# Draft: CTC Contract Milestones Summary

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|  | **Year 1**  | **Year 2**  |  **Year 3** |
| **Risk Stratified Care Management and Planned Care for Population Health** | * Care manager Resume, date of hire, (end of 4th month)
* Submits budget inclusive of staffing plan by 4 months
* Submits Care Management Policy (inclusive of formal vision for care coordination) indicating who provides care management services, who receives care management services, process for assessment, outreach, care plan development and re-evaluation per OHIC guidelines (6 months)
* Generates registry of high risk patients per CTC specifications and process for reporting NCM activity (9 months)
* Provides health plan with patient engagement reports (9 months) per health plan guidelines
 | * Reports on CM activity with high risk patients per CTC guidelines (1st month Transition )
* Submits budget inclusive of staffing plan (4 months)
* Per population health assessment, practice selects and plans for care management strategy See Year 3 for options (6th month Transition)
 | * Provides care management for 80% of highest need patients (1st month Year 3)

Implements 1 or more care management strategies (3rd month Year 3): * IBH
* Self-management support for 3 risk conditions (preferred consideration: obesity, tobacco cessation, cancer morbidity and mortality, preventable ED, hospitalizations, re-hospitalizations, child health and immunizations, asthma control, end of life and palliative care
* Medication management and review
* Submits budget inclusive of staffing plan (4 months)
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| **Access and Continuity** | * Provider panel report: accepting new patients/3rd next available appointment with provider panel submission (3 months)
* Submits written Telephone Response Time Policy (office open and after hours) inclusive of real time access to medical record (6 months)
* Submit empanelment report (unless single provider practice): 9 months
 | * Submits Before/After Hour Protocol/ staffing plan with Expanded office hours to so services are available 4 hours over week-end, two hours am or 2 evenings (may be provided through affiliation as long as they are able to share medical information electronically either through shared EHR or each (3rd month Year 2)
* Submits Compact with Urgent Care or other service that is open during week end and evenings (3rd month Year 2)
* Submits plan to implement at least 1 asynchronous form of patient communication (i.e. patient portal, email, text messaging) inclusive of timely response protocol
* Empanelment report indicates 95% of patients assigned to PCP (9 month Year 2)
 | * Submits PDSA process to assess and improve expanded access (3rd and 9th month of Year 3)
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| **Patient and Family Caregiver Engagement** | * Identify a priority condition, decision or test that would benefit from shared decision aid; make a decision aid available to appropriate patients and generate a metric for proportion of patients who received decision aid : 9 months
* Obtains baseline patient satisfaction results using CAHPS or How’s Your Health report (10 months) or patient portal usage report
 | Options for improving patient experience * Option A: Conducts practice-based customer experience survey monthly
* Option B: Patient/family advisory meets quarterly
* Option C: Office based surveys quarterly and PFAC meets semi-annually
* Option D: Implements Open Notes
* Submits communication plan to family/patients about specific changes and explains medical care and services at practices (6months Year 2)
 | * Submits PDSA for improving a patient experience metric (1month and 6 month report)
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| **Comprehensiveness and Medical Home Coordination** | Submits compacts : (all required 9 months)Required compacts* Behavioral Health inclusive of OHIC requirements
* Hospitalist Compact
* 2 high volume specialists with consideration of high value information if available to practice

Two additional compacts from following list of options: * Lab service
* Imaging service
* Physical Therapy
* Home Health service

Submits Transition in Care Policy and Procedure inclusive of OHIC functions by end of Year 1  | Provides report selecting 1 of 2 options: (1st month Year 2) * Tracks % of high risk patients with ED visits who received f/u phone care within 72 hours
* Tracks % of high risk patients who were contacted within 72 hours
* Submits PDSA to achieve 75% for at least one option (6 and 9 months)
 | Provides report both options: (1st month Year 1) * Tracks % of high risk patients with ED visits who received f/u phone care within 72 hours
* Tracks % of high risk patients who were contacted within 72 hours
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| **Quality Reporting** | First Required quarterly report (with minimal look back period as defined by CTC quality measurement specifications) * Due 6months (15th of month) and quarterly thereafter
 | * Due quarterly
 | * Due quarterly
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| **Patient Centered Medical Home** | * Submit work plan for achieving NCQA Level 3 recognition (due 9 months)
* Meet with Practice Facilitator at least monthly for practice transformation consultation and together completes self-assessment
* Present Best Practice Sharing at requested Committee meeting
 | * Submit updated work plan for achieving NCQA Level 3 recognition (due 9 months)
* Meet with Practice Facilitator at least every other for practice transformation consultation
* Present Best Practice Sharing at requested Committee mee3ting
 | * Achieve Level 3 (3 months prior to end of Year 3)
* Meet with Practice Facilitator at least quarterly for practice transformation consultation
* Present at Best Practice Sharing at requested Committee meeting
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| **Learning Networks:**Orientation Best Practice Committee meetings Breakfast for Champions Learning Collaborative  | **Notes: CPCI**Meets 100% requirements with exception of risk stratification of entire population. This will be done through APCD but does not provide patient specific information; may be an option through work being done by SIM/RIQI clinical dashboard if entire patient panel was included  | **Notes: OHIC:** Meets 100% of OHIC functions when one considers 80% requirement  | **Notes: TCPI:** Meets requirements with exception of reducing unnecessary tests and hospitalizations by 20%; shared care plan may be option through work being done by RIQI; There is requirement of practice monthly report that is not met; maybe something that can be done by practice combinations with CTC monthly PF report  |