Ohio | Department of Medicaid

Ohio Comprehensive Primary Care

2020 Activity Requirements

December 30th, 2019

2020 CPC Activity Requirements

New in 2020

Unchanged in 2020

Community services and supports integration	The practice uses screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.
Behavioral health Integration	Practice identifies, refers, and tracks follow-ups for patients in need of behavioral health services; practice has planned improvement strategy for behavioral health outcomes.
24/7 and same-day access to care	The practice provides and attests to 24 hour, 7 days a week patient access to a primary care physician, primary care physician assistant, or a primary care nurse practitioner with access to the patient's medical record, including providing same-day access (within 24 hours of initial request) and regularly offering at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population.
Risk stratification	Providers use risk stratification from payers in addition to all available clinical and other relevant information to risk stratify all of their patients, and integrates this risk status into records and care plans
Population health Management	Practices identify patients in need of preventative or chronic services and implements an ongoing multifaceted outreach effort to schedule appointments; practice has planned improvement strategy for health outcomes
Team-based care Delivery	Practice defines care team members, roles, and qualifications; practice provides various care management strategies in partnership with payers and ODM (and behavioral health qualified entities, as applicable) for patients in specific patient segments.

2020 CPC Activity Requirements Cont.

New in 2020

Unchanged in 2020

Care management plans	Practice creates care plans for all high-risk patients as identified by risk stratification system, which includes key necessary elements.
Follow up after hospital Discharge	Practice has established relationships with all EDs and hospitals from which they frequently get referrals and consistently obtains patient discharge summaries and conducts appropriate follow-up care
Tests and specialist Referrals	The practice has a documented process for tracking referrals and reports, and demonstrates that it: - Asks about self-referrals and requests reports from clinicians - Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results - Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports - Tracks fulfillment of pharmacy prescriptions where data is available
Patient experience	The practice assesses their approach to patient experience and cultural competence at least once annually through use of a Patient and Family Advisory Council or other quantitative or qualitative means, and integrates additional data sources into its assessment where available; information collected by the practice covers access, communication, coordination and whole person care and self-management support; the practice uses the collected information to identify and act on improvement opportunities to improve patient experience and reduce disparities; and the practice has process in place to honor relationship continuity throughout the entire care process.

Additional Detail on New Activity Metrics Added in 2020

Activity Requirement	Community Services and Supports Integration
Rule	The practice uses screening tools to identify patients in need of community services and supports, and implements and maintains a process to connect patients to necessary services.
Provider requirement	• Practice identifies patients in need of community services and supports through the use of screening tools or other means (e.g., Screening, Brief Intervention, and Referral to Treatment (SBIRT), adverse childhood experiences screening (ACES), social determinants of health questionnaire) • Practice has a systematic approach to refer and link patients to necessary community services and supports, including validating that services recommended were received with a provision to close gaps in care if necessary • Practice integrates community services and supports activities into broader practice systems, including risk stratification, care management plan, population health management • Practice has planned improvement strategy for outcomes with community services and Supports
Activity Requirement	**Behavioral Health Integration**
Rule	Practice identifies, refers, and tracks follow-ups for patients in need of behavioral health services; practice has planned improvement strategy for behavioral health outcomes.
Provider requirement	• Practice identifies patients in need of behavioral health services through regular use of specific tools and processes designed for anticipatory diagnosis • Practice has a systematic approach to timely referral and ongoing follow-up for members with behavioral health needs, including validating that services recommended were received with a provision to close gaps in care if necessary • Practice integrates behavioral health activities into broader systems, including care plans, risk stratification, and team based care delivery • Practice has planned improvement strategy for behavioral health outcomes

Additional Detail on Activity Metrics

Activity Requirement	24/7 and Same-day Access to Care
Rule	The practice provides and attests to 24 hour, 7 days a week patient access to a primary care physician, primary care physician assistant or a primary care nurse practitioner with access to the patient's medical record, including providing same-day access (within 24 hours of initial request) and regularly offering at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population.
Provider requirement	• Practice provides same day (within 24 hours of initial request) appointments with a practitioner (primary care physician, primary care PA/NP) connected to the CPC practice (i.e. who can access patient records) who can diagnose and treat the patient. • Practice must provide a response to requests for clinical advice received after hours in accordance with the CPC practice's written policy, and within a reasonable time frame. • Practice must regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living facilities), and/or expanded hours in early mornings, evenings, and weekends • Practice makes patient clinical information available 24/7 to on-call staff, external facilities, and other clinicians outside the practice when the office is closed through paper or electronic records or telephone consultation

Activity Requirement	Risk Stratification
Rule	Providers use risk stratification from payers in addition to all available clinical and other relevant information to risk stratify all of their patients, and integrates this risk status into records and care plans.
Provider requirement	• Providers have a stated definition and documented methodology for identifying patient risk tiers, including a high risk tier that includes roughly 25-30% of the patient population • Providers use risk stratification to assign a risk status for each patient, using data from ODM and contracted MCPs in addition to all available clinical and other relevant information such as cost data or screening results, tobacco use, health risk behaviors Patient risk status is fully integrated into patient records and used to drive decisions around patient treatment, including development of individualized care management plans • Providers update their risk stratification periodically (whenever updated information is available from payers or when the practice is informed of a significant change event e.g. hospitalization for the patient) and correspondingly update care plans to reflect changes in risk status

Additional Detail on Activity Metrics

Activity Requirement	Population Health Management
Rule	Practices identify patients in need of preventative or chronic services and implements an ongoing multifaceted outreach effort to schedule appointments; practice has planned improvement strategy for health outcomes
Provider requirement	• Practices identify who needs preventative or chronic services and performs outreach to those (either patients or their families/caregivers) who have not been recently seen in order to schedule an appointment or identify additional services to meet the needs of the patient • Practices identify patients with gaps in care (e.g., high-risk patient, children who have not had well-checks, and patients who take specific medications), and implement an ongoing multifaceted outreach effort to schedule appointments (independently or through partnership with payers and community) • Practices have a planned improvement strategy for at least one metric related to health outcomes and business processes for population health management, as defined by CPC. Billing process includes appropriate detailed coding for health risk factors (e.g., ICD-10 code z59.0 for lack of housing)
Activity Requirement	**Team Based Care Delivery**
Rule	Practice defines care team members, roles, and qualifications; practice provides various care management strategies in partnership with payers and ODM (and behavioral health qualified entities, as applicable) for patients in specific patient segments.
Provider requirement	• Practice has designated and trained individual(s) to fill care manager role, which is to help overcome the barriers to the patient getting the evidence-based treatment that they need • Practice incorporates non-traditional workers into the care team and establishes processes to ensure that each care team member has responsibilities that make use of the full extent of their training and credentials. Non-traditional workers may include, but not be limited to, psychologists, pharmacists, community health workers, dietitians, social workers, data analysts, physical therapist and other non-traditional staff that the practice deems useful to supporting effective and efficient care management • Practice defines who is on the care team (including the payer(s) and a quality improvement lead as appropriate), care team member qualifications, roles and responsibilities of care team members especially with regard to development and maintenance of care management plans for high risk patients, how team members function in relationship to other providers, ODM and/or contracted MCPs outside the care team; provides orientation and ongoing education and training to staff and holds scheduled patient care team meetings • The practice provides various care management strategies in partnership with ODM and/or contracted MCPs including coordination with practitioners and external care agencies, integration of behavioral health, self-management support for patients

Additional Detail on Activity Metrics

Activity Requirement	Care management plans
Rule	Practice creates care plans for all high-risk patients as identified by risk stratification system, which includes key necessary elements
Provider requirement	• Practice creates care plans for all high-risk patients as identified by risk stratification system, which includes key necessary elements, including at minimum patient preferences and functional/lifestyle goals, treatment goals, potential barriers to meeting goals, self-management plan; and is easy to understand and provided in writing to the patient/family/caregiver. • Care plans integrate behavioral health care management elements, as applicable. • Practice identifies and flags key activities that require action/follow-up by care team members, including the contracted MCP.

Activity Requirement	Follow up after hospital discharge
Rule	Practice has established relationships with all EDs and hospitals from which they frequently get referrals and consistently obtains patient discharge summaries and conducts appropriate follow-up care
Provider requirement	• Practice has established relationships with all EDs and hospitals from which they frequently get referrals and has established process to ensure a reliable flow of information • Practice proactively and consistently obtains patient discharge summaries from hospitals and other facilities, and connects information from discharge summaries to risk stratification process and care management of highest risk tier of patients • Practice tracks patients receiving care at hospitals and EDs, proactively contacts patients/families for appropriate follow-up care given the cause of admission within an appropriate period following a hospital admission or emergency department visit • Follow-up care may include an in-person visit, physician counseling, referrals to community resources, and disease or case management or self-management support programs

Additional Detail on Activity Metrics

Activity Requirement	Test and specialist referrals
Rule	The practice has a documented process for tracking referrals and reports, and demonstrates that it: • Asks about self-referrals and requests reports from clinicians • Tracks lab tests and imaging tests until results are available, flagging and following up on overdue results • Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports • Tracks fulfillment of pharmacy prescriptions where data is available
Provider requirement	• Practice has established bidirectional communication with specialists, pharmacies, labs and imaging facilities necessary for referral tracking • All of the above, plus the practice has a documented process for and demonstrates that it: • Asks about self-referrals and requests reports from clinicians • Tracks lab tests and imaging tests until results are available • Tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports • Tracks fulfillment of pharmacy prescriptions where data is available
Activity Requirement	**Patient experience**
Rule	The practice assesses their approach to patient experience and cultural competence at least once annually through use of a Patient and Family Advisory Council or other quantitative or qualitative means, and integrates additional data sources into its assessment where available; information collected by the practice covers access, communication, coordination and whole person care and self-management support; the practice uses the collected information to identify and act on improvement opportunities to improve patient experience and reduce disparities; and practice has process in place to honor relationship continuity through the entire care process
Provider requirement	• The practice has a process to orient all patients to the CPC practice and incorporates patient preference in the primary care provider selection process. The practice builds the continuity of patient relationships through the entire care process • The practice assesses their approach to patient experience and cultural competence at least once annually through use of a Patient and Family Advisory Council as well as other quantitative or qualitative means (e.g., a patient/family advisory council, focus groups, or a patient survey), and integrates additional data sources into its assessment where available • Information collected must cover access, communication, coordination, and whole person care and self-management support • The practice uses the information collected to identify improvement opportunities, and take action via concrete initiatives with dedicated staff time to improve overall patient experience and reduce disparities in patient experience