own phone?
   Answer: You may choose to use your own phone and receive reimbursement.

4. **Question:** Does the Mobile Device Network Access and Reimbursement policy apply to someone who needs to replace (due to damage) and/or upgrade their existing company-provided phone?
   Answer: Yes, the new policy applies. Users upgrading/replacing a company-provided phone will need to complete the Mobile Device Request Form, including the User Agreement, obtain required signatures and forward the request to Anthelio.

5. **Question:** I have a Smartphone (e.g., iPhone/Android with data features and internet access) and want to access my work email and calendar on my personal phone. What do I need to do?
   Answer: Complete a Mobile Device Request Form. If your Director agrees you have a business need for network access to email and calendar, obtain the required signatures and forward the Request Form to Anthelio. You will be required to download and activate Airwatch on your mobile device.

6. **Question:** How will the reimbursement appear in my paycheck?
   Answer: Your monthly reimbursement ($40 or $85) will be split between the first and second paycheck each month (e.g., for a $40 reimbursement you'll receive $20 in the first pay and $20 in the 2nd pay).

7. **Question:** I'm an independent (not employed) physician, but my professional services contract provides for a $35 phone allowance for on-call coverage. How does this policy affect my contract and allowance?
   Answer: As an independent physician you will continue to receive a check from Accounts Payable for the amount specified in your contract until the next renewal, at which time your

agreement must be changed to reflect the current year's reimbursement rate (e.g., $40 if renewed this year).

8. **Question:** I am an employee and have been receiving monthly reimbursement for business use of my personal phone as part of my monthly expense reimbursement. Will this change, and if so, what do I need to do?
   Answer: Yes, this process will change. Over the next 60 days, Accounts Payable and Payroll Departments will be transitioning individuals currently receiving reimbursement through expense checks, to automated payroll reimbursement. In order to continue receiving reimbursement you must:
   a. Complete the Mobile Device Request Form (including the Personally Owned Device Request for Access, User Agreement and required signatures);
   b. Complete the Mobile Phone Reimbursement Request Form (all sections, including signatures);
   c. Once approved, forward the Mobile Device Request Form to the IT Service Desk and the Mobile Phone Reimbursement Form to Payroll; and
   d. When notified by IT, download the Airwatch application on your phone and activate it.

9. **Question:** I have a phone or tablet with MHC network access, but don't want to install Airwatch. Do I have an option?
   Answer: No. Except for company-provided Blackberry phones, every smartphone or tablet that accesses email, calendar or other applications on the MHC network (whether provided by MHC or personally owned) must have Airwatch activated. Blackberry devices are on a separate server and are not compatible with Airwatch.

10. **Question:** Can I receive reimbursement for using my personal laptop or tablet for work purposes?
    Answer: No. In accordance with IRS regulations, the company-provided phone/ reimbursement exception only applies to mobile phones. If a laptop or tablet is needed for MHC business, it must be provided by MHC and appropriately secured with encryption software (laptops) or Airwatch (tablets).

11. **Question:** Will MHC support any type of mobile phone or tablet?
    Answer: No. Only certain types of devices will be authorized for email/network access and reimbursement. IT will maintain the list of company-provided devices that may be selected. If you are using your own device, only phones and tablets with Android and iOS operating systems will be authorized for email/network access and/or reimbursement (phones only).

12. **Question:** If it is determined that I don't have a business need to have email and calendar pushed to my phone, how can I access them when I'm out of the office?
    Answer: You are able to access your email and calendar through the email webserver(s). The links are available on the corporate website at www.mclaren.org.
    Some devices may require you to download an application to access the mail server.

Introducing CPC+

1) Overview and Eligibility Criteria
2) Care Delivery Transformation
3) Payment Innovations
4) Health IT Requirements
5) Data Feedback and Learning Support

For more information and application toolkit materials:
https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

CPC+ a New Advanced Primary Care Medical Home Model

CPC+ By the Numbers

5
Years

Beginning January 2017, progress monitored quarterly

2
Program Tracks

Based on practices' readiness for transformation

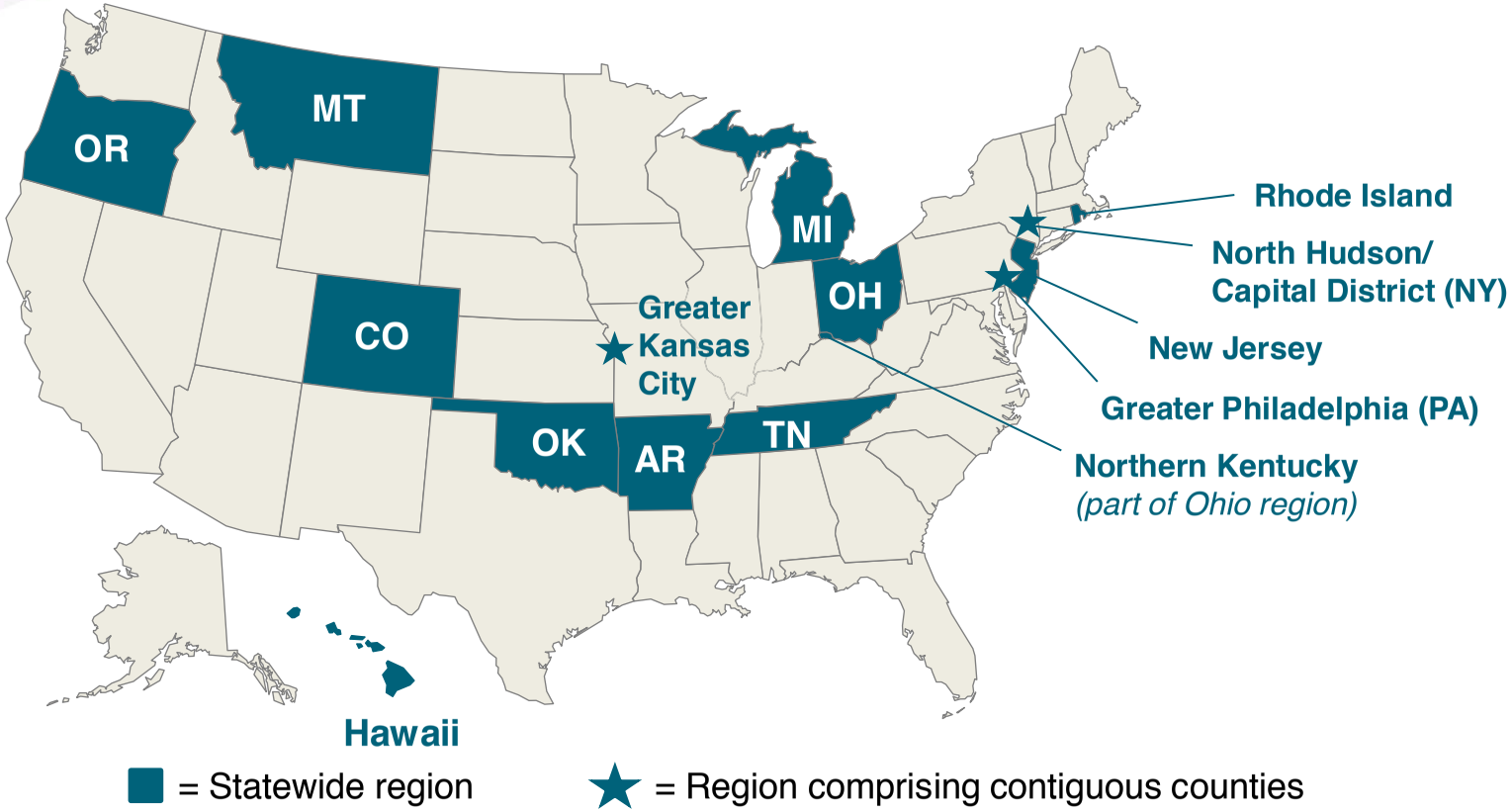
Up to 2,500
Practices Per Track

Dependent upon interest and eligibility

Online Resource: CPC+ In Brief

CPC+ Offered in Fourteen Regions

Only Practices in Selected States/Counties May Apply

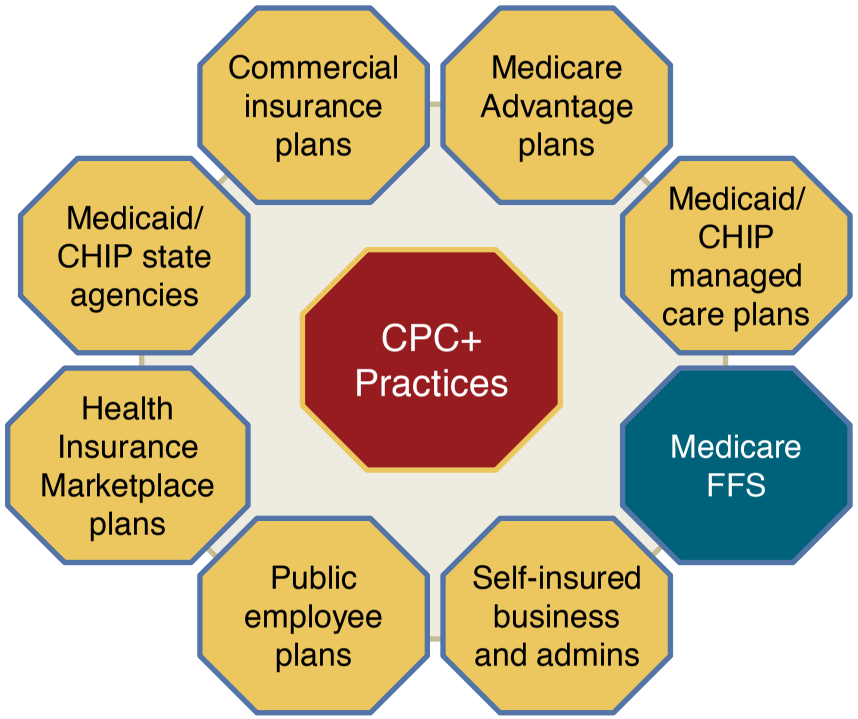


Online Resource: CPC+ Payer and Region List

CPC+ Regions Selected Based on Multi-Payer Support

Partner Payers Aligned With But Not Identical to Medicare

Payers Invited to Partner



Required Payer Alignment

- Enhanced, non-FFS support
- Change in cash flow mechanism from fee-for-service to at a least a partial alternative payment methodology for Track 2 practices
- Performance-based incentive
- Aligned quality and patient experience measures with Medicare FFS and other payers in the region
- Practice- and member-level cost and utilization data at regular intervals

Online Resource: CPC+ Payer and Region List

CPC+ Applicants Must Have Practice Transformation Experience

Practice Eligibility Criteria

- Must have at least 150 attributed Medicare beneficiaries
- Must have support from CPC+ payer partners
- Must use CEHRT
- Existing care delivery activities must include:

Track 1

- Assigning patients to provider panel
- Providing 24/7 access for patients
- Supporting quality improvement activities
- Developing and recording care plans

Track 2

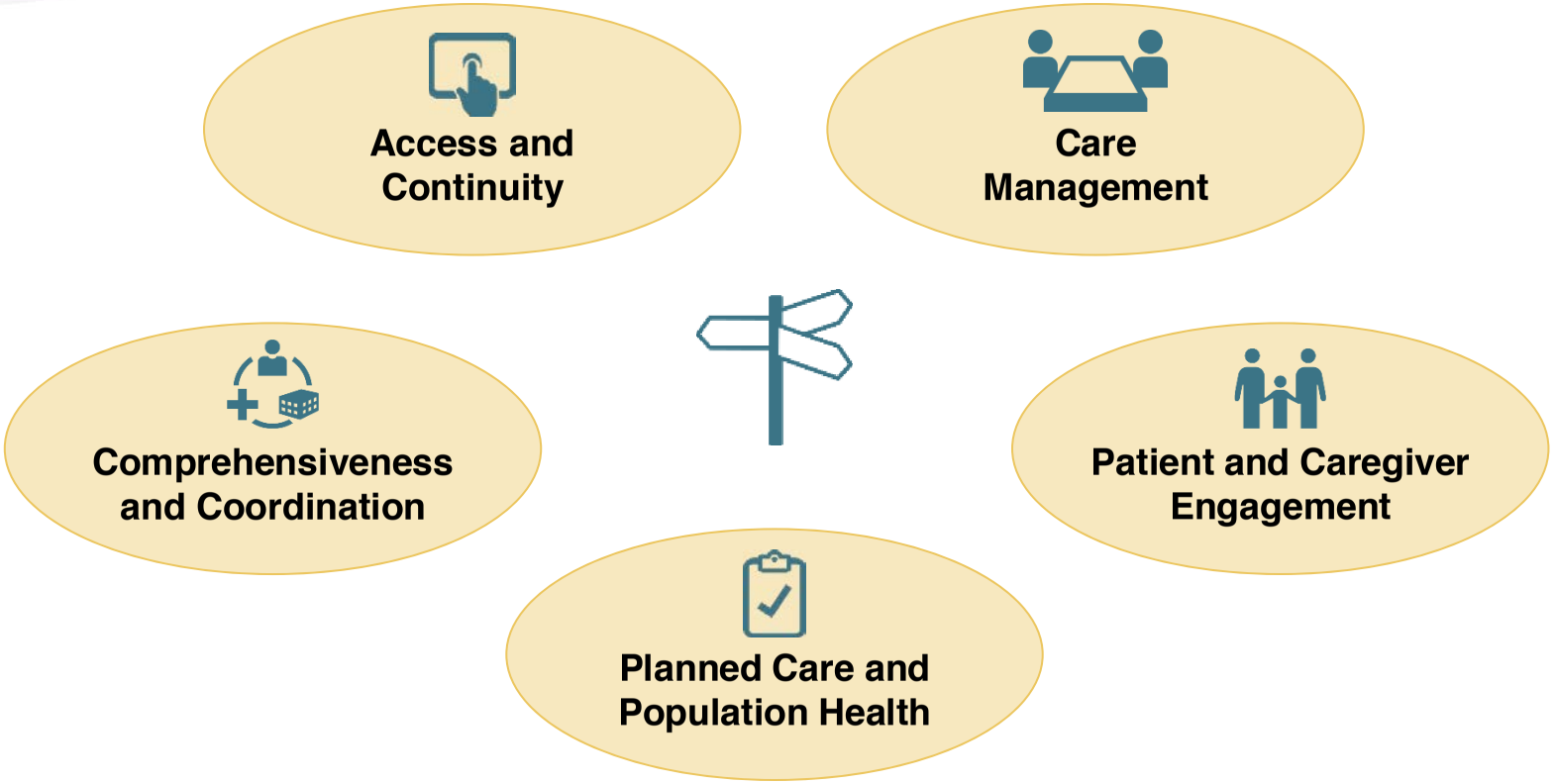
- Following up with patients after ED or hospital discharge
- Implementing a process to link patients to community-based resources

- Must apply with a letter of support from health IT vendor that outlines the vendor's commitment to support the practice in optimizing health IT.

Track 2 applicants will indicate on their applications if they would like to join CPC+ in the event that CMS deems them eligible only for Track 1.

Online Resource: CPC+ Practice Frequently Asked Questions

Five Functions Guide CPC+ Care Delivery Transformation



Online Resources: Care Delivery Transformation Brief and Video

CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

Track 2 capabilities are inclusive of and build upon Track 1 requirements.

	Requirements for **Track 1**	Requirements for **Track 2**
Access and Continuity	Empanelment 24/7 patient access Assigned care teams	Alternative to traditional office visits, e.g., e-visits, phone visits, group visits, home visits, alternate location visits, and/or expanded hours.
Care Management	Risk stratified patient population Short-term and targeted, proactive, relationship-based care management ED visit and hospital follow-up	Two-step risk stratification process for all empanelled patients Care plans for high-risk chronic disease patients

Online Resources: Care Delivery Transformation Brief, Video, and Practice Requirements

Upcoming Open Door Forums: *Care Delivery Overview and Q&A*: Fri, Aug 12, 9:30-10:30am ET

CPC+ Practices Will Enhance Care Delivery Capabilities in 2017

	Requirements for Track 1	Requirements for Track 2
Comprehensiveness and Coordination	Identification of high volume/cost specialists Improved timeliness of notification and information transfer from EDs and hospitals	Behavioral health integration Psychosocial needs assessment and inventory of resources and supports to meet psychosocial needs Collaborative care agreements Development of practice capability to meet needs of high-risk populations
Patient and Caregiver Engagement	At least annual Patient and Family Advisory Council Assessment of practice capabilities to support patient self-management	At least biannual Patient and Family Advisory Council Patient self-management support for at least three high-risk conditions
Planned Care and Population Health	At least quarterly review of payer utilization reports and practice eCQM data to inform improvement strategy	At least weekly care team review of all population health data

Three Payment Innovations Support CPC+ Practice Transformation

	Care Management Fee (PBPM)	Performance-Based Incentive Payment (PBPM)	Payment Structure Redesign
Objective	*Support augmented staffing and training for delivering comprehensive primary care*	*Reward practice performance on utilization and quality of care*	*Reduce dependence on visit-based fee-for-service to offer flexibility in care setting*
Track 1	$15 average	$2.50 opportunity	N/A (Standard FFS)
Track 2	$28 average; including $100 to support patients with complex needs	$4.00 opportunity	Reduced FFS with prospective "Comprehensive Primary Care Payment" (CPCP)

Online Resources: Payment Innovations Brief and Video

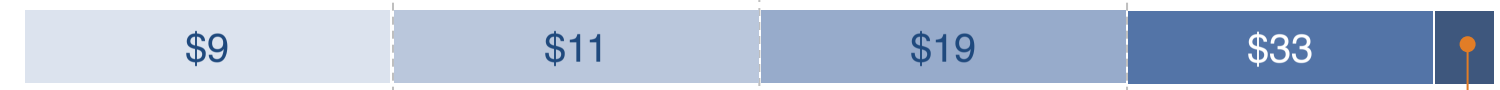
Upcoming Open Door Forum: *Financial Overview and Q&A*: Tues, Aug. 9, 2:30-3:30pm ET

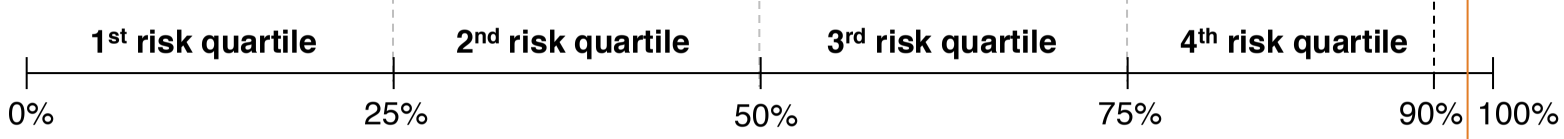
PBPM Care Management Fees Determined by Patient Risk Levels

Payments Support Practice Capabilities to Better Manage Care

Track 1: Four Risk Tiers (Average $15)

Track 2: Five Risk Tiers (Average $28)





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- Risk adjusted, PBPM (non-visit-based) payment
- Designed to augment staffing and training, according to specific needs of patient population
- No beneficiary cost sharing
- Risk tiers relative to regional population

Complex Tier: $100

Top 10% of risk or dementia diagnosis

Opportunity to Earn Performance-Based Incentive Payments

Practices Will Keep Percentage of Upfront Payment

Two Components of Incentive Payment

Quality and patient experience measures
- Examples: eCQMs, CAHPS
- Measured at practice level

Utilization measures that drive total cost of care
- Examples: inpatient admissions, ED visits
- Measured at practice level

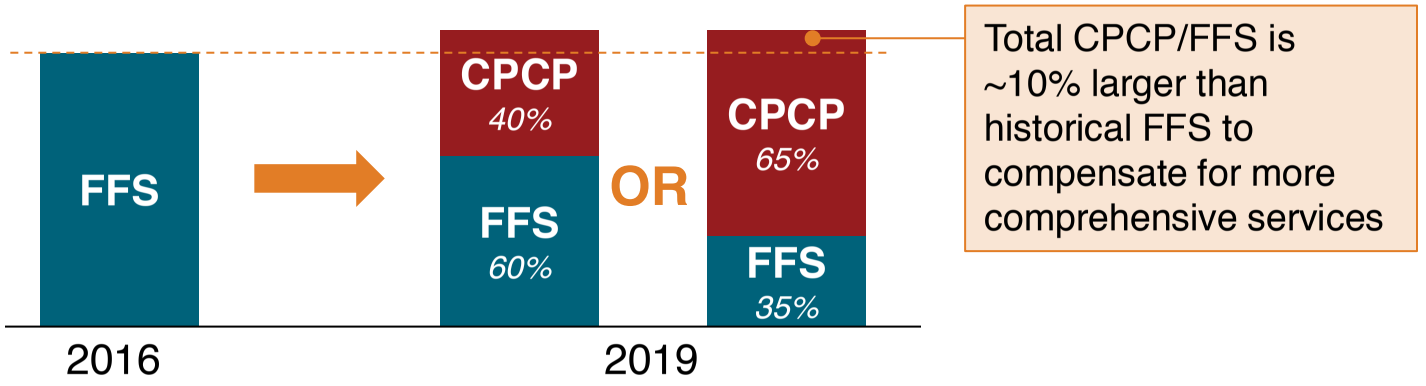
	Track 1	Track 2
Quality (PBPM)	$1.25	$2.00
Utilization (PBPM)	$1.25	$2.00
Total (PBPM)	**$2.50**	**$4.00**

? **Prospectively paid** PBPM incentive**; retrospectively reconciled** based on practice performance

Track 2 Reimbursement Redesign Offers Flexibility in Care Delivery

Designed to Promote Population Health Beyond Office Visits

Hybrid of FFS and Upfront "Comprehensive Primary Care Payment" (CPCP) for Evaluation & Management



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- Practices receive enhanced fees with roughly half of expected FFS payments upfront and subsequent FFS billings reduced by the prepaid amount
- CPCP reduces incentive to bring patients into the office for a visit but maintenance of some FFS allows for flexibility to treat patients in accordance with their preferences
- Practices select the pace at which they will progress towards one of two hybrid payment options (both roughly 50/50) by 2019

Practices Will Use Advanced Health IT to Improve Patient Care

All Practices Must Adopt Certified EHR Technology

General Requirements

- Adopt certified health IT modules which meet the definition of CEHRT according to the timeline and requirements finalized for use in CMS programs supporting certified EHR use (e.g. EHR Incentive Programs, proposed Quality Payment Program)
- Use 2015 Edition technology (may use 2014 Edition in 2017 only)

Quality Reporting Requirements

- Adopt health IT certified to the (c)(1) – (c)(3) certification criteria for all eCQMs in the CPC+ measure set
- Use the latest annual measure update for the CPC+ measures
- Be able to filter eCQM data by practice site location and TIN/NPI beginning in 2017. Beginning in 2018, adopt 2015 Edition health IT certified to the criterion 45 CFR 170.315(c)(4) to filter eCQMs.

Additional for Track 2

By January 1, 2019 (beginning of CPC+ PY3), adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9) and the 2015 Edition "Social, Behavioral, and Psychosocial Data" criterion found at 45 CFR 170.315(a)(15)

Many Opportunities for Learning, Collaboration, and Support

CPC+ Practice Portal

Online tool for reporting, feedback, and assessment on practice progress

CPC+ Connect

Web-based platform for CPC+ stakeholders to share ideas, resources, and strategies for practice transformation

Aligned Data Feedback

Actionable data reports on attribution and cost, utilization, and quality at the practice and patient level from multiple payers

Learning Opportunities

National Learning Communities

- Cross-region collaboration
- National learning opportunities
- Annual Stakeholder Meeting

Regional Learning Communities

- Virtual and in-person learning sessions
- Outreach and support for practice leads
- Leadership engagement
- Alignment with regional reform

Affiliated Practices May Apply but Must Apply Independently

- CMS encourages **all practices**, including those with the same owner or those in the same ACO, to apply to CPC+.
- Every practice must submit a **separate application**; eligibility will be determined at the practice level.
- CMS will accept affiliated practices (e.g., in a health system, ACO, etc.) as a group **to the extent possible**.
- Affiliated practices (including practices in the same health system) may participate in **different tracks** of CPC+.
- Up to 1,500 primary care practices participating in a Medicare Shared Savings Program **ACO may participate** in CPC+.
- CPC+ practices must use **one billing TIN** for all primary care services. This TIN may be shared with other practices in a medical group or organization; CMS will identify specific CPC+ practitioners by their National Provider Identifier (NPI).

Online Resource: CPC+ Practice Frequently Asked Questions

Practice Types Ineligible for CPC+

CPC+ is designed to test payment reform for traditional fee-for-service payment under the Medicare Physician Fee Schedule.

Therefore, the following practices are not eligible to apply:

Pediatric Practices

CPC+ practices must include at least 150 eligible Medicare fee-for-service beneficiaries and pediatricians generally do not treat Medicare patients.

Concierge Practices

Retainer fees usually replace traditional co-insurance under Medicare fee-for-service and/or conflict with CPC+ Care Management Fees.

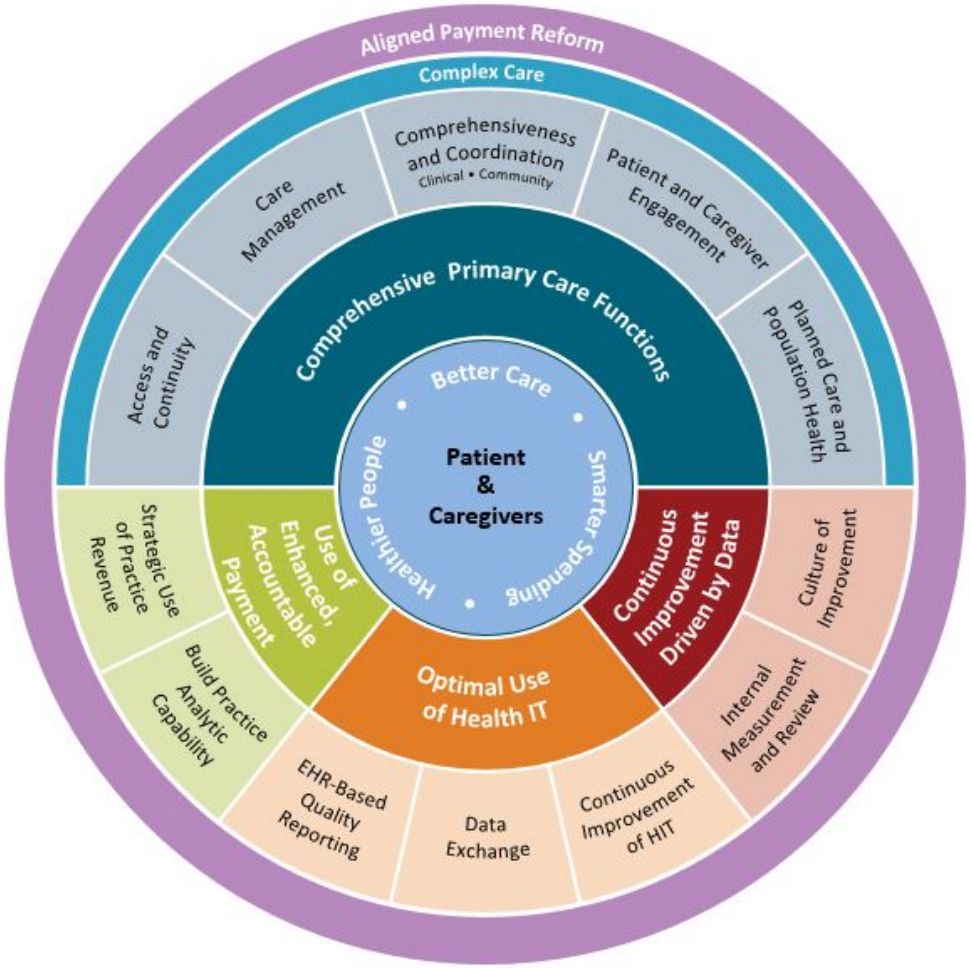
Rural Health Clinics

RHCs do not submit claims on a Medicare Physician/Supplier claim form and are not paid according to the Medicare Physician Fee Schedule for routine office visits.

Federally Qualified Health Centers

FQHCs do not submit claims on a Medicare Physician/Supplier claim form and are not paid according to the Medicare Physician Fee Schedule for routine office visits.

CPC+ Logic Model



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

CPC+
Comprehensive Primary Care Plus

Interested in CPC+?

Visit

https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus
to learn more and apply.

Practice Applications due September 15, 2016

Contact

CPCplus@cms.hhs.gov

1-844-442-2672

TAB 3

Important Contact Information
Allscripts Touchworks EHR

Allscripts MMG Team Email

allscripts_MMG@mclaren.org

The Allscripts MMG Team email is available for providers and staff to use if they have an Allscripts TouchWorks EHR-related question. If you send an email to this address, your email will be sent to all of the Allscripts MMG team members listed below. This is a great way to get your Allscripts-related questions answered quickly by the EMR Team.

Please Note: EMR Team is available Monday through Friday, during normal business hours.

Anthelio Provider Hotline (Open 24/7)

T: (810) 424-8455

Anthelio Healthcare Solutions (also known as Atos) is the IT vendor that supports McLaren with any IT-related needs. Providers can contact the "Provider Hotline" number listed above if they are experiencing any IT related issues (i.e. laptop/ desktop issues, connectivity issues, VPN, etc.).

Please Note: This line is available 24 hours a day, 7 days a week.

Allscripts MMG Team Contact List

The table below consists of the current Allscripts MMG Team contact list. Staff are separated by role and region. If you have an Allscripts-related question and you wish to reach out via phone, you can start by contacting the EMR Trainer in your region for assistance.

Name	Title	Cell	Office	Region
Maria Packer (Silvestri)	Manager of Education	(586) 808-8152	(586) 741-4064	Macomb
Amy Andrich	EMR System Analyst	(989) 928-5401	(989) 316-4258	Bay
Kimberly Cherryhomes	EMR Coordinator	(248) 464-4000	(989) 296-1295	West Branch
Laura Constable	MU Coordinator	(810) 444-9801	(810) 342-1596	Flint/Lapeer
Brenda Maldonado	EMR Trainer	(989) 450-3403	(989) 316-4268	Bay
Dawn Masters	EMR Trainer	(989) 429-2335	(810) 342-1597	Flint/Lapeer
Sean Shukri	EMR Trainer	(248) 388-0399	NA	Oakland
Tonya Williams	EMR Trainer	(313) 948-0798	(586) 741-4315	Macomb

Allscripts Touchworks EHR
Frequently Asked Questions

FAQs:

Question: I am unable to log into Allscripts Touchworks EHR and/or I am locked out. Who do I contact?

Answer: During normal business hours, please email the Allscripts MMG Team at allscripts_MMG@mclaren.org and the team will unlock and/or reset your password. If this is after normal business hours, please contact the service desk at 810-424-8400.

Question: My note is locked and I am unable to finish documenting.

Answer: Email the Allscripts MMG Team at allscripts_MMG@mclaren.org, and an EMR Team member will unlock your note.

Question: I am unable to prescribe controlled medications in Allscripts. What is wrong?

Answer: Your DEA license has expired and needs to be updated in Allscripts. Please have your office manager email a scanned copy of your DEA to the Allscripts MMG Team at allscripts_MMG@mclaren.org so an EMR Team member can update. In order for the changes to take place, you must log out and log back in.

Question: Who is the Allscripts trainer for my region?

Answer: Please see the document at the beginning of this section titled "Important Contact Information", and locate your trainer based on the region that you work in.

Question: What type of training will I receive for Allscripts?

Answer: Your options include either attending an 8 hour in-person training session with an EMR Trainer, or completing online modules through McLaren University.

Question: What does the term Go-Live mean, how long does it last, and who do I contact after the go-live phase?

Answer: Go-Live is a term that refers to the 2 days that a trainer is on-site with a new provider, and the provider is "going live" with Allscripts Touchworks EHR-seeing patients/placing orders/medication refills/documenting in the note/etc. Once this phase is complete, your first contact, should you have Allscripts questions, will be the trainer in your region (this will normally be the trainer that was with you during the Go-Live phase).

Question: Are there regular in-person follow-up visits from an EMR Trainer after the go-live has been completed?

Answer: Yes, your Allscripts trainer will schedule a follow-up visit within two weeks of the initial Go-Live, and then on an as-needed basis after that.

Question: Are there any Allscripts guides available?

Answer: Yes. The most common Allscripts tools/guides are included in this manual. Also, all of our Quick Reference Guides are located on the intranet: MHCC→McLaren Medical Group→Allscripts Training Manuals→Provider QR Guides.

Question: I would like to use a speech-recognition software program for documenting in the Allscripts Touchworks EHR. What is available?

Answer: McLaren Medical Group offers Dragon dictation software. If you are interested in using this, please notify your Operations Manager or Director, and they will make software installation and training arrangements for you.

Question: I am unable to connect to VPN. What do I do and/or who do I contact?

Answer: Refer to the guide "Unable to Connect to VPN from Home" or "Connecting to Cisco AnyConnect at Home". The guide you will follow is dependent upon which version of Windows is on your computer. If you are unsure of the version

that you are using, or still have questions after reviewing the guide, please contact the Anthelio Provider Hotline at (810) 424-8455.

Question: What is Meaningful Use/MIPS and why is it important?

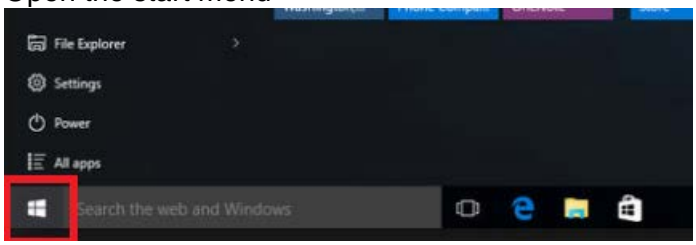
Answer: Meaningful Use/MIPS is a government program created by CMS (Centers for Medicare & Medicaid Services). The intention of this program is to set standards on the use of the EMR. Measures have been established and Eligible Clinicians must attest that they are meeting the measures, in other words, “meaningfully using” their EMR. The MU/MIPS program is not intended to be deemed extra work, but encouragement to leverage the use of the EMR.

Connecting to Cisco AnyConnect (formerly called VPN) at Home Workflow for Windows 10 Users

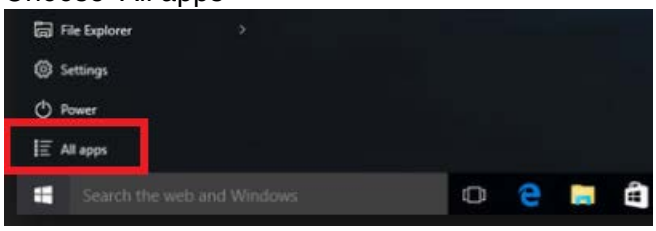
Below outlines the process to Locate Cisco AnyConnect Client (formerly called VPN) on a Windows10 device.

1) If no Cisco AnyConnect Client icon is visible on your desktop, first check to see if VPN AnyConnect is installed on your Windows 10 device.

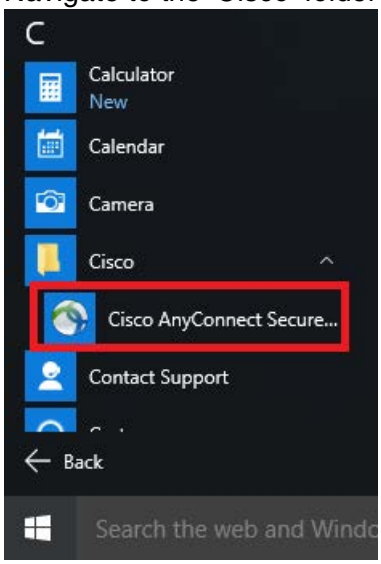
2) You will need to:
   - Open the start menu



   - Choose ‘All apps’



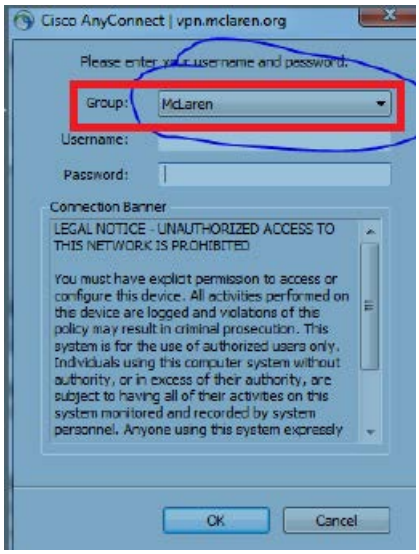
   - Navigate to the ‘Cisco’ folder and look for the AnyConnect client



3) Once you have located AnyConnect on your Windows 10 device, to log in:

   - Make sure: VPN.mclaren.org is in the address bar and hit ‘Connect’

- Verify that the Group is set to: McLaren & enter your McLaren Network Username and Password



FAQ's

1) **I'm not finding the AnyConnect icon in the start menu on my Windows 10 device.**
   Answer: Contact the Anthelio Service Desk to see if customer was granted access to VPN. If so, they will open a case for Anthelio Field Services Staff to repair any issues with the software.

2) **After launching AnyConnect, I still cannot login.**
   Answer: Make sure you are using your McLaren Network Login and password. If you still are not able to log in, contact the Anthelio Service Desk for additional support.

3) **When I log into AnyConnect while at a McLaren site, it doesn't work.**
   Answer: AnyConnect isn't meant to be used when you are on site, you should connect using the McLaren Wireless Network. AnyConnect should only be used when you are remote from the McLaren Network (like from home). If you cannot connect to the McLaren Wireless Network while at one of the McLaren facilities, contact the Anthelio Serivce Desk for additional support.

Radiology Prefixes by Region	
BAY REGION	
BA ALMA	Bay Nuclear Med Alma
BA AM	Bay Allen Medical
BA	Bay
BA WMR	Bay West Med Mall MRI
BA WUS	Bay West Med Mall Ultrasound
BA WVAS	Bay Women's DX Center Vascular US
CENTRAL REGION	
CM	Central
FLINT REGION	
FL	Flint
GREATER LANSING REGION	
GL	Greater Lansing
LAPEER REGION	
LR	Lapeer
MMG	Knollwood
MACOMB REGION	
HARPER	Harper Radiology
LENOX	Lenox Radiology
SHELBY	Shelby Radiology
NORTHERN REGION	
BH and/ or MG	Mammography and related tests i.e ductograms or galactograms
NV and/or US	Ultrasounds
XR	Xray
NM	Nuclear Medicine
OAKLAND REGION	
BCC	Bow Pointe Clarkston Breast Center
CLRK	Clarkston
DCC	Clarkston Diagnostic
OA	Oakland
OXF	Oxford Diagnostic

Icon Quick Reference

This reference provides a quick description of the icons that appear throughout the application.

> **Note:** There might be additional icons in the application that do not appear on this list. Also, the meaning of an icon might be different depending on where it appears in the application. If you encounter an icon in the application that does not appear in this list, or might appear in a different area of the application, check the *Application Design and Behavior Resource* (ADBR) topic that corresponds to the page in the application where you encounter the icon.

New for 11.4.1

	Click to display **Allscripts Information Viewer**. The icon is displayed on: • **Encounter Summary** • **Problem**, **Meds/Orders**, **Allergies**, and **Health Management Plan** (HMP) of **Clinical Desktop** • **Add Clinical Item** (ACI) • Details and viewers pages for a problem, allergy, medication, and orderable item (for example, **Medication Details** and **Medication Viewer**)
	Indicates that at least 1 alert is displayed in **My Alerts** on **Encounter Summary** for the patient in context. Point to the icon to display a tooltip indicating the numbers of alerts. Click to display **Encounter Summary**. The icon is displayed on: • Patient banner • Add Clinical Item
	Indicates that all alerts are displayed in **All Other Alerts** on **Encounter Summary** for the patient in context. Point to the icon to display a tooltip indicating the numbers of alerts. Click to display **Encounter Summary**. The icon is displayed on: • Patient banner • Add Clinical Item
	Indicates that an order status reason in **Change Status** meets Meaningful Use Stage 2 Clinical Quality Measure reporting criteria, and that a qualifying reason is required.
	Existing order.
	Existing reminder.
	Existing order and reminder.
	Existing medication order.
	In the **CareGuide Template Editor** or the **Problem-based tab** of **Add Clinical Item** (with the **CareGuide** option

	selected), indicates that a guideline exists for the template, item, or group.
	Indicates that the patient is registered with Allscripts Patient Portal™. Click to display **Patient Portal Registration**. The icon is displayed on the patient banner and in the **Clinical Information** section of **Patient Profile**.
	Indicates that the patient has not received information about registering for the patient portal. Click to display **Patient Profile**. The icon is displayed on the patient banner and in the **Clinical Information** section of **Patient Profile**.
	Indicates that the patient received information about registering for the patient portal but has not registered. Click to display **Patient Profile**. The icon is displayed on the patient banner and in the **Clinical Information** section of **Patient Profile**.
	Indicates that the patient declined to register with the patient portal. Click to display **Patient Profile**. The icon is displayed on the patient banner and in the **Clinical Information** section of **Patient Profile**.
	Indicates that the patient's registration request for the patient portal was rejected. The icon is displayed on the patient banner and in the **Clinical Information** section of **Patient Profile**.
	Indicates that the document is attached as a result. Result documents can also be indicated by **(Summary)**, **Summary**, or **Result Doc Attached** when a result is displayed in table format.
	Indicates that the document is attached as additional information.

General icons

	Patient info button. Displayed on the patient banner depending on the setting in **Patient Banner Setup**. Opens **Patient Profile Dialog**.
[R]	This icon or [R] displayed next to the patient's name indicates that data is restricted within a patient's record and that information is filtered and hidden from view.
	Launch Clin-eguide.
	New task.

	Search.
	Quick filter (**Chart Viewer** only).
	Clear search criteria.
	Lookup items based on search criteria.
	Display only QuickList items.
	Include all diagnoses in search results.
	Include only diagnoses with ICD9 codes in search results.
	Data will be applied to a Version 10.x note.
	Select a date and time.
	Launch keypad.
	Insert dictation pointer in note.

Navigational and view change icons

	Refresh view.

	Edit view.
	Tile view.
	Full screen view.
	Expand.
 or 	Expand section.
 or 	Contract section.
	Launch worklist view editor.

Clinical Toolbar icons

	qChart
	Native Integration Document Viewer and Portal Document Viewer.
	Encounter summary.
	Add new vital.
	Add new problem.

	Add new medication.
	Add new order.
	Problem-based order.
	Clinician choice.
	Display **Note Authoring** workspace.
	Post to encounter.
+	Indicates that there are additional chart alerts that cannot be displayed in the given space on **Clinical Toolbar**. Pause your pointer over + to view the rest of the chart alerts. **Note:** This icon has a different meaning when displayed with problems.

Health Management Plan icons

	Display flowsheet view.
	Display graph view.

Data indicators for medications, orders, reminders, and results

	Do Not Release information about order or result to Allscripts Patient Portal™.
	Diagnostic.
	Invalid diagnostic.

	Diagnostic marked Do Not Release.
	Diagnostic with abnormal results marked Do Not Release.
	Unverified diagnostic.
	Unverified diagnostic marked Do Not Release.
	Unverified diagnostic with abnormal results marked Do Not Release.
	Note result scanned image.
	Result.
	Result marked Do Not Release.
	Abnormal result.
	Abnormal result marked Do Not Release.
	Invalid result.
	Unverified result.
	Unverified result marked Do Not Release.
	Unverified abnormal result.
	Unverified abnormal result marked Do Not Release.

	Indicates that the document is attached as a result. Result documents can also be indicated by **(Summary)**, **Summary**, or **Result Doc Attached** when a result is displayed in table format.
	Indicates that the document is attached as additional information.
	Medication preferred by insurance.
	Medication approved by insurance, but may require a higher co-pay.
	Medication not approved by insurance.
	Prior authorization required by insurance.
	Over the counter medication.
	Hierarchical condition categories.
	For medications, this is the Overdue indicator. If it's a medication administration, it indicates that the med admin is overdue to be administered. For a medication, it indicates that the expected action is renew and the renewal date has passed. Also for medications, when Expected Action is Renew and Evaluate and the Expected Action Date is earlier than today's date, the application displays the icon. For medication administrations, when the Overdue Date is earlier than today's date, the application displays the icon. Health Management Plan (HMP) and Alerts/Reminder also use the red triangle with a black exclamation mark to indicate an overdue medication renewal or evaluation. Encounter Summary also uses this same icon.
	Indicates that an order status reason in **Change Status** meets Meaningful Use Stage 2 Clinical Quality Measure reporting criteria, and that a qualifying reason is required.
	Existing order.
	Existing reminder.
	Existing order and reminder.
	Existing medication order.

	In the **CareGuide Template Editor** or the **Problem-based tab** of **Add Clinical Item** (with the **CareGuide** option selected), indicates that a guideline exists for the template, item, or group.

Data indicators and icons for problems and diagnoses

	Not a billable diagnosis.
	Problem is not ready for billing.
	Edit problem.
	Assess problem.
	Problem assessed.
	If there are multiple ICD-9 or ICD-10 codes associated with the problem, the problem code is formatted in italics and a blue plus sign icon is displayed to the right of the code. Pause the pointer over the icon to display all primary and secondary ICD-9 or ICD-10 codes associated with the problem in a comma-separated list.

Data indicators for encounter forms

	Locked encounter form.
	Submitted encounter form.
	Unsubmitted encounter form.

Data indicators for note

	Note.
	Invalid note.

	Note needs to be signed.
	Note result scanned image.

Data indicators for allergies

	Urgent, life-threatening allergic reaction.
A!	Existing allergy with urgent reaction.
A	Existing allergy with non-urgent reaction or no documented reaction.

Task icons

	Urgent task.
	Task to be performed as soon as possible.

Dictation Toolbar icons

	Place on hold.
	Volume indicator.
	Play bar.
	Rewind.
	Fast forward.
	Volume control.

	Play.
	Stop.
	Record.
	Pause recording.
	Delete.
	Done.

Keywords: Lab Orders

The following "Keywords" have been added to the Lab/Procedures tab in the ACI. The purpose of "Keywords" is to eliminate the need to search for multiple items that are often ordered as a "standard" for certain Active Problems. The keywords are listed below in green, along with the corresponding items that will be pulled up when searching for that given keyword. Follow the steps below to utilize these keywords. Please note, that the period is a part of the searchable entry.

".DM"

Hemoglobin A1C – In Office
Microalbuminuria – In Office
Urine Dip – In Office
Glucose Testing (Glucometer) – In Office
Glucose Fasting
Hemoglobin A1C Direct
Lipid Panel Calculated
Comprehensive Metabolic Panel
Urinalysis with Culture if Indicated
Urine Microalbumin 24 Hr
Urine Microalbumin Random

".HTN"

Microalbuminuria – In Office
Urine Dip – In Office
Creatinine
Electrolytes
Glucose
Glucose Fasting
Lipid Panel Calculated
Urinalysis with Culture if Indicated
Urine Microalbumin 24 Hr
Urine Microalbumin Random

".CAD"

ALT (SGPT)
Apolipoprotein B-Warde
AST (SGOT)
CRP High Sensitivity
Fibrinogen
Homocysteine
Lipid Panel Calculated
Lipoprotein A

".HM"

BUN
Urine Dip-In Office
EKG-In Office
Hemocult-In Office
Microalbuminuria- In Office
Chlamydia PCR
Complete Blood Count with Auto Diff
Comprehensive Metabolic Panel (CMP)
Culture, Genital
Cytology PAP
GC by PCR
Lipid Panel Calculated
PSA Screen
Urinalysis with Culture if Indicated
HPV High Risk
Fecal Occult Blood Test Screen (Immunochem)(FOBT)
Urine Microalbumin Random

".ANEMIA"

(Iron Panel) Total Iron and IBC
Complete Blood Count with Auto Diff
Ferritin
Iron

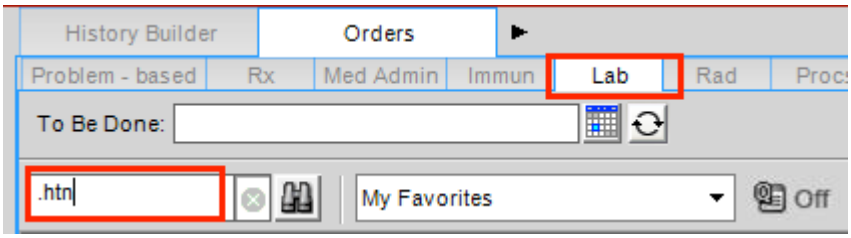
".LIPID"

ALT (SGPT)
AST (SGOT)
Lipid Panel Calculated
Total CK

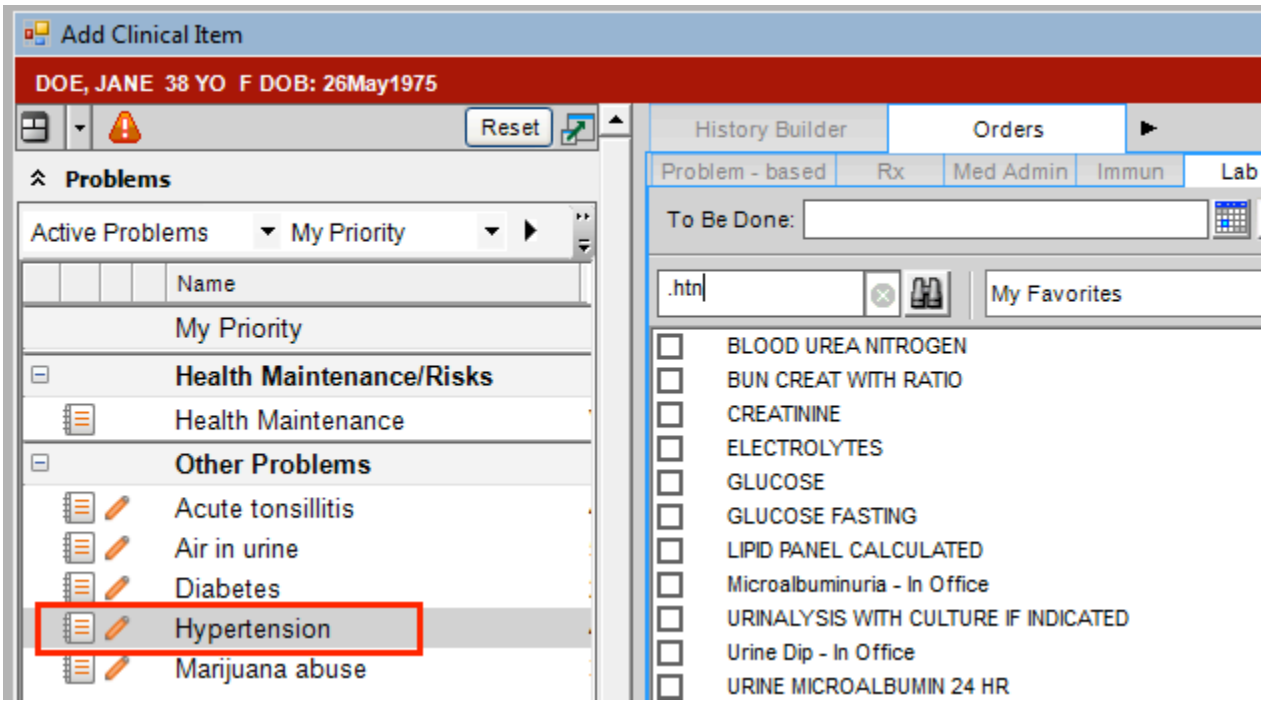
Using “Keywords” When Ordering Lab Tests

In the following example, the Provider is going to use the “.HTN” Keyword to order some labs for a selected patient.

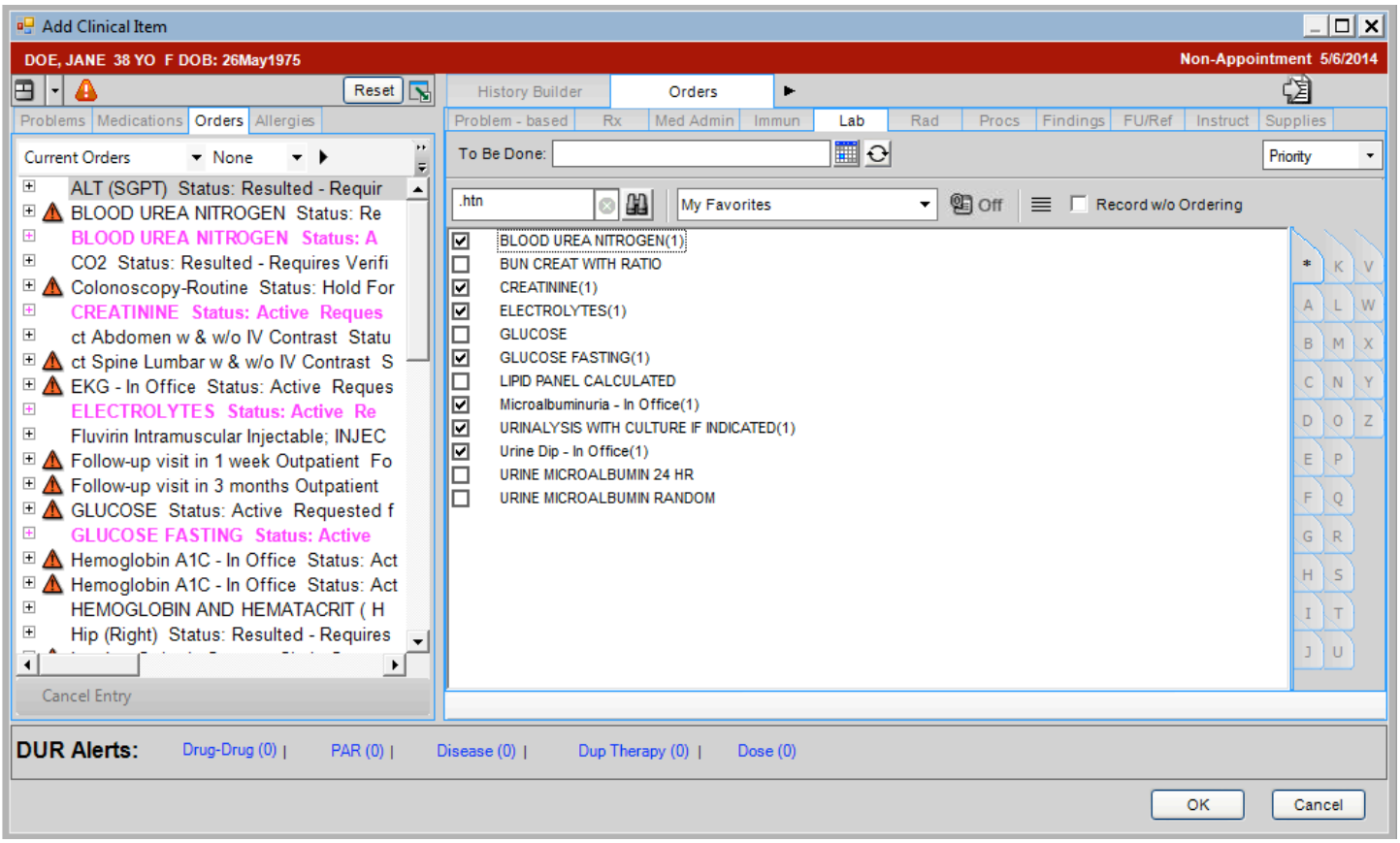
1. In the “Lab” tab of the ACI, search for “.HTN” then hit enter, or click on the binoculars.



2. Before selecting the items that you would like ordered for this patient, highlight the associated active problem in the Active Problems viewing pane.



3. Now that the Active Problem is highlighted, place a check mark in the corresponding box, for the lab items that you wish to order.



4. Once all items are ordered, click OK. Commit your information, then “Save and Continue”

Quick Reference Guide
Invalidating and Copy Forward Functions

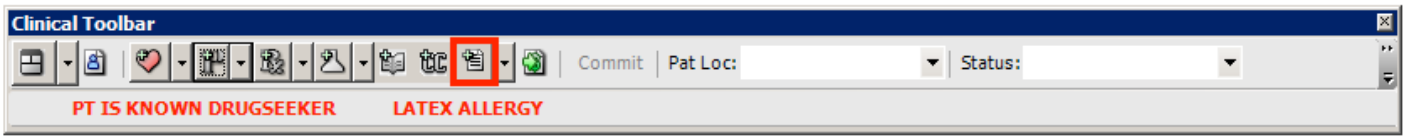
Invalidating a Note

In some instances, Providers may need to invalidate clinical documents so they are essentially removed from the patient's chart. This may occur if the note that was created was the wrong note type or was created on the wrong patient account. Invalidating clinical documents hides the documents from the chart viewer window by default.

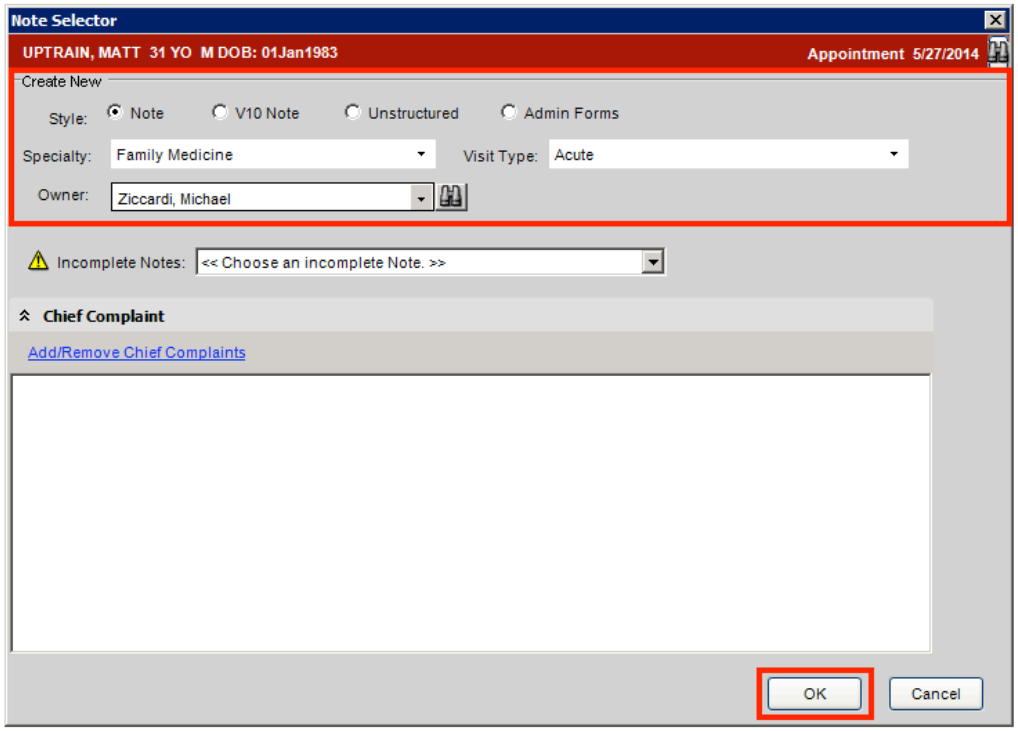
Copy Forward & Invalidating an Incorrect Note

In some instances, a provider may have to copy their documentation from a note that was incorrectly generated into a new note with the correct visit type information. An example of this would be if a Clinical Staff member created a note for a Health Maintenance visit and the provider began documentation on the note but realized it should have been an Established Visit type for billing purposes. The documentation can be copied from the initial Health Maintenance note, pulled into the Established Visit note, and in turn the original note can be invalidated from the patient's record.

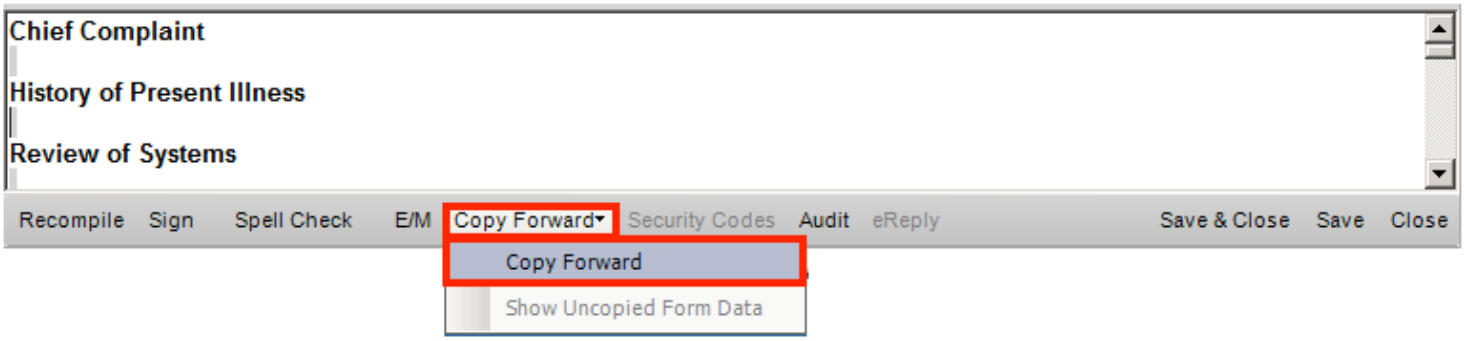
1. The provider must first start a correct, new note. To do so, click on the **Note** icon on the Clinical Toolbar.



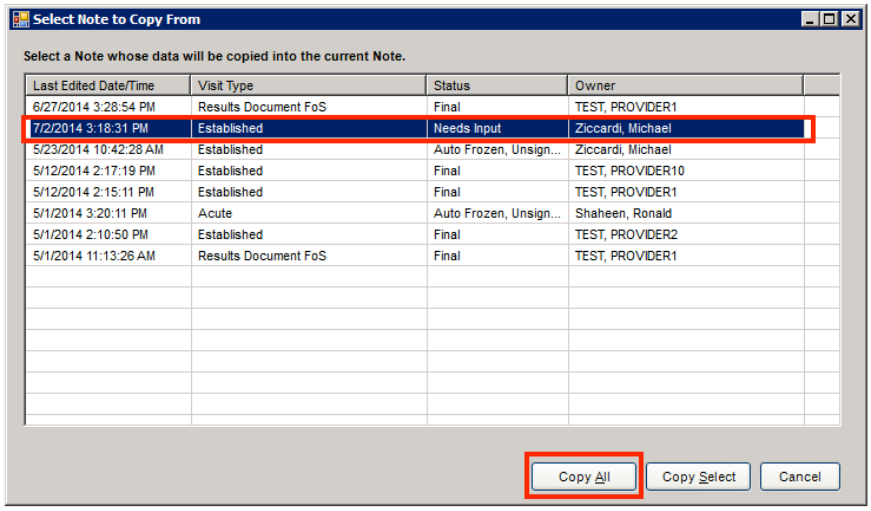
2. The Note Selector window appears. Fill out the **Style**, **Specialty**, **Owner**, and **Visit Type** sections. Click **Ok**.



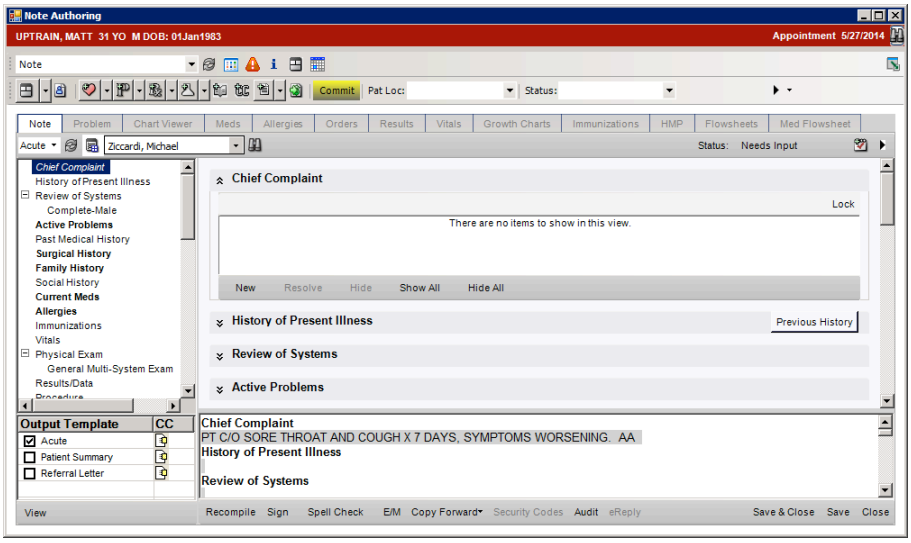
3. Once on the Note Authoring screen, click the **Copy Forward** button at the bottom of the screen and select **Copy Forward** from the menu.



4. The "**Select Note to Copy From**" window displays. Click on the desired note to copy from and then click **Copy All** or **Copy Select**. In this example, we will select **Copy All**.

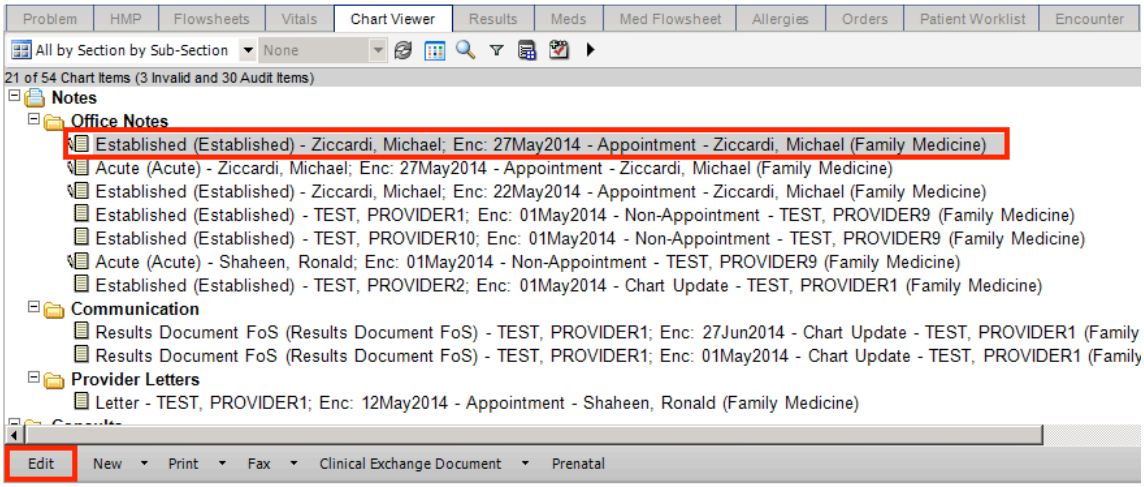


5. The items will be copied over into your current note, as shown in the example below.

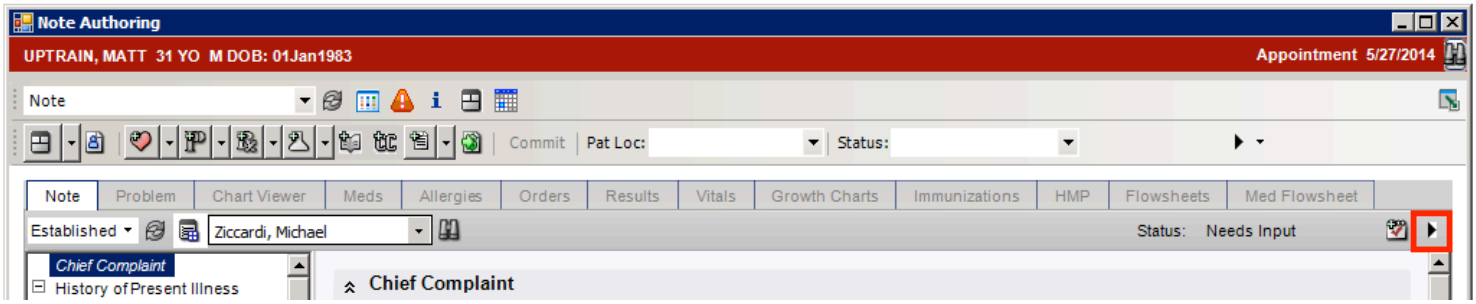


6. Click **Save and Close.**

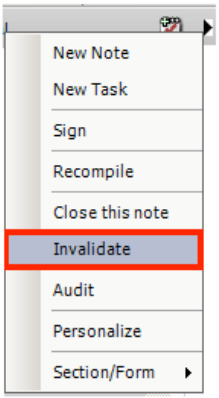
7. Navigate to the Clinical Desktop and click on **Chart Viewer**. Highlight the note that needs to be invalidated and click the **Edit** action button at the bottom of the screen



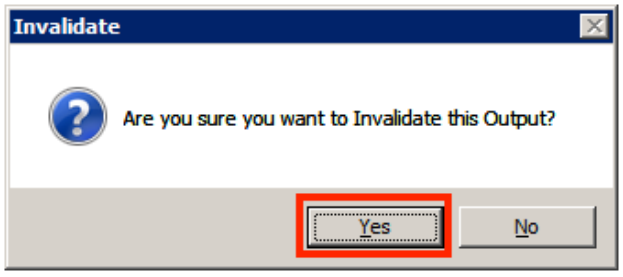
8. This launches the **Note Authoring** workspace. Navigate to the right side of the screen and click on the bold arrow.



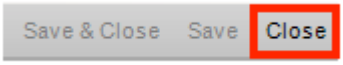
9. Select "**Invalidate**" from the drop down menu.



10. The provider will get the following warning. Click **Yes**.

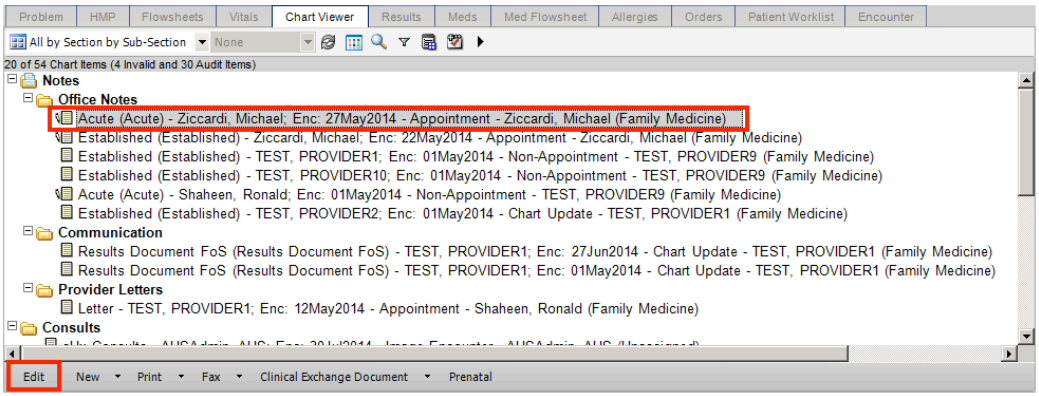


11. This will put lines through all of your entries within that note and gray out all other options with the exception of the "Close" button at the bottom of the screen. Click **Close**.

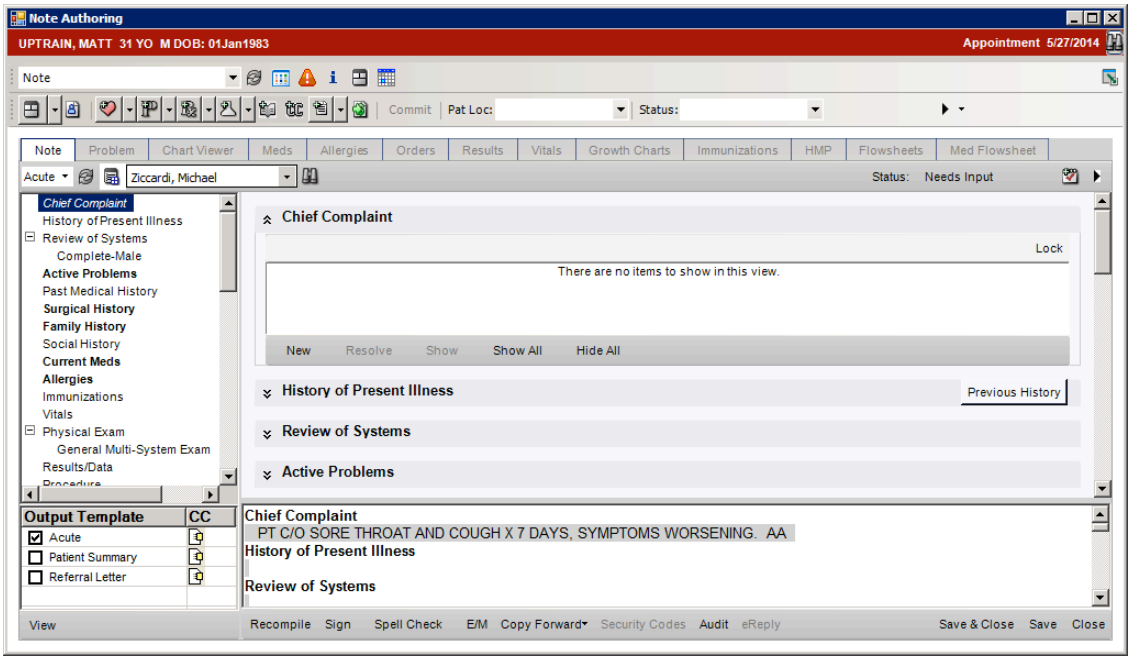


12. Navigate back to the **Chart Viewer** to ensure that the note you just invalidated is no longer visible.

13. Locate the correct note and click “**Edit**”.



14. Review the information that has been pulled into your new note and make any necessary changes. Complete your regular documentation.



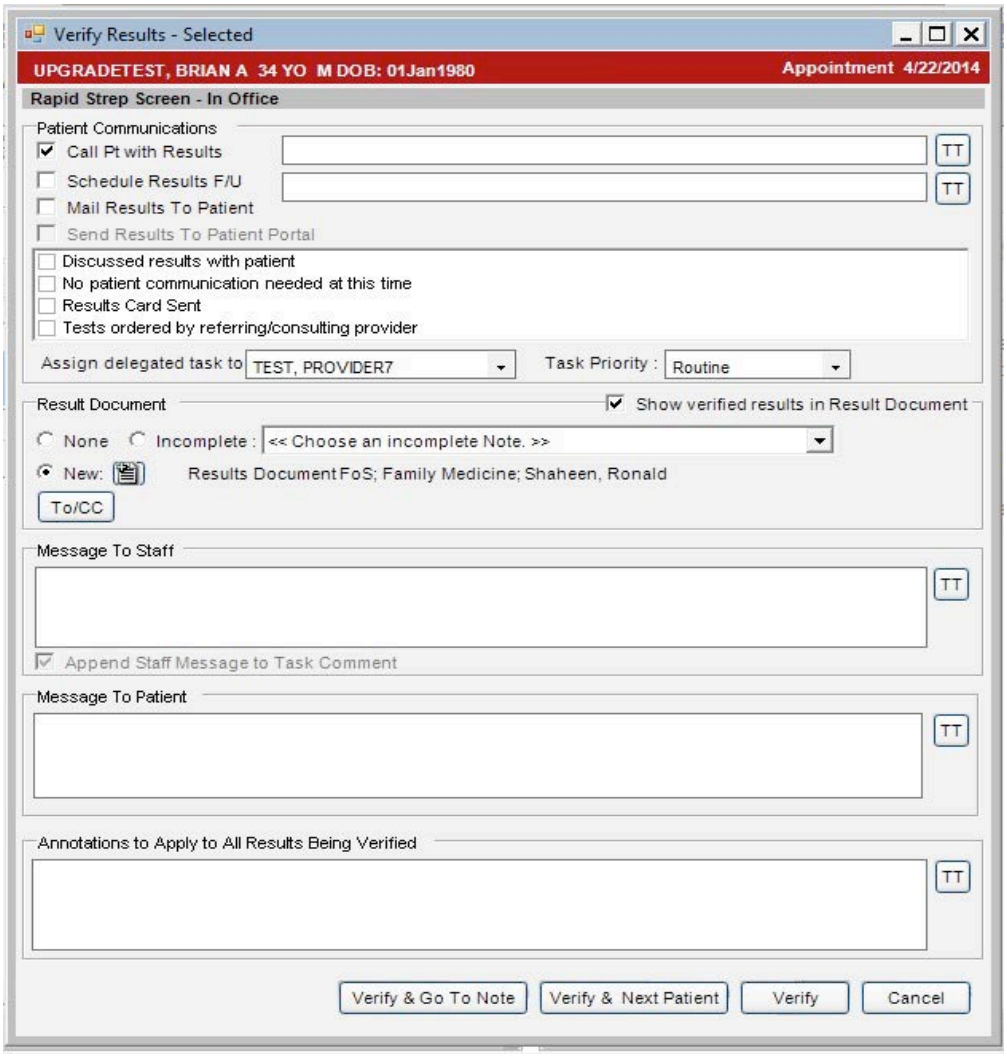
Quick Reference Guide

Results Verification

Just as signatures were required on paper results, verification is required on electronic results within the EMR. Results that need verification populate automatically on your Tasklist as a “Verify Patient Results” task. From the Tasklist, double click on the “Verify Patient Results” task and the user will be directed to the Patient Worklist.

Results Verification Dialog Overview

Providers can verify results by right-clicking on the result, or clicking the **Verify** action button and selecting the appropriate option. If Verify or Verify all is selected the **Verify Results – Selected** Window will launch. Here the provider will select how they want the results communicated to the patient.



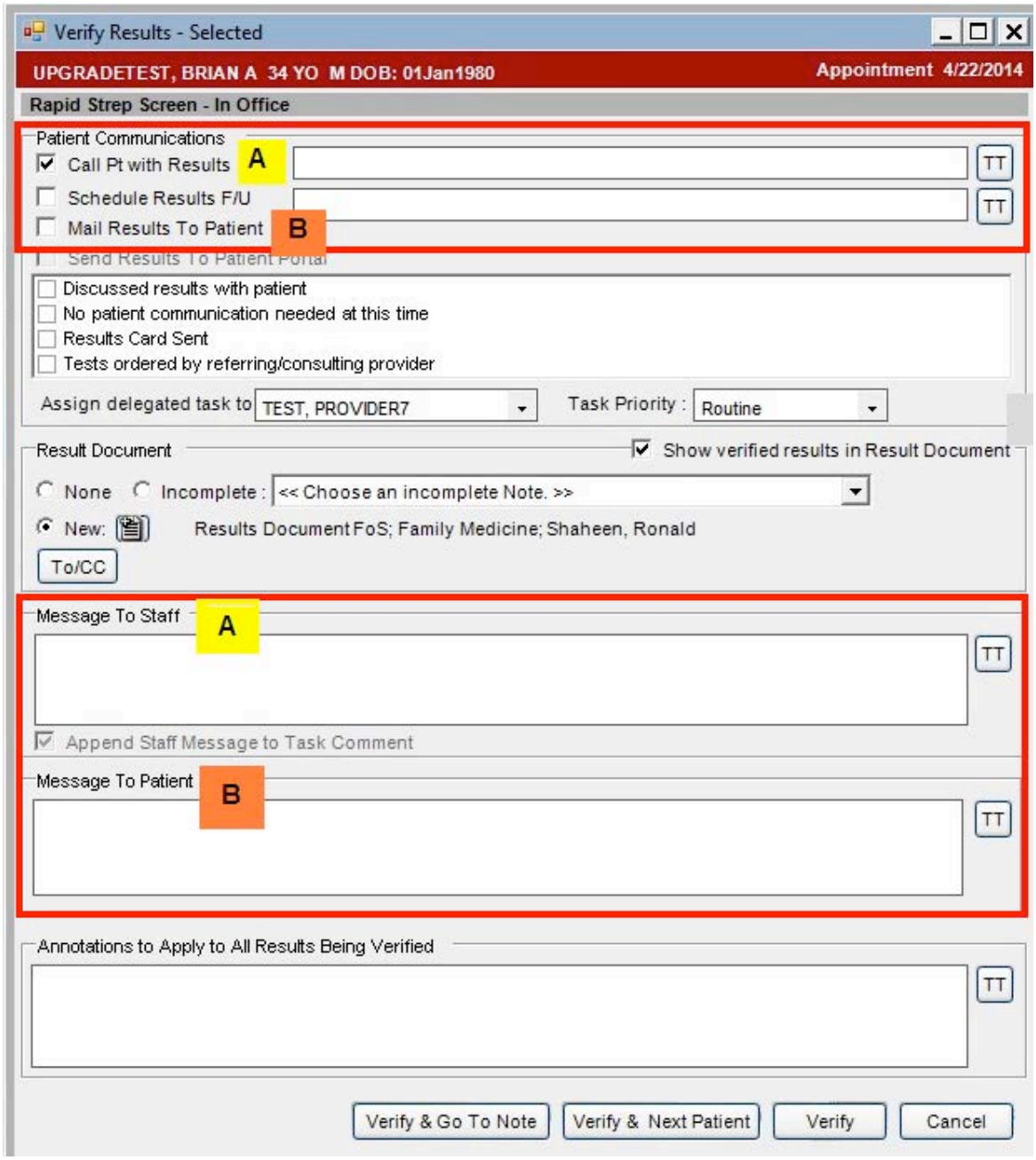
Patient Communication Options

Patient Communication (Generating a Task)

If the Provider would like a task generated with the results that are being verified, one of the first three options must be selected. The three patient communications that will generate a task to the delegated staff members are as follows:

1. Call Pt with Results
2. Schedule Results F/U
3. Mail Results to Patient

If one of these three options is selected, the provider will enter any related information in the “Message to Staff” or “Message to Patient” fields. Typically, if “Call Pt with Results” is selected, the provider puts their correspondence in the “Message to Staff” field. Additionally, if “Mail Results To Patient” is selected, the corresponding information should be entered in the “Message to Patient” field.



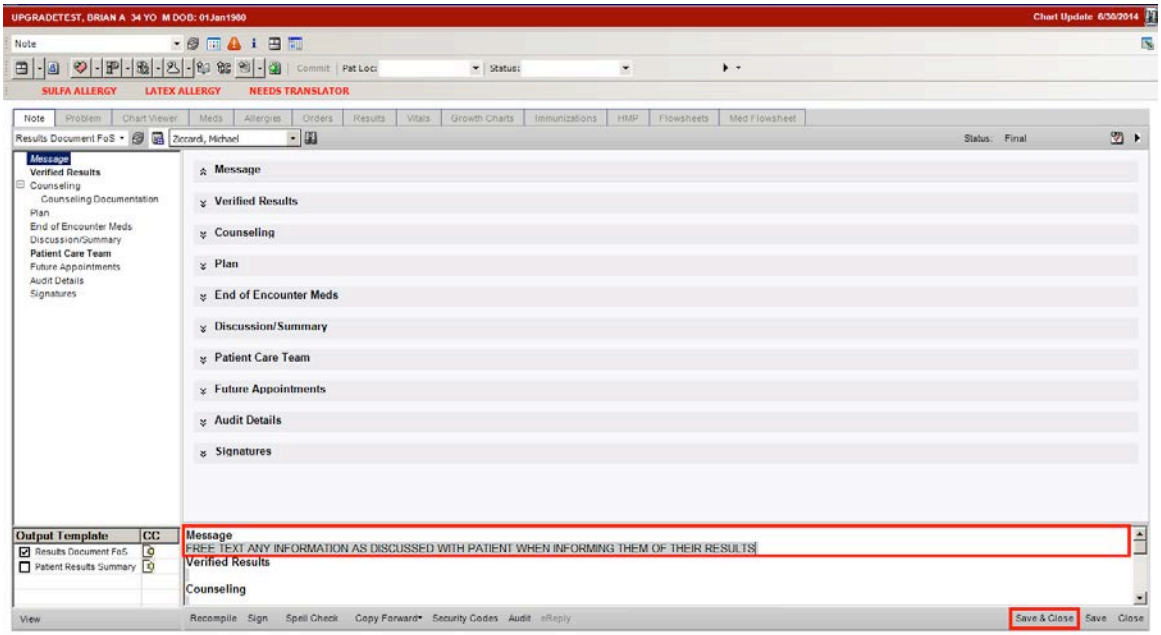
Patient Communication (No Task Generated)

If the Provider selects any of the four options below, a task will NOT be generated. If the Provider wants a support staff member to carry out the rest of the process, these four options should not be used.

Available Verify Options

The user has three verify options to choose from when performing the verification process.

1. **Verify & Go To Note:** This action will launch the Note Authoring Workspace for a “Results Document FoS”. Providers can order items, or document any other pertinent information in this workspace. Once all items are noted, click “Save and Close.” Please note, if no details need to be added in the Note Authoring Workspace, click “Close.”

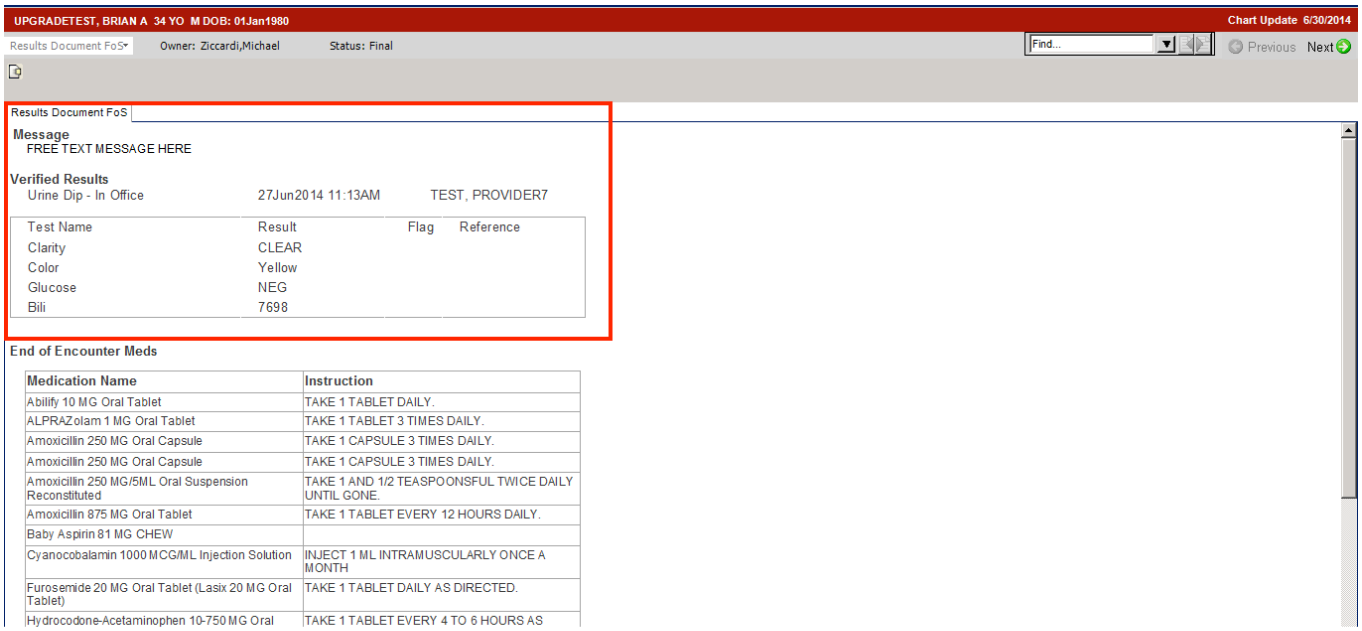


2. **Verify & Next Patient:** This action will verify the results for the patient currently in context and pull up the next patient in the **Patient Worklist.** Please note, that while this option will not launch the Note Authoring Workspace, it will still generate a Results Document FoS.

3. **Verify:** This action will verify the results and bring the user back to the current patient’s worklist. Please note, that while this option will not launch the Note Authoring Workspace, it will still generate a Results Document FoS.

Results Document FoS Overview

The **Results Document** allows the provider to document any details and discussed items as it relates to the result they have verified.

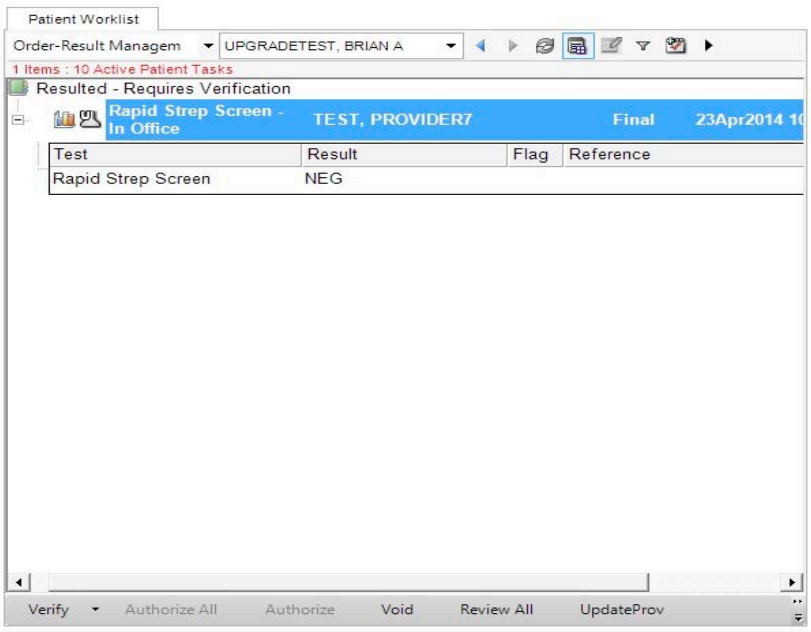


QVerify

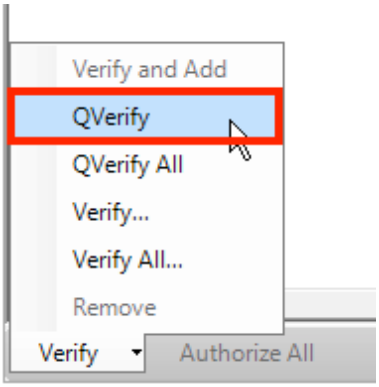
QVerify allows the Provider to quickly verify the selected result, where no further action is needed. To QVerify, follow the directions listed below.

1. Navigate to the **Tasklist** tab and double-click on the **Verify Patient Results** task. The user will be directed to the **Clinical Desktop** tab.

2. Review the result in the Patient Worklist (Order-Result Management View).



3. Select the **Verify** action button and click **QVerify**



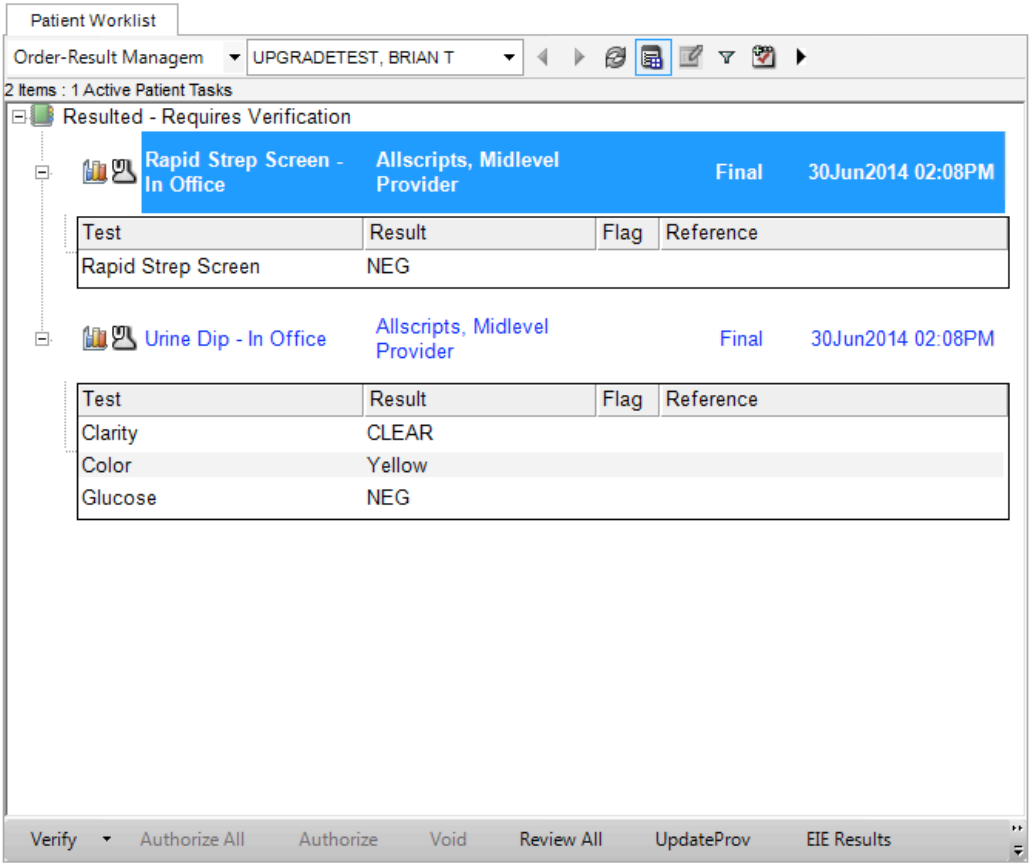
NOTE: The system will automatically advance you to the next patient that has a result that requires verification or order that requires authorization.

QVerify All

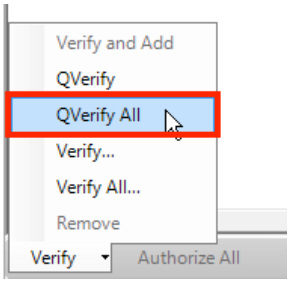
QVerify All allows the Provider to quickly verify all results for the patient, where no further action is needed. To QVerify All, follow the directions listed below

1. Navigate to the **Tasklist** tab and double-click on the **Verify Patient Results** task. The user will be directed to the **Clinical Desktop** tab.

2. Review the results on the Patient Worklist (Order-Result Management View).



3. Select the **Verify** action button and click “QVerify All”



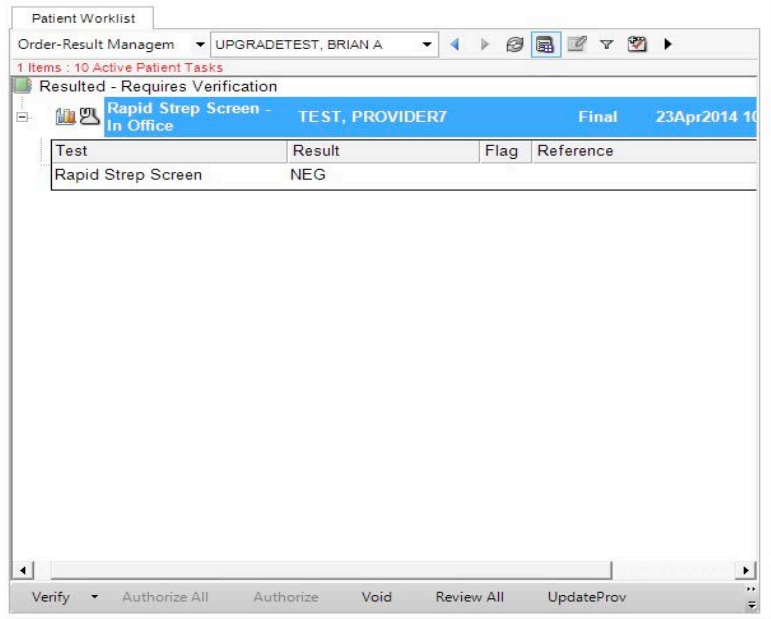
NOTE: The system will automatically advance you to the next patient that has a result that requires verification or order that requires authorization.

Verify (Call Patient with Results)

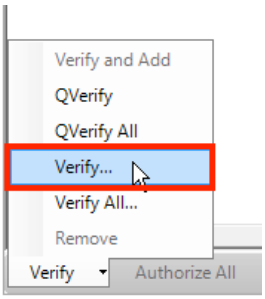
Verify allows the Provider to verify a single result, where further patient communication and action is needed. To call the patient with results, follow the directions listed below.

1. Navigate to the **Tasklist** tab and double-click on the **Verify Patient Results** task. The user will be directed to the **Clinical Desktop** tab.

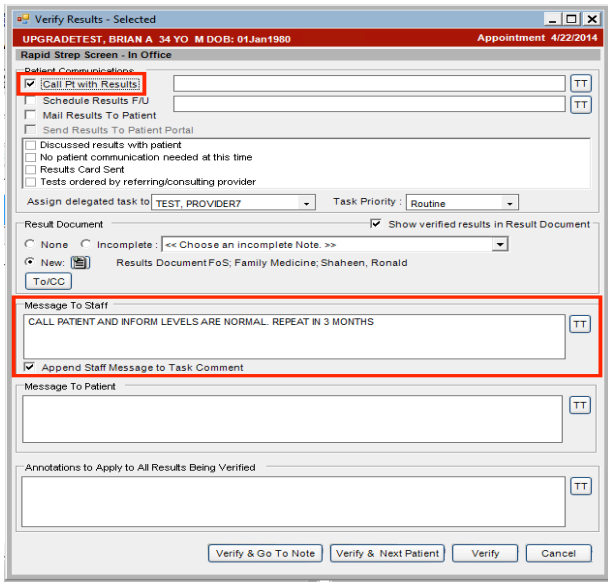
2. Review the result on the Patient Worklist (Order-Result Management View).



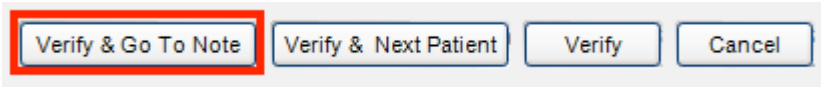
3. Select the **Verify** action button and click “Verify”. The **Verify Results** window launches.



4. **Call Pt with Results** is selected by default. In the **Message To Staff** field the Provider will free text the message they want the staff to relay to the patient regarding their results.



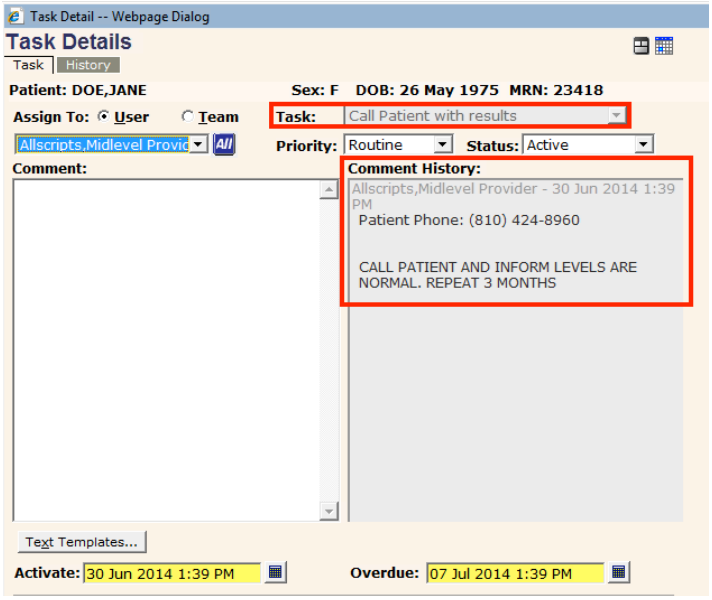
5. Click the **Verify and Go To Note** button.



6. Once the Note Authoring Window appears, click **Save and Close**.

NOTE: If no details have been added once the Note Authoring Window appears, click Close.

7. A task called “Call Patient With Results,” is automatically generated for the Clinical Staff. The task will include your comments entered. If the task is double-clicked, the staff have the results that were referenced along with the notes as well.

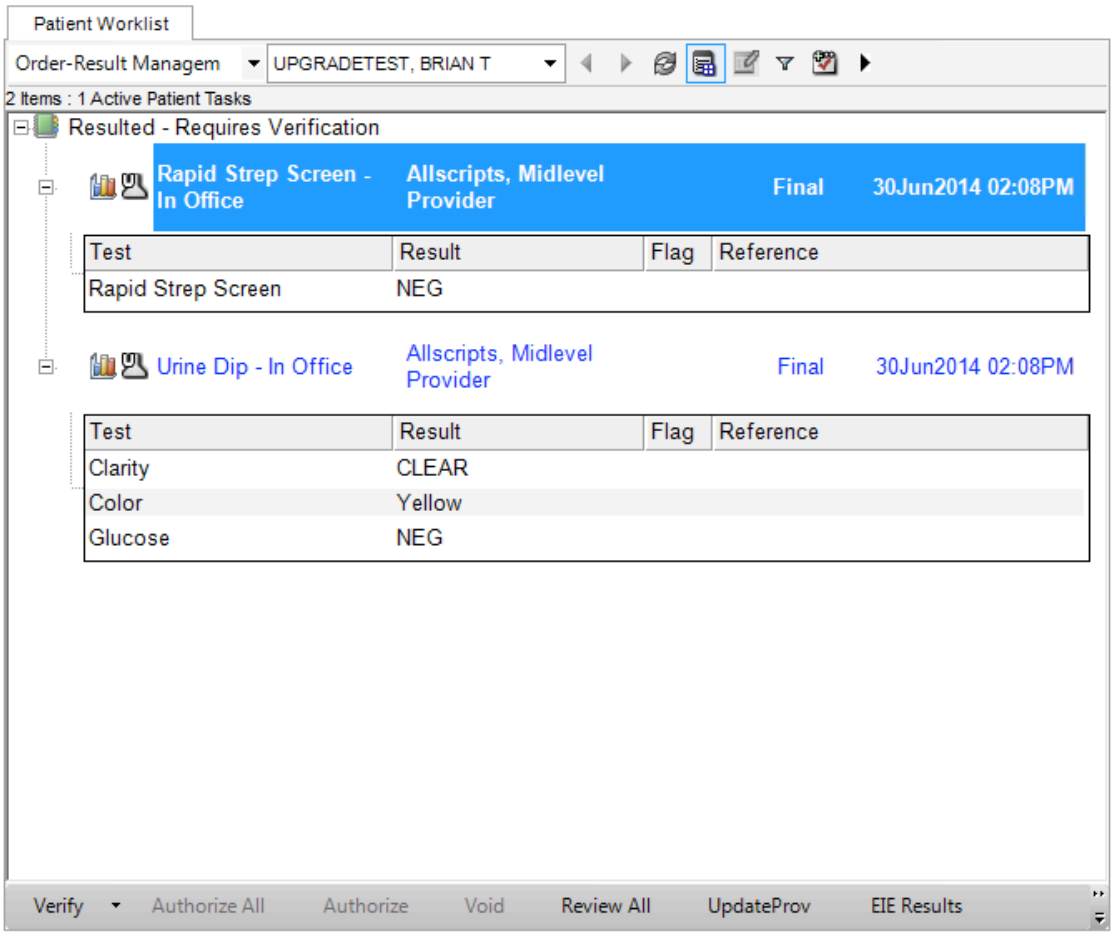


Verify All

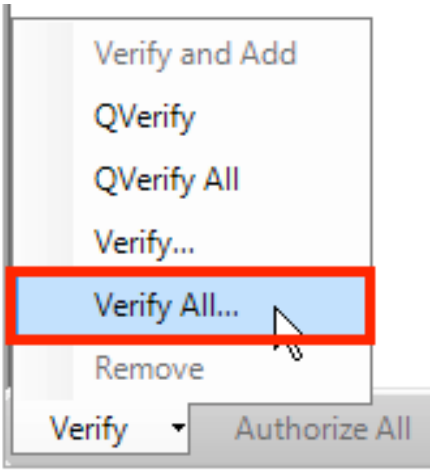
Mail Results to Patient

1. Navigate to the **Tasklist** tab and double-click on the **Verify Patient Results** task. The user will be directed to the **Clinical Desktop** tab.

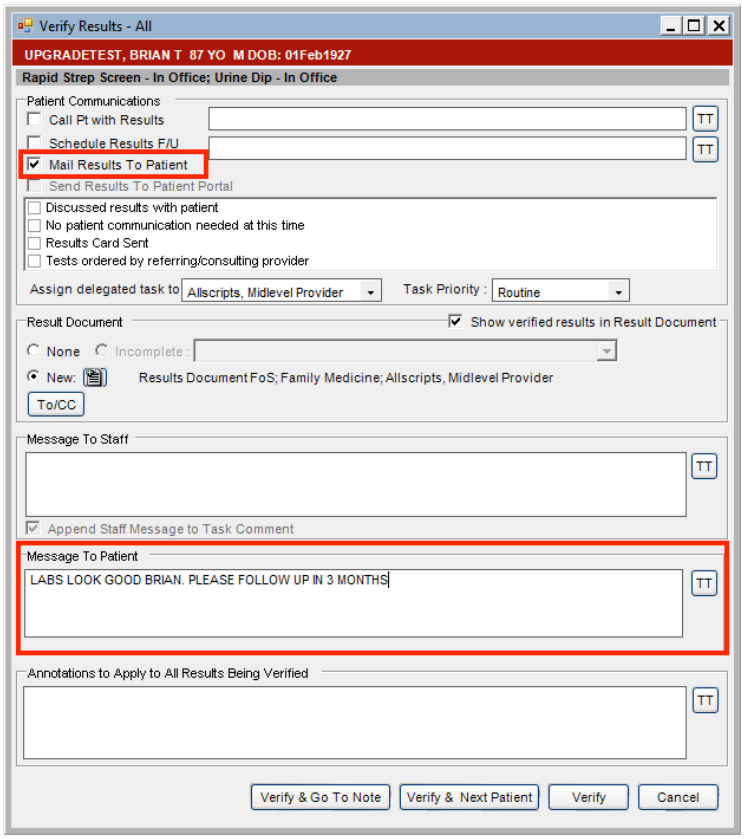
2. Review the results on the Patient Worklist (Order-Result Management View).



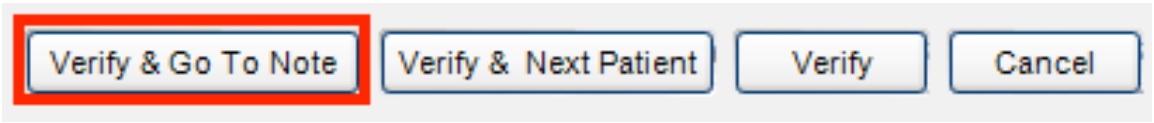
3. Select the **Verify** action button and click “Verify All”**.**



4. Uncheck **Call Pt with Results** and place a checkmark in **Mail Results to Patient.** In the **Message to Patient** field the Provider will free text the message they want the patient to receive in regards to their results.



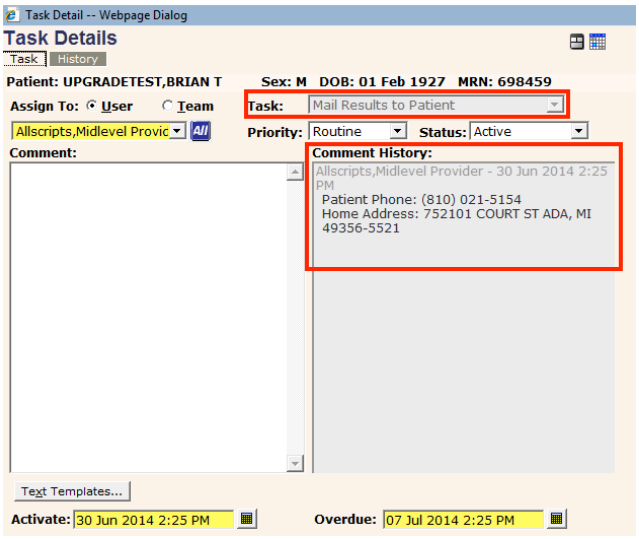
5. Click the **Verify and Go To Note** button.



6. Once the Note Authoring Window appears, click **Save and Close**.

NOTE: If no details have been added once the Note Authoring Window appears, click Close.

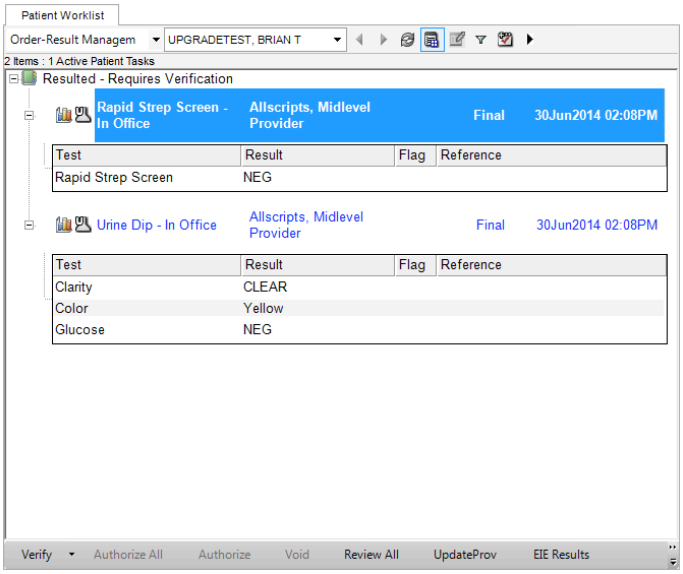
7. A **“Mail Results to Patient”** task is automatically generated for the Clinical Staff to print the results and mail them to the patient. The document printed will include your comments noted in the verification process as listed above, along with the results that were verified.



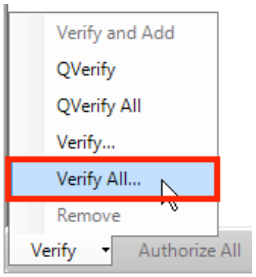
Scheduling Results Follow-up

1. Navigate to the **Tasklist** tab and double-click on the **Verify Patient Results** task. The user will be directed to the **Clinical Desktop** tab.

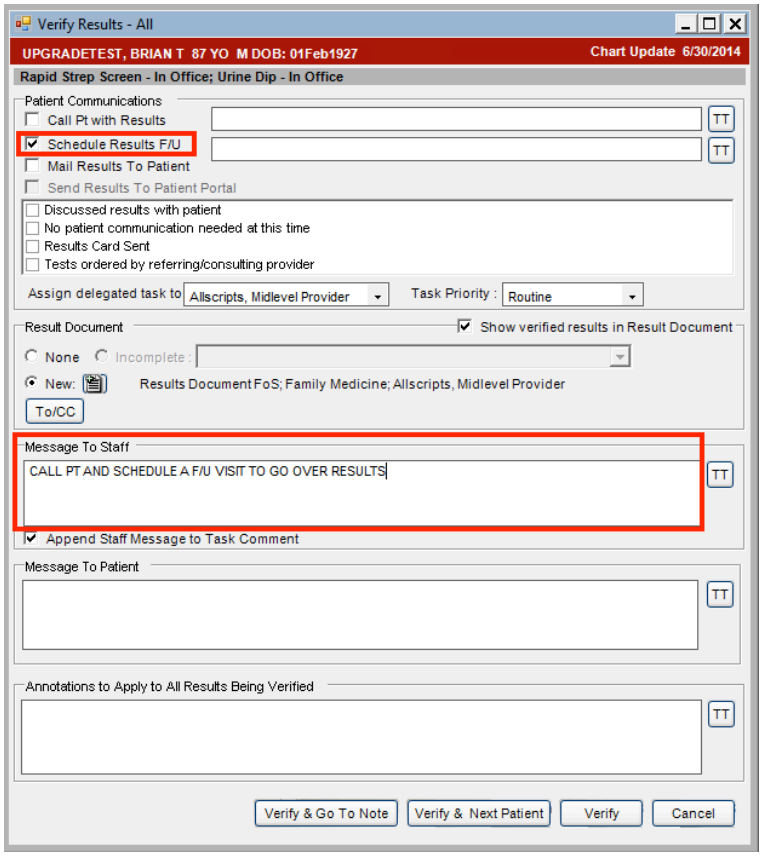
2. Review the results on the **Patient Worklist** (Order-Result Management View).



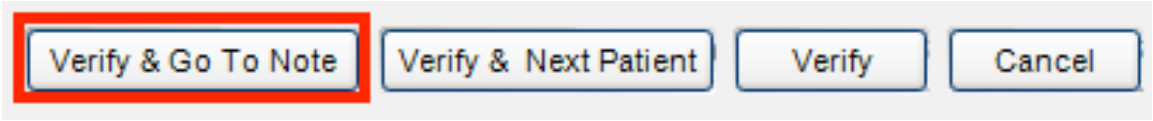
3. Select the **Verify** action button and click “Verify All”



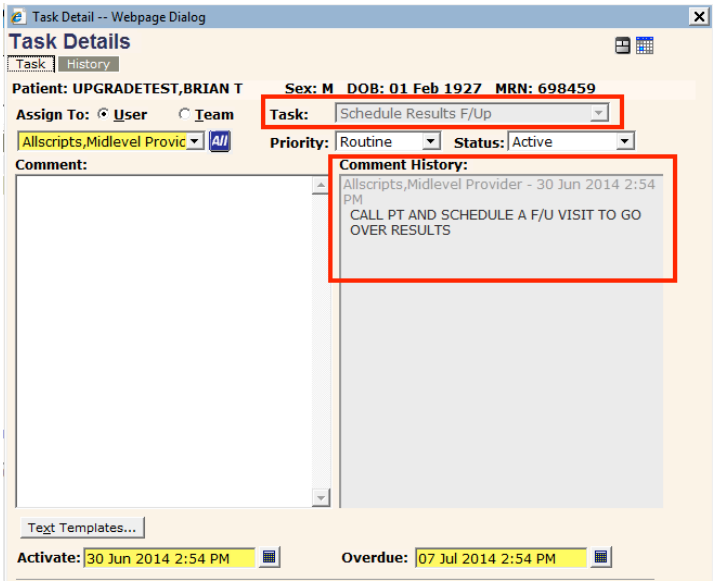
4. Uncheck **Call pt with Results** and place a checkmark in **Schedule Results F/U.** In the **Message to Staff** field the Provider will free text the message they want the staff to relay to the patient in regards to their results.



5. Click the **Verify and Go To Note** button. Once the Note Authoring Window appears, click **Save and Close**.



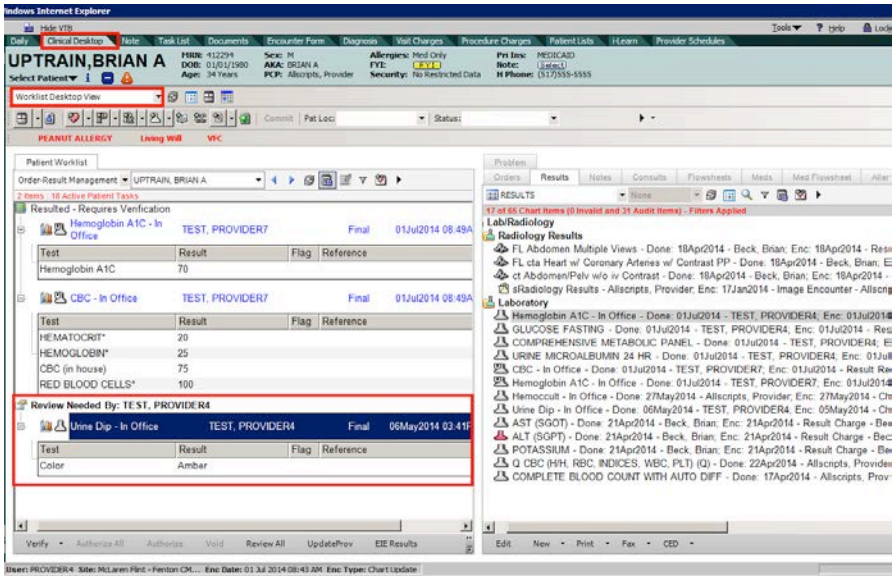
6. A **"Schedule Results F/Up"** task is automatically generated for the Clinical Staff to schedule a follow-up to go over their results.



Review

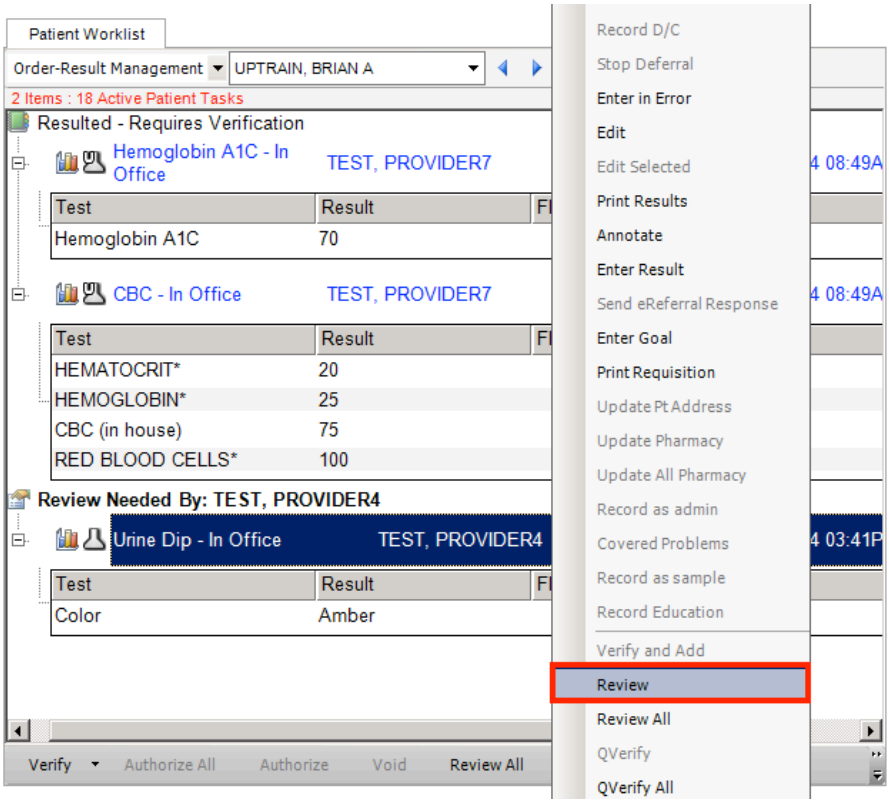
Review allows the provider to review one selected result while covering for another provider. In any scenario that the provider acknowledging the results is not the ordering provider, **Review** will most likely be utilized versus the Verify functions.

1. Navigate to the **Clinical Desktop** tab and ensure that the **Worklist Desktop View** is selected from the drop down. This will display the **Patient Worklist.** Please note that if you are not the ordering provider, and you are copied on a result, you will have a “Review Results” task in your Tasklist. Double clicking on that item will take you to the proper worklist as indicated in the displayed image below.



2. Review the results in the **Patient Worklist**.

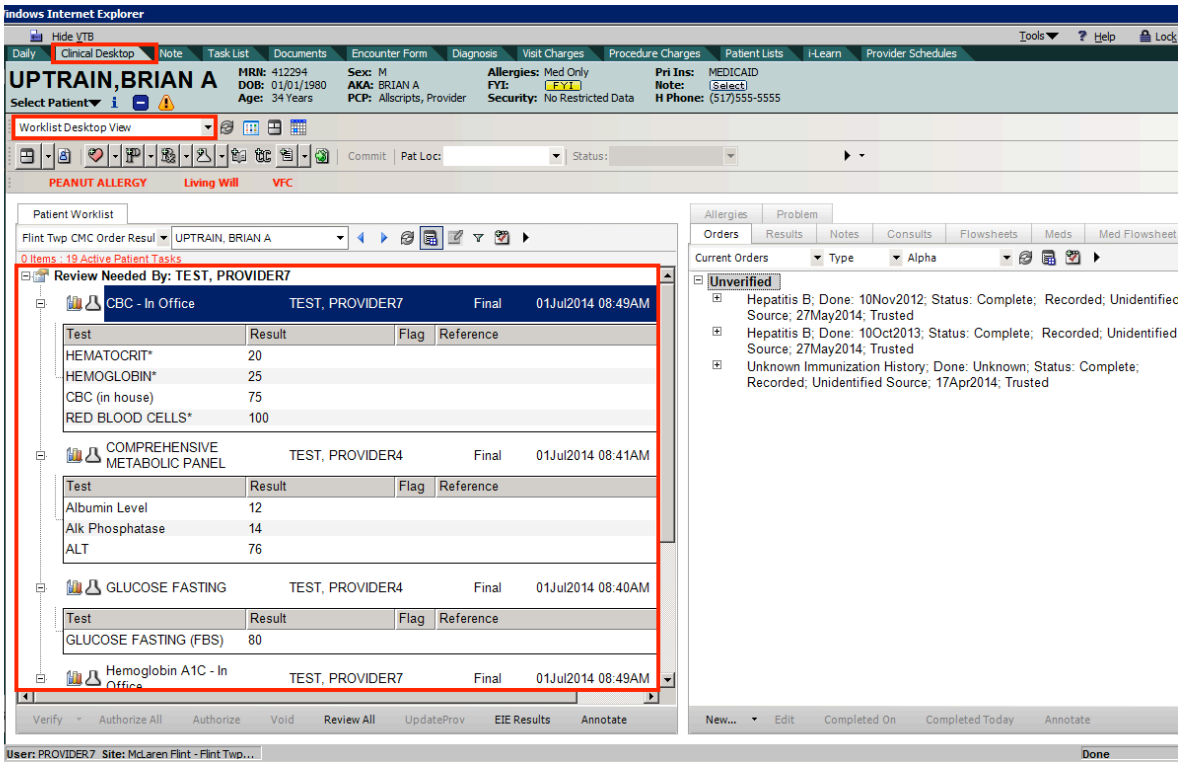
3. Right click on the result you have reviewed and select **Review.**



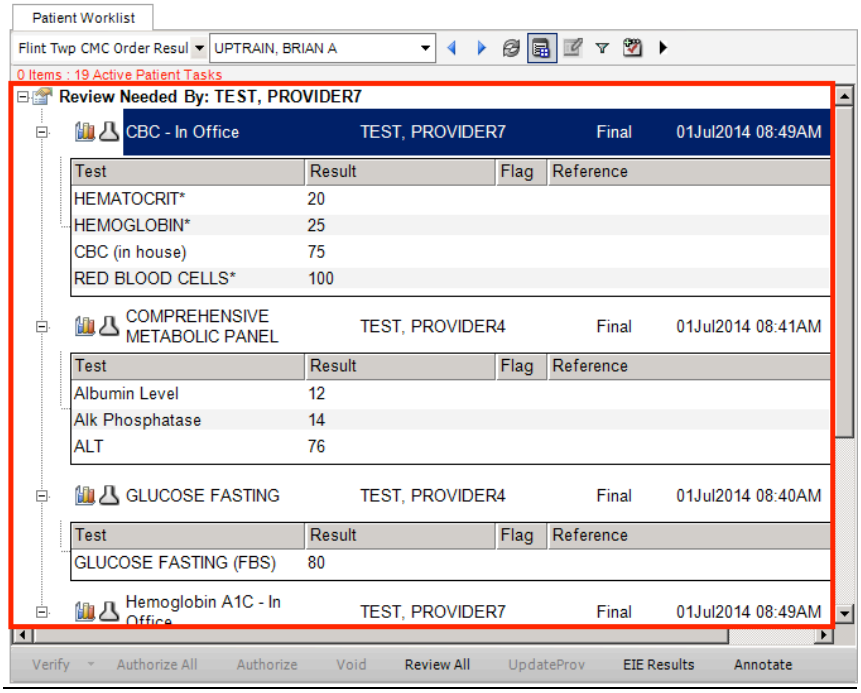
Review All

Review All allows the Provider to review all results displayed while covering for another provider or if copied on a result as the Primary Care Provider where you are not the ordering provider.

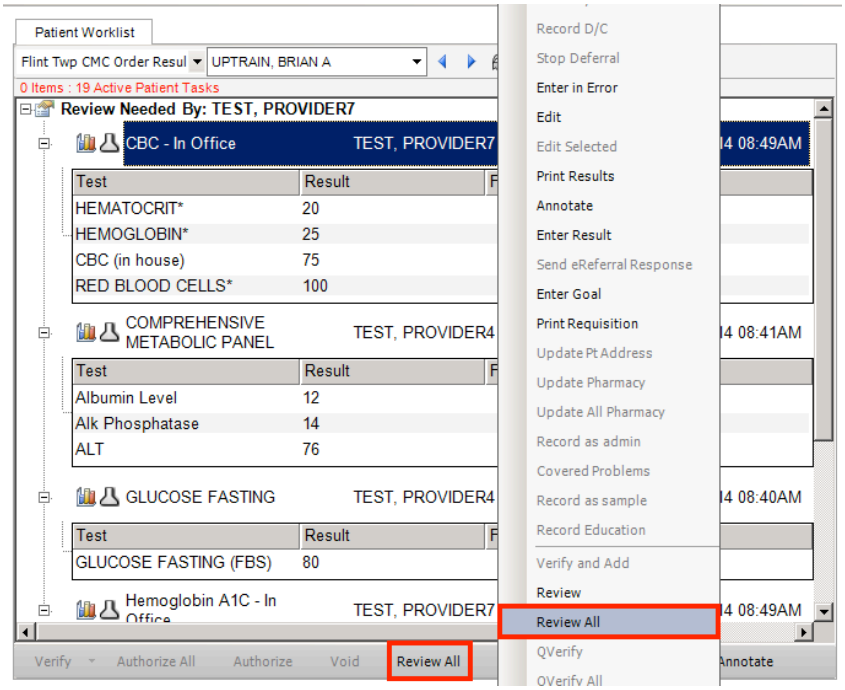
1. From the **Clinical Desktop** tab, ensure that the **Worklist Desktop View** is selected from the drop down. This will display the **Patient Worklist.** Please note that if you are not the ordering provider, and you are copied on a result, you will have a “Review Results” task in your Tasklist. Double clicking on that item will take you to the proper worklist as indicated in the displayed image below.



2. Review the results in the **Patient Worklist**.



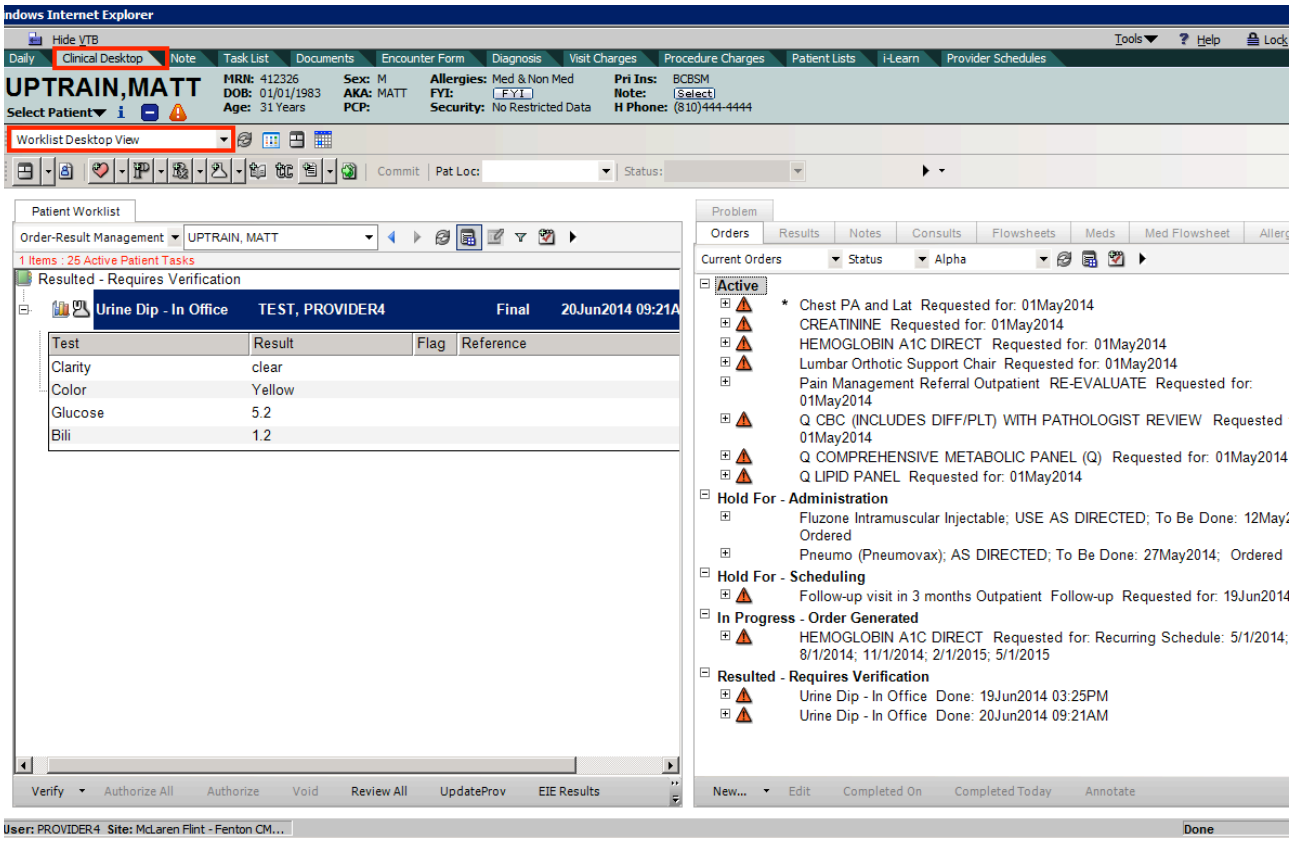
3. Right click on a result and select **Review All**, or select the **Review All** Action button.



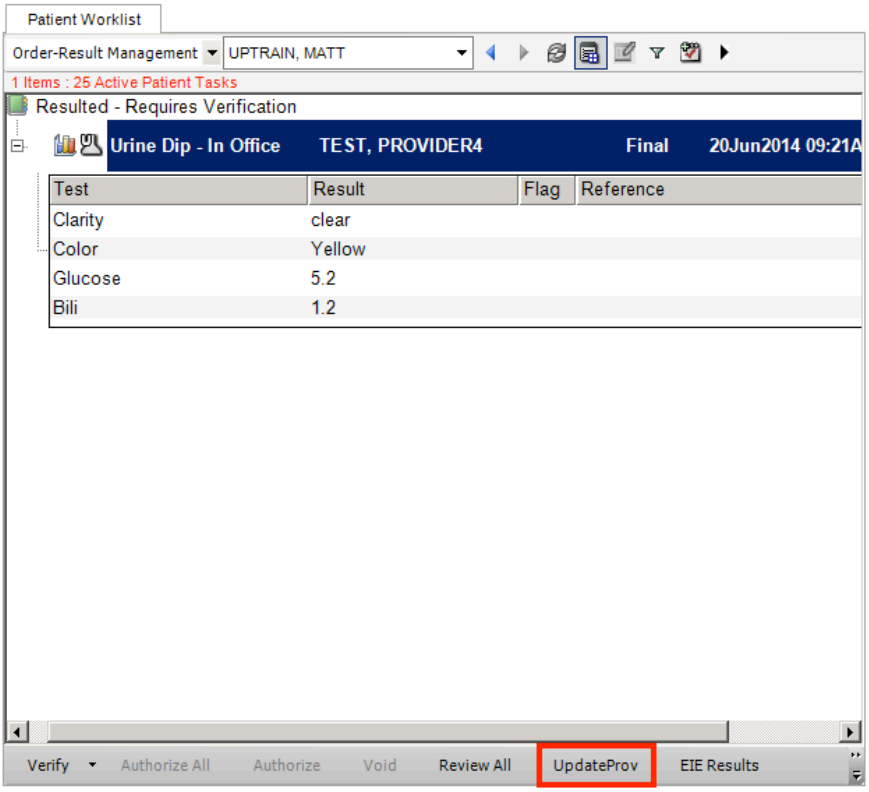
Update Provider

The **Update Provider** function allows the provider to indicate the appropriate provider, when the wrong ordering provider was entered on the result. This will complete the task that the incorrect provider had received, and will automatically generate a new task to the updated provider's Task list.

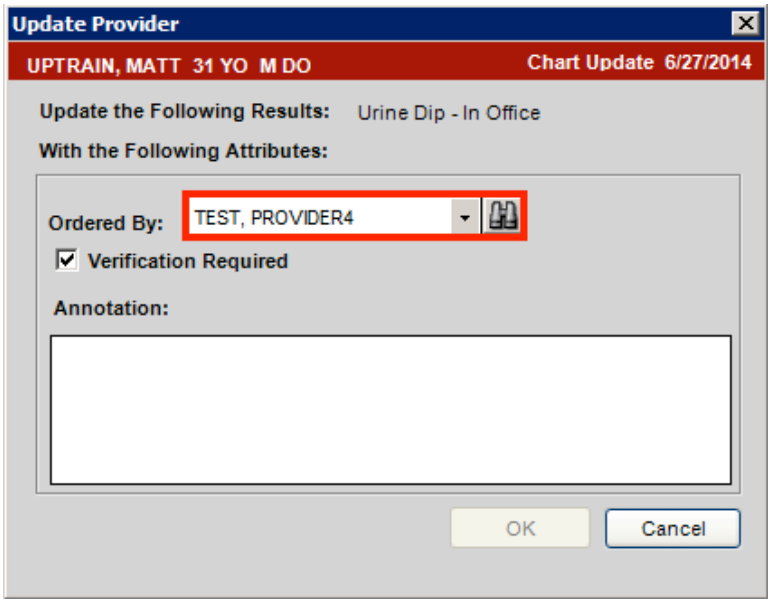
1. From the **Clinical Desktop** tab, ensure that the **Worklist Desktop View** is selected from the drop down. This will display the **Patient Worklist.**



2. Either right-click on the result and select **Update Provider,** or click the **UpdateProv** Action Button at the bottom of the screen. The **Update Provider** window will launch.



3. Click the drop down arrow to select the correct Provider from the list. If you do not see the Provider you are looking for, click on the binoculars to the right of the arrow. The binoculars allow you to search for the appropriate ordering provider assuming that they are not already populated in your drop down list.

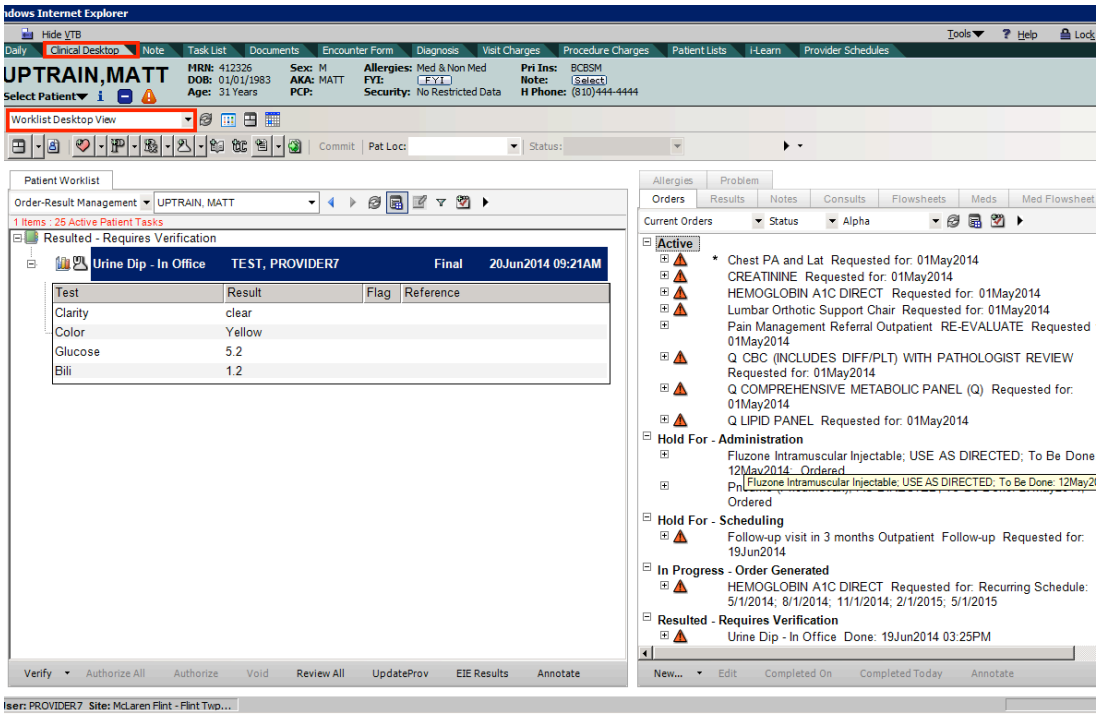


4. Once the correct Provider has been selected, click **OK.** The result will be taken off of the user's **Worklist** and put on the correct Provider's list.

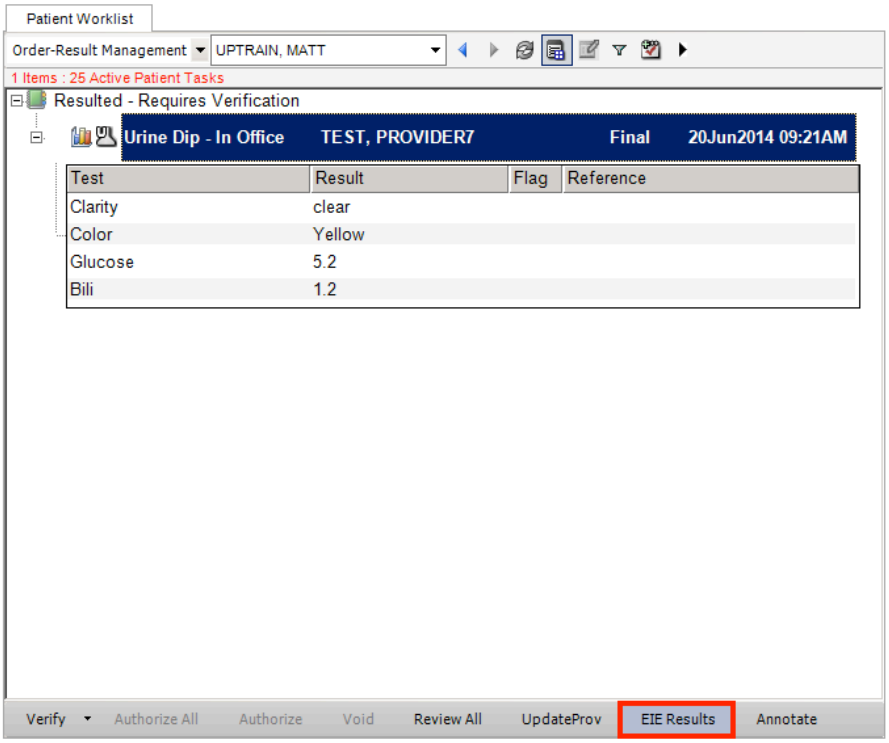
EIE Results

Enter in Error (EIE) allows the Provider to enter the results in error, if they were populated incorrectly into the EMR. The following workflow will remove the items from the chart along with appropriately removing the task associated with the incorrect results.

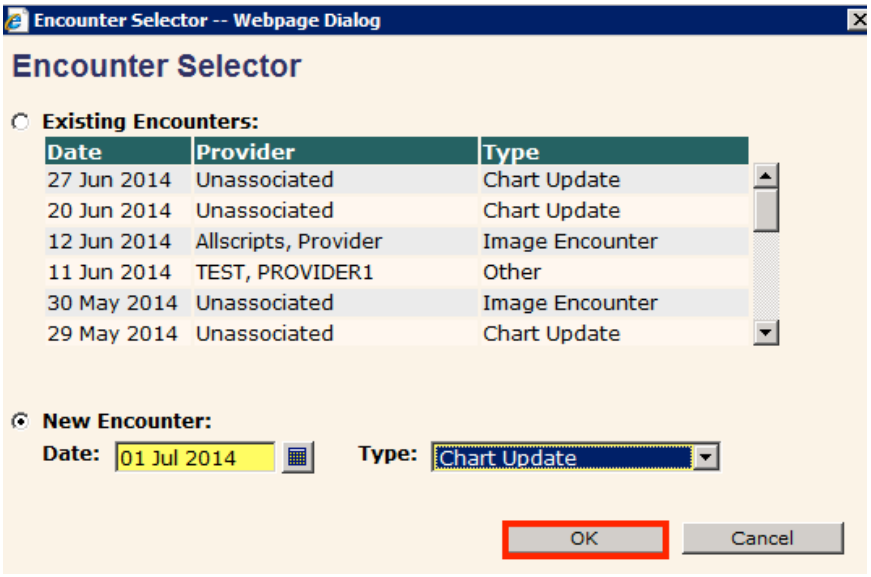
1. From the **Clinical Desktop** tab, ensure that the **Worklist Desktop View** is selected in the drop down. This will display the **Patient Worklist.**



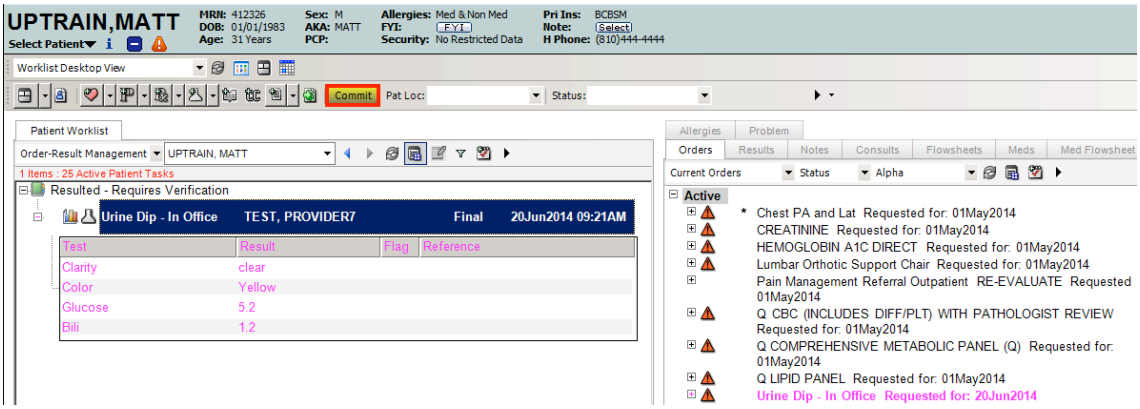
2. Either right-click on the result and select **Enter in Error,** or click the **EIE Results** action button at the bottom of the screen. The **Encounter Selector** window will launch.



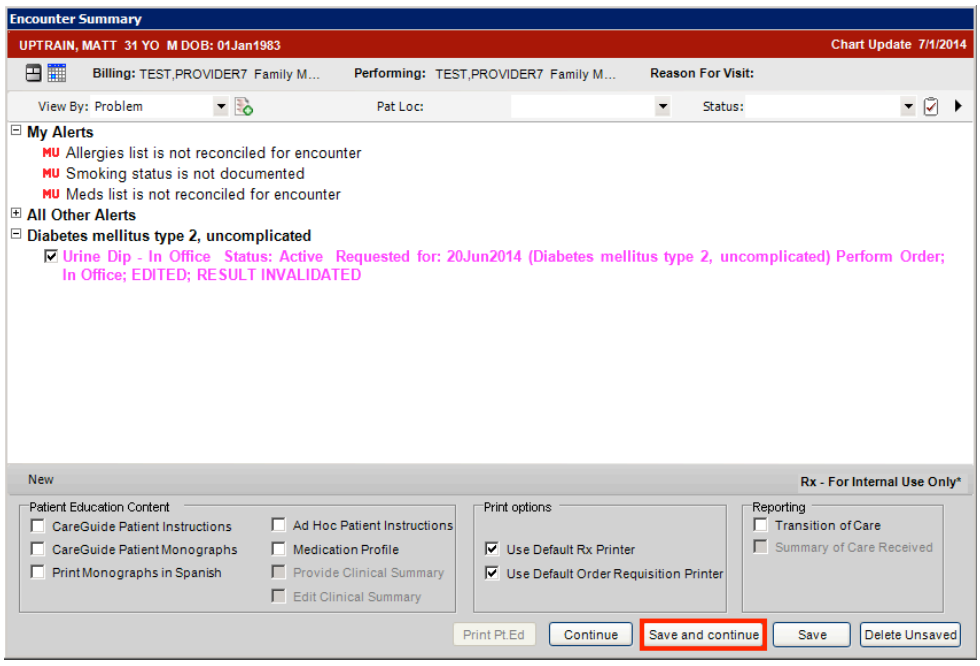
3. Appropriately select either an existing encounter or create a new encounter. Click **OK.** The text will turn Magenta/Pink.



4. Click **Commit.**



5. Once the **Encounter Summary** launches, click **Save and Continue.**

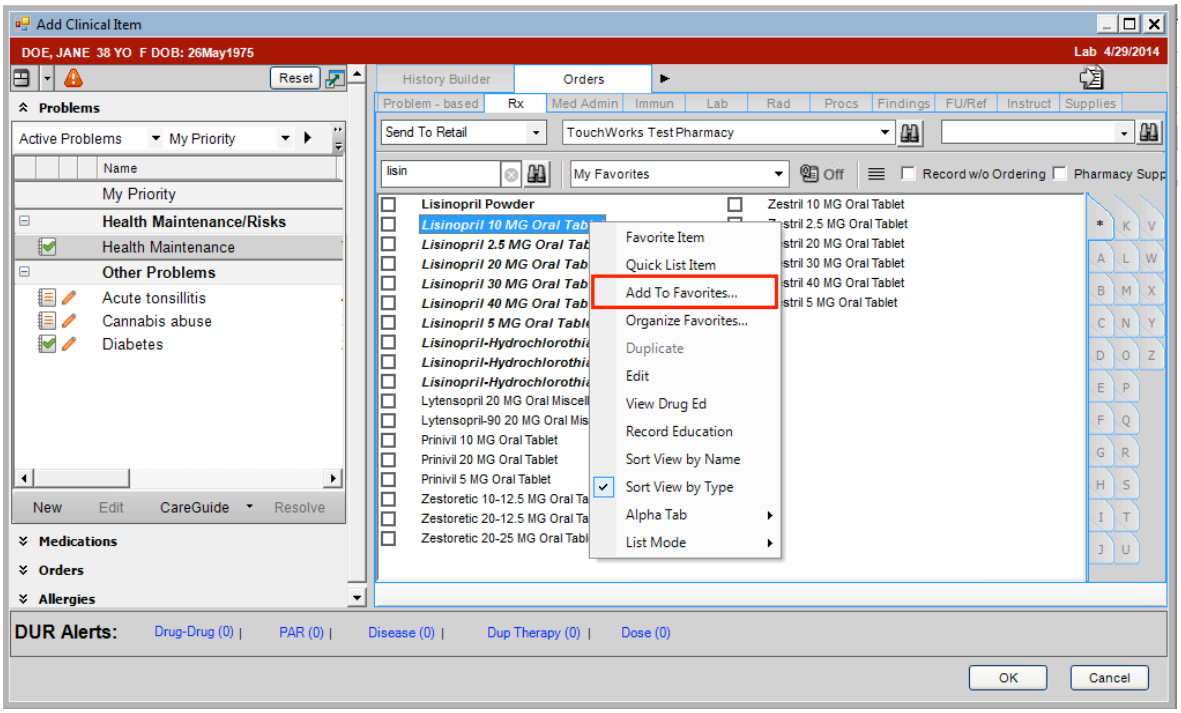


Order Groups

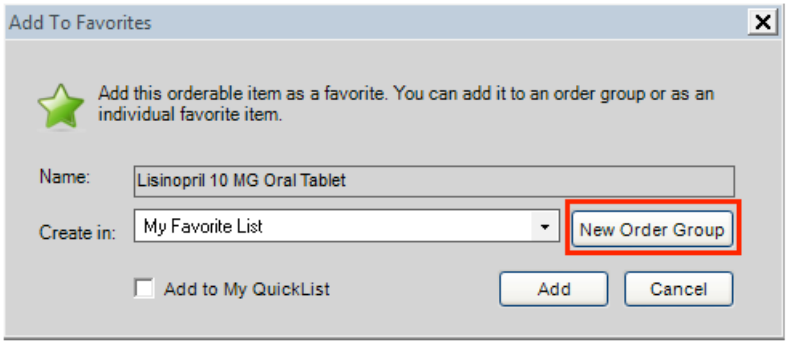
Allscripts TouchWorks EHR gives users the option of creating personalized order groups based on what is preferred by the user.

Creating Order Groups

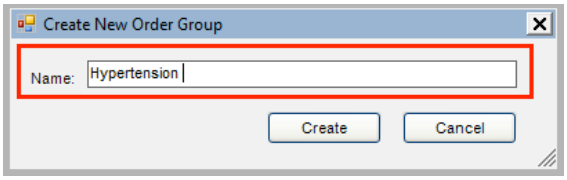
1. To create an order group, first search and locate the entry you would like to add in any of the secondary tabs under **Orders**. Simply right-click and select “Add To Favorites”.



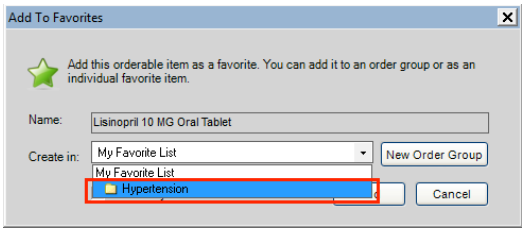
2. The **Add To Favorites** dialog window will appear. If a user already has established Orders groups, users can choose to add to it, or create a new Order Group entirely.



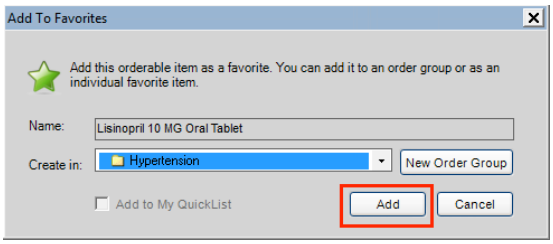
3. When prompted, enter the name in which you would like to title your group, then select “Create”.



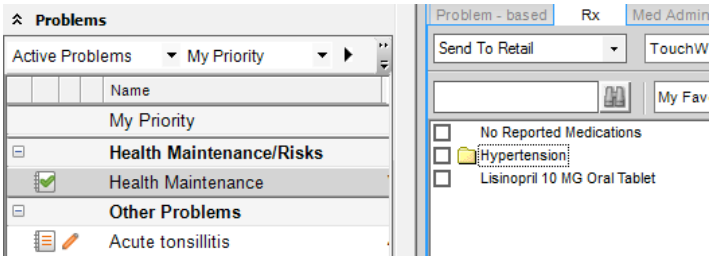
4. The newly created Order Group is now available from the “Create in” drop down.



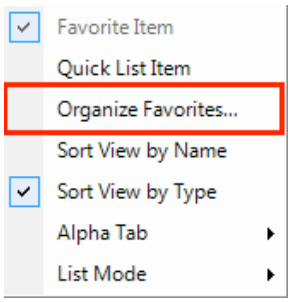
5. Once the appropriate folder has been selected, click “Add”.



6. Created Order Groups will now be displayed for the user within the respective tabs of the ACI



7. Users also have the option to edit/modify their order groups. To do so, right-click in the white space in the ACI and select “Organize Favorites”.



8. Numerous options are available for users to edit/organize their groups:

New Order Group

- Click this button (or select **Create New Group** from the context menu) to add a new order group.

Copy Order Group

- Click this button (or select **Copy Order Group** from the context menu) to copy the orders in an order group and create a new order group so that you can modify it.

Move Item

- Select an item or hold **CTRL** to select multiple items, then click this button (or select **Move Item** from the context menu) to display **Move Item to**. Here you can move the selected favorite orderable items to a group, if they are not already in one, or to another group.

Copy Item

- Select an item or hold **CTRL** to select multiple items, then click this button (or select **Copy Item** from the context menu) to display **Copy Item** and add the selected favorite orderable items to an additional order group. Select the group to which you want to copy the selected items, or click **New Order Group** to create a new group to copy the orderable items to.

Rename

- Select a group and click **Rename** (or select **Rename** from the context menu) to change the name of the group.

Add to Quicklist

- Select a favorite orderable item or an order group and click this button (or select **Quicklist** from the context menu) to add it to your quick list.

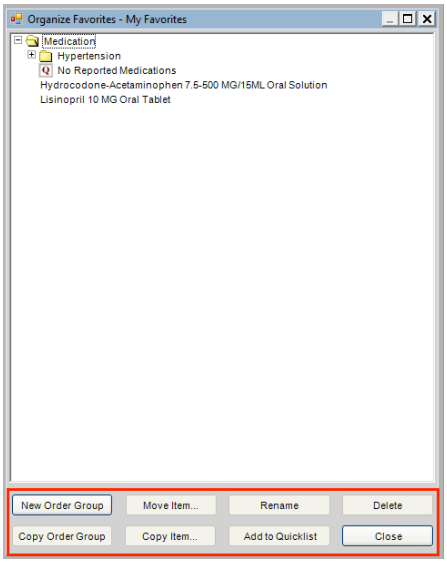
Delete

- Select favorite orderable items or order groups and click **Delete** (or select **Delete** from the context menu) to remove the items from the favorites list. If the user tries to delete a group from the favorites list and it contains orders, the **Delete Group Confirmation** warning is displayed. If the user clicks **Yes**, the group is deleted; unless the orders in it exist as favorites outside of the order group, they will no longer be in your favorites list. If you do not want the favorite orders deleted, click **No**, move the orders out of the group, and then delete the empty group.

  Note: Deleting a favorite item does not delete the orderable item itself.

Close

- Click to close the **Organize Favorites** page and return to the **Add Clinical Item** workspace.

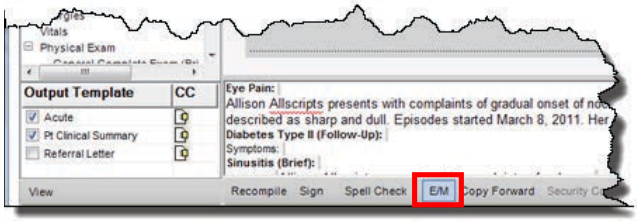


Using the E/M Coder

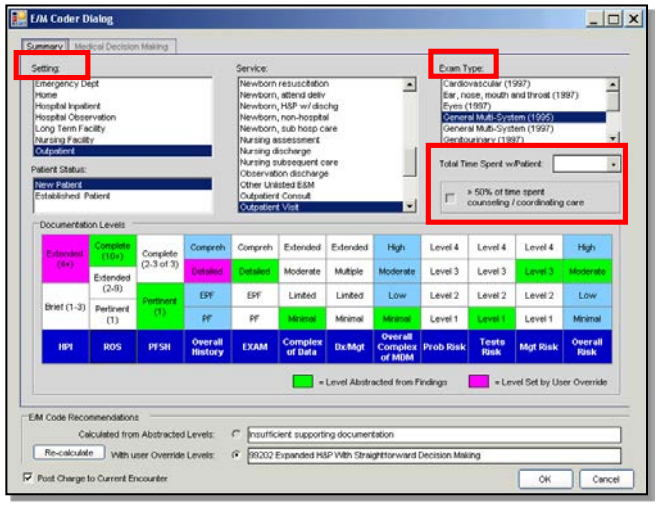
Using the E/M Coder

The **E/M Coder** utility helps users select the appropriate level of service coding for documenting a clinical encounter. It suggests the calculated E/M code that is based on the patient's documented encounter data.

1. Click the **E/M** button located at the bottom of the **Note Authoring Workspace**.



*The **E/M Coder** page displays with a suggested code derived from data already documented in the Note.*



Available documentation levels are displayed in four colors:

- **White** – Indicates an unselected, but available level.
- **Blue** – Indicates an unselected and unavailable level due to its value being based on prior levels.
- **Green** – Indicates a level derived by the system.
- **Fuchsia** – Indicates a level overridden by the user.

2. Review the **Setting** and **Service** selections. These are based on appointment type.
3. If applicable, change the **Exam Type** and/or select a time from the **Total Time Spent w/Patient** drop-down menu and select the **>50% of time counseling/coordinating care** check box.
4. From the **E/M Code Recommendations** section, review the **Calculated from Abstracted Levels** field to view the suggested code.

5. Select the **Post Charge to Current Encounter** check box to insert the derived E/M code in the Visit Charges section of the Encounter Form.
6. Click **OK** to accept the suggested code.

Free text and text templates are not taken into consideration in the E/M Code recommendation.

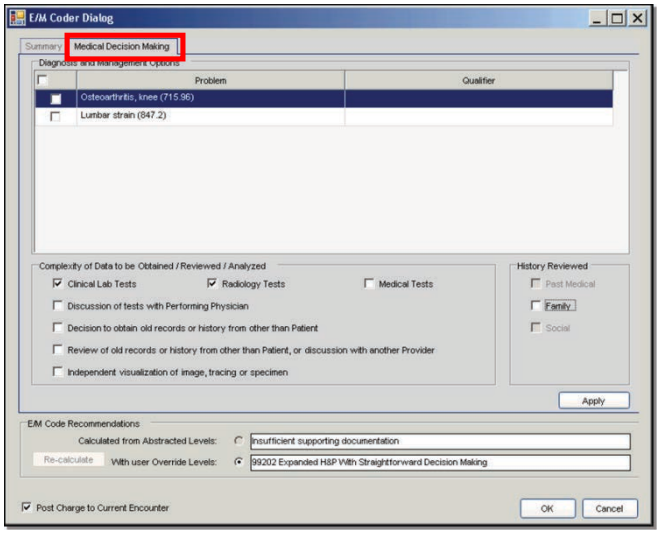
For this reason, Allscripts allows the user to override the suggested levels by manually selecting a documentation level.

Manually Selecting the E/M Code

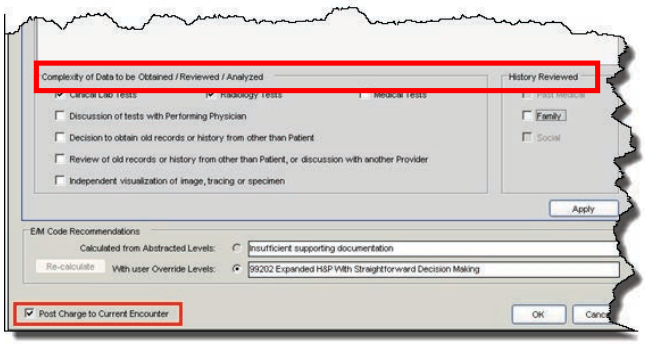
The **Medical Decision Making** tab of the **E/M Coder** is used to enter additional information that affects the level of service as appropriate, for example, calculating the number of diagnoses or treatment options, amount and/or complexity of data reviewed, and the level of risk.

1. Click the **Medical Decision Making** tab on the top of **E/M Coder**.

   The page displays.

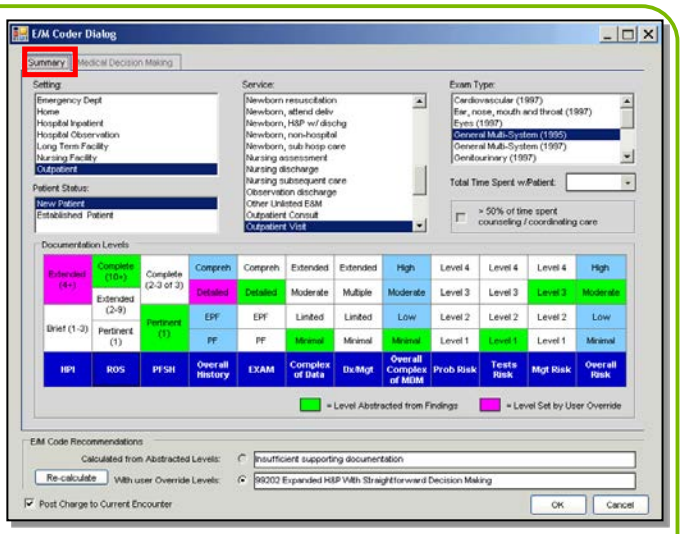


2. Select the check box next to the problems that have been assessed.
3. Choose any pertinent topics of the patient's chart in the **Complexity of Data to be Obtained/Reviewed/Analyzed** section that were reviewed and/or ordered by checking the appropriate check boxes.



4. Select the check box next to any of the items that apply to the visit under the **History Reviewed** section. (If you added or edited any historical problems during the Encounter the check box will be grayed out and you will automatically receive credit for those items.)
5. Click the **Apply** button.
6. Select the **Post Charge to Current Encounter** check box to insert the derived E/M code in the **Visit Charges** section of the **Encounter Form**.
7. Click **OK** to accept the suggested code.

   You may also override the E/M Code Recommendations by making changes to the levels calculated in the **Setting**, **Service**, **Exam Type**, **Total Time Spent w/Patient**, and **Documentation Levels** fields on the **Summary** tab.
8. Click the **Summary** tab on the top of **E/M Coder**.



9. Override the general encounter information or documentation levels by making changes to the levels.
10. When finished, click **Re-calculate**. The new suggested code displays in the **With user Override Levels** field.

11. Select the **Post Charge to Current Encounter** check box to insert the derived E/M code in the **Visit Charges** section of the **Encounter Form**.
12. Click **OK** to accept the suggested code.

The **Tests Risk** and **Mgt Risk** sections on the E/M Coder must be manually updated.
Hovering the mouse pointer over entries in the **Documentation Levels** box gives more detailed descriptions of the fields.

Allscripts Task Manual

Contents

About Tasks

A task is a request or reminder for action, for example:

- A request to respond to a telephone message
- A request to verify a test result
- A request to renew a prescription

Tasks are created manually by users or automatically, that is, triggered by the application, as a result of specific activities. Tasks are organized by filters, also referred to as views.

Which Task Views are Required for Each Role?

Assigned Tasks Based on Role

The following provider-specific task views will be listed for each user, based upon their role in the clinic.

***Please Note**: These task views will be named after the provider (Ex: Shaheen Med Tasks) unless noted otherwise.

1. **Provider**
    a. Med Tasks
    b. Order-Result Management
    c. Overdue Tasks
    d. Result/Doc Communication

2. **Manager**
    a. Overdue Tasks (site-specific)
    b. Adjust Charges
    c. Med Tasks
    d. Order-Result Management
    e. Orders Requiring F/Up
    f. Overdue Tasks
    g. Referral Tasks
    h. Result/Doc Communication
    i. Review Encounter Form

3. **Clinical**
    a. Med Tasks
    b. Orders Requiring F/Up
    c. Result Communication
    d. Referral Tasks

4. **Clerical**
    a. Referral Tasks

5. **Billing**
    a. Adjust Charges
    b. Review Encounter Form

Tasks for all Users

The following task views will appear for EVERY user, regardless of their role in the clinic.

1. **My Active Tasks**
    a. This task view will contain tasks that were assigned to the user by another user.

2. **Active Patient-Today**
    a. This task view will contain tasks that are ACTIVE for the current patient for today only.

3. **Current Patient-All**
    a. This task view will contain ALL tasks that have been created for this patient. Please note, all active, completed, removed, and in-process tasks will appear on this task view.

4. **Current Patient-Active**
    a. This task view will contain tasks that are ACTIVE for the current patient.

Which Tasks are Included in Each Task View?

Adjust Charges
This task view will contain tasks that are generated when a user changes or removes a charge previously submitted for billing. Once the charges have been edited in the practice management system, a user can manually resolve this task by clicking “Done”.

Task Included in this View:
1. Adjust Charges

Med Tasks
This task view will contain medication-related tasks, such as med renewal request tasks and medication administration tasks.

Tasks Included in this View:
1. Call in Failed Rx
2. Call in Rx
3. Call Order

4. Dispense Sample
5. Immunization Administration (also appears on the Orders Req F/up view)
6. Immunization Documentation (also appears on the Orders Req F/up view)
7. Med Admin
8. Med Renewal Request
9. Med Admin Documentation
10. Rejected Rx
11. Rx Info-Pharm
12. Rx Renew Request
13. Rx Xmit Fail

Order Result Management
This task view will contain both medication and non-medication orders that require provider authorization, as well as results that require provider review or verification.

Tasks Included in this View:
1. Authorize Order
2. Review Results
3. Rx Renew Request
4. Verify Patient Results

Orders Requiring F/up
This task view will contain tasks that are to be completed by the clinical staff, such as a urine dip in-office (Perform Order) and B12 administration documentation (Med Admin).

Tasks Included in this View:
1. Call Order
2. Expired Orders
3. Immunization Administration (also appears on the Med Tasks view)
4. Immunization Documentation (also appears on the Med Tasks view)
5. Med Admin
6. Med Admin Documentation
7. Overdue Orders
8. Perform Order
9. Referral Follow-up

Referral Tasks
This task view will contain referral-related tasks, and appears on this task view after a provider has ordered a referral for a patient.

Tasks Included in this View:
1. eReferal Request
2. Financial Auth
3. Manual SOC Failed
4. Referral Failed
5. Referral F/up
6. Referral Request
7. Referral Response
8. Referral Response Failed
9. Schedule Appointment
10. SOC Acknowledgement

Result/Document Communication
This task view will contain all result/document communication tasks, such as when the provider wants the clinical staff to call a patient and/or mail results to a patient.

Tasks Included in this View:

1. Call Patient Communication
2. Call Patient with Results
3. Distribute Document to Recipient
4. Mail Results to Patient
5. Schedule Results F/up

Review Encounter Form

This task view will contain provider-specific review encounter tasks.

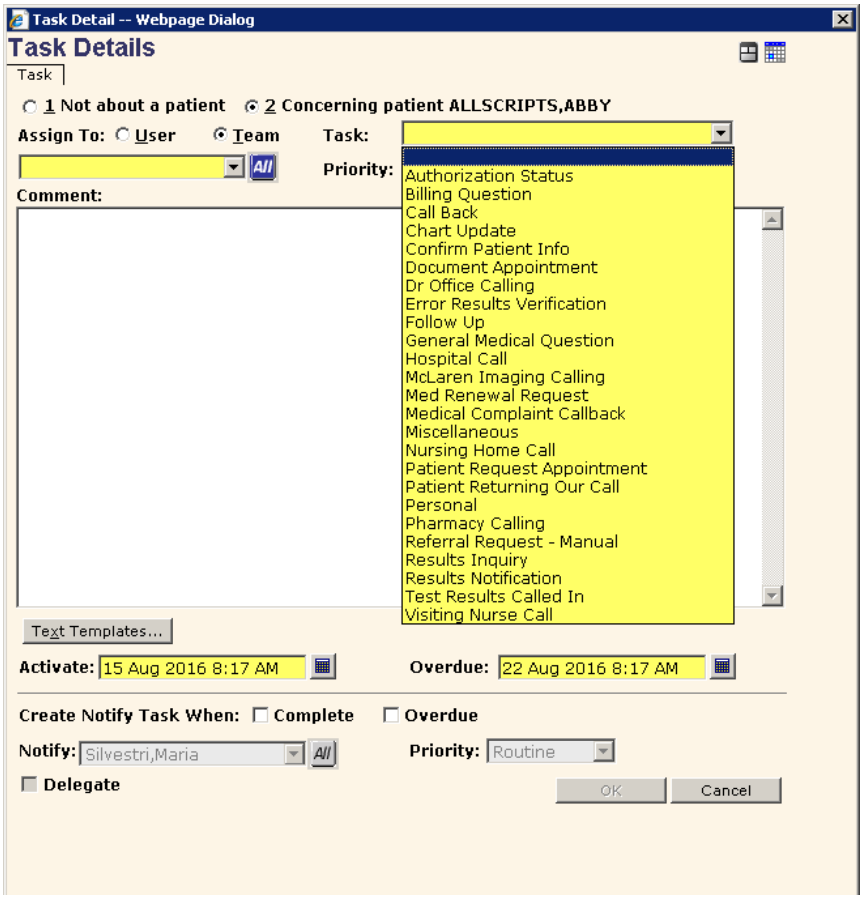
Task Included in this View:

1. Review Encounter Form

Manual Tasks

Manual Tasking

Manual Tasks can be started from various areas of the application. Depending on the workspace the task is initiated from, different task types will appear in the dropdown.



Manual "Go To" Tasks from Clinical Desktop

"Go To" tasks are special task types that are initiated from different tabs within the Clinical Desktop, when a clinical data element is highlighted. You will notice when creating a new task while a data element (such as a med) is highlighted, different tasks are available in the Task Name Dropdown.

The Go To Task Types can be used to 'link' clinical documentation to a manual task. For example, a patient calling in for their Lisinopril to be renewed- the MA can either start a new task as normal, and type out all the needed information OR- with the Go To Med task type, the task and the med can be 'tied together' so when the provider received and opens the task, they can be taken right to the medication in question and proceed to do the renewal. This provides a much more streamlined process for both staff and provider.

Delegated Tasks

Delegated Tasks are designed as a way to funnel tasks away from the provider and to route them to their support staff who are actually responsible for completing.

Delegated Tasks are generated by the system, and in most cases, are created as a result of another action performed in the system. For example, when a provider orders a referral, in response, the application automatically fires a task to schedule the appointment. The task to schedule the appointment will be worked by the provider's support staff, however the system does not know who is responsible for working this task. Because of this, the Schedule Appointment task will always be assigned to the provider who placed the order, and will be marked Delegated. Tasks that are categorized as Delegated are incorporated in certain task lists views, so the support staff can see them. In this example, the Schedule Appointments task are listed in the "Referral Tasks" view for that provider.

Delegate Button
When cleared, this checkbox indicates that this task will be displayed on the Task List of the person assigned.

When selected, the task is displayed on the Task List for the user responsible for the completion of the task- rather than the person in the "Assigned To" column.

Task Teams

What is a task team?

A task team is a task view that is specific to either a provider (Shaheen MA Task Team) or a clinic (Bay IM MA Staff Tasks), and there is usually one task team specific to clerical staff, and another specific to clinical staff.

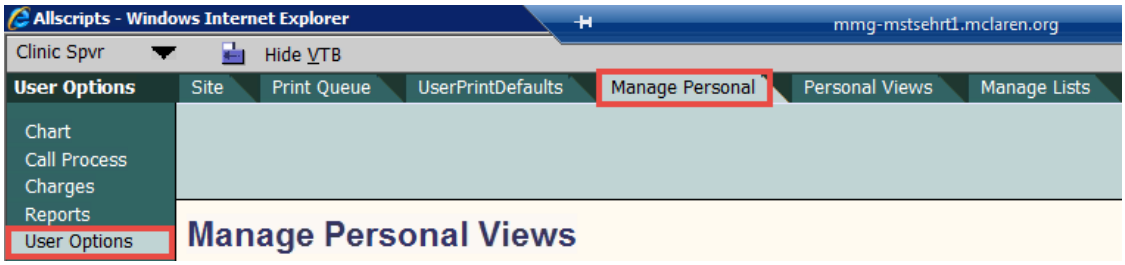
What are the benefits of using task teams?

This allows a user to send a task and multiple users will be able to view it immediately. The turnaround time for tasks sent to team task views is usually quicker because multiple users have access to this task view. This is also useful when a staff member is sick or on vacation, so others users are still able to view those tasks.

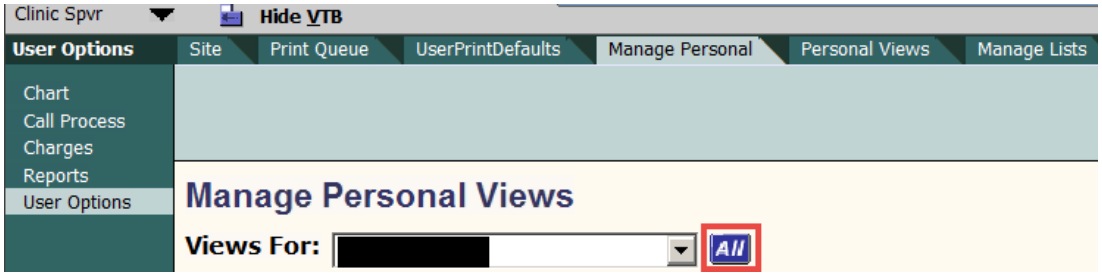
How do I add a task team for a user?

Please note: A user can add a task team on the front end of Allscripts. While in the **Task Details** window, click the **All** button and search for the task team, then highlight it and click **Ok**.

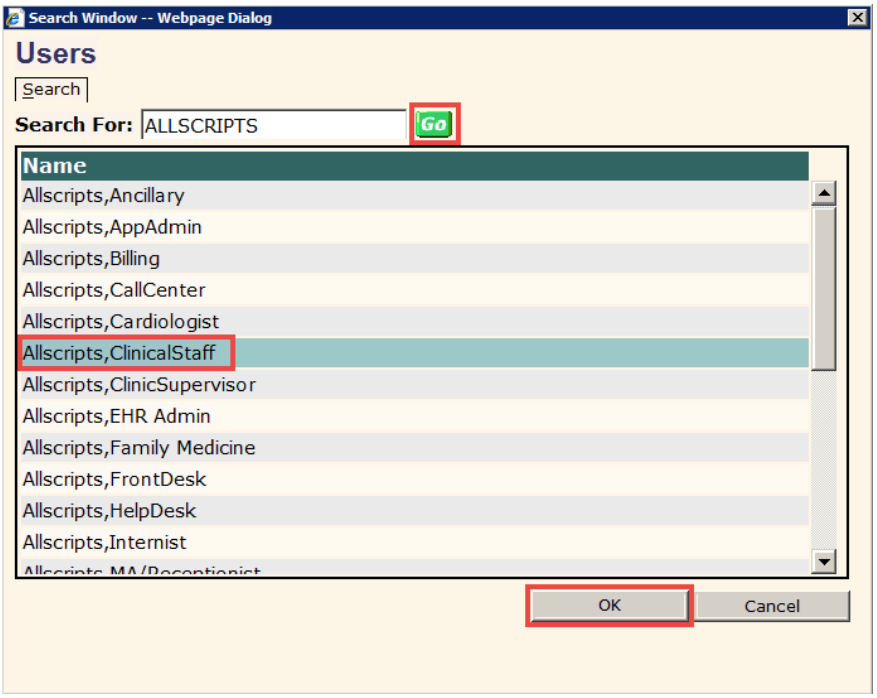
1. Click **User Options** from the Vertical Toolbar, then click the **Manage Personal** Tab.



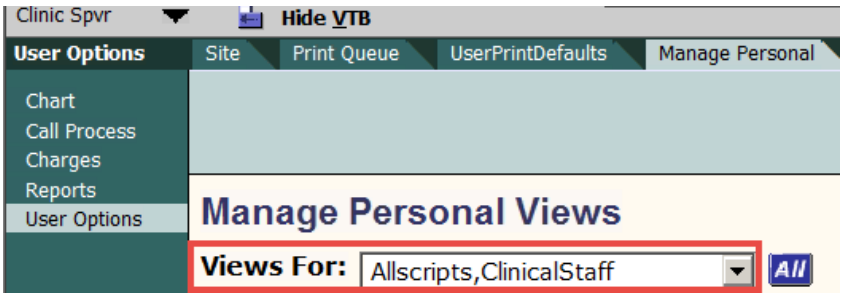
2. Click the **All** button to search for the user that you would like to add the task team to.



3. Type the last name of the user in the **Search For** field and click **Go**. Then, double-click on the user's name, or single-click and select **Ok**.



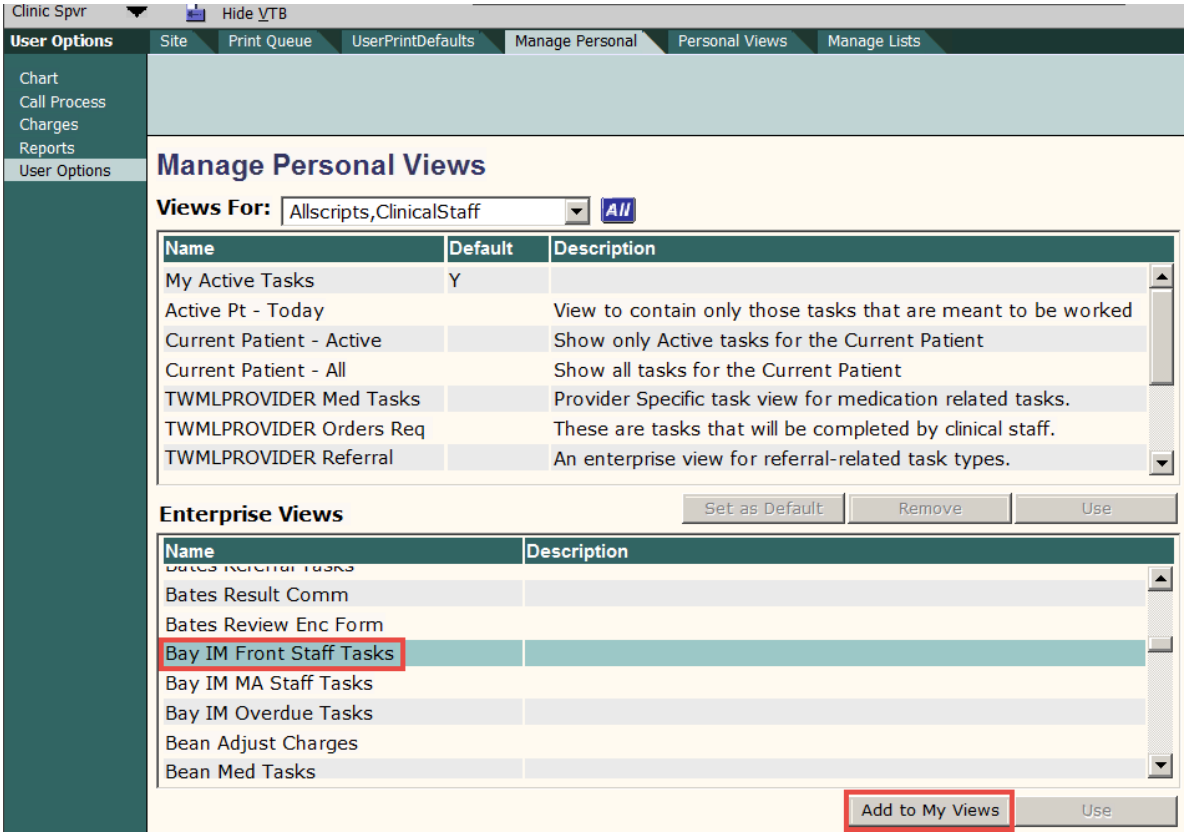
4. This user's name will now appear in the **Views For** field.



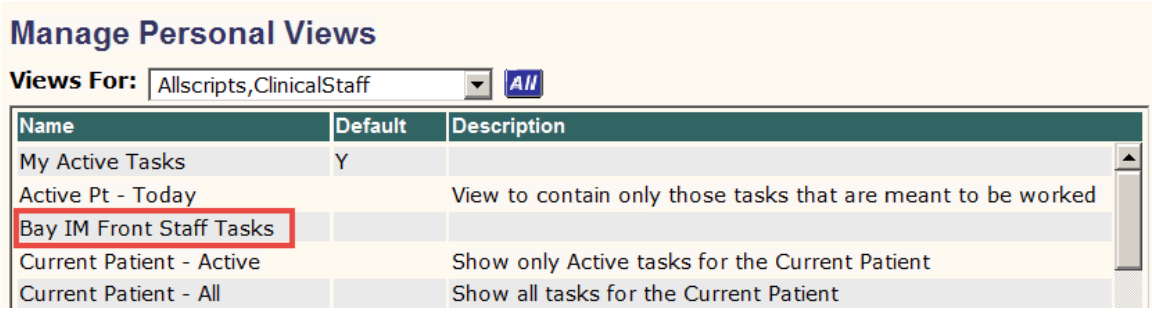
5. On your keyboard, hold down the **ALT** key and click **M** five times to get a complete list of Enterprise Views.

6. Scroll down the list of Enterprise Views to locate the task team view that you would like to add. Please note, not all MMG Clinics use task teams.

7. Click on the task team that you would like to add for the user, then click **Add to My Views**.



8. The task team view will now appear on the user's dropdown list.

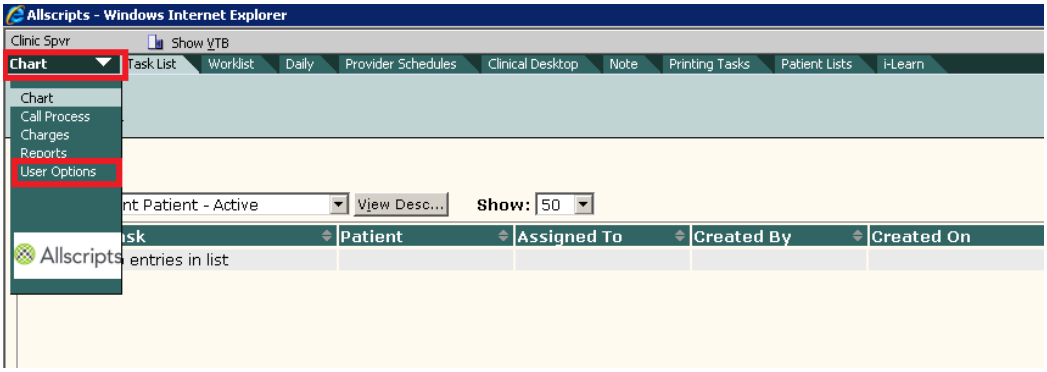


How to Create a Personal Task View

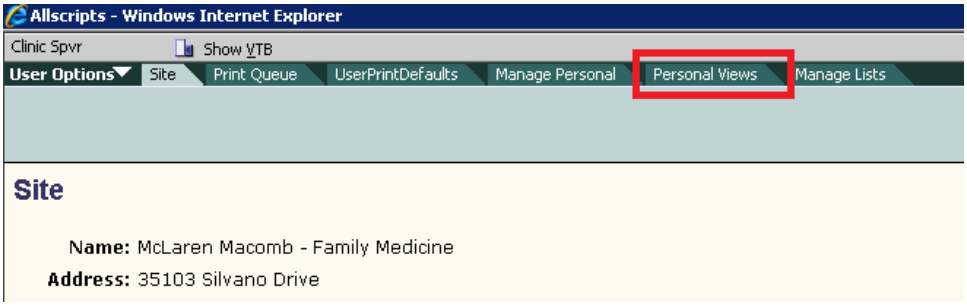
Creating Personal Task Views

Managers can use this feature to create task views so that they are able to view their staff's active task list, or create a task list for another staff member to view.

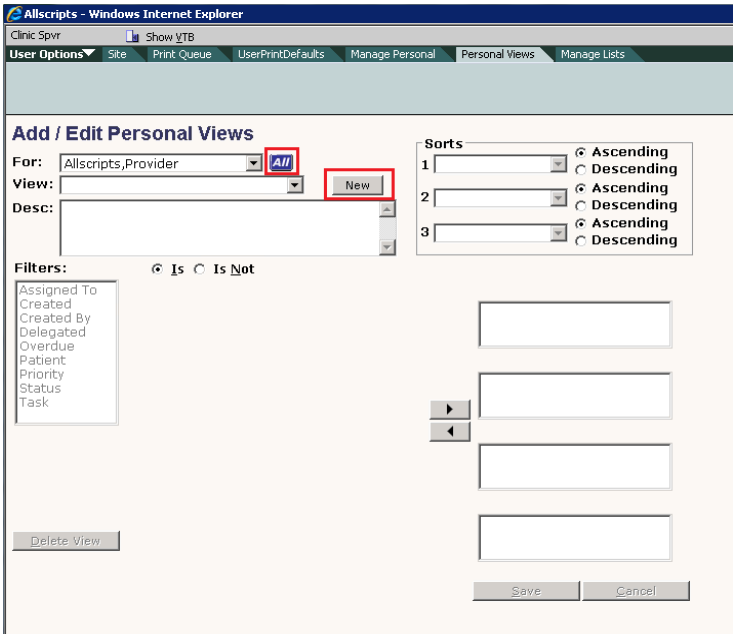
1. Select **Chart** to access the **Vertical Tool Bar**, then select **User Options**.



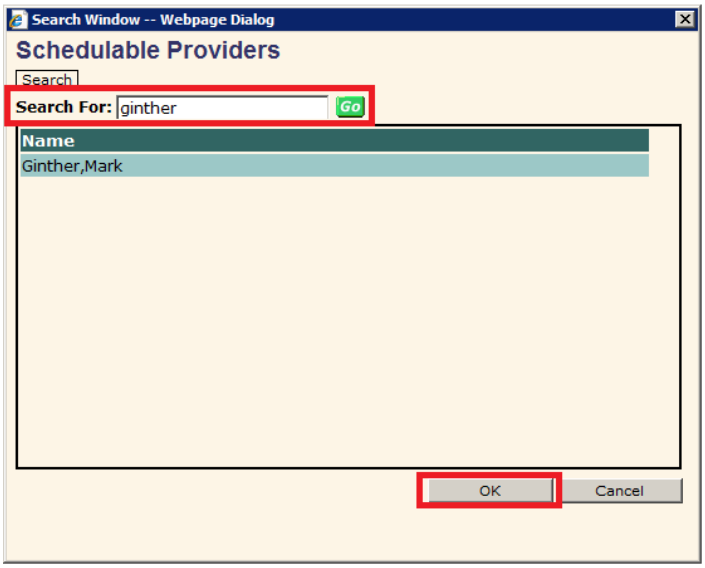
2. Navigate to the **Personal Views** tab.



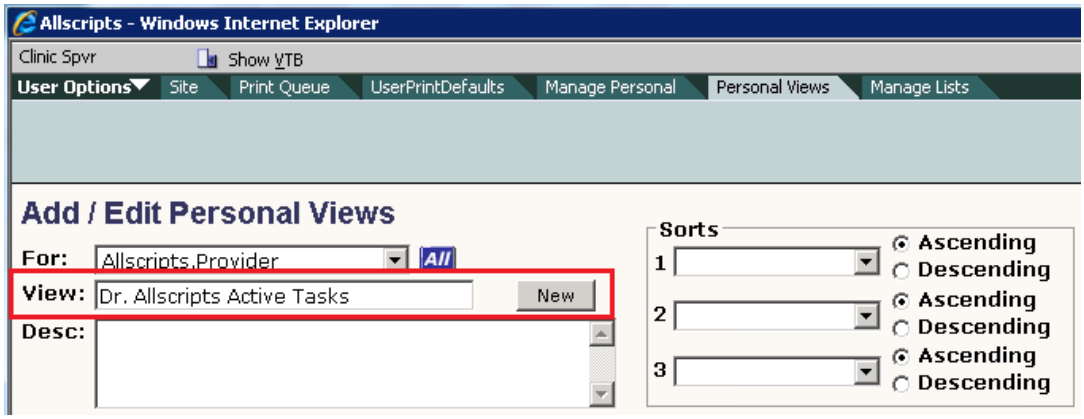
3. Select the **All** Button on the **Add/Edit Personal Views** screen
   a. This function allows users to search for a user if they do not appear in their dropdown menu.



   b. Once the **Search Window** appears, type in the name of user that you are looking for, then double-click on their name, or single-click on their name and click **Ok**



4. Select the **New** Button on the **Add/Edit Personal Views** screen
    a. This function allows users to create and name new task views.
    b. Click **New**, then type in the name you chose to call the task view.



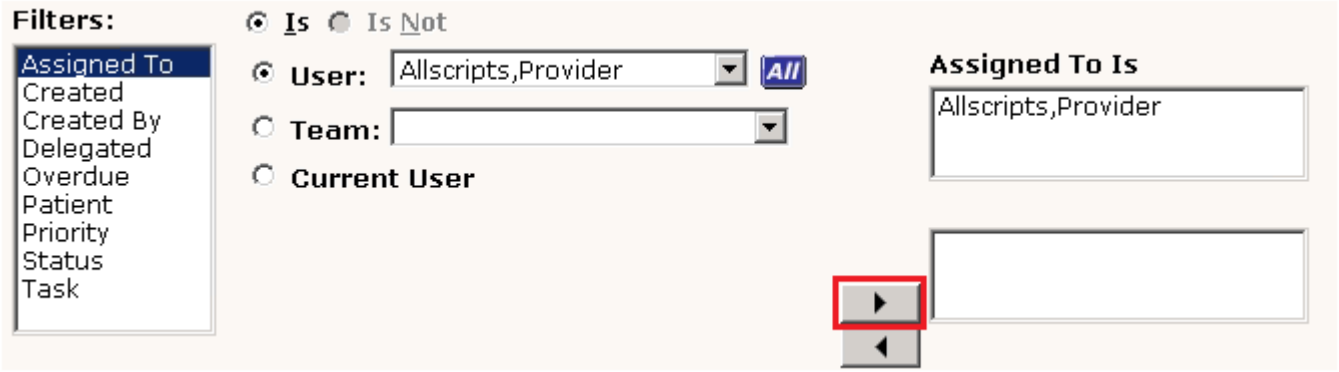
5. Navigate to the **Filters** section
    a. This function allows users to create and filter task views to show exactly what they are looking for.

Example 1

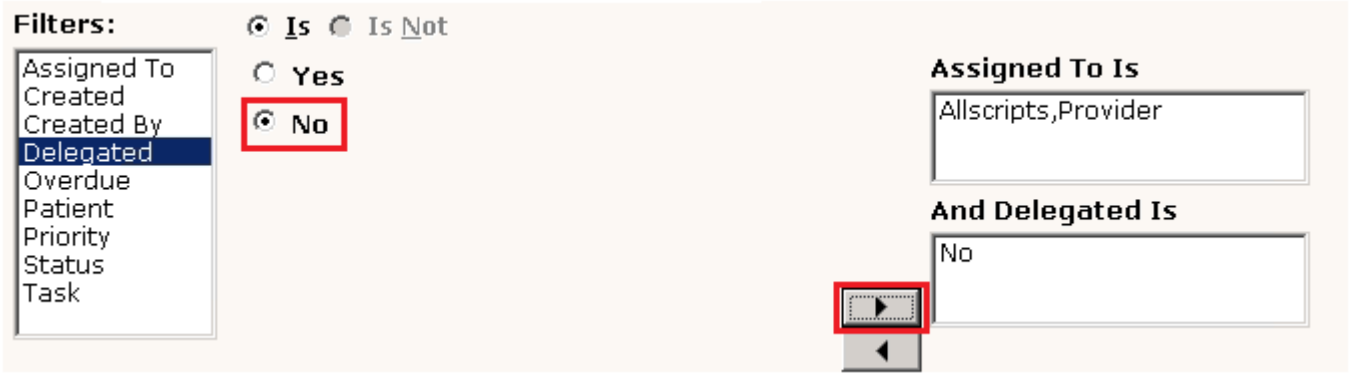
In this example, we will create a task view that will display all Active and In Progress tasks assigned to a provider.

a. Select the **Assigned To** filter. This will display tasks assigned to a specific user.

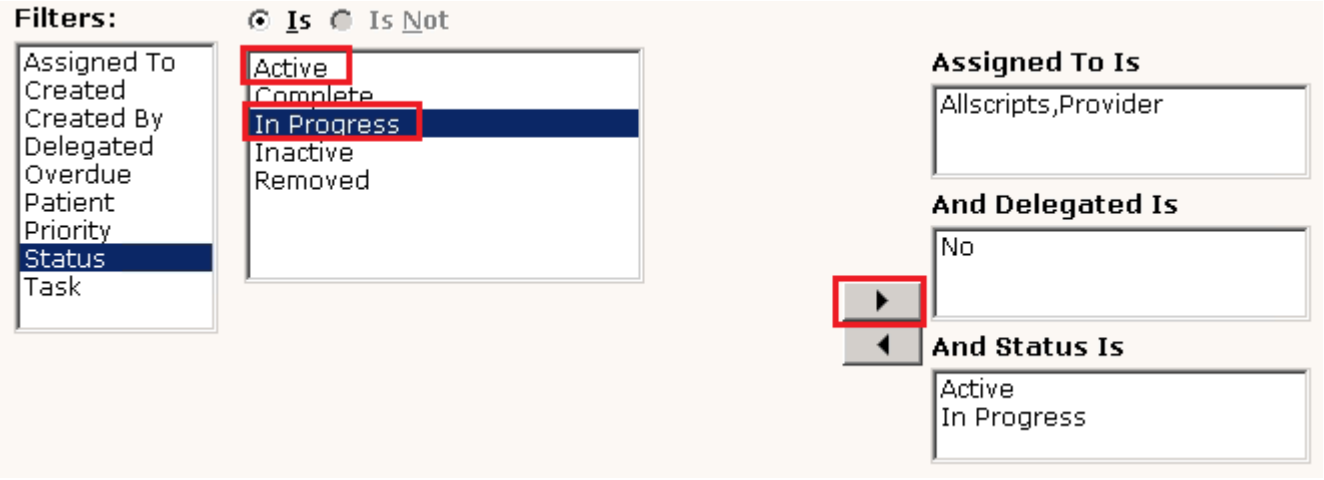
b. In the **User** field, click the **All** button and search for the user. Then, click the **Right-facing arrow** to add the user. The user's name will now appear in the **Assigned To Is** section.



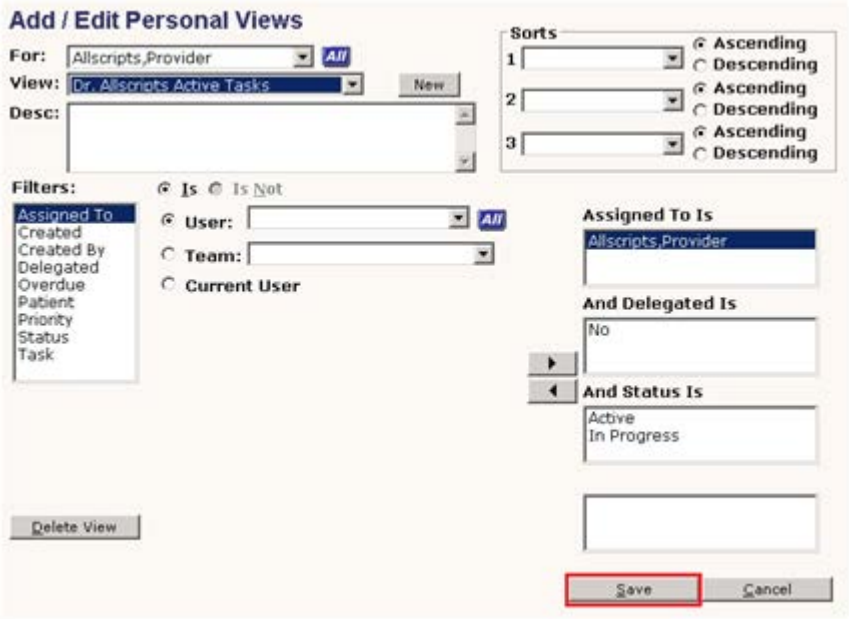
c. Next, select **Delegated** from the list of filters. Click the **No** radio button, then click the **right-facing arrow.** This selection will now appear in the **And Delegated Is** section.



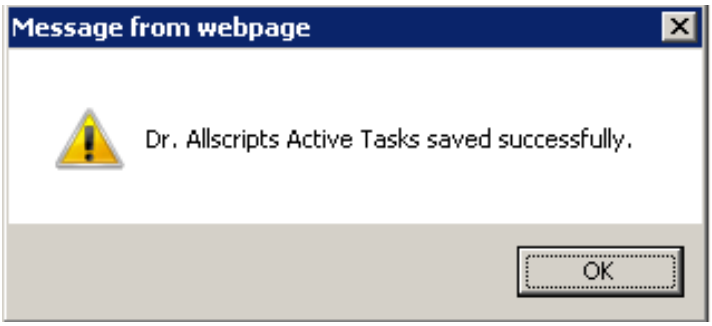
d. Select the **Status** filter. This will give you the option to select the status of the tasks displayed. Add both the **Active** and **In Progress** filters by selecting the filter, then click the **right-facing arrow.** Your selections will now appear in the **And Status Is** section.



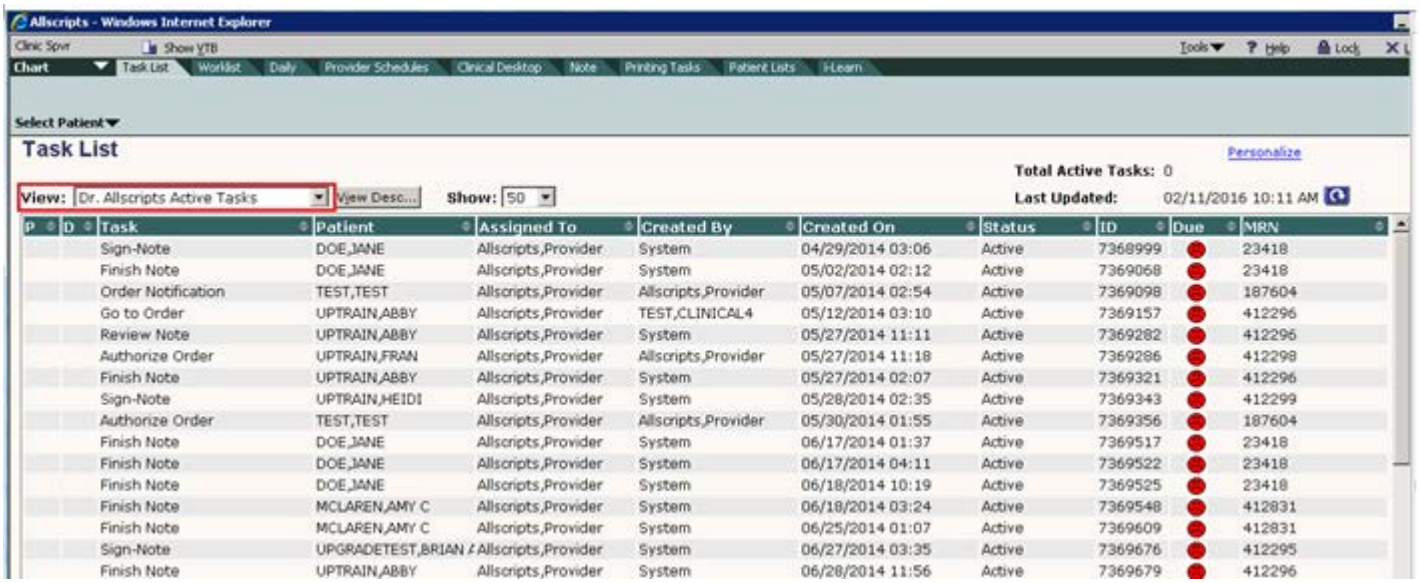
e. Once the filter selection has been completed, your screen will look like the screenshot below. Click the **Save** button to save this task view.



f. Upon clicking **Save**, you will receive the following message:



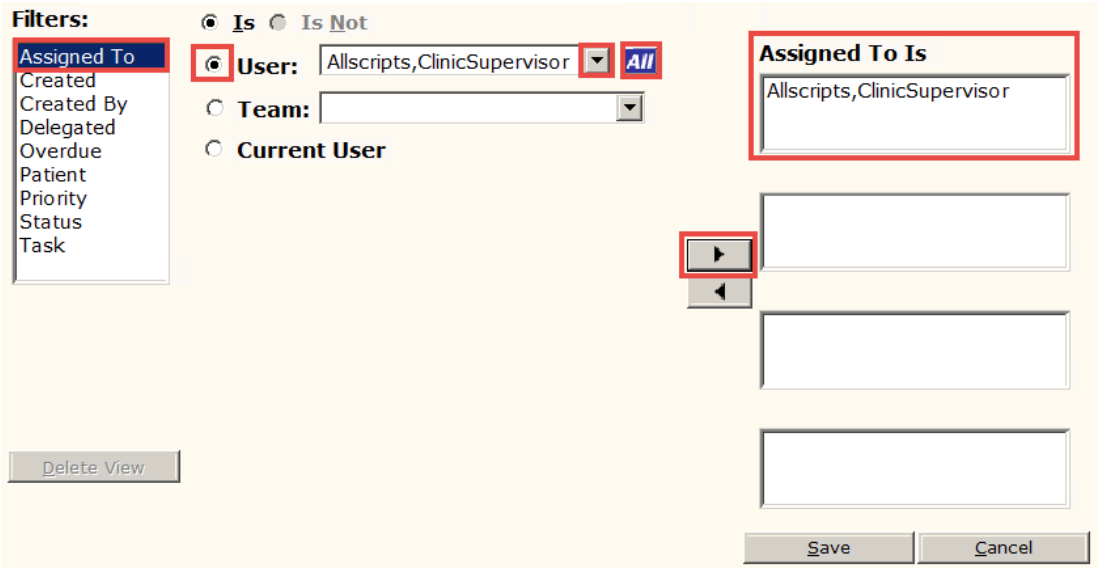
g. When you navigate back to the **Task List,** you will now have the new task view available in your dropdown menu.



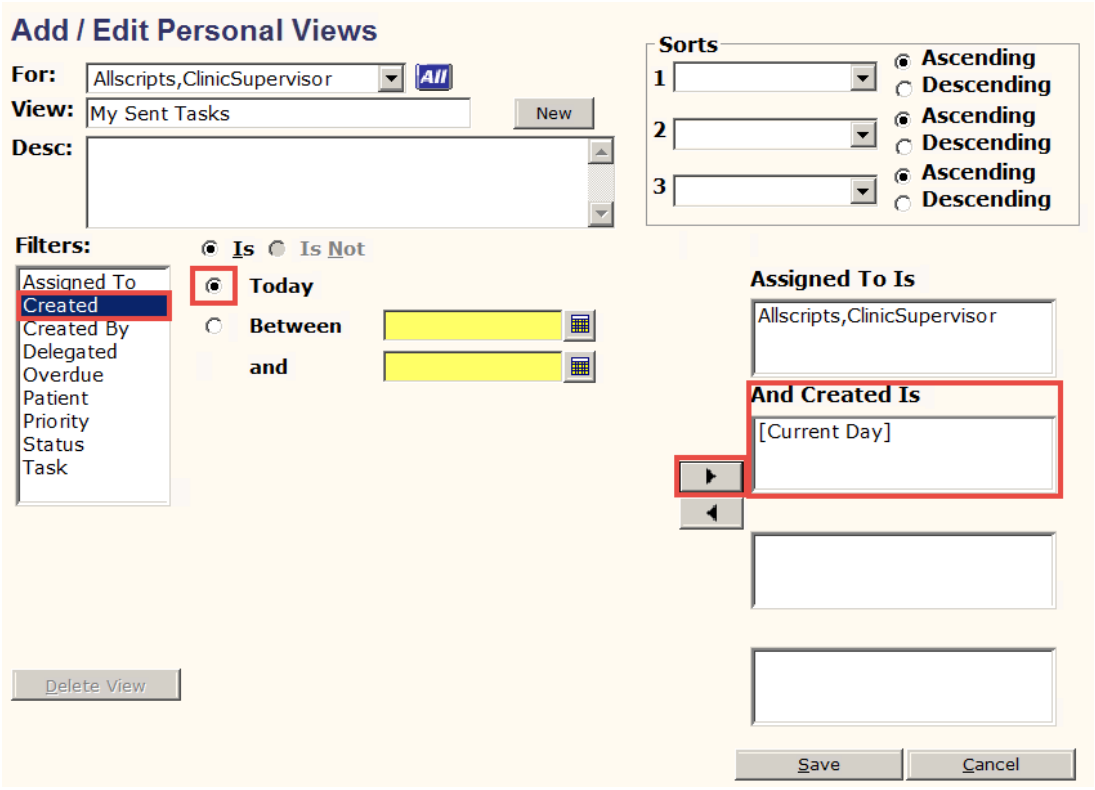
Example 2

In this example, we will create a task view that will display all tasks sent by a user. We will title this task view **My Sent Tasks**.

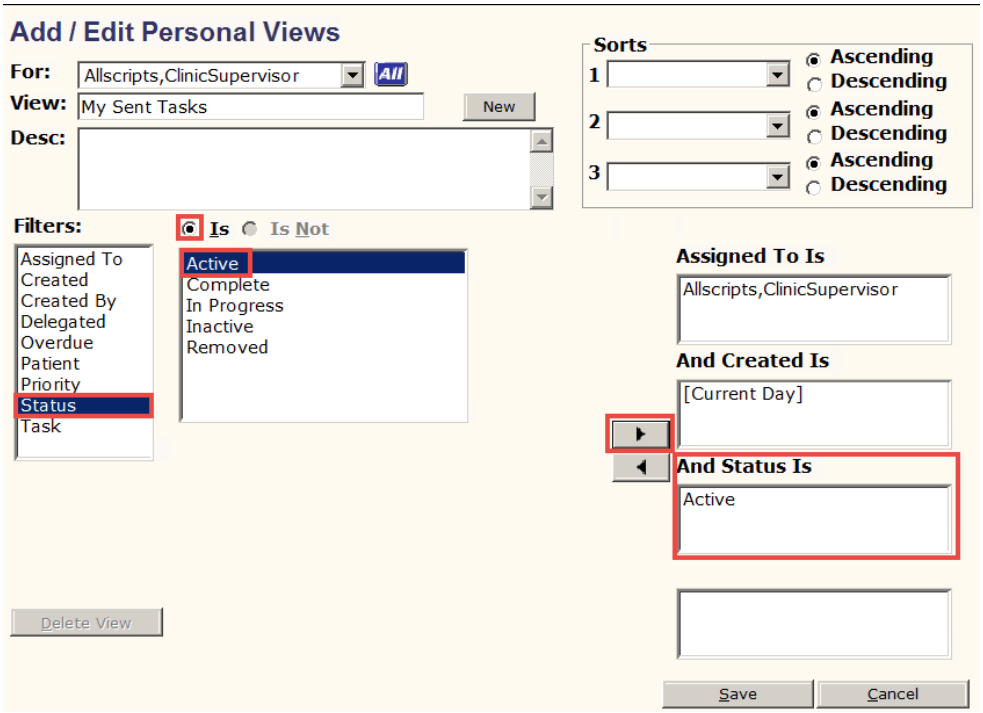
a. Select the **Assigned To** filter, then click the **User** radio button. Select the user from the dropdown menu, or click the All button if the user does not appear in your dropdown menu. Then, click the right-facing arrow, and the user that you chose will now appear in the **Assigned to Is** field.



b. Select the **Created** filter. Here, you can either choose to view tasks from today only or you can choose a date range. In this example, we will click the radio button for **Today**, then click the right-facing arrow. Now, **[Current Day]** will appear in the **And Created Is** field.



c. Select the **Status** Filter. Once this filter is clicked, notice the radio button next to **Is** and **Is Not**. One of these radio buttons will need to be selected. In this example, we will select **Is**. Also, notice that 5 status options display: Active, Complete, In Progress, Inactive, and Removed. Users can select as few or as many of these as appropriate. In this example, we will select **Active**, and then click the right facing arrow. Now, **Active** will appear in the **And Status Is** field.

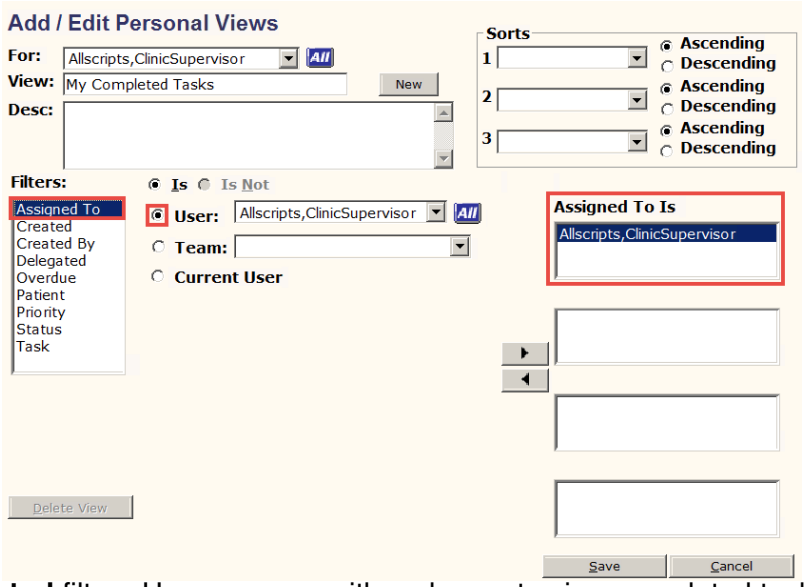


d. Click **Save** to save your task view.

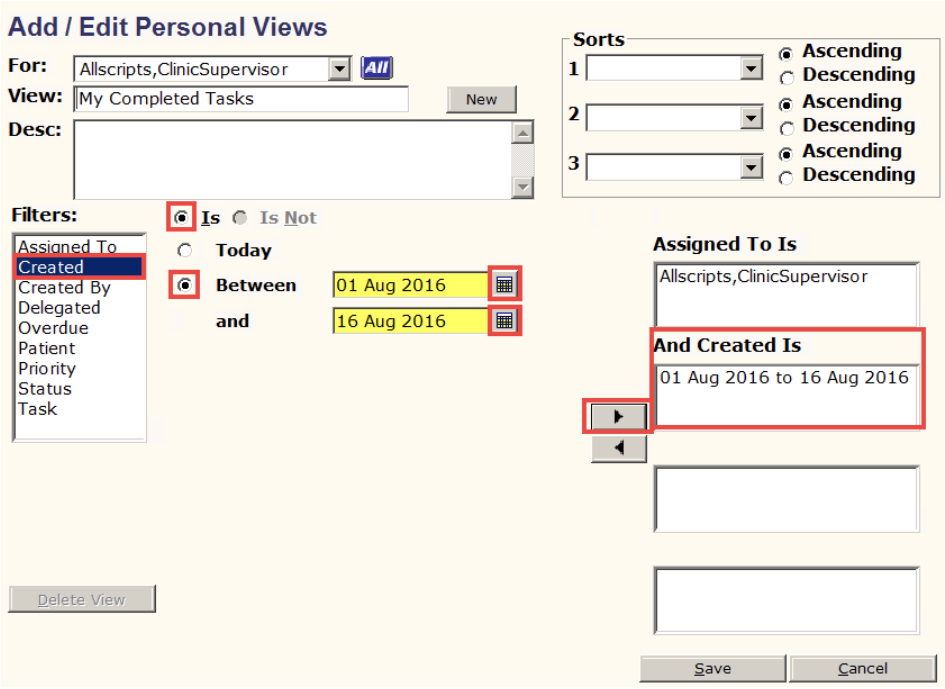
Example 3

In this example, we will create a task view that will display all completed tasks for a user. We will title this task view **My Completed Tasks**.

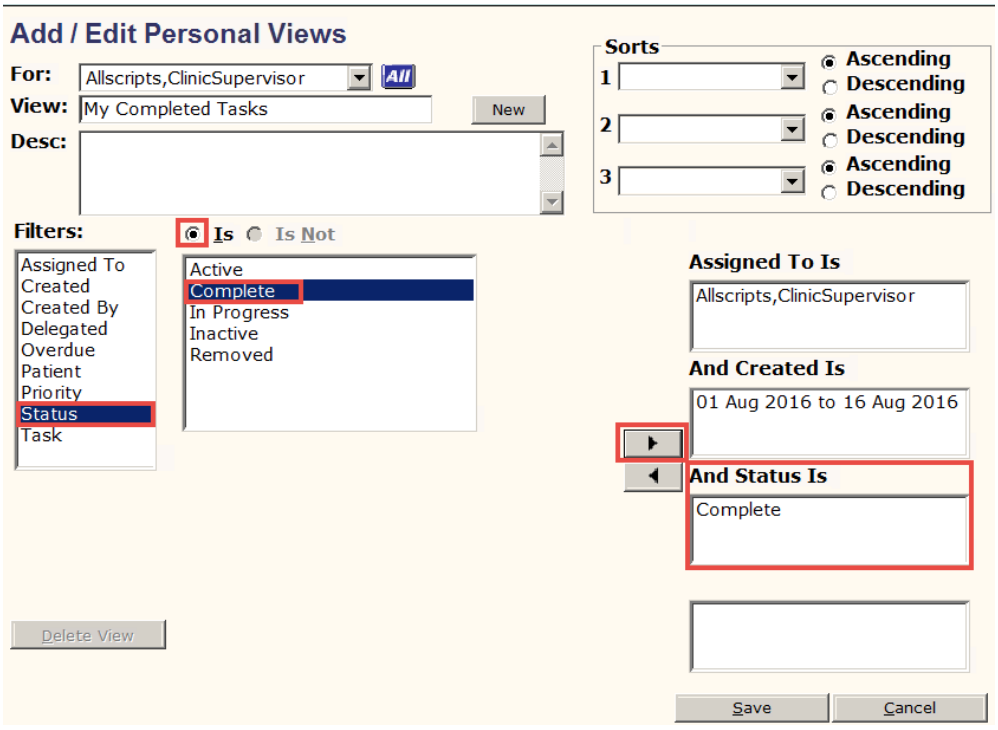
a. Select the **Assigned To** filter, then click the **User** radio button. Select the user from the dropdown menu, or click the All button if the user does not appear in your dropdown menu. Then, click the right-facing arrow, and the user that you chose will now appear in the **Assigned to Is** field.



b. Select the **Created** filter. Here, you can either choose to view completed tasks from today only or you can choose a date range. In this example, we will click the radio button for **Between and**. Click the calendar icon for both yellow fields to enter a date, then click the right-facing arrow. Now, the dates that you selected form the calendar icon will appear in the **And Created Is** field.



c. Select the **Status** filter. Once this filter is clicked, notice the radio button next to **Is** and **Is Not**. One of these radio buttons will need to be selected. In this example, we will select **Is**. Also, notice that 5 status options display: Active, Complete, In Progress, Inactive, and Removed. Users can select as few or as many of these as appropriate. In this example, we will select **Complete** because we want to view all completed tasks, then click the right facing arrow. Now, **Complete** will appear in the **And Status Is** field.



Task List Dictionary

Task Name	Task Definition	How to Resolve/Complete the Task
Authorize Order	The intent of this task is to notify an authorizing provider that an order has been entered in the system by another user that requires their authorization. The authorizing provider must review and approve the unauthorized order(s) associated with the task for the order(s) to be activated. **Helpful Tip**: This task is most commonly seen when the MA renews a medication with the "Renew w/ Changes" option.	Select the task, and then click Done.
Call In Rx	The system automatically creates this task when the prescriber selects the action of "Call Rx" when creating a prescription.	When the user clicks Done.
Call Patient with Results	This task is intended to facilitate the notification and processing of results that should be phoned to the patient. The system creates this task when the provider selects the "Call Patient w/ Results" checkbox on the Results Verification Dialog box.	When the user clicks Done.
Expired Order	If the system finds an active order for which the expiration date has passed, then the task is created. In creating the task, the order status is changed to Canceled with a Reason of Expired. Helpful Tip: Orders have an expiration date of one year.	When the user clicks Done.
Immunization Admin	The system creates this task when an Immunization is ordered.	This task is completed automatically by the system when the requirements for documenting the administration of a medication have been satisfied. The required documentation consists of the following fields on the Administration tab on the Medication Detail: Dose, Route, Site, Admin by, and Admin date.
Immunization Documentation	The system creates this task when all of the immunization required fields needed to send an immunization to a registry have not been completed. *Helpful Tip: When ordering immunizations, it is best to order by trade name. For instance, ordering Fluvirin over Influenza is desired since the general Influenza entry will not have the correct manufacturer available as a choice in the dropdown.	The task is completed automatically by the system when the requirements for documenting the administration of an immunization have been completed. The required documentation consists of any required fields in the Administration Details section as well as any required questions in the Clinical Questions section of the Immunization Details Record Administration tab.
Mail Results to Patient	The task is indented to facilitate the notification and printing of results that should be mailed to the patient. The system creates this task when the provider chooses to leave the "Mail Results to Patient" checkbox marked on the Results Verification Dialog box.	One of the following: (1) By the system when the document is printed via the task list Go To button. (2) By printing the document from the batch printing page. (3) Manually.

	*__Helpful Tip__: The "Mail Results to Patient" checkbox is set to be checked by default, so this check would have to be removed if mailing results isn't desired.	
Medication Admin Documentation	The system creates this task when all the indicated required fields to for a medication administration have not been completed. Helpful Tip: When ordering through the Medication Admin tab, it is recommended to check the DAW box on the Medication Details screen. If not checked, the system will automatically change the order to a generic entry which results in the correct manufacturer missing from the dropdown. If a generic IS desired, search for the appropriate order in the ACI workspace.	The task is completed automatically by the system when the requirements for documenting the administration of an medication have been completed. The required documentation consists of any required fields in the Record Administration tab of the Medication details dialog.
Overdue Order	Created by a database job which queries for all orders whose overdue date has passed. If query finds an order for which the overdue date has passed and the status of the order is neither Canceled nor D/C, then the task is created.	The task is automatically completed when the user either (1) Edits the order due date to a future date, or (2) changes the status of the Order to Completed, D/C, Canceled, or EIE.
Perform Order	This task is created when the provider initiates an and the Communicated By box is set to Perform Order. Helpful Tip: Orders should only be set to Perform Order if it is expected that the MA will perform that item in-office.	When the status of the order is Completed or Resulted, automatically complete the task. D/C and EIE should not complete the task – those order statuses should remove the task.
Review Document	The Review Document task is used to alert the appropriate provider to review a document that has been sent through TouchChart (the scanning application) to Allscripts Enterprise EHR.	When the user navigates to the document in Allscripts Enterprise EHR.
Review Results	When a user is CC'd on a result with a notification method of task, a review result is created for them when the result is verified or if it does not need verification, when it is filed.	Manually completed or completed when the user who was carbon copied marks the result as reviewed.
Rx Info-Pharm	This task is automatically created when generating a prescription and the pharmacy field is left blank. The applicable Rx actions that will generate this task are: Retail, Mail Order, and Phone.	The task is completed when pharmacy information for all med orders for the patient is provided.
Rx Info-Problem	The task is automatically generated by the system when a med order is created without specifying a problem. An Rx requires an associated problem in order to be filled.	This task is automatically completed when a problem is associated to the order and committed to the patient record.
Schedule Appointment	The system creates this task when a follow-up or referral order is issued through the ACI. The appointment status flag is set to Appointment Needed.	The task is automatically completed when the user either (1) edits the order to "Appointment Scheduled" or (2) edits the order to either "Appointment Not Needed" or "Patient Will Schedule", or (3) changes the order status to Completed, D/C, Canceled, or EIE.
Sign Amended Note	Amending a Note should be based on what is done – explicitly - preserving the snapshot. The administrator can decide which event will trigger amendments.	Signing and finalizing the amended Note.
Sign Note	Created when a note is first created and is not yet signed, indicating to the note owner that the note needs to be signed. The Sign Note task is also generated	When the user signs the note.

	when a note has been signed but not finalized because the user does not have ownership authority sufficient for the note. Initial signing indicates note input has been completed or is ready for next clinician.	
Verify Patient Results	This task provides notification that a result is available for verification. The task facilitates the verification of patient results. The task is created when a result is filed that requires verification.	Completed when the all results associated with the encounter and ordering provider combination have either been verified or the ordering provider for the result has been changed to another user.

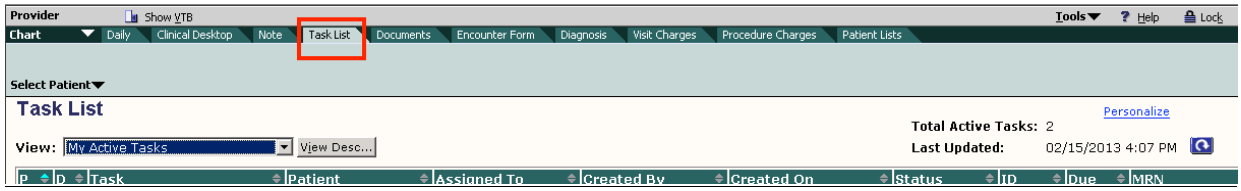
Allscripts- Provider Coverage Process

SCENARIO 1

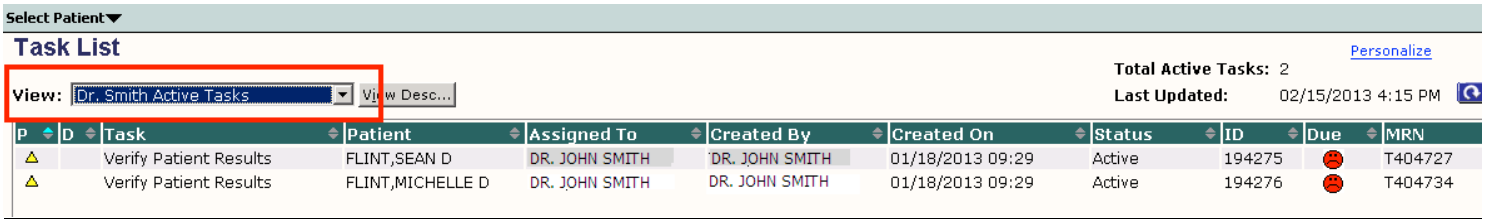
Dr. Smith is out of the office. Upon assessment of a patient's results, it is determined that these results are not of an urgent nature, and can wait until Dr. Smith returns to the office.

Covering Provider

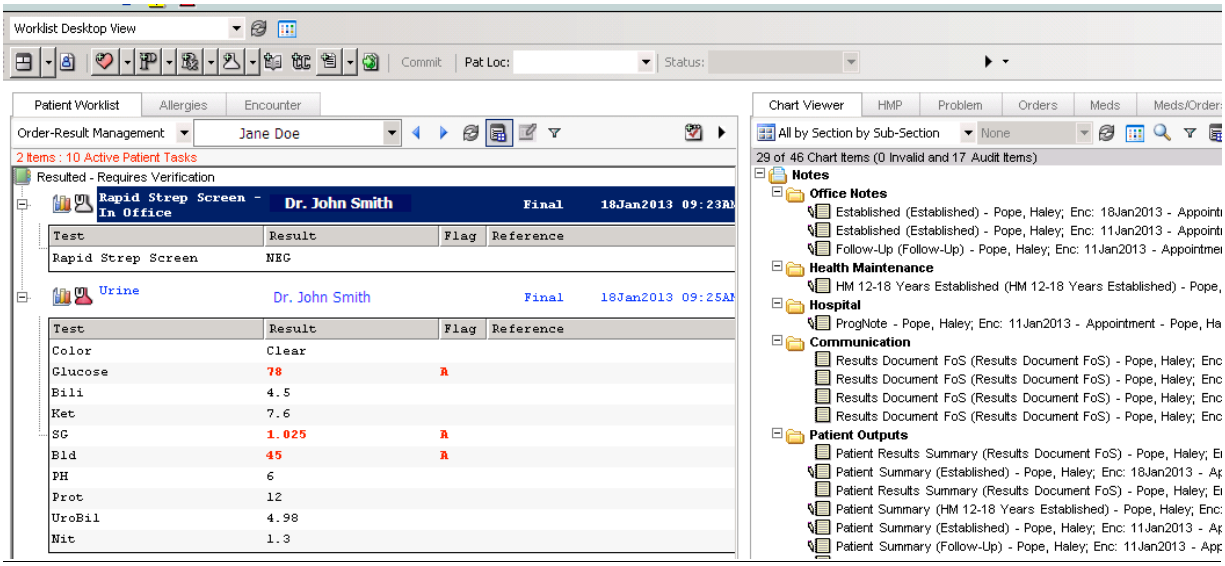
1. Navigate to the **Task List** tab located on your HTB. In the "View" field, "My Active Tasks" is displayed by default.



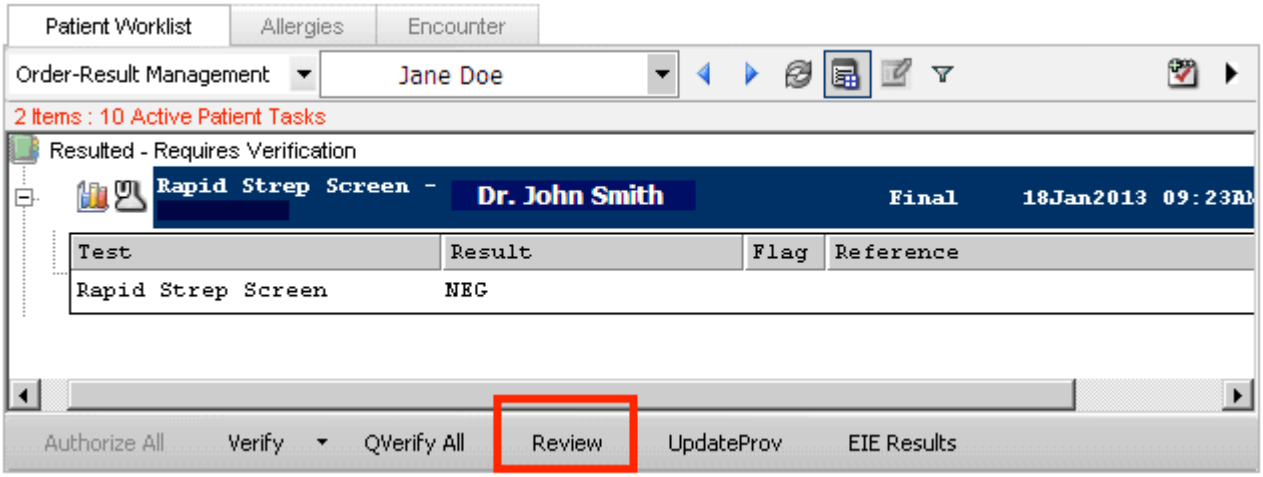
2. In order to provide coverage for a provider who is out of the office, the user will need to select their provider-specific **Active Task View**. In this example, since Dr. Smith is out of the office, the "View" that needs to be referenced is "Dr. Smith Active Tasks." This list will display all tasks assigned to Dr. Smith, which are either in an "Active" or "In-Progress" status.



3. To examine patient results, double click on a "Verify Patient Results" task. This directs the user to the **Clinical Desktop** with the patient's results displayed. Assess all results for that patient.

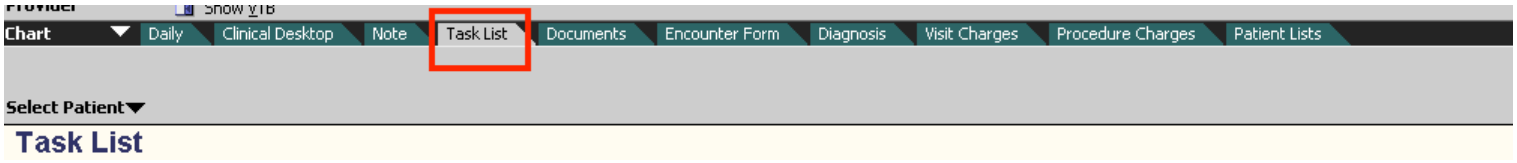


4. Since no immediate action needs to be taken, highlight the test result and click the **Review** button. Do this for all tests for that patient, in order to document that you have reviewed each result.

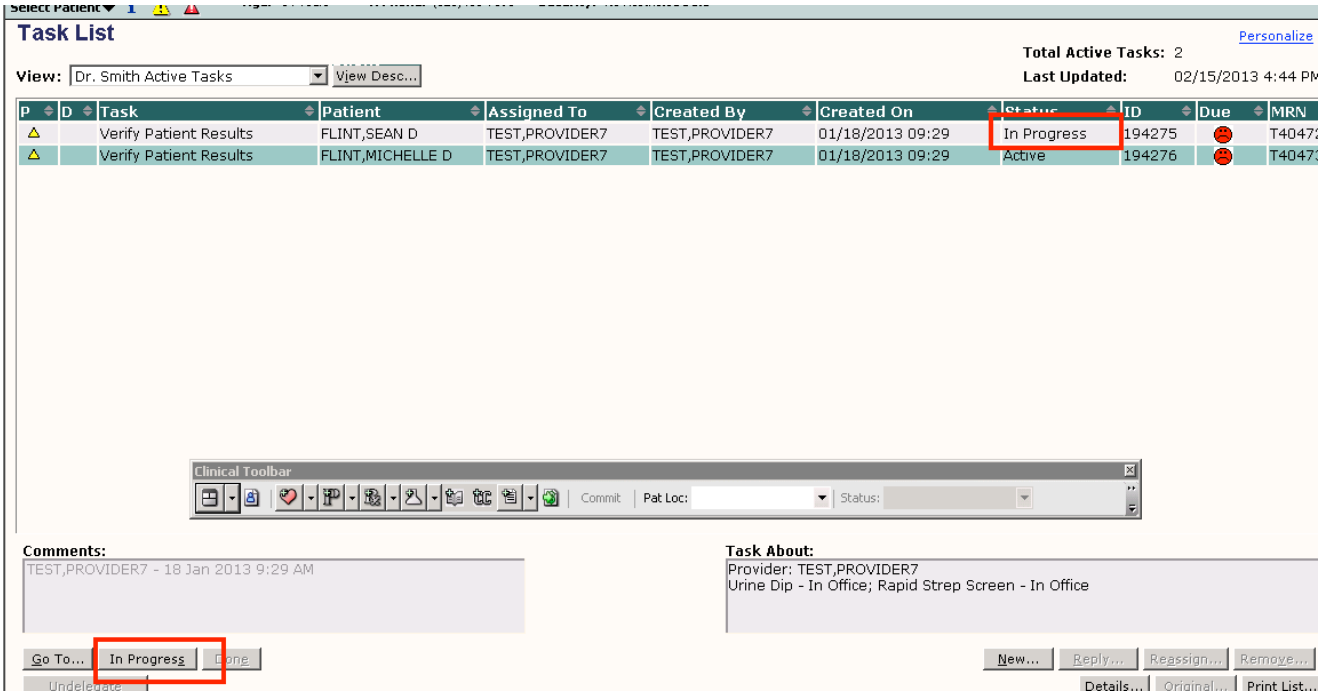


Please Note: After the user clicks **Review**, this button will be grayed out.

5. Navigate back to the **Task List** tab on the Horizontal Toolbar.



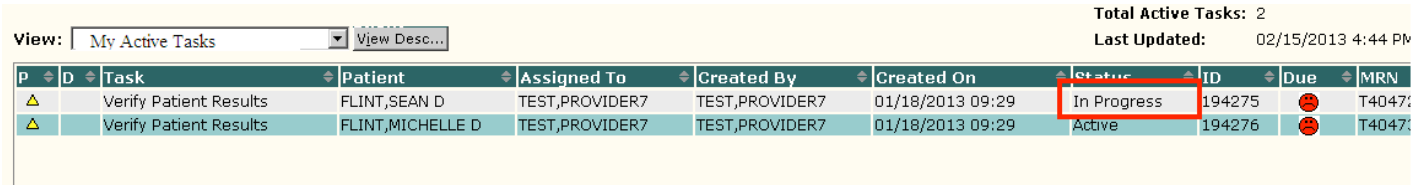
6. Once again, find the task for the items that you have just "reviewed". Single-click on the task this time, and click the **In Progress** button, located on the bottom of the **Tasklist**. This changes the status to "In Progress." This allows the task to stay on the Ordering Provider's list, enabling them to Review and Verify the results upon returning.



Please Note: Marking the task as "In Progress" is helpful to the Covering Provider. This allows them to see which items they have already reviewed, without having to go back to the result to see the "Reviewed" status of the result.

Ordering Provider

7. Upon returning to the office, review your task list. The “Verify Patient Results” tasks with a status of “In Progress” are the items that your covering colleague has “reviewed” but has not taken any action on due to their non-urgent nature.



8. These results still need to be “Verified” by you, the ordering provider. To do so, double-click on the task. This will take the user to the patient’s results. To determine when it was “reviewed” by your covering colleague, double-click on the result to open them. You can then note the date/time of the “review” process by your covering provider.

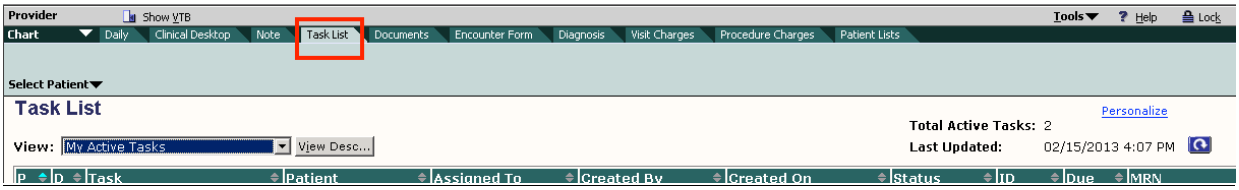
9. Verify these results as you typically would, using either the **QVerify** function or the **Verify** function.

SCENARIO 2

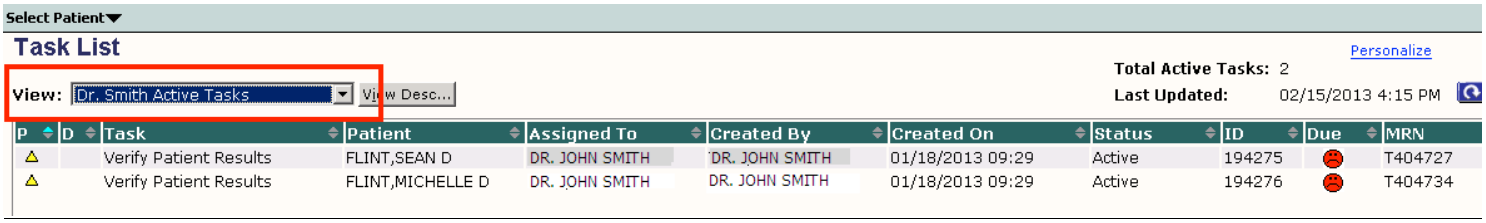
Dr. Smith is out of the office. Upon assessment of a patient's results, it is determined that these results need action taken prior to Dr. Smith's return. (NOTE: this process should also be used if your office has determined that the covering physician will review and verify all tests in the absence of the ordering physician)

Covering Provider

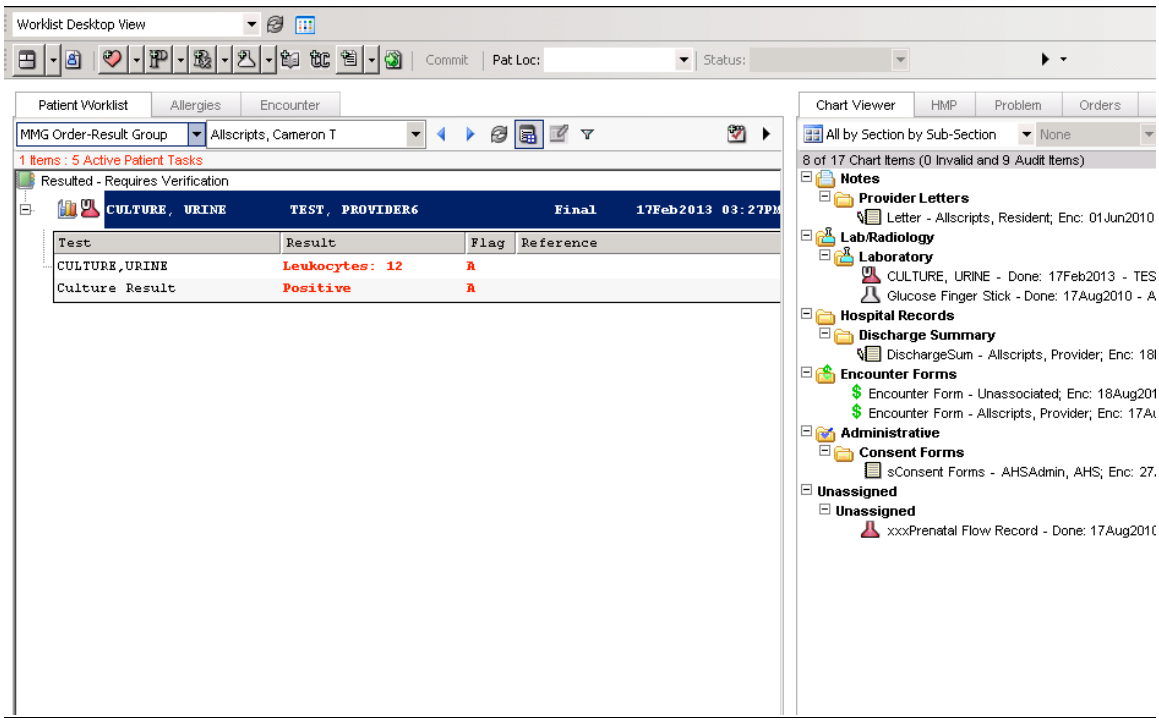
1. Navigate to the **Task List** tab, located on your HTB. In the "View" field, "My Active Tasks" is displayed by default.



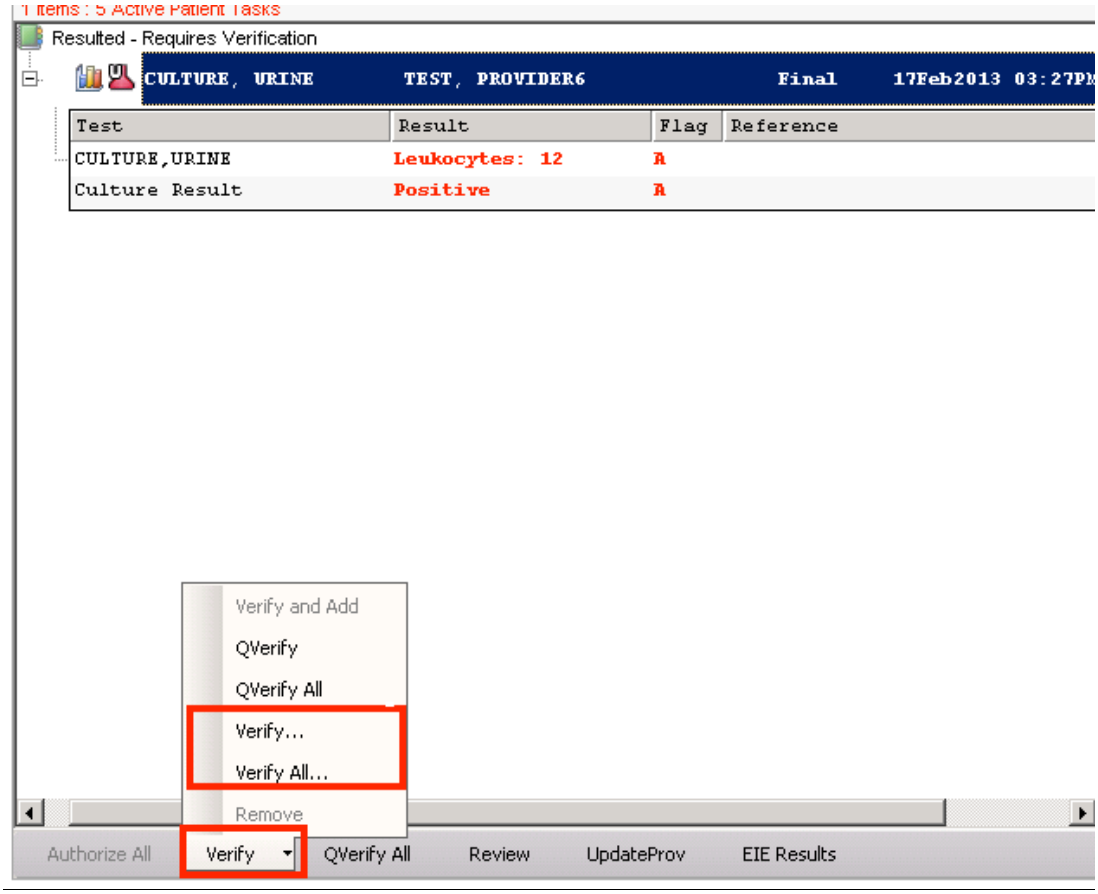
2. In order to provide coverage for a provider who is out of the office, we need to select their provider-specific **Active Task View**. In this example, since Dr. Smith is out of the office, the "View" that needs to be referenced is "Dr. Smith Active Tasks." This list will display all tasks that are either in an "Active" or "In-Progress" status, assigned to Dr. Smith.



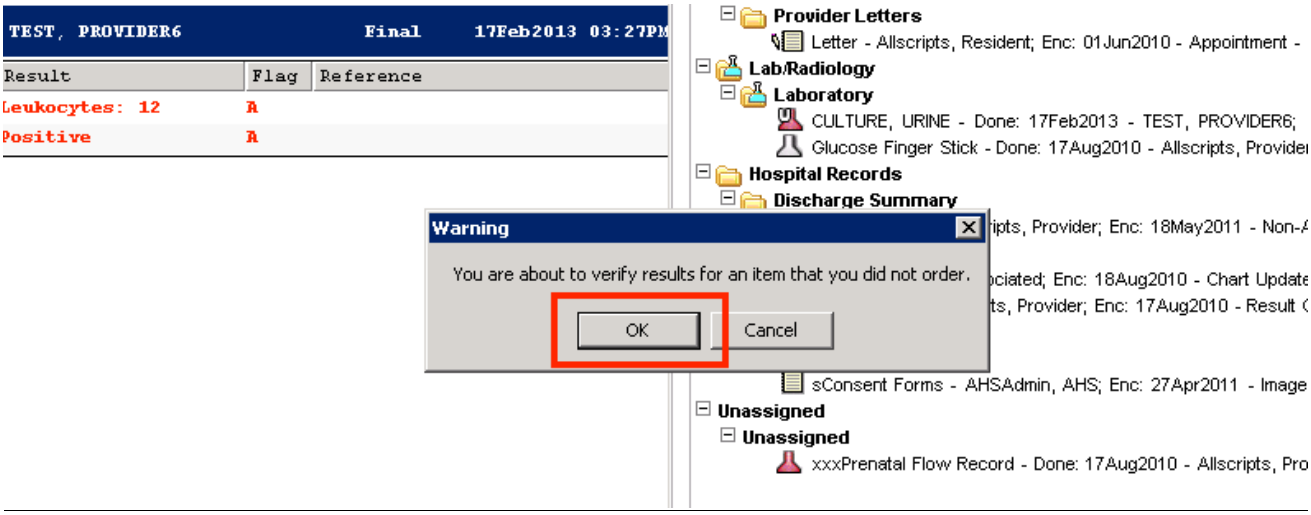
3. To examine patient results, double-click on a "Verify Patient Results" task. This takes the user to the **Clinical Desktop** with the patient's results displayed. Assess all results for that patient.



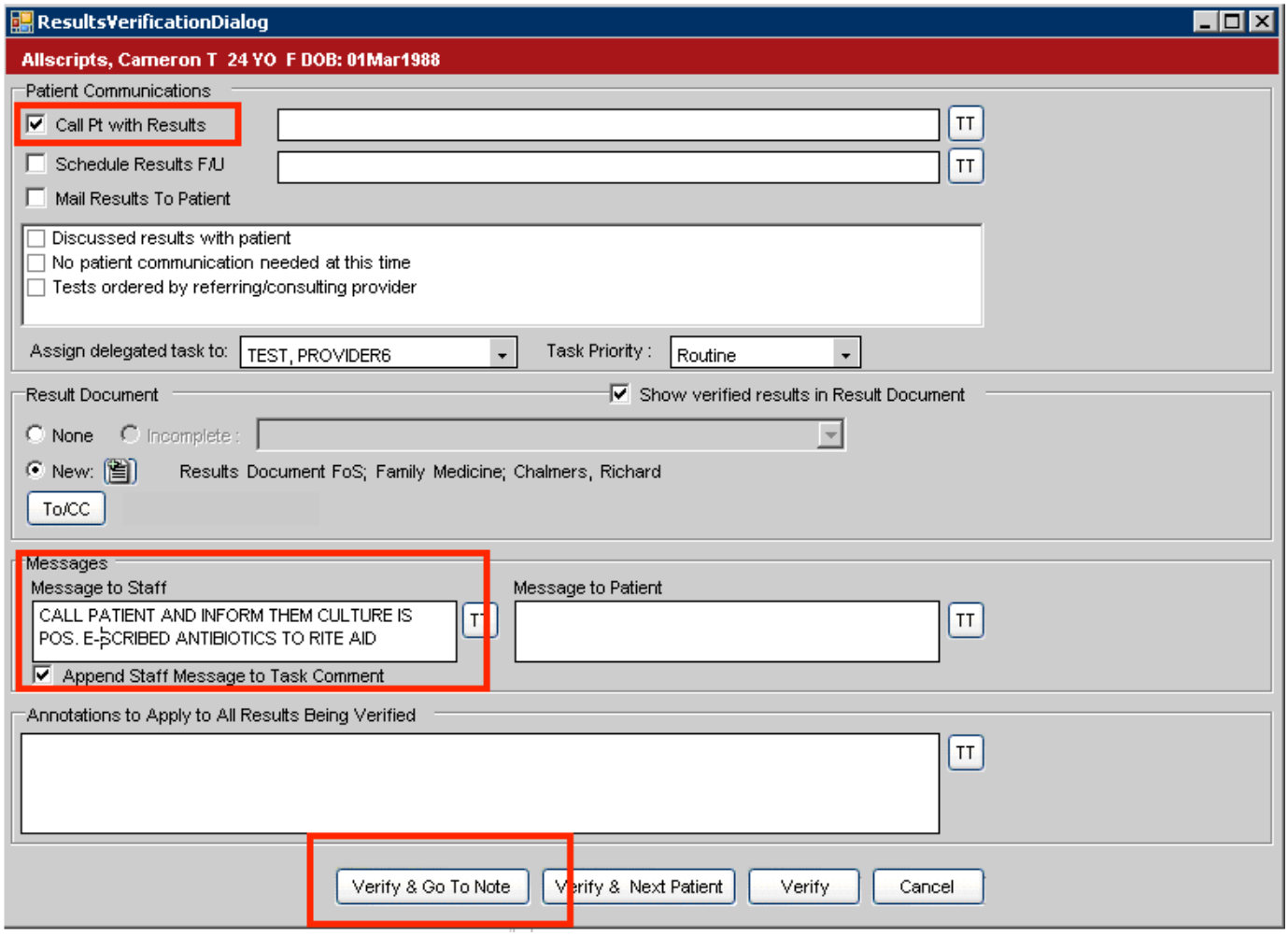
4. Upon reviewing the results, you determine action is necessary. Click on the **Verify** button and select **Verify All.** Do not use the **QVerify** option when verifying results, in which you are not the Ordering Provider. Instead, follow the instructions listed in Scenario 1.



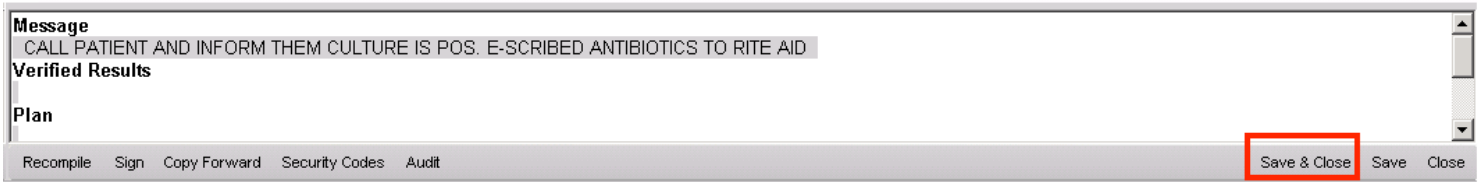
5. Upon clicking **Verify** or **Verify All**, a warning box will appear. This is letting the user know that they are about to verify results for an item that they did not order. Click **OK** to proceed.



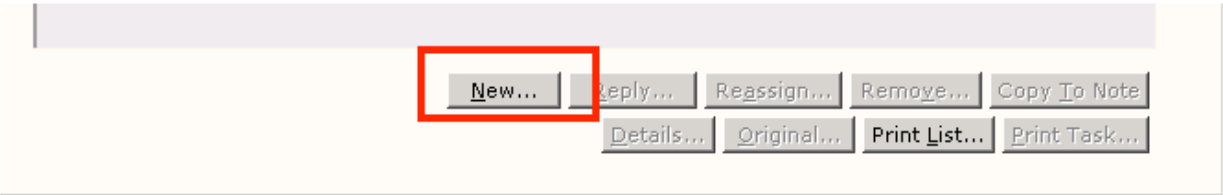
6. This prompts the **Results Verification Dialogue** window, where the user will enter the necessary action, as they typically would if they were the ordering provider. After the communication method and messages are entered, click **Verify and Go To Note.**



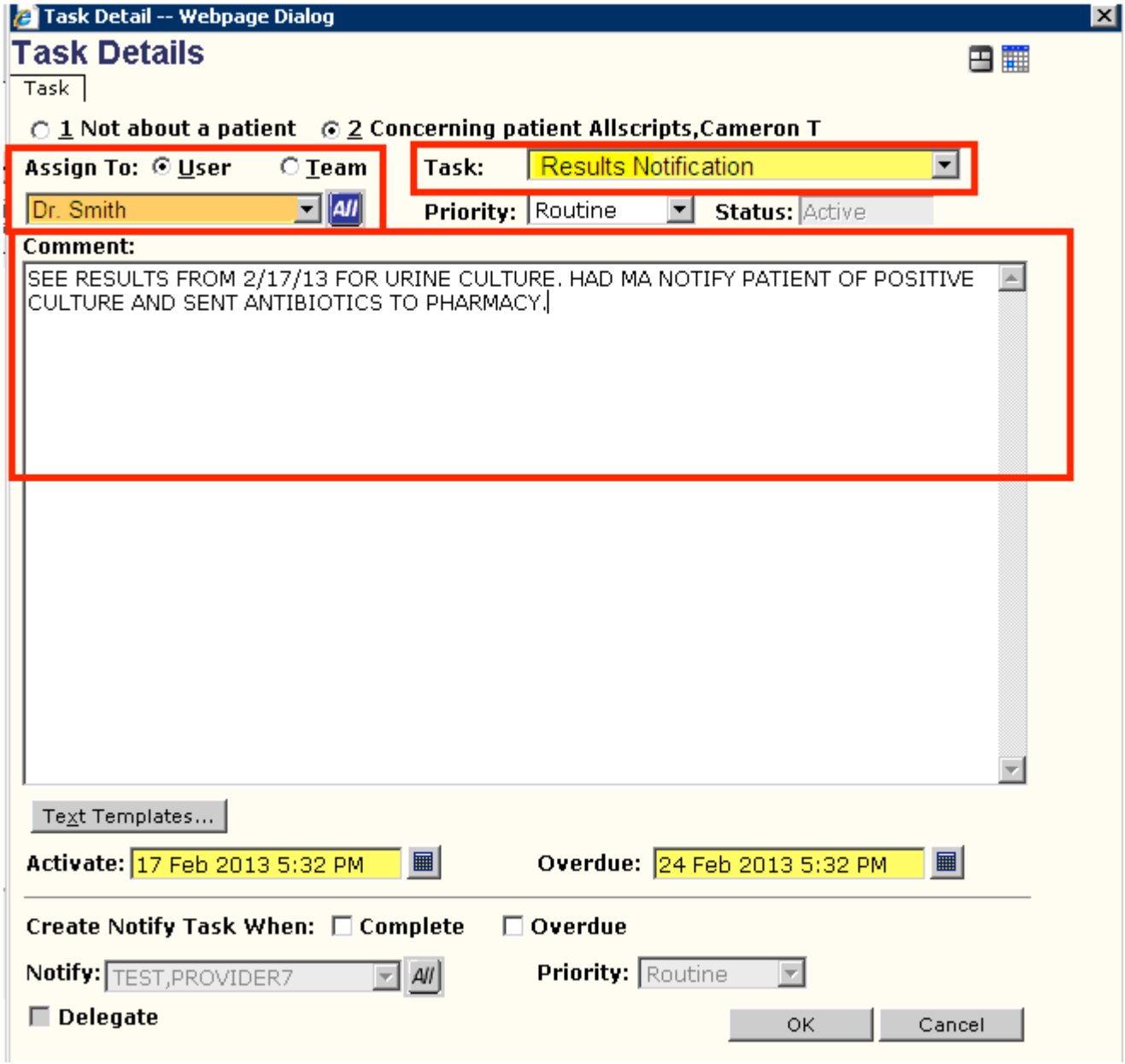
7. Once the **Note Authoring** workspace opens, click **Save and Close**. Take any further action necessary. For example, in this instance, it has been noted that the covering provider would send an antibiotic to the pharmacy. Proceed as you typically would to complete those items.



8. Next, we need to generate a manual task back to the Ordering Provider to inform them of the action taken on the results for this particular patient. Navigate back to the task list and click on “New”.

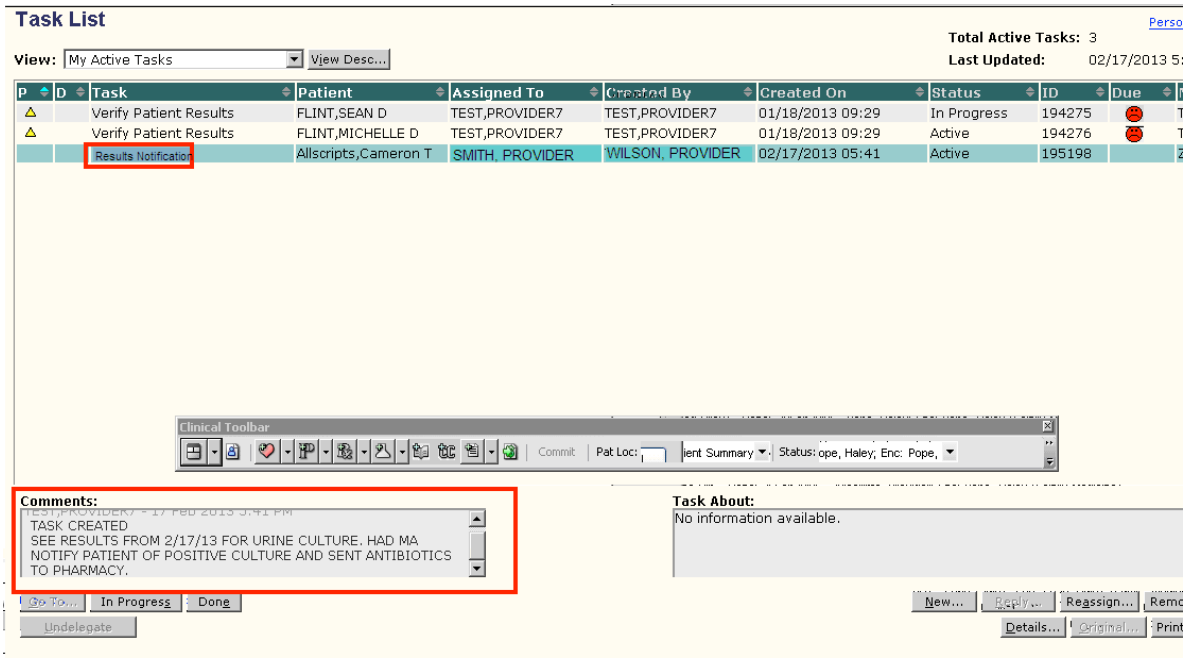


9. In the **Task Details** window, fill in the “Assign To” field with the Ordering Provider’s name. From the task type drop down, select “Results Notification.” Enter task details as shown below.

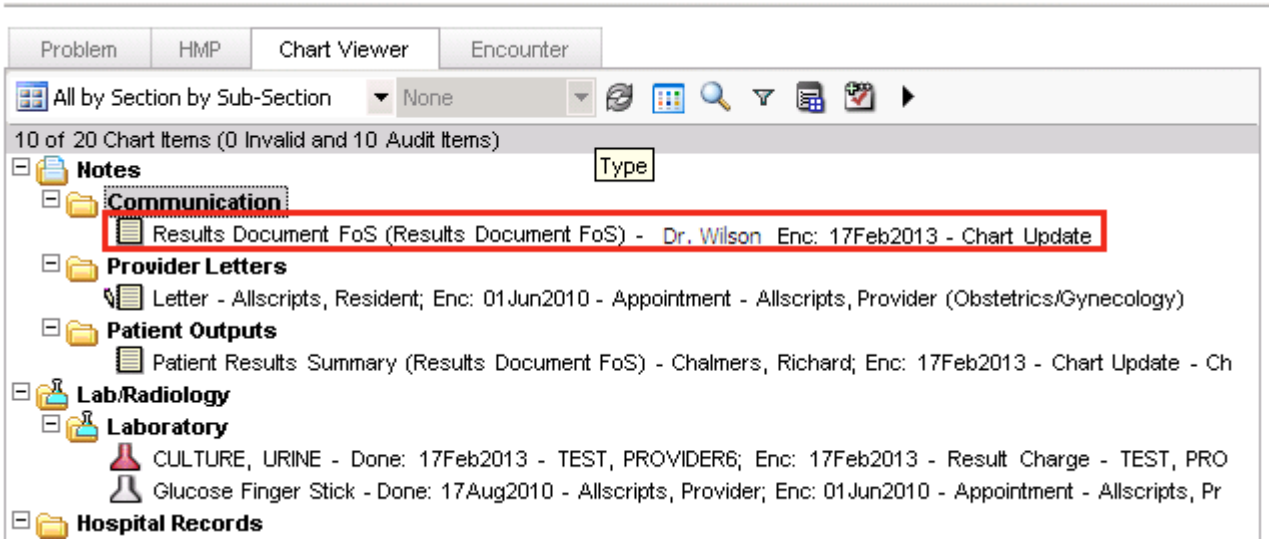


Ordering Provider

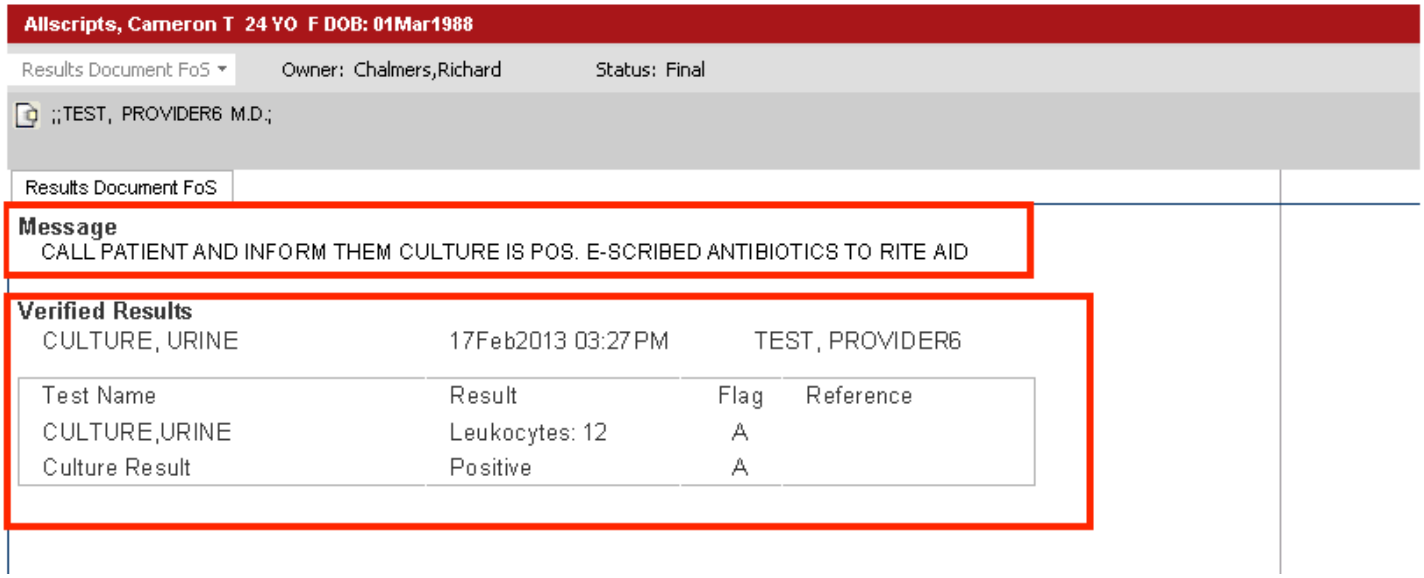
10. Upon return, navigate to your **My Active Tasks** list. Any tasks from the Covering Provider, titled “Results Notification”, are the tasks where results came back and needed attention prior to your return. The Covering Provider has sent you a task, in order to make you aware of the results and the action taken on these results. Single-click on the task, and review the information in the “Comments” section at the bottom of your screen.



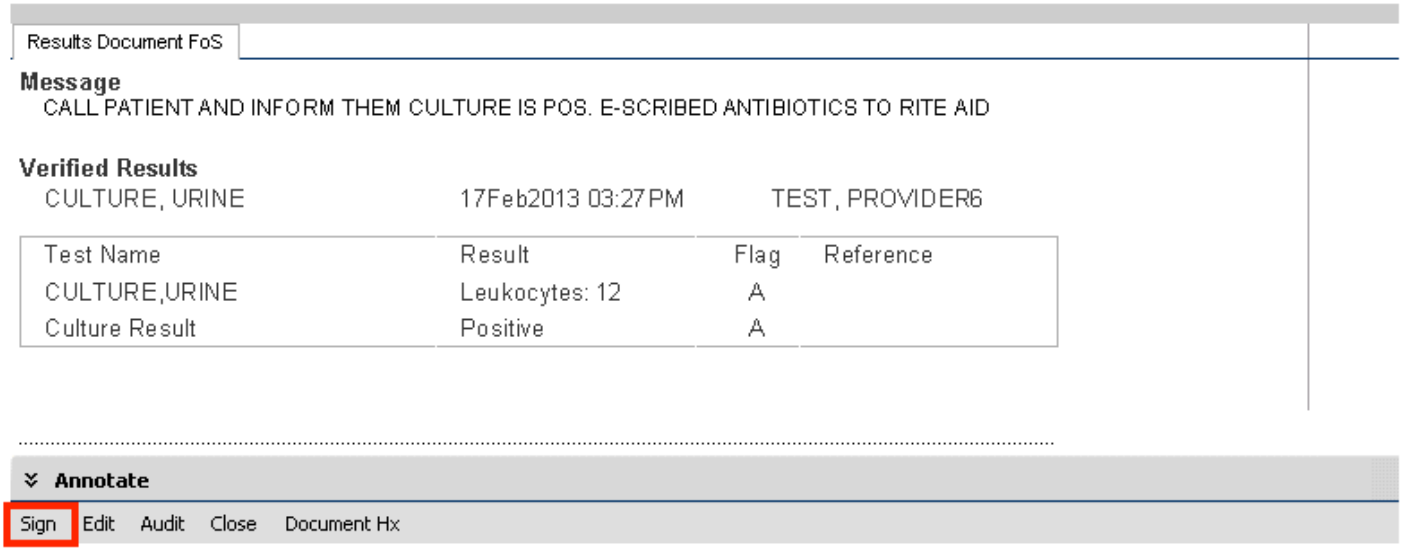
11. After reading the “Comments” section, navigate to the **Clinical Desktop** tab in the HTB. Once on the Clinical Desktop, click on the **Chart Viewer** component. There will be a “Results Document FoS” with the appropriate date.



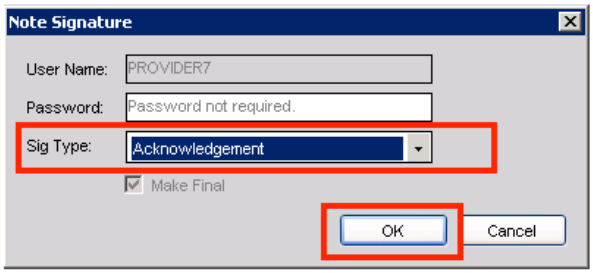
12. Double-click on the Results Document FoS to view both the results and the action taken by your Covering Provider.

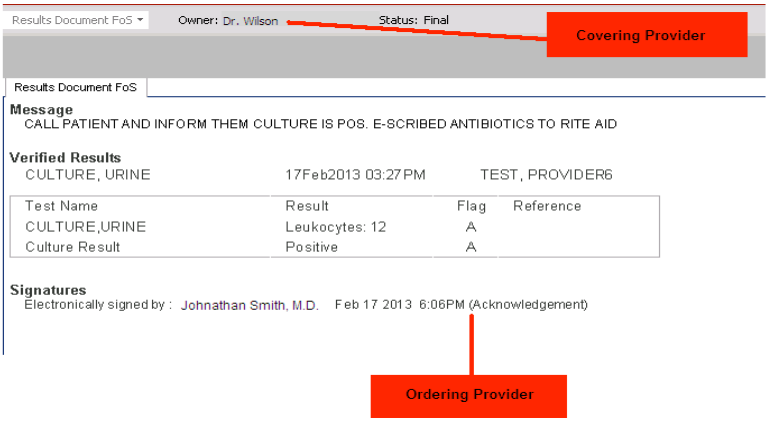


13. If no further contact or action needs to be made, click **Sign** at the bottom of the “Note Viewer”.



14. In the **Note Signature** window, select “Acknowledgement” in the “Signature Type” drop down. This just recognizes that you have seen and acknowledge the results and subsequent action taken by your covering colleague.





15. Finally, navigate back to your **Task List** and click “Done”. This will remove this task from your Active Task list and moves it to a “Complete” status.

2019 MIPS Program

On October 14, 2016, the Department of Health and Human Services implemented the Quality Payment Program (QPP) that is part of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The MIPS program is a component of the QPP. MMG providers, including Physicians, NPs, and PAs will participate in MIPS. Eligible Providers will receive either a positive, neutral, or negative adjustment of their Medicare payments for covered professional services.

Moving forward, Eligible Providers must report on the following 4 categories:

1. **Clinical Practice Improvement Activities**
2. **Quality (replaced PQRS)**
3. **Promoting Interoperability (PI) (formerly Meaningful Use/ACI)**
4. **Cost (Value Modifier-Cost Program)**

Improvement Activities Category

Clinicians are rewarded for care focused on care coordination, beneficiary engagement, and patient safety. There are a total of 118 available improvement activities this year. This category is 15% of the final MIPS score in 2019.

MMG will report these metrics; no other action is needed by providers.

Quality Category

The Quality Category for the MU/MIPS program replaced the Physician Quality Reporting System (PQRS). This category is 45% of the final MIPS score in 2019.

Because McLaren is considered an ACO, McLaren Physician Partners (MPP) will submit the Quality data on behalf of the MMG providers. This data is submitted directly to the ACO.

Promoting Interoperability (PI) Category

This category has been renamed- we previously called this "Meaningful Use" or "ACI".

WHAT YOU NEED TO KNOW:

- **Scoring**:
  - This category is 25% of the final MIPS score in 2019.
  - Higher percentages for each measure yield a higher score. The Base category was eliminated. This year is performance-based scoring only.
  - Scores for all measures are tallied to create a 'Composite Score' and compared to providers across the country.
  - ***Providers have the potential to earn 110 points between 4 objectives, even though 100 is the max amount of points needed.***

- **END GOAL:** To be the most successful and earn the most points, aim for the highest score possible.

2019 Promoting Interoperability (MU/MIPS) Measures:

In these objectives, aim for the highest score for each measure to earn the most points.

Objective Name	Measure Details	Responsible Party
Electronic Prescribing	e-Prescribing Requirement: o Prescriptions must be generated/queried for a drug formulary and transmitted electronically through EMR. o Up to 10 points available. Bonus 1 Requirement: o EMR must be used to conduct query of PDMP for prescription drug history when ordering Schedule II Opioids. *(not yet available in our EMR)* o Up to 5 bonus points available. Bonus 2 Requirement: o Provider must seek to identify signed opioid treatment agreement and incorporate in patient's EMR chart when electronically prescribing an Opioid. *(not yet available in our EMR)* o Up to 5 bonus points available.	Measure and Bonus 1: Provider Bonus 2: Provider and MA
Health Information Exchange	Measure 1 – Support Electronic Referral Loops by Sending Health Information Requirement: o For all transition of care patients, a summary of care record must be created using EMR and exchanged electronically to referring provider including all of patient's required demographics. o Up to 20 points available. Measure 2 – Support Electronic Referral Loops by Receiving and Incorporating Health Information Requirement: o When receiving a referral, clinical information must be reconciled using EMR for 3 clinical information sets: o Medication, Medication Allergy and Current Problem List o Up to 20 points available.	Measure 1 and 2: Provider and MA
Provider to Patient Exchange	Provider to Patient Exchange Requirement: o Patients must be provided timely access (within 4 days) to health information to view, download and transmit to a 3rd party and access using an application of their choice that is configured to meet tech specs of the API in the EMR. *(Apple Watch only app available to connect with Cerner portal - none in Allscripts)* o Up to 40 points available.	Atos/Cerner MA/Provider responsible for encouraging patients to provide email for portal invite.
Public Health & Clinical Data Exchange	Public Health & Clinical Data Exchange Requirement: o MMG must choose 2 data exchange reporting registries to submit provider data on. o Up to 10 points available.	MMG Education Department

Cost Category

There are 2 performance measures for this category and 8 episode-based measures for this category. This is 15% of the final MIPS score.

MMG will be responsible for reporting data for this category; no other action is needed by providers.

Michigan Cancer Consortium
Screening Guidelines for Early Detection of Breast Cancer
December 2009

The Michigan Cancer Consortium supports the breast cancer screening guidelines for average and high-risk women as recommended by the American Cancer Society (2009)[1] and the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology for Breast Cancer Screening and Diagnosis (V.1.2010).[2]

I. Recommendations for Breast Cancer Screening – **Average Risk Women**

Screening Exam	Interval	Age to Begin	Additional Information
Breast Awareness/ Breast Self Exam[1,2]	Optional	Mid-20's	See NOTE*
Clinical Breast Exam (CBE)[1, 2]	Every three (3) years	Asymptomatic women in their 20's and 30's	CBE should be part of a periodic health exam
	Annually	Women age 40 and older	
Mammography[1, 2]	Annually	Average risk women starting at age 40	Yearly exams should continue for as long as a woman is in good health.

*** NOTE:** Breast Awareness/Breast Self Exam

- Breast self exam (BSE) is an option for women starting in their 20s. Women should be informed about the benefits and limitations of BSE. [1]
- Women should be familiar with their breasts and promptly report changes to their healthcare provider. Periodic, consistent BSE may facilitate breast self awareness. Pre-menopausal women may find BSE most informative when performed at the end of menses. [2]

II. Recommendations for Breast Cancer Screening – **High Risk Women**

Risk Factor	Screening Exam	Interval	Age to Begin	Additional Information
1. Prior thoracic radiation therapy* [2]	CBE	6-12 months	Begin 8-10 years after Radiation Therapy or age 25 whichever occurs last.	* See Note Breast Self Awareness
	Mammogram	Annual		
	Consider MRI as adjunct to CBE/ Mammogram	Annual		
2. Personal history of atypical hyperplasia or Lobular Carcinoma In Situ (LCIS) [2]	CBE	6-12 months	Begin 5-10 years prior to earliest index case but not under age 25	* See Note Breast Self Awareness Consider Risk Reduction Strategies (See NCCN Breast Cancer Risk Reduction Guidelines)
	Mammogram	Annual		
	For LCIS: MRI as adjunct with CBE/Mammogram	Annual		
3 Strong family history of breast cancer or genetic predisposition [2] (Hereditary Breast and Ovarian Cancer Patients – HBOC)	CBE	6-12 months	Start at age 25 for HBOC patients 5-10 years prior to youngest breast cancer case for strong family history of other genetic predispositions	* See Note Breast Self Awareness Consider Risk Reduction Strategies (See NCCN Breast Cancer Risk Reduction Guidelines) Consider referral to genetic counselor
	Mammogram	Annual		
	MRI as adjunct with CBE/Mammogram	Annual		
4. Personal History of Breast Cancer [2]	CBE	6-12 months	Post Diagnosis	* See Note Breast Self Awareness See NCCN Breast Cancer Guidelines- Surveillance Section
	Mammogram	Annual		
Women >/= 35 with 5-year risk of invasive breast cancer >/= 1.7% [2]	CBE	6-12 months	After age 35.	* See Note Breast Self Awareness Consider Risk Reduction Strategies (See NCCN Breast Cancer Risk Reduction Guidelines)
	Mammogram	Annual		

Risk Factor	Screening Exam	Interval	Age to Begin	Additional Information
Moderate Breast Cancer Risk (15% - 20% lifetime risk) [1]	CBE	6-12 months	Age risk is identified	* See Note Breast Self Awareness Discuss with Health Care Provider about the benefits and limitations of adding MRI screening to yearly mammogram * ACS recommendations
	Mammogram	Annual		
High Breast Cancer Risk (> 20% lifetime risk) [1, 2]	CBE	6-12 months	Age Risk is Identified	* See Note Breast Self Awareness Consider Risk Reduction Strategies (See NCCN Breast Cancer Risk Reduction Guidelines)
	Mammogram	Annual		
	MRI	Annual		

*** NOTE:** Breast Awareness/Breast Self Exam

- Breast self exam (BSE) is an option for women starting in their 20s. Women should be informed about the benefits and limitations of BSE. (ACS 2003, 2009)
- Women should be familiar with their breasts and promptly report changes to their healthcare provider. Periodic, consistent BSE may facilitate breast self awareness.. Pre-menopausal women may find BSE most informative when performed at the end of menses. (NCCN Clinical Practice Guidelines in Oncology for Breast Cancer Screening and Diagnosis V.1.2010).

III. Evaluation of Abnormal Clinical Breast Exam and/or Mammogram Results

Refer to National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology for Breast Cancer Screening and Diagnosis (V.1.2010).[2]

Michigan Cancer Consortium
Guidelines for the Early Detection of Cervical Cancer
December 2007

The Michigan Cancer Consortium recognizes and promotes the use of the American Society for Colposcopy and Cervical Pathology's (ASCCP) 2006 Consensus Guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests and 2006 Consensus Guidelines for the Management of Women with Cervical Intraepithelial Neoplasia or Adenocarcinoma in Situ. Guidelines are referenced in this document and may be found at http://www.asccp.org/

Screening Tests

Testing for cervical cancer is performed using either Liquid-Based Cytology or Conventional (slide) Pap Test. Consideration should be given to the use of HR-HPV (High-Risk Human Papillomavirus) testing in conjunction with cervical cytology for screening women 30 years of age and older

Age to Initiate Screening:

Screening for cervical cancer should begin at age 21 or 3 years after the onset of sexual activity, **whichever comes first.**

General Information

- The need for cervical cancer screening should not be the only basis for the onset of gynecological care.
- Adolescents must be able to obtain appropriate preventative health care, including, but not limited to, an assessment of health risks, counseling for pregnancy and sexually transmitted disease (STD) prevention, provision of contraception methods, and treatment of STD's; even if they do not need a Pap smear.
- Clinical breast exam and yearly speculum and bimanual pelvic examinations should be provided even if no cervical cancer screening is performed.
- For the purpose of these guidelines an ADOLESCENT is defined as 20 years of age or younger.
- Adolescents and young women who have received the HPV vaccine should continue cervical cancer screening according to the current guidelines.
- In the absence of endocervical cells, if a Pap smear is satisfactory and negative, then regular screening should be continued.

Frequency of Screening:

Age to Begin	Screening Exam	Screening Interval
Age 21 or 3 years after the onset of sexual activity until age 29	Conventional Pap Test **OR**	Annual
	Liquid Based Cytology (LBC)	Every two years
Age $\geq$ 30* with three consecutive, negative cytology results	Conventional Pap Test OR Liquid Based Cytology	Every two to three years

* HR-HPV as an adjunct to cervical cytology testing may be used for cervical cancer screening in women 30 years of age or older. If both tests are negative, testing occurs every three years. For abnormal results, follow-up guidelines may be found on http://www.asccp.org/.

Special Considerations:

- Women with a histologically-confirmed HSIL, whether or not they receive treatment - continue cervical cancer screening on a regular basis, for **20** years.
- Women who are HIV+, immunocompromised, or had *in utero* DES exposure – continue ANNUAL cervical cancer screening regardless of the testing method.
- For women whose cytology exam is satisfactory but obscured or partially obscured by inflammation – repeat the exam in 6 months. Refer for colposcopy if subsequent cytology is still interpreted as obscured, partially obscured or otherwise abnormal.
- Women whose cytology exam is unsatisfactory need a repeat cytology exam within the next 2 to 4 months.
- Per the ASCCP guidelines, adolescents and pregnant women are also given special consideration. See guidelines for details at http://www.asccp.org/.
- Endocervical curettage is unacceptable in pregnant women
- Colposcopy may be deferred until the postpartum examination
- Invasive cancer is the only indication for treatment during pregnancy

For Women Who Have Had a Hysterectomy:

- Hysterectomy for cervical cancer or cervical dysplasia - continue ANNUAL Pap testing.
- For women who still have a cervix, continue testing as indicated by age, type of cytology test and Pap history.
- Total hysterectomy for benign gynecological disease (no cervix present) - screening with vaginal cytology is NOT indicated; this does not preclude a pelvic exam.

Upper Age Limit for Screening: Consider not screening after age 70 if the woman has had 3 documented Negative Paps and no abnormal Pap tests in the last 10 years. Consider continuing to screen if the woman is sexually active. Women with comorbid illnesses may forego cervical cancer screening. Continue screening if there is a history of cervical cancer, *in utero* DES exposure, or the woman is HIV + or immunocompromised.

Indications for Referral to a Qualified Colposcopist:

- Women age 20 and under requiring treatment for CIN2/3
- Pregnant women with HSIL cytology.
- Women with a significant cervical lesion in which "see and treat" may be indicated
- Women desiring fertility who, after excisional treatment, have recurrent or persistent cervical dysplasia
- Women who have had two "unsatisfactory for evaluation" tests 2-4 months apart
- Women with AGC (Atypical Glandular Cells) or AIS (Adenocarcinoma in situ) on cytology. Management follows the algorithm found at http://www.asccp.org/.
- **Women with any gynecologic cancer should be referred to a Gynecologic Oncologist.**

Follow-up of Abnormal Cytology Results:

The website http://www.asccp.org/ contains algorithms on the:

- Follow-up of ASC-US cytology results for all women
- Management of adolescent women with HSIL results, ASC-US or LSIL cytology
- Management of pregnant women with LSIL results
- Management of HSIL, ASC-H and LSIL cytology for all women
- Management and follow-up of AGC cytology.

A diagnostic excisional procedure is recommended for women with HSIL and an unsatisfactory colposcopy, except when pregnant.

A diagnostic excisional procedure is recommended for adolescents and young women with HSIL when CIN of any grade is identified on ECC

Ablation is unacceptable for HSIL cytology if:

- No colposcopy was done
- CIN 2/3 is not identified colposcopically
- ECC identifies CIN of any grade

In women less than 35 years of age with an AGC cytology result, an endometrial biopsy should be performed in the presence of, but is not limited to, the following conditions:

- Dysfunctional uterine bleeding
- At risk for chronic anovulation
- A change in menstrual flow

Management of Women and Adolescents with Histologically-confirmed Cervical Intraepithelial Neoplasm:

The website http://www.asccp.org/ contains algorithms on the:

- management of women with histological results of CIN1, preceded by ASC-US, ASC-H or LSIL cytology
- management of women with histological results of CIN1, preceded by HSIL or AGC-NOS cytology
- management of adolescents, with a histological result of CIN1
- management of women with a histological result of CIN2/3
- management of women with AIS (Adenocarcinoma in situ) diagnosed from diagnostic excisional procedure.

Reminder and Tracking System: Clinicians and agencies should be encouraged to develop a system which will both remind women to schedule cancer screening testing and notify women of abnormal cervical cancer screening tests (which include positive HPV – High Risk test results), asking them to schedule follow-up diagnostic testing.

Patient Education: Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV.

MCC Guidelines for the Early Detection of Colorectal Cancer
February 2009
Recommendations for Colorectal Cancer Screening (Table 1)

Based on the 2008 Joint Guideline from the American Cancer Society, the U.S. Multi-Society Task Force, and the American College of Radiology, and the U.S. Preventive Services Task Force (2008)

- **Colon cancer prevention should be the primary goal of colorectal cancer screening. Tests that are designed to detect both early cancer and adenomatous polyps should be encouraged if resources are available and patients are willing to undergo an invasive test.**
- **If patient reports rectal bleeding a diagnostic evaluation is recommended, see Table 3.**
- **Screening should continue throughout life unless age or comorbid conditions limit life expectancy. The U.S. Preventive Services Task Force recommends against screening in adults older than age 85 years.**

Table 1

AVERAGE RISK

Risk Category	Recommendation[1]	When to Begin	Interval
All people ages 50 and over not in the categories below ***FOBT is defined as the at-home procedure of collecting two samples from three consecutive bowel movements.	-Guiac-based fecal occult blood test (gFOBT)* -Fecal Immunochemical Test (FIT) -Flexible sigmoidoscopy (FSIG) -Flexible sigmoidoscopy plus FOBT -Double Contrast Barium Enema (DCBE) - Computed Tomographic Colonography (CTC) -Colonoscopy (CS) *-Stool DNA test (sDNA)*	Age 50	-gFOBT every year, or -FIT every year, or -FSIG every 5 years, or -FOBT every year & FSIG every 5 years, or -DCBE every 5 years, or -CTC every 5 years, or -CS every 10 years, or *–sDNA guidelines being developed*

INCREASED RISK

Risk Category	Recommendation	When to Begin	Interval
History of Polyps at Prior Colonoscopy			
Small, rectal hyperplastic polyps	Any screening option as recommended for average risk individuals	Time of initial diagnosis	Follow average risk recommendations unless hyperplastic polyposis syndrome
Single, small (< 1 cm) adenomatous polyp OR 1-2 small tubular adenomas with low grade dysplasia	Colonoscopy	3-6 years after initial polypectomy	If normal, follow average risk recommendations
People with one large (≥ 1 cm) adenoma *or* 3-10 adenomas of any size *or* any adenoma with villous features or high grade dysplasia	Colonoscopy	3 years after initial polypectomy	If normal or 1-2 small tubular adenomas with low-grade dysplasia found, interval may be 5 years
People with more than 10 adenomas on a single exam	Colonoscopy	< 3 years after initial polypectomy	Consider possibility of familial syndrome
Persons with sessile adenomas that are removed piecemeal	Colonoscopy	2-6 months to verify complete removal	Based on endoscopist's judgment. Completeness of removal should be based upon both endoscopic and pathologic assessments
History of Colorectal Cancer			
Personal history of curative-intent resection of colorectal cancer	Colonoscopy	Within 1 year after resection	If normal, colonoscopy in 3 years; if still normal, colonoscopy every 5 years Colorectal cancer or other visceral cancers[2] under age 50 should be considered for counseling for genetic testing
Family History			
Colorectal cancer or adenomatous polyp in one first degree relative (parent, sibling or child) before age 60 OR in two *or* more first degree relatives of *any* age	Colonoscopy	Age 40 or 10 years before the youngest case in the family, whichever is earlier	Every 5 years Counseling to consider genetic testing, with referral to a specialist/specialty center[2]
Colorectal cancer or adenomatous polyp in a first-degree relative ≥ age 60 or two second –degree relatives with colorectal cancer	Any screening option as recommended for average risk individuals	Age 40 years	As recommended for average risk persons, depending on type of screening procedure chosen

MCC Guidelines for the Early Detection of Colorectal Cancer
February 2009

Recommendations for Colorectal Cancer Screening (Table 1)

Based on the 2008 Joint Guideline from the American Cancer Society, the U.S. Multi-Society Task Force, and the American College of Radiology, and the U.S. Preventive Services Task Force (2008)

And

Recommendations for Follow-up of Abnormal Colorectal Cancer Screening Results (Table 2)
Recommendations for Diagnostic Evaluation of Rectal Bleeding (Table 3)

Table 1 (Continued) **HIGH RISK**

Risk Category	Recommendation Includes referral to a specialist/specialty center	When to Begin	Interval
Genetic or clinical diagnosis, or family history of familial adenomatous polyposis (FAP)	Annual FSIG to determine if FAP is present and counseling and consideration of genetic testing	Puberty (Age 10-12 years)	If familial polyposis is confirmed, colectomy is indicated; otherwise, endoscopy every 1-2 years
Genetic or clinical diagnosis, or family history of hereditary non-polyposis colon cancer (HNPCC)	Colonoscopy and counseling and consideration of genetic testing	Age 20-25 years	Every 1-2 years until age 40, then every year
Inflammatory bowel disease, chronic ulcerative coliltis, and Crohn's colitis	Colonoscopy with biopsies for dysplasia	8 years after the start of colitis	Every 1-2 years

1 Digital rectal examination should be done at the same time as sigmoidoscopy or colonoscopy.
2 Personal or family history of visceral cancers such as endometrial, ovarian, gastric, hepatobiliary, or small bowel cancer or transitional-cell carcinoma of the renal pelvis or ureter may be suggestive of HNPCC. See above section on HNPCC.

Table 2

Abnormal Screening Test Result	Recommended Procedure	Future Screening Protocol
Abnormal Fecal Occult Blood Test (gFOBT or FIT) (If only one of the three cards tests positive, this is considered a positive test. Proceed to recommended procedure and do not repeat FOBT.)	Colonoscopy	Reassess risk status based upon results of colonic exam and follow appropriate future screening protocol.
Abnormal Flexible Sigmoidoscopy	If biopsy done: If hyperplastic polyp: colonoscopy not necessary If adenoma: colonoscopy **OR** If no biopsy done: colonoscopy	Reassess risk status based upon results of biopsy and follow appropriate protocol.
Abnormal Double Contrast Barium Enema **OR** Abnormal CTC	Colonoscopy	Reassess risk status based upon results of biopsy and follow appropriate protocol.
Abnormal Colonoscopy	Biopsy or Polypectomy	Reassess risk status based upon results of biopsy and follow appropriate protocol.
Incomplete Colonoscopy	Double Contrast Barium Enema or CTC	Reassess risk status based upon results and follow appropriate protocol.

Table 3

Symptom Reported by Patient	Recommended Procedure	Future Screening Protocol
Bright red rectal bleeding, on tissue, in bowl, or on stool	Age 50 and up: Colonoscopy or flexible sigmoidoscopy with double contrast barium enema. Age 40-50: If obvious anorectal disease, and no risk factors: flexible sigmoidoscopy. Otherwise: colonoscopy or flexible sigmoidoscopy with double contrast barium enema. Below age 40: If obvious anal source, and no risk factors: treat symptomatically. If recurrent symptoms then flexible sigmoidoscopy. Further testing if clinically indicated.	Reassess risk status based upon results of colonic exam and follow appropriate future screening protocol.
Burgundy blood marbled into the stool	Colonoscopy	Reassess risk status based upon results of colonic exam and follow appropriate future screening protocol.

Michigan Quality Improvement Consortium

Michigan Quality Improvement Consortium Guideline

Adult Preventive Services (Ages 18 - 49)

January 2012

The following guideline recommends clinical preventive services for adults. The grade definitions used for this guideline are as defined by the United States Preventive Services Task Force (USPSTF).

Grade	Grade Definition
A	**The USPSTF recommends the service. There is high certainty that the net benefit is substantial.**
B	**The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.**
C	**The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.**
D	**The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.**
I	**The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.**

	Recommendation
Health Assessment Screening, History & Counseling	One health maintenance exam (HME) every 1 - 5 years according to risk status, including: ◆ Height, weight and Body Mass Index (BMI) **[B]**; risk evaluation and counseling for obesity **[B]**, tobacco use **[A]**, and alcohol use **[B]**
Blood Pressure Screening	◆ Screen for high blood pressure in adults 18 years and older **[A]**. Screen every two years if BP ≤ 120/80 mm Hg. Annually if BP 120-139/80-89 mm Hg, and more frequently if warranted.
Aspirin Use	◆ Recommend the use of ASA for men age 45 to 79 years when the potential benefit due to a reduction in MI outweighs the potential harm due to an increase in gastrointestinal hemorrhage **[A]**.
Cholesterol and Lipid Screening	◆ Measure a fasting lipoprotein profile (i.e. total cholesterol, LDL-C, HDL-C), in men aged 35 years and older **[A]**. ◆ Measure a fasting lipoprotein profile in women aged 45 years and older if they are at increased risk for CHD (i.e. diabetes, family history cardiovascular disease before age 50 in male relatives or age 60 in female relatives, tobacco use, hypertension, BMI ≥ 30) **[A]**. ◆ Screen men aged 20-35 and women aged 20-45 if they are at increased risk for CHD **[B]**. ◆ Screen every five years for low risk adults if initial test normal; consider more frequent screening in individuals at increased risk.
Diabetes Mellitus Screening	◆ Screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg **[B]**. Screen every three years. ◆ In persons with BP < 135/80 mm Hg, screen on an individual basis according to CHD risks and benefits.
Colorectal Cancer Screening	◆ No requirement unless high risk (e.g. first degree relatives who have had colorectal adenomas or cancer; specific inherited syndromes, the Lynch syndrome, history of colorectal polyps; chronic inflammatory bowel disease **[B]**).
Cervical Cancer Screening Pap Smear	◆ Screen for cervical cancer in women who have been sexually active and have a cervix **[A]**. Screen every three years. ◆ Routine pap smear screening not recommended in women who have had a total hysterectomy for benign disease **[D]**.
Chlamydia Screening	◆ Recommended for all sexually active non-pregnant women aged 24 and younger and for older non-pregnant women who are at increased risk (i.e. new or multiple sexual partners, history of sexually transmitted diseases, not using condoms consistently or correctly) **[A]**. Screen at least annually if at increased risk. ◆ Recommend screening for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk **[B]**. Screen at first prenatal visit. If continued risk, screen again in third trimester. ◆ Routine screening not recommended for women aged 25 and older, whether or not pregnant, if they are not at increased risk **[C]**.
Breast Cancer Screening	◆ Biennial mammography screening before the age of 50 years should be an individual decision taking patient context into account **[C]**[1]. ◆ The current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older [I].
HIV Screening	◆ HIV screening for all high risk patients **[A]** annually. CDC recommends one-time testing for all patients 13 to 64 years of age.
Immunizations (Consult ACIP website, www.cdc.gov/vaccines/recs/acip/ for up-to-date recommendations and other vaccine indications based on medical and other indications):	
Tdap/Td	After primary series, Td every 10 years. Give Tdap once after age 12.
HPV	Females age ≤ 26 years should receive three doses of any HPV. Males age ≤ 26 years may receive HPV4.
MMR	One or two doses for persons who lack history of immunization or convincing history of infection.
Varicella	Two doses for persons who lack history of immunization or convincing history of infection.
Influenza	Annual vaccine.
HepA, HepB, Meningococcal,	If risk factors present.

[1]The Affordable Care Act considers mammography at age 40 as an essential benefit.

This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2010-2011, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2011 Immunization Recommendations (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors July 2005, 2007; March 2009, 2011; April 2011; January 2012 **MQIC.ORG**

Michigan Quality Improvement Consortium

Michigan Quality Improvement Consortium Guideline

Adult Preventive Services (Ages 50 - 65+)

The following guideline recommends clinical preventive services for adults. The grade definitions used for this guideline are as defined by the United States Preventive Services Task Force (USPSTF).

Grade	Grade Definition
A	**The USPSTF recommends the service. There is high certainty that the net benefit is substantial.**
B	**The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.**
C	**The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.**
D	**The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.**
I	**The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.**

	Recommendation
Health Assessment Screening, History and Counseling	One health maintenance exam (HME) every 1 - 3 years according to risk status, including: Height, weight and Body Mass Index (BMI) **[B]**; risk evaluation and counseling for obesity **[B]**, tobacco use **[A]**, and alcohol use **[B]**
Blood Pressure Screening	◆ Screen for high blood pressure in adults **[A]**. Screen every two years if BP ≤ 120/80 mm Hg. Annually if BP 120-139/80-89 mm Hg, and more frequently if warranted.
Aspirin Use	◆ Recommend the use of ASA for men age 45 to 79 years when the potential benefit due to a reduction in MI outweighs the potential harm due to an increase in gastrointestinal hemorrhage **[A]**. ◆ Recommend the use of ASA for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage **[A]**.
Cholesterol and Lipid Screening	◆ Measure a fasting lipoprotein profile (i.e. total cholesterol, LDL-C, HDL-C), in men aged 35 years and older **[A]**. ◆ Measure a fasting lipoprotein profile in women aged 45 years and older if they are at increased risk for CHD (i.e. diabetes, family history cardiovascular disease before age 50 in male relatives or age 60 in female relatives, tobacco use, hypertension, BMI ≥ 30) **[A]**. ◆ Screen every five years for low risk adults if initial test normal; consider more frequent screening in individuals at increased risk.
Diabetes Mellitus Screening	◆ Screen for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg **[B]**. Screen every three years. ◆ In persons with BP ≤ 135/80 mm Hg, screen on an individual basis according to CHD risks and benefits.
Colorectal Cancer Screening for average risk adults	◆ Screen for colorectal cancer using FOBT, sigmoidoscopy, or colonoscopy, in adults (excluding those with specific inherited syndromes - Lynch syndrome and familial adenomatous polyposis, and IBD) beginning at age 50 years and continuing until age 75 years **[A]**. Screening intervals assuming 100% adherence to the regimen: Annual FOBT, sigmoidoscopy every 5 years combined with high-sensitivity FOBT every 3 years, or screening colonoscopy every 10 years. The risks and benefits of screening methods vary. ◆ Recommend against routine screening for colorectal cancer in adults age 76 to 85 years **[C]**. Considerations may support colorectal cancer screening in an individual patient. ◆ Recommend against screening for colorectal cancer in adults older than age 85 years **[D]**.
Osteoporosis Screening with DXA scan	◆ Screen for osteoporosis in women aged 65 years or older **[B]**. Optimal screening interval not known. Repeating DXA within eight years does not improve prediction of fractures. ◆ Screen women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors **[B]**. ◆ The current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men **[I]**.
Cervical Cancer Screening Pap Smear	◆ Screen for cervical cancer in women who have been sexually active and have a cervix **[A].** Screen every three years. ◆ If not high risk, have had adequate screening with normal Pap smears, recommend against screening women older than age 65 **[D].** ◆ Routine Pap smear screening not recommended in women who have had a total hysterectomy for benign disease **[D].**
Mammography with or without Clinical Breast Exam (CBE)	◆ Biennial screening mammography for women aged 50 to 74 years **[B].** ◆ The current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older **[I].** ◆ Recommend against teaching breast self-examination (BSE) **[D].** ◆ The current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older **[I].**
Prostate Cancer Screening	◆ The current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years **[I].** ◆ Recommend against screening for prostate cancer in men age 75 years or older **[D].**
HIV Screening	◆ HIV screening for all high risk patients **[A]** annually. CDC recommends one-time testing for all patients 13 to 64 years of age.
Immunizations (Consult ACIP website, www.cdc.gov/vaccines/recs/acip/ for up-to-date recommendations):	
Tdap/Td	After primary series, Td every 10 years. Give Tdap once after age 12.
Varicella	Two doses for persons who lack history of immunization or convincing history of infection.
Zoster	One dose after age 60, unless contraindicated.
Influenza	Annual vaccine.
Pneumococcal vaccine	If risk factors present before age 65. (Dosing intervals depend on risk factors.) One dose for everyone 65 and older. (If a person received a first dose prior to age 65 years, give a single revaccination at age 65, if 5 years or more have elapsed since the first dose.)
HepA, HepB, Meningococcal	If risk factors present.

This guideline lists core management steps. It is based on several sources, including: The Guide to Clinical Preventive Services 2010-2011, Recommendations of the U.S. Preventive Services Task Force (www.preventiveservices.ahrq.gov) and the Advisory Committee on Immunization Practices (ACIP) 2011 Immunization Recommendations (www.cdc.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors July 2005, 2007; March 2009, 2011; rev. April 2011 **MQIC.ORG**

Michigan Quality Improvement Consortium

Michigan Quality Improvement Consortium Guideline

Management of Overweight and Obesity in the Adult

The following guideline recommends specific interventions for treatment of overweight and obese conditions in adults.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
Adults 18 years or older	Assessment of Body Mass Index (BMI)	◆ Measure height and weight, and calculate patient's BMI[1] to determine if patient is overweight or obese, and pattern of weight change **[C].** ◆ If overweight, assess for complicating risk factors: ◆ Hypertension ◆ High triglycerides, high LDL or low HDL ◆ Impaired fasting glucose ◆ Diabetes mellitus ◆ Family history of premature CHD ◆ Presence of atherosclerotic disease ◆ Sleep apnea ◆ Smoking ◆ Assess current eating, exercise behaviors, history of weight loss attempts and psychological factors or medications that contribute to weight gain[2].	At each periodic health exam; more frequently at the discretion of the physician
Patients with BMI ≥ 25	Interventions to promote weight management	**Help your patients establish their own realistic lifestyle goals:** ◆ Help your patient set a realistic goal for reducing calories and adjusting to maintain gradual weight loss **[A]**, ideally to maintain a 1- to 2-pound weight loss per week and improve dietary choices (such as increasing low-caloric density foods). ◆ Help your patient set a realistic goal for physical activity: at a minimum, more activity than present; ideally 30 minutes of moderate physical activity such as brisk walking most days of the week **[A].** ◆ Recommend weight loss strategies and resources as needed. (**See www.mqic.org/physician-tools.htm.)**	At each periodic health exam; more frequently when possible
Patients with BMI ≥ 30 or ≥ 27 with other risk factors or diseases	Interventions to promote weight management	**All of the above plus:** ◆ Consider referral to a program that provides guidance on nutrition, physical activity and psychosocial concerns. ◆ Consider pharmacotherapy only for patients with increased medical risk because of their weight with co-existing risk factors or comorbidities (monitor for weight loss and medication side effects; periodically review need for medication).	
BMI ≥ 40 or BMI ≥ 35 with uncontrolled comorbid conditions[3]	Surgical treatment	◆ Weight loss surgery should be considered only for patients in whom other methods of treatment have failed and who have clinically severe obesity, i.e., BMI ≥ 40 or BMI ≥ 35 with life-threatening comorbid conditions[3] **[B].** ◆ Evaluate for psychological readiness for surgical intervention and post-surgical lifestyle commitment.	

[1] BMI is an accurate proxy for body fat in average adults but may be misleading in muscular individuals.

[2] Weight gain may be associated with medications: antidiabetics, SSRI and tricyclic antidepressants, atypical antipsychotics, anticonvulsants, beta-blockers and corticosteroids.

[3] Serious comorbidities including: Severe cardiac disease (CHD, pulmonary hypertension, congestive heart failure, and cardiomyopathy); type 2 diabetes; obstructive sleep apnea and other respiratory disease (chronic asthma); hypoventilation syndrome (Pickwickian syndrome); end-organ damage; pseudo-tumor cerebri; hypertension; hyperlipidemia; severe joint or disc disease if interferes with daily functioning

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline represents core management steps. It is based on the Prevention and Management of Obesity (Mature Adolescents and Adults), Institute for Clinical Systems Improvement, 2009; and the National Institutes of Health, National Heart, Lung and Blood Institute Obesity Education Initiative, The Practical Guide: Identification, Evaluation and Treatment of Overweight and Obesity in Adults, 2000 (www.nhlbi.nih.gov). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium

Michigan Quality Improvement Consortium Guideline

Screening, Diagnosis and Referral for Substance Use Disorders

The following guideline recommends detection, diagnosis and referral considerations for substance use disorders.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adolescents and adults	Screening for Substance Use Disorder	■ Screen by history for substance use at every health maintenance exam or initial pregnancy visit (repeat as indicated), using a validated screening tool (improves accuracy of detecting substance abuse or dependence)[1]. **[D]** ■ Maintain high index of concern for substance use in persons with: ◆ Family history of substance use disorder **[B]** ◆ Recent stressful life events and lack of social supports ◆ Chronic pain or illness, trauma ◆ Mental illness (e.g. depression, bipolar disorder, etc.) ◆ Drug seeking behaviors ◆ Physical and cognitive disabilities ◆ Started alcohol use before age 15 ◆ Medical condition associated with substance use
	Diagnosing Substance Use Disorder (indicates a maladaptive pattern of substance use resulting in clinically significant impairment or distress)	**Relevant issues include:** ◆ Recurrent substance use resulting in a failure to fulfill major role obligations. ◆ Recurrent substance use in situations that are physically hazardous. ◆ Recurrent substance-related legal problems. ◆ Substance use despite having persistent or recurrent social or interpersonal problems. ◆ Tolerance, withdrawal, use in larger amounts or over a longer period than intended. ◆ Persistent desire or unsuccessful efforts to cut down. ◆ Great deal of time spent in obtaining, using or recovering from use of the substance. ◆ Reduction in social, occupational or recreational activities because of substance use. ◆ Substance use continues despite knowledge of problems.
Patients with Substance Use Disorder	Patient Education and Brief Intervention by PCP or Trained Staff (e.g. RN, MSW, etc.) **[A]**	◆ Assess patient's risk, understanding and readiness to change. ◆ Discuss the relationship of substance use to presenting medical concerns or psychosocial problems. ◆ Negotiate goals and strategies for reducing consumption and other change. ◆ Involve family members as appropriate.
	Referral Considerations	◆ Consider referral to community-based services (e.g., AA, NA, etc.), an Employee Assistance Program, a substance abuse or behavioral health specialist, or a physician experienced in pharmacologic management of addiction. **[D]** ◆ Initiate treatment within 14 days. ◆ Frequent follow-up is helpful to support behavior change. ◆ Schedule appropriate follow-up with PCP within 30 days to re-assess and support behavior change.

[1] Validated tools include: Alcohol Use Disorders Identification Test (AUDIT), TWEAC (for pregnant women), Michigan Alcohol Screening Test (MAST, MAST-G), CAGE Survey, Substance Abuse Subtle Screening Inventory (SASSI), Drug Abuse Screening Test (DAST)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps for non-behavioral health specialists. It is based on several sources including: Practice Guideline for the Treatment of Patients With Substance Use Disorders, Second Edition, American Psychiatric Association, August 2006 (psych.org). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Michigan Quality Improvement Consortium Guideline

Tobacco Control

The following guideline recommends specific interventions for cessation services for current smokers and tobacco users.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All patients 12 years of age and older (regardless of prior use status)	Identification of tobacco use and exposure status (never, former, current) and type (all forms, including smokeless tobacco, pipe, snuff, cigars, hookah [water pipe] and second-hand smoke)	◆ ***Ask*** and document tobacco use status in the medical record and/or problem list. **[A]**	At each outpatient visit and inpatient admission
All patients identified as current smokers/tobacco users	Intervention to promote cessation of tobacco use	◆ ***Advise*** to quit **[A]**/avoid second-hand smoke. ◆ ***Assess*** patient willingness to attempt to quit. **[C]** ◆ The Prochaska and DiClemente's Stages of Change Model: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Relapse ◆ ***Assist:*** Try to move patients along one stage. If ready to quit: ◆ Establish a quit date. ◆ Provide self-help materials (e.g. free Quit Kits; see (www.michigan.gov/tobacco). ◆ Offer nicotine replacement therapy (adults only) and/or non-nicotine medications e.g., sustained release bupropion **[A]** (adolescents and adults). ◆ Recommend a smoking cessation program (e.g. MI Quit Line 1-800-480-7848 or your preferred program). ◆ The combination of medication plus a smoking cessation program is more effective than either alone. **[A]** ◆ ***Arrange*** follow-up contact, either in person or by telephone **[D]**: ◆ First week after quit date. ◆ First month after quit date.	At each periodic health exam, more frequently at the discretion of the physician Patient may be more receptive to quit during respiratory illness

SPECIAL CIRCUMSTANCES

- **Pregnant Smokers:** Due to the serious risks to the mother and fetus, pregnant smokers should be offered interventions such as referral to a smoking cessation program.
- **Hospitalized Smokers:** Clinicians should provide appropriate pharmacotherapy and counseling during hospitalization to reduce nicotine withdrawal symptoms and assist smokers in quitting.
- **Smokers with Psychiatric Comorbidity:** Nicotine withdrawal symptoms may exacerbate depression among patients with a prior history of affective disorder. Stopping smoking may affect the pharmacokinetics of certain psychiatric agents. Clinicians should monitor closely the actions or side effects of psychiatric medications in smokers/tobacco users who are attempting to quit.

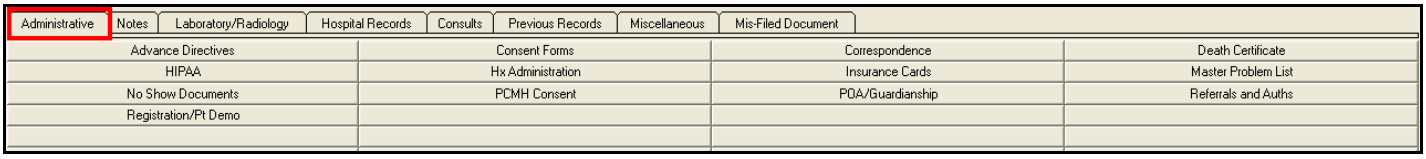
Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on several sources including the Clinical Practice Guideline for the Management of Tobacco Use, Veterans Health Administration/Department of Defense, 2004 (oqp.med.va.gov); and Treating Tobacco Use and Dependence: 2008 Update - Clinical Practice Guideline, Fiore MC, Jaen CR, Baker TB, et al. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Chart Filing Guide

Scanned items must be placed in the designated folders/sub-folders as listed below.

ADMINISTRATIVE



Advance Directives

Consent Forms

- Influenza Consent
- Pneumococcal Consent
- Consents for Procedures
- "Acknowledgment of Sports Physical"
- Pain Management Contracts

Correspondence

- Blood Pressure Readings
- Release Forms
- Medical Records Release Forms
- Any documents faxed/copied and sent out
- Patient discharge letters from office/network
- Half Sheet Letters (lab results)
- Recall Letters to Patients

Death Certificate

HIPAA Folder

- HIPAA Forms (Consent for Payment/Treatment and Confidential Communications, etc)

Hx Administration

- Medicare ABN's
- Blue Care Network Qualification Forms
- Tricare ABN's

Insurance Cards

- Copy of License & Insurance Card (Write patient Name and DOB on copy of these)

Master Problem List

No Show Documents

PCMH Consent (Patient Centered Medical Home)

- Any PCMH Consents/Forms
- PCMH Goal Forms

POA/Guardianship

- Power of Attorney Papers
- Guardianship documentation
- Parental letter stating "OK to treat."

Referrals & Authorizations

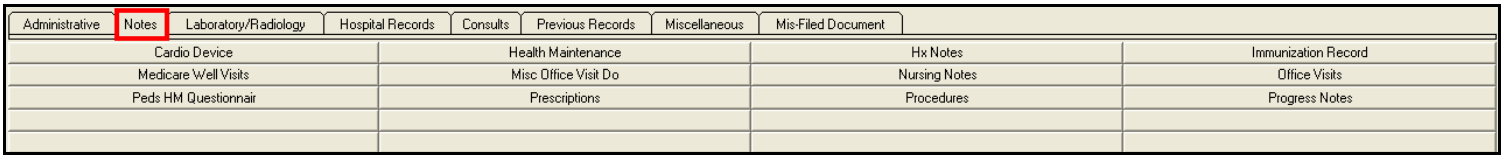
- Referral Authorizations
- Referral Requests
- Prior Authorizations

Registration/Pt Demographics

- Registration Forms
- "Adult Registration"
- "Child/Adolescent Patient Registration"

Disability Papers

NOTES



Health Maintenance

Any Wellness Visits/Physicals/Well Child Visits except Medicare visits

HX Notes

History Forms-"Adult Patient History"
Medication List provided by the Patient

Immunization Record

Vaccination Records
MICR Records
Other Past Immunization Records

Medicare Wellness Visits

Documents used specifically for documenting Medicare Wellness Exams

Misc Office Visit Docs

Work/School Notes
Patient Self Evaluation
New Patient Triage
Autism Checklist
Medical/Surgical Clearance Forms
FMLA Paperwork
Audiogram/Tympanogram
TB Screening Questionnaire
School/Sport Physical Forms

Nursing Notes

Any nursing notes from Nurse Appointments where Patient did not see the Provider

Office Visits

T-Sheets and any other documents used by the Provider to document a Patient Visit
School/Sport Physical Forms

Peds HM Questionnaire

Paper questionnaires that the parents fill out when bringing their child to their HM visits

Prescriptions

RX copies
Faxed RX's
DME (Speech Evaluations)
Patient Preferred Pharmacy Sheet

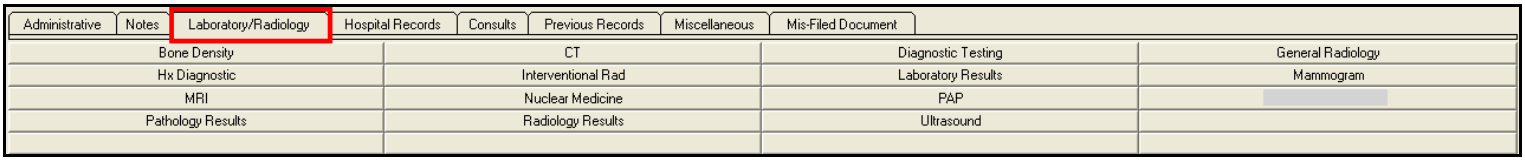
Procedures

Any procedures done in office (outside procedures are filed in the appropriate consult folder.)
Colposcopy
IUD Insertions
ENDO Aspiration

Progress Notes

Handwritten documentation to support immunizations/medication administration

LABORATORY/RADIOLOGY



Bone Density
CT
Diagnostic Testing
- Carotid Doppler
- EKG (only EKG's ordered/performed by your Provider)
- PFT (only PFT's ordered/performed by your Provider)
- NST Results

General Radiology
HX Diagnostic
Interventional Radiology
Laboratory Results
- McLaren/Quest Labs
- Warde Labs
- University of MI Labs
- In office test results

Mammogram
- Mammogram Documentation and reports

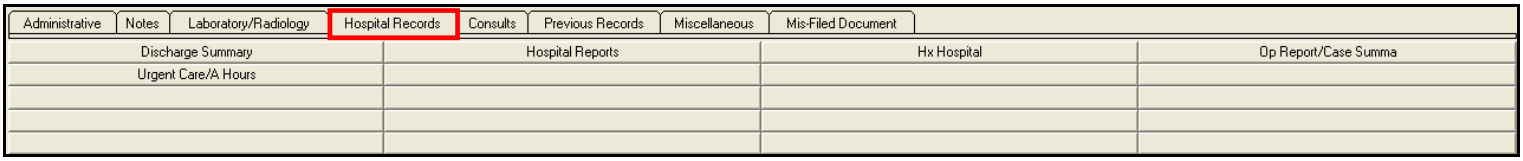
MRI
- MRI Reports
- MRA Scans

Nuclear Medicine
PAP
Pathology Results
- Surgical/Procedure Pathology Results

Radiology Results
- X-rays

Ultrasounds

HOSPITAL RECORDS



Discharge Summary

Any report documents given upon patient discharge

Yellow Discharge Summary Sheets (Carbon Copies in Convenient Care Offices)

Hospital Reports

Emergency Department Reports

Other Inpatient correspondence

“Physician Follow-Up Notification”

Hx Hospital

Any previous hospital documents that do not fit another folder

Op Reports/Case Summaries

Surgical Boarding Documents

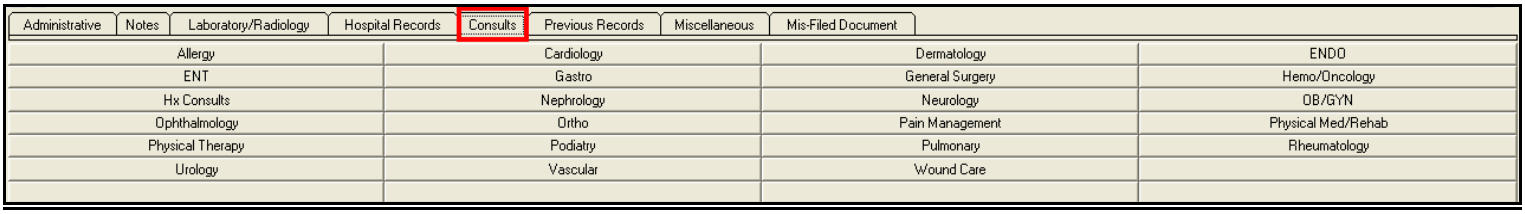
Case Summaries/Operative Reports

Urgent Care/After Hours

Urgent Care Summaries/Documents

After Hours Clinic Summaries/Documents

CONSULTS



Allergy
Cardiology
- Consults
- EKG'S ordered by a Cardiologist
- Stress Tests
- Holter Monitors
- ECHO
- Event Monitors
- Tilt Table
- Heart Catheter

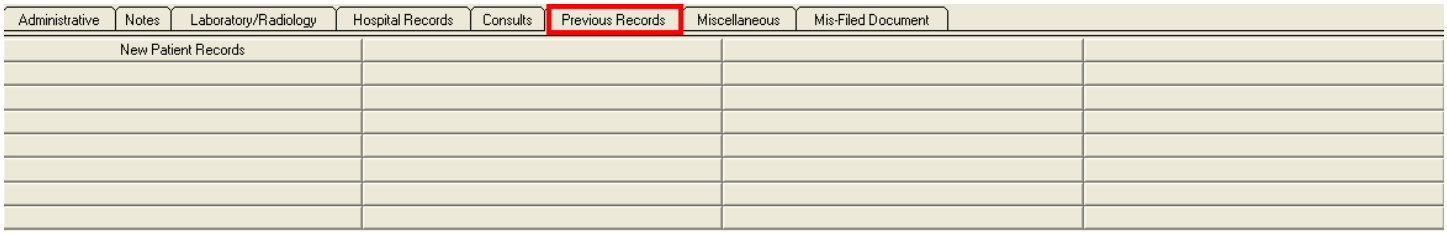
Dermatology
ENDO
ENT
Gastro
- Consults
- EGD
- Colonoscopy

General Surgery
Hem/Oncology
HX Consults
- All other consults not corresponding to a specific consult type

Nephrology
Neurology
OB/GYN
Ophthalmology
Ortho
Pain Management
Physical Medicine and Rehab
Physical Therapy
Podiatry
Pulmonary
- PFT'S ordered by a Pulmonologist
- Sleep Studies
- CPAP Results

Rheumatology
Urology
Vascular
Wound Care

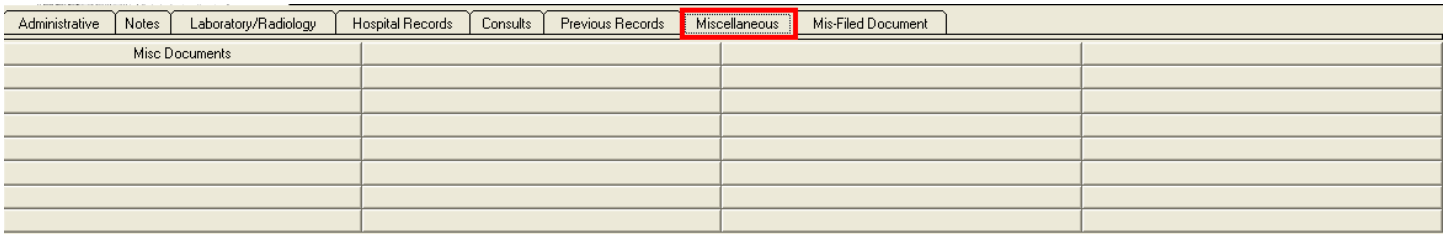
PREVIOUS RECORDS



New Patient Records

Medical Records transferred from another Provider

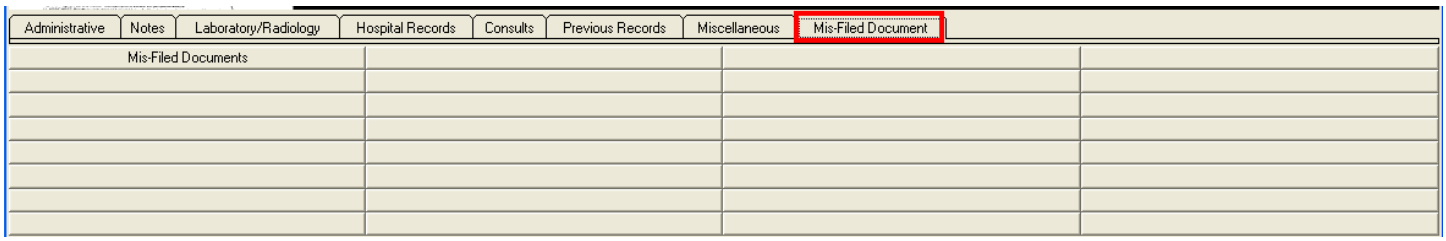
MISCELLANEOUS



Miscellaneous Documents

Mammogram Orders
Physical Therapy/Occupational Therapy Orders
Cardio Testing Orders
Diagnostic Imaging Orders
Nutrition Counseling/Diabetic Management
Gastro Testing Orders
Certified Letters
Rehab/Home Care Orders

MIS-FILED DOCUMENTS



Mis-Filed Documents

Any papers that need to be deleted
Documents you have scanned poorly/incorrectly

Paper Chart Filing Guide

REFERRALS (if no tab, file under MISCELLANEOUS)
Any referral forms
Consultation/Referral Information form

PATIENT DEMOGRAPHICS/INS. (stands alone, no tab)
Patient Registration form with Consent for Treatment/Financial Authorization
Pain Management Agreement
Copy of insurance card
Any other insurance information

RELEASE OF INFORMATION/MISCELLANEOUS
Authorizations with any attachments
Medical record transfers
State of Michigan Disability Determination
SSI forms
Return to work forms
Sick leave papers
Tumor Registry follow-up forms
Specific consents/waivers

LAB
All laboratory reports
Surgical pathology reports
Biopsies
Urinalysis dipstick results
Culture and sensitivities
Pregnancy tests
Hemoccult results

PAP/MAMM (if no tab, paps under LAB and mamms, breast ultrasounds under RADIOLOGY)
Pap smears
Cervical/endometrial pathology report
Colposcopy report
Hysteroscopy report
Mammogram report
Breast ultrasound
Breast biopsy pathology report

RADIOLOGY (tab may also read X-RAY or DIAGNOSTIC IMAGING)
All radiology reports including upper gastrointestinal, gallbladder, barium enema
MRI's
Ultrasounds (excluding breast)
Bone scan
Intravenous pyelogram (IVP)
Angiograms
MUGA scan
CT scans
Nuclear studies
Hida scan

SPECIAL TESTS (tab may read OTHER MODALITIES)
Electrocardiogram (EKG)
Echocardiogram
Stress tests
Doppler studies
Cardiac catheterization/angiography
Holter monitor
Electroencephalogram (EEG)
Electromyogram (EMG)
Pulmonary Function Test
Urodynamics
Endoscopies
Tympanograms (or, with progress notes if less than full sheet)
Allergy Testing
Hearing test results
Vision test results
Sleep Study

H&P/IMMUN./GROWTH CHART (IMMUN./GROWTH CHART tab for Peds.)
Past history and physical exams (may be filed in progress notes or behind Problem List)
Adult/child immunization form
Growth charts
Medical Examination Report (Michigan Department of Human Services)
Sports Physicals

CONSULTATIONS
All consultant letters/reports
Nursing home reports
Hospice reports
VNS of MI (formerly, VNA)/Home health agency reports
Physical Therapy reports
Maternal Health and Infant Services
Weight Management Correspondence
MPRO Consultations
Recall letters

HOSPITAL RECORDS (tab may read HOSP. H&P)
All reports (grouped by episode) related to affiliate hospitals
Emergency Room reports **(may appear under tab ER SHEETS)**
Convenient Care reports **(may appear under tab ER SHEETS)**

OTHER EXTERNAL REPORTS (tab may read PREV. RECORDS OR MISC.)
Copies of records from other facilities

McLaren MEDICAL GROUP		Policy Title:	Defined Clinical Order Sets
Effective Date:	1/7/2014	**Policy Number:**	3525
Review Date:		**Category:**	Clinical
Revised Date:	2/20/2019	**Oversight Level:**	2
Administrative Responsibility:	Operations Directors, Operations Managers		

1. Purpose

1.1. To provide Defined Clinical Order Sets which clinical staff may initiate based on a patient's symptoms or condition.

2. Scope

2.1. All employees of McLaren Medical Group and/or employees working at a MMG-managed site.

3. Definitions

3.1. Clinical Staff - medical assistant, Licensed Practical Nurse (LPN) or Registered Nurse (RN)

3.2. Defined Clinical Order Set - a written order set issued by a provider that allows clinical staff to operate to the fullest extent of their scope of practice. Defined Clinical Order Sets are based on evidence-based practice, reduce variation through standardized formatting and support quality initiatives. Defined Clinical Order Sets outline the testing that the clinical staff may perform.

3.3. Provider - is inclusive of the physician (Doctor of Medicine or Doctor of Osteopathic Medicine), Nurse Practitioner (NP), Physician Assistant (PA) and Certified Nurse Midwife.

4. Policy

4.1. All Defined Clinical Order Sets will be reviewed and approved by the McLaren Medical Group (MMG) Ambulatory Quality Improvement Committee.

4.2. Defined Clinical Order Sets may not be altered or customized by an individual provider.

4.3. Providers at each practice site will select applicable Defined Clinical Order Sets and authenticate those in use with their signature. A copy will be maintained at the site.

5. Procedure

5.1. Patient presents with symptoms or conditions that align with an authenticated Defined Clinical Order Set.

5.2. Clinical Staff will initiate the Defined Clinical Order Set as written.

5.3. Clinical staff will document care in the patient's medical record indicating "per Defined Clinical Order Set."

6. Exceptions

6.1. NONE

7. References

7.1. Institute for Safe Medication Practices. (January 12, 2010). Guidelines for Standard Order Sets. (2010). Retrieved from http://www.ismp.org/Tools/guidelines/StandardOrderSets.pdf

7.2. The Joint Commission e-dition. (January 1, 2019). MM.04.01.01, EP 15

8. Appendix

8.1. List of Approved Defined Clinical Order Sets

9. Approvals

Rochelle Schiller **Vice President, Operations**	**Date** 3/6/19
Brad Ropp, MD **Chief Medical Officer**	**Date** 3/6/19

Previous Revision Dates/Supercedes Policy:

4/19/2017, 1/7/2014

McLaren MEDICAL GROUP		Policy Title:	Defined Clinical Order Sets - Appendix A
Policy Title:	Defined Clinical Order Set - Appendix A	**Policy Number:**	3525
Policy Number:	3525 - Appendix A	**Category:**	Medical Records/HIPAA
Standard Effective Date:	1/7/2014	**Oversight Level:**	2

I. PURPOSE

To identify the Defined Clinical Order Sets approved for use at McLaren Medical Group managed clinics.

II. Approved Defined Clinical Order Sets

Acute Cardiac
Asthma
Complete Metabolic Panel (CMP) / Complete Blood Count (CBC)
Chlamydia Screening
Diabetic
FIT/FOBT Home Test Kit
Influenza Vaccine
Mammogram
Pneumonia Vaccine
PT/INR
Rapid Strep Test
Urinalysis
Urine Pregnancy Test

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the **Acute Cardiac Order** when the patient meets the following criteria:

An adult patient presents to the clinic with the Chief Complaint of Acute Chest Pain/Chest Heaviness:

- Instruct front desk staff to notify a provider immediately.
- Room the patient immediately.
- Obtain all medication and non-medication-related allergies (i.e. aspirin, latex, etc.).
- Obtain blood pressure, pulse, pulse ox and respirations.
- Assess chest pain/chest heaviness on a scale of 1-10 (1=least and 10=most).
- Assess for other symptoms, including: shortness of breath, diaphoretic (perspiration), nausea and/or emesis (vomiting)

Testing/Procedures:

- Obtain an EKG.
- Administer Oxygen at 2 liters per minute.

References:

Up-to-Date. (January 25, 2018). Outpatient Evaluation of the Adult with Chest Pain.

heart.org. (January 19, 2016). What a Heart Attack or Stroke Can Feel Like.

_____ _____

Provider Signature (required) **Date and Time (required)**

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group (MMG) my clinical staff (RN, LPN and/or MA) has permission to complete the **Asthma Order** set when the patient meets the following criteria:

An adult or child presents to the clinic for a visit with a current Diagnosis of Asthma:

- Complete the following vital signs at every visit: blood pressure, temperature, height, weight, BMI/BMI percentile, respirations and pulse.
- Assess for Emergency Department (ED), Urgent Care and Hospitalizations associated with asthma every asthma-related visit.
- Ensure the patient completes the 5-question Asthma Control Test (ACT) self-assessment every asthma-related visit. Clinical staff may assist the patient in completing the ACT if needed, and/or in calculating the score.
- Pull the written Asthma Action Plan (also referred to as an Asthma Management Plan) for the provider's review every asthma-related visit.
- Set/review Asthma Self-Management Goal(s) every asthma-related visit.

Testing/Procedures:

- Spirometry - Annually

References:

American Thoracic Society. (June 2016). Asthma Control Test.

Michigan Quality Improvement Consortium (MQIC). (September 2018). General Principles for the Diagnosis and Management of Asthma.

National Heart, Lung and Blood Institute. (September 2012). Asthma Care Quick Reference.

Provider Signature (required) **Date and Time (required)**

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group (MMG) my clinical staff (RN, LPN and/or MA) has permission to complete the **CMP/CBC Order** when the patient meets the following criteria:

An adult patient age 18 years or older presents to the clinic for a visit:

- The patient is currently prescribed a persistent medication (also referred to as a chronic medication), including any of the following:
  - Angiotensin Converting Enzyme (ACE) Inhibitors,
  - Angiotensin II Receptor Blockers (ARB's), and
  - Diuretics

Testing/Procedures:

Complete Metabolic Panel (CMP) and Complete Blood Count (CBC) with Differential Annually

References:

Michigan Quality Improvement Consortium (MQIC). (November 2018). Medical Management of Adults with Hypertension.

National Committee for Quality Assurance (NCQA). (2019). HEDIS 2019 Measure for Annual Monitoring for Patients on Persistent Medications.

Provider Signature (required) _____

Date and Time (required) _____

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the **Chlamydia Screening Order** when the patient meets any of the following criteria:

- Sexually active women age 16 - 24, Annually
- Sexually active women older than 24 who are at increased risk (new partner, more than 1 partner/concurrent partners, partner has an STI, inconsistent condom use, previous or coexisting STI)
- Sexually active women with the following symptoms:
    - Abnormal vaginal discharge
    - Burning sensation when urinating

Testing/Procedures:

Chlamydia/GC PCR, Urine

References:

National Committee for Quality Assurance (NCQA). (2019). HEDIS 2019 Measure for Chlamydia Screening in Women.

U.S. Preventive Services Task Force (USPSTF). (September 2014). Chlamydia Screening Guidelines.

Provider Signature (required) _____

Date and Time (required) _____

McLaren
MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the **Diabetic Order** Set when the patient meets the following criteria:

An adult patient age 18 and older with Type 1 or Type 2 Diabetes Mellitus presents to the clinic for a Diabetic follow-up:

- Complete vital signs at every visit, including: blood pressure, temperature, respirations, pulse, height, weight and calculate BMI
    - If BP ≥ 140/90, retake before end of visit (document both BP's in medical record)

Testing/Procedures:

- Prepare patient for a foot exam (ask patient to remove shoes and socks) - Annually, at minimum, and as clinically indicated

Lab Orders:

- HgbA1c
    - If patient has **Good Control (i.e., last result <8),** test every 6 months
    - If patient has **Poor Control (i.e., last result ≥8)**, test every 3 months
- Lipid panel - Annually
- Urine Microalbumin - Annually
- Serum Creatinine Level - Annually

Specialty Notifications:

- Optometrist/Ophthalmology for a Retinal Eye Exam - Annually (or every two years if last documented exam was negative for retinopathy).
- Give the patient the Diabetic Eye Exam Report Request form to give to their eye care provider upon exam.

References:

National Committee for Quality Assurance (NCQA). (2019). HEDIS 2019 Measure for Comprehensive Diabetic Care.

American Diabetes Association. (2019). Treatment & Care.

Michigan Quality Improvement Consortium. (MQIC). (November 2018). Management of Diabetes Mellitus.

Provider Signature (required) _____ **Date and Time (required)** _____

McLaren
MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the following, **Fecal Immunochemical Test (FIT)/Fecal Occult Blood Test (FOBT) Home Test Kit Order** when the patient meets the following criteria:

- An adult patient, age 50 years and older, with no colonoscopy in the past 10 years
- Exclude the patient if they have been diagnosed with colorectal cancer (past or present), or have had a total colectomy.
- Exclude the patient if they are age 65 and older **and** currently reside in a skilled nursing or long term care facility, or are currently in Hospice.

Testing/Procedures:

- Complete testing annually.
- Print Patient Demographic Sheet (Face Sheet). This must be included with all test kits that go to a McLaren laboratory.
- Provide the patient with instruction on how to complete testing. Provide the patient with instruction to place the Patient Demographic Sheet inside the FIT/FOBT kit before mailing.
- An in-office iFOBT or FOBT obtained by a Digital Rectal Exam (DRE) **does not** meet screening requirements

References:

American Cancer Society (May 30, 2018). Guidelines for Colorectal Cancer Screening.
National Committee for Quality Assurance (NCQA). (2019). HEDIS 2019 Measure for Colorectal Cancer Screening.
US Preventive Services Task Force (USPSTF). (June 2016). Colorectal Cancer Screening Guidelines.

Provider Signature (required) **Date and Time (required)**

McLaren
MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the following **Influenza Vaccine Order** when the patient meets the following criteria:

A patient presents to the clinic for a visit during flu season:

- A provider **MUST** be on site for administration.
- Follow CDC Guidelines for **CONTRAINDICATIONS:**
    - Do not give vaccine to anyone who has ever had a life-threatening allergic reaction to a dose of influenza vaccine.
    - Do not give vaccine to anyone with a severe allergy to any part of the influenza vaccine.
    - Do not give vaccine to children younger than 6 months of age.
    - Do not give vaccine to patients who are sick with a fever.
    - Do not give vaccine to people who developed Guillian-Barre syndrome within 6 weeks of getting an influenza vaccine previously.
- Obtain signed consent form and document administration on consent form. Alternately, document administration in patient's medical record.
- Give the patient current Vaccine Information Sheet (VIS).
- Report the dose to the Michigan Care Improvement Registry (MCIR).

Testing/Procedures:

Administer the influenza vaccine using the correct product and presentation based on the patient's age. If two doses are needed, the second dose will be administered according to the CDC's guidelines and within the timeframe stated in the vaccine manufacturer's requirements.

References:

Centers for Disease Control & Prevention (CDC). (August 7, 2015). Inactivated Influenza Vaccine Information Statement.
Michigan Department of Health & Human Services. (MDHHS). (August 29, 2018). Pediatric & Adult Influenza Webinar: 2018-2019

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Provider Signature (required) **Date and Time (required)**

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to provide a **Mammogram Order** if the patient meets any of the following criteria:

A patient presents to the clinic for a visit and meets any of the following Breast Cancer Screening criteria:

- Any female 40 and older, screen annually.
- Any female under 40 with a direct family history of breast cancer, screen annually.
- Exclude the patient if they have had a bilateral mastectomy.
- Exclude the patient if they are age 65 or older **and** currently reside in a skilled nursing or long-term care facility, or are currently in Hospice.

Testing/Procedures:

- Bilateral Screening Mammogram
- Unilateral Screening Mammogram if patient has only one breast

References:

American Cancer Society. (October 9, 2017). Recommendations for Early Detection of Breast Cancer.

National Committee for Quality Assurance (NCQA). (2019). HEDIS 2019 Measure for Breast Cancer Screening.

Provider Signature (required) _____

Date and Time (required) _____

McLaren
MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group (MMG) my clinical staff (RN, LPN and/or MA) has permission to complete the following **Pneumococcal Vaccine Order** when the patient meets the following criteria:

An adult patient age 65 years or older presents to the clinic for a visit:

- A provider **MUST** be on site for administration.
- Follow CDC Guidelines for **CONTRAINDICATIONS:**
    - Do not give vaccine to anyone who has ever had a life-threatening allergic reaction to any dose of pneumococcal vaccine or to any vaccine containing diphtheria toxin.
    - Do not give vaccine to anyone with a severe allergy to any component of PCV13 or PPSV23.
    - Patients who are sick with a fever.
- Give patient current Vaccine Information Statement (VIS)
- Document the administration in the patient's medical record.
- Report dose to the Michigan Care Improvement Registry (MCIR)

Testing/Procedures:

- If no history of pneumococcal vaccines, give one dose of PCV13. Give one dose of PPSV23 one year later.
- If patient received PPSV23 before age 65, give PCV13. Give PPSV23 one year later.
- If patient received PPSV23 at age 65 or older, give PCV13. Do not give PPSV23 one year later.
    - Do not administer PCV13 and PPSV23 at the same visit.
    - The provider will screen any patients age 19 through 64 years with underlying conditions and make a decision based on clinical judgment for pneumococcal vaccination.

References:

Centers for Disease Control & Prevention (CDC). (November 5, 2015). Pneumococcal Conjugate Vaccine Information Statement (PCV13).

Centers for Disease Control & Prevention (CDC). (April 24, 2015). Pneumococcal Polysaccharide Vaccine Information Statement (PPSV23).

Michigan Department of Health & Human Services. (MDHHS). (January 2018). Pneumococcal Vaccine Timing for Adults.

Prevnar 13 product insert. (August 2017).

Pneumovax 23 product insert. (May 2014).

Provider Signature (required) _____

Date and Time (required) _____

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the **Urine Pregnancy Test Order** when the patient meets the following criteria:

- Suspected Pregnancy
- Prior to a procedure that requires assessment of pregnancy status (e.g. IUD insertion, colposcopy, etc.)
- Document the results in the patient's medical record.

Testing/Procedures:

Pregnancy (hCG) Urine

References:

The American College of Obstetricians and Gynecologists. (January 2018). Long-Acting Reversible Contraception: Intrauterine Device and Implant

Michigan Quality Improvement Consortium (MQIC). (June, 2018). Routine Prenatal and Postnatal Care.

Provider Signature (required) _____ **Date and Time (required)** _____

McLaren

MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete a **PT/INR Test Order** when the patient meets the following criteria:

An adult patient presents to the clinic for a visit and is taking Warfarin (Coumadin) and/or may have had one of the following:

- Valve Replacement
- Pulmonary Embolism
- Recurrent Transient Ischemic Attack (TIA)
- Cerebral Vascular Accident (CVA)
- Deep Vein Thrombosis (DVT)
- Atrial Fibrillation
- Other Coagulation Defects

- Document the test results in the patient's medical record.

Testing/ Procedures:

Complete a PT/INR test a minimum of once per month or at the provider's discretion.

References:

American Heart Association (AHA). (September 30, 2016). A Patient's Guide to Taking Warfarin.

American College of Cardiology. (2019). Warfarin Considerations for Use.

Warfarin Manufacturer's Product Insert (October 2011).

Provider Signature (required) **Date and Time (required)**

McLaren
MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete a **Rapid Strep Test** when the patient meets at least 3 of the following criteria or at the provider's discretion:

A patient age 2 - 18 presents to the clinic with the Chief Complaint of at least three of the following (or at the provider's discretion):

- Sore throat
- Throat/tonsil redness with white patches
- Difficulty swallowing
- Fever over 101°F
- Tender/swollen neck

- Document the test results in the patient's medical record.

Testing/Procedures:

Rapid Strep Test - In Office

References:

National Committee for Quality Assurance (NCQA). (2019). HEDIS 2019 Measure for Appropriate Testing for Children with Pharyngitis.

Barbosa, Jr, A.R., Di Lorenzo Oliveira, C., Jussara Fernandes Fontes, M., de Lima Bezário Facury Lasmar, L., & Moreira Camargos, P. (December 2014). Diagnosis of streptococcal pharyngotonsillitis in children and adolescents: clinical picture limitations. doi: 10.1016/j.rpped.2014.04.001

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Provider Signature (required) **Date and Time (required)**

McLaren
MEDICAL GROUP

Defined Clinical Order Set

As a provider of McLaren Medical Group my clinical staff (RN, LPN and/or MA) has permission to complete the **Urinalysis Order** when the patient meets at least three of the following criteria or at the provider's discretion:

A patient presents to the clinic for a visit with complaint of at least three of the following (or at the provider's discretion):

- Patient has difficulty urinating
- Patient is experiencing pain with urinating
- Frequent urination
- Getting up in the middle of the night to urinate
- Low back/flank pain
- Incontinence/leaking urine
- Foul odor to urine
- Blood in urine
- Cloudy urine
- Urgency with urination
- Fever
- Chills

- Document the results in the patient's medical record.

Testing/Procedures:

Urinalysis

References:

American Academy of Family Physicians. (November 1, 2015). Dysuria: Evaluation and Differential Diagnosis in Adults.

American Academy of Family Physicians. (October 15, 2014). Urinalysis: Case Presentations for the Primary Care Physician.

Provider Signature (required) _____ **Date and Time (required)** _____

McLaren MEDICAL GROUP		Policy Title:	Contents/Organization of the Clinical Record
Effective Date:	10/96	**Policy Number:**	6215
Review Date:		**Category:**	Medical Records/HIPAA
Revised Date:	4/26/2017	**Oversight Level:**	2
Administrative Responsibility:	Regional Directors, Vice President of Operations, Chief Medical Officer		
Interpretation:	Regional Directors, Vice President of Operations, Chief Medical Officer		

1. Purpose

To establish that the basic components are included in the clinical record and presented in a meaningful/predefined format; to ensure that information is easily retrievable and complete and leads to wise treatment decisions on the part of the healthcare provider.

2. Scope

All employees of McLaren Medical Group (MMG) and employees working at an MMG managed site.

3. Definitions

None

4. Policy

4.1. A complete and accurate clinical record is maintained for every individual who is assessed and/or treated in an MMG office.

4.2. Each clinical record will contain sufficient information about the patient to identify the patient, support the diagnosis, justify the treatment, document the course and results, describe the patient's progress and response to medications and services, and promote continuity of care among healthcare providers.

4.3. Each clinical record will maintain ongoing accuracy and a timely level of communication.

4.4. The contents of the clinical record are arranged in an organized, uniform format.

5. Procedure

5.1. All administrative items (including forms filled out by the patient), handwritten notes (including documents filled out by staff), laboratory/radiology reports received from outside MMG, hospital records, consult reports, medical records received from

other providers, and other miscellaneous documents are scanned in to the electronic medical record in its designated folder/sub-folder.

5.1.1. Patient medical record information, such as, laboratory reports, test results, consults, assessments, radiology reports, dictated notes, etc. is promptly filed in the patient's medical record and available to the provider.

5.2. All entries in the medical record are dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.

5.2.1. Rubber stamps are not allowed to authenticate a medical record.

5.2.2. All orders are dated, timed, and authenticated promptly.

5.3. All medical records must contain the providers' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.

5.4. The medical records must contain a discharge summary with the outcome of treatment, disposition of the patient, and provisions for follow up care.

5.5. All medical records must contain a final diagnosis with completion of the medical records.

5.6. Documentation relative to patient education is evident in the provider's progress notes, the multidisciplinary notes, and the nursing notes.

6. Exceptions

None

7. References

7.1. Centers for Medicare and Medicaid Services (CMS), *Condition of Participation: Medical record services,* Section 482.24.

7.2. The Joint Commission (January 9, 2017), *Accreditation Requirements: Record of Care, Treatment, and Services 01.01.01*

8. Appendix

None

9. Approvals

William Hardimon
(Original signed policy on file in MMG Practice Management)
William Hardimon
President/CEO

06/07/2017
Date

Brad Ropp, M.D.
(Original signed policy on file in MMG Practice Management)
Brad Ropp, M.D.
Chief Medical Officer

05/11/2017
Date

Previous Revision Dates/Supercedes Policy:
4-1-2014 / 10-5-10 / 8-21-07 / 6-01

McLaren MEDICAL GROUP		Policy Title:	Electronic Health Record Downtime
Effective Date:	10/19/2010	Policy Number:	6375
Review Date:		Category:	Medical Records/HIPAA
Revised Date:	5/17/2017	Oversight Level:	2
Administrative Responsibility:	Regional Operations Directors, Operations Managers, EHR Team		
Interpretation:	EHR Team, Security Officer		

1. Purpose

The purpose of this standard is to ensure that all Electronic Health Record (EHR) users are aware of the procedures to be used during an outage and to make certain that McLaren Medical Group (MMG) Department Staff are aware of the communication plan for downtimes and outages.

2. Scope

All employees of MMG and employees working at an MMG managed site that have an EHR.

3. Definitions

3.1. Levels of Downtime

3.1.1. Level 1 -EHR is completely unavailable on all MMG site's devices due to a server, network or electrical outage.

3.1.2. Level 2 -All wireless devices are non-functional due to a wireless access point outage. This may affect an entire clinic or only portions of a clinic.

3.1.3. Level 3 -Printing/faxing are adversely affected due to a server outage.

3.1.4. Level 4 - Practice Management System (PMS) and Results interfaces are down or impaired.

3.1.5. Level 5 - Pre-Scheduled downtime due to System upgrades.

4. Policy

4.1. Patient continuity of care will be ensured during downtime through implementation of appropriate/applicable procedures. These are:

- Level 1 - Users should follow Level 1 downtime procedures outlined in this document.
- Level 2 - Users should perform all functions via the web application.
- Level 3 - Prescriptions should be generated via phone call or paper pad and documented in the EHR.
- Level 4 -Follow individual Level 4 downtime procedures as outlined in this document.

- Level 5 - Pre-Scheduled downtime due to System upgrades will be performed after 10 p.m. on a mutually agreeable day of the week to limit the impact on provider documentation.

5. Procedure

5.1. LEVEL 1 PROCEDURE: The EHR is completely unavailable on all MMG site's devices due to a server, network or electrical outage. Users should revert to the downtime procedures, if the downtime is anticipated to last a short period of time or if the provider can determine that there are adequate resources to practice medicine. If the downtime is anticipated to last a long period of time or if the provider determines that there are not adequate resources to practice medicine, then the provider has the option to not see patients.

5.1.1. To obtain patient information for an emergent situation during a downtime. Open a case with Atos by calling (810) 424-8400 and ask that the EHR On-Call Team be paged for medical record retrieval.

5.1.2. In preparation for a potential outage, all MMG offices, at the end of a business day, will print the next day's provider schedules. A master paper schedule will then be maintained during an outage in which the PMS is unavailable. Triaging of patients will need to occur for any new requests for appointments.

5.1.3. If a super-bill (charge ticket) cannot be automatically generated, the patient's name and date of birth will be filled in on the paper form.

5.1.4. If able to, the front office staff will make a copy of the insurance card. The demographics sheet will be completed, either automatically or manually. All paperwork obtained at check-in will be sent back with the patient, attached to the downtime form. The pertinent patient information at the top of the clinical downtime form will be completed by the front office staff.

5.1.5. All phone messages will be recorded using the clinic's previous paper process and later scanned into the Office Notes folder.

5.1.6. If lab or radiology results are needed, the clinical staff will place a call to the performing lab or radiology site. Outstanding results will be queued in the interface for later import into the EHR.

5.1.7. Staff will room the patient and complete the appropriate sections of the downtime form. They will need to review the patient's current medications, allergies and problems and initial the form.

5.1.8. The provider can complete the downtime form.

5.1.9. It will be at the provider's discretion as to whether or not they choose to wait until the system is back up to document a note or standard dictation.

5.1.10. The allergies, problems, medications (including immunizations) and new prescriptions must be entered into the EHR by a clinical staff member after the system becomes available.

5.1.11. The downtime form should be scanned (when available) into the Office Notes folder and the paper copy destroyed.

5.1.12. If a refill or prescription is needed, the provider will utilize a script pad or phone in the medication to the pharmacy. If a script pad is used, a copy of the script

can be attached to the downtime paperwork. All new scripts should be recorded on the downtime paper form for later entry into the EHR.

5.1.13. Refill requests sent to a clinical staff member can be phoned into the pharmacy. A paper log with the patient's name, date of birth, and refills should be kept for later entry into the EHR. The form can be shredded once the information has been entered in to the EHR.

5.2. LEVEL 2 PROCEDURE: All wireless devices are non-functional due to a wireless access point outage. This may affect an entire MMG office or only portions of an MMG office. Users should perform all functions via the web application.

5.2.1. All functionality is available using the web application via the desktop. Wireless tablet PC's are not functional.

5.2.2. Desktop dictation or structured notes should be used.

5.3. LEVEL 3 PROCEDURE: Printing/faxing are adversely affected due to a server outage. Prescriptions should be generated via phone call or paper pad and documented in the EHR.

5.3.1. All modules and devices are functional with the exception of the ability to print or fax a document or prescription.

5.3.2. Prescriptions should be documented per usual procedures with an action type of 'record' or 'phone call'. The prescription should then be phoned into the pharmacy.

5.3.3. Any prescriptions that were previously marked as 'retail' that did not fax prior to or during the downtime will process once the server is functional.

5.4. LEVEL 4 PROCEDURE: Practice Management System and/or Results interfaces are down or impaired. Follow individual processes as outlined in this document.

5.4.1. **PMS**

5.4.1.1. Established patient in organization: If the EHR is not receiving transactions from the PMS; the patient's arrival status will not be updated. Follow physician office back-up procedures for notifying staff of a patient's arrival. In addition, all documentation can still be done electronically in the EHR. If a note is completed, it will not be tied to the appointment and will display the Note in the Chart Viewer as "Audit." When the interface is back up, this note will need to be linked to the appointment.

5.4.1.2. New patient in organization: The patient name or account will not be accessible in the EHR. In this instance, utilize the paper downtime form and follow guidelines as outlined in a Level 1 Downtime.

5.4.2. **Results**

5.4.2.1. If the results interface is down, new lab and radiology results will not be sent to the EHR.

5.4.2.2. Please call the respective lab or radiology location for results if they are necessary for the patient's encounter.

5.4.2.3. Lab and radiology results will queue in the interface and arrive in the EHR once the outage is resolved.

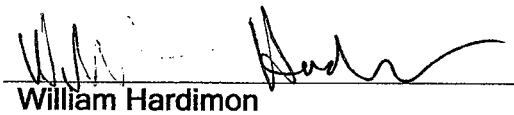
5.5. LEVEL 5 PROCEDURE: Any scheduled downtimes due to upgrades will be planned for after hours and communicated in a downtime notice sent out via email prior to the scheduled upgrade.

6. Exceptions
None

7. References
None

8. Appendix
Appendix A -EHR Downtime Form

9. Approvals



7-23-2018

William Hardimon
President/Chief Executive Officer

Date

Approved by Compliance Committee:
5/17/2015, 1/15/2014

Previous Revision Dates/Supersedes Policy: 1/15/2014; 12/14/2010

Appendix A
EHR Downtime Form
Policy: 6375

McLaren
MEDICAL GROUP

Date of Service: _____ **Provider:** _____

Patient Name: _____ Date of Birth: _____

Age: _____ Weight: _____ Height: _____ Blood Pressure: _____/_____ BMI: _____

Temperature: _____ Respiration: _____ Pulse: _____ SaO_2: _____

Nurse/MA Signature: _____

Reason for Visit/Chief Complaint:

History of Present Illness:

Review of Systems:

Active Problems:

Past Medical History:

Past Surgical History:

Family History:

Social History:

Smoker _____ppd

ETOH use _____

Patient Name: _____ **Date of Birth:** _____

Allergies:

Current Medications:

Physical Exam:

Clinical Impression/Assessment:

Treatment Plan:

Labs/Diagnostic Testing:

Radiology:

Consults/Referrals:

Follow Up Appointments:

Discharge Medications:

Health Education/Patient Instructions:

Provider Signature: _____ **Date/Time:** _____

TAB 4

McLaren
MEDICAL GROUP

Dear New Provider,

Welcome to McLaren Medical Group (MMG)! We are pleased to have you on our team. You were selected for employment due to the attributes you displayed that appear to match the qualities MMG values in a provider. MMG is dedicated to creating a culture that is accountability: where all members work together to achieve positive outcomes.

People choose a career in healthcare because the work is worthwhile and provides a sense of purpose. At MMG, our goal is to provide quality care and excellent service to "every patient, every time". You will, no doubt, hear this phrase often as it embodies our commitment to patient-centered care. We look forward to helping you shine as an outstanding provider that exhibits a high level of care, concern, and compassion for others. In order to accomplish these goals, we focus on provider engagement and satisfaction, acknowledging that personal job satisfaction is essential for patient satisfaction and the overall success of our organization.

Please take a look at the Clinician Patient Communication Tips that follows this letter. It's important you understand what is expected, which will allow you to make a positive contribution and find your role to be rewarding, challenging, and meaningful. Please don't hesitate to contact us with any questions or suggestions. We look forward to a positive working relationship!

Sincerely,

Ashley Leach
Director, Patient Experience

Carla K. Henry
Vice President, Human Resources and Provider Services

Brad Ropp, MD
Chief Medical Officer

McLaren

MEDICAL GROUP

MEDICAL PRACTICE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS

1. Was this your first visit here? ..... ○ Yes ○ No

2. How many **minutes** did you wait after your scheduled appointment time before you were called to an exam room? ☐☐☐ minutes

3. How many **minutes** did you wait in the exam room **before** you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife? ..... ☐☐☐ minutes

INSTRUCTIONS: Please rate the services you received from our practice. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely.
Example: ●

ACCESS

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Ease of scheduling your appointment	○	○	○	○	○
2. Ease of contacting (e.g., email, phone, web portal) the clinic	○	○	○	○	○
3. Courtesy of staff in the registration area	○	○	○	○	○

Comments (describe good or bad experience): _____

MOVING THROUGH YOUR VISIT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Degree to which you were informed about any delays	○	○	○	○	○
2. Wait time at clinic (from arriving to leaving)	○	○	○	○	○

Comments (describe good or bad experience): _____

NURSE/ASSISTANT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the nurse/assistant listened to you	○	○	○	○	○

this section continued on next page...

1234567890-1-1

NURSE/ASSISTANT (...continued)

	very poor 1	poor 2	fair 3	good 4	very good 5
2. Concern the nurse/assistant showed for your problem	○	○	○	○	○

Comments (describe good or bad experience):_____

CARE PROVIDER

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Concern the care provider showed for your questions or worries	○	○	○	○	○
2. Explanations the care provider gave you about your problem or condition	○	○	○	○	○
3. Care provider's efforts to include you in decisions about your care	○	○	○	○	○
4. Care provider's discussion of any proposed treatment (options, risks, benefits, etc.)	○	○	○	○	○
5. Likelihood of your recommending this care provider to others	○	○	○	○	○

Comments (describe good or bad experience):_____

PERSONAL ISSUES

	very poor 1	poor 2	fair 3	good 4	very good 5
1. Our concern for your privacy	○	○	○	○	○
2. How well the staff protected your safety (by washing hands, wearing ID, etc.)	○	○	○	○	○

Comments (describe good or bad experience):_____

OVERALL ASSESSMENT

	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well the staff worked together to care for you	○	○	○	○	○
2. Likelihood of your recommending our practice to others	○	○	○	○	○

Comments (describe good or bad experience):_____

Patient's Name: (optional)_____

Telephone Number: (optional)_____

PRESS GANEY®

1234567890-1-1


Include
Care
Understand
Safety
Privacy
Work Together
Wash Hands
Very Good
Discuss
ID BADGE
Concern
SMILE
Questions
Email
Delay
Explain
Listen
Survey
Wait Time

AIDET® helps us to better serve our patients

A – Acknowledge: Greet the patient by name, make eye contact and smile to make them feel welcome.

I – Introduce: Introduce yourself by name and offer a personal commitment to provide excellent care. Remember to manage up.

D – Duration: Give the patient a specific time expectation of how long they will be waiting.

E – Explanation: Explain what you are doing and/or what to expect next.

T – Thank you: Thank the patient and show appreciation.

McLaren
MEDICAL GROUP

MM-351 (1/17)

Provider Communication

Patient perception of care has evolved to being dependent on the ability of the provider to match excellent clinical care with equally excellent communication. McLaren Medical Group is dedicated to the AIDET® communication tool to aid in the ability to practice effective communication with patients. AIDET is a communication framework that explains things to help reduce anxiety and improve quality and compliance. AIDET stands for Acknowledge, Introduce, Duration, Explain and Thank You. MMG has identified patient-centered communication as an important provider competency and is a critical component of high quality health care. Effective communication can improve patient outcomes, patient safety and the patient's perception of quality. It's important that all MMG providers use AIDET with every patient, every time which will foster trust and create lasting relationships and will ultimately promote patient loyalty to our organization.

The Press Ganey Medical Practice Survey that will be sent to our patients indicates that meeting patient expectations yields a 3 or 4. To achieve a result of 5 on a patient experience survey providers need to exceed patient expectations. Providers need to make sure the patient is at ease and has complete confidence in his or her care which is what these result rankings are really about. In short, they need to "wow" the patient!

How does a provider "wow" a patient? By following the simple concepts outlined in the communication model below:

- AIDET communication components need to be used throughout the entire patient conversation.
- Equally important in the use of AIDET skills are the non-verbal communication attributes that influence patient perception. These include:
    - Warm tone of voice and demeanor
    - Engaging body language
    - Consistent eye contact
    - Showing empathy and appropriate use of touch
    - Not coming across as rushed: demonstrating a relaxed bedside manor
    - Showing appropriate emotions such as enthusiasm, positive attitude, and warmth

Understanding that the above communication skills need to be imbedded into the three components that make up every patient encounter: the beginning, middle, and close. Maximizing the quality of each of these three components will yield a great patient experience. Here's how to create a best practice for each of the three components:

THE BEGINNING – CREATING A GOOD FIRST IMPRESSION WITH EVERY PATIENT ENCOUNTER

1. Knock on the door.
2. Smile. Acknowledge the patient by name and greet them in a warm and friendly manner.
3. Introduce yourself and the role you will play in their care.
4. Acknowledge all visitors and inquire who they are.
5. Sit down whenever possible.
6. Maintain consistent eye contact.
7. Begin the conversation with a very brief sentence or two on a non-medical topic. Show them that you are easy to talk to, do not come across as rushed, and show them you are genuinely interested in them as a person. Examples might include: the weather, their genealogy, recent travels, sports, family or pets.

AIDET components used: A, I, E

Upon entering the room, always shake the patient's hand. Shaking hands is common courtesy that applies in most social and business settings and belongs in our clinical encounters as well. Providers' who start by washing/sanitizing while narrating that they are doing this for the patient's safety also get recognition by patients for good hand hygiene.

It's helpful to create a short summary that can be reviewed before knocking on a patient's door. The summary should contain a couple of critical data points to reassure the patient he is in good hands and that nothing is "falling through the cracks." It should also highlight any current or recent non-medical key life events, to enable the provider to "connect" with the patient on a personal level. It's most helpful if the nurse/assistant informs the provider, before entering the room, of any medical care received since their last visit (rooming question). This will allow the provider to be prepared to

discuss the past history with the patient. Remember to manage up the nurse/assistant by letting the patient know of your communications with him/her prior to coming in the room.

Proper introductions at the beginning of the visit sets the tone for the entire visit. An example for a new patient would be, "*Good morning, Mrs. Wilson. My name is Dr. Andrews but feel free to call me 'Barbara.' I will be your provider today. I've been practicing medicine for over 30 years and specialize in chronic gastrointestinal conditions, which my nurse Anne tells me is why you're here today. I am sorry you are having these problems; I know how painful and inconvenient they can be. But I do want you to know I've been able to help many patients with similar symptoms get them under control and I'm optimistic that I can help you, too.*" Letting the patient know you will "*take great care of them*", or will "*address their concerns*" are examples of providing a promise to deliver great care. An example for a returning patient is, "*Good afternoon, it's nice to see you, Robert. Sorry you are experiencing a sore throat, I promise to help with that. How did your vacation last month go?*"

THE MIDDLE – PROVIDNG A GREAT EXPLANATION USING LANGUAGE THEY UNDERSTAND

1. Begin medical conversation/review.
2. Perform the history and physical exam.
3. Maintain eye contact when speaking.
4. Explain next steps in the plan of care: tests to be performed, approximately how long until results are back, additional people they will meet (e.g., respiratory therapist, CT technician, consultant, etc.), or any needed procedures (explain indications, risks, and procedure details).
5. If test and/or procedure results are completed during the visit, explain all findings.
6. Explain the three elements of their plan of care: what is the diagnosis or status of their condition, what is the proposed treatment, and what follow-up is/may be needed.
7. Use language patients can understand. Avoid using any medical jargon.

AIDET components used: D, E

Slow down and get to know your patient. Review their medical record and ask basic get-to-know-you questions. Take time to establish rapport. A comprehensive assessment is worth the time it takes because your patient education efforts will be more effective. Providers have a reputation for rushing into a room, asking a few superficial questions, performing a perfunctory exam, and hurrying out. To save time, they may provide an "information dump", unloading all the information as quickly as possible. Such pressured practices do not foster good communication. In order to use individualized patient care providers must determine the patient's "what". Follow the two-minute rule by spending two minutes at the beginning of the patient encounter actively listening and engage in conversation with the patient. Ask open-ended questions and allow the patient to speak uninterrupted while maintaining eye contact and positive body language. Learning the patient's perspective will allow gained knowledge about their worries, fears, and possible misconceptions. The information you receive can help guide your patient teaching. Providers who have high quality and experience scores are known to listen as much as they talk. A frequently cited study showed providers redirected the patient's opening statements after a mean of 23 seconds. Don't be that provider. Patients have their own agenda, and listening to them may reveal deeper concerns, new problems, useful diagnostic information and potential barriers to therapy.

Acknowledge the patient's concerns and repeat them back to reassure them you are listening and care about understanding their concerns to determine the next steps or right treatment. Use non-verbal actions to acknowledge to the patient you are listening and engaged in the visit. Practice reflective listening by listening carefully so you can repeat it back to the patient. By paraphrasing what the patient just said, you are creating trust. Be mindful of what your body language and facial expressions are saying. Body language can impact the quality and perception of the provider/patient encounter. Smiling, nodding and leaning forward when listening is good. Avoid crossing your arms and leaning into the table or counter.

Speak in a language that patients understand by assessing language barriers and educational limitations. Avoid medical jargon by understanding it's natural for providers to let medical jargon roll off the tongue. But when talking to patients, medical terminology can seem like a foreign language. To them, even terms like hypertension can sound like white noise.

Use the teach-back method to ensure they fully understand the reason and possible side effects of the medication or treatment by asking the patient to repeat back what was discussed.

Look for ways to demonstrate empathy. In the race to pass exams, see patients, stay abreast of guidelines, and get some sleep, providers often forget why they went into medicine — to help patients feel better. As part of that goal, a patient's emotional health should not be overlooked. The tone with which you speak can lessen pain and reduce anxiety. Subtleties in demeanor, facial expression, body language, time spent, and acknowledgment of the patient's feelings will convey concern and positive regard. Genuine caring has a long-term impact that reaches far beyond the moment. Use words such as "*I'm so sorry you are here and not enjoying the fun vacation you planned. I'm sure this must be really tough. I promise, we're going to do everything we can to take care of you.*"

Use "Key Words at Key Times" to demonstrate active listening. This can be accomplished by narrating that you're switching gears from "talking" to "listening." For example, "*Mrs. Jones, I've done a lot of the talking; it is my turn to listen to you. How do you feel about the treatment plan I've proposed?*" Another way to demonstrate careful listening and note taking is to explain that you are taking notes, for example, "*Mr. Smith, as we talk I may look down and take notes to document the points you are making and what is important to you. It is very important to me that you have a say in your care and that I capture that. However, I am still listening to you as I enter information into the computer.*" With today's technological requirements it's tough to balance the personal aspect with the technological, however this can be done by explaining what you are doing and why you are doing it. For example, "*I want to make sure I accurately review your health conditions, recent visits, and medications. Even though I may look at the screen from time to time, please know that I am listening and taking notes.*"

Use "Key Words at Key Times" to connect back to the patient's medical history. Question the patient about relevant facts deeper in their history, for example, "*I see a few years back you were treated for acid reflux. I am wondering if that could be affecting your breathing problem. Are you still taking the Protonix?*" Reference family history if applicable, for example, "*I see that you have a family history of heart disease and your cholesterol level has been increasing. With that in mind, can we talk about your cholesterol level and what you are doing to lower it?*" Ask open-ended questions whenever possible, for example, "*Can you tell me about your recurring headaches? What patterns do you see in terms of when they occur, what precedes them, how long they last, and so forth?*" Allow time for the patient to answer by resisting the temptation to answer for the patient or to make assumptions. For example, "*Please take all the time you need. It's important that we know exactly when this problem started so I urge you to think carefully about it before you answer.*"

Demonstrate empathy for their questions or worries, and also when delivering bad news. In medicine, it's essentially the ability to say, "*I understand that you are frightened/anxious/hurting/sad, and while I can't literally 'feel your pain, I have experienced similar feelings because I'm human… and I do care.*" Saying "*I'm sorry*" can go a long way! For example, "*I'm sorry to hear that you're having so much trouble sleeping, let's try to find out why.*" Always try putting yourself in the patient's shoes, explaining that you can relate to or understand their concerns. Demonstrating empathy also includes being honest. There are two reasons why providers sometimes fail to completely disclose the truth: to protect patients from emotional suffering, or protect themselves from litigation. Neither is justifiable. We may be well intended in attempting to shield patients from grief, but not at the expense of omitting essential information. Instead of increasing the chances of a lawsuit, full disclosure, including an apology, may actually decrease the chances and costs of litigation. Honesty is always the best policy.

If a patient wanders off course it's important to redirect them by explaining why it's crucial to keep the appointment efficient in a gentle, non-offensive way. For example, "*It's very important to me that we maximize our time together and that I focus on the main reason you are here today. So, for now, let's focus on your digestive issues.*"

THE CLOSE – CONCLUDING THE PATIENT ENCOUNTER WITH A STRONG ENDING

A strong ending will make patients feel that you listened well, answered all their questions, gave them a chance to participate in the decision making process, and will portray you as a more caring, sensitive, and attentive provider. The goal is to make sure the patient doesn't leave feeling as if their questions weren't answered. It's important that both the patient and the provider feel as if the time was well spent. There are a number of key words/phrases that should be imbedded into the closing conversation.

1. Summarize the plan of care and next steps.
2. Ask if there is any additional questions or anything else you can do for them.
3. Escort the patient to check-out.

AIDET components used: E, T

The end of the visit is the time that providers need to assure understanding in what was discussed and the plan for follow up. It has been said that most of the information presented to patients is immediately forgotten, and nearly half of what is retained is incorrect. Providers need to do a better job making sure patients understand — and remember — what is being said. Consider using printed information and instructions. Use the teach-back method to confirm that you have explained the information in a way that the patient understands. A way to summarize the visit and plan of care would be, for example "*Let me summarize the plan of care so that both of us have a good understanding of what happens next.*" After giving the patient your summary, ask: "*How does this sound to you? Are you okay with this plan*?" Another example is "*I want to make sure that I have thoroughly explained everything well to you. Based on everything I just covered, what questions do you have*?" This allows the patient an opportunity to feel like they are participating in the decision making process and promotes better buy-in and compliance.

End the encounter with a statement that makes the patient feel appreciated and lets them know you enjoyed meeting them. Create a phrase that fits your personality and use it consistently. Examples are, "*It was a pleasure meeting you today*," "*I hope you feel better soon*," "*I'm glad you came in to see me today*," "*I'm glad I was able to help you today*," *or*, "*I'm glad you are doing better.*"

CONCLUSION

Consistent use of the AIDET communication model and the tips provided above will maximize patient perception of care and positively impact clinical outcomes through improved compliance. It's not only the right thing to do, but it makes us all better providers. MMG is focused and dedicated to providing the information and education necessary to create an exceptional experience for our providers, staff and patients. Please reach out to your Assistant Chief Medical Officer or the Patient Experience Director if you have questions, need help, or would like to coach or be coached.

TAB 5

McLaren Medical Group
Quality Assurance Department

The MMG Quality Assurance Department offers an array of services to providers and clinics to help assure our patients receive the highest quality of care possible.

Insurance Incentive Program Coordination (Primary Care Providers)

- Program specific Information is distributed by the Quality Assurance Manager
- Data is processed continually by the Quality staff throughout the year for: BCN, BCNA (Medicare), BCBS, BCBS MAPPO (Medicare), Humana, Priority and United HealthCare and others as the need arises
- Incentive program payments to providers are handled through the MMG Finance Department

Gap in Care Processing (Primary Care Providers)

- Centralized Quality staff members assist primary care providers with closing gaps in care. Performing outreach to patients in an effort to obtain testing and results, as described in the HEDIS Standing Orders Policy
- On a yearly basis, the HEDIS Standing Order Policy is reviewed by the Ambulatory Quality Improvement Committee for updates (See example)
- HEDIS Standing Order Policy consent forms are sent out annually to MMG primary care providers for signature (See example)
- Outreach by the Quality staff is made via patient specific letters, testing order slips, and follow up phone calls
- On January 1st the insurance companies reset the clock at zero for yearly measures
    - If a patient had a yearly required test performed on December 31st, on January 1st the system would say the patient is due for the service
- Overall quality scores can have an impact on the reimbursement amounts for BCBS and BCN patients and your ability to be a participating provider with the insurance

Process Improvement Assistance (All providers/clinics)

- Specially trained staff can offer guidance on improving current processes and maximizing work flow

Quality Assurance Department Contacts

- Open – Director of Quality Management
    - Phone:
    - E-mail:
- Brittany Parks – Quality Data Coordinator
    - Phone: 517-913-6593
    - E-mail: brittany.parks@mclaren.org

Additional Quality Resources

- Michigan Quality Improvement Consortium – provides evidence-based recommendations for providers
    - Website: www.mqic.org

McLaren MEDICAL GROUP		Policy Title:	HEDIS Standing Orders
Effective Date:	April 13, 2015	**Policy Number:**	9750
Review Date:		**Category:**	Performance Improvement
Revised Date:	2/20/2019	**Oversight Level:**	2
Administrative Responsibility:	MMG Providers; MMG Quality Staff		

1. Purpose

To provide direction for the use of HEDIS Standing Orders.

2. Scope

Providers and designated staff working at McLaren Medical Group (MMG) managed sites.

3. Definitions

3.1. Healthcare Effectiveness Data and Information Set (HEDIS) - one of health care's most widely used performance improvement tools published by the National Committee for Quality Assurance (NCQA), and used to measure dimensions of care and service

3.2. Standing Order - approved order that may be executed prior to an individual provider order. HEDIS Standing Orders are limited to a subset of the HEDIS guidelines.

3.3. Designated staff - includes staff who have been educated on the standing order process and who have been designated to initiate the order set.

3.4. Provider - is inclusive of physicians and mid-level providers (i.e. Physician Assistants and Nurse Practitioners) with their own patient panels as defined by individual insurance payers.

4. Policy

4.1. This policy is in effect for the HEDIS measurement period.

4.2. Standing orders may be used only for those identified measures in 5.3.

4.3. A Standing Order set must be selected and signed for by each provider.

4.4. If there is a question at any time about the needed test, the designated staff will not proceed with the Standing Order and will contact the provider.

4.5. Use of the Standing Orders will be monitored for accuracy and effectiveness and full program evaluation will occur at the end of the HEDIS measurement period.

5. Procedure

5.1. Providers will be identified for inclusion and will sign the HEDIS Standing Order form.

5.2. Designated staff reviews gaps in care through the payer systems or patient registry and the patient's medical record. If the result is present, staff will enter the data into the payer system, as applicable. If the result is not present, go to 5.3.
5.3. Designated staff transcribes the Standing Order into the electronic medical record based on the identified gap using the assigned problem from the active problem selection matrix below.

Test type	Select active problem
○ HgbA1c ○ Urine Microalbumin ○ Notification for Ophthalmology for annual retinal eye exam	Diabetes mellitus
Notification for OB/GYN for Cervical Cancer Screening	Not applicable
Comprehensive Metabolic Panel	Chronic medication monitoring
Bilateral Screening Mammogram	Health care maintenance
Colorectal Cancer Screening FOBT	Health care maintenance

5.4. Designated staff will create a patient notification letter and test requisition in the Electronic Medical Record (EMR). Alternately, a patient notification letter and paper order slip may be printed for providers lacking access to an EMR.
5.5. The letter and corresponding test requisition are mailed to the patient.
5.6. Designated staff will create a reminder task in the EMR for tracking purposes. Alternate methods of follow-up will be utilized for providers without access to an EMR.
5.7. Designated staff will track the letters against the completed services and contact patients as appropriate to follow-up.
5.8. If the patient indicates the test was already completed, the designated staff will contact the testing facility to obtain a copy of the report.
5.9. Upon completion of the test, the designated staff will assure that the report or result is either electronically interfaced, scanned into the EMR or a copy included in the patient's chart.

6. Exceptions
6.1. None

7. References

7.1. Centers for Medicare & Medicaid Services, http://www.cms.gov
7.2. Michigan Quality Improvement Consortium (MQIC), http://www.mqic.org/guidelines.htm
7.3. National Committee on Quality Assurance (NCQA), http://www.ncqa.org/
7.4. United States Preventive Service Task Force (USPSTF), https://www.uspreventiveservicestaskforce.org/

8. Appendix

8.1. HEDIS Standing Order form
8.2. HEDIS patient letter

9. Approvals

Rochelle Schiller
Vice President, Operations

3/6/19
Date

Brad Ropp, MD
Chief Medical Officer

3/6/19
Date

Previous Revision Dates/Supercedes Policy:
3/1/2016; 4/13/2015; 3/14/2017

McLaren
MEDICAL GROUP

HEDIS Standing Order

As a provider of McLaren Medical Group, designated staff may provide all of the following orders regarding HEDIS gaps in care if the patient meets the criteria listed below:

1. Labs/Other:

HgbA1c	If last result less than 8%, test every 6 months, If greater than 8%, test every 3 months.
Urine Microalbumin	Annually
Comprehensive Metabolic Panel	Annually, for patients prescribed drugs with renal side effects (includes ACE inhibitors, ARB's, diuretics)

2. Specialty Notifications:

Optometrist/Ophthalmology for retinal eye exam	Annually
OB/GYN for Cervical Cancer Screening	Females age 21-64, pap every three years; or Females age 30-64, pap and HPV co-testing every 5 years, exclude if hysterectomy with no residual cervix

3. Cancer Screening:

Bilateral Mammogram for screening	Females 50 years and older, every two years, exclude if bilateral mastectomy
Colorectal Cancer Screening Fecal Occult Blood	50 years and older with no colonoscopy in the past 10 years, exclude if colorectal cancer or total colectomy

Provider Name (Printed) _____ Provider Office Location _____

Provider Signature (required) _____ Date (required) _____ Time (required) _____

McLaren
MEDICAL GROUP

Mid-Michigan Healthcare Associates
1540 Lake Lansing Road; Suite 102
Lansing, MI 48912
Phone: (517) 913-3810 Fax: (517) 913-3811

[Date]

[Patient First Name; Patient Last Name]
[Patient Address]
[City, State ZIP CODE]

Dear [Patient First Name],

Thank you for choosing McLaren for your health care. As part of your patient-focused medical team, the Quality staff is contacting you on behalf of your primary care provider, [Provider's Name].

Based on our records, you are due for the following: [ ].
We show your last one was: [ ].

Your provider recommends you have this done. Receiving evidence-based care early is the secret to good health and a key factor in preventing diseases and managing health conditions.

___ Please complete testing by using the enclosed slip.

___ Please schedule an appointment with [Provider's Name].

Please call the McLaren Quality staff at our toll free number,
1-844-508-6647

- For questions regarding this letter
- If you have already had this testing. *Please be prepared to provide the patient's name, date of birth, type of test, date of test and location where it was done so that we can obtain a copy of the report and update our records.*
- To be removed from future mailings

If you have changed primary care providers, please disregard this letter/test request. Please contact the office directly to have your medical record updated or forwarded.

Thank you, our goal is to help you maintain good health!

McLaren Medical Group Quality Staff/ [Provider's Name]

TAB 6

MEDICAL GROUP

Human Resource Contact Information
Fax: (810) 342-1070

Main Human Resources Line…….……. (810) 342-1580 &
Main Administration Line…… (810) 342-1043
Tracy Valentine
Administrative Assistant
Office coordination, password resets for McLaren University, tracking of McLaren University modules, compliance and tracking of new hire documentation, verifications of employment, malpractice letters, uploading contracts into Mediregs, auditing provider licenses, new hire files, I-9's, CME tracking for providers, maintenance of the MMG directory and general administrative support

Ann Kurzyniec…….……. (810) 342-1535
HR Generalist
Recruitment of MMG positions (posting, reviewing/forwarding applicants for consideration, scheduling HR phone screening and pre-hire assessment, answering questions regarding the process, extending offers of employment), tracks affiliation agreements and student documents to support MMG's intern and extern programs, tuition reimbursement, short term disability tracking, processing unemployment claims, general questions

Denise Dostilio…….……. (810) 342-1004
Senior Recruiter
Recruitment of MMG and hospital-based positions (posting, reviewing/forwarding applicants for consideration, scheduling HR phone screening and pre-hire assessment, answering questions regarding the process, extending offers of employment), badge preparation, tracking of Recruit for Loot program, general questions

Stephanie Hoover……..… (810) 342-1578
Recruiter
Recruitment of MMG and hospital-based positions (posting, reviewing/forwarding applicants for consideration, scheduling HR phone screening and pre-hire assessment, answering questions regarding the process, extending offers of employment), general questions

Kimberly Voltenburg…….……. (810) 342-1085
Senior HR Business Partner
Onboarding of MMG providers, provider and employee relations, investigations, provider inquiries, HR reports/audits, FMLA and general LOA questions

Sherri Bryant …….. (810) 342-1546
HR Business Partner
Onboarding of MMG providers, provider and employee relations, investigations, provider inquiries, general questions

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Susan Theakston…..…… **(810) 342-1585**
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Recruitment, Staff Development, School Partnerships

Carla Henry…..…… **(810) 342-1037**
VP of HR and Provider Services
Employee Relations, Provider Contract Management, Operations

Benefit Services
Fax: (810) 342-4660

Brenda Johns…… **(231) 487-3023**
Benefits Analyst
Analyst for new hire benefit offerings, benefit status changes, benefit payroll deductions, open enrollment processing, COBRA

Retirement Services……... **(866) 238-2419 ext. 1**
Donna Aho, Director, Corporate Retirement
Kim Confer, Senior Retirement Svs. Analyst
Laura Gill, Senior Retirement Svs. Analyst
Teresa Dewyer, Retirement Svs. Analyst

Lincoln Financial……... **(800) 290-0164**
Leave of absence requests/paperwork

Lincoln Financial……. **(866) 783-2255**
Short-term disability claims

Mass Mutual Customer Service……. **(888) 643-7343**

McLaren Health Advantage…… **(888) 327-0671**
Health care coverage, medical/dependent care flexible spending account administration

GuidanceResources Program……... **(844) 449-6539**
Employee assistance program

Lincoln Financial Group®

Report your absence online

You can use our company's self-service benefits website **(www.MyLincolnPortal.com)** as a one-stop, fast and easy way to securely report your claim or absence to Lincoln Financial Group.

When do I report an absence?

Lincoln Financial Group is available 24 hours a day, 7 days a week. You may report a claim when you have been absent from work because of a non-work related illness or injury and will not be returning to work within the elimination period (the period of time before your benefits kick in) outlined in your company's policy or you are within one week of a planned surgery or childbirth.

For absences that relate to caring for a family member with a serious health condition; to care for a newborn, foster or adopted child; for a military leave; personal leave, bereavement leave, jury duty or for your own serious health condition. You may report a leave when you will be out of work for more than 3 consecutive days or on an intermittent basis.

How do I report an absence?

1. **Log in to MyLincolnPortal.com.** (NOTE: First-time users will need to register using our company code: MCLAREN.)
2. **Select "Report a New Claim or Leave" and answer a few questions.**
   a. About you: You'll need your employee identification number or other ID as required by your employer.
   b. About your absence: Include the reason for your absence, dates of absence, and if applicable, physician diagnosis information.
3. **Click "Submit."** For disability claims, you'll be asked to download, sign and submit a medical authorization form to send to your doctor.
4. **Keep record of your claim or Leave number.** Reporting your claim online provides the added convenience of printing a report that includes your claim number and a summary of your claim details.

   Note: Employees without internet access can report an absence anytime by calling 800-290-0164.

Use MyLincolnPortal.com anytime to:

- Check the status of your claim 24/7
- Access contact information for your case manager
- Access claim forms

Use MyLincolnPortal.com anytime to:

- Check the status of your claim or absence 24/7
- Access contact information for your case manager or absence specialist
- Check FMLA absence balances, so you don't exceed your leave duration
- Access claim forms

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-2250900-092118
POD 10/18 **Z01**
Order code: AM-REPCL-FLI001

Lincoln Financial Group®

Lincoln Financial Group®
You're In Charge®

An easier way to submit your STD claim

Short-term disability/One Call Claims

Less time, less paperwork

With One Call Claims, it's simple to submit your short-term disability (STD) claim over the phone in a matter of minutes.

When should I call?

Submit an STD claim over the phone if:

You've been absent from work because of a nonwork illness or injury and will not be returning within the elimination period outlined in your company's policy.

You're within one week of a planned surgery or childbirth.

What number should I call?

Call 866-STD-CALL (866-783-2255) and provide:

- Name and date of birth
- Address and phone number
- Social Security Number
- Employer: McLaren Medical Group (MCLARENMG)
- Group policy number: 000500216709 - ATP
- Doctor's name, address, phone and fax numbers
- Your occupation and the last day you worked
- Your condition or diagnosis
- Direct deposit information

A claims examiner will process your claim and, if necessary, contact your employer and physician.

If more information is needed from you, your employer, or physician, the claims examiner will inform you of the necessary steps to complete the claim process.

What days and times can I call?

Call a Lincoln Financial Group® claims examiner between:

8 a.m. to 8 p.m. ET Monday through Thursday.
8 a.m. to 6 p.m. ET Friday.
Or fax us anytime at 877-843-3950.

In some cases, a decision regarding the claim will be made the same day.

Insurance products issued by:
The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York

What to expect when you call

During the call, your claims examiner will explain the process and how they will work with your physician to obtain the necessary information.

In most cases, your physician will need to complete an "STD Attending Physician's Statement." There are three ways for your physician to receive this form:

You can supply your doctor's fax number during your call, and we will send the form directly to their office.

Your claims examiner can send you the form for you to provide to your doctor.

You can print the form from Lincoln4Benefits.com.

Once we receive all your information, a claim decision will be made. If your claim is approved, your benefits will be paid as outlined in your company's policy.

You can also access forms and personal benefit information online

1. Go to **LincolnFinancial.com,** and click the 'Register Now' link in the Login box.
2. Select 'Group Insurance Policy/Certificate' and follow the instructions.
3. Once you're registered, you can review coverage, claim status, and policy information. You can also print forms and report claim information such as child delivery or a return-to-work date.

If you have any questions or need further information, call 866-STD-CALL or fax 877-843-3950.

LincolnFinancial.com

PDF 7/15 **Z03**
Order code: STD-CLM-FLI001

Lincoln Financial Group®

You're In Charge®

TAB 7

McLaren
MEDICAL GROUP

PowerChart or Scanning Clinical Questions?

Contact the MMG EMR Training Team

All EMR Trainers (from every region) are on the below email list and are available by phone or email.
It is the best route to provide quickest resolution to education or training needs.

MMGCernerTraining@mclaren.org

Lansing EMR Trainers

Name	Title	Email	Phone	Location
Brian Moody	Senior EMR Trainer	Brian.moody@mclaren.org	(517) 507-4142	Lansing
Karen McGettigan	EMR Trainer	Karen.mcgettigan@mclaren.org	(269) 327-4081	Lansing
Tracey Minarik	EMR Trainer	Tracey.minarik1@mclaren.org	(989) 413-7855	Lansing

Technical Issues?

Contact the Atos Service Desk

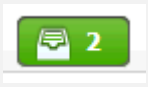
Call the Atos Service Desk to log a case for issues related to the following:

- access issues/errors, technical issues (error messages, screen is frozen, etc),
- hardware issues (scanners, printers, etc), and Cerner application issues.

810-424-8400

PowerChart Icon Guide

Order Icons	
	View Orders. Check mark indicates that a type of order is available and will be displayed in the window on the right. The user will need to change the filters to display the desired order statuses.
	Quick Discontinue. Check mark indicates 'Active'. Toggling off the check mark will bring up the Details window so that you can specify discontinue reason.
	Ambulatory order for administration in an outpatient clinic.
	Order details are not complete.
	Proposed order waiting for provider to sign.
	Favorites Folder.
	Order has an associated annotation.
	Takes you to next missing order detail.
	Launches the dose calculator.
	Medication is associated with a high level of risk.
	Indicates that a provider signature is required for the order
	Review Schedule – the schedule for this order should be reviewed as doses may be too close.
	Nurse has not reviewed the new order.
	Non-LAM Medication – Not on the **L**ist of **A**pproved **M**edications
	Documented medications by history or home medication. Not an order until converted by a provider.
	Indicates this is an inpatient order.

	Indicates this order is a prescription.
	Indicates that the order is part of a PowerPlan.
	Care Sets- indicates a care set orderable.
	Discontinued Medication.
	Hard Stop Renewal- Medication has a defined stop time.
	Green shopping cart.
	This order is available to be scheduled for an appointment.
	The appointment is confirmed
Order Reconciliation Icons	
	Continue medication order as an Inpatient order.
	Create a new discharge prescription.
	Do not continue order.
	Order not reconciled – decision to continue/not continue has not yet been made.
Medication Administration Icons	
	Overdue Task.
	Order waiting verification by pharmacist.
	Order rejected by pharmacist.
	Priority / Urgent Task.
	Inactive order.

	Task due now.
Task at a Glance Legend	
	A task in a Pending status.
	A task in a Pending status that cannot be Quick Charted or Quick Charted as Done.
	A task in a Canceled / Discontinued status.
	A task in a Complete status.
	A task that was completed as Chart Not Done.
	A task in an In-Process status.
	A task in an Overdue status.
	A task in an Overdue status that cannot be Quick Charted or Quick Charted as Done.
	A task in a Pending Validation status.
PowerForm Icons	
	**Sign Form**. Once a form is signed it is released for others to view it.
	**Save Form**. Saving a form only allows the original user to see the form, it is not released for others to view it.
	**Cancel**. This button cancels the user's entries and returns the user to the previous window.
	**Clear**. This button clears the user's entries and allows the user to begin again.
	**Previous**. This button opens the previous section.
	**Next**. This button opens the next section.
	**Clinical Calculator**. This button opens the Online Clinical Calculator window that allows you to calculate the answer to the selected formula.
Ambulatory Summary Icons	
	Comment
	Documented Medication

	Find
	Item has been modified.
	Orders for Signature
	Prescribed Medication
	Refresh individual section
	Tag Result
	Return to top
	Vitals above normal
	Vitals below normal
Ambulatory Summary Input Icons	
	Align text to center
	Align text to left
	Align text to right
	Justify text
	Copy text
	Cut text
	Paste text using source formatting
	Font color
	Italic
	Bold
	Underline text
	Manage Auto Text
Document Viewer Icons	
	Add document
	Clinical Calculator
	Exit Viewer

	Forward
	History
	In Error
	Review
	Print
	View Image
Documentation Icons	
	Full Screen Mode
	Review Document
	Save Note
	Sign/Submit
	View Document
	View Image
Form Browser Icons	
	Form incomplete
	Form complete
Notes Icons	
	Add
	Forward
	History
	In Error
	Modify
	Print
	Review
	Scan/Import
	Scanner Properties
	Sign

Problem List Icons	
	Comment entered
	Convert to Diagnosis
	Medline search
	Problem specified
	Problem unspecified
Recommendations Icons	
	Due soon
	Overdue
	Not due soon
Results Review Icons	
	Graph
	Flowsheet seeker