PCMH CTC Adult Service Delivery Requirements July 2017 Expansion

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).

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| **Measurement Period** | **Care Delivery Requirement**  | **Date Due (if applicable) Due last day of month**  |
| **Start Up (MP 1)**7/1/17 to 6/30/18 |  |  |
| **Care Management**  | Hire 1.0 Nurse Care Manager (NCM)/Care Coordinator for every 3,000 attributed patients ($2.50 pmpm)  | Month 4  |
|  | Develop High Risk Registry and reportable fields for care management. Confirm completion with CTC  | Month 6  |
| NCM/CC completes standardized learning program as defined by CTC | Month 7  |
| Report level(s) of engagement of high risk patients as defined by CTC | Month 9  |
| 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  |
|  | Submit 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  | Timeframe determined by CTC  |
| **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  | Month 3  |
|  | 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)**7/1/18 to 6/30/19 | **CTC PCMH Adult Care Delivery Requirements**  | **Due Date (if applicable) Due last day of month**  |
| **Care Management**  | Submits reports on high risk patients, as defined by CTC, to Health Plans and CTC and achieves 40% engagement rate  | Quarterly (July/October/January/April)  |
|  | Submits to OHIC Cost Management Strategy Attestation  | October 15  |
|  | 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  | 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  | 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 qualified 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 6  |
| **Practice Transformation** | Submits a quality improvement activity for improving a performance measure (Quality/customer experience/utilization) | Month 2  |
|  | Submits a quality improvement activity demonstrating performance to improve a performance measure  | Month 7  |
|  | Submits NCQA PCMH recognition application | 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** 7/1/19 -6/30/20  | **CTC PCMH Adult Care Management Requirement**  | **Due Date (if applicable) Last day of month**  |
| **Care Management**  | Submits reports on high risk patients, as defined by CTC, to Health Plans and CTC and achieves 40% engagement rate | Quarterly (July/October/January/April) |
|  | Provides report that demonstrates that 75% high risk patients with ED visit receive a follow interaction including medication reconciliation within 1 week of discharge 6 month | Month 6 |
| Submits attestation to OHIC and demonstrates achievement 80% of Cost Management Strategy elements  | Oct 15  |
| **Planned Care: Population Health /Quality Reporting** | Submits quarterly data  | July/October /January/April  |
|  | Submits to OHIC quality data measurement report  | 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  | Quarterly  |
| **Patient/Family Engagement**  | Submits patient panel for CAHPS survey to approved 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**  | Achieves NCQA PCMH recognition | Month 2 |
|  | Meet with CTC practice facilitators once per quarter | Month 1 and quarterly  |
| Attends 50% of Learning Network meetings  | Month 1 and quarterly  |