PCMH CTC Adult Service Delivery Requirements July 2017 Expansion

Practices agree to fulfill CTC's Program care delivery requirements as described on line (www.ctc.ri.org). All reports and measures identified in the Care Delivery Requirements use methodology as defined and approved by the CTC Data and Evaluation Committee. Requirements may be subject to change based on changes to requirements (i.e. OHIC, NCQA).

Measurement Period	Care Delivery Requirement	Date Due (if applicable) Due last day of month
Start Up (MP 1) 7/1/17 to 6/30/18		
Care Management	Hire 1.0 Nurse Care Manager (NCM)/Care Coordinator for every 3,000 attributed patients ($2.50 pmpm)	Month 4
	Develop High Risk Registry and reportable fields for care management. Confirm completion with CTC	Month 6
	NCM/CC completes standardized learning program as defined by CTC	Month 7
	Report level(s) of engagement of high risk patients as defined by CTC	Month 9
	Submits to OHIC Cost Management Attestation	October 15
Planned Care: Population Health /Quality Reporting	Submit clinical quality data as defined in Performance Incentives Exhibit 3	Month 6
	Submits to OHIC quality measure information	October 15
Access and Continuity	Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients	Month 6
	Submit before and after hours protocol, as defined by CTC	Month 9
Patient/Family Engagement	CAHPS survey: Submits patient panel to approved data vendor (or "How's Your Health" option to be determined	Timeframe determined by CTC
Comprehensiveness and Coordination	Submits Transition of Care Policy and Procedure	Month 6
	Identifies high volume specialists serving patient population and submits 2 compacts**:** a) high volume specialist b) behavioral health	Month 9
Practice transformation	Submits budget and staffing plan and use of funds to support care delivery model to CTC	Month 3
	Submit NCQA PCMH work plan to CTC	Month 9
	Meets with Practice Facilitator 1-2 x a month	Month 1 and on-going
	Attends 50% of learning network meetings [1]	Month 1 and on-going

[1] Learning Network Meetings: Orientation, Best Practice Meetings, Breakfast for Champions, and Large Learning Collaborative

Measurement Period 2 (MP 2) 7/1/18 to 6/30/19	**CTC PCMH Adult Care Delivery Requirements**	**Due Date (if applicable) Due last day of month**
Care Management	Submits reports on high risk patients, as defined by CTC, to Health Plans and CTC and achieves 40% engagement rate	Quarterly (July/October/January/April)
	Submits to OHIC Cost Management Strategy Attestation	October 15
	Submits report that demonstrates 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days	Month 12
Planned Care: Population Health /Quality Reporting	Submits quarterly quality data	January/April/July/October
	Submits to OHIC quality data information	October 15
Access and Continuity	Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients	Quarterly
	Submit to CTC screenshots demonstrating patient access to a secure web portal, enabling secure messaging, appointment requests, referrals, and prescription refills.	Month 3
	Submits schedule demonstrating that it has expanded office hours as defined by OHIC Cost Management Strategies	Month 6
Patient/Family Engagement	Submits patient panel for CAHPS survey to qualified data vender (or "How's Your Health" option to be determined)	Timeframe determined by CTC
Comprehensiveness and Coordination	Provides report that demonstrates that 75% of high risk patients who were hospitalized receive a follow up interaction including medication reconciliation within 2 business days	Month 6
Practice Transformation	Submits a quality improvement activity for improving a performance measure (Quality/customer experience/utilization)	Month 2
	Submits a quality improvement activity demonstrating performance to improve a performance measure	Month 7
	Submits NCQA PCMH recognition application	Month 9
	Meet with practice facilitators at a minimum of once per month	On-going
	Attends 50% of Learning Network Meetings	On-going

Measurement Period MP 3 7/1/19 -6/30/20	CTC PCMH Adult Care Management Requirement	Due Date (if applicable) Last day of month
Care Management	Submits reports on high risk patients, as defined by CTC, to Health Plans and CTC and achieves 40% engagement rate	Quarterly (July/October/January/April)
	Provides report that demonstrates that 75% high risk patients with ED visit receive a follow interaction including medication reconciliation within 1 week of discharge 6 month	Month 6
	Submits attestation to OHIC and demonstrates achievement 80% of Cost Management Strategy elements	Oct 15
Planned Care: Population Health /Quality Reporting	Submits quarterly data	July/October /January/April
	Submits to OHIC quality data measurement report	October 15
Access and Continuity	Reports to CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment for existing patients	Quarterly
Patient/Family Engagement	Submits patient panel for CAHPS survey to approved data vender (or How's Your Health option to be determined)	Timeframe determined by CTC
Comprehensiveness and Coordination	Submits 2 additional compacts as defined by OHIC cost management strategies	Month 6
Practice Transformation	Achieves NCQA PCMH recognition	Month 2
	Meet with CTC practice facilitators once per quarter	Month 1 and quarterly
	Attends 50% of Learning Network meetings	Month 1 and quarterly