**Call for Applications**

**Rhode Island Quality Institute**

***Care Management Dashboard Project***

**Rhode Island Quality Institute (RIQI) is pleased to offer primary care practices the opportunity to apply to participate in a care management pilot program designed to provide timely, accurate, actionable, organized information about hospital based services on high risk patients to practices via a care management dashboard. Outlined below is the “Call for Applications” for primary care practices.**

**Background:**

Funded by Rhode Island Foundation’s Fund for a Healthy Rhode Island, RIQI will support up to 30 primary care practices and up to 10,000 high risk patients in primary care practices, with preference given to those in the Care Transformation Collaborative (CTC), by managing and merging multiple lists of high-risk patients for each individual practice into our Care Management Alerts patient panel management system.

This project will:

1) Merge and manage payer and practice high risk lists into the RIQI data management process;

2) Deliver standard (not customized) RIQI Care Management Dashboards (CMD), presenting near-real time data on hospital services for those high risk patients; and

3) Provide predictive risk scores to the care team to support prioritization care management services.

The following outcomes will be measured:

1. Practice workflow improvements;
2. Reductions in hospital admissions and readmissions; and
3. Reductions in emergency department returns within 30 days.

Selected practices would have access to RIQI standard CMD and webinar training to assist them with incorporating the information gleaned from the dashboard into their care management processes. As part of this grant, RIQI will conduct a robust evaluation, including measurement of improvements in clinical care and changes to practice workflows. Due to limited resources, a staggered implementation will occur. Practices will be randomly assigned to one of four implementation waves, beginning between Q2 2016 and Q4 2017.

**Benefits to Practice:**

This project will help to prepare primary care practices for value-based payment models by sharing essential health information regarding hospital use by high risk patients with primary care teams in a timely and efficient manner. The aim is to reduce preventable ED and hospital admissions by identifying and intervening with those at risk for an avoidable ED or hospital visit. Using the same data that supports the RIQI Hospital Alerts, RIQI has developed a Care Management Dashboard which provides a daily care manager work list, identifying patients currently in the hospital as well as those recently discharged from both the inpatient and emergency room settings. Details about the patient’s admitting diagnosis and number of recent inpatient and emergency department visits will also be included. These dashboards will present a prioritized high-risk patient work list to the care manager with the data needed to immediately initiate appropriate care management services, augmenting or replacing the current patient-by-patient notifications of inpatient or hospital discharges.

**Prerequisites:**

* Agree to a randomized staggered entry into the program;
* Current NCQA Level 2 recognition or above;
* Presence of a nurse care manager in the practice at least 20 hours per week; and
* A high-risk patient panel of not more than 330 patients at a site location **or** a willingness to limit the patients included in the project to a subset of those assigned to a limited number of providers in the practice.

**Practice Requirements:**

* Execute a contract for Care Management Alerts and business associates agreement with RIQI to provide HIPAA compliant data sharing for high-risk patients who are not enrolled in CurrentCare;
* Identify a nurse care management liaison to RIQI who will act as the program champion in the practice;
* Document current workflow processes associated with care management follow-up for patients either in or discharged from an inpatient or emergency department setting (e.g., workflow diagram and time study);
* Provide a file or files – in a specified format - including up to 330 patients identified as high risk by the practice or a health plan within one (1) month of award notification;
* Attend an in-person and/or web-based training on the use of the Care Management Dashboard;
* Commit to redesign, establish and document modified CMD workflows to incorporate CMD data into care management processes within two (2) month of award notification; and
* Assist with meeting the evaluation plan requirements which will include but not be limited to producing quarterly practice reports regarding workflow and care management processes (e.g., workflow diagram and time study)

**Timeline for Selection Process:**

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| **Step** | **Activity** | **Date** |
| 1 | Complete survey monkey letter of intent | Monday, December 14, 2015 by 5:00 pm |
| 2 | Information SessionCall-in number: 866-951-1151, code 869951115 | Tuesday, December 15, 2015, 7:30 – 8:30 am |
| **3** | **Practices submit completed application package- electronically to efontaine@riqi.org****Please include application checklist.**  | **Thursday, December 31, 2015 by 5:00pm**  |
| 4 | A selection committee comprised of leadership from RIQI, CTC and Brown, will meet to review and score submitted applications and randomize selected practices to a staggered implementation wave. | January 4 – January 22, 2016 |
| 5 | Notification will be sent to the 30 practices with the highest score on the application, along with information about the staggered implementation wave to which they have been randomized.  | Friday, January 29, 2016 |
| 6 | Orientation for newly selected practices  | **Monday, February 1, 2016****(Please hold the date)**7:30 – 9:00 am, RIQI, Washington Conference Room |

*Following the call, a FAQ document will be emailed to all parties completing the online letter of intent via survey monkey. The document will include responses to all questions posed during the call as well as any questions received via the email below.*

**For questions contact:**

Elaine Fontaine, Director, Data Quality and Analytics

Rhode Island Quality Institute

50 Holden St., Suite 300

Providence, RI 02908

Office: 401-276-9141, ext. 284

efontaine@riqi.org

***Care Management Dashboard Project***

***Application Package Submission Checklist***

**Rhode Island Quality Institute**

**Due Date: December 31, 2015 by 5:00 pm**

|  |  |
| --- | --- |
| **Check if complete** | **Item** |
| Final Package for Submission |
|  | Completed Application Package Checklist |
|  | Cover letter indicating the practice’s commitment and acceptance of the conditions stated in the application, signed by the organization’s CEO, CMO and care management champion.  |
|  | Copy of current NCQA Recognition indicating recognition at Level 2 or greater. |
|  | Application Form, filled out completely |
|  | Written response to four essay questions |
|  | Copy of practice level performance on quality measures for periods ending Q2 2014 and Q2 2015. |

**Completed application packages – including completed checklist - should be received by 5:00 PM on 12/31/15. Email application package to:** efontaine@riqi.org

**For questions, contact:**

Elaine Fontaine

Director, Data Quality and Analytics

Rhode Island Quality Institute

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***Application for Care Management Dashboard Project***

**Rhode Island Quality Institute**

**Due Date: December 31, 2015 by 5:00 pm**

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| **Pre-Requisites** |
| Does your practice agree to a randomized staggered entry into the pilot to use RIQI’s Care Management Dashboard? |  |
| Current NCQA Level 2 recognition or above | Level:Year:Expiration:Please provide a copy with your application |
| Presence of a nurse care manager in the practice at least 20 hours per week | Number of Nurse Care Mangers (FTE): |
| A high-risk patient panel of not more than 330 patients at a site location **or** a willingness to limit the patients included in the project to a subset of those assigned to a limited number of providers in the practice.  | Number of patients identified as high-risk:If the number of high-risk patients in the practice is greater than 330, is the practice willing to limit the number of high-risk patients to a specific set of providers to participate in the pilot?  |
| **Practice Information** |
| Practice Name |  |
| Address |  |
| Phone |  |
| Type of Practice(e.g. Adult, Family, FQHC, Hospital-Based Clinic) |  |
| Multisite Practice |  |
| Date of Entry into CTC |  |
| Participating in ACO / Risk Contracts? |  |
| Participating in Community Health Team? |  |
| Participating in Integrated Behavioral Health Program? |  |
| CEO Name |  |
| CEO email |  |
| CMO Name |  |
| CMO email |  |
| Care Management Champion Name |  |
| CM Champion email |  |
| Practice Manager Name |  |
| Practice Manager email |  |

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| --- |
| **Provider Information**  |
| Number of FTE Clinical Providers |  |
| Number of FTE Nurse Care Managers |  |
| Number of Community Health Workers |  |

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| --- | --- |
| **NPI (MD, DO, PA, NP)** | **Name** |
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| **Practice Payer Mix** |

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| --- | --- | --- | --- | --- | --- |
| Payer | Number of Pts | Number of High Risk Patients | Payer | Number of Pts | Number of High Risk Patients |
| Medicare Adv |  |  | NHP-RI |  |  |
| Medicare FFS |  |  | Tufts |  |  |
| Medicaid FFS  |  |  | Medicaid MCO |  |  |
| BCBS |  |  | Insured Other |  |  |
| United |  |  | Uninsured |  |  |

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| **Questions About Current Care Management Processes For High-Risk Patients** |
| **Question** | **Response****Yes/No** | **Comment** |
| Does the practice have documented workflow in place for management of discharge planning and post-discharge follow-up for high-risk patients? |  |  |
| Does the practice have a documented workflow in place for management of data and notifications concerning patient admissions and discharges from the inpatient or emergency department settings? |  |  |
| Does the practice track time between hospital discharge and patient outreach and follow up visits? If not, is the practice able to collect that data for this project – at baseline, 6 months, 12 months and 18 months after implementation? |  |  |
| Does the practice track discharge planning and post-discharge follow-up interactions with the patient and time spent on those activities (phone calls, home visits, etc.)? If so, how are these data stored? If not, is the practice able to collect that data for this project- at baseline, 6 months, 12 months and 18 months after implementation? |  |  |
| Is the practice interested in or already in conversations or contracted with RIQI to provide care management alerts or dashboards for their practice or any subset of their panel? |  |  |
| Does the practice have integrated EMR and Care Management Software |  |  |
| Does the practice have a shared direct address or does each provider have a direct address? |  |  |

**Essay Questions:**

**Please provide a response to each question (limit responses to a maximum of 500 words per question)**

**Questions 1 -3 will be scored:**

1. One of the qualities of successful practices is strong physician and/or organizational leadership with commitment to practice transformation and broad support from practice team.
	1. Please describe the physician, NCM and top organizational leadership commitment to transformation in your practice.
	2. Please identity the qualifications of the person who will be designated as project manager for this project
	3. Is there broad support for this project from all nurse care managers and providers in the practice?
	4. What are the anticipated barriers in moving this project forward and how would the organization respond?
2. Please describe a successful implementation of workflow redesign conducted at your practice in the past 18 months. Include details about your data systems and the metrics used to demonstrate the effectiveness of the project.
3. Please describe a successful improvement project associated with your quality measures conducted at your practice in the past 18 months. Include details about your data systems and copies of your reporting/metrics used to demonstrate the effectiveness of the project.

**Question 4 is Informational Only – *Please submit a separate file*, which will be reviewed only after practice selection has been completed:**

Rhode Island Foundation’s Fund for a Healthy Rhode Island is funding the implementation of the Care Management Dashboard with predictive modeling data for up to 10,000 high risk patients for in up to 30 practices for a limited time period (through October 2018). The expectation is that the product will significantly improve the ability of practices to succeed in value-based contracts by helping to identify and prioritize outreach to patients for discharge planning and post-discharge follow up. To better understand the long-term sustainability of this project, we would like to know if and how you envision your organization being able to fund Care Management Dashboards or other similar fee-based products:

a. For the broader population in your practice not covered by this project?

b. At the end of the pilot project?

RIQI anticipates more applications than available slots, therefore it is critical that applications for participation in the RIQI Care Management Dashboard Project be reviewed and scored in an objective, fair, and transparent manner. The following reflects procedure for application review:

**Conflict of interest:**

Reviewers must disclose any potential conflict of interest related to a specific applicant. A conflict of interest is defined as a real or potential monetary benefit or having an organizational affiliation with the applicant. The Selection Committee will discuss the potential conflicts of interest and make a determination of whether a conflict of interest exists. If so, the reviewer must recuse themselves from the review of that application.

**Selection Committee Group Process for Review of Total Scores:**
The Selection Committee will convene in January 2016, when a primary and secondary reviewer will present and discuss the rationale for scoring. *The Selection Committee reserves the right to interview applicants if further review is warranted.*

The group will then discuss the ratings to reach consensus on application scoring. Final scores will be entered into a spread sheet. Once this process has been completed for all applications, the applications will be rank-ordered by their base score.

**Review Criteria:**
All reviewers will read and score each application independently using the scoring form and criteria established by the Selection Committee. Reviewers will submit their scores to RIQI by January 22, 2016. RIQI will compile all scores into one table per application with a total number of points. The maximum number of points is 100.

We anticipate that we will select up to 10,000 attributed high-risk patient lives individuals at up to 30 practice sites. The primary limitation is number of covered high-risk patients.

In the event of a tie, the following criteria will be used to establish a supplemental score:

1. Completion of application-submitted on time and complete;
2. Number of Medicaid members-we desire a balance in population served;
3. Participation in value-based contracting outside of CTC;
4. Demonstrated improvement on practice-level quality measures from Q2 2014 to Q2 2015.

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| **Topic** | **Scoring** | **Score** |
| **Prerequisites (min:** |
| **NCQA (min 5, max 10)** |  |
| Level 2 achieved  | 5 |  |
| Level 3 achieved  | + 5 |  |
| **Nurse Care Managers (min 10)** |  |
| > 0.5 FTE | 10 |  |
| **High Risk Panel Limitation (min 10)** |  |
| < 330 High-Risk Patients or the ability to limit the list based on PCP assignment or the ability to self-fund pmpm for additional patients | 10 |  |
| **Differentiators:** |
| **Workflow and Data Systems (min 0, max 25 )** |  |
| Workflow for discharge planning for high-risk patients is documented, including flowcharts. | 5 |  |
| Workflow for post-discharge follow-up for high-risk patients is documented, including flowcharts. | 5 |  |
| There are data collection systems in place to capture nurse care manager work efforts associated with discharge planning. | 5 |  |
| There are data collection systems in place to capture nurse care manager work efforts associated with post-discharge follow-up | 5 |  |
| The practice currently routinely (at least monthly) reports on NCM work efforts. | 5 |  |
| **CurrentCare (min 0, max 6)** |  |
| Enrolling patients | 1 |  |
| More than 50% enrolled  | 1 |  |
| Sharing data with CurrentCare | 1 |  |
| Use of CurrentCare Viewer or Cross Document exchange in past 3 months | 1 |  |
| Contracted to receive CurrentCare Hospital Alerts | 1 |  |
| **Technology (min 0, max 10)** |  |
| Integrated EMR and Care Management (Care Planning) Software | 5 |  |
| Direct Account | 5 |  |
| **Essay Questions (min 0, max 30)** |  |
| Practice Leadership and commitment to the project | 10 |  |
| Successful workflow redesign experience | 10 |  |
| Successful quality measure improvement experience | 10 |  |
| **Base Score** |
| **Tie Breakers:** |
| Application complete, properly formatted, and on-time | 1 |  |
| Percent of practice panel who represent underserved patients  | 2 |  |
| Participation in any value-based contracting outside of CTC | 5 |  |
| Demonstrated practice-level improvement on quality or patient experience measures from Q2 2014 to Q2 2015. | 5 |  |
| **Supplemental Score (used in the event of a tie)** |  |  |