Rhode Island PCMH Cost Management Strategies
Self-Assessment Tool
June 13, 2016

Name of Practice: ___________________________________

Name of Contact: ___________________________________ **e-mail Address:** ___________________________

Practice Address: ___________________________________ **Phone Number:** ____________________________

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Contracted provider for (check all that are applicable):

____ **Blue Cross Blue Shield of Rhode Island**

____ **Neighborhood Health Plan of Rhode Island**

____ **United Healthcare**

____ **Tufts Health Plan**

NPI numbers for all clinicians managing a patient panel: (list each MD's, NP's, PA's NPI, adding additional spaces, as necessary)

1. _________________
2. _________________
3. _________________
4. _________________
5. _________________
6. _________________
7. _________________
8. _________________
9. _________________
10. ________________

Transformation Year:

- Less than one year ("Year 1"): practice joined CTC on January 1, 2016; joined TCPI in 2016; or practice is not participating in any transformation initiative
- One to two years ("Year 2"): practice joined CTC on January 1, 2015 or independently achieved NCQA PCMH Level 3 recognition during 2015
- Three or more years ("Year 3"): practice joined CTC prior to January 1, 2015 or independently achieved NCQA PCMH Level 3 recognition prior to January 1, 2015.

Date survey completed: __________________________

Background:

The following standards must be met by primary care practices seeking PCMH designation from Rhode Island payers in order to qualify for medical home financial support, consistent with terms of the OHIC-approved 2016 Care Transformation Plan.

Practices that have received NCQA PCMH Level 3 designation will be deemed to have met all requirements listed below that are substantially the same as one or more NCQA PCMH requirements.

To meet the OHIC definition of a PCMH, practices must have implemented 80% of the requirements specified for their transformation year by the survey date.

Instructions: Please ask the staff most knowledgeable about the activities of the practice to complete the following survey. Please answer honestly using the most accurate information available.

<u>Requirement #1: The practice develops and maintains a high-risk patient registry:</u>

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services (referred to as "high-risk patients).	NCQA: requirement deemed met if 2011 NCQA PCMH 3, Element B or 2014 NCQA PMCH 4, Element A is met TCPI: requirement deemed met if Milestone 4D is achieved	**X**	**X**	**X**		

<table>
<tr><th rowspan="2">Cost Management Requirement</th><th rowspan="2">Deeming Option</th><th colspan="3">Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:</th><th colspan="2">Practice Self-Assessment</th></tr>
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<tr><td>2. Using information from a variety of sources, including payers and practice clinicians, the practice updates the list of high-risk patients at least quarterly.</td><td>NCQA: requirement deemed met if 2011 NCQA PCMH 3, Element B or 2014 NCQA PCMH 4, Element A is met AND practice is using payers and practice clinicians to update high-risk patient lists AND lists are updated at least quarterly.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>3. To identify high-risk patients, the practice has developed a risk assessment methodology that includes at a minimum the consideration of the following factors:
a. assessment of patients based on co-morbidities;
b. inpatient utilization, and
c. Emergency Department utilization.</td><td>NCQA: requirement deemed met if 2011 NCQA PCMH 3 or 2014 NCQA PCMH 4, Element 4 is met.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
</table>

Requirement #2: The practice offers Care Management/Care Coordination services with a focus on high-risk patients enrolled with the carriers that are funding the Care Management/Care Coordination services. Other staff may provide Care Management/Care Coordination services in addition to the designated Care Manager or Care Coordinator so long as those services promote care management and care coordination and are provided under the direct supervision of the Care Manager or Care Coordinator.

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform all of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has a designated resource(s) that at the minimum includes a trained licensed Registered Nurse or Social Worker Care Coordinator for pediatric practices to provide Care Management/Care Coordination services that focuses on providing services to high-risk patients.	NCQA: requirement deemed met if 2011 NCQA PCMH 3 or 2014 NCQA PCMH 4 is met AND practice employs an RN/LPN or social worker as CM/CC.	**X**	**X**	**X**		
2. The practice has an established methodology for the timely assignment of levels of Care Management/Care Coordination service needed by high-risk patients based on risk level, clinical information including disease severity level and other patient-specific characteristics. The purpose of the assessment is to promptly identify which high-risk patients should be in the Care Manager's/Care Coordinator's active caseload at any point in time.	TCPI: requirement deemed met if Phase 3H is achieved and practice's methodology includes consideration of clinical information, including severity level and other patient-specific characteristics.	**X**	**X**	**X**		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
3. The Care Manager/Care Coordinator completes within a specified period of time <u>(from the time that the high-risk patient is placed in the Care Manager's/Care Coordinator's active caseload)</u>[1] a patient assessment based on the patient's specific symptoms, complaints or situation, including the patient's preferences and lifestyle goals, self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk. For children and youth, the care coordinator shall complete a family assessment that includes: a. a family status and 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 & family), and b. a growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance and needs, and emotional/behavioral strengths and needs).	NCQA: requirement is deemed met if NCQA 2011 PCMH 3, Element C or NCQA PCMH 4, Element B is met AND the practice has established and implemented a process within specified timeframes for assessing and adding new patients onto the high-risk patient list, based on care manager capacity.	X	X	X		

[1] Assessment is initiated within one week, with at least three contact attempts (if needed) within two weeks. Assessment must be completed within two weeks of caseload assignment, unless patient is non-responsive to outreach.

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<tr><td colspan="2">The practice must perform <u>all</u> of the following functions:</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4. Working with the patient and within two weeks of completing the patient assessment, the Care Manager/Care Coordinator completes a written care plan, that includes:
a. a medical/social summary;
b. risk factors;
c. treatment goals;
d. patient-generated goals;
e. barriers to meeting goals, and
f. an action plan for attaining patient's goals.</td><td>NCQA: requirement is deemed met if 2014 NCQA: PCMH 4, Element B is met AND practice is meeting the required timeline.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>5. The Care Management/Care Coordination resources update the written care plan on a regular basis, based on patient needs to affect progress towards meeting existing goals or to modify an existing goal, but no less frequently than semi-annually.</td><td>NCQA: requirement is deemed met if NCQA PCMH 3, Element C or 2014 NCQA PCMH 4 is met AND practice is developing care plans for all patients on the high-risk patient list and are meeting the timeframe for updating the care plan.</td><td></td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>6. For high-risk patients known to be hospitalized or in a SNF, the Care Management/Care Coordination resources shall contact the patient and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient's discharge.</td><td>NCQA: either 2011 or 2014 NCQA PCMH 5, Element C is met AND the practice is beginning TOC planning within the required timeframe.</td><td></td><td>X</td><td>X</td><td></td><td></td></tr>
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<tr><td colspan="2">The practice must perform <u>all</u> of the following functions:</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>7. The Care Management/Care Coordination resources contact every high-risk patient who has been discharged from hospital inpatient services after discharge to determine care management needs.

• Year 1: within 72 hours after discharge.
• Years 2 and 3: within 48 hours after discharge.</td><td>NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element C is met AND the practice is meeting the specific timeframe for completing the outreach contacts.

TCPI: requirement is deemed met if Phase 3 N is achieved.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>8. The Care Management/Care Coordination resources contact every known high-risk patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient's high-risk status.

• Year 1: within 72 hours of an ED visit.
• Years 2 and 3: within 48 hours of an ED visit.</td><td>NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element C is met AND practice is meeting the specific timeframe for completing the outreach contacts.

TCPI: requirement is deemed met if Phase 3 N is achieved.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
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<tr><td colspan="2">The practice must perform <u>all</u> of the following functions:</td><td>Yr 1</td><td>Yr 2</td><td>Yr 3</td><td>Fully or Substantially Achieved</td><td>Not Achieved</td></tr>
<tr><td>9. The Care Management/Care Coordination resources complete a medication reconciliation after a high-risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person.

• Year 1: within 7 days of discharge.
• Years 2 and 3: within 72 hours of discharge.</td><td>NCQA: requirement is deemed met if 2011 NCQA PCMH 3, Element D or 2014 NCQA PMCH 4, Element C is met AND the practice is meeting the specific timeframe for completing the medication reconciliations.

TCPI: requirement is deemed met if Phase 2 F is met AND the practice selected medication management review as one of its case management strategies.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
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Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
10. The Care Management/Care Coordination resources arrange for, and coordinate all medical, developmental, behavioral health and social service referrals and tracks[2] referrals and test results on a timely basis for high-risk patients.	NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 5, Element A is met. TCPI: requirement is deemed met if Phase 4 E is achieved.	**X**	**X**	**X**		
11. The Care Management/Care Coordination resources provide health and lifestyle coaching for high-risk patients designed to enhance the patient's/caregiver's self/condition-management skills.	NCQA: requirement is deemed met if 2011 NCQA PHC 4, Element A or 2014 PCMH 4, Element E is met.	**X**	**X**	**X**		
12. Practices shall provide patient-engagement training to Care Managers/Care Coordinators, as necessary, to achieve these requirements.	NCQA: requirement is met if 2014 NCQA PCMH 2, Element 6 is met. TCPI: requirement is met if Phase 1 D is achieved AND training topics include patient engagement.	**X**	**X**	**X**		
13. The Care Management/Care Coordination resources have in-person or telephonic contact with each high-risk patient at intervals consistent with the patient's level of risk.		**X**	**X**	**X**		

[2] Consistent with 2014 NCQA PCMH recognition Standard 5, Element B, "tracking" here means that the practice "tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports."

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
14. The Care Management/Care Coordination resources participate in relevant team-based care meetings to assure whole-person care is provided to high-risk patients. For pediatric practices, participants in practice-initiated team meetings 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.	NCQA: requirement is deemed met if 2011 NCQA PCMH1, Element G or 2014 NCQA PCMH2, Element D is met.	**X**	**X**	**X**		
15. The Care Management/Care Coordination resources use HIT to document and monitor care management service provision.		**X**	**X**	**X**		
16. The Care Management/Care Coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery	NCQA: Allow deeming. TCPI: Allow partial deeming when Phase 2.H is achieved. Separately verify that PDSA cycles assess and improve effectiveness of care management service delivery Allow deeming when Phase 4.A milestone is achieved.	**X**	**X**	**X**		

Requirement #3: The practice improves access to and coordination with behavioral health service.

Cost Management Requirement	NCQA Requirement	TCPI Requirement	Deeming Recommendation	
The practice has implemented one of the following approaches to behavioral health integration by the end of Year 1:			**Fully or Substantially Achieved**	**Not Achieved**
1. To promote better access to and coordination of behavioral health services, the practice has developed preferred referral arrangements with community behavioral health providers such that appointments are available consistent with the urgency of the medical and behavioral health needs of the practice's patients and there is an operational protocol adopted by the PCP and the preferred specialists for the exchange of information. The terms of the preferred arrangement are documented in a written agreement.				
2. To promote better access to and coordination of behavioral health services, the practice has arranged for a behavioral health provider(s) to be co-located (or virtually located) at the practice for at least one day per week and assists patients in scheduling appointments with the on-site provider(s).				
3. To promote better access to and coordination of behavioral health services, the practice is implementing or has implemented a co-located (or virtually located), integrated behavioral health services model that is characterized by licensed behavioral health clinicians serving on the care team; the team sharing patients, and sharing medical records, and the practice promoting 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).

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform all of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has a written policy to respond to patient telephone calls within the following timeframes: a. For urgent medical/behavioral calls received during office hours, return calls are made the same day. b. For urgent calls received after office hours, return calls are made within 1 hour. c. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.	NCQA: requirement is deemed met if 2011 NCQA PCMH 1, Element B or 2014 NCQA PCMH 1, Element B is met AND the practice has written policies that meet the specified time frames for responding to patient calls.	X	X	X		
2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day. • Years 1 and 2: for urgent care only. • Year 3: for urgent and routine care. Routine care is care that patients believe they need but not "right away."	NCQA: requirement is deemed met if 2011 or 2014 PCMH 1, Element A is met.	X	X	X		
3. The practice has an agreement with (or established) an urgent care clinic or other service provider which is open during evenings and weekends when the office is not open as an alternative to receiving Emergency Department care.		X	X	X		

Cost Management Requirement	Deeming Option	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform <u>all</u> of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
4. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access.	NCQA: requirement is deemed met if NCQA 2014, Element A is met. TCPI: requirement is deemed met if Phase 2 H is achieved and practice's PDSA cycles are designed to assess and improve the effectiveness of its programs to expand access. Requirement is deemed met when Phase 4 is achieved.	**X**	**X**	**X**		

<table>
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<tr><td colspan="2">The practice must perform <u>at least 2</u> of the following functions:</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>5. The practice has created a secure web portal that enables patients to:
• send and receive secure messaging;
• request appointments;
• request referrals;
• request prescription refills, and
• review lab and imaging results (beginning in Year 2).

The practice clearly communicates to patients that the portal should not be used for urgent matters and that patients should call the practice under such circumstances.</td><td>NCQA: requirement is deemed met if 2011 or 2014 NCQA PCMH 1, Element C is met.</td><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>6. The practice has expanded office hours so that services are available at least two mornings or two evenings a week for a period of at least 2 hours beyond standard office hours.
• Year 2: urgent care only.
• Year 3 urgent and routine care.</td><td></td><td></td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>7. The practice has expanded office hours so that services are available at least four hours over the weekend. Services may be provided by practice clinicians or through an affiliation of clinicians, so long as the affiliated physicians are able to share medical information electronically on a near real- time basis through either a shared EMR system or by ready access to a patient’s practice physician who has real-time access to patient’s medical records.
• Year 2: urgent care only.
• Year 3 urgent and routine care.</td><td></td><td></td><td>X</td><td>X</td><td></td><td></td></tr>
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Requirement #5: The practice refers patients to specialty and ancillary providers who are known to provide high quality, efficient services (e.g., value-based care.)

Cost Management Requirement	Deeming Recommendation	Transformation Year by which requirements must be implemented. Requirements must be met by the survey date:			Practice Self-Assessment	
The practice must perform all of the following functions:		**Yr 1**	**Yr 2**	**Yr 3**	**Fully or Substantially Achieved**	**Not Achieved**
1. The practice has developed referral protocols for its patients for at least two of the following: a. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist; b. laboratory services; c. imaging services; d. physical therapy services, and e. home health agency services.	TCPI: requirement is deemed met once Phase 2 B is achieved and formal agreements are with community partners detailed in this requirement.	**X**	**X**	**X**		
2. Should one or more payers provide the practice with readily available, actionable data, the practice has used such data 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") and prioritizes referrals to those providers.			**X**	**X**		