

PCMH Kids Service Delivery Requirements/and Educational Resource Training Schedule

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 updated guidelines from such parties as OHIC, NCQA

| Measurement Period | PCMH-Kids Care Delivery Requirements | Date Due (if applicable) last day of month | Best Practice Sharing Committee meeting/Respirces |
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| 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 October 31, 2017 | Sample NCM/CC job description <u>NCM best practice sharing</u> 10/17/17: Panel Discussion with NCM/CC “Ask the NCM/CC” |
| | Develop High Risk Registry and reportable fields for care management. Confirm completion with CTC-RI. | Month 6 December 31, 2017 | <u>NCM/CC : 8/15/17:PCMH Kids</u> discussion on high risk screening tool; <u>Resource guide</u> with links to updated documents (NCM measurement specifications, BCBS 2018 Policy, check list for PF to complete <u>NCM best practice sharing:</u> 12/19/17: New practice discussion on high risk patient registry development and reportable fields |
| | NCM/CC completes standardized learning program as defined by CTC-RI. | Month 7 Starts January 2018 | <u>NCM/CC meeting 12/19/17:</u> feedback and recommendations for xG Learn program <u>NCM/CC meeting 1/16/18;</u> xG Learn applications released Training starts end of February 5, 2018 |

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| | | | Provided PCMH Kids practices ECHO as second option |
| | Report level(s) of engagement of high risk patients as defined by CTC-RI. | Month 9 1 st report due April 15 2018 | <u>Practice reporting 2/27/18</u> Breakout sessions with like EHR to discuss reportable fields <u>Webinars:</u> by United and NHPRI on how to access high risk lists (Dec-Jan) |
| | Submit to OHIC Cost Management Attestation | October 15 | <u>Practice Reporting: 7/25/17:</u> OHIC letter discussion <u>Practice Reporting 9/26/17</u> OHIC presentation on expectations and how to use portal <u>Resource guide :</u> Policy and procedure templates that include OHIC cost strategy elements; |
| Planned Care: Population Health /Quality Reporting | Submit clinical quality data as defined in Performance Incentives Exhibit 3 | Month 6 1 st report due January 15 2018 | <u>Practice Reporting: 10/24/17</u> Revised Measurement specification 11/28/17: Getting ready to report on quality measures; <u>Resources:</u> Adult and pediatric checklists |
| | 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 3 rd next available appointment for existing patients | Month 6 Project Coordinator will notify | <u>Practice Reporting 8/25/17</u> Reporting on 3 rd next available appointment |

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| | Submit before and after hours protocol, as defined by CTC-RI. | Month 9 March 31, 2018 | <u>Resource</u> : Policy template with OHIC cost management strategies |
| Focus area | Service Delivery Requirement | Date Due | <u>Best Practice Sharing/ Resources</u> |
| 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 | <u>Practice Reporting</u> : 10/24/17 CAHPS training on using portal and reporting |
| Comprehensiveness and Coordination | Submits Transition of Care Policy and Procedure | Month 6 December 31, 2017 | <u>Practice Transformation Committee</u> 12//15/17: Practice presentation on TOC; RIQI tools (dashboard and current care <u>Resource</u> : TOC policy template with OHIC cost management elements |
| | Identifies high volume specialists serving patient population and submits 2 compacts: a) high volume specialist, and b) behavioral health. | Month 9 March 31, 2018 | <u>Practice Transformation</u> 3/15/18 Best practice sharing on use on identifying specialist and using compact <u>Resource</u> : sample compacts with OHIC cost management elements |
| Practice transformation | Submits budget and staffing plan and use of funds to support care delivery model to CTC | Month 3 September 30, 2017 | <u>Practice Transformation</u> 10/19/17: “Ask the practice” panel discussion on using resources for practice transformation |
| | Submit NCQA PCMH work plan to CTC | Month 9 March 31, 2018 | <u>Learning Collaborative</u> 7/17/-7/19 NCQA program |

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| | | | <u>Practice Reporting</u> : Biz Med Presentation on NCQA standards and work plan |
| | Meets with Practice Facilitator 1-2 x a month | Month 1 and on-going August –June 2018 | |
| | Attends 50% of learning network meetings ¹ | Month 1 and on-going August-June 2018 | |

Other programs:

Practice Transformation: 8/17/17: “Using Community Resources” Diabetes self-management program; DOH referral system

NCM/CC: 1/16/18: “Using KIDSNET”; BCBS resources for transition of care from pediatrics to adulthood

NCM/CC 2/20/8: “Using the Family Visiting Program”

NCM/CC 1/16/18: Best Practice Sharing on work being done to obtain and use social determinant of health information”

Practice Reporting: 1/23/18: On Point presentation and resource guide on accessing and using utilization performance information

Breakfast of Champion: 9/8/17: Demonstration of On Point Performance Portal and Pediatric Break out session on ED use reduction strategies

Breakfast of Champions: 2/9/18: Well Being Survey Results and Discussion: OHIC update

Large Learning Collaborative: 11/7/17: Track on patient engagement/complex care management/ pediatric focus areas/SUD

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 | PCMH-Kids Care Delivery Requirements | Due Date (if applicable) last day of month | Best Practice Sharing/Resources |
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| 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 June 30 2019 | |
| 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 3 rd next available appointment for existing patients | Quarterly Project Coordinator will notify | |
| | Submit to CTC screenshots demonstrating patient access to a secure web portal, enabling secure messaging, appointment requests, referrals, and prescription refills. | Month 3 September 30, 2018 | |
| | Submits schedule demonstrating that it has expanded office hours as defined by OHIC Cost Management Strategies | Month 6 December 31, 2018 | |
| 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 December 31, 2018 | |

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| Practice Transformation | Submits a quality improvement activity for improving a performance measure (Quality/customer experience/utilization) | Month 2 August 31, 2018 | |
| | Submits a quality improvement activity demonstrating performance to improve a performance measure | Month 7 January 31, 2019 | |
| | Submits NCQA PCMH recognition application | Month 9 March 31, 2019 | |
| | Meet with practice facilitators at a minimum of once per month | On-going July 2018-June 30 2019 | |
| | Attends 50% of Learning Network Meetings | On-going July 2018-June 30, 2019 | |

| Measurement Period MP 3 7/1/19 -6/30/20 | 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 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 December 31, 2019 |
| | 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 3 rd next available appointment for existing patients | Quarterly Project Coordinator will notify |
| 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 December 31, 2019 |
| Practice Transformation | Achieves NCQA PCMH recognition | Month 2 August 31 2019 |
| | Meet with CTC practice facilitators once per quarter | Month 1 and quarterly July 2019 –June 30 2020 |
| | Attends 50% of Learning Network meetings | Month 1 and quarterly July 2019-June 30, 2020 |