Resources

Driver 1: The Comprehensive Primary Care Functions

Secondary Driver 1.1: Access and Continuity

Coding for Group Visits (http://www.aafp.org/practice-management/payment/coding/group-visits.html)

Continuity of Care, Definition of, AAFP (2015). http://www.aafp.org/about/policies/all/definition-care.html

Continuity of Care: a multidisciplinary review, BMJ (2003). http://www.bmj.com/content/327/7425/1219

CPC On Demand Video: Group Visits: Expanding Access to Care (2017). This video illustrates how group visits can benefit the needs of a practice's patient population. https://www.youtube.com/watch?v=ae--zQ0ufJk&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=5

CPC Practice Spotlight 12: DTC Family Health and Walk-in (2014). DTC Family Health and Walk-in from Colorado share insights about use of the portal. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=30

CPC Practice Spotlight 59: Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care (2015). Providence Medical Group-Glisan (Ore.) shares its home visit process for high-risk patients. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=22

Empanelment Implementation Guide (2013). Safety Net Medical Home Initiative. http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf

Group Visit Billing Information (http://www.acponline.org/running_practice/patient_care/group_visits/billing_info.htm)

Group Visit Starter Kit (2001). Group Health. www.improvingchroniccare.org/downloads/group_visit_starter_kit_copy1.doc

Secondary Driver: 1.2 Planned Care and Population Health

AHRQ National Guidelines Clearinghouse. https://www.guideline.gov/

Always Use Teach-back! Training Toolkit. http://www.teachbacktraining.org/

AMA STEPS*forward* (2016). https://www.stepsforward.org/modules/pre-visit-planning

Brief Action Planning – The Centre for Collaboration Motivation and Innovation. This support technique is a structured method of working with patients to create a concrete action plan for their health. http://www.centrecmi.ca/learn/brief-action-planning/

Chronic Disease Self-management Program, Stanford Medicine. This is an example of a peer-led, evidence-based support resource. There is also be state and local references. https://www.ncoa.org/healthy-aging/chronic-disease/chronic-disease-self-management-program/ and http://patienteducation.stanford.edu/programs/cdsmp.html

Clinical Decision Support: Using Technology to Identify Patients' Unmet Needs (2012). http://www.aafp.org/fpm/2012/0300/p22.html

CPC On Demand Video: Integrating Advanced Primary Care Strategies: Behavioral Health and Medication Management (2017). On-site behavioral health specialists and a strong focus on medication management benefited the patients at this practice. https://www.youtube.com/watch?v=6yfH-nSTPJ0&index=16&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Leveraging the Whole Team for Planned Care (2017). This practice demonstrates how team-based care and pre-visit planning helped improve their quality measures. https://www.youtube.com/watch?v=PlDg27RvJQc&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=2

CPC On Demand Video: Proactive Management of Chronic Conditions to Improve Outcomes and Empower Patients (2017). A CPC practice discusses using COPD rescue packs as part of a team-based approach to delivery of chronic disease management for an at-risk population. https://www.youtube.com/watch?v=TTcFaW0edKg&index=14&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). A practice shares how they established effective goal setting for patients with chronic conditions. https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand: Self-management Support for Vulnerable Patient Populations (2017). How to reach the vulnerable patients in your population (economically disadvantaged, racial and ethnic minorities, low-income children, HIV+) and provide them with self-management support. https://www.youtube.com/watch?v=m2f0bJAruWo&index=19&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Testing New Workflows through Pre-Visit Planning (2017). In this video, a practice describes how they established a new system for pre-visit planning. The new system made patients more engaged, and the physicians and staff appreciate it. https://www.youtube.com/watch?v=8PurmJIhTEM&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=10

CPC On Demand Video: Utilizing Pre-visit Planning Tools and Teamwork (2017). A CPC practice describes the tools and strategies staff and providers use to prepare for patient visits. Chart scrubs and QM cards are part of the daily workflow. https://www.youtube.com/watch?v=rUG8QV9Hd90&index=11&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 17: Patient-centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity (2014). Clopton Clinic (Ark.) uses the skill of their health coach to improve outcomes for chronically ill patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=39

CPC Practice Spotlight 33: Check for Literacy When Evaluating Patient Self-management Skills (2014). Warren Clinics in Jenks, Okla., found teach back to be a valuable tool to use with a patient with limited literacy. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=56

CPC Practice Spotlight 43: Beyond Patient Education: Self-management Support (2015). Hunterdon Family Practice and Obstetrics from Flemington, N.J., describes its observation of changes in process measures (patient goals, community resources accessed and

number of follow-up phone calls tracked in the EHR) as well as outcome measures (i.e., CQMs, PHQ scores). https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=8

CPC Practice Spotlight 50: A Simple Ask: How One Request Can Quickly Engage and Activate Patients (2015). This New Jersey medical group engages patients in their exercise and food tracking activities as a means of self-management support. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=14

CPC Practice Spotlight 60: Pharmacist Integration Strategy: Working Directly with Patients to Improve Medication Adherence and Outcomes (2015). Banner Health (Colorado) pharmacists engage directly in patient care, working closely with patients with complex medication regimens. This article includes an outline of workloads and patient touches as well as suggestions for measurement. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=23

CPC Practice Spotlight 76: Strategies for Meeting Patients 'Where They Are' and Making Self-management Support Work in a Busy Primary Care Practice (2016). Summit Family Physicians in Middletown, Ohio, integrates self-management support into how they engage patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=36

CPC Practice Spotlight 84: Geriatric Care Coordinator Boosts Patient Confidence, Satisfaction (2016). This New Jersey practice found it could best serve the needs of its largely elderly population by including a care coordinator specializing in geriatrics on its care team. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=42

CPC Practice Spotlight 86: Pre-visit Planning Helps Eliminate Gaps in Patient Care (2016). This Spotlight describes how an Ohio practice uses both population health software and chart audits to identify patient care needs, including a brief list of the steps in the practice's visit planning process. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=44

Culture and Health Literacy http://www.cdc.gov/healthliteracy/culture.html

Health Literacy Measurement Tools http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html

Health Literacy Universal Precautions Toolkit http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

Healthy Huddles (2013). https://cepc.ucsf.edu/healthy-huddles

How's Your Health https://www.howsyourhealth.org/

Motivational Interviewing videos:
a. ***The Ineffective Physician: Non-Motivational Approach*** (2009). https://www.youtube.com/watch?v=80XyNE89eCs
b. ***The Effective Physician: Motivational Interviewing Demonstration*** (2009). https://www.youtube.com/watch?v=URiKA7CKtfc

An Organized Approach to Chronic Disease Care (2011). This article discusses the development of organized, team-based care with the use of registries and other tools to improving the care of chronically ill patients. http://www.aafp.org/fpm/2011/0500/p27.html

Partnering in Self-management Support: A Tool-kit for Clinicians (2012). http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf

The Patient Activation Measure Survey http://www.insigniahealth.com/products/pam-survey

Patient Activation Measure Tool Helps Patients Avoid Hospital Readmissions (2014). http://www.the-hospitalist.org/hospitalist/article/126322/patient-activation-measure-tool-helps-patients-avoid-hospital

The Primary Care Team Guide – Improving Primary Care: A guide to better care through teamwork (2016). Improving Primary Care. http://www.improvingprimarycare.org/

Secondary Driver: 1.3 Risk-Stratified Care Management

The Academy: Integrating Behavioral Health and Primary Care – The Playbook (2016). Provides a good description of its developed Shared Care Plan. http://integrationacademy.ahrq.gov/playbook/about-playbook

Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs (2011). The authors discuss care coordination and management of patients with the highest need for this strategy. http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Care Management: A Review of CPC Practice Approaches (2014). Additional information on care management with CPC practice implementation case studies are found here. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=2

Care Management: Implications for Medical Practice, Health Policy, and Health Services Research (2015). http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html

Chronic Care Management Services (2015). https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Clinical Decision Support Starter Kit (2017). Order sets are used to make the ordering process more efficient and to standardize a level of care across the practice. This starter kit describes the use of order sets as a part of clinical decision support. https://www.healthit.gov/providers-professionals/implementation-resources/clinical-decision-support-starter-kit

Collaborative Practice Agreements and Pharmacists' Patient Care Services: A Resource for Pharmacists (2013). http://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf

CPC On Demand Video: How to Enhance Transitions of Care (2017). In this video, you will explore the tools you can use to help in your effort to reduce unnecessary emergency room visits and hospital readmission rates. https://www.youtube.com/watch?v=LK2ILb9SgQs&index=20&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Longitudinal and Episodic Care Management (2017). This video describes how one practice differentiates between patients who need long term care management and those who need shorter term or episodic care management during transitions of care. https://www.youtube.com/watch?v=99bbAZn_0Uo&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=3

CPC On Demand Video: Patient-centered Plan of Care (2017). A practice describes their tactics for care management and risk stratification, which helped them reach their goals. https://www.youtube.com/watch?v=LK2ILb9SgQs&index=20&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Targeted Care Management (2017). Features DTC Family Health and Walk-in (Colorado) sharing data to show the how care management improved care for high-risk patients. https://www.youtube.com/watch?v=wtIvLQOez-g&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=7

CPC On Demand Video: Using Data to Identify Patients with Behavioral Health Needs (2017). In this video, a practice talks about how they used data to identify the behavioral health needs of their patient population. https://www.youtube.com/watch?v=G6s7AuHyIQs&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=8

CPC On Demand Video: Using Risk Stratification to Drive Workflow (2017). This video describes one practice's experience using a risk-stratification methodology to determine the level of involvement for care management and to drive their care management and coordination workflows. https://www.youtube.com/watch?v=rOjMOJ0YnHI&t=3s

CPC Practice Spotlight 2: SAMA Healthcare (2013). SAMA Healthcare describes its risk stratification tool and how the practice EHR plays a role in accomplishing this task and keeping care teams informed. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=6

CPC Practice Spotlight 6: TriHealth (2014). Using a standardized process, this practice established a four-level care management needs assessment as a means of identification of risk level. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=14

CPC Practice Spotlight 7: Oregon Medical Group (2014). This group used the services of a knowledgeable psychologist to develop their BHI program. Article describes steps taken, including selecting the appropriate BHS professional, and the screening used to identify patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=17

CPC Practice Spotlight 8: OU Physicians and Associates in Family Medicine (2014). Two CPC practices describe the benefits when they included medication management as a part of their primary care services. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=20

CPC Practice Spotlight 16: Lower A1c Among Patients with Diabetes Through Standardized Team Approach (2014). One CPC practice in Oklahoma developed a standard approach to care management of patients with diabetes that demonstrated promising results. In taking a proactive approach to the care management of this population, this practice saw a notable improvement on this clinical quality measure. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=38

CPC Practice Spotlight 21: Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes (2014). Cherokee Nation Health Services' Wilma P. Mankiller Health Center engaged the expertise of a pharmacist as it launched an intensive diabetes management education program for patients with an A1c greater than 9. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=43

CPC Practice Spotlight 22: Heeding the Signs: Know When It's Time to Modify Your Risk Stratification Methodology (2014). This example shows how a practice changed its three-tier risk stratification methodology after noting some trends that the team found troubling. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=44

CPC Practice Spotlight 28: It Takes a Neighborhood to Increase Medication Safety for Patients (2014). A CPC practice closed the gaps in its medical neighborhood by collaborating with two pharmacies. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=51

CPC Practice Spotlight 42: Critical Elements in Care Management: Process/Data, Protocols and Reinforcement/Response (2015). CPC Spotlight dives into the use of data for care management, as well as implementation of innovative methods of care. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=7

CPC Practice Spotlight 49: Patient-centered Care Plan Curbs Patient's Hospital Use, Savings to Top $150,000 (2015). This CPC practice in Kentucky modified a patient's care plan to meet her needs, resulting in a large reduction in high-cost utilization and ultimately expenditures. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=13

CPC Practice Spotlight 55: Measuring the Effectiveness of Behavioral Health Management (2015). Boulder Community Health in Boulder, Colo., included behavioral health services in its five CPC practices. To evaluate the effectiveness of the practice's behavioral health services, the team of social workers tracked the PHQ-9 scores among patients with moderate and severe depression following treatment. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=18

CPC Practice Spotlight 57: Shared Decision Making Can Be Part of Behavioral Health (2015). Vanguard Medical Group (Verona, N.J.) has an imbedded behavioral specialist. The use of a shared decision aid assists the patient and practice team to decide if use of medication for depression is the best option. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=20

CPC Practice Spotlight 65: Social Worker Contributes to Collaborative, Team-based Care Management (2016). Stillwater Medical Physicians Clinic (Okla.) finds that the addition of a social worker to their care management team has a positive impact on the services provided to the patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=26

CPC Practice Spotlight 72: Small Practice Leverages Team-based Care and Care Management (2016). Learn about an Ohio solo practitioner's care management strategy that led to reduced hospital admissions and ED visits. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=30

DIAMOND for Depression (2016). ICSI's DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program united a physician, care manager and consulting psychiatrist to provide a team-based model for caring for patients with depression in the primary care clinic. https://www.icsi.org/about_icsi/legacy_work/diamond_for_depression/

DIAMOND Study Findings (2014). Study results of the model, implemented in almost 100 clinics. https://www.icsi.org/_asset/nn70fc/ICSI-DIAMOND-Study-Finding-6-4-14.pdf

FP Credits CPC Initiative With Practice Turnaround, AAFP (2016). http://www.aafp.org/news/macra-ready/20161116cpcplus.html

A Guide to Evidence-Based Practices. SAMHSA-HRSA (2016). http://www.samhsa.gov/ebp-web-guide

Improving Care for Complex Patients: The Role of the RN Care Manager (2012). http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Supplement-Evidence-Based-Care.pdf

Integrating Comprehensive Medication Management to Optimize Patient Outcomes, PCPCC Resource Guide, Second Edition (June 2012). https://pcpcc.org/sites/default/files/media/medmanagement.pdf.

Medicare Medication Therapy Management (2016). Medicare has a standardized format for medication therapy management for those participating in Medicare Part D. It includes a cover letter, medication action plan and personal medication list. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Memo-Contract-Year-2017-Medication-Therapy-Management-MTM-Program-Submission-v-040816.pdf

Medicare Part D Medication Therapy Management Program Standardized Format (2012). A written summary of a comprehensive medication review. https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MTM-Program-Standardized-Format-English-and-Spanish-Instructions-Samples-.pdf

Partnering in Self-management Support: A Tool-kit for Clinicians (2009). http://www.improvingchroniccare.org/downloads/selfmanagement_support_toolkit_for_clinicians_2012_update.pdf

Patient Self-management Tools (2016). http://champsonline.org/tools-products/clinical-resources/patient-education-tools/patient-self-management-tools

PHQ-2. This questionnaire is used as the initial screening test for major depressive episodes. https://integrationacademy.ahrq.gov/sites/default/files/PHQ-2_0.pdf .

PHQ-9. A multipurpose questionnaire for screening, diagnosing, monitoring and measuring the severity of depression. https://integrationacademy.ahrq.gov/sites/default/files/PHQ-9_0.pdf

Recognition and management of dementia. In: Evidence-based geriatric nursing protocols for best practice, AHRQ National Guidelines Clearinghouse (2012). This provides tools to screen for dementia. https://www.guideline.gov/summaries/summary/43921

Risk Stratification Implementation Guide (2014). This 23-page guide captures how CPC practices tested and implemented a range of risk-stratification methodologies. Sample tools are included. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=35

SAMHSA National Registry of Evidence-based Programs and Practices (2016). http://www.samhsa.gov/nrepp

SBIRT (Screening Brief Intervention and Referral to Treatment) - A Primary Care Tool to Assess for Substance Use Disorder (2016). Tool used to identify patient who are moderate or high risk users with the goal of early intervention to prevent health problems related to Substance Use Disorder. http://ejournal.tnmed.org/cgi/viewcontent.cgi?article=1039&context=home

Screening Tools, SAMHSA-HRSA Center for Integrated Health Solutions (2016). This site offers multiple screening tools for behavioral health concerns that may be used in the primary care setting. http://www.integration.samhsa.gov/clinical-practice/screening-tools

Stanford Chronic Disease Self-management Program (2016). This is an example of a peer lead, evidence-based support resource. http://patienteducation.stanford.edu/programs/cdsmp.html

Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting (2017). http://www.sprc.org/sites/default/files/tipsandstrategiesforbilling.pdf

Secondary Driver: 1.4 Patient and Caregiver Engagement

CPC On Demand Video: Principles for Patient and Family Engagement (2017). How practices can integrate patients and families into the fabric and function of their practice, for a mutually beneficial relationship. https://www.youtube.com/watch?v=wkYj4k7_ay0&index=1&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Shared Decision Making – Informing Decisions and Decreasing Costs (2017). This practice shares its process and outcomes to implementation of low back pain share decision-making, including how cost of care decreased. https://www.youtube.com/watch?v=QIrBJHFxAUw&feature=youtu.be

CPC On Demand Video: Using Patient Feedback to Drive Practice Change (2017). This practice initially worked with their PFC on workflows and signage. Expanded to patient education and outreach. Helped add the patient voice. https://youtu.be/6_maGI-MKfk.

CPC Practice Spotlight 4: Primary Care Partners (2014). This Colorado practice describes its workflow for shared decision-making. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=10

CPC Practice Spotlight 10: Capital*Care* Medical Group (2014). The ten CPC practices in this upstate New York group chose Patient and Family Advisory Council as their option to improve patient experience. They share how they planned, recruited for and gleaned insights from the council input to make changes in their practices. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=25

CPC Practice Spotlight 13: Grants Pass Clinic (2014). Using tools from the Mayo Clinic, this Oregon practice finds shared decision-making standardizes conversations with patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=32

CPC Practice Spotlight 25: One-Two Combination of Surveys and PFAC Guide: This Practice's Implementation of Patient-centered Changes (2014). This Ohio practice uses both surveys and a PFAC to drive change in its clinic. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=48

CPC Practice Spotlight 51: Developing a Highly Effective PFAC over Time: How Structure and Transparency Foster Useful and Actionable Feedback (2015). This independent practice in Batesville, Ark. made changes to their PFAC over time, resulting in their "chronically displeased" council members becoming cheerleaders due to the transparency and positive results the group has on practice improvement. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=15

CPC Practice Spotlight 52: A Small Practice and Shared Decision Making: Start Simple to Scale Up (2015). This small practice has developed a reproducible workflow for use of shared decision aids and tracks the data in its EHR for analysis using dummy codes. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=16

Creating Patient and Family Advisory Councils, Institute for Patient and Family Centered Care (2010). IPFCC outlines process steps for creating PFACs. http://www.ipfcc.org/resources/Advisory_Councils.pdf

Enhanced Support for Shared Decision Making Reduced Costs of Care For Patients With Preference-Sensitive Conditions (2013). This article describes outcomes from a study focusing how shared decision making provided by health coaches resulted in population cost savings. http://content.healthaffairs.org/content/32/2/285.abstract

Healthwise: Boost shared decision making (2016). Link to the Healthwise tools, including ability to create a demo login. http://www.healthwise.org/products/decisionaids.aspx.

Helping Patients Make Decisions about Screening (2016). This link leads to the American Cancer Society shared decision aid for PSA screening. http://www.cancer.org/healthy/informationforhealthcareprofessionals/prostatemdcliniciansinformationsource/helpingpatientsmakedecisionsaboutscreening/index.

International Patient Decision Aid Standards (IPDAS) Collaboration (2015). http://ipdas.ohri.ca/

Key Steps for Creating Patient and Family Advisory Councils in CPC Practices, NPWF (2015). Written by the National Partnership for Women & Families, this guide focuses on initiating and maintaining PFACs. https://innovation.cms.gov/Files/x/cpci-patientfamengresource.pdf

Pathways to Patient and Family Engagement in CPC Practices (2015). This guide from the National Partnership for Women & Families focuses on patient experience survey data, quality improvement teams and developing shared decision-making tools. https://innovation.cms.gov/Files/x/cpci-patientfamengresource.pdf.

Patient and Family Engagement in Primary Care, AHRQ (2016). This guide offers tools to help practices in their patient engagement journey. http://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions.html

The SHARE Approach (2016). http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

Shared Decision Making: An In-Depth Review of the Critical Elements for Success (2014). This CPC Implementation Guide provides an overview of the task and examples from CPC practices. https://downloads.cms.gov/files/cmmi/cpci-combined-implementationguide.pdf#page=58

Secondary Driver: 1.5 Coordination of Care Across the Medical Neighborhood

Administration on Aging: Administration for Community Living (2016). Locate resources in your community. https://aoa.acl.gov/

Always Use Teach-back! Training Toolkit. This training tool will assist the practice staff to learn this valuable technique. http://www.teachbacktraining.org/

Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs, IHI Innovation Series white paper (2011). http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

Clinical-Community Relationships Measures Database (2016). This measures database may help the practice to identify measures to evaluate their relationships with community-based resources. https://primarycaremeasures.ahrq.gov/clinical-community

CPC On Demand Video: Building Relationships and Referral Processes with Specialist in Your Medical Neighborhood (2017). A practice manager explains how providers developed close working relationships with specialists in their medical neighborhood. https://www.youtube.com/watch?v=gJZjMUMrBYw&index=21&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Building Relationships with Community Resources to Meet Patient Needs (2017). This practice describes how finding and connecting patients to community resources supported their patients' health. https://www.youtube.com/watch?v=JzknAjzakSM&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=9

CPC On Demand Video: Creating Effective Care Compacts with Behavioral Health Specialists (2017). In this video, one practice describes how it successfully manages referrals to behavioral health specialists. The specialists, in turn, inform the providers about the patient's course of therapy. https://www.youtube.com/watch?v=WB_MlNQbG6Y&index=23&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: How to Enhance Transitions of Care (2017). In this video, you will explore the tools you can use to help in your effort to reduce unnecessary emergency department visits and hospital readmission rates. https://www.youtube.com/watch?v=BlnCROIysJQ&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=4

CPC On Demand Video: Self-management Support for Patients with Chronic Conditions (2017). One practice shares how they established effective goal setting for patients with chronic conditions. Includes resources for SMS in the community. https://www.youtube.com/watch?v=aEwPg-unkhY&index=12&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Using the Health Information Exchange to Improve Communication and Coordination Across the Medical Neighborhood (2017). A practice describes using HISP to share information across the medical neighborhood, which helps guide care and patient transitions. https://www.youtube.com/watch?v=xa1x3Oy8Amg&index=22&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 19: Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider (2014). This small independent practice initiated care compacts to address the needs of their patient population. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=41

CPC Practice Spotlight 20: Focused Care Management and Coordination Reduced Emergency Room Visits for Patient (2014). This practice dealt with managing a complex patient with multiple needs by coordinating care with home health agencies and other community resources, yielding a reduction in emergency room visits. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=42

CPC Practice Spotlight 28: It Takes a Neighborhood to Increase Medication Safety for Patients (2014). This solo-provider independent practice established informal care compacts with two local pharmacies to help their patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=51

CPC Practice Spotlight 29: Care Compacts Can Work with Various Health Partners (2014). This small independent practice set up a meeting with local hospitals, home health agencies and extended care facilities to deal with gaps in transitions of care. Use of a collaboration agreement and bi-directional communication has benefited their patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=52

CPC Practice Spotlight 30: Full HIE Access Facilitates Real-Time Care Management (2014). The system-affiliated practice worked with their HIE as well as hospitals to establish the ability to get information needed to provide care for transitions, as well as a working relationship to help patients with their transitions of care to reduce readmissions. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=53

CPC Practice Spotlight 41: Following Data Over the Long Term Aids in Maintaining Improvement (2015). This Oregon practice developed a workflow to track referrals and the resultant testing, including tags in their EHR. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=6

CPC Practice Spotlight 46: Innovative Care Compacts Result in Timely Care, Continuity and Efficiency (2015). A solo practitioner in New York created a wrap-around care compact process that resulted in timely specialist consults and bi-directional communication. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=11

CPC Practice Spotlight 78: Manage Care Coordination with Teamwork, Persistence and Technological Support (2016). This practice scours the community for resources for patients, in addition to reaching an agreement with local hospitals to allow access to patient EHR portals to monitor transitions in care for their patients. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=38

The Current State of Sharing Behavioral Health Information in Health Information Exchanges (2014). SAMHSA-HRSA Center for Integrated Health Solutions. This paper provides insight into some of the regulations in place for sharing behavioral health information. http://www.integration.samhsa.gov/operations-administration/HIE_paper_FINAL.pdf

Health Information Exchange (HIE) (2014). https://www.healthit.gov/HIE

HealthLeads (2016). Resource for screening for social determinants of health; discusses locating pertinent community resources for the patient population. https://healthleadsusa.org/

Healthy People 2020: Social Determinants of Health (2016). https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

High Value Care Coordination Toolkit (2016). This online toolkit from the American College of Physicians provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. Scroll through the page to find data sets, checklists, and tips on facilitating patient- and family-centered conversations about the referral process. https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

Primary Care Team Guide: Clinic-Community Connections (2016). This learning module will help guide the primary care team with these important connections. http://www.improvingprimarycare.org/work/clinic-community-connections

Reducing Care Fragmentation. Prepared by Group Health's MacColl Institute for Healthcare Innovation, supported by The Commonwealth Fund (2011). Includes a change package and tools as well as relevant case studies and resources. http://www.improvingchroniccare.org/downloads/reducing_care_fragmentation.pdf

Referral Coordinator Curriculum (2011). Published by Group Health's MacColl Institute for Healthcare Innovation as a portion of their Reducing Care Fragmentation Toolkit. http://www.improvingchroniccare.org/downloads/5_referral_coordinator_curriculum.pdf

Referral Tracking Guide (2008). Published by Improving Chronic Care, with permission from the American College of Physicians as a portion of their Reducing Care Fragmentation toolkit. http://www.improvingchroniccare.org/downloads/3_referral_tracking_guide.pdf

Social Determinants of Health: Know What Affects Health (2016). This resource from CDC provides links and education about this topic. https://www.cdc.gov/socialdeterminants/

United Way 2-1-1 Community Resources Directory (2016). Easily locate resources in your community. http://www.referweb.net/211CommunityResources/

Driver 2: Use of Enhanced, Accountable Payment

Compensation Strategies Implementation Guide (2015). This Guide reflects on how CPC practices have approached using compensation strategies to incentivize the non-visit-related work and population management activities. https://downloads.cms.gov/files/cmmi/pathwaysguide-programyr2015.pdf

CPC Practice Spotlight 1: SAMA Healthcare (2013). Focus on building care teams to sustain change and support transformation. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=4

CPC Practice Spotlight 2: SAMA Healthcare (2013). Focus on building care teams to sustain change and support transformation. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=6

CPC Practice Spotlight 31: Building a Transformative Culture to Sustain Change (2014). This Spotlight explores how this 39-site practice group has sought ways to stave off "change fatigue" by cultivating engagement and building a culture focused on continual improvement. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=54

CPC Practice Spotlight 70: Practice 'Re-Attacks' ED Visits Following Changes in the Medical Neighborhood (2016). Describes how one practice used its data to identify the root cause of rising emergency department rates. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=29

CPC Practice Spotlight 86: Pre-visit Planning Helps Eliminate Gaps in Patient Care (2016). Describes a well-coordinated system of pre-visit planning to eliminate gaps in patient care. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=44

Estimating the Costs of Primary Care Transformation, A Practical Guide and Synthesis Report (2015). The intention of this guide is to list the key steps in an analysis of the costs of a primary care transformation effort, review the range of methodological options, and describe key considerations for each method. http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/tpc/estimating-costs-primary-care-transformation.pdf

Guidance for Structuring Team-Based Incentives in Health Care. Discusses the structuring of care delivery processes around teams of clinicians working toward common patient care goals. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3984877/

IHI Run Chart Tool (2017). Run charts are graphs of data over time are one of the most important tools for assessing the effectiveness of change. http://www.ihi.org/resources/pages/tools/runchart.aspx

IHI Triple Aim Measures (2017). A list of suggested measures that also help operationally define the IHI Triple Aim. http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/MeasuresResults.aspx

Measuring What Matters in Primary Care, Health Affairs (2015). Discusses key components of primary care and how measurement is critical for advancement. http://healthaffairs.org/blog/2015/10/06/measuring-what-matters-in-primary-care/

PCMH-A Tool. Patient Centered Medical Home Assessment Tool used as a gap analysis and planning tool for practice transformation. http://www.safetynetmedicalhome.org/resources-tools/assessment

Science of Improvement: Establishing Measures (2016). Measures are essential for determining if changes in priority areas are affecting outcomes. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx

Driver 3: Continuous Improvement Driven by Data

AHRQ Module 7 – Measuring and Benchmarking Clinical Performance. This source identifies key steps for selecting measures and identifying benchmarks. While at the target audience is practice facilitators, it is also valuable for quality-improvement staff within a practice or health system. https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod7.html

Analytics Adoption Model: https://www.healthcatalyst.com/healthcare-analytics-solutions/

The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement (2003). This white paper describes the use of the Breakthrough Series model to transform healthcare in various settings. http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx .

CMS Core Quality Measures (PCMH/ACO) (2016). The Centers for Medicare & Medicaid Services (CMS) and partners worked together through the Core Quality Measures Collaborative to identify core sets of quality measures that payers have committed to using for reporting. Listed here is a link to Core Measures for Primary Care. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/ACO-and-PCMH-Primary-Care-Measures.pdf

CPC On Demand Video: Building a Culture for Practice Improvement (2017). How a medical center in Colorado used data to improve their practice. They encourage staff in improvement efforts through a variety of methods. https://www.youtube.com/watch?v=WEd4LhB-oe0&index=26&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Creating and Sustaining a Culture of Improvement (2017). This small, rural practice team accepted "Change is the New Normal" as its mantra. They meet regularly, educate staff and embrace change. https://youtu.be/ZP3dooe4pMI

CPC On Demand Video: How Sharing Duties and Better Coordination Drive Improvement in Health Care Measures (2017). At this practice, having all team members work at the top of their certification helped achieve the practice's goals. https://www.youtube.com/watch?v=aldKmbIoyL8&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh&index=6

CPC On Demand Video: Using Cost Data to Support and Direct Comprehensive Primary Care (2017). This system demonstrates how patient contact with primary care drives the cost of care. Data-driven research drives the system's improvement efforts. https://www.youtube.com/watch?v=ei8Q4-u-Mco&feature=youtu.be

CPC On Demand Video: Using Patient Feedback to Drive Practice Change (2017). This practice initially worked with their PFAC on workflows and signage before expanding to patient education and outreach. The practice presented data about cancer screening to the PFAC. https://youtu.be/6_maGI-MKfk

CPC Practice Spotlight 24: How Your Approaches to Improvement Strategies Also Builds Your Culture for Improvement (2014). This system leadership implemented quality improvement across 17 sites based on team collaboration and shared data. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=47

CPC Practice Spotlight 31: Building a Transformative Culture to Sustain Change (2014). Leadership at this medical group committed to a cohesive approach supporting transformation. Staff engagement and both leadership and staff engagement in learning activities is key to their success. CQM measures with staff surveys measure their progress. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=54

CPC Practice Spotlight 44: Teamwork, Transparency and Rewards Drive Improvement in Quality Measures (2015). This physician group pursued three strategies to help providers and practice teams with their integration of CQMs into improvement work: teamwork, data transparency and rewards for performance. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=9

CPC Practice Spotlight 45: PDSA Cycles Focused on Reducing Falls Risk Help Reduce ED Use (2015). This independent practice used the PDSA process driven by data to study fall risk screening, identifying cause and reducing ED visits. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=10

CPC Practice Spotlight 48: Million Hearts® 'Champion' Practice Honed Performance in Hypertension Control through Multiple Tests of Change (2015). Transformation teams tested workflows, using data as their measurement of improvement. Refresher training was employed to improve outcomes. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=12

CPC Practice Spotlight 55: Measuring the Effectiveness of Behavioral Health Management (2015). This system-affiliated group used data to evaluate the effectiveness of their BH interventions. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=18

CPC Practice Spotlight 56: Explore Potential Efficiencies Using Your Patient Portal as an Outreach Tool (2015). This system-affiliated site tested the patient portal as an outreach tool. Process data assisted the change process. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=19

CPC Practice Spotlight 58: Setting Your Improvement Project in Motion: Get a Quick Start with Pre-Planning, Guidelines, Communication and Tools (2015). This team approach using data to improve identification and treatment of COPD patients hit some snags. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=21

CPC Practice Spotlight 66: Co-located Primary and Urgent Care Helps Reduce ED Use (2016). This practice used feedback reports, payer data and practice research to evaluate and change ED usage. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=27

CPC Practice Spotlight 70: Practice 'Re-attacks' ED Visits Following Changes in the Medical Neighborhood (2016). This small practice assesses conditions inside and outside the clinic's walls to identify factors that could affect ED usage. This drove their change to reduce after-hours ED usage. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=29

CPC Practice Video Spotlight 73: Utica Park Clinic: CPC from the Leader's Perspective (2016). This physician discusses the leader's role and processes necessary to implement change. Teambuilding, training, and dealing with resistance to change were needed to improve metrics. https://www.youtube.com/watch?v=jxt1tcibOtI&feature=youtu.be

CPC Practice Video Spotlight 74: Utica Park Clinic: Starting at the Clinic and Going Beyond (2016). This video highlights a change process between the primary care practices and the hospital to address transitions in care. https://www.youtube.com/watch?v=LA4QVFJpceo

eCQM Library (2016). CMS provides updates to electronic CQM measures that are used for report to CMS programs. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

Engaged Leadership Implementation Guide: Strategies for Guiding PCMH Transformation (2010). This Safety Net Medical Home implementation guide explains the importance of leadership during practice transformation. This includes the use of data to guide improvement and management of change. http://www.improvingchroniccare.org/downloads/engaged_leadership.pdf

Enhancing the Primary Care Team to Provide Redesigned Care: The Roles of Practice Facilitators and Care Managers (2013). Facilitators (or quality improvement coaches) work with the primary care practice on their quality improvement activities. This article discusses their role, with the role of the care manager, as primary players in redesign efforts. http://www.annfammed.org/content/11/1/80.full.

HRSA Quality Toolkit (2017). This site has a wide range and assortment of tools for free use in health care quality improvement. https://www.hrsa.gov/quality/toolbox/index.html

IHI Run Chart Tool (2017). IHI. This resource offers a guide to run charts and an Excel template for practice use. Registration on the IHI site is free. http://www.ihi.org/resources/pages/tools/runchart.aspx

LEAN: http://www.lean-concepts.com/

The Model for Improvement (MFI): https://www.ahrq.gov/professionals/prevention-chronic-care/improve/.../mod4.htm

PDSA Cycle Template (2016). This template from CMS may help practices as they adopt the PDSA tool for improvement. https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pdsacycledebedits.pdf

Primary Care Practice Coach (2016). IHI's 11-month virtual professional development program and associated community. http://www.ihi.org/education/WebTraining/Webinars/PrimaryCare/Pages/default.aspx

Practice Facilitation (2016). AHRQ's Primary Care Practice Facilitation (PCPF) learning community is a valuable resource for practices as they begin or continue their journey of practice improvement. https://www.pcmh.ahrq.gov/page/practice-facilitation

Run Charts (2016). IHI Open School provides videos on run charts and how to construct this visual of data for evaluating variation or change. Explanation is provided of run chart rules and the use of run charts. http://www.ihi.org/education/WebTraining/OnDemand/Run_ControlCharts/Pages/default.aspx

Science of Improvement: Establishing Measures (2016). The authors discuss the use of process, outcome and balancing measures for learning and process improvement. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx

Successful Measurement for Improvement (2016). This IHI article, which is part of the Improvement Series, provides an overview of how to create a system of measurement that is rewarding and useful to organizations. http://www.ihi.org/resources/Pages/ImprovementStories/SuccessfulMeasurementForImprovement.aspx

TeamSTEPPS for Office-Based Care Version (2016). Primary care practice teams are the audience for this version of the TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) program. The focus is on creating high-performing teams that improve quality and safety. Sections cover change management and measurement. http://www.ahrq.gov/teamstepps/officebasedcare/index.html

Driver 4: Optimal Use of Health IT

Case Study: Practice Transformation, Health Information Technology, Payment Reform: Is There Optimism for Primary Care? (2011). A Colorado physician describes implementing EHR and other health IT as part of his primary care improvement journey. https://www.healthit.gov/providers-professionals/primary-care/practice-transformation-health-information-technology-payment-r

Certified Health IT Product List (2016). The CHPL is a comprehensive and authoritative listing of all certified HIT, with search capability. https://chpl.healthit.gov/#/overview

CPC On Demand Video: Building a Culture for Practice Improvement (2017). How a Colorado medical center used data to improve their practice. They encourage staff in improvement efforts through a variety of methods. https://www.youtube.com/watch?v=WEd4LhB-oe0&index=26&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC On Demand Video: Improving the Accuracy of Information from your EHR (2017). How to gather data for eCQM reporting, validate its accuracy and educate your staff. https://www.youtube.com/watch?v=8PNHTDprYTM&index=30&list=PLaV7m2-zFKpgNDwSSnQ6QMys_LbIaZXjh

CPC Practice Spotlight 12: DTC Family Health and Walk-in (2014). This Colorado practice shares how it registered 90 percent of its patients for portal use, with 72 percent as active users. The team used iPads connected to the EHR to enter registration data, saving time for front-desk personnel. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=30

CPC Practice Spotlight 30: Full HIE Access Facilitates Real-Time Care Management (2014). This practice benefited from their access to a HIE by gaining insights into their patients ongoing treatment status in the hospital. This information improved transitions of care for patients. https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=53

CPC Practice Spotlight 44: Teamwork, Transparency and Rewards Drive Improvement in Quality Measures (2015). This group practice leveraged its effective teamwork and transparency to provide performance scorecards for each team to motivate friendly competition to drive its quality improvement efforts. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=9

CPC Practice Spotlight 45: PDSA Cycles Focused on Reducing Falls Risk Help Reduce ED Use (2015). This Oregon practice focused on eCQM CMS139v5, Falls: Screening for Future Fall Risk as a practice improvement initiative with positive results in positive results both in reduction in ED visits, and identification of the root cause of the falls. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=10

CPC Practice Spotlight 46: Innovative Care Compacts Result in Timely Care, Continuity and Efficiency (2015). This practice increased the effectiveness of its referrals of patients to specialists by establishing Coordination of Care agreements with those specialists and using its EHR to track and follow-up on patient referrals. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=11

CPC Practice Spotlight 52: A Small Practice and Shared Decision Making: Start Simple to Scale Up (2015). This practice used its EHR to track the use of shared decision making tools by using codes developed by the IT department. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=16

CPC Practice Spotlight 56: Explore Potential Efficiencies Using Your Patient Portal as an Outreach Tool (2015). This system-affiliated site tested the patient portal as an outreach tool for certain targeted eCQMs. Process data assisted the change process. https://innovation.cms.gov/Files/x/cpcipsl-2015summary.pdf#page=19

CPC Practice Spotlight 85: Expanding Access to Care through E-visit Technology (2016). This system found e-visits effective for increasing access to care without compromising quality. The system was on track to complete 4,800 e-visits in 2016. https://innovation.cms.gov/Files/x/cpcipsl2014-2016.pdf#page=43

CPC+ Quality Reporting Overview for Performance Year (PY) 2017 (2016). This is an example of an initiative requiring reporting at the practice level. These requirements indicate the need to report from the EHR at the practice level. https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2017.pdf

Direct Basics: Q&A for Providers (2014). This National Learning Consortium resources provides an understanding of what Direct is and how to use it. https://www.healthit.gov/sites/default/files/directbasicsforprovidersqa_05092014.pdf

EHR Incentives and Certification: Meaningful Use Definition & Objectives (2015). This site will help the reader understand the MU program. https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

Five Things to Know about CCD (2012). Healthcare IT News provides a description of CCDs and their use. http://www.healthcareitnews.com/news/5-things-know-about-ccd

Getting Started with HIE (2016). This site provides contacts for each state to help providers locate an HIE in their region. https://www.healthit.gov/providers-professionals/health-information-exchange/getting-started-hie

Going Lean in Health Care (2005). This IHI white paper describes how the use of Lean in healthcare improves processes with elimination of waste, less rework and better quality. http://www.ihi.org/resources/pages/ihiwhitepapers/goingleaninhealthcare.aspx

Health Information Exchange (HIE) (2014). This site contains an overview of HIE, as well as interoperability courses that may benefit the practice. https://www.healthit.gov/HIE

Health Information Exchange Case Studies (2013). Contains a description of the three forms of HIE with case studies. https://www.healthit.gov/providers-professionals/health-information-exchange-case-studies

Heath IT Dashboard: Health Care Professional EHR Vendors (2016). Overview of certified EHRs. https://dashboard.healthit.gov/quickstats/pages/FIG-Vendors-of-EHRs-to-Participating-Professionals.php

Health IT Dashboard: Quick Stats (2016). This site provides stats on the use of HIT in both office-based settings and hospitals. https://dashboard.healthit.gov/quickstats/quickstats.php

Health IT Evaluation Toolkit and Evaluation Measures Quick Reference Guides (2009). This site provides a guide to measures for evaluation. https://healthit.ahrq.gov/health-it-tools-and-resources/health-it-evaluation-toolkit-and-evaluation-measures-quick-reference

Health IT Implementation Toolbox: 9 Steps to Implement EHRs (2016). This site covers 9 topics of importance when implementing the EHR. The knowledge provided is helpful as you work on practice workflows, build staff, evaluate, and optimize your HIT. https://www.hrsa.gov/healthit/toolbox/healthitimplementation/index.html

High Value Care Coordination Toolkit (2016). This online toolkit from the American College of Physicians provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. Scroll through the page to find standard documents for communication between providers. https://www.acponline.org/clinical-information/high-value-care/resources-for-clinicians/high-value-care-coordination-hvcc-toolkit

How to Get Started with Direct Messaging (2016). This article provides insight into this secure tool for providers. http://medicaleconomics.modernmedicine.com/medical-economics/news/how-get-started-direct-messaging?page=full

Impact Insights: "MIPS, MACRA & MU – The Next Evolution of Healthcare Payment Reform" (2017). A discussion of the relationships among the merit-based payment programs and how they relate to meaningful use. http://www.impact-advisors.com/meaningful-use/mips-macra-mu-the-next-evolution-of-healthcare-payment-reform/#sthash.m2KdCyam.dpuf

Implementing Direct Secure Messaging (2015). HealthIT.gov provides an overview of this valuable tool. https://www.healthit.gov/policy-researchers-implementers/implementing-direct-secure-messaging

Importance of Cross Training in the Workplace (2015). This blog identifies the many benefits of cross training in any workplace. http://www.directrecruiters.com/uncategorized/blog/importance-of-cross-training-in-the-workplace/

Measuring the Impact of Patient Portals: What the Literature Tells Us (2011). This report examines the impact of patient portals and provides information to health care workers looking to implement and measure their own portals. http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MeasuringImpactPatientPortals.pdf

The Merit-based Incentive Payment System: Quality Performance Category (2016). This site provides an overview of the Quality Payment Program (QPP), with a focus on the quality performance category that replaces PQRS. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Performance-Category-training-slide-deck.pdf

ONC Health IT Certification Program (2016). Describes the ONC structure, testing and certification process. https://www.healthit.gov/policy-researchers-implementers/about-onc-health-it-certification-program

Physician Quality Reporting System (2016). This site provides an overview of the PQRS system. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

Physician Quality Reporting System Qualified Clinical Data Registries (2016). This site lists the 2016 QCDRs meet the CMS requirements outlined in the 2016 Medicare Physician Fee Schedule final rule. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QCDRPosting.pdf

Practice Facilitation Handbook: Module 17. **Electronic Health Records and Meaningful Use** (2013). This AHRQ resource provides useful information for both the practice facilitator and practice staff. https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod17.html

Quality Payment Program (2016). This site describes the QPP with the differences between MIPS and Alternative Payment Model (APM) reviewed. Allows the practice to use the embedded tools to understand how the QPP may affect its reporting and incentives. https://qpp.cms.gov/

Quality Payment Program: Quality Measures (2016). This tool allows the practice to review and select the quality measures that best fit the needs of your practice. https://qpp.cms.gov/measures/quality

Regional Extension Centers (RECs): Advising Providers in All Phases of Electronic Health Record Implementation (2015). https://www.healthit.gov/providers-professionals/regional-extension-centers-recs

Science of Improvement: How to Improve (2016). This IHI resource provides instruction in the Model for Improvement used in many healthcare settings. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

State Health Information Exchange Cooperative Agreement Program Key Contacts (2014). Program ended in 2014, and not all states have an HIT Coordinator position. https://www.healthit.gov/policy-researchers-implementers/state-health-information-exchange-cooperative-agreement-program-key

What Is EHR Optimization, How Does It Start? (2017). EHR optimization begins soon after implementation. The EHR vendor is a crucial partner in this journey. https://ehrintelligence.com/features/what-is-ehr-optimization-how-does-it-start

What is HIE? (2014). Overview of HIE and the different types. Includes a video depicting consumer-mediated exchange. https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie#consumer-mediated_exchange

Driver 5: Environment to Support Comprehensive Primary Care

Comprehensive Primary Care Initiative Shared Savings Methodology (2016). This paper describes the technical details for the methodology CMS uses to determine shared savings for CPC practices. https://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Shared-Savings-Methodology-PDF.pdf

Science of Improvement: Establishing Measures (2016). The authors discuss the use of process, outcome and balancing measures for learning and process improvement. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx