PCMH Kids Service Delivery Requirements

Practices agree to fulfill CTC’s Program care delivery requirements as described on line ([www.ctc-ri.org](http://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 updated guidelines from such parties as OHIC, NCQA

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| **Measurement Period** | **PCMH-Kids Care Delivery Requirements** | **Date Due (if applicable) last day of month** |
| **Start Up (MP 1)**  1/1/19 to 12/31/19 |  |  |
| **Care Management** | Hire 1.0 FTE (prorated based on actual attribution) Nurse Care Manager (NCM) or Care Coordinator for every 3,000 attributed patients ($2.50 pmpm) | Month 4  May 1, 2019 |
|  | Develop High Risk Registry and reportable fields for care management per PCMH Kids high risk framework; Confirm completion with CTC-RI. | Month 6  June 30, 2019 |
| NCM/CC completes standardized learning program as defined by CTC-RI. | Month 12 (TBD)  12/15/19 |
| **Planned Care: Population Health /Quality Reporting** | Submit clinical quality data as defined in Performance Incentives Exhibit 3 | Month 6; Month 9  July 15 and October 15 2019 |
|  | Submits to OHIC quality measure information | October 15, 2019 |
| **Access and Continuity** | Reports to On Point Quarterly Provider Panel Report; Reports to CTC portal open/closed panel status for new patients and 3rd next available appointment for existing patients | Month 2, 5, 8 and 11  February 15, May 15, August 15 and November 15 |
| **Patient/Family Engagement** | CAHPS survey: Submits patient panel to approved data vendor | Timeframe determined by CTC |
| **Comprehensiveness and Coordination** | Submits Transition of Care Policy and Procedure | Month 11  November 30, 2019 |
|  | Identifies high volume specialists serving patient population and submits 2 compacts | Month 12  December 15, 2019 |
| **Practice transformation** | Submits budget and staffing plan and use of funds to support care delivery model to CTC | Month 3  March 31, 2019 |
|  | Submits Quality Improvement Plan to improve performance to prepare for OHIC and NCQA requirement | Month 7  July 31, 2019 |
|  | Submits NCQA PCMH work plan to CTC | Month 9  September 30, 2019 |
| Submits a quality improvement outcome for improving a performance measure (per OHIC definition) | Month 10  October 15, 2019 |
| Meets with Practice Facilitator 1-2 x a month | Month 1 and on-going  Feb –Dec 2019 |
|  | Attends 50% of learning network meetings 1Practice Reporting Mandatory | Month 1 and on-going  August-June 2019 |

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

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| **Measurement Period**  **2 (MP 2)**  1/1/20 to 12/31/20 | **PCMH-Kids Care Delivery Requirements** | **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 by April and on-going 50% engagement (system of care) and 45% (non-system) | Quarterly (Jan, April, July, Oct 15th) |
| **Planned Care: Population Health /Quality Reporting** | Submits quarterly quality data to CTC | January/April/July/October |
|  | Submits to OHIC quality data information | October 15 |
| **Access and Continuity** | Reports to On Point Quarterly Provider Panel Report; Updates CTC portal open/closed panel status for new patients and 3rd next available appointment for existing patients | Quarterly  (February, May, August, Nov) |
|  | Submits Before and After Hours protocol including schedule for expanded office hours as defined by CTC | Month 3  March 31, 2020 |
| **Patient/Family Engagement** | Submits patient panel for CAHPS survey to qualified data vender | Timeframe determined by CTC |
|  | Submits compact for high volume specialist: behavioral health | Month 6  June 30, 2020 |
| **Practice Transformation** | Submits a quality improvement activity plan to improve a performance measure to prepare for OHIC and NCQA requirements | Month 7  July 31, 2020 |
|  | Submits to OHIC and CTC a quality improvement activity outcome to improve a performance measure to meet OHIC and NCQA requirements | Month 10  (October 15, 2020) |
|  | Meet with practice facilitators every other month | On-going  January-Dec 2020 |
|  | Attends 50% of Learning Network Meetings: Practice Reporting Mandatory | On-going  Jan-Dec 2020 |

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| **Measurement Period**  **MP 3**  1/1/21 to 12/31/21 | **PCMH Kids Care Delivery Requirements** | **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 50% engagement rate (system of care) 45% (non-system) | Quarterly (Jan 15, April, July Oct. ) |
| **Planned Care: Population Health /Quality Reporting** | Submits to CTC quarterly data | Jan, April, July October 15th |
|  | Submits to OHIC quality data measurement report | October 15 |
| **Access and Continuity** | Reports to On Point Quarterly Provider Panel Report; Updates CTC portal indicating open/closed panel status for new patients and 3rd next available appointment for existing patients | Quarterly  February, May, August, Nov: 15th |
| **Patient/Family Engagement** | Submits patient panel for CAHPS survey to approved data vender | Timeframe determined by CTC |
| **Practice Transformation** | Submits confirmation of NCQA application | Month 3  March 31, 2021 |
|  | Reports to CTC on quality improvement plan to improve performance to prepare for OHIC and NCQA requirements | Month 7  July 31 20121 |
|  | Achieves NCQA PCMH recognition | Month 7  July 31, 2021 |
|  | Submits a quality improvement outcome for improving a performance measure (per OHIC definition) | Month 10  October 15, 2021 |
|  | Meet with CTC practice facilitators every other month | Month 1 and quarterly  January-December 2021 |
| Attends 50% of Learning Network meetings: Practice Reporting Mandatory | Month 1 and quarterly  January-December 2021 |