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**CTC-RI Practice Transformation Program**

The CTC-RI practice transformation program is focused on assisting your practice with meeting the core elements outlined in the Service Delivery Model and the RI Office of the Health Insurance Commissioner’s (OHIC) patient centered medical home definition. The program is designed to help prepare your practice for patient centered population health management and to perform successfully in alternative payment contracts.

There are multiple facets to the program including support for Patient Centered Medical Home transformation (PCMH) and managing information for performance improvement. CTC offers learning network opportunities and incentive payments for achieving results.

A practice facilitator is assigned to your practice to increase your internal capacity for improving health outcomes, help patients have better care experiences and manage overall costs, with special emphasis on transitions of care and emergency department and inpatient utilization. Your practice facilitator will provide direct assistance with achieving NCQA practice centered medical home recognition, meeting the Rhode Island Office of the Health Insurance Commissioner’s PCMH definition and meeting the CTC-RI contract requirements.

If your practice is part of a system of care (i.e. Charter Care, Lifespan, Coastal, RIPCPC or other accountable entity), your system of care will be providing your practice with support for practice reporting and meeting the patient centered medical home competencies that are part of the NCQA PCMH program. The CTC practice facilitator will be working collaboratively with your practice and the SOC practice facilitator to support your efforts.

What practice transformation support will be available to your practice?

Practice Facilitation services (adjusted based on your SOC support):

1. One-on-one site visits from your assigned practice facilitator who will provide direct support with meeting the NCQA patient centered medical home standards and submitting the application;
2. Support in the implementation of core PCMH principles, such as engaged leadership, team-based care, patient engagement, improving partnership with specialists and building the medical neighborhood;
3. Help in optimizing scheduling to provide same-day and after-hour access;
4. Help in the integration of the nurse care manager into the care team, inclusive of a web-based core curriculum nurse care manager training curriculum and coaching support from a CTC-RI nurse care manager faculty member;
5. Assistance in meeting the OHIC PCMH definition.

What practice reporting services are available (adjusted based on if you are part of a SOC):

1. Assistance with understanding how to report on the CTC quality measures;
2. Learning how to capture data and information for quality and process improvement
3. Using Current Care to improve care transitions

What are the expectations of your practice?

**Time and commitment:**

There is a minimum expectation that the practice will meet with the practice facilitator according to the following schedule:

Year 1: twice a month with telephone conferences in between meetings as needed

Year 2: once a month

Year 3: once a quarter

**Quality improvement informed by data and reporting is an integral part of the CTC program.**

Minimum practice expectations: The practice will appoint a PCMH team which will meet a minimum of once a month to develop systems to support principles of being a patient centered medical home and practicing quality improvement, such as developing and implementing PDSA (Plan, Do Study, Act) cycles to drive and sustain improvement.

Best practice sharing and committee based learning are some of the fundamental strengths of the CTC program. Practices have varied backgrounds and affiliations, but all have the common goal of improved quality, enhanced patient experience, and cost containment. As a CTC practice, you will be expected to participate in best practice sharing (attend 50% of learning network meetings with Practice Reporting Committee as a required meeting) – not only to learn from others, but also to offer your experiences to others.

What are the benefits to your practice?

Support for providing better patient care within your practice team

Practices that have been part of CTC-RI report that team members learn to work together, develop skills, and form relationships with other primary care practices that result in better care for the patients and families and more joy in practice for the practice team.

Primary Care Voice

CTC-RI provides primary care practices with a mechanism for learning from others. Joining a primary care network that works together with the health plans helps practices achieve better care, smarter spending, and healthier people. Your practice will be ready to succeed in other quality payment programs including those offered by the Rhode Island OHIC and the Medicare Access and CHIP Re-Authorization Act of 2015 (MACRA).

Obtain Infrastructure and Incentive Payments for Care Transformation

Under CTC, your practice/System of Care will receive supplemental payments1 for three years from health plans in the multi-payer initiative to transform your practice and be recognized as a patient centered medical home (PCMH), be better prepared to practice within systems of care, and receive enhanced payments made available through the Office of the Health Insurance Commissioner and local health plans.[[1]](#footnote-1)

1. 1**3.50** per member per month for pediatric practices in Year 1, $3.00 in Year 2 and 3 with opportunity for incentive payment ($.50 pmpm) in Years 2 and 3 for achieving improvements in quality, customer experience and utilization thresholds [↑](#footnote-ref-1)