CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome

Care Transformation Collaborative of Rhode Island

Andrea Galgay, PR/PT Co-chair
Sarah Fessler, MD, PR/PT Co-chair
Susanne Campbell, RN, MS, PCMH CCE, Senior Program Director

Practice Reporting and Transformation Committee Meeting | December 8, 2021

Agenda

Topic *Presenter(s)*	Duration
Welcome & Review of Agenda *Andrea Galgay and Sarah Fessler, Co-chairs*	8:00-8:05AM
2022 NCQA Annual Reporting Demystified with 15 minute Q&A *Bernadett Parrillo, QI Specialist, RIPCPC* *Vicki Crowningshield & Suzanne Herzberg to facilitate*	8:05-8:50AM
Review of Clinical Quality Results *Susanne Campbell, Andrea Galgay, Sarah Fessler to facilitate*	8:50-9:10AM
Review of High Risk Data w/ PCHC's Community Health Advocate Interventions by Amy Perry *Susanne Campbell, Andrea Galgay, Sarah Fessler to facilitate*	9:10-9:30AM

Annual Reporting 2022 Demystified

Presented by: Bernadette Parrillo,
Quality Improvement Specialist

RHODE ISLAND PHYSICIANS CORPORATION PRIMARY CARE
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The more things change. . .

- Annual Reporting 2022 has some new requirements
  - No QI Worksheet in 2022
- New Standardized Measures list for QI reporting
  - 17 measures to pick from 6 measure categories
    - ✓ *Quality measure categories*: Behavioral health, Immunizations, Preventive care, Chronic or acute care
    - ✓ *Resource stewardship measure categories*: Care coordination, Healthcare costs
- No Special Topics informational form in 2022 (was SDoH & telehealth in 2021)

. . .The more they stay the same!

- Submit evidence and/or attest to key criteria from all 6 PCMH concept areas:
  - Team-Based Care (TC)
  - Knowing and Managing Patients (KM)
  - Access and Continuity (AC)
  - Care Management (CM)
  - Care Coordination & Transitions (CC)
  - Performance Measurement & Quality Improvement (QI)
- Use Q-Pass to submit data and track progress
- Use the AR 2022 guidelines for renewals due in 2022
- Evidence must fall within your recognition period


CHANGE
1.
2.
3.
ADJUST
NEW
MODIFY
SHIFT
TRANSFORM
SITION

Comparing AR 2022 to AR 2021

AR 2022 Requirement	PCMH Criteria	AR 2021 Requirement	PCMH Criteria
TC 1 Staff Involvement in QI	TC 07	TC 1 Patient Care Team Meetings	TC 06
KM 1 Up-to-Date Medication Lists >80% of pts.	KM 15	KM 1 Proactive Reminders	KM 12
KM 2 Clinical Decision Support	KM 20	KM 2 Depression Screenings	KM 03
AC 1 Timely Clinical Advice by Telephone	AC 04	AC 1 Access Needs and Preferences	AC 01
AC 2 Patient Visits with Clinician/Team	AC 11	AC 2 Access for Patients Outside Business Hours*	AC 03 AC 04*
		AC 3 Technology-Supported Alternative	AC 06
CM 1 Care Plans for Care Managed Patients	CM 04	CM 1 Identifying and Monitoring Patients for Care Management	CM 01 CM 03
		CM 2 Care Plans for Care Managed Patients*	CM 04* CM 05
CC 1 Care Coordination Process	CC 01	CC 1 Care Coordination Process*	CC 01*
CC 2 Referral Management Process	CC 04	CC 2 Referral Management Process*	CC 04*
CC 3 Lab & Imaging Test Tracking (Option)	CC 01	CC 3 Care Coordination with Other Facilities Processes	CC 14, 15, 16
CC 4 Referral Tracking (Option)	CC 04	CC 4 Lab & Imaging Test Tracking (Option)*	CC 01*
		CC 5 Referral Tracking (Option)*	CC 04*
QI 1 Clinical Quality Measures	QI 01	QI 1 Clinical Quality Measures*	QI 01* & QI 08
QI 2 Resource Stewardship Measures	QI 02	QI 2 Resource Stewardship Measures*	QI 02* & QI 09
QI 3 Patient Experience Measures	QI 04	QI 3 Patient Experience Measures*	QI 04* & QI 11
		QI 4 Monitoring Access	QI 03 & QI 10
		QI 5 eCQMs (Informational)	N/A
		QI 6 Value Based Payment Agreement (Informational)	QI 19
		SD 1 Collection and Assessment of SDoH Data (Informational)	KM 02G, KM 07, KM 21 & CM 01D
		SD 2 Use of Care Interventions and Community Resources (Informational)	KM 07 & KM 26
** Indicates measures carried over from AR 2021 → AR 2022*		SD 3 Care Interventions and Community Resources Assessment (Informational)	KM 27

A few things to keep in mind

- Submit the following in Q-PASS by the practice's reporting date (30 days prior to its anniversary date):
- • **Annual Questionnaire:** Practices must attest that they have maintained and will continue to meet the requirements of the current PCMH program. No additional evidence is required for this attestation.
- • **Evaluation:** This is where practices answer questions or enter data. Practices must meet the minimum number of requirements in each concept category.

Overview of AR 2022 Requirements

Key: | *Required* | *Option*

Team-Based Care and Practice Organization (AR-TC)

Report the following requirement:

AR-TC 1
Staff Involvement in Quality Improvement

Knowing and Managing Your Patients (AR-KM)

Report each of the following:

AR-KM 1
Medication Lists

AND

AR-KM 2
Clinical Decision Support

Patient-Centered Access and Continuity (AR-AC)

Report each of the following:

AR-AC 1
Timely Clinical Advice by Telephone

AND

AR-AC 2
Patient Visits with Clinician/Team

AR 2022 Overview (continued)

Care Management and Support (AR-CM)

Report the following:

AR-CM 1
Care Plans for Care Managed Patients

Care Coordination and Care Transitions (AR-CC)

Report each of the following requirements:

AR-CC 1
Care Coordination Process

AND

AR-CC 2
Referral Management Process

***AND** report **one** of the following options:*

AR-CC 3
Lab and Imaging Test Tracking

OR

AR-CC 4
Referral Tracking

Performance Measurement and Quality Improvement (AR-QI)

Report the following requirements:

AR-QI 1
Clinical Quality Measures

AND

AR-QI 2
Resource Stewardship Measures

AND

AR-QI 3
Patient Experience Measures

Tips for success (TC)

Team-Based Care and Practice Organization (AR-TC)

The practice continues to involve staff in quality improvement.

Report the following:

AR-TC 1 Staff Involvement in Quality Improvement	(Required)

1. **Staff Involvement in Quality Improvement—Attestation**
   Shared

   Practices must involve care team staff in performance evaluation and improvement activities. How often does your staff meet to plan and implement quality improvement activities?

   Select all that apply:

   - ☐ Weekly.
   - ☐ Monthly.
   - ☐ Quarterly.
   - ☐ Other_____.

- Describe the frequency and content of staff QI meetings in your P&P
- Save meeting minutes for backup: Title, Attendees, Topics Discussed
- ➡ Be sure to explain “who did what” in the meeting minutes!

Tips for success(KM 1)

Knowing and Managing Your Patients (AR-KM)

The practice continues to maintain medication lists and implement clinical decision support.

Report the following:

AR-KM 1 Medication Lists	(Required)

1. **Medication Lists—Report**
   Site-specific

   Practices maintain an up-to-date list of medications for more than 80% of patients.

   Enter:
   - Numerator: Number of patients from the denominator with an up-to-date medication list.
   - Denominator: Number of unique patients seen during the reporting period.
   - Reporting period.

- Include all patients in the report, not just a subset
- Reporting timeframe isn't specified; aim for at least 3 months
- Medication data should be in searchable fields in the EHR
- ➡ Check for practice's compliance early! Correct deficiencies as needed.

Tips for success(KM 2)

AR-KM 2 Clinical Decision Support **(Required)**

1. **Clinical Decision Support—Attestation**
   Shared

   Practices must implement clinical decision support following evidence-based guidelines for the care of conditions across at least 4 categories. For which categories does the practice have clinical decision support implemented?

   Select all that apply:
   - ☐ A mental health condition.
   - ☐ A substance use disorder.
   - ☐ A chronic medical condition.
   - ☐ An acute condition.
   - ☐ A condition related to unhealthy behaviors.
   - ☐ Well-child or adult care.
   - ☐ Overuse/appropriateness issues.

- Use flow sheets, EHR prompts, or other provider alert mechanisms as evidence
- Demonstrate implementation of clinical decision support at the point of care
  - Provide information on the medical condition addressed AND the source of the evidence-based guideline
- Align selected categories with your practice's quality goals!

Tips for success (AC 1)

Patient-Centered Access and Continuity (AR-AC)

The practice continues to monitor timely access to clinical advice and patient visits with their selected personal clinician.

Report the following:

AR-AC 1 Timely Clinical Advice by Telephone	(Required)

1. Timely Clinical Advice by Telephone—Report

Shared

Practices outline their expected response time for returning clinical advice by telephone in their documented process.

Enter:

- Numerator: Number of clinical advice calls returned within the expected timeframe.
- Denominator: Number of clinical advice calls during and after business hours.
- Reporting period.

Note: *"Clinical advice" refers to a response to an inquiry about symptoms, health status or an acute/chronic condition. Do not include patient calls regarding referrals, prescription refills or appointment scheduling in the report. The reporting period should include at least 7 consecutive days of data and calls received both during and after business hours.*

- Check that P&P response times reflect actual practice function
- Encourage staff to label applicable telephone encounters as "Clinical Advice"
- Ensure that after-hours calls are being documented in the EHR

Tips for success (AC 2)

AR-AC 2 Patient Visits with Clinician/Team **(Required)**

2. Patient Visits with Clinician/Team—Report

Site-specific

Practices outline their goal in their documented process.

Enter:

- Numerator: Number of patient visits where the patient was seen by their selected personal clinician or care team.
- Denominator: Number of patient visits.
- Reporting period.

Note: *All patients should have a selected personal clinician or care team. A "care team" may be a defined pair of clinicians (e.g., physician and nurse practitioner, physician and resident) or a practice team. The practice may not assign all patients to a site and label this as the care team unless it is a solo clinician site.*

- Solo practice sites have one provider –OR- a provider with mid-levels practicing under the provider's panel of patients
- Be sure the P&P states the goal for % of visits with the patient's selected PCP
- Reporting period should be long enough (about 1 month) to account for unusual circumstances like practice closures, provider absences, etc.

Tips for success (CM 1)

Care Management and Support (AR-CM)

The practice continues to complete care plans for patients in care management.

Report the following:

AR-CM 1 Care Plans for Care Managed Patients	(Required)

1. Care Plans for Care Managed Patients—Report

Site-specific

Practices have a process for identifying patients for care management that incorporates at least 3 categories outlined in CM 01 of the PCMH standards and guidelines or that utilizes comprehensive risk stratification.

Enter:

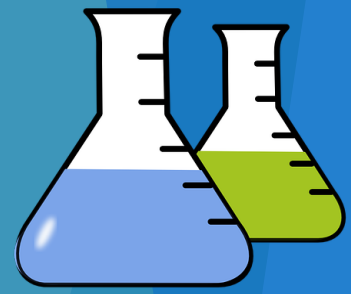
- Numerator: Number of patients from the denominator with a complete care plan.
- Denominator: Number of patients enrolled in care management.
- Reporting period.

Note: *A complete care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan. Care plans are updated at all relevant visits. At least 75% of patients in care management must have a complete care plan. The practice must identify at least 30 patients in the denominator.*

For practices that do not have the ability to pull this report in their EHR, refer to the manual chart option utilizing the RRWB (see page 5 for details).

- Include >=30 patients from at least 3 CM categories: BH, high cost/high utilization, poorly controlled or complex conditions, SDoH, referrals from outside organizations
- Follow RRWB instructions to conduct a manual audit if indicated

Tips for success (CC 1)



Care Coordination and Care Transitions (AR-CC)

The practice continues to coordinate care with labs, specialists or other care facilities.

*Report AR-CC 1-2 and report **one** of the following options between AR-CC 3–4:*

AR-CC 1 Care Coordination Process	(Required)

1. Care Coordination Documented Processes—Attestation
Shared

Does your practice have an implemented documented process for all of the following?
Select one: (Yes/No)

- Lab and imaging tracking until results are available, flagging and following up on overdue results.
- Flagging abnormal lab and imaging results, bringing them to the attention of the clinician.
- Notifying patients/families/caregivers about normal and abnormal diagnostic test results for both lab and imaging.

***Note:** Practices must have a documented process for and implement all of the above to sustain PCMH Recognition.*

- Verify that P&P processes reflect actual practice function
- Check for compliance throughout the recognition period!

Tips for success (CC 2)

AR-CC 2 Referral Management Process	(Required)

1. Referral Processes and Tracking—Attestation

Shared

Does your practice have an implemented documented process for all of the following?
Select one: (Yes/No)

- Giving the consultant/specialist the clinical question, the required timing and the type of referral.
- Giving the consultant/specialist pertinent demographic and clinical data, including test results and the current care plan.
- Tracking referrals until the consultant/specialist's report is available, flagging and following up on overdue reports.

Note: *Practices must have a documented process for and implement all of the above to sustain PCMH Recognition.*

- Verify that P&P processes reflect actual practice function
- Check for compliance throughout the recognition period!
- Utilize referrals between a primary care provider and a medical specialist
  - Don't use referrals to nutritionists, physical therapy, hospice, home health, etc.

Tips for success – Pick 1 option (CC 3 – OR – CC 4)

AR-CC 3 Lab and Imaging Test Tracking **(Option)**

1. **Tracking Lab Test Results—Report**
   Site-specific

   Enter:
   - Numerator: Number of labs ordered for which the practice received a lab order results report.
   - Denominator: Number of lab orders.
   - Reporting period.

2. **Tracking Imaging Test Results—Report**
   Site-specific

   Enter:
   - Numerator: Number of imaging tests ordered for which the practice received an imaging results report.
   - Denominator: Number of imaging orders.
   - Reporting period.

Note: *Practices that cannot generate automatic reports may instead complete a manual chart audit of 30 applicable patients (see page 5 for details). If the practice has a very low volume of lab and imaging tests ordered (<30), it should extend the review time frame or choose to report a different reporting option.*

AR-CC 4 Referral Tracking **(Option)**

1. **Tracking Referrals—Report** *This measure is the equivalent of CMS #374.*
   Site-specific

   Enter:
   - Numerator: Number of patients with a referral for which the referring provider received a report from the provider to whom the patient was referred.
   - Denominator: Number of patients, regardless of age, who were referred by one provider to another provider and had a visit during the measurement period.
   - Reporting period.

Note: *Practices that cannot generate automatic reports may instead complete a manual chart audit of 30 applicable patients (see page 5 for details). If the practice has a very low volume of referrals (<30), it should extend the review time frame or choose to report a different reporting option.*

- Report on either AR-CC 3 or AR-CC4
- Ensure denominator >30
- Conduct manual audit if no automatic reporting is available

Quality Improvement Measures Overview

- New! Enter data into the **Measures Reporting** tile on the Organization Dashboard
  - No more QIWS
  - Enter Numerator, Denominator, Reporting period, Numerator Description, Denominator Description for each measure
    - No goals or actions to improve are required for AR 2022 reporting . . . yet
- The number of required reporting measures has increased:
  - 5 ***Clinical Quality*** measures across 4 categories
  - 2 ***Resource Stewardship*** measures from care coordination & health care costs categories
  - 1 ***Patient Experience*** measure related to access, communication, coordination, or whole-person care / self-management support
- For AR-QI 1&2, choose measures from the Standardized Measures List in Appendix 5 or enter text in Q-Pass fields manually
  - If using Standardized Measures, choose measure from drop-down menu
  - Measure parameters will auto-populate

Tips for success (QI 1)

Performance Measurement and Quality Improvement (AR-QI)

The practice continues to collect and use performance measurement data for quality improvement activities.

Report the following:

AR-QI 1 Clinical Quality Measures	(Required)

1. Clinical Quality Measures—Report

Site-specific

At least annually, the practice monitors at least 5 clinical quality measures across 4 categories (must monitor at least 1 measure of each type):

- Immunization.
- Other preventive care.
- Chronic/acute care.
- Behavioral health.

- Measurement period needs to be within 12 months of submission date
- It's OK to use both pedi and adult measures for family med practices
- Select measures with opportunities for improvement in the future

Tips for success (QI 2)

AR-QI 2 Resource Stewardship Measures	(Required)

2. Resource Stewardship Measures—Report

Site-specific

At least annually, the practice monitors at least 2 measures of resource stewardship (must monitor at least 1 measure of each type):

- Measures related to care coordination.
- Measures affecting health care costs.

- Measurement period needs to be within 12 months of submission date
- Some care coordination examples: Med rec or f/u post-ER/IP, decreased % of pts. seeing multiple providers, rate of mammography results received in a timely manner to mammograms ordered
- Some health care costs examples: Use of high-cost meds, # visits to urgent care during office hours, hospital readmissions, ED recurrences
- Select measures with opportunities for improvement in the future

Tips for success (QI 3)

AR-QI 3 Patient Experience Measure	(Required)

1. Patient Experience Measure—Report

Site-specific

At least annually, the practice monitors at least 1 measure of patient experience relating to 1 of the following categories:

- Access.
- Communication.
- Coordination.
- Whole-person care, self-management support and comprehensiveness.

- Measurement period needs to be within 12 months of submission date
- Survey must represent the entire patient population and not focus on specific conditions or patient groups
- Start early! It may take time to accumulate enough responses
- Select measures with opportunities for improvement in the future

Lessons Learned. . .

- Spot-check for compliance throughout the recognition year
  - Some criteria may require extra time to effect change (AR-KM 1, AR-AC 1, AR-CM 1)
- Add “Comments to Reviewer” to explain any unusual or atypical data
- Ensure all report denominators >30
- All reporting periods must be 12 months or less from submission date
- Avoid reporting quality measures with high baseline scores / no room for improvement
- For multi-site practices, customize site-specific evidence for each practice site

What Happens After Submission?

- NCQA evaluator reviews the submission
  - If approved, the project advances to ROC review and final determination
  - Recognition status can be denied if practice fails to meet requirements or deadlines

- Practice can be selected for audit – random or for cause!
  - Notification through Q-Pass and e-mail
  - Audits are conducted by virtual review by NCQA
  - Recognition status can be denied if practice fails to complete the audit or fails to meet requirements during the audit review

- If approved for recognition, practice is notified by e-mail and via Q-Pass
- Recognition certificate shows new recognition period

Maintaining PCMH Standards & Guidelines

Core standards and measures not addressed in the annual renewal process

(TC) Team-Based Care and Practice Organization

- *TC 01: Identifies and clinical lead *and* transformation manager
- TC 02: Provides and overview of practice staff roles and an outline of staff responsibilities/skills to support key practice functions
- TC 06: Has regular patient care team meetings or a structured communication process focused on individual patient care.
- TC 07/AR-TC 1: Involves care team staff in the practice's performance evaluation and quality improvement activities
- TC 09: Has a process for informing p/f/c about the role of the medical home and provides p/f/c materials with that information.

* New to PCMH 2017

(KM) Knowing and Managing Your Patients

- KM 01: Up-to-Date Problem Lists
- *KM 02: Comprehensive Health Assessment (All 9 items are required - Social functioning & Social Determinants of Health are new)
- KM 03: Depression Screening for adults and adolescents using standardized tool
- KM 09: Diversity – Collect information on how patients identify in at least 3 areas (race, ethnicity, sexual orientation, religion, occupation, geographic residence)
- KM 10: Language – Assess the language needs of patient population
- KM 12: Proactive Reminders of Needed Services (from at least 3 of these 4 categories: Preventative care services, Immunizations, Chronic or Acute care services, Patients not recently seen)
- KM 14: Medication Reconciliation for >80% of Care Transitions
- KM 15/AR-KM 1: Up-to-Date Medication Lists for >80% of Patients
- KM 20/AR-KM 2: Implements clinical decision support following evidence-based guidelines for care of at least 4/7 (mental health, SUD, chronic condition, acute condition, unhealthy behaviors, well child/adult care, overuse/appropriateness issues)
- *KM 21: Identify priority needs of patient population to inform resource list

* New in 2017

(AC) Patient-Centered Access and Continuity

- *AC 01: Collects data to evaluate and assess patients needs and preferences specific to appointments
- AC 02: Practice provides same-day appointments for routine and urgent care needs
- AC 03: Provides routine and urgent appointments outside of typical business hours
- AC 04: Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient's medical record
- AC 05/AR-AC 1: Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient's medical record
- AC 10: Gives p/f/c a choice of clinician
- AC 11/AR-AC2: Establishes a goal for the proportion of visits a patient should have with the primary care provider and care team.

*New in 2017

(CM) Care Management and Support

- CM 01: Identifying patients for Care Management for at least 3 of the following 5 criteria: (Behavioral health condition, high cost/high utilization, poorly controlled or complex conditions, social determinants of health, referrals by outside organizations)
- CM 02: Determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services (Recommended 150 per 3,000 patients, min of 30 patients)
- CM 04/AR CM 1: Establishes a person-centered care plan for at least 75% of patients identified for care management.
- CM 05: Provides a written care plan to the p/f/c for at least 75% of patients identified for care management

(CC) Care Coordination and Care Transitions

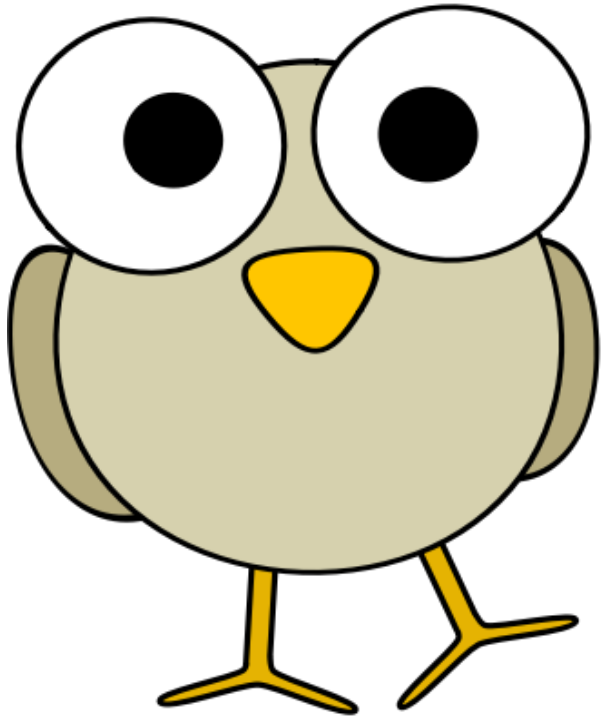
- CC 01/AR-CC 1&3: Systematically manages lab and imaging tests by tracking & f/u on overdue tests until results are available, flagging abnormal results, notifying pts. of normal & abnormal results
- CC 04/AR-CC 2&4: Systematically manages referrals by providing specialist w/ clinical question, timing, type of referral, demographic & clinical data. Track, flag, f/u on overdue reports
- CC 14: Systematically identifies patients with unplanned hospital admissions and emergency department visits
- CC 15: Timely sharing of information with admitting hospitals and EDs
- CC 16: Post-Hospital/ED Visit Follow-Up - Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit

(QI) Performance Measurement and Quality Improvement

- *QI 01/AR-QI 1: Monitoring Clinical Quality Measures
- QI 02/AR-QI 2: Monitoring Resource Stewardship Measures QI 03: Appointment availability assessment
- QI 04/AR-QI 3: Patient experience feedback
- QI 08: Sets Goals & Actions to Improve Clinical Quality Measures
- QI 09: Sets Goals & Actions to Improve Resource Stewardship Measures
- QI 10: Sets Goals & Actions to Improve Appointment Availability of Major Appointment Types
- QI 11: Sets Goals & Actions to Improve Patient Experience
- QI 15:Reporting Performance Within the Practice

* New in 2017

What Questions do you have for me?



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Practice Transformation Summary of Requirements

	OHIC	CTC-RI/PCMH Kids Incentive Payment
Data due	By October 15, 2021	By April 15, 2022
Measures & Targets	**Well Child:** Commercial: 75.10%; Medicaid: 53.66% **Developmental Screening:** 67.98% **Lead Screening:** 73.11%	**Well Child:** <=50% Medicaid: 75.10%; >50% Medicaid: 53.66% **Developmental Screening:** 67.98% **Lead Screening:** 73.11% **BMI:** <=50% Medicaid: 90%; >50% Medicaid: 88% **2 MMR:** 90% of December 31, 2019 Immunization rates
Incentive Methodology	• practices must meet a high-performance benchmark as summarized above ***or*** • practice performance for the 2020-2021 performance period must be higher than the 2018-2019 performance period. • practices are required to meet performance expectations for 2 of 3 pediatric measures.	• practices must meet a high-performance benchmark as summarized above ***or*** • practice performance for the 2020-2021 performance period must be higher than baseline. • practices are required to meet performance expectations for 3 of 5 pediatric measures ***and*** • Field CAHPS Survey (reporting only)
Baseline data	**Well Child:** October 1, 2018 - September 30, 2019 **Developmental Screening:** October 1, 2018 - September 30, 2019 **Lead Screening:** 2017-2018 cohort as of March 1, 2021	**Well Child:** April 15, 2020 **Developmental Screening:** April 15, 2020 **Lead Screening:** 2017-2018 cohort as of March 1, 2021 **BMI:** April 15, 2020 **2 MMR:** December 31, 2019

Current PCMH NCQA recognition required for OHIC and PCMH Kids

OHIC Affordability Standards
Advance Notice of Proposed Rulemaking

- OHIC has issued a brief paper titled Next Generation Affordability Standards: Concepts, Rationale, and Additional Information which contains an overview of potential policies that are currently under consideration by OHIC for incorporation into the regulation.
- Advance Notice of Proposed Rulemaking

PCHC
PROVIDENCE COMMUNITY
HEALTH CENTERS

Community Health Advocates

PCHC Case Management Department

AMY PERRY, DIRECTOR OF CASE MANAGEMENT

NOVEMBER 2021

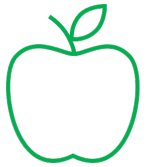
Community Health Advocate Interventions

Care Coordination

- Support Patient and Care Team Plan of Care
- Home or Community Visits
- Telephonic Outreach

Transitions of Care

- Medical Emergency Room Discharge Follow-up
- Behavioral Emergency Room Discharge Follow-up



Food

- Prescription Produce Program
- Food Pantry Access
- Food Box Delivery
- SNAP Applications

Social Determinants of Health

- Support social needs impacting health of an individual. Examples:
  - financial
  - legal
  - transportation
  - language barriers
  - safety

Housing

- Permanent Supportive Housing
- Street Outreach
- Housing Stabilization Services

Friendly Reminders…

Remaining Practice Reporting / Transformation Meetings

- February 23, 2022 – review PDSA results + clinical quality data submitted 1/15/2022
- May 26, 2022 – Review FINAL clinical quality, CAHPS and Contract Adjudication Results

All other Practice Reporting / Transformation Meetings are FAKE calendar invites.

Friendly Reminders of Deliverables Due…

Due Date	Deliverable
Jan 15th	Submit clinical quality data to CTC Portal and report on high risk patients to CTC Portal
Jan 31st	Submits a quality improvement activity demonstrating improvement to improve a performance measure (quality, customer experience, utilization) to deliverables@ctc-ri.org or ckarner@ctc-ri.org

Friendly Reminders of Upcoming Meetings…

Date	Meeting
Dec 10th	Breakfast of Champions, 7:30-9:00AM https://ctc-ri.zoom.us/j/712460640?pwd=cWpIYUNTc2RxK0oyemNMUGRUZzFhdz09 Meeting ID: 712 460 640; Passcode: 646876; One tap mobile: 6468769923,,712460640#,,,,,,0#,,646876# **Panel: Addressing Clinician and Clinical Team Well-Being During the Pandemic** Moderator: **Patricia Flanagan, MD,** Hasbro Children's Hospital, & Brown Univ. Pediatrics Professor Panelists: **Jerome Finkel, MD,** Henry Ford Health System Chief Primary Health Officer, MI **Matthew Malek, MD,** Medical Director of Provider Experience, Thundermist Health Center; Assistant Professor (Clinical), Department of Family Medicine, Alpert Medical School of Brown University **Nicolas Nguyen, MD,** Associate Chief Medical Officer, Beth Israel Lahey Health Primary Care South Region; Clinical Instructor Harvard Medical School ***CME credits available*** ***Please Register via*** Eventbrite
Dec 21st	NCM/CC Best Practice Sharing meeting, 8:00-9:00AM, **Part 2 RIGEC Geriatric Education Series - Dementia Diagnosis: Treatment Options** ***You must register for this event:*** https://uri-edu.zoom.us/meeting/register/tJ0kfu6orjMjGNORcLkl3LrO5S7ag6ZG2LSE
Jan 6th	PCMH Kids Stakeholder meeting, 7:30-8:30AM https://ctc-ri.zoom.us/j/95963024930?pwd=NHMzOGVZdEkzdTQyVk0yZE9CWi80dz09 Meeting ID: 959 6302 4930; Passcode: 646876 One tap mobile: +16468769923,,95963024930#,,,,,,0#,,646876# US

CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Thank you
Stay Healthy and Safe

Next Meeting: February 23, 2022

Appendix: PCMH Kids Practice Performance

PCMH Kids Quality & KIDSNET

- https://ctcpracticedata.shinyapps.io/QualityKidsHistory/
- https://ctcpracticedata.shinyapps.io/QualityKidsCohort/
- https://ctcpracticedata.shinyapps.io/KidsNet/