**GAP Analysis Document for PY2 Practices and OHIC Cost Management Strategies**

Instructions: *Practices need to meet 80%, of functions; In Year 1 there is 24 functions so a practice would need to meet 19 functions.*

*Deeming: OHIC indicates deeming\* status (meaning that a practice can count that element as having been met, if the practice has the specified NCQA status. Some elements indicate “partial” deeming; practice will want to check policy/procedure and current practice to see if practice would meet the functions with verification; if not, what would a practice need to do in “action plan” to meet the requirements of the functions. Practices that are presently in PY 2 may be asked to meet functions by 6/30/16. (Note: For 2011 NCQA, there are 8 deemed functions and for2014 there are 10 deemed functions; there are an additional 9 functions that are considered “deemed” with verification).*

 **#1 High Risk Registry: Must meet all Functions**

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| Functions | Year 1 6/30/2016 | Deeming\* | Year 2 | Self-Assessment | Action Plan |
| 1 | Practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services | X | X |  |  |  |
| 2 | Using information from a variety of sources, including payers and practice clinicians the practice updates the list of high risk patients **at least quarterly** | X | X *(partial with timeframe checked)* |  |  |  |
| 3 | Practice has a risk assessment methodology that includes:1. Assessment of co-morbidities
2. Inpatient utilization
3. ED utilization
 | X | X |  |  |  |

 **#2: Care Management (CM)/ Care Coordination (CC) Services: Must meet all Functions**

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| --- | --- | --- | --- | --- | --- |
| Functions | 6/30/2016 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 1 | Practice has a designated resource (RN or Social Worker care coordinator for pediatric practice) focused on providing care focused on high risk patients  | X | X*(with verification)* |  |  |  |

 **#2: Care Management (CM)/ Care Coordination (CC) Services: Must meet all Functions**

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| --- | --- | --- | --- | --- | --- |
| Functions | 6/30/2016 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 2 | Practice has methodology for the timely assignment of levels of care management/care coordination needed by high risk patients based on risk level to promptly identify which patients should be in the care manager/care coordinator’s active caseload at any point in time | X |  |  |  |  |
| 3 | The care manager/care coordinator completes within an assessment within 2 weeks (unless patient unable to reach after 3 attempts) from the time the patient is placed on case load based on the patient’s specific symptoms including patient’s preferences, lifestyle goals, self-management abilities, socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk | X | X*(regarding content of assessment; verify specified timeframes for assessing and adding new patients onto the high risk patient list based on NCM capacity)* |  |  |  |
| 4 | Working with patient and within 2 weeks of completing the patient assessment, cm/cc completes a written care plan that includes: 1. Medical/social summary
2. Risk factors
3. Treatment goals
4. Patient-generated goals
5. Barriers to meeting goals
6. An action plan for attaining goals
 | X |  |  |  |  |

 **#2: Care Management (CM)/ Care Coordination (CC) Services: Must meet all Functions**

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| --- | --- | --- | --- | --- | --- |
| Functions | 6/30/2016 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 5 | CM/CC resources update the written care plan on a regular basis based on a patient needs to affect progress towards meeting goals but no less frequently than semi-annually  |  | X *(partial and verify practices are developing care plan for all patients on the high risk patient list and are meeting timeframe for updating care plan)* | X |  |  |
| 6 | For high risk patients known to be hospitalized or in a SNF, cm/cc resources shall contact the patient and/or hospital discharge planner and begin TOC planning at least 24 hours prior to patient’s discharge  | Waived Year 1  | X *(partial and verify practice beginning TOC)* | X |  |  |
| 7 | CM/CC resources contact every high risk patient who has been d/c from hospital inpatient services after discharge to determine care manager needs  | X *(within 72 hours)* | X *(partial and verify practice is meeting timeframe)* | X*(within 48 hours)* |  |  |
| 8 | CM/CC resource contacts every known high risk patient who has ED visit for a situation or condition that is related to high risk status  | X *(within 72 hours)* | X *(partial and verify practice is meeting timeframe)* | X*(within 48 hours)* |  |  |

 **#2: Care Management (CM)/ Care Coordination (CC) Services: Must meet all Functions**

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| --- | --- | --- | --- | --- | --- |
| Functions | 6/30/2016 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 9 | CM/CC resources completes a med reconciliation after high risk patient has been d/c from inpatient (to extent possible in person)  | X *(within 7 days)* | X *(partial and verify practice is meeting timeframe)* | X*(****within 7 days Year 2****; within 72 hours Year 3)* |  |  |
| 10 | CM/CC resources arrange for and coordinate all medical developmental behaviorally health and social service referrals and tracks referrals and test results on a timely basis until completed  | X | X |  |  |  |
| 11 | CM/CC resources provide health and lifestyle coaching for high risk patients designed to enhance the patient’s caregiver’s self-condition-management skills  | X | X |  |  |  |
| 12 | Practice provides patient engagement training to CM/CC | X | X |  |  |  |
| 13 | CM/CC resources have in person or telephonic contact with each high risk patient at intervals consistent with patient’s level of risk  | X |  |  |  |  |
| 14 | CM/CC participate in relevant team based care meetings  | X | X |  |  |  |
| 15 | CM/CC resources use HIT to document and monitor the cam service provisions  | X |  |  |  |  |
| 16 | CM/CC resources participate in formal practice QI initiatives to assess and improve CM service delivery  | X | x |  |  |  |

 **#3: Behavioral Health Integration: Practice must meet only 1 of the following Functions by the end of Year 1**

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| Functions | 6/30/2016 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 1 | Practice has developed preferred referral arrangements with community behavioral health providers such that appointments are available consistent with the urgency of the medical and behavioral health needs of the practice’s patients and there is an operational protocol adopted by the PCP and the preferred specialists for exchange of information and terms of the preferred arrangement are documented in a written agreement **OR** | X  |  |  |  |  |
| 2 | Practice has arranged for behavioral health provider to be co-located (or virtually located) at the practice for at least one day per week and assists patients in scheduling appointments with the on-site providers **OR**  | X |  |  |  |  |
| 3 | Practice is implementing or has implemented a co-located (or virtually located) integrated behavioral health service s model that is characterized by licensed behavioral health clinicians serving on the care team, the team sharing patients, and sharing medical records and the practice promoting consistent communications at the system, team and individual provider levels that includes regularly scheduled case conferences and warm hand-offs. | X |  |  |  |  |

 **#4: Practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am-5pm); must meet all Functions:**

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| Functions | 6/30/2016 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 1 | Practice has a written policy to respond to patient telephone calls within the following timeframes: 1. For urgent medical/behavioral calls received during office hours, return calls are made the **same day**;
2. For urgent calls received after office hours, **return calls are made within 1 hour**
3. For all non-time sensitive calls, return calls are made **within 2 business days of receiving the call**
 | X | X *(partial and verify policy has timeframes)* |  |  |  |
| 2 | Practice has implemented same-day scheduling such that patients can call and schedule an appointment for the same day | X*(for urgent type visits)* | X *(2011 if meeting factor 1; 2014 allow deeming)* | X *(Year 2 urgent; Year 3 urgent & routine)* |  |  |
| 3 | Practice has agreement with (or established) an urgent care clinic or other service provider which is open during evenings and weekends when the office is not open as an alternative to receiving ED Care  | X |  |  |  |  |
| 4 | Practice utilizes formal quality improvement processes to assess and improve the effectiveness of its program to expand access | X | X *(2011 DO NOT allow deeming; 2014 allow deeming)* |  |  |  |

 **#4: Practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am-5pm; must meet at least 2 of**

 **The following 3 functions:**

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| Functions | Year 1 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 1 | Practice has created a secure web portal that enables patients to: * Send and receive secure messaging
* Request an appointment
* Request referrals
* Request prescription refills
* Review lab and imaging results
 | X*(all functions with exception of lab and imaging)* | X | Year 3: lab and imaging must be functional |  |  |
| 2 | Using information from a variety of sources, including payers and practice clinicians the practice updates the list of high risk patients at least quarterly | Waived Year 1  |  | For urgent type visits |  |  |
| 3 | Practice has expanded office hours so that services are available at least 4 hours over the weekend. Services may be provided by practice clinicians or through an affiliation of clinicians so long as physicians are able to share medial information electronically on a near real-time basis through either a shared EMR system or by a ready access to a patient’s practice physician who has real-time access to the patient’s medical record | Waived Year 1  |  | For urgent type and routine visits |  |  |

  **#5: Practice refers patients to referral service providers who provide value-based care; must perform all the following functions:**

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| Functions | Year 1 | Deeming | Year 2 | Self-Assessment | Action Plan |
| 1 | Practice has developed referral protocols for its patients for **at least 2** of the following: 1. One high volume specialty (i.e. cardiovascular, pulmonary, ortho, endocrine)
2. Lab service
3. Imaging service
4. PT services
5. Home health services
 | X |  |  |  |  |
| 2 | Should one or more payers provide the practice with readily available, actionable data, the practice has used such data and any other sources to identify referral service providers who provide higher quality services at costs lower than or the same as their peers (i.e. high-value referral service providers) and prioritizes referrals to those providers | Waived year 1  |  | X  |  |  |