CTC-RI has selected DataStat as its qualified vendor for conducting the customer experience survey (CAHPS). CTC-RI, with financial support from the health plans, covers the costs associated with administering the CAHPS survey for practices currently participating in the CTC-RI program. All participating CTC-RI practices are required to meet the CAHPS survey project milestones within the outlined timeframes.

DataStat has prepared a "Starter Kit" to assist practices with meeting the CAHPS survey expectations. As the certified data vendor for this project, DataStat will administer the survey and collect data from the patients at your practice site using approved NCQA protocols. Conducting the patient experience survey using a standardized survey tool will enable the practice to obtain credit for the NCQA quality improvement competency. CTC and DataStat will not be submitting data to NCQA for the NCQA "distinction" option as there is added cost to submit data to NCQA for distinction, and practices do not need "distinction" for NCQA quality improvement credit.

For the project to be successful, each practice site needs to generate and submit patient data files and materials to DataStat in a consistent and timely manner. When registering for the project, it will be important for practices to review the submission requirements prior to starting the online entry because the registration portal does not have a "save and return" function.

Included in this packet you will find:

- Instructions for registering your practice for the survey project using DataStat's online registration portal
- A timeline of project milestones and deadlines
- Instructions for generating your patient data file
- Patient data file layout specifications and a sample Excel template
- Instructions for submitting files using the DataStat Transfer Center
- A pre-signed BAA if your practice requires one. (Optional - DataStat does not require practices to sign a BAA.)

In addition, we have found that it is very helpful if you let your patients and staff know that you will be participating in this survey. Often patients call the practice to confirm that the survey is legitimate. If your front office staff is aware of the survey, they can reassure patients that the survey is legitimate and their patient record has not been compromised. This packet includes an English and Spanish version of a notice that you might want to post in your office or send to your patients to encourage their participation.

- English Information for patients
- Spanish information for patients
- FAQs for the practice office staff

If you have questions about survey implementation or generating your patient data file, please contact Donna Fowlkes, DataStat Project Manager at (734) 994-0540 ext. 143 or email RIPCMH@datastat.com.

If you have any questions for CTC, please contact your assigned CTC practice facilitator, Candice Brown, Project Coordinator (CBrown@ctc-ri.org) or Susanne Campbell, CTC Senior Project Director (SCampbell@ctc-ri.org).

Registering for the 2018-2019 CTC Rhode Island PCMH Survey Project

All practices must register for the survey project using DataStat's online registration portal located at:

https://www.datastat.com/CTC

You will be asked to provide the information listed below. Please gather the necessary information before starting the registration process, as you will not be able to save the entry and return to finish it later; you will need to re-enter all the information from the beginning. For definitions of multi-site group and eligible clinicians, please see the instructions for generating and submitting patient data files.

Multi-site group – the information for each practice site must be entered individually, even if all the sites have the same primary contact and data contact. Please use the street name, city, or some other unique identifier to differentiate each site that is part of the same practice. For example: First Medical-Main St., First Medical-Providence.

Practice Name – The practice name to be used in survey materials. Provide the practice name most recognizable to patients.

Survey Type - Identify whether your practice is participating in the Adult Survey, Child Survey, or both.

Primary Contact - DataStat will contact this person regarding administrative tasks for the survey such as approving the practice logo and executive's signature to be used in survey materials. Provide the contact's First Name, Last Name, Email Address, and Telephone Number.

Data Contact - This person will be responsible for generating the practice's patient data file and uploading it to DataStat using the DataStat Transfer Center. Provide the contact's First Name, Last Name, Email Address, and Telephone Number.

Practice Type - Identify whether your practice is a stand-alone practice or part of a medical group. *(A medical group is a group of practices that want to grant permission to have their data looked at as a group, in addition to individual practices.)*

Number of Eligible Clinicians - The number of eligible clinicians we should expect to be represented in your patient data file.

When you are finished entering all the information on the registration portal, click the "DONE" button located at the bottom of the last screen. A confirmation screen will appear after you have completed your registration.

2018-2019 CTC Rhode Island PMCH Survey Project

PROJECT MILESTONES

Milestone	Dates
Practices participate in Practice Reporting Committee training	September 25, 2018 8:00 to 9:30 held at RIQI 50 Holden Street Providence RI
Practices complete DataStat's online registration form to participate in the survey project	September 25 – October 9, 2018
Final deadline for practices to complete online registration	October 9, 2018
DataStat sends Transfer Center invitations to the practice's data contact person, if there's no existing account. (This will occur after the practice has completed registration.)	September 25 – October 10, 2018
DataStat sends logo/signature forms to the practice's primary contact person. (This will occur after the practice has completed registration.)	September 25 – October 10, 2018
Final deadline for practices to activate any new Transfer Center accounts. (For new data contacts.)	October 15, 2018
Practices generate patient data files - **submission window opens**	October 15, 2018
Practices submit patient data files to DataStat using the DataStat Transfer Center	October 15 – October 26, 2018
Practices sign and return BAAs to DataStat (if required by the practice)	October 16, 2018
Final deadline for practices to complete logo/signature forms and send any new logos/signatures to DataStat	October 23, 2018
Final deadline for practices to submit patient data files (Any data file issues must be resolved by this date)	October 26, 2018
1st survey mailing	November 21, 2018
2nd survey mailing	December 12, 2018
Telephone surveys begin	January 9, 2019
Survey field period ends	January 30, 2019
DataStat submits final datasets to CTC	February 20, 2019
DataStat submits final spreadsheets with scores to CTC	February 27, 2019
DataStat submits final Summary Reports to CTC	March 29, 2019

Generating and Submitting Patient Data Files

Each participating practice site must submit a patient data file to DataStat. **October 26, 2018 is a firm deadline** for all sites to submit a complete and usable patient data file to DataStat with any issues resolved. **Practice sites are encouraged to submit their files to DataStat early, so any issues can be resolved by October 26, 2018.**

When generating your patient data file, please refer to the section "Sample Frame Data File Elements" or the sample template (template.xlsx). Data fields should not contain words such as "N/A", "Missing", or "NULL". If an item is not available, leave the field blank. Dates should be in the format MMDDYYYY with no separators, and phone numbers should be 10 digits with no parentheses or dashes.

The method of submission is through the DataStat Transfer Center (DTC). **For privacy reasons, patient data files cannot be submitted via e-mail**. To use the DTC, you must be invited to create an account. DataStat will send out invitations to any new data contact persons between September 25, 2018 and October 10, 2018. **Practices should activate any new DTC accounts no later than October 15, 2018.** Existing account holders are encouraged to log in to the DTC to confirm that you have access to your account.

Patient Data File Deadlines

- The measurement period is defined as April 16, 2018 through October 15, 2018.
- Patient data files may be submitted to DataStat between **October 15, 2018 and October 26, 2018.** All final patient data files must be received at DataStat by **October 26, 2018**. **Any data file issues must be resolved by this date.**

File Generation Guidelines

- The measurement period is defined as April 16, 2018 through October 15, 2018.
- All eligible patients that had a visit (scheduled or walk-in) with an eligible clinician within the measurement period must be included in the data file. (See "Key Definitions" on the next page for the definition of "eligible clinician".)
- For patients with more than one visit during the measurement period, use the most recent eligible visit. Each eligible patient should only be in the file once.
- Patient eligibility is defined as, for adults, 18 years old or older as of the last day of the measurement period. For children, 17 years old or younger as of the last day of the measurement period. (The last day of the measurement period is October 15, 2018.)
- DataStat prefers adult and child data files to be submitted separately, but combined files can be accepted if adult and child cases are clearly identified (see the sample layout).
- Multiple sites may be submitted as separate files or a combined file. If the file is combined, cases must be clearly identified with a 'practice unique ID' variable. For combined submissions, a crosswalk of the variable 'practice unique ID' must be included (see the sample layout).
- Files may be submitted as an Excel file or as a flat, ASCII, rectangular, fixed field width file with no delimiters. Either file type must follow the sample specifications included.

- DataStat will check patient data files for accuracy and completeness. If DataStat finds that a data file is found to be inaccurate or incomplete, the practice site will need to resubmit the data file before the final submission deadline.

Key Definitions

- **Eligible Clinician:** Only clinicians who can be selected by a patient/family as a personal clinician are eligible for inclusion. Eligible clinicians include physicians, nurse practitioners and physician assistants who practice in the specialty of internal medicine, family medicine or pediatrics and serve as the personal, primary care clinician for their patients. Clinicians must have an active, unrestricted license as a doctor of medicine, doctor of osteopathy, naturopathic doctor, nurse practitioner or physician assistant. All eligible clinicians practicing together at a practice site must be included when identifying the PCMH Survey eligible population. *Note: Specialists, nurse practitioners and physician assistants who do not have their own panel of patients or who do not practice in primary care are not typically eligible. Residents are not normally considered eligible clinicians.*

- A **practice** is one or more clinicians who practice together and provide patient care at a single geographic location. The practice must provide primary care for all patients in its practice, not just for selected patients. **Practicing together** means that, for all the clinicians in a practice:

  a. The practice care team follows the same procedures and protocols.

  b. Medical records (paper and electronic) for all patients treated at the practice site are available to all clinicians and are shared by all clinicians, as appropriate.

  c. The same systems (paper based or electronic) and procedures support both clinical and administrative functions (e.g., scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up).

  d. A rehabilitation facility or hospital may not define itself as a practice; however, hospital-based primary care practices and residency clinics are eligible to be defined as practices.

- A **multi-site group** is three or more practice sites using the same systems and processes including an electronic medical record system shared across all practice sites. A multi-site group must collect and report PCMH Survey results separately by practice site.

Sample Frame Data File Elements - Standardized Layout

Each of the elements listed below should be included in the sample frame provided to the survey vendor. The columns and widths indicated in the Data Format column describe a flat, ASCII, rectangular, fixed field width file with no delimiters. *If your file does not match this description, it is critical that the practice deliver a detailed dataset description including the order of variables and relevant coding schemes.*
If a field is blank (such as Address 2), leave it blank. Do NOT put N/A, Missing, or Null.

#	Required Data Element	Specifications and Value Labels	Field Position and Data Format
1	Practice name	Name of practice to be used in survey materials and scripts. Provide practice name MOST recognizable to patients.	Columns: 1-60 Width: 60 Type: Alpha-Numeric
2	Patient first name		Columns: 61 - 85 Width: 25 Type: Alpha
3	Patient middle initial	Middle initial only	Columns: 86 Width: 1 Type: Alpha
4	Patient last name		Columns: 87 - 111 Width: 25 Type: Alpha
5	Patient gender	1=Male 2=Female 9=Missing/not available	Columns: 112 Width: 1 Type: Numeric
6	Patient date of birth	In **MMDDYYYY format with no separators**. Single digit months and days must be preceded by a zero; i.e., April 8, 1965 would be 04081965.	Columns: 113 - 120 Width: 8 Type: Alpha-Numeric
7	Patient mailing address 1	Used to generate cover letters and mail questionnaires. Put simple street address here. For example: 100 Main St.	Columns: 121 - 170 Width: 50 Type: Alpha-Numeric
8	Patient mailing address 2	Use as necessary for apartment number, apartment complex name or other long addresses; otherwise leave blank	Columns: 171 - 220 Width: 50 Type: Alpha-Numeric
9	Patient - City		Columns: 221 - 250 Width: 30 Type: Alpha
10	Patient - State	2-character postal service state code	Columns: 251 - 252 Width: 2 Type: Alpha
11	Patient - Zip Code (5 digit)	5-digit zip code. Use leading zero if appropriate.	Columns: 253 - 257 Width: 5 Type: Numeric
12	Patient telephone number	Home phone number. Area code and phone number with **no separators**, e.g. 5551234567. Members without phone numbers should still be included in the file. If there is no phone number, leave this field blank.	Columns: 258 - 267 Width: 10 Type: Numeric
13	Clinician first name	Name of the clinician who provided care at the patient's most recent visit during the measurement period. This clinician need not be the patient's regular clinician or primary care provider.	Columns: 268-292 Width: 25 Type: Alpha
14	Clinician middle initial		Columns: 293 Width: 1 Type: Alpha
15	Clinician last name		Columns: 294-318 Width: 25 Type: Alpha
16	Clinician credentials	For example: MD, PA, RN	Columns: 319-328 Width: 10 Type: Alpha-Numeric
17	Clinician Nation Provider Identifier (NPI)		Columns: 329-338 Width: 10 Type: Numeric

18	Date of most recent office visit during the measurement period	In **MMDDYYYY format with no separators**. Single digit months and days must be preceded by a zero; i.e., August 4, 2018 would be 08042018.	Columns: 339-346 Width: 8 Type: Alpha
19	Patient Visit Count (optional)	Total number of visits the patient had during the 6 months prior to the date the eligible population data file was generated (include visits with any eligible clinician). *Please leave blank if not including.*	Columns: 347-349 Width: 3 Type: Numeric
20	Patient survey group	1=Adult survey 2=Child survey	Columns: 350 Width: 1 Type: Numeric
21	Practice unique ID	Provide for multi-practice sample frames. Please include a crosswalk for this variable. Example: 01=Main St, 02=St. John's,03=Madison Heights	Columns: 351-352 Width: 2 Type: Numeric
22	Indicate if Spanish or Portuguese language materials are required (if known)	01=Spanish Language Materials Required 02=NO Spanish Language Materials Required 03=Unknown/not available 04=Portuguese materials requested	Columns: 353-354 Width: 2 Type: Numeric

Submitting Files Using the DataStat Transfer Center

To upload a patient data file, log in to your Transfer Center account at https://www.datastat.com/tcenter/

From the main menu, select Upload Files.

1. Browse and select your file, then click on the "Send this file" button on the right.
2. Enter a description for the file (and additional information, if needed). Please include the name of the practice or site, so DataStat can easily identify the file. If you're only submitting one file, click on "Batch is complete". If you're submitting multiple files, click on "Add additional files."
3. Step 3 is for entering additional files if you are uploading separate files for more than one practice or site. You will repeat steps 1 and 2 for each file.
4. Upload files - verify the file name(s) and select the recipient: RIPCMH@datastat.com
   Click "Continue" at the bottom of the screen.
5. Final - verify recipient and click "Submit".
6. Upload complete – **If this screen does not appear, the file may not have been uploaded successfully, and you should try uploading the file again**. Click "Done".

You should receive an email notification from tcenter@datastat.com confirming that the file was uploaded. The recipient will receive an email notification that the file is available to download.

If you have any questions about the Transfer Center, please contact the DataStat Project Manager, Donna Fowlkes, at RIPCMH@datastat.com or (734) 994-0540 ext. 143.

HIPAA BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT is made as of the _____day of _____, 2018 by and between _____ ("Covered Entity") and DataStat Inc.

RECITALS:

WHEREAS, **DataStat Inc.** (hereinafter referred to as Business Associate), provides services for Covered Entity (the "Service Arrangement") pursuant to which Covered Entity may disclose Protected Health Information ("PHI") to Business Associate in order to enable Business Associate to perform one or more functions for Covered Entity related to Treatment, Payment or Health Care Operations; and

WHEREAS, the parties desire to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Final Rule for Standards for Privacy of Individually Identifiable Health Information adopted by the United States Department of Health and Human Services and codified at 45 C.F.R. part 160 and part 164, subparts A & E (the "Privacy Rule"), the HIPAA Security Rule, codified at 45 C.F.R. Part 164 Subpart C (the "Security Rule") and Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH") including 45 C.F.R. Sections 164.308, 164.310, 164.312 and 164.316.

NOW THEREFORE, the parties to this Agreement hereby agree as follows:

1. Definitions. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 164.501 and 164.502.

2. Obligations and Activities of Business Associate.

    a. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement, as Required by Law or as permitted by law, provided such use or disclosure would also be permissible by law by Covered Entity.

    b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Business Associate agrees to implement Administrative Safeguards, Physical Safeguards and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the confidentiality, integrity and availability of PHI as required by the "Security Rule" , including those safeguards required pursuant to 45 C.F.R. §§ 164.308, 164.310, 164.312, 164.314 and 164.316, in the same manner that those requirements apply to Covered Entity pursuant to 45 C.F.R. § 164.504.

c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

d. Business Associate agrees to report to Covered Entity any use or disclosure for the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware.

e. Business Associate agrees to ensure that any agent, including a subcontractor or vendor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.

f. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and format; or, if not, in a readable electronic form and format as requested by Covered Entity.

g. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall notify Covered Entity upon receipt of such request.

h. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for the purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule and Security Rule.

i. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered

Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 §C.F.R. 164.528.

k. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it shall, following the discovery of a breach of such information, promptly notify Covered Entity of such breach. Such notice shall include: a) the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.

l. Business Associate agrees that it will not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 13405(d) of the HITECH Act applies.

m. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 C.F.R. §164.501 unless permitted by the HITECH Act.

n. If applicable, Business Associate agrees that it will not use or disclose genetic information for underwriting purposes, as that term is defined in 45 C.F.R. § 164.502.

o. Business Associate hereby agrees to comply with state laws applicable to PHI and personal information of individuals' information it receives from Covered Entity, including the Massachusetts Data Security Regulations, 201 CMR 17.00, as applicable, during the term of the Agreement.

    i. Business Associate agrees to: (a) implement and maintain appropriate physical, technical and administrative security measures for the protection of personal information as required by any state law, including 201 CMR 17.00 as applicable; including, but not

limited to: (i) encrypting all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information to be transmitted wirelessly; (ii) prohibiting the transfer of personal information to any portable device unless such transfer has been approved in advance; and (iii) encrypting any personal information to be transferred to a portable device; and (b) implement and maintain a Written Information Security Program as required by any state law, including, 201 CMR 17.00, as applicable.

ii. The safeguards set forth in this Agreement shall apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" shall not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

p. Business Associate agrees that no PHI may be received, maintained, stored, accessed or transmitted outside of the United States of America.

3. Permitted Uses and Disclosures by Business Associate.

a. Except as otherwise limited to this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Service Arrangement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity required by 45 C.F.R. §164.514(d).

b. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

c. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it

was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504 (e)(2)(i)(B).

e. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

4. Obligations of Covered Entity

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

5. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, provided that, to the extent permitted by the Service Arrangement, Business Associate may use or disclose PHI for Business Associate's Data Aggregation activities or proper management and administrative activities.

6. Term and Termination.

a. The term of this Agreement shall begin as of the effective date of the Service Arrangement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Section.

b. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Service Arrangement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity.

ii. Immediately terminate this Agreement and the Service arrangement if Business Associate has breached a material term of this Agreement and cure is not possible; or

iii. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

c. Except as provided in paragraph (d) of this Section, upon any termination or expiration of this Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall ensure that its subcontractors or vendors return or destroy any of Covered Entity's PHI received from Business Associate.

d. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous.

a. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy and Security Rules and HITECH.

c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement shall survive the termination of this Agreement.

d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and HITECH.

e. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

f. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

g. Modification of the terms of this Agreement shall not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.

h. This Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.

i. Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.

j. This Agreement and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Rhode Island, including all matters of construction, validity and performance.

k. All notices and communications required or permitted to be given hereunder shall be sent by certified or regular mail, addressed to the other part as its respective address as shown on the signature page, or at such other address as such party shall from time to time designate in writing to the other party, and shall be effective from the date of mailing.

l. This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signature hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

m. Business Associate shall maintain or cause to be maintained sufficient insurance coverage as shall be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Business Associate Agreement and such insurance coverage shall apply to all services

provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible identity theft, financial harm, reputational harm, or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Agreement.

IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date first set forth above.

COVERED ENTITY

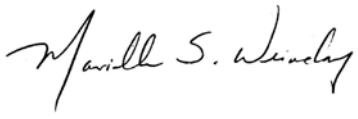
By:_____

Title: _____

Address: _____

Date: _____

DataStat Inc.

By:__  _____

Title: Health Care Research Director_____

Address: 3975 Research Park Dr. Ann Arbor, MI 48108_____

Date: _09/21/2018_____

Your opinion matters!

During the next two months, a company named DataStat may call you or send you a survey in the mail. They are doing a survey of patients in our practice.

Your opinion is important to us. If DataStat contacts you, please try to complete the survey. Your answers will tell us what you think about our practice. Please be as honest as possible. The results will help us make our services better.

The survey is voluntary. You do not have to do the survey. You can also skip any questions that you do not want to answer.

If you do the survey, we will not see your personal responses. DataStat will give us a summary of the results.

Let us know if you have any questions about the survey.

¡Su opinión es importante!

Durante los próximos dos meses, una compañía llamada DataStat puede estar llamándole o enviándole una encuesta por correo. Ellos están haciendo una encuesta con los pacientes de nuestra práctica.

Su opinión es importante para nosotros. Si DataStat le contacta, por favor complete la encuesta. Sus respuestas nos dirán lo que piensa usted sobre nuestra práctica. Por favor sea lo más honesto posible. Los resultados nos ayudarán a mejorar nuestros servicios.

La encuesta es voluntaria. No tiene que hacer la encuesta. También puede saltar cualquier pregunta que no quiera contestar.

Si contesta la encuesta, nosotros no veremos sus respuestas individuales. DataStat nos dará un resumen de los resultados.

Nos deja saber si tiene preguntas sobre la encuesta.

CAHPS® PCMH Survey
Frequently Asked Questions - Patients

Important Note: Staff may familiarize themselves with the survey instrument, but should not try to help respondents fill out the survey. If respondents ask staff the meaning of a question, staff should not rephrase the question on the survey instrument or try to interpret the meaning of the question. If this situation occurs, explain that the purpose of using a third party vendor is to increase the accuracy of the results and **ask the patient to call DataStat at 1-888-506-5135 with his/her questions**. See the questions and answers below for frequently asked questions about the survey. Practices are discouraged from answering other questions about the survey, as this might compromise the survey results. You may confirm that Care Transformation Collaborative Rhode Island has contracted with DataStat as the third party survey vendor to conduct the survey on behalf of the practice. The practice may also tell the patient the survey is being conducted to help improve healthcare quality.

General Questions about the Survey

Who is conducting this survey? Who is sponsoring this survey?

- Care Transformation Collaborative Rhode Island is sponsoring this survey on behalf of our practice.
- Care Transformation Collaborative has contracted with DataStat, an independent survey research organization, to help conduct the survey.

Who is DataStat?

- DataStat is an independent research organization in Ann Arbor, Michigan that Care Transformation Collaborative contracted with on our behalf to help conduct the survey.

What is the purpose of the survey? How will the data be used?

- The survey is designed to collect information on patients' experiences with the care and services provided by their clinicians. It will help our practice improve the quality of care we provide.

Are my answers confidential? Who will see my answers?

- Your answers will be seen by the research staff and will be combined with answers from other surveys to make a statistical report. Your/your child's clinician will not receive your individual responses, nor will any response be attached to your/your child's name during the study.

What happens to my answers?

- Your individual responses will be combined with the responses given by other patients who are in the same practice and a summary will be made available to the practice.

How long will this take?

- The survey will take about 10 minutes to complete.

What questions will be asked?

- The survey asks questions about the experiences you/your child had receiving care and services from the clinician. There will be questions asking you about any problems you/your child may have had receiving care or services. It asks you to rate different types of care and services you/your child may have received.

CAHPS® PCMH Survey
Frequently Asked Questions - Patients

How did DataStat get my/my child's name? How was I/my child chosen for the survey?

- Your/your child's name was randomly selected from all patients who had a visit here in the last 6 months. We did not share any information about your/your child's personal medical history with DataStat.

I am confused by the term 'provider'.

- For the purposes of this survey, the term "provider" refers only to the clinician named in the survey. It does not refer to any health plan from which you or your child receive benefits or to any practice group from which you or your child obtain health care services.

I am no longer a patient of clinician/clinic listed.

- Ask if they have seen the clinician listed on the letter and questionnaire in the last 6 months. If yes, they should fill in the circle next to 'Yes" for Question 1 and continue filling out the rest of the survey according to the visit that is listed. If no, they should fill in the circle next to 'No' for Question 1 and continue filling out the rest of the survey following the skip instructions.

I am/my child is not a patient at the listed clinic/clinician, but another family member is.

- The person whose name is on the letter should fill out the survey. If the person named was not a patient of the clinic within the last 6 months, please fill in the circle next to 'No' for Question 1 and follow the remaining instructions.
- If the person whose name is on the letter is a child, either you or another parent/caretaker will need to answer the questions according to experiences with the clinician/clinic of the child named on the letter.

This is not the clinician I normally see.

- You may still complete the survey even if this is not the clinician you or your child normally sees. The intent of this survey is to gather information about your/your child's particular visit with the named clinician only, so please keep this clinician in mind as you answer the survey questions.

Is the survey for me or (my spouse/my child)?

- The survey is for the person whose name is on the letter. This will be either you or your child, in which case you or another parent/caretaker will need to answer the questions according to experiences with the clinician/clinic of the child named on the letter.

Can someone else complete the survey on behalf of the patient?

- The survey is designed to be completed by the patient. We prefer the survey be completed by the patient, but another person may complete the survey for the patient if it is not possible for the patient to do it.
- If the patient is a child, either you or another parent/caretaker will need to answer the questions according to experiences with the clinician/clinic of the child named on the letter.

My spouse didn't get a survey, but wants to fill one out.

- Survey recipients were randomly selected, and only those who were selected may participate.
- Random selection of participants helps to ensure confidentiality and ensures we hear opinions from all kinds of people.

Is the survey available in Spanish or Portuguese?

- Yes. To request materials in Spanish, please contact DataStat at 888-506-5135. To request materials in Portuguese, please call 800-465-0435.

Is the survey available in languages other than English, Spanish and Portuguese?

- I'm sorry. This survey has not been translated into any other languages.

Is there a deadline to fill out the survey?

- Since we need to contact so many people, it would really help if you could return it within the next few days.

Where do I put my name and address on the questionnaire?

- You should not write your name or address on the questionnaire. Each survey has been assigned an identification number that allows DataStat to track which respondents have returned a completed questionnaire.

  IF NEEDED: The names and addresses are stored separately from the answers to the survey questions, so that your answers are not associated with your name.

My ____ is deceased. What should I do with the questionnaire?

- I'm sorry to hear that. You don't need to fill out the questionnaire. I'll ask DataStat not to contact you again.

NOTE TO STAFF: Please call DataStat at 1-888-506-5135 to let them know that the patient is deceased.

Why does DataStat keep asking the same questions over and over?

- I'm sorry if the questions seem repetitive, but DataStat needs to ask all of the questions exactly the way they are written in the questionnaire.

Concerns about Participating in the Survey

I am concerned about my privacy.

- We did not share any information about your/your child's personal medical history with DataStat.
- DataStat abides by HIPAA regulations. Your/your child's name and address will be kept absolutely confidential and will not be seen by anyone other than the research staff.
- Your answers will be seen by the research staff and will be combined with answers from other surveys to make a statistical report. Your clinician will not receive your individual responses, nor will any response be attached to your/your child's name during the study.

I don't do surveys.

- I understand, however I hope you will consider participating. This is a very important study for our practice. The results of the survey will help us understand what we are doing well and what needs improvement.

I'm not interested.

- We could really use your help. Could you tell me why you're not interested in participating?

I'm extremely busy. I don't really have the time.

- I know your time is limited, however it is a very important survey, and we would really appreciate your help. The interview will take about 10 minutes.

I don't want to answer a lot of personal questions.

- I understand your concern. This is a very important survey. If a question bothers you, you may just skip it.

I'm very unhappy with your practice. I don't see why I should help you with this survey.

- I'm sorry you're unhappy. This is a good reason for you to participate. Your responses will help the clinician understand what improvements are needed.

Do I have to complete the survey? What happens if I do not? Why should I?

- Your participation is voluntary. There are no penalties for not participating. But, it is a very important survey and your answers will help to improve the quality of care we provide.

I have been advised not to participate in telephone surveys.

- I can understand your concern. But this is an important survey for our practice. Your answers will help your clinician understand what he/she is doing well and what needs improvement.

I don't want to buy anything.

- We're not selling anything or asking for money. We want to ask you some questions about the care and services provided by our practice.

Will I get junk mail if I answer this survey?

- No, you will not get any junk mail. Your/your child's name and address will be kept absolutely confidential and will not be seen by anyone other than the research staff.

Will my responses affect my health care?

- No. Your answers will be kept absolutely confidential and will not be seen by anyone other than the research staff. Your individual answers will not be seen by your clinician and will not affect your/your child's care in any way.

What does CAHPS stand for?

- CAHPS stands for the Consumer Assessment of Healthcare Providers and Systems program. The program is managed by the Agency for Healthcare Research and Quality, the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. They make survey tools available to health plans, doctors and hospitals to collect information about the healthcare and services people receive and to improve the quality of healthcare.

What does PCMH stand for?

- PCMH is an abbreviation for Patient Centered Medical Home. The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. Your physician works with a team of providers to better coordinate your health care and meet your needs. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.