Rhode Island PCMH Cost Containment Strategy Survey

The following survey is to be completed by practices seeking PCMH designation by Rhode Island payers in order to qualify for medical home financial support, consistent with terms of the OHIC-approved Care Transformation Plan.

**Requirement #1: The practice develops and maintains a high risk patient registry:**

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| The practice must perform all of the following functions: | | |
| Function | Yes | No |
| 1. The practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services. |  |  |
| 1. The practice updates the high risk patient list at least quarterly. |  |  |
| 1. The practice has developed a risk assessment methodology using provider/team identification of patients based on disease severity levels and co-morbidities. |  |  |
| The practice must perform *at least 3* of the following functions: | | |
| Function | Yes | No |
| 1. The practice includes within its risk assessment methodology an assessment of patient self-care abilities. |  |  |
| 1. The practice includes within its risk assessment methodology an assessment of the patient’s socioeconomic issues. |  |  |
| 1. The practice includes within its risk assessment methodology an assessment of the patient’s functional abilities and challenges, which may include developmental challenges. |  |  |
| 1. The practice includes within its risk assessment methodology consideration of information regarding inpatient utilization. |  |  |
| 1. The practice includes within its risk assessment methodology consideration of information regarding emergency department utilization. |  |  |

**Requirement #2: The practice offers Care Management/Care Coordination Services.**

*Adult Practices*

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| The practice must perform all of the following functions: | | |
| Function | Yes | No |
| 1. The practice has a designated resource(s) that at the minimum includes a licensed Registered Nurse or Licensed Practical Nurse to provide care management services that focuses on providing services to patients on the high risk patient list. |  |  |
| 1. The care manager has an established methodology for assigning levels of care management service based on risk level and patient-specific characteristics. |  |  |
| 1. The care manager initiates within one week of the patient’s placement on the high-risk patient list a patient assessment based on the patient’s specific symptoms, complaints or situation that are contributing to elevated near-term hospitalization and/or ED risk. |  |  |
| 1. Working with the patient and within one week of completing the patient assessment, the care manager completes a written care plan that includes:    1. a medical/social summary    2. risk factors    3. patient-generated goals    4. an action plan for attaining patient’s goals |  |  |
| The practice must perform *at least 7* of the following functions: | | |
| Function | Yes | No |
| 1. The care management resources arrange for, sets up and coordinates all medical, developmental, behavioral health and social service referrals and tracks referrals and test results. |  |  |
| 1. The care management resources provide health and lifestyle coaching designed to enhance the patient’s/caregiver’s self/condition-management skills. |  |  |
| 1. The care management resources support and facilitate all care transitions between providers, and perform timely medication reconciliations as part of the transition-of-care process. |  |  |
| 1. The care management resources contact every practice patient who has been discharged from hospital inpatient services within 48 hours of discharge to determine care management needs. |  |  |
| 1. The care management resources arrange for a clinical contact (e.g. PCP or specialist office visit, care manager meeting or in home visit, etc.) within one week of discharge from an inpatient hospital for patients who are assessed to be at high risk for readmission and/or a post-discharge ED visit. |  |  |
| 1. The care management resources have in-person or telephonic contact with each high-risk patient at intervals consistent with the patient’s level of risk. |  |  |
| 1. The care management resources update the written care plan on a regular basis, based on patient needs, but no less frequently than quarterly. |  |  |
| 1. The care management resources participate in team-based care meetings to assure whole-person care is provided. |  |  |
| 1. The care management resources use HIT to document and monitor care management service provision. |  |  |
| 1. The care management resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery as evidenced by participating in at least 1 team-based, PDSA project annually |  |  |

*Pediatric Practices*

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| The practice must perform all of the following functions: | | |
| Function | Yes | No |
| 1. The practice has a designated resource(s) to provide care coordination services that focus on providing services to patients on the high risk patient list and to their families[[1]](#footnote-1). |  |  |
| 1. The care coordination resources have an established methodology for assigning levels of care coordination service based on risk level and patient and family characteristics. |  |  |
| 1. The care coordination resources complete within one week of the patient’s placement on the high-risk patient list a child/youth and family assessment that includes:    1. a family status and home environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth and family), and    2. a growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance/needs, and emotional/behavioral strengths and needs). |  |  |
| 1. Working with the patient and family, and within one week of completing the patient assessment, the care coordination resources complete a written care plan that includes:    1. a medical/social summary    2. risk factors    3. patient/family goals    4. an action plan for attaining the patient’s/family’s goals. |  |  |
| The practice must perform *at least 5* of the following functions: | | |
| Function | Yes | No |
| 1. The care coordination resources arrange for, set up and coordinate all medical, developmental, behavioral health, educational and social referrals and tracks referrals and test results. |  |  |
| 1. The care coordination resources provide health and lifestyle coaching designed to enhance the patient’s/family’s self/condition-management skills. |  |  |
| 1. The care coordination resources support and facilitate all care transitions between providers. |  |  |
| 1. The care coordination resources have in-person or telephonic contact with each patient/family at intervals consistent with the patient’s level of risk. |  |  |
| 1. The care coordination resources update the written care plan on a regular basis, based on patient needs, but no less frequently than quarterly. |  |  |
| 1. The care coordination resources participate in team-based care meetings to assure whole-person care is provided. Team members may include primary care and specialist providers, school liaisons, behavioral health providers, developmental specialists, government support program representatives (e.g., SSI), and social service agency representatives. |  |  |
| 1. The care coordination resources use HIT to document and monitor care coordination services provided. |  |  |
| 1. The care coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care coordination service delivery. |  |  |

**Requirement #3: The practice improves access to behavioral health services.**

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| The practice has implemented one of the following approaches to behavioral health integration | | |
| Function | Yes | No |
| * 1. The practice has developed preferred referral arrangements, including requirements around exchange of information, with community behavioral health providers such that appointments are timely and convenient for the practice’s patients and care is coordinated. The terms of the preferred arrangement are documented in a written agreement. |  |  |
| * 1. The practice has arranged for a behavioral health provider(s) to be co-located at the practice for at least one day per week and assists patients in scheduling appointments with the on-site provider(s). The practice and the on-site provider has a written protocol covering access to services, scheduling and exchange of information. |  |  |
| * 1. The practice is implementing or has implemented a co-located, integrated behavioral health services model that is characterized by shared patients; shared medical records; and consistent communications at the system, team and individual provider levels that includes regularly scheduled case conferences, and warm hand-off protocols. |  |  |

**Requirement #4: The practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am and 5pm).**

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| The practice must perform the following function: | | |
| Function | Yes | No |
| 1. The practice has a written policy to respond to patient telephone calls within the following timeframes:    1. For time-sensitive calls received during office hours, return calls are made before the close of business.    2. For time-sensitive calls received after office hours, return calls are made within 3 hours.    3. For all non-sensitive calls, return calls are made within 36 hours of receiving the call. |  |  |
| The practice must perform *at least 4* of the following functions: | | |
| Function | Yes | No |
| 1. The practice receives email communications from patients and has a written policy to respond to emails within the following timeframes:    1. For time-sensitive emails received during office hours, return emails are sent before the close of business.    2. For all non-sensitive emails, return emails are sent within 36 hours of receiving the patient email.   The practice clearly communicates to patients that time-sensitive emails should not be sent after hours and that patients should call the practice under such circumstances. |  |  |
| 1. The practice has created a secure web portal that enables patients to:  * request appointments * request referrals * request prescription refills * review lab and imaging results. |  |  |
| 1. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day. |  |  |
| 1. The practice has expanded office hours so that services are available at least two evenings a week. |  |  |
| 1. The practice has expanded office hours so that services are available at least four hours over the weekend. |  |  |
| 1. The practice has established an urgent clinic which is open during some of the hours when the office is not open. |  |  |
| 1. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access as evidenced by completing at least 1 team-based, PDSA project annually that is access/effectiveness-focused . |  |  |

**Requirement #5: The practice refers patients to referral service providers who provide value-based care.**

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| The practice must perform the following functions: | | |
| Function | Yes | No |
| 1. The practice has used readily available data from payers 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”). |  |  |
| 1. The practice has developed a referral protocol(s) for its patients that promotes use of the high-value referral service providers for at least two of the following:    1. One high volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist.    2. Laboratory services    3. Imaging services    4. Physical therapy services    5. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Requirement #6: The practice develops and maintains an avoidable ED use reduction strategy.**

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| The practice must perform the following function: | | |
| Function | Yes | No |
| 1. The practice participates in CurrentCare to receive next-day or real-time information regarding patient ED visits. |  |  |
| The practice must perform at *least 2* of the following functions: | | |
| Function | Yes | No |
| 1. The practice contacts all patients seen in the ED within 48 hours of the visit to assess care management/coordination needs and to arrange for a follow-up office visit, as needed. |  |  |
| 1. The practice contacts all patients discharged from inpatient hospitalization within 48 hours of the discharge to assess care management/coordination needs and to arrange for a follow-up office visit, as needed. |  |  |
| 1. The practice conducts physician or nurse practitioner rounds on nursing home patients at least weekly. |  |  |
| 1. The practice engages community health workers or other trained personnel to work with high ED utilizers to identify risk factors and link patients to medical, behavioral health and/or social services to reduce ED utilization. |  |  |
| 1. The practice utilizes pharmacists to the treatment teams for high ED utilizers that are prescribed a high number of drugs. |  |  |
| 1. The practice implements a specialized, multi-disciplinary care team (including behavioral health providers) that targets high ED utilizers to provide intensive, “whole-person” outpatient services. |  |  |

1. For the purposes of this survey, “family” includes non-family caregivers in the event that the child is cared for by someone other than family. [↑](#footnote-ref-1)