**CARE DELIVERY REQUIREMENTS**

**Care Transformation Collaborative of RI Program for January 2017 Expansion**

**Care Delivery Requirements**

The Program Provider agrees to fulfill CTC’s Program care delivery requirements as described online at [www.ctc-ri.org](http://www.ctc-ri.org)

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| **Practices agree to fulfill CTC’s Program care delivery requirements as described on line (**[**www.ctc-ri.org**](http://www.ctc-ri.org)**).**  **All reports and measures identified in the Care Delivery Requirements use methodology as defined and approved by the CTC Data and Evaluation Committee. Requirements may be subject to change based on changes to requirements (i.e. OHIC, NCQA)** | | |
| **Measurement Period** | **Care Delivery Requirement for Adult Practices** | **Date Due (if applicable) Last day of the month** |
| **Start Up (MP 1)** January 1, 2017 **–**December 31, 2017 |  |  |
| **Care Management** | Hire 1.0 Nurse Care Manager/Care Coordinator for every 3,000 attributed patients ($2.50 pmpm) | September 30, 2017 |
|  | Develop High Risk Registry and reportable fields for care management. Confirm completion with CTC | November 30, 2017 |
| NCM /CC completes standardized learning program as defined by CTC | December 31, 2017 |
| Report level(s) of engagement of high risk patients provided high risk patients as defined by CTC | January 31, 2018 |
| Submits to OHIC Cost Management Attestation | October 15 |
| **Planned Care: Population Health /Quality Reporting** | Submit clinical quality data as defined in Performance Incentives Exhibit 3 | Month 6 |
|  | Submits to OHIC quality measure information | October 15 |
| **Access and Continuity** | Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients | Month 6 |
|  | Submits to CTC before and after hours protocol, as defined by CTC | Month 9 |
| **Patient/Family Engagement** | CAHPS survey: Submits patient panel to approved data vendor (or “How’s Your Health” option to be determined) | October 2017 |
| **Comprehensiveness and Coordination** | Submits Transition of Care Policy and Procedure | Month 6 |
|  | Identifies high volume specialists serving patient population and submits 2 compacts: a) high volume specialist b) behavioral health | Month 9 |
| **Practice transformation** | Submits budget and staffing plan and use of funds to support care delivery model to CTC | October 2017 |
|  | Submit NCQA PCMH work plan to CTC | Month 9 |
| Meets with Practice Facilitator 1-2 x a month | Month 1 and on-going |
|  | Attends 50% of learning network meetings 1 | Month 1 and on-going |

1 Learning Network Meetings: Orientation, Best Practice Meetings, Breakfast for Champions, and Large Learning Collaborative

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| **Measurement Period**  **2 (MP 2)** January 1 2018 –December 31, 2018 | **Care Delivery Requirements for Adult Practices** | **Due Date (if applicable) by last day of the month** |
| **Care Management** | Submits reports on high risk patients, as defined by CTC and achieves 40% engagement rate | Quarterly (January/April/July/October) |
|  | Submits to OHIC Cost Management Strategy Attestation | Month 10 |
|  | Submits report that demonstrates 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days. | Month 12 |
| **Planned Care: Population Health /Quality Reporting** | Submits quarterly quality data | January/April/July/October |
|  | Submits to OHIC quality data information | Month 10 |
| **Access and Continuity** | Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients | Quarterly |
|  | Submit to CTC screenshots demonstrating patient access to a secure web portal, enabling secure messaging, appointment requests, referrals, and prescription refills. | Month 3 |
|  | Submits schedule demonstrating that it has expanded office hours as defined by OHIC Cost Management Strategies | Month 6 |
| **Patient/Family Engagement** | Submits patient panel for CAHPS survey to data vender (or How’s Your Health option to be determined) | Timeframe determined by CTC |
| **Comprehensiveness and Coordination** | Provides report that demonstrates that 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days | Month 9 |
| **Practice Transformation** | Submits quality improvement activity for improving a performance measure (quality/customer experience/utilization) | Month 3 |
|  | Submits quality improvement activity demonstrating performance to improve a quality measure (quality/customer experience/utilization) | Month 9 |
|  | Meet with practice facilitators at a minimum of once per month | On-going |
|  | Attends 50% of Learning Network Meetings | On-going |

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| **Measurement Period**  **MP 3**  January 1, 2019-December 31, 2019 | **Care Management Requirement** | **Due Date (if applicable) last day of the month** |
| **Care Management** | Submits reports on high risk patients, as defined by CTC and achieves 40% engagement rate | Quarterly (January/April/July/October) |
|  | Provides report that demonstrates that 75% high risk patients with ED visit receive a follow interaction including medication reconciliation within 1 week of discharge | Month 6 |
| Submits attestation to OHIC and demonstrates achievement 80% of Cost Management Strategy elements | Month 10 |
| **Planned Care: Population Health /Quality Reporting** | Submits quarterly data | January/April/July/October |
|  | Submits to OHIC quality data measurement report | Month 10 |
| **Access and Continuity** | Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for new patients | Quarterly |
| **Patient/Family Engagement** | Submits patient panel for CAHPS survey to data vender (or How’s Your Health option to be determined) | Timeframe determined by CTC |
| **Comprehensiveness and Coordination** | Submits 2 additional compacts as defined by OHIC Cost Management Strategies | Month 6 |
| **Practice Transformation** | Submits NCQA application | Month 3 |
|  | Achieves NCQA PCMH recognition | Month 9 |
|  | Meet with CTC practice facilitators once per quarter | Quarterly |
| Attends 50% of Learning Network meetings | Quarterly |