**PCMH Kids 2019 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 and NCQA. The first column identifies concepts from NCQA PCMH Recognition 2017, and outcome competencies with becoming and sustaining PCMH transformation We have labeled each deliverable as such as they pertain to NCQA PCMH 2017

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| **Measurement Period**  **Start up thru Year 2**  **2019 -2021** | **PCMH-Kids Care Delivery Requirements** | **Date Due Please note some deliverables are due yearly, qtrly, or have a single due date** | **NCQA PCMH 2017 Concepts** | **Notes** |
| **Practice Transformation** | Meets with Practice Facilitator 1-2X per month; year 1; Year 2: Monthly Year 3: Quarterly | Monthly starting July 2019 –  June 2022 |  | Practice Facilitator will meet with practices April- June 2019 to complete practice assessment and NCQA workflow plan |
| **Practice Transformation**  **TC03 (Credit)** | Attends ¾ Breakfast of Champions, 2/4 PCMH Stakeholders, Annual Conference, Practice Reporting/Transformation and NCM/CC once hired | Monthly thru July 2019-June 2022 | TC03 The practice is involved in external PCMH- oriented collaborative activities. | NA |
| **Access and Continuity**  **AC13 Credit** | Submit CTC Quarterly Provider Panel Report indicating open/closed panel status for new patients and 3rd next available appointment | QRTLY Aug 2019, Nov, Feb, May (Due back to CTC 15th) | AC03The practice has a process to review the number of patients assigned to each clinician and balance the size of each providers’ patient panel. Reviewing and balancing patient panels facilitates improved patient satisfaction, patient access to care and provider workload because supply is balanced with patient demand. The American College of Family Physicians provides a tool for practices to use when considering and managing panel sizes: http://www.aafp.org/fpm/2007/0400/p44.pdf | **Will receive and email reminder and directions on how to submit information via:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Practice Transformation**  **TC02 (Core)** | Submits budget and staffing plan and use of funds to support care delivery model to CTC | Sept 30, 2019 | TC02 Defines practice organizational structure and staff responsibilities/skills to support PCMH. | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |

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| **Measurement Period**  **Start up thru Year 2**  **2019 -2021** | **PCMH-Kids Care Delivery Requirements** | **Date Due Please note some deliverables are due yearly, qtrly, or have a single due date** | **NCQA PCMH 2017 Concepts** | **Notes** |
| **Practice Transformation QI02** | Submits to OHIC cost management strategy QI project (per OHIC definition) | Yearly  Oct 15,2019, 2021, 2022 | Monitors QI09 (Core) Sets goals and acts to improve at least one measure of resource stewardship. | **Submit to:**  [**OHIC**](mailto:Michele.Brown@umassmed.edu) **Website** |
| **Care Management**  **CM03 Credit** | Hire 1.0 FTE (prorated based on actual attribution) Nurse Care Manager (NCM) or Care Coordinator (CC) for every 3,000 attributed patients ($2.50 pmpm) | Oct 31, 2019 | CM03 The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need. | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Planned Care; Population Health/Quality Reporting** | Submits to OHIC quality measures information | YEARLY  October 15, 2019, 2021, 2022 |  | **Submit to:**  [**OHIC**](mailto:Michele.Brown@umassmed.edu) **Website** |
| **Patient/Family Engagement**  **QI17, (credit)**  **QI 04 (core)**  **QI06 (credit)** | Submit patient panel for CAHPS survey to approved vendor | YEARLY Fall 2019, 2021,2022 | QI17 The practice has a process for involving patients and their families in its quality improvement efforts or on the practice’s patient advisory council (PFAC). At a minimum, the process specifies how patients and families are selected, their role on the quality improvement team and the frequency of team/PFAC meetings. The ongoing inclusion of patients/families/caregivers in quality improvement activities provides the voice of the patient to patient-centered care.  QI04 Monitors patient experience through quantitative data.  data available.  QI06 The practice uses a standardized, validated patient experience survey tool with benchmarking | Data Stat Portal |

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| **Care Management** | Develop High Risk Registry and process for care plan for patients identified for care management | Dec 31, 2019 |  | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Comprehensiveness and Coordination**  **CC16 Core** | Submits Transition of Care Policy and Procedure | Dec 31,2019 | CC16 The practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate. The practice’s policies define the appropriate contact period in addition to a log documenting systematic follow-up was completed. Contact includes offering care to prevent worsening of a condition, clarify discharge instructions and encouraging follow-up care, which may include, but is not limited to, physician counseling, referrals to community resources and disease or case management or self-management support programs. | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Planned Care; Population Health/Quality Reporting**  **QI01 (core)** | Submit clinical quality data as defined in CTC Performance Standards and measurement specifications | QRTLY 1st report due 1/15/20, 4/15, 7/15, 10/15 thru  2022 | QI01Monitors clinical quality measures | **Submit to:**  [**CTC Portal**](https://www.ctc-ri.org/) |
| **Care Management** | NCM/CC completes standardized learning program as defined by CTC-RI. | Program starts Jan 2020 |  | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Practice Transformation** | Submits NCQA PCMH work plan to CTC | September 30, 2019 |  | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |

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| **Measurement Period**  **Start up thru Year 2**  **2019 -2021** | **PCMH-Kids Care Delivery Requirements** | **Date Due Please note some deliverables are due yearly, qtrly, or have a single due date** | **NCQA PCMH 2017 Concepts** | **Notes** |
| **Comprehensiveness and Coordination** | Enrolls in Pedi PRN and submits 1 compact for behavioral health | March 31, 2020 | Enrolls in Pedi PRN and submits 1 compact for behavioral health | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Access and Continuity**  **AC04 Core** | Submits Before and After-Hours protocol as defined by CTC | March 31, 2020 | AC04 Patients can telephone the practice any time of the day or night and receive interactive (i.e., from a person, rather than a recorded message) clinical advice. Clinical advice refers to a response to an inquiry regarding symptoms, health status or an acute/chronic condition. Providing advice outside of appointments helps reduce unnecessary emergency room and other utilization. A recorded message referring patients to 911 when the office is closed is not sufficient. Clinicians return calls in a time frame determined by the practice. Clinical advice must be provided by qualified clinical staff, but may be communicated by any member of the care team, as permitted under state licensing laws. NCQA reviews a report summarizing the practice’s expected response times and how it monitors its performance against standards for timely response. The practice must present data on at least 7- days of such calls. | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Practice Transformation** | Submits NCQA recognition application | March 31, 2020 |  | **Submit to:**  [**CTCRI@healthcentricadvisors.org**](mailto:CTCRI@healthcentricadvisors.org) |

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| **Measurement Period**  **Start up thru Year 2**  **2019 -2021** | **PCMH-Kids Care Delivery Requirements** | **Date Due Please note some deliverables are due yearly, qtrly, or have a single due date** | **NCQA PCMH 2017 Concepts** | **Notes** |
| **Practice Transformation** | Submits a quality activity improvement activity for improving: clinical; quality, customer experience or utilization | May 2020, 2021, 2022 | Submits a quality activity improvement activity for improving: clinical; quality, customer experience or utilization | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Care Management**  **CM03 Credit** | Submits reports on high risk patients, as defined by CTC | QRTLY (15th) First report due Jul 2020, Oct, Jan, April 2020-2022 | The practice demonstrates that it can identify patients who are at high risk, or likely to be at high risk, and prioritize their care management to prevent poor outcomes. Practice identifies and directs resources appropriately based on need. | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Access and Continuity**  **AC07 (credit)** | Submit to CTC screenshot demonstrating patient access to a secure web portal for patients to request appointments, referrals, prescription refills and test results | Sept 31,2020 | Has a secure electronic system for patients to request appointments, prescription refills, referrals and test results | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Practice Transformation** | Registers for Q Pass 12 months prior to NCQA submission date  **Achieves NCQA recognition**  For NCQA renewal, re-registers for Q Pass three months prior to due date and uploads responses/documents 1 month prior to expiration | **Sept 30, 2021** |  | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |

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| **Comprehensiveness and Coordination**  **CC04(core)**  **CC07 (credit)**  **CC08 (credit)** | Submits 1 additional compact with high volume specialists based on needs of patient population as defined by CTC | Dec 31, 2021 | CC04 The practice systematically manages referrals by giving the consultant or specialist the clinical question, the required timing and type of referral, pertinent demographic and clinical data, including test results and current care plan  CC07 considers available performance information on consultants/specialists when making referrals  CC08Works with non- behavioral health care specialists to whom the practice frequently refers to set expectations for information sharing and -patient care. | **Submit to:** [**CTC-ri@ctc-ri.org**](mailto:CTC-ri@ctc-ri.org) |
| **Practice Transformation** | Submits a quality improvement activity demonstrating improvement to improve a performance measure (quality, customer experience, utilization) | Jan 31, 2021 and January 31 2022 | Measuring and reporting clinical quality measures helps practices deliver safe, effective, patient-centered and timely care. The practice shows that it monitors at least five clinical quality measures, including at least: | **Submit to: CTC-ri@ctc-ri.org** |

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| **Learning Network Opportunities Attends 3 out of 4 Breakfast of Champions; 2 out of 4 PCMH Kids Stakeholder meetings; at least one practice representative at Annual Conference; Practice reporting/transformation are required meetings; NCM/CC are required meetings once NCM/CC hired; Practices may also be asked to present their work at “best practice sharing” committee meetings** | | | |
|  | **Year 1** | **Year 2** | **Year 3** |
| **Orientation\*** | April 11, 2019 5:30 to 7:00pm |  |  |
| **Breakfast of Champion (BOC) Events** | May 10, 2019  September 13, 2019;  December 13,2019 |  |  |
| March 13, 2020; | Dates TBD | Dates TBD |
| and June 12, 2020 7:30-9:00am |  |  |
| **PCMH Kids Stakeholder** | October 3 2019; | October 1 2020; | October 7, 2021; |
| January 9, 2020 | January 7 , 2021; | January 6., 2022; |
| April 2,2020; | April 1, 2021 | April 7 2022; |
| July 9, 2020 (7:30-8:30am) | July 8,2021 (7:30-8:30am) | July 14,2022 (7:30-8:30am) |
| **Practice Reporting/Transformation** | 4th Wednesday of every month; 7:30 - 8:30 (except months with BOC; no meeting in December) | 4th Wednesday of every month; 7:30 - 8:30 (except months with BOC; no meeting in December) | 4th Wednesday of every month; 7:30 - 8:30 (except months with BOC; no meeting in December) |
| **Nurse Care Manager/Care Coordinator Best Practice Sharing** | 3rd Tuesday of every month (except month of Annual Conference) | 3rd Tuesday of every month (except month of Annual Conference) | 3rd Tuesday of every month (except month of Annual Conference) |
| **Annual Learning Collaborative** | 24-Oct-19 | Date TBD | Date TBD |