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
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 NCM best practice sharing 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	NCM/CC : 8/15/17:PCMH Kids discussion on high risk screening tool; Resource guide with links to updated documents (NCM measurement specifications, BCBS 2018 Policy, check list for PF to complete NCM best practice sharing: 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	NCM/CC meeting 12/19/17: feedback and recommendations for xG Learn program NCM/CC meeting 1/16/18; xG Learn applications released Training starts end of February 5, 2018

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

	Submit before and after hours protocol, as defined by CTC-RI.	Month 9 March 31, 2018	Resource: Policy template with OHIC cost management strategies
Focus area	**Service Delivery Requirement**	**Date Due**	**Best Practice Sharing/ Resources**
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	Practice Reporting: 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	**Practice Transformation** Committee 12//15/17: Practice presentation on TOC; RIQI tools (dashboard and current care Resource: 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	**Practice Transformation** 3/15/18 Best practice sharing on use on identifying specialist and using compact Resource: 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	**Practice Transformation** 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	Learning Collaborative 7/17/-7/19 NCQA program

			Practice Reporting: 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**
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 3rd 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	

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 3rd 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