RI Care Transformation Collaborative (CTC) Nurse Care Manager (NCM)
Strategy Checklist for meeting Service Delivery Requirement: Develop High Risk Registry and Reportable Fields for Care Management (Due 12/31/17)

Rhode Island Quality Institute and CTC have developed this checklist to assist practices with achieving the December 2017 service delivery requirement to develop high risk registry and reportable fields for care Management. This is a guide to help navigate the requirements with the understanding that practices need to be able to report on engagement with high risk patients by April, 2018.

Note: There are two quarterly reports for reporting on NCM engagement with high risk patients: 1) Goes to Health Plans: Patient specific engagement reports (BCBSRI, Tufts, NHPRI) and 2) Goes to CTC: Aggregated Report on NCM engagement on health plan identified high risk patients

Practice Name: **Practice Location:**

Certified EHR Vendor/Version:

Important Steps: What is due December 31, 2017	Recommend that you coordinate with you practice facilitator prior to 12/22/17 as staff may have time off during the holiday season
By December 31, 2017 - Practice reviews with practice facilitator plan for capturing high risk patients as defined by CTC and health plans	☐ **Plan for capturing high risk patients reviewed**
-Practice reviews with practice facilitator plan for capturing NCM engagement per patient specific health plan reporting requirements	☐ **Health Plan Patient Specific Reporting Plan: for capturing NCM engagement per patient specific health plan reporting requirements reviewed**
-Practice reviews with practice facilitator plan for reporting aggregated NCM engagement reporting on high risk patients per CTC reporting requirements	☐ **CTC Aggregate NCM Engagement Plan: for reporting on high risk patients**
- Practice facilitator reports to CTC practice status on meeting service delivery requirement: Develop high risk registry and reportable fields for NCM reporting	**Practice Facilitator: _____ Date: _____** **Adult practices: submit to Candice Brown: candice.brown@ummassmed.edu** **PCMH Kids practices: submit to Michele Brown: michele.brown@umassmed.edu** **Due Date: 12/31/17**

Define Practice/ACO roles and responsibilities

- ☐ On-going: Attend Nurse Care Manager/CC and Practice Reporting Best Practice Sharing Collaborative
- ☐ Attend health plan webinars on how to access high risk patient information
- ☐ The practice team reviews important documents to learn requirements
  - ✓ Review "How to Access Health Plan High Risk Patient Information.
  - ✓ Review "CTC NCM Measurement Specification " document
  - ✓ Review "Nurse Care Manager Engagement Report" included with the NCM Measurement Specification Document
  - ✓ Review BCBSRI 2018 Policy
  - ✓ Review NCQA 2017 care management core competencies
  - ✓ Review OHIC cost management strategies
- ☐ Review with ACO leadership work that will be done centrally and locally (if applicable)
- ☐ Identify person to develop and generate health plan high risk reports
- ☐ Identify person to provide health plan high risk patient reports to NCM
- ☐ Identify person to report to CTC on NCM Engagement with high risk patients per stated schedule:
- ☐ Identify person to report to specific health plans on patient specific engagement results through secure method
- ☐ Plan for disseminating results within practice for performance improvement

Health Plan Patient Specific Reporting:

Creating high risk registry and NCM template for being able to document and provide health plans with quarterly patient specific NCM engagement with high risk patients (BCBSRI, Tufts, NHPRI)

Best Practice is to understand and create mechanisms to report out of the EHR; if that is not possible, will need to develop strategy such as using excel spread sheets.

- ☐ Review with ACO (if applicable) what work will be done centrally and at the practice level
- ☐ Examine EHR capabilities for recording NCM activity and flagging high risk patients;
- ☐ Contact EHR vender or other practice using same EHR to gain assistance on potential options for reporting out of EHR -
- ☐ Identify how to flag high risk patients in EHR (best practice strategy)
- ☐ Develop NCM reporting template with reportable fields -

  Engagement status (actively engaged, not engaged, case closed)Reason:

  Not enrolled: In LTC, d/c from practice, patient refused, unable to reach after 3 attempts, expired

  Closed: goals met, expired, LTC placement, Patient stopped participating, d/c from practice

  Status date: date of most recent NCM/CC engagement with patient or another CM provider (VNA, CHT, IBH)

- ☐ Identify and address any problems with EHR reporting capabilities
- ☐ Develop reports – run test reports and examine for accuracy prior to 3/31/18

☐	**CTC Aggregate Report on NCM Engagement with High Risk Patients: Create Plan for quarterly CTC high risk patient NCM engagement reporting** ☐ Denominator: # of high risk patients per health plan (BCBS, Tufts, NHPRI, United) Managed Medicaid for United* and NHPRI applicable with 200 or more attributed lives ☐ Numerator: # of patients with NCM engagement with high risk patients per health plan (NCM encounter date) ☐ Determine options for practice to capture NCM engagement with health plan high risk patients (i.e. NCM telephone encounter form, face to face encounter, home visit); Note: practice does not need to report specific encounter type ☐ Determine how practice will add information on practice identified high risk patients ☐ By April 15th: Report on NCM engagement with all high risk patients (health plan agnostic and health plan specific) and NCM engagement with high risk patients per health plan ***United expects practice to use high risk patient reports and have NCM engagement; does not expect practices to send to United the patient specific results of NCM engagement.	
	Timeline for required Quarterly Submission of NCM measures: *(use rolling quarters)* *a) Patient Specific Report to Health plans (BCBS, Tufts, NHPRI) : sent directly to health plans per health plan specifications* *b) CTC aggregated health plan reports on patient engagement with high risk patients* Due 4/15/2018; Q1 2018 Due 7/15/2018; Q2 2018 Due 10/15/2018; Q3 2018 Due 1/15/2019; Q4 2018 Due 4/15/2019; Q1 2018 Due 7/15/2018; Q2 2018 Due 10/15/2018; Q3 2018	The portal form assumes all measures are submitted at the same time so it's best to have all results ready at time of submission. If this is not possible, you may submit data on more than one occasion. Be sure to follow instructions on the form about submitting with missing data. -If you do not receive an email about a week before submission deadline, go to **https://www.ctc-ri.org**, locate your practice site and submit your high risk patient engagement data -Follow health plan directions for submitting patient specific engagement information to health plans.