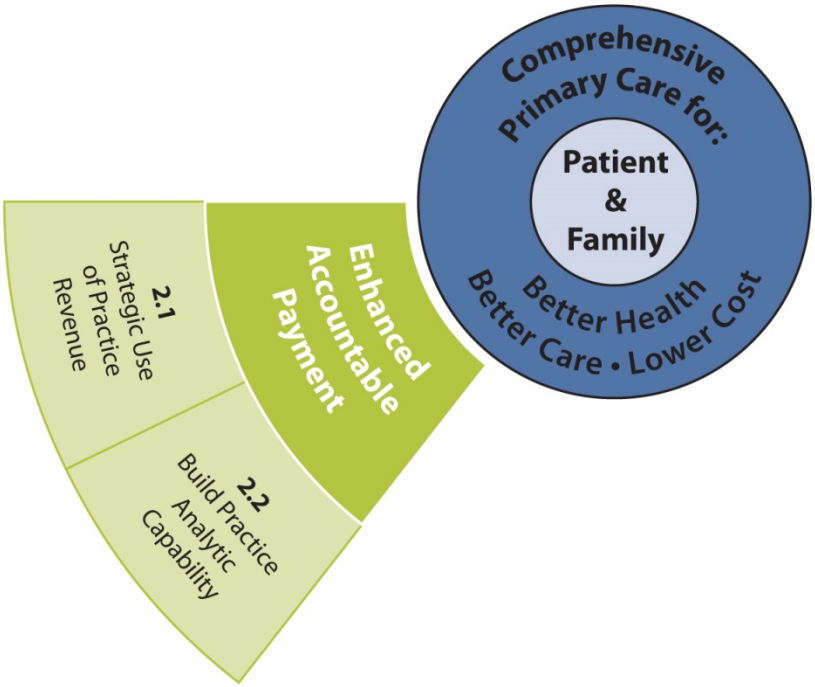
Driver 2:
Use of Enhanced, Accountable Payment

CPC practices combined the non-visit based payments they received from multiple commercial and public payers to deliver comprehensive primary care. They were strategic in their use of these alternate payments to build and sustain the capability to deliver the comprehensive primary care functions, and they invested in the analytic capability needed to meet the health care needs of their population with attention to the cost of care.



Driver 2: The Secondary Drivers

The secondary drivers described below support Use of Enhanced Accountable Payment:

2.1 Strategic Use of Practice Revenue

This secondary driver focuses on the strategic use of practice revenue as a catalyst for providing comprehensive primary care.

2.2 Build Practice Analytic Capability

This secondary driver focuses on building analytic capacity to track and respond to trends in cost of care and health outcomes.

Secondary Driver 2.1: Strategic Use of Practice Revenue

This section focuses on the strategic use of practice revenue as a catalyst for providing comprehensive primary care.

Traditional fee-for-service (FFS) payments reward practices for the volume of visits and clinical services provided at those visits. Services that occur outside of the office visit, such as care coordination and care management activities, often show improved health outcomes and reduced total cost of care. However, they offer few opportunities for compensation in a traditional FFS model. Provider and care team productivity in FFS payment environments are generally based on the volume of care provided instead of the patient outcomes.

Change Concepts for strategic use of practice revenue

- Use budgeting and accounting processes effectively to transform care processes and build capabilities to deliver comprehensive primary care
- Align practice productivity metrics and compensation strategies with comprehensive primary care

CMS paid CPC practices a per-member, per-month (PMPM) payment to support comprehensive primary care functions that were not visit-based and not reimbursed under fee-for-service payments. Practices also had the opportunity to share in savings accrued to the Medicare Trust Fund resulting from a decrease in the total cost of care. Other CPC payers (insurance companies) also committed to an aligned strategy with population-based payment to support the Comprehensive Primary Care functions, which encouraged practices to participate in savings from reducing the cost of care. Throughout CPC, practices explored and implemented strategies for aligning productivity metrics and compensation strategies with the CPC model of comprehensive primary care.

CPC introduced two Change Concepts for practices to address how payment reform would affect the CPC aims. The first was to use budgeting and accounting processes effectively to transform care processes. The second was to create value and support processes of care that align with the CPC aims of achieving better health, better care and lower costs through improvement.

The phases of the work in CPC:

- Initially in CPC, practices were unsure of what changes and budget items would be necessary within their practice to successfully transform and provide comprehensive primary care. They began by assessing their current practice workflows and determined how to spend their new revenue. In the beginning, these decisions were driven less by outcome data and more by qualitative, internal reflection and assessment by practice leaders.
- In the first year, practices invested largely in personnel (care managers) and health information technologies (generally electronic health record software) to lay the foundation for practice transformation.
- After the first year of the program, practices began to seek out other sources of data to guide their budgeting processes for the upcoming years. They reviewed payer cost/utilization data and quality metric data from their EHR. They also anticipated future benchmarks for shared savings when creating their budgets for the upcoming year.
- Leveraging the data that was available to them, practices were able to make informed decisions about their budgets in the last years of the CPC initiative.

Change Concept: Use budgeting and accounting processes effectively to transform care processes and build capabilities to deliver comprehensive primary care

Fully understanding all of the necessary changes a practice should make to achieve the aims of the CPC initiative proved to be a challenge for many practices at CPC's onset. Practices had to use some means of evaluating where they were at the time and where they needed to be to meet the CPC aims (better health, better care and lower costs for patients and families). In the beginning, practices were unsure of how to budget their revenue. They understood the initiative's aims but were unclear about what concrete steps they should take for success to meet those aims. Practices began to self-assess or perform gap analyses to determine where to budget funds. Over the years, practices became better at using self-assessment data, along with payers' outcome data, and their respective EHRs to guide revenue allocation.

Throughout the initiative, practices found it necessary to continually identify and prioritize areas within their practice that needed improvement, invest revenue based on these priorities, and identify how to monitor revenue allocation to determine whether funds were allocated appropriately and whether focus areas were effective.

Change tactics CPC practices used:

- Develop a process for prioritizing practice changes necessary to improve patient outcomes and population health
- Invest revenue in priority areas for practice transformation
- Use accounting and budgeting tools and processes to allocate revenue

Implementation tips for budgeting and accounting

- Identify who will be responsible for budget process. Include all necessary personnel.
- Identify and engage in practice self-assessment, including against relevant data from external sources on the practice's performance.
- Use assessment and data, along with initiative requirements, to create priority areas for practice transformation.
- Allocate revenue after considering priority areas.
- Establish a budget process including accounting tools and a mechanism for monitoring predicted versus actual revenues and expenditures.
- Establish a monitoring process for reviewing outcome data and budget data to ensure that allocated resources are producing intended results.

Change Tactic: Develop a process for prioritizing practice changes necessary to improve patient outcomes and population health

Due to the varying levels of functionality and capacity within practices at the beginning of CPC, practices' budgets varied widely. To ensure practices allocated revenue to the highest priority areas, CMS encouraged practices to self-assess, which included the review of payer data, and then identify priority areas for their new PMPM revenue.

CMS guided practices to use PMPM revenue for improvements that mapped directly to CPC milestones or patient care. Practices were not to use this funding for existing expenses or any expenses not tied to delivering comprehensive primary care. This included paying for utilities or the salaries of existing team members.

CPC resources related to developing processes to prioritize practice changes

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

In the beginning, practices assessed priorities based solely on internal operations around the nine CPC milestones. Over the years, they became more comfortable with incorporating data from external sources, such as cost and utilization data from payers. About half-way through the initiative, since the milestone requirements only changed slightly, many practices began to prioritize their revenue allocation based on multiple sources of outcome data, including cost, quality and patient experience.

Essential components

- Form a budget/finance committee.
- Identify PMPM revenue expected from each payer.
- Develop or adopt a self-assessment methodology (including data from multiple relevant sources), and establish a monitoring and re-assessment plan.
- Identify priority areas and determine if and how revenue is necessary to achieve the desired change.
- Involve the entire team in the assessment and prioritization phases to ensure that no assumptions are made about the current state of operations.

Considerations for your practice

- To make an effective change, you must know how you are performing at the time, along with what resources you use. Self-assessments can be beneficial if used appropriately.
- Practice transformation is complex. Including multiple team members from various departments is critical to fully understand how your practice currently functions, as well as what the ideal future state of operations would look like.

Online (external) resources for developing processes to prioritize practice changes

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

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

Change Tactic:
Invest revenue in priority areas for practice transformation

After practices self-assessed to ensure revenue was allocated to high-priority areas, they sought ways to make strategic investments in their practices that would ensure high-yield and long-term change. In the first and second year of CPC, practices found it beneficial to allocate revenue to foundational areas such as EHR capacity and capability and staffing/resources for providing care management to high-risk patients. Practices' budgets commonly prioritized care management personnel/resources and EHR capability. Having established resources in place proved beneficial in the later years when the CMS care management fees dropped by approximately 25 percent. Practices that focused on care management and EHR capabilities early on found they had a strong foundation for practice transformation. They then allocated other revenue in later years to enhance their care management services for high-risk patients in the form of integrated behavioral health services, medication management and/or self-management support.

Online (external) resources for investing in priority areas for practice transformation

Science of Improvement: Establishing Measures (2017). Measures are essential for determining whether changes in priority areas are affecting outcomes. http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementEstablishingMeasures.aspx

In the initiative's later years, practices looked to outcome data to guide revenue allocation and change. For example, practices began to expand their focus from individual patient care to entire patient populations, such as those who frequently used the ER or had frequent hospital stays. This population health approach drove revenue allocation, allowing focused changes to practice operations that benefited both the targeted population and the health and wellness of their entire patient population. Practices then began building or enhancing relationships with interdisciplinary staff, such as behavioral health specialists, pharmacists, diabetes educators and nutritionists, to better meet patients' needs and, thus, their outcomes in cost/utilization, quality and patient experience.

Essential components

- Identify priority areas through self-assessment including data from relevant sources.
- Focus initial investments on building capacity for future change.
- Work with your teams to ensure revenue and resources are allocated appropriately to identified priority areas.
- Monitor priorities and progress to goal using process, outcome and balance measures.
- Reconcile revenue allocation predictions with actual expenditures at least annually.

Considerations for your practice

- Priority areas will vary between practices. Collect data to identify these areas and document the historical changes made, along with what progress is made in these areas.
- Involve team members with the skills and knowledge to determine the current and future state of priority areas. This eliminates the possibility for assumptions that could lead to undesirable results.

Change Tactic: Use accounting and budgeting tools and processes to allocate revenue

Assessment and budgeting processes are critical to ensure practices focus revenue in areas of need. It is also important that practices have a mechanism for establishing and monitoring their budgets. This may include specific accounting-type tools or software for practice-based budgeting, or it may include outsourcing this task to a financial consultant or institution. Both options require a practice to identify a process for regular monitoring, either through internal budget reports or reports from an external source. Although system-affiliated practices have departments responsible for budgeting, they need to be aware of their site budgets as well, including quarterly revenue and expenses. Budget data should be part of any practice's regular data review. Items reviewed can include outcome data on cost and utilization, quality data and patient-experience data. This review is necessary for ensuring that allocated dollars are having the anticipated effect.

Budget tools and processes in CPC varied from practice to practice. Some practices outsourced this process to other organizations or departments. Others used their own accounting software, while several practices relied on simple processes involving electronic spreadsheets and quarterly updates. Regardless of the chosen method, practices that regularly monitored their revenue and expenditures were better informed. They then made effective, meaningful changes in their day-to-day workflows.

Online (external) resources for using budget and accounting processes effectively

Estimating the Costs of Primary Care Transformation: A Practical Guide and Synthesis Report. This AHRQ guide lists the key steps in an analysis of the costs of a primary care transformation effort, reviews the range of methodological options and describes key considerations for each method. http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/tpc/estimating-costs-primary-care-transformation.pdf

Essential components

- Identify the budgeting process, either internal or external, including information management (revenue versus expenditures) and reporting frequency.
- Ensure the budget committee is made aware of budget position at least quarterly.
- Review budget data alongside other data on cost/utilization, quality and patient experience.
- Monitor and track all budget changes for easy reporting.

Considerations for your practice

- Even if an external entity, such as the finance department of an affiliated hospital system, is responsible for the budget, the practice-level leadership should still be involved in the budget process and kept informed of the budget throughout the year.

Measure Success for Change Concept: Use budgeting and accounting processes effectively to transform care processes and build capabilities to deliver comprehensive primary care

Consider these measures to help you evaluate the effectiveness of your budget processes:

- Monitor the budget position (expected revenue and expenses versus actual) at least quarterly.
- Translate performance metrics and outcomes in cost/utilization and quality, along with patient experience, into budget priority areas. Monitor performance accordingly.
- Ensure process, outcome and balance measures are all in place for identified practice changes that affect the budget.

Change Concept: Align practice productivity metrics and compensation strategies with comprehensive primary care

In CPC, CMS and other payers set out to change how primary care practices provide patient care. To do so, they had to pay practices in a different way. Similarly, practices had to begin to do things differently to produce a different outcome and, thus, care for patients in different ways. Because practices began being paid differently and were asked to provide care differently, they had to think differently about how they incentivized their personnel.

Just as patients are often resistant to changing their lifestyles and behaviors to produce different health outcomes, practice personnel are often resistant to changes in their day-to-day duties. Therefore, aligning productivity metrics and compensation strategies can encourage change, leading to improved outcomes and progress toward other goals.

In CPC, practices were encouraged to use productivity measures that included non-visit related care and to financially incentivize efficient and effective team-based care. The following sections discuss specific change tactics the practices used.

Change tactics CPC practices have used:

- Use performance measures that include non-visit related care
- Incentivize cost-efficient and effective team-based care

Implementation tips for aligning productivity metrics

- Determine which committee/staff will be responsible for identifying measures and planning for alignment.
- Create a communication strategy for ensuring all personnel are informed.
- Communicate performance feedback regularly through identified measures.
- Create an environment for collective feedback and innovation from all personnel regarding changes and new processes for improvement.
- Use data to guide all changes and monitor them with quality improvement methods, such as PDSA (Plan-Do-Study-Act) cycles.

Change Tactic:
Use performance measures that include non-visit related care

As payments to practices became focused around patient population, practices had to begin measuring different processes that affected population health. A shift in focus to population health also required a shift from provider-based to team-based care. Due to this shift, practices had to also reconfigure their measures from provider-based to team-based. Many practices chose to be transparent with productivity measures and performance measures to encourage innovation and engagement, as well as foster healthy competition. For example, practices traditionally used provider-specific data to influence a provider's pay. In CPC, the entire care team was responsible for its measures, and practices incentivized accordingly. Practices would often have contests among care teams in areas of clinical quality measures and patient experience measures.

Examples spanned several areas of friendly competition:

- Who could achieve the best controlled A1c measure (fueled by in-patient visits, care management via phone encounters or interaction via the patient portal)?
- Which teams completed all of their pre-visit planning by deadline?
- Who had the best performance on executing daily huddles or completing all transition-of-care outreach within the designated period?

Team-based competitions further encouraged a team environment where everyone was working to find his or her place in the workflow and helping others on the team, as needed.

CPC resources related to using performance measures

Spotlight 31: Building a Transformative Culture to Sustain Change (2014). This Spotlight explores how a 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

Online (external) resources for using performance measures

Measuring What Matters in Primary Care, Health Affairs (2015). This article 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/

Essential components

- Form a team or designate specific team members responsible for setting focus measures and benchmarks for productivity and performance.
- Identify process, balance and outcome measures for monitoring progress toward goals and outcome of changes.
- Communicate all measures and benchmarks to all team members, including information on opportunities for incentives and/or disincentives based on performance.
- Designate a frequency for monitoring measures and regularly communicate performance to all personnel.

Considerations for your practice

- Shift from focusing on a single provider's performance to the entire care team's performance. This requires planning and open communication.
- Clearly communicate all expectations to all involved and resolve any confusion or questions your teams may have.

Change Tactic:
Incentivize cost-efficient and effective, team-based care

In CPC, a shift occurred from provider-centric care to patient-centric care that is directed by a care team (a team of clinical personnel). In the beginning of CPC, this notion of team-based care was a new concept. One of the first steps was to ensure that everyone worked to the top of his or her licensure so that the care team was efficient and effective. When changes in daily tasks were necessary, it proved challenging to get full buy-in for these changes from everyone. Practices identified that incentivizing (not just financially but with time and appreciation) encouraged their personnel to adopt a team-based approach. Many practices began to identify ways to encourage the adoption of team-based care and to incentivize their teams to participate in daily huddles and pre-visit planning in preparation for the day. They started monitoring the frequency of daily huddles and the percentage of gaps in care, and practices began to incentivize team members based on their performance in some of these areas.

CPC resources related to encouraging effective and efficient team-based care

Spotlights 1 and 2: SAMA Healthcare (2013). Focus on building care teams to sustain change and support transformation.
Spotlight 1: https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=4

Spotlight 2: https://innovation.cms.gov/Files/x/cpcipsl1.pdf#page=6

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

Essential components

- Ensure that all team members know their roles and responsibilities and work closely together in an environment open to questions, clarification and modification of tasks. This should ensure that the workflow is conducive for providing high-quality, cost-effective care.
- Identify performance measures and benchmarks to ensure that the team is meeting and/or exceeding the definition of efficiency and effectiveness.
- Regularly communicate performance to everyone in the practice.
- Use QI techniques, such as PDSA cycles, to test new changes within the team.

Considerations for your practice

- Balance measures must be in place. A team can be efficient and drive down costs, but it should never be at the expense of quality and the patient's experience.
- Realize that team-based care will not occur overnight. It takes planning, work and intentional communication among members to make the model work.
- Incentivizing teams is a new concept for most practices. Give your team members time to process the change, understand expectations and figure out how to best work together to achieve the identified goals.

Online (external) resources for encouraging effective and efficient team-based care

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/

Measuring Success for Change Concept: Align practice productivity metrics and compensation strategies with comprehensive primary care

The following measures will help evaluate this change concept:

- Non-visit based performance such as care management encounters outside the office visit
- Portal utilization
- Huddle execution and value of time spent
- Team-based versus provider-based performance in regards to quality, cost/utilization and patient experience
- Pre-visit planning measures, including gaps in care
- Employee satisfaction measures based on the new model of team-based care
- Patient-experience measures (CAHPS) for care team

Secondary Driver 2.2: Build Practice Analytic Capability

This section focuses on building analytic capacity to track and respond to trends in cost-of-care and health outcomes.

Change Concepts for analytic capability

- Build the analytic capability required to manage total cost of care for the practice population

For practices to understand their data and use it effectively, they must first have the capacity and capability for analysis. Analytic capacity is a major piece of overall data management that includes data collection and distribution. This data will indicate where changes need to occur in a practice, particularly for total cost of care, health outcomes and maintenance of access. Analytic capacity is the key to data driven improvement.

These were the phases of the work in CPC:

- In the beginning of CPC, most practices were not accustomed to gathering data and reviewing it; they started with basic reports. In addition, there was a variance between the capacity and capability for data analysis from the small and independent practices to the practices with system affiliation.
- Aside from capacity and capabilities, many practices did not see the value in using data from external sources such as payers. They were not regularly reviewing claims-based payer data for multiple reasons.
- As CPC progressed, practices began to appreciate the value of data from external sources and worked to build the capacity for teams to focus on data, provide training and set aside time to learn how to turn data into action.
- Practices used various types of data, including but not limited to cost and utilization data, patient experience data, quality data and self-assessment data, to guide changes and inform transformation within their practices and their medical neighborhood.

Change Concept: Build the analytic capability required to manage total cost of care for the practice population

Building analytic capacity will provide practices with the means track the cost of care for a practice population. Tracking total cost of care allows practices to begin to identify patterns of health care within their patient population. Once a trend is identified, practices will still need to drill down into patient-level data to pinpoint the specific populations and characteristics of patients that are utilizing services in similar patterns. Getting to this level of detail can be difficult at times and may take some work with payers and health IT vendors to create reports that allow you to view this level of detail. For example, practices may want to identify patients who should be seeking care at the primary-care level for back pain, instead of the ER. Or, practices may want to consider where they may leverage the skills and abilities of their team members to meet patient needs. As practices mature in their analytic capabilities, they can move into descriptive analytics through which they can determine PMPM costs based on health care utilization. This, in turn, allows for payer and practice partnerships, along with innovative payment models.

Outlook on payer data (cost and utilization data) evolved over time in CPC. As the CPC initiative progressed and practices gained a better understanding of data, payer data began to be used in an actionable way. It was coupled with internal-process data, EHR data, practice-self-assessment data and patient-experience data to drive change. As practices became more fluent with their data and how to use it, they began to request more data and developed data committees, along with other processes, to ensure that data directed all changes and QI projects.

Change tactics CPC practices have used:

- Train appropriate team members on interpretation of cost and utilization information
- Use available data regularly to analyze opportunities for cost reduction through improved care

Implementation tips for building analytic capability to manage population

- Identify staff/committee to lead the analytics development and implementation.
- Create a plan for data analysis and application, including allocation of time and resources, regular meetings, review, and communication of data and resulting QI projects.
- Determine capacity for analytics within the EHR or whether a "data warehouse" needs to be developed external to the EHR.
- Vet vendors for data analytics, if applicable.
- Determine reports to be developed (both external and internal).
- Develop data exchange agreements, if applicable.
- Determine how reports will be distributed and how your teams will access them.
- Develop goals/targets for population.
- Determine training needs of team members and provide instruction.
- Use data to guide all changes and monitor through QI methods such as PDSA cycles.

Change Tactic: Train appropriate team members on interpretation of cost and utilization information

It is not enough for practices to have access to data; they must also know how to interpret the data and identify opportunities for action. In CPC, many practices struggled to interpret data, and they needed education to understand how variables affect each other and how workflows inside a practice can affect its outcome data. Early in CPC, practices were frustrated when a change in workflow failed to produce a specific outcome. As they become more aware of the complexity of cost and utilization data, practices had a stronger understanding of how entities outside of primary care, such as hospitals, specialists, labs, long-term care and emergency rooms, could affect their numbers.

The complexity of the data required practices to delve into the data to identify outcome measures that their work could directly affect. They commonly focused on hospital admissions, including 30-day readmissions and ambulatory care sensitive conditions. Practices could easily see how their intentional approach to transitions of care and care management could affect these measures. They often used hospital admissions to gauge the effectiveness of their care management programs, along with EHR-derived measures in clinical quality and patient goals.

Online (external) resources for training team members on cost and utilization information

IHI Run Chart Tool (2017). Run charts are graphs of data over time; they 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

Most practice personnel lacked fluency with cost and utilization data and how it applies to quality-improvement efforts. They frequently needed training in data analysis—or practices sought out external resources, potentially from an affiliated system department—to be partners in data analysis. To develop these skills, CPC practices participated in group educational opportunities focused on interpreting cost and utilization data. The opportunities were typically web-based events offered through the CPC national curriculum, but they also took place in-person during large group meetings in each CPC geographic region. Usually, educators tailored sessions to specific disciplines. For example, during large learning sessions, educators might tailor data analysis to care managers, facilitating conversations on the use of data to drive care management and the importance of knowing when and where high-risk patients are seeking care.

Essential components

- Identify which team members will be responsible for data analysis and assess their skill sets.
- Educate your teams on data interpretation and application (intensive education for dedicated data analysts and general education for everyone about the importance of data and using it to guide changes).
- Allow time and resources for planning data-driven changes.
- Continuously monitor data and new variables or reports, and adjust team member assignments and build skills, as necessary.

Considerations for your practice

- Consider that your personnel may need informal or formal training in data analysis.
  - The American Health Information Management Association (AHiMA) offers a Certified Health Data Analyst certification along with training to earn this certification: http://www.ahima.org/certification/chda
  - The Healthcare Information and Management Systems Society (HIMSS) is another reliable source of professional development education: http://www.himss.org/

- Prioritize time and resources for data analysis, because data analysis is essential for successful transformation.
- Cost and utilization data is highly complex; it is critical to understand what factors contribute to data points and how different data categories balance each other.

Change Tactic: Use available data regularly to analyze opportunities for cost-reduction through improved care

Throughout CPC, it was critical for practices to use data to guide change. Practices had a large amount of data available to them and often found it overwhelming. It became critical for practices to designate time and resources to sorting through data, identifying actionable data and forming a plan for the ongoing review and analysis of their data. This required training and the allocation of time for team members to perform this work. Often, practices had limited knowledge of data analysis; even creating run charts was foreign to some.

Over time, practices found it valuable to use multiple sources of data to monitor high-risk patients and their patterns of care. This data included clinical-quality data from their EHR, cost/utilization data from payers, and admission and discharge data from local hospitals and emergency departments. Additionally, practices found value in analyzing data on specialist utilization, home health and skilled nursing facility data. Through all of this data, practices identified trends and patterns of utilization in certain patient populations. They were able to pinpoint leading diagnoses for admissions, readmissions and emergency department utilization. They were also able to spot gaps in care and transitions of care opportunities. All of this data allowed practices to focus their care management efforts for maximum patient and population benefit.

CPC resources related to using data to analyze opportunities for cost reduction

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

Essential components

- Determine which personnel or committee is responsible for data analysis.
- Use existing data to determine opportunities for reduced cost.
- Determine targets for reduced cost.
- Use improvement tools to test changes and use run charts to track improvement.
- Make adjustments as needed.

Considerations for your practice

- Identify meaningful trends and patterns over time rather than looking at single points in time.
- Data is complex, and multiple variables can affect it. This makes it difficult to match a single process to a large and complex outcome measure.

Online (external) resources for using data to analyze opportunities to reduce costs

IHI Run Chart Tool (2017). Run charts are graphs of data over time; they 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 Success for Change Concept: Build the analytic capability required to manage total cost of care for the practice population

Below are suggested measures to help you evaluate progress in this change concept:

- Tally the number of data reports and frequency of their review.
- Measure the surrounding use of data to guide improvement.
  - Identify opportunities for change through data, and track progress to goals.
- Self-assess team members dedicated to data analysis and application to determine their skills and assess their understanding of data.
- Take notice of potential overuse of health care services.
- Identify underuse of health care services.

Resources for 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

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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