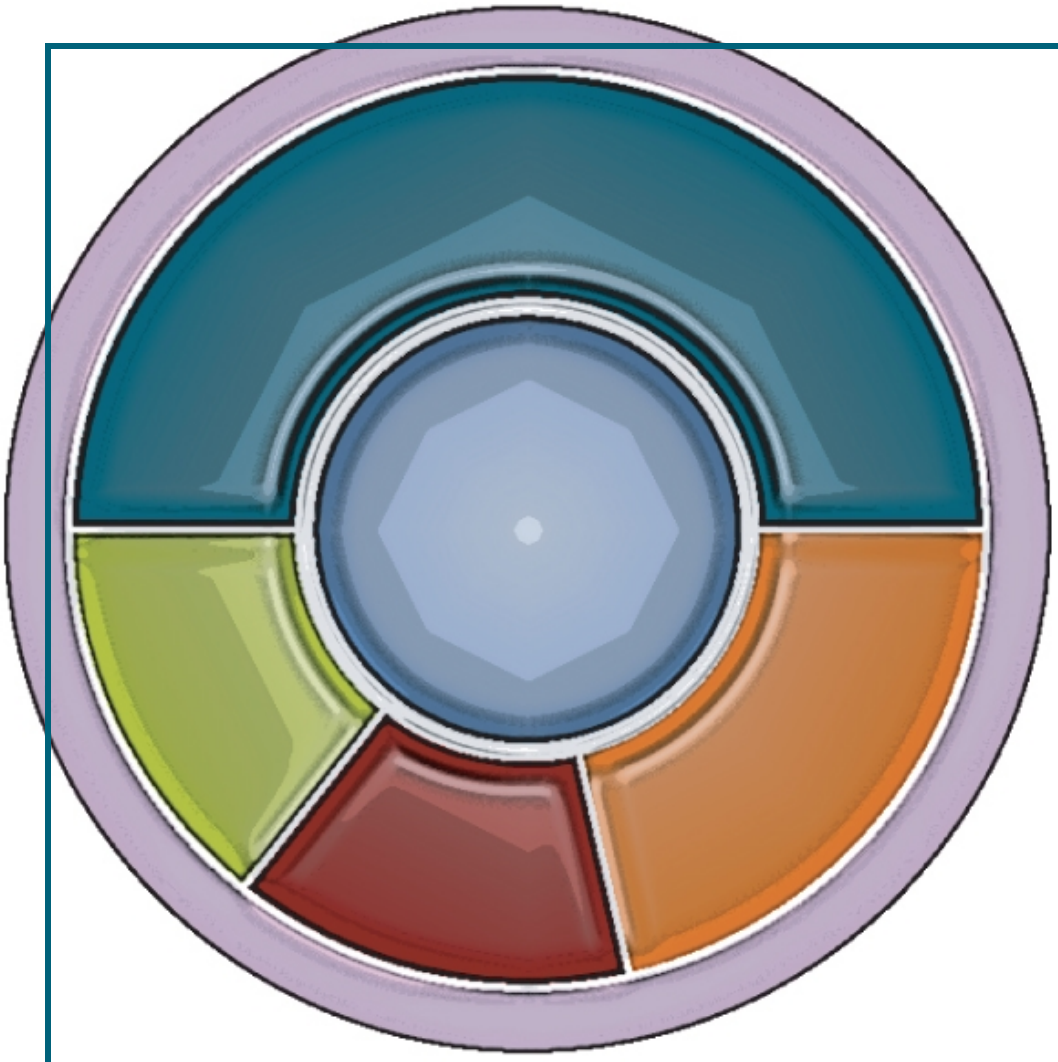


CPC Program Year 2016 Implementation and Milestone Reporting Summary Guide

December 2015

CPC
Comprehensive Primary Care

An Initiative of the Center for Medicare & Medicaid Innovation

Contents

Introduction

Welcome to the Comprehensive Primary Care (CPC) Program Year 2016.

This Program Year (PY) 2016 Implementation Guide provides you with an orientation to our work together in this next program year, guidance for reporting on the Milestones in the CPC Web Application and resources to support your efforts in the coming year. It is our hope that you will find this Guide helpful as you work on delivering the five primary care functions supported by enhanced payment, better data and optimal use of health information technology to improve care, achieve better health outcomes and reduce the total cost of care.

Key Areas to Note for 2016

Practices will note few changes have been made overall to the Milestones for PY 2016. However, as you continue to build on the capabilities you have developed to provide comprehensive primary care, we see three emerging areas as opportunities:

- Further refining care management processes (Milestone 2)
- Using a plan of care to support care management of patients with complex needs (Milestone 2)
- Building the relationship between patient and care team that is at the heart of effective primary care (Milestone 3)

These areas are discussed in more detail in the noted Milestone sections noted above and placed in the context of your integrated work in all of the Milestones to achieve the CPC aims. You will also see that we continue to streamline and refine Milestone reporting in an effort to better understand the pattern of care you provide.

How to Use This Guide

The PY 2016 Guide is an update of the information provided in the PY 2015 Implementation Guide. Following the same basic format, this Guide is divided into three sections: Milestones, Reporting and an Appendix.

Section 1: Milestones

Each Milestone chapter focuses on three key questions:

1. The Goal of the Milestone: *What is the aim of the work in this Milestone?*
We review the intent of each Milestone and any important differences in the work from previous years. The PY 2016 Milestone requirements are included for your reference.

2. The Milestone and the Work of Comprehensive Primary Care: *What changes are we testing and implementing in our practice through our work in this Milestone?*
To answer this question we look beyond the details of the Milestone to the aims of CPC (improve care for individuals, achieve better health outcomes for the patient population and reduce the total cost of care through this improvement in care) and the factors that drive achievement of those aims, the CPC "Drivers."

Through your work in each Milestone you have been building toward delivery of the five Comprehensive Primary Care Functions (Driver 1), supported by your work in the following:

- Use of Enhanced Accountable Payment (Driver 2),
- Continuous Improvement Driven by Data (Driver 3),
- Optimal Use of Health IT (Driver 4) and
- Environment to Support Comprehensive Primary Care (Driver 5)

For each of the CPC Drivers there are broad ideas about how a practice organizes to achieve the CPC aims (Change Concepts), implemented through specific tactics in the practice (Change Tactics). This is mapped out in the CPC Key Drivers and Changes.

Through your work in the Milestones over the first three years of CPC you have developed capability in all five key drivers of Comprehensive Primary Care. You can use the CPC Key Drivers and Changes to identify new ideas and tactics to test in your practice, guided by data from your practice and from CMS and other payers.

3. Using Data to Understand Changes in Your Practice: *How will we know that the changes we are making in our practice are leading to the CPC aims?*

Over the first two years of CPC, the Milestones provided guideposts for your practice's transformation. In the second half of the initiative, you are largely charting new territory, relying on data from your practice and from CMS and other payer sources to guide your work. These data, reflecting processes of care, important health and utilization outcomes and the possible unexpected consequences of your practice changes, link your work to the CPC aims. This section includes a series of questions and suggestions for data that are meant to help you frame ways to use data to inform further testing and refinement in your delivery of comprehensive primary care.

Section 2: The PY 2016 Milestone Reporting Worksheets

The PY 2016 Milestone Reporting Worksheets walk through the Milestone reporting process. These worksheets closely mimic the web-based reporting application, and if your practice gathers the information needed to complete these worksheets, you will be well prepared to report each quarter. We hope that the worksheets also give you a useful assessment of your practice transformation.

Section 3: Appendix

The Appendix contains resources that will support your work in CPC. Practices are encouraged to use the CPC collaboration site (CPC Connect — only registered users may access) as a primary source of peer-provided insight and tools. Additional resources are the 2014 CPC Pathways Guide, an online portfolio of artifacts of real practice learning and change, as well as the CPC Key Drivers and Changes, which serves as a navigational aid to understand how the CPC practices are delivering care and how CMS, our payer partners, and regional stakeholders are supporting this care delivery.

Section 1 — The Milestones

Milestone 1: The Budget

The Goal of Milestone 1

Milestone 1 Requirements

Record actual CPC funding and expenditures from PY 2015.

Milestone 1 requires your practice to allocate CPC payments to efforts that will change how care is provided in your practice to improve outcomes for patients. This work involves planning and prioritizing for change, developing "line of sight" into the structural and process changes needed to deliver comprehensive primary care, and understanding the resources required to make and sustain changes. It also requires understanding practice revenue available to support non-visit related care (e.g., the enhanced payment from multiple payers associated with CPC). Although not directly addressed in the requirements of Milestone 1, this should raise questions about how your practice measures and values staff productivity. This is especially true for those practices using traditional productivity measures based on RVUs, which primarily reward the volume of visits and procedures.

Milestone 1 and the Work of Comprehensive Primary Care

The work in Milestone 1 may present different challenges for small practices compared to large practices, and for independent practices compared to practices owned by health care systems. Many smaller, independent practices may not have engaged in detailed budget forecasting and analytics in the past. Larger practices and systems may have more experience in forecasting and budget analytics but may not have connected the forecasts and analyses with clinical strategic plans. Using a structured process is an effective way to determine the financial investments needed to deliver comprehensive primary care. This is facilitated by developing the budget using a planning and prioritizing analysis of financial resources among those activities.

The budget process includes a review of staff financial incentives (such as salaries, awards and bonuses) to determine whether they align with the practice's clinical activities. If not, strategize about changing the incentives to help staff transition from an encounter-based clinical culture, where patient volume is the priority, to a patient-centered approach where patient satisfaction with health care delivery and population health are the priorities.

CPC Driver 2.1: Strategic Use of Practice Revenue

Concept	Change Tactics (examples)
A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	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.
B: Align practice productivity metrics and compensation strategies with comprehensive primary care.	Use productivity measures that include non-visit related care.
	Incentivize financially efficient and effective team-based care.

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how to use data to help you understand the changes that you are making in your practices. Reporting for Milestone 1 will capture key data on revenue from participation in CPC for PY 2015 and costs associated with the changes in your practice. You will estimate the number of patients attributed to your practice and report total practice revenue represented by enhanced payments from all CPC payers. You can use this data to support your practices' budget planning and prioritizing for PY 2016.

Payer reports, practice CQM data, and results from patient satisfaction surveys or PFACs can provide helpful information to guide your practice in deciding on top clinical priorities for the upcoming year.

- In reviewing payer reports, are you surprised by any areas of high cost or utilization? Do you see opportunities to lower these costs?
- Is your practice achieving internal benchmarks on your CQMs? How might you use your financial resources to target such priorities?
- In review of revenue and expenses for PY 2015, do you find that you allocated your financial resources in a way that is consistent with your clinical priorities? Do you see opportunities to reallocate resources to achieve your practice goals in a more cost-effective manner?
- How is your practice measuring and rewarding staff productivity? You can track the amount of time providers and other staff members spend in regular non-visit activities such as asynchronous communication, care team huddles, care management or behavioral health reviews, participation in PFACs and working on practice improvement.
- How does your practice reward these activities and are the rewards aligned with the value of the activity for your practice and patients?
- Does your practice reward other activities or outcomes? Have you considered whether those are aligned with your overall goals for your practice and patients?

Milestone 2: Care Management for High-Risk Patients

The Goal of Milestone 2

The work in Milestone 2 addresses population health, with a focus on those at high and rising risk for poor outcomes and preventable harm. The work in this Milestone builds practice capability to help patients manage and reduce their risk, with the expectation of a reduction in utilization and the total cost of care.

In PY 2016, the foundation of this work remains empanelment of every active patient to a provider or care team and risk stratification of every empanelled primary care patient. Practices can use their own definition of "active patient," with most practices using a two- to three-year period to identify patients who need primary care intermittently.

Risk stratification is one pathway to identification of patients at high and rising risk, and identifies a cohort of patients with complex medical and behavioral health conditions, sometimes complicated by social and economic factors, that may benefit from intensive, ongoing, relationship-based (longitudinal) care management. We can expect to see this care management lead to be improved health outcomes and reduced utilization for individuals and reduced cost of care in the population as a whole.

This year, you will need to review your stratification methodology in light of your clinical quality and utilization data as well as your care management resources and continue to refine the methodology as needed to achieve the best possible match between your patients' needs and your care management resources.

Practices also identify a second cohort of patients who will benefit from short-term (episodic) care management. This group of patients includes individuals who are otherwise clinically stable but experience hospitalization, receive a new major diagnosis or experience a short-term exacerbation of a chronic condition. These patients won't be

Milestone 2 Requirements

a. Maintain at least 95% empanelment to provider and care teams.
b. Continue to risk stratify all patients, maintaining risk stratification of at least 75% of empanelled patients.
c. Using available data on the needs of the practice population and the strengths and weaknesses of the chosen risk stratification methodology, review – and if needed, refine – the methodology being used to assign a risk status to every empanelled patient.
d. Provide care management resources to the population identified as most likely to benefit from those services. Focus on patients identified by the practice's risk stratification methodology to be high risk or with rapidly rising risk (e.g., those that are clinically unstable, in transition, and/or are high utilizers of services) and likely to benefit from active, ongoing, **longitudinal care management** and those patients not otherwise at high risk who are identified by a triggering event (e.g., transition of care or new diagnosis) as requiring **episodic care management** for a limited period of time.
e. Provide information about the care plans that are used for both longitudinal care management and episodic care management.
f. Maintain the implementation of, and further refine, one of the following three specific advanced care management strategies for patients in higher risk cohorts (beginning with those at highest risk):
    1. Integration of behavioral health;
    2. Self-management support for at least three high-risk conditions;
    3. Medication management and review.
g. Specify what changes the practice is making to implement the other two specific advanced care management strategies for patients in higher risk cohorts (beginning with those at highest risk).

identified by the risk stratification process but may benefit from short-term, goal-directed (episodic) care management and care coordination. A focus on this cohort of patients clearly overlaps with the work in Milestone 6.

Over the past two years you have developed capabilities in medication management, integration of behavioral health and support for self-management, with most practices concentrating in one or two areas of focus. These three advanced primary care strategies are complementary and while you continue to develop your major area(s) of focus you may also look to add capability in the other strategies.

Milestone 2 and the Work of Comprehensive Primary Care

Empanelment and Risk Stratification

Empanelment is a series of processes that assign each active patient to a provider and/or care team, confirm assignment with patients and clinicians, and use the resultant patient panels as a foundation for individual patient and population health management.

Empanelment identifies the patients and population for whom the provider and/or care team is responsible and is the foundation for the relationship continuity between patient and provider/care team that is at the heart of comprehensive primary care. Effective empanelment requires identification of the "active population" of the practice: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, and CPC does not impose a single definition on practices. Generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal acute or preventive health care needs.

CPC Driver 1.1: Access and Continuity

Concept	Change Tactics (examples)
B: Empanel all patients to a care team or provider.	Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.

Assigning a risk status to each patient (risk stratification) gives your practice a more granular view into the needs of your patients and population and gives you the ability to target care management resources more effectively. Risk stratification is a science (and art) that uses historic data (e.g., utilization) and current status (e.g., burden of illness, health risks and social factors) to predict future risk that can be mitigated. This is an area of active learning in CPC and your practice will need to review and refine your methodology over time, learning from your experience and the experience of other practices what is working best to change outcomes for patients.

CPC requires risk stratification of the entire population rather than just identification of the high-risk cohort. This allows your practice to develop strategies to address patients with rising risk – patients with health risks and chronic conditions that are not well controlled. Risk stratifying the entire population also helps you identify the at-risk patients who view you as their primary care provider but seek care only occasionally for acute problems.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
A: Assign and adjust risk status for each patient.	Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification.

Care Management

Care management is a primary care function tailored to patients at highest risk for adverse, preventable outcomes, including iatrogenic harm.

In CPC practices we see two approaches to care management, triggered differently and meeting the differing needs of two cohorts of patients. Patients identified as at high or rising risk by a risk stratification methodology will benefit from ongoing, relationship-based (longitudinal) care management.

These are the essential features of ongoing, relationship-based, longitudinal care management, triggered by the risk stratification process:

- **A mutually agreed upon and documented plan of care.** The plan of care is based on the patient's goals and the best available medical evidence; it is accessible to all team members providing care for the patient and is up to date, addressing all major and significant ongoing health problems and risks.
- **Ongoing assessment and monitoring with interventions as appropriate and using an EHR or registry for tracking.** Patients in care management should be clearly identified in the EHR and tracked with the aid of the EHR registry functionality or through a stand-alone registry. Care management of these patients includes monitoring of clinical data used to manage chronic conditions as well as interventions triggered by regularly scheduled and ad hoc reviews.
- **Proactive care that does not require waiting for office visits or crises (e.g., ED care or hospitalization) and is not primarily visit-based.** While office visits are opportunities to define goals, plan patient care, engage in shared decision making and build a trusting relationship, most care management activities take place by phone, patient portal, email or home visits (as well as visits to SNFs or hospitals to support transitional care). These activities are appropriately targeted based on patient needs.
- **Dedicated, clinically trained staff working closely with the provider in a team-based approach to care for individuals with complex health needs.** Care management staff members are typically in the nursing or social work disciplines and trained to manage patients with complex health needs. Multiple team members, including physicians, non-physician providers and other disciplines, may engage in care management, but each patient at high risk should have a clinically trained individual in the practice accountable for his or her active, ongoing care management that goes beyond office-based clinical diagnosis and treatment.
- **Care management is documented as a structured part of the medical record, capturing critical information.** These include the nature and substance of contacts, data reviewed, assessment of current status, changes to care pathways or the overall care plan, unresolved questions and next scheduled follow-up contact or review.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
B: Provide longitudinal care management to patients at high risk for adverse health outcome or harm.	Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities.
	Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.

Patients who are not otherwise identified as high risk by the risk stratification process may receive short-term, goal-directed (episodic) care management and coordination during an episode of risk, such as transition from hospital, new diagnosis or injury, or exacerbation or clinical instability in a chronic condition. Contact with the patient may be frequent initially but will be short-term in nature with resolution once the triggering event is addressed, and these patients may require relatively more coordination and less disease management. These patients will also require a plan of care addressing the immediate needs; for the sake of efficiency this plan is often incorporated into an identifiable care management or clinic note.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
C: Provide episodic care management, including management across transitions and referrals.	Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management.
	Manage care intensively through new diagnoses, injuries and exacerbations of illness.

The Plan of Care

All patients receiving care management need a plan that reflects the patient's goals for care and informs all members of the care team. This is an area of active learning among CPC practices and practices will be asked to report on how they are using care plans for both longitudinal and episodic care management and what those care plans address.

Care Management Versus Coordination of Care Across the Medical Neighborhood.

In CPC we have made a distinction between Care Management and **Coordination of Care Across the Medical Neighborhood (Driver 1.5),** which is addressed in the work of Milestone 6. **Coordination of Care Across the Medical Neighborhood** refers to the systematic organization of care within the practice and between the practice and community settings, labs, specialists and hospitals and involves development of standard work processes to close care gaps, enhance coordination in transitions and reduce fragmentation of care.

Care Management activities are person-focused, ensuring individuals at high or rising risk get the care that addresses their values and needs, and **Care Coordination activities are system-focused,** ensuring that care is seamless across providers and transitions.

At the practice level, the terms Care Management and Care Coordination are often used interchangeably, and the individuals responsible for care management may be called "care coordinators." In smaller practices, the same person(s) may be responsible for person-focused care management and the system-focused care coordination work.

Population Health Strategies

Even as practices focus intensively on the patients at highest risk, many strategies can be implemented across the practice to improve health care and outcomes. These strategies will affect the quality metrics addressed in Milestone 5.

CPC Driver 1.2: Planned Care and Population Health

Concept	Change Tactics (examples)
B: Proactively manage chronic and preventive care for empanelled patients.	Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning.
	Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target.
	Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions.
	Use panel support tools (registry functionality) to identify services due.
	Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due.
	Routine medication reconciliation.

Team-Based Care

Intensive care management strategies, systematic planned care and population health strategies require effective team-based care.

CPC Driver 1.2: Planned Care and Population Health

Concept	Change Tactics (examples)
C: Use team-based care to meet patient needs efficiently.	Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs effectively and efficiently.
	Use decision support and protocols to manage workflow in the team to meet patient needs.
	Manage workflow to address chronic and preventive care, such as through pre-visit planning or huddles.
	Enhance team resources with staff such as a health coach, nutritionist, behavioral health specialist, pharmacist and physical therapist as feasible to meet patient needs.

Advanced Primary Care Strategies

Three specific primary care strategies — integration of behavioral health (BHI), comprehensive medication management (MM) and routine and effective support for self-management (SMS) — add important capabilities to address the needs of those at high and rising risk.

These three strategies overlap in significant ways and must also integrate into the risk stratification and care management capability you have already built. All practices have begun incorporating one of these strategies into their practice and many already use a combination. In 2016, practices will continue to test and implement these strategies and will tell us the how they are integrating elements of each strategy into their team-based care to best meet the needs of their patients and population.

Behavioral Health Integration

Behavioral health care is an umbrella term for care that addresses mental health and substance abuse conditions, stress-linked physical symptoms, patient activation and health behaviors. In CPC the scope of behavioral health care is broadened to address needs of individuals with dementia and their caregivers. Little of what we do in primary care is unrelated to behavioral health, but most practices have limited resources to support the clinician in providing this care. While most patients with mental illness and substance abuse present in primary care, most resources for managing these conditions have been built in silos outside of the primary care practice. The movement toward integration of behavioral health into primary care brings services and resources to patients where they seek care.

CPC Implementation Framework for Behavioral Health Integration

1. The practice is able to identify and meet the behavioral health (BH) care needs of each patient and situation, either directly or through co-management or coordinated referral.
    - The practice has an available range of skills in BH in the practice for primary care management of BH issues.
    - There is a training strategy (formal or on-the-job) to develop capacity for primary care management of BH.
    - The practice identifies and collaborates with appropriate specialty referral resources in the health system (as applicable) and the medical neighborhood.

2. The practice has a systematic clinical approach that does the following:
   - Identifies patients who need or may benefit from BH services
   - Engages patients and families in identifying their need for care and in the decisions about care (shared decision making)
   - Uses standardized instruments and tools to assess patients and measure treatment to target or goal
   - Uses evidence-based treatment counseling and treatment
   - Addresses the psychological, cultural and social aspects of the patient's health, along with his or her physical health, in the overall plan of care
   - Provides systematic assessment, follow up and adjustment of treatment as needed, reflected in the care plan
3. The practice measures how integrated behavioral health services affect patients, families and caregivers receiving these services and on target conditions or diseases and adapts and improves upon these services to improve care outcomes.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
D: Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions.	Use evidence-based treatment protocols and treatment to goal where appropriate.
	Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services.
	Ensure regular communication and coordinated workflows between primary care and behavioral health providers.
	Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment.
	Use a registry or EHR registry functionality to support active care management and outreach to patients in treatment.
	Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

Concept	Change Tactics (examples)
E: Manage referral networks to meet behavioral health needs not available in the practice.	Develop formal referral relationships with mental health and substance abuse services in the community.

Medication Management

The use of medications for primary and secondary prevention and for treatment of chronic conditions is a mainstay of medical practice. The potential for medication-related harm increases in older individuals, those with multiple comorbidities, and those receiving care from multiple providers and settings. Many medications require scheduled monitoring for safe use. Protocol-guided medication management can improve outcomes in many chronic conditions. Medication reconciliation is a starting point for safer, more effective medication management, but great opportunities exist to more effectively and safely

manage medication therapy across transitions of care. Practices implementing medication management and review as a core strategy include a pharmacist on their care team.

CPC Implementation Framework for Medication Management

1. Medication Management is built around the specific skills of a clinical pharmacist as a member of the care team who engages in a range of activities. The pharmacist
   - Is involved in patient care, either directly or through chart review and recommendations, and documents care in the EHR
   - Participates in the identification of high-risk patients who would benefit from medication management
   - Participates in care team meetings
   - Participates in development of processes to improve medication effectiveness and safety
2. Comprehensive medication management service can include the following:
   - Medication reconciliation
   - Coordination of medications across transitions of care settings and providers
   - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
   - Development of a medication action plan and integration of that plan into a global care plan
   - Medication monitoring
   - Support for medication adherence and self-management
   - Collaborative drug therapy management (when within the state's scope of practice)
3. An effective program includes a systematic approach to the identification of patients in need of medication management services, including some or all of the following:
   - Patients in high-risk cohorts already defined under Milestone 2
   - Patients who have not achieved a therapeutic goal for a chronic condition
   - Patients in care transitions
   - Patients with multiple ED visits or hospitalizations
   - Patients with high-risk medications or complex medication regimens
4. The practice measures key processes and outcomes to improve medication effectiveness and safety.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
E: Manage medications to maximize efficiency, effectiveness and safety.	Reconcile and coordinate medications and provide medication management across transitions of care settings and providers.
	Integrate a pharmacist into the care team.
	Conduct periodic, structured medication reviews.
	Provide medication self-management support and medication action plans.
	Provide collaborative drug therapy management for selected conditions or medications.

Self-Management Support

Support for self-management of chronic conditions requires a collaborative relationship: a health partnership between health care providers/teams and patients and their families. The partnership should support patients in building the skills and confidence they need to reach their health goals.[1]

CPC Implementation Framework for Support of Self-Management

1. The practice team embeds self-management support tactics and tools into care of all patients and has intensive strategies available for patients at increased risk.
    - All members of the care team have basic communication skills to support patient self-management.
    - The practice routinely uses tools and techniques that reinforce patient self-management skills.
    - The practice routinely and systematically assesses the self-management skills and needs of patients with chronic conditions and uses this information to guide support for self-management.
        - Use of self-management care plans is an effective strategy for support of self-management and would likely improve care and health outcomes. Your practice could certainly consider testing this strategy.
    - The practice has a systematic approach to identifying patients with poorly controlled chronic conditions for intensive self-management support.
    - The practice has a training strategy (formal or on-the job) to develop staff/care team capacity to support self-management.
2. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases.
    - Routine interval follow up with patients about their goals and plans is a critical tactic for supporting patient self-management.
3. The practice is able to measure how self-management support strategies affect target conditions or diseases and adapts and improves these strategies to improve care outcomes.
4. The practice develops and maintains formal and informal linkages to external resources to support self-management.

[1] Adapted from Schaefer J, Miller D, Goldstein M, Simmons L. Partnering in Self-Management Support: A Toolkit for Clinicians. Cambridge, MA: Institute for Healthcare Improvement; 2009.

CPC Driver 1.2: Planned Care and Population Health

Concept	Change Tactics (examples)
A: Integrate culturally competent self-management support into usual care across conditions.	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR.
	Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or Motivational Interviewing.
	Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).
	Provide peer-led support for self-management.
	Use group visits for common chronic conditions (e.g., diabetes).
	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.
	Provide self-management materials at an appropriate literacy level and in an appropriate language.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
F: Provide intensive self-management support for patients with poorly controlled chronic conditions.	Provide a pre-visit development of a shared visit agenda with the patient.
	Provide coaching between visits with follow-up on care plan and goals.
	Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

Concept	Change Tactics (examples)
D: Develop pathways to neighborhood/ community-based resources to support patient health goals.	Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information.
	Provide a guide to available community resources.

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices. Your focus on using data to understand and guide changes in your practice in Milestone 2 is more important than in any other Milestone.

Empanelment and Risk Stratification

- What percent of your active patients is assigned to a specific provider or care team?
  - Does your operational definition of "active patient" in your practice include patients seen infrequently but for whom your practice is their main source of primary care?
  - If you have patients who are not your primary care patients (e.g., patients referred to you for specialty consultation or presenting for urgent care who receive primary care elsewhere), are you able exclude them from your empanelment process?
  - Do you have an efficient process for keeping your empanelment up to date?
- What percent of your empanelled patients is risk stratified?
- What is the distribution of your patient population in each risk tier?
- What percent is in the highest and next highest risk tiers?
- Can you see differences in key utilization measures (hospitalization, ambulatory care sensitive hospitalizations, re-admissions, ED visits and total cost of care) and quality measures for each tier?

Care Management

- What is the percent of patients in each risk tier that are under care management?
  - How well do your care management resources "match" your risk stratification methodology?
  - What work does your practice do with and for patients "under care management" in each risk tier?
  - How efficient and effective are these activities addressing the needs of patients? This will be an area of active learning in the next year in CPC.
- What is the caseload of care managers in your practice? Is it helpful to differentiate between longitudinal care management (ongoing, relationship based) and episodic care management (short term, goal directed) for this purpose?
- What is the percent of all patients and/or number of patients in high-risk tiers with care plans?
- What is the percent of all patients and/or number of patients receiving episodic are management with care plans?
- Do you track key utilization measures (hospitalization, ambulatory sensitive care hospitalizations, re-admissions, ED visits total cost of care) or quality measures for patients under care management?

Advanced Primary Care Strategies

For each of the advanced primary care strategies you are asked to identify measures that you are using to assess implementation (process measures) or impact (outcome measures) of the strategy. We have provided some examples below to give you some ideas. This will continue to be an area of active learning in CPC.

Behavioral Health Integration

Process measures:

- For those sites with a behaviorist on site, the number of patient visits with the behaviorist
- Number of patients receiving behavioral health care reviewed by the team
- Number of patients with an identified behavioral health concern referred for behavioral health care
- "Screening for Clinical Depression and Follow-Up Plan" (NQF#0418) is a CPC clinical quality measure that provides a useful process measure for behavioral health integration.
- For those practices using behavioral health interventions to support health behavior choice, the CPC clinical quality measure "Tobacco Use: Screening and Cessation Intervention" (NQF#0028) can be a useful process measure.

Outcome measures:

- The use of assessment tools such as the PHQ-9 or GAD can provide valuable outcome metrics for treatment of behavioral health conditions:
  - The average PHQ-9 score of patients with a depression diagnosis
  - Number of patients with a PHQ-9 score > 14 (moderately severe or severe depression)
  - Average GAD score in patients with an anxiety disorder
  - Number of patients with a GAD score > 14 (severe anxiety)
- For those practices targeting patients with poorly controlled chronic disease for behavioral health services, the CPC clinical quality measures related to the chronic disease can be useful:
  - Diabetes: Hemoglobin A1c Poor Control (NQF#0059)
  - Controlling High Blood Pressure (NQF#0018)

Medication Management

Process measures:

- A measure for medication reconciliation and review that you already use for Meaningful Use
- Percent of patients with a transition of care who had medication reconciliation
- Number of patients with medication review each month
- Patients seen in collaborative drug therapy management

Outcome measures:

- The CPC clinical quality measures of lipid management in diabetes (CMS ID & ver. 163 v4.1.000), diabetes control (NQF#0059), hypertension control (NQF#0018) and heart failure therapy (NQF#0083) will all be responsive to improved medication management, but you may be following other measures that may also indicate the effects of mediation management.
- Improved medication management should also result in changes in utilization among your high-risk patients.
- For those practices engaging pharmacists in tobacco-cessation efforts, the percent of patients using tobacco products could be a useful measure.

Self-Management Support

Process measures:

- Number of patients receiving health coaching
- Number of patients receiving training or skills for self-management of a target condition
- Number of patients receiving peer-training or in group visits
- Percentage of patients with a personalized goal documented for a target condition
- Percent of patients with an action plan for a target condition
- Number of patients receiving intensive self-management support for a poorly controlled chronic condition

Outcome measures:

- Quality metrics related to your target conditions will give you important insight into how support for self-management affects outcomes.
- Utilization measures for patients in your high-risk tier or with target conditions will also provide insight as to their effect.

Milestone 3: 24/7 Access and Continuity

The Goal of Milestone 3

The focus of the work in Milestone 3 is on increasing access to care and on continuity of care in all of its dimensions.

Early work in this Milestone focused on ensuring 24/7 access to the patient's EHR when required for care. Subsequent Milestone work has focused on using the flexibility provided by the enhanced payment in CPC to provide increased access to care through asynchronous communication between the patient and provider/care team. In PY 2015 practices began to measure continuity of relationship between patients and the providers/care team to whom they are empanelled.

In PY 2016, your practice will continue these efforts and will measure relationship continuity quarterly so that you can monitor and address trends in this important component of care.

Milestone 3 Requirements

a. Attest that patients continue to have 24-hour/7-day-a-week access to care team practitioner who has real-time access to the electronic medical record.
b. Continue to implement at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment to responding to patients within a specific time.
c. Measure continuity of care by measuring visit continuity quarterly for each provider and/or care team in the practice.

Relationship continuity strengthens the bond between the patient and his or her provider/care team and is critical to success in improving the health and health care utilization of patients. Most, but not all practices, have the capability to measure relationship continuity using their EHR, practice management software or other mechanisms. Practices vary in how they measure relationship continuity. Some practices measure continuity with a provider (physician, NP or PA), while others choose to measure it in reference to the care team responsible for the panel of patients. Some practices measure continuity only in terms of visits, while others will capture non-visit communication in the measurement. What's most important is that the practice applies a consistent measurement strategy and uses that measurement to guide efforts to optimize continuity of relationship between the provider/care team and their panel of patients.

Relationship continuity — An ongoing therapeutic relationship between a patient and one or more providers (can be measured in reference to a single provider or to a care team)

Because visit access has historically been incentivized by the fee-for-service payment structure, there are no requirements in this Milestone to optimize visit access. Yet we know that this is important work for your practice, especially as you increase efforts to manage care across transitions from hospitalizations and emergency departments.

Milestone 3 and the Work of Comprehensive Primary Care

CPC practices are working in Milestone 3 to increase access to care by broadening access beyond the traditional face-to-face office visit. While the emphasis of the work in this Milestone is on non-visit/non-reimbursed access, there are visit-based strategies for increasing access and continuity identified in the

Key Drivers and Changes, including strategies that are reimbursable by some payers (e.g., group visits, visits in alternate locations, alternate hours and potentially even e-visits). Similarly, same-day or next-day access is generally reimbursable, can increase continuity and reduce need for ED or urgent care, and is an important element in the management of transitions of care.

CPC Driver 1.1: Access and Continuity

Concept	Change Tactics (examples)
A: Ensure timely access to care guided by the medical record.	Provide 24/7 access to provider or care team for advice about urgent and emergent care, for example: ○ Provider/care team with access to medical record ○ Cross-coverage with access to medical record ○ Protocol-driven nurse line with access to medical record
	Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate small practices to provide alternate hours office visits and urgent care).
	Use alternatives to increase access to care-team and provider, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers).
	Provide same-day or next-day access to a consistent provider or care team when needed for urgent care or transition management.
	Provide a patient portal for patient-controlled access to health information.

Continuity of relationship begins with an effective patient empanelment process, a foundational process for Comprehensive Primary Care. Empanelment, while specifically addressed in Milestone 2, is key to measuring continuity in Milestone 3.

CPC Driver 1.1: Access and Continuity

Concept	Change Tactics (examples)
B: Empanel all patients to a care team or provider.	Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.

Though Milestone 3 focuses on relationship continuity, continuity can be thought of more broadly as occurring in three dimensions[2]:

- **Interpersonal/Relationship** – continuity with a provider/care team
- **Management** – there are no conflicts or inconsistencies among providers in the management plan for a patient (this is also addressed in the work of Milestone 6)
- **Information** – all providers and teams caring for the patient have access to the patient's electronic health record, either by direct access to the EHR, through an HIE or another method.

[2] Continuity of care: a multidisciplinary review, *BMJ* 2003;327:1219; http://www.bmj.com/content/327/7425/1219

CPC Driver 1.1: Access and Continuity

Concept	Change Tactics (examples)
C: Optimize continuity with provider and care team.	Measure continuity between patient and provider and/or care team.
	Use scheduling strategies that optimize continuity while accounting for needs for urgent access.
	Use a shared care plan and referral management strategies to ensure continuity of management between within the practice and with consultants.
	Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices.

Continuity

The most common approach to understanding relationship continuity is to look at patient-centric and provider-centric continuity rates.

A patient-centric measure of continuity measures the number of times patients see the provider or care team to whom they are empanelled (numerator) divided by the total number of visits by empanelled patients to the practice (denominator). You will report this continuity rate quarterly for your practice.

The provider-centric measure divides the number of visits to a clinician by patients empanelled to a clinician or clinician team (numerator) by the total number of visits to that clinician (denominator). For example, if a clinician provides 3,000 visits in a year and 2,000 visits are by patients in his or her panel, the provider-centric continuity rate is 66.6%. While you will not report this rate, your practice can use it, in conjunction with the patient-centric continuity measure, to assess the appropriateness of panel sizes and the adequacy and timing of provider/care team visit schedules.

A clinician team may be a physician with a PA or APRN caring for the same panel of patients. If the PA/APRN has his or her own panel, he or she is considered an individual clinician.

Continuity measures can be adapted to answer additional specific questions asked by the clinic. For example:

- What percent of same-day visits are with the provider to whom the patient is empanelled?
- What percent of routine appointments are scheduled with the provider or care team to whom the patient is empanelled?
- In addition to measuring continuity within the clinic, measurement of continuity in referral management is also important. These are potential measures:
    - What percent of referrals included use of a shared care plan to manage the care?
    - How long after the consultant appointment is documentation received to allow update of shared care plan?

Access

A commonly used measure for access is the "Third next available appointment." The Institute for Healthcare Improvement (IHI) defines it as the "average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam or return visit exam." Information about the use and collection process for this measure can be found at the IHI website: http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx.

Practices working on increasing access may find it useful to measure internal and external demand for appointments and match the measure of demand against visit supply. To learn more about supply and demand and how they affect access, go to the IHI website: www.ihi.org/resources/Pages/Changes/MeasureandUnderstandSupplyandDemand.aspx.

Additional views of access can be gained by measures that answer questions such as the following:

- How many non-emergent visits to the ED or urgent care were made during regular practice business hours?
- How many patients seen in emergency department or admitted to hospital were for ambulatory care sensitive conditions?
- What is the rate of missed appointments and/or no-shows?
- What is the ratio of ED visits to hospitalization in the practice?
- What does your CAHPS survey, PFAC, and practice based survey tell you about your patient's access to timely appointments, care, and information?

Practices may find it valuable to measure important processes that affect access or may be affected by strategies that improve access such as the following:

- What is the average time patients spend on the telephone on hold? What is the number of dropped calls?
- What is the rate of general portal signup among the clinic population or the number of appointments booked through the portal?
- What proportion of patients has sent a message to their provider?
- What happens to phone volume with introduction of the portal?
- What is the average response time to messages sent through the portal?
- How many emergency department or urgent care visits are made without a phone call to the practice or on-call provider?

Milestone 4: Patient Experience

The Goal of Milestone 4

The work in Milestone 4 puts the patient and family at the center of care, utilizing their critical input to improve processes and accelerate practice transformation. In PY 2016, your practice will continue your efforts from previous program years: using a Patient and Family Advisory Council (PFAC) and/or brief, in-office surveys to understand the patient perspective and use the voice of the patient to guide efforts to improve care, reduce wasteful and harmful utilization, and reduce the total cost of care. These activities are intended to engage patients and families as valuable partners in improving care as well as to communicate improvements.

You continue to have the option of creating a hybrid approach using both office-based surveys and PFAC. This hybrid approach allows practices to benefit from the advantages of both the data-driven survey process as well as the more qualitative PFAC approach.

There are, of course, other ways to capture the insight, ideas and valuable perspective of your patients to guide your efforts. We'll ask you to tell us if you are using other approaches, such as focus groups, social media or community meetings.

Milestone 4 Requirements

a. Continue efforts in previous program years by conducting surveys and/or meetings with a Patient and Family Advisory Council (PFAC).
   - **Option A:** Conduct a practice-based survey monthly.
   - **Option B:** PFAC that meets quarterly.
   - **Option C:** Office-based surveys administered quarterly and PFAC convened periodically.

b. Specify the changes to the practice that have occurred during each reporting period as a result of, or influenced by, practice survey/PFAC activities.

c. Continue to communicate to patients (either electronically, on posters, via pamphlets or similar) about the specific changes the practice is implementing as a result of the survey or PFAC.

Milestone 4 and the Work of Comprehensive Primary Care

Your work in this Milestone builds practice capabilities in several key areas of Comprehensive Primary Care (see the CPC Key Drivers and Changes). You may find other strategies, such as focus groups, comment boxes and use of Facebook or other social media, helpful for obtaining the perspectives of patients and families on the care they receive. You might consider bringing your Milestone 7 (shared decision making) approach to the PFAC for discussion.

Engaging patients and families as equal partners can be accomplished in a number of ways. If you have a PFAC, developing an

A Note About Diversity on PFAC: When choosing patients and family caregivers to engage in your PFAC, it is important to consider those who are representative of the patient population served by the practice — e.g., age, race, gender, ethnicity, language, disability, geography, sexual orientation, diagnosis and family structure. Also look for patients and family caregivers who are representative of high-risk patients as well as those with varying experiences at the practice — both positive and negative.

agenda for PFAC meetings with input from all members of the PFAC is one method of demonstrating their key role in the practice. In addition, whether you gather patient experience data using a PFAC or survey, this information should be used to drive practice change. You will want to communicate the results of that work to improve care to all patients and families. This can be accomplished in a variety of methods: posters in the practice, newsletters and news posted on the portal or in social media are examples of communication tools.

Remember, engaging patients and families in the design of care is not just a nice thing to do; it is also an extremely efficient process for understanding and motivating changes in your practice to better meet the needs of your patients.

CPC Driver 1.4: Patient and Caregiver Engagement

Concept	Change Tactics (examples)
B: Engage patients and families to guide improvement in the system of care.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
	Communicate to patients and families the changes being implemented by the practice.

Some practices use their PFACs to help them prioritize investments in Comprehensive Primary Care. Many opportunities for change present themselves; the PFAC can help prioritize them in terms of importance and value to your patients.

CPC Driver 2.1: Strategic Use of Practice Revenue

Concept	Change Tactics (examples)
A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	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.

Whether you choose a PFAC, office-based surveys or both, the Milestone asks you to have a communication strategy for how you tell all patients about the changes your practice is making. In your communication strategy, you might consider sharing the data you receive from your surveys and the qualitative data you get from your PFAC with your patients. Think of your communication strategy as both a way to convey the changes you are making to provide better care and a way to invite even more patient engagement.

CPC Driver 2.2: Analytic Capability

Use the perspective and insights of your patients to help you understand the utilization patterns you see in your data from CMS and other payers. Ask them to help you understand what's driving potentially wasteful and harmful utilization and what might make a difference.

Concept	Change Tactics (examples)
A: Build the analytic capability required to manage total cost of care for the practice population.	Train appropriate staff on interpretation of cost and utilization information.
	Use available data regularly to analyze opportunities to reduce cost through improved care.

CPC Driver 3.2: Culture of Improvement

Concept	Change Tactics (examples)
A: Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.	Train all staff in quality improvement methods.
	Integrate practice change/quality improvement into staff duties.
	Engage all staff in identifying and testing practice changes.
	Designate regular team meetings to review data and plan improvement cycles.
	Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff.
	Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.

Using Data to Understand the Changes in Your Practice

In this section, we will explore how you might use data to help you understand the changes that you are making in your practices.

Surveys and PFACs (as well as other strategies for understanding your patients' experience of care) provide invaluable data that you can use to "see" the effect of changes you are making in your practice through your work in other Milestones. As such, these strategies support all of your work in the CPC Milestones.

Be sure you incorporate this valuable data into your practice improvement efforts in a systematic way.

You may find it helpful to capture and review data that tells you about the implementation of these strategies in your practice (process measures). The questions below are examples of the kind of data that can help you gain a greater understanding of your process:

- What is your attendance rate at your PFAC meetings?
- How many ideas for change are emerging from PFAC meetings? Of these ideas, how many have been implemented or tested? Of those implemented, is there a measure of impact?
- What tangible products have been created as a result of your PFAC?
- How many patients are requesting to participate in your PFAC?
- What is your response rate to vendor-administered surveys?

- How many patients are surveyed each month or quarter on vendor-/practice-administered surveys?
- How many survey responses were taken to the PFAC to review?
- How many changes in the practices were initiated by survey data?
- What is the number of “likes” on your practice’s Facebook page?
- How many suggestions are submitted in your drop box at the office each month?
- Have changes your practice made from PFAC or Survey data impacted your patient experience measures noted in your feedback reports?

You might also find it useful to capture data that tells you about the cost and benefits of these efforts, such as these examples:

- How much staff time is involved in the PFAC or survey activities?
- What is the cost to the practice of the PFAC or survey process?
- How have changes your practice made from PFAC or survey data contributed to improving the quality of care your practice delivers or your patients receive outside of your practice?
- How have changes your practice made from PFAC or survey data contributed to reducing the cost of your patients’ care, as reflected on payer feedback data your practice receives?

Milestone 5: Quality Improvement

The Goal of Milestone 5

The intention of Milestone 5 is to help your practice take a systematic approach to using data from and about your practice to guide improvement in care.

In PY 2016, your practice will continue to use data from your Electronic Health Record (EHR) to guide improvement in at least three areas of care measured by the electronic clinical quality measures (eCQMs). By measuring at both the practice level and at the provider/care team level (where the patient actually receives care), your practice gains perspectives that help guide your changes to improve that care.

In addition, you will use the CMS Practice Feedback Reports and other payer reports to identify opportunities to improve the quality of care and reduce the total cost of care. Reducing the total cost of care while focusing on the quality of care delivered (using your eCQMs and other quality of care measures) guides your practice toward providing the highest value care possible.

Milestone 5 Requirements

a. Perform continuous quality improvement using EHR CQM data on at least three such measures, at both the practice and panel level, at least quarterly.
b. Review quarterly at least one payer data feedback report (CMS Practice Feedback Report, other payers' data reports, or an aggregated report where available) to identify:
   - A high cost or utilization area
   - A practice strategy to reduce cost or utilization in this area.

In PY 2016, the eCQM measures have not changed, yet the version numbers have changed on some of the measures. Please refer to the eCQM table for details.

Milestone 5 and the Work of Comprehensive Primary Care

Your work in this Milestone lays the foundation for data guided improvement in your practice, which are the changes identified in CPC Driver 3 (Continuous Improvement Driven by Data).

CPC Driver 3.1: Internal Measurement and Review

Concept	Change Tactics (examples)
A: Measure and improve quality at the practice and panel level.	Identify a set of EHR-derived clinical quality and utilization measures that are meaningful to the practice team.
	Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or provider (panel).
	Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.

Of course, measurement by itself changes nothing. It is important that the use of the measures to identify opportunities for change and the assessment of whether the changes you are making in your practice result in improvement in care and cost. This requires building capability, systems and processes to regularly make changes and practice improvements. A discussion of using data transparency to

engage patients and families is a focus in the Milestone 4 section; however, by sharing the data with your staff and patients, you can create a culture to improve the delivery of care.

CPC Driver 3.2: Culture of Improvement

Concept	Change Tactics (examples)
A: Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.	Train all staff in quality improvement methods.
	Integrate practice change/quality improvement into staff duties.
	Engage all staff in identifying and testing practice changes.
	Designate regular team meetings to review data and plan improvement cycles.
	Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff.
	Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.

As identified in CPC Driver 2, the work in this Milestone should lead to new capabilities to understand opportunities to manage total cost of care by reducing harm and waste, including redundant or unnecessary tests and care. The intent of the CMS quarterly Practice Feedback Report is to support this work, as are the reports generated by other payers. To use these reports effectively requires analytic capability that may be new to your practice.

CPC Driver 2.2: Analytic Capability

Concept	Change Tactics (examples)
A: Build the analytic capability required to manage total cost of care for the practice population.	Train appropriate staff on interpretation of cost and utilization information.
	Use available data regularly to analyze opportunities to reduce cost through improved care.

The EHR is a primary source of data to answer important clinical and utilization questions. This includes data entered into the EHR from external care sources as well as data generated in the practice. As you attend to the EHR-derived quality measures, you will likely find that you also need to pay increased attention to the quality of the data entered into in the EHR's structured fields. Practices will need to think about how they retrieve data from the EHR, how they will create meaningful and "actionable" internal reports and who in the practice takes on this role. The focus on data derived from the EHR may stimulate more interaction with EHR vendors as you explore the full capability of the EHR to manage population health.

CPC Driver 4.1: Continuous Improvement of HIT

Concept	Change Tactics (examples)
A: Align with the Meaningful Use (MU) program to improve EHR function and capability.	Use an ONC-certified EHR.
	Align practice changes for Comprehensive Primary Care with MU requirements.
B: Develop practice capacity for optimal use of EHR.	Identify staff with responsibility for management of EHR capability and function.
	Cross-train staff members in key skills in the use of HIT to improve care.
	Convene regularly to discuss and improve workflows to optimize use of the EHR.
	Engage regularly with EHR vendors about EHR requirements to deliver efficiently the five CPC functions and for EHR-based quality reporting.

Panel-level reporting should already be a function of all ONC-certified EHRs, since measurement of the panel will generally be the same as measurement of care provided by a MU Eligible Professional (EP). As you know, CPC requires annual practice-level reporting of eCQMs from the EHR. Practice-level reporting is a requirement for eligibility to participate in any shared savings generated by the CPC practices in your region.

CPC Driver 4.3: EHR-Based Quality Reporting

Concept	Change Tactics (examples)
A: Develop the capability for practice- and panel-level quality measurement and reporting from the EHR.	Develop capability for practice-level reporting of Clinical Quality Measures derived from the EHR.
	Develop capability for panel-level reporting of Clinical Quality Measures derived from the EHR.
	Develop capability for electronic transmission of quality reports.

Continuity of relationship is addressed in Milestone 3 but links closely to the work in Milestone 5. When providers/care teams have a good view of their panel and are working to improve important health outcomes and reduce the total cost of care in their panel of patients, continuity of relationship, planning, and information are critical to their success.

CPC Driver 1.1: Access and Continuity

Concept	Change Tactics (examples)
C: Optimize continuity with provider and care team.	Measure continuity between patient and provider and/or care team.
	Use scheduling strategies that optimize continuity while accounting for needs for urgent access.
	Use a shared care plan and referral management strategies to ensure continuity of management between within the practice and with consultants.
	Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.

Using Data to Understand Quality Improvement Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practice.

As you work on Milestone 5, consider questions and process measures that can help you think about how you are managing practice changes based on data gathered from your EHR, CMS feedback reports and other payer data reports to improve population health and reduce costs:

Cost of care, quality and utilization data

- Have you identified cost of care, quality and utilization benchmarks and goals for performance at the practice and panel level?
- Do you have a set of key cost of care, quality and utilization measures (a dashboard) so that all staff in the practice can see whether the practice is meeting its goals?
- How often do you review these goals with practice staff and patients?
- How do you train the appropriate staff in interpretation of cost and utilization measures?
- What is the process for review and analysis of payer reports?
- How are you assessing workflow for data retrieval and reporting?
- How are you using practice-level and panel-level data?
- Do you have a strategy for identifying high-cost and/or low-value areas of care, developing a plan for change and measuring the results?

EHR data/eCQMs

- Do you have a way to assess the quality of the data entered into your EHR?
- How do you monitor data quality deficiencies (e.g., "misfiled notes or tests, missing data")?
- Do you have confidence in your eCQM data?

Process improvement/Tests of change

- Does your staff have the basic skills in practice improvement (e.g., rapid cycle testing, using process maps, run charts, etc.)?
- How many of your staff members are actively participating in testing changes in the practice?
- Are they using the data to identify changes to test in the practice?

- Do you have meeting time set aside to plan and prioritize changes and to assess the results of testing?
- Do staff members feel responsible for testing changes? How deep and wide is the involvement in improvement in your practice?
- How much time spent is allocated to and/or spent on managing change in the practice?
- Do you keep track of the number and type of projects and personnel that working on making changes in your practice?
- Would process maps help you see and improve your workflows?
- What measures do you use to monitor your processes (process measures look at the action you are taking – for example, number of HgbA1c ordered/number of patient visits for diabetes)
- How are these tests of change communicated to the entire team as well as patients?

Table 1. 2016 CPC eCQM Set

CMS ID & Ver.	NQF #	Clinical Quality Measure Title	Domain
165 v4.0.000	0018	Controlling High Blood Pressure	Clinical Process/Effectiveness
138 v4.0.000	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health
125 v4.0.000	N/A*	Breast Cancer Screening	Clinical Process/Effectiveness
130 v4.0.000	0034	Colorectal Cancer Screening	Clinical Process/Effectiveness
147 v5.0.000	0041	Preventive Care and Screening: Influenza Immunization	Population/Public Health
127 v4.0.000	0043	Pneumonia Vaccination Status for Older Adults	Clinical Process/Effectiveness
122 v4.0.000	0059	Diabetes: Hemoglobin A1c Poor Control	Clinical Process/Effectiveness
163 v4.1.000	N/A*	Diabetes: Low Density Lipoprotein (LDL) Management	Clinical Process/Effectiveness
182 v5.1.000	N/A*	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Clinical Process/Effectiveness
144 v4.0.000	0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness
139 v4.0.000	0101	Falls: Screening for Future Fall Risk	Patient Safety
2 v5.0.000	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health
68 v5.0.000	0419	Documentation of Current Medications in the Medical Record	Patient Safety

* CMS 125, 163 and 182 are no longer NQF endorsed.

Milestone 6: Care Coordination Across the Medical Neighborhood

The Goal of Milestone 6

The purpose of the work in Milestone 6 is to develop systematic coordination of care across the medical neighborhood. In PY 2016, your practice will continue to build on the implementation of at least two of the three options for this Milestone. In previous program years you worked with hospitals, emergency departments (EDs) and/or specialists to bridge seams of care for your patients as they transition between settings and providers. The three care coordination strategies in this Milestone all have the potential to improve care and reduce harm and cost. Depending on the characteristics of your medical neighborhood and your practice demographics, some strategies may offer more promise than others, though all three strategies will be valuable for practices working toward the CPC aims of better care, better health and lower total cost of care.

Milestone 6 Requirements

Select two of the three options below, building on your activities in previous program years:

a. Track % of patients with ED visits who received a follow up phone call within one week.
b. Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours or 2 business days.
c. Maintain or enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.

Milestone 6 and the Work of Comprehensive Primary Care

The work in Milestone 6 is system-focused and aimed at creating reliable and predictable processes for ensuring coordination and continuity of care for patients as they move between settings and providers. This work differs from care management in Milestone 2, which is person-focused and aimed at meeting the specific needs of individual patients at increased risk.

In PY 2016 we ask that you focus attention on building more reliable communication with hospitals and emergency departments so that you have the timely data you need to follow-up with patients on discharge and bridge that transition. You will be asked to use all available data sources to identify the hospitals and emergency departments where your patients get care. You can use that information to focus efforts to improve transitions on those facilities where the majority of your patients are seen.

Optimizing Continuity

The work in this Milestone builds toward optimal continuity of information and management (see Milestone 3 for a full discussion of these concepts) to ensure that all providers caring for your patients have access to the same patient health information and that the management plan used by these providers reflects a common vision for the patient's care. This work also requires attention to access, ensuring that patients have timely and reliable access to your practice for care, including care management and visits when necessary, as they come "home" to you after hospitalization, urgent or emergent visits, or consultations with specialists.

CPC Driver 1.1: Access and Continuity

Concept	Change Tactics (examples)
C: Optimize continuity with provider and care team.	Measure continuity between patient and provider and/or care team.
	Use scheduling strategies that optimize continuity while accounting for needs for urgent access.
	Use a shared care plan and referral management strategies to ensure continuity of management between within the practice and with consultants.
	Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.

Managing Care Transitions

In this Milestone, you create processes at a system level for establishing and maintaining a reliable flow of information from one setting to another, for timely access to primary care following hospitalizations and ED visits and for reconciliation of therapeutic plans. This work sets up a system to support your person-focused care management efforts under Milestone 2. As you build a more reliable system for coordinating care across the medical neighborhood, care management of individual at-risk patients becomes easier.

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

Concept	Change Tactics (examples)
A: Establish standard operations to manage transitions of care.	Formalize lines of communication with local settings in which empanelled patients receive care to ensure documented flow of information and seamless transitions in care.
	Partner with community or hospital-based transitional care services.

CPC Driver 1.3: Risk-Stratified Care Management

Concept	Change Tactics (examples)
C: Provide episodic care management, including management across transitions and referrals.	Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management.
	Manage care intensively through new diagnoses, injuries and exacerbations of illness.

Referral Management

Using care compacts or agreements with high-volume or high-cost specialists can also make care management more efficient and effective. Practices use care compacts to establish formal working relationships and common expectations around communication, flow of information and shared plans for management. As you consider specialists with whom to develop care compacts, start with specialists with whom you share many patients or whose services are costly for your patients. It also might facilitate progress (and learning) to start with specialists with whom you already have strong working

relationships. Once you develop and refine your initial care compacts, you can broaden your use of compacts to include additional specialists.

Let's not forget the patients' part in this. When they are clear about what to expect from a referral to a specialist they will better manage their own care. Does your practice educate your patients on what to expect, and how to proceed when they are referred to another provider? Do they know how to report back to you their experience with the referral provider?

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

Concept	Change Tactics (examples)
B: Establish effective care coordination and active referral management	Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings.
	Provide patients with information that sets their expectations consistently with the care coordination agreements.
	Track patients referred to specialist through the entire process.
	Systematically integrate information from referrals into the plan of care.

Medical Neighborhood

Use of health information exchange (if one exists in your region) and structured referral notes (with fields for essential information) "hardwires" the flow of information and helps build a more stable and reliable care coordination process. This will support your efforts establishing and maintaining processes for hospital and ED follow-up and is an important feature in care compacts.

Think also about the use of care compacts or agreements with community-based services that your patients use, such as senior centers, chronic disease self-management programs and exercise/wellness programs. CPC practices are also using this approach to build stronger, more integrated behavioral health and pharmacy services for their patients.

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

Concept	Change Tactics (examples)
C: Ensure that there is bilateral exchange of necessary patient information to guide patient care.	Participate in a Health Information Exchange if available.
	Use structured referral notes.
D: Develop pathways to neighborhood/ community-based resources to support patient health goals.	Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information.
	Provide a guide to available community resources.
E: Manage referral networks to meet behavioral health needs not available in the practice.	Develop formal referral relationships with mental health and substance abuse services in the community.

Using Data to Understand the Changes in Your Practice

This section explores how you might use data to help you understand the changes that you are making in your practices.

- **30-day readmission rate** is an outcome measure that may be affected by your efforts to coordinate care across the medical neighborhood more effectively. You may be able to derive this data from the patient-specific report you receive as part of your CMS Feedback Report, from other payer reports and from hospital data. Plotting the 30-day readmission rate data on a simple run chart or control chart[3] will help you identify trends in that data. You may also see possible associations if you plot 30-day readmissions and your Milestone 6 measures for hospital follow-up on the same chart.
- **Hospital admission and ED visit rates** may be sensitive to both your care management efforts and to follow-up on all ED visits. Following this data on run charts or control charts will similarly help you to see trends in the data that may be affected by your ED follow-up efforts.
    - **Tracking frequency.** Milestone 6 only requires quarterly reporting of follow-up after hospitalization and ED visits, but practices seeking to make that follow-up systematic and reliable will want to track these important process measures internally on a weekly or monthly basis. Plotting this data in a run chart format will show trends in performance. Annotating the run chart with changes that you are testing in your process will help you understand whether those changes are associated with an improvement in performance.
    - **Setting internal benchmarks.** CPC provides a benchmark of 75% follow-up of patient discharges from target hospitals, but your practice may set a higher goal. There is no benchmark set for follow-up contacts from the ED; your practice may decide to set an explicit internal goal for ED follow-up.
    - **Targeting hospitals.** The hospital discharge measure identifies the population for intervention (the denominator for the measure) as patients discharged from "target hospitals." This is an acknowledgement that practices may not have timely discharge data for all hospitals that their patients may use. Use the CMS and other payer data to understand what percentage of discharges you are capturing in your "target hospitals?" If you are missing a significant number of discharges, you should consider targeting those "missing" hospitals as well. Similarly, you may find in review of the CMS Practice Feedback Report or other payer reports that you are missing ED visits; this may represent an opportunity for further outreach. Practices whose patients use multiple hospitals, EDs or urgent care clinics may want to track the use of the major settings for care to inform priorities for outreach.
    - **Reducing hospital admissions**. Robust care management and close relationships with local EDs can help reduce hospital admissions. Identify and track preventable hospitalizations and their root causes to establish actionable methods to reduce them.

[3] For more information on run charts and control charts, see this source at IHI: http://www.ihi.org/education/WebTraining/OnDemand/Run_ControlCharts/Pages/default.aspx

- **Data on specialist referrals,** such as monthly counts of patients referred to specialists or the cost of care by the specialists your patients see, will give you an idea of where your efforts to coordinate care will have the most impact (perhaps the top 5 or 10 most-referred specialists).
    - A run chart in which you plot the count of all patients referred to specialists with whom you have a care compact is a simple way to see how your work towards systematically coordinating care is affecting your patients. A run chart can also help you communicate your work in this area to your patients. Consider, also, how you can use your PFAC or patient survey to help identify issues to address in your compacts.
    - As you look at utilization data, identify consultants that are duplicating testing or using high cost test centers or treatment options. There may be higher quality, lower cost alternatives available. Alternatively, you might address these findings through the use of care compacts or agreements as well as patient engagement and education.

Milestone 7: Shared Decision Making

The Goal of Milestone 7

The intention in Milestone 7 is to provide patients with the decision-making support they need to be fully engaged, informed and effective partners in their own health care.

Milestone 7 Requirements

a. Use at least three decision aids to support shared decision making in preference-sensitive care.
b. Track use of the aids using one of the following methods:
    1. A metric tracking the proportion of patients eligible for the decision aid who receive the decision aid; OR
    2. Quarterly counts of patients receiving individual aids.

You have now gained quite a bit of experience working with the use of decision aids to support shared decision-making in preference sensitive care. This has been an area of intensive learning in CPC, and PY 2016 presents a good opportunity to reassess the topics and the associated decision aids you have selected in prior years. Have you selected preference-sensitive care that matters, that is, it affects a large number of your patients or involves utilization of high cost care? Are the aids you have been using helping patients to make choices that reflect their values and preferences? Are they making these challenging discussions easier? If not, you may select three new areas of priority and decision aids that your practice will implement. (You may also choose to continue with your current SDM selections.

You will measure the use of the aids as a rate with the count of eligible patients who received a decision aid in the past quarter as the numerator, and the total number of eligible patients for each decision aid as the denominator.

Milestone 7 and the Work of Comprehensive Primary Care

The work in this Milestone requires your practice to foster the use of decision aids for shared decision making with your patients. This work intentionally focuses on preference-sensitive care and supports broader practice strategies for support of self-management and patient engagement.

CPC Driver 1.4: Patient and Caregiver Engagement

Concept	Change Tactics (examples)
A: Shared decision making.	Engage patients in shared decision-making about risk and benefits of care options in preference-sensitive conditions.
	Use evidence-based decision aids to support shared decision making.

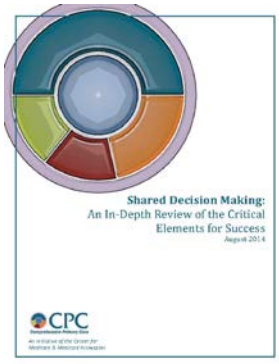
These are the three key components to this work:

1. A condition where legitimate treatment options exist and the scientific evidence can clarify the options but doesn't present a clear best choice
2. A decision aid that helps the patient understand the evidence and think through the choices
3. The opportunity to engage with the provider in making the decision (shared decision making)

These are among the ongoing challenges of Milestone 7:

- Selecting topic areas in which decision aids are most useful to patients,
- Identifying aids that go beyond simple patient education to engage patients to apply their own values and preferences to the described risks and benefits of the various options for care and
- Incorporating these aids into the clinic workflow in a way that supports discussion with the provider.

In PY 2014, the CPC program published a **Shared Decision Making (SDM) Implementation Guide** that includes definitions for shared decision-making, preference-sensitive care and decision aids. Brief definitions are included here. To access the complete Guide, registered users of CPC Connect will find it in the site's library. Another online source for this Guide is the CPC Pathways Portfolio, which is posted on the public-facing CPC website: http://downloads.cms.gov/files/cmmi/pathways_july2015.pdf (32MB PDF).



- **Shared decision making** is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments for preference-sensitive conditions and engage them as participants in decisions about the treatments. *Source:* Veroff, Marr and Wennberg: http://content.healthaffairs.org/content/32/2/285.full.html
- **Preference-sensitive care** comprises treatments for conditions where legitimate treatment options exist — options involving significant tradeoffs among different possible outcomes of each treatment (some people will prefer to accept a small risk of death to improve their function; others won't). Decisions about these interventions — whether to have them, and which ones to have — should thus reflect patients' personal values and preferences and should be made only after patients have enough information to make an informed choice, in partnership with their provider. *Source:* The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2938
- **Decision Aids** are interventions designed to support patient decision making in preference-sensitive care by making explicit the decision, providing information about treatment or screening options and their associated outcomes, compared to usual care and/or alternative interventions. *Source:* Cochrane Database of Systematic Review 2014

Using Data to Understand the Changes in Your Practice

Consider questions and process measures that can help you see the effect of shared decision making on your practice, on patient engagement and on outcomes.

- Does your focus on shared decision making and the use of decision aids in preference-sensitive care align with your efforts to improve quality and reduce cost and utilization? Can you use the data available to you from the CMS Feedback Report and other payer reports to assess the impact of your strategy?
- How frequently are shared decision making aids used in your practice? Are the patients who could benefit from the aids getting them? The measurement of rates of use or simple counts as Milestone 7 requires gives insight into the use of decision aids in practice. Consider using a run chart to follow counts of use over time.
- Can you use existing quality measures to assess the impact of the use of the aid on the quality outcome? For example, does use of an aid on diabetes treatment options reduce the number of patients with uncontrolled diabetes and improve the results in your practice on the Diabetes in Poor Control quality measure? Does engaging patients in the choice of screening approaches for colorectal cancer improve overall screening rates?
- What do patients tell you about use of the decision aids? Can your PFAC or in-office survey help you to understand their perspective on the use of decision aids, or can they help you identify aids or preference-sensitive care for which an aid would be useful?How does the use of the decision aid affect the length of visit (cycle time) for patients? Does it add significantly to their time in the office? What decision aid delivery methods work best for your patients and your practice: in-office or in-home decision aids?

For clinicians and patients, shared decision making can translate into the potential for

- Patients who are better able to manage their health and treatment
- Increased awareness among patients regarding potential adverse consequences from a medical decision or treatment option
- A better match between treatment and patient goals.
- Overall increase in quality of patient care
- More appropriate utilization

Milestone 8: Participation in the CPC Learning Collaborative

The Goal of Milestone 8

Milestone 8 asks that you actively participate in your regional learning community and the national network of CPC Practices. CPC practices are breaking new ground as they learn what it takes to achieve better health outcomes and better care while reducing the overall cost of care. New knowledge about how to achieve these aims comes from the practices engaged in the initiative, and the success of the initiative depends on the active engagement and sharing by CPC practices in the Rapid Cycle Action Groups (RCAGs), in virtual and in-person learning sessions, webinars, on the CPC Connect site, through case studies and Spotlight articles and through informal exchanges in the regions.

Milestone 8 Requirements

a. Participate in all CPC learning sessions in your region.
b. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress toward Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty is bound by confidentiality agreements.

The quarterly virtual/in-person learning sessions are especially important opportunities for practices to review regional and practice data and to share ideas, tools, and strategies for achieving their collective aims in CPC. It is an expectation of the program that practices participate each quarter.

Regional Learning Faculty (RLF) provide support to individual practices and facilitate exchange of ideas and strategies between practices in each region as well as across regions.

Milestone 8 and the Work of Comprehensive Primary Care

Practice transformation is challenging and risky work. To be successful in CPC, practices need to have committed and coordinated care teams with strong and engaged clinical and administrative leadership willing to make difficult choices, allocate time for improvement and break down barriers to change. Engaging with other practices in this work helps maintain the energy for change.

Practices also need ideas for change. Practices will test and implement home-grown innovative ideas, promising ideas based on anecdotal evidence and evidence-based practices. The best solutions come from other practices that have shown that these ideas can work. One effective strategy for collecting these methods is participation in the Rapid Cycle Action Groups where practices working on similar improvement activities openly share with their peers during live sessions and on CPC Connect. Another method is participation in groups on CPC Connect that relate to practice team roles, size of practice and EHR employed. Use of this mode of communication will help your practice and your peers as you work through change in your practice.

Practices need to be able to put the ideas into the daily workflow. Learning from other practices about how they implemented a new idea and what the challenges and successes were in that implementation can provide valuable shortcuts in executing changes. In addition, assistance from the Regional Learning

Faculty have proven to be a valuable asset for practices engaged in making significant changes in their care processes.

Driver 3.2: Culture of Improvement

Concept	Change Tactics (examples)
C: Active participation in shared learning.	Share lessons learned from practice changes (successful and unsuccessful changes) and useful tools and resource materials with other practices.
	Engage with other practices through transparent sharing of common measures used to guide practice change.
	Access available expertise to assist in practice changes of strategic importance to the practice.

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices.

Participation in the regional virtual and face-to-face learning sessions, national webinars, Rapid Cycle Action Groups (RCAGs) and other learning activities supports your practice transformation efforts. Note the level of your practice's engagement and the correlation with your practice's changes as well as changes undertaken by other CPC practices, both regionally and nationally.

As you work on changes in your practice, refer to Milestone 5 for measures that will assist you to track your quality improvements. Allocating time for the work of change is crucial to the success of your work in CPC. This is particularly true as your practice teams participate in the RCAGs. Training and engaging staff in the change process will be necessary. Monitoring the progress and sharing that data with the practice team and with your peers using CPC Connect and live RCAG sessions will have an impact on the continuous improvement process.

You might find it helpful to explore all learning activities offered and as a team determine what topics and which team member(s) are best suited as subject matter experts or active learners, responsible for conveying lessons learned to the rest of your team. Below are some questions that can help you determine how to maximize learning through engagement with the CPC community:

- Are there CPC topics or areas of work that your practice has successfully implemented? Have you found other practices that could use your help as they work on similar changes? Which team member is most skilled at sharing your successful experiences? Would presenting in a shared learning environment be a growth opportunity for your staff members? Can you reach out to Regional Learning Faculty to present your expertise regionally or nationally?
- What is the expectation for your practice representatives when they attend an event? What processes will help your practice assimilate ideas gathered at learning events? In what areas of practice change do you need to invest the most time?
- If you are struggling with a particular change in your practice, have you sought ideas and solutions from others on the Rapid Cycle Action Groups, through CPC Connect or in a regional meeting?

- Which team members would be most appropriate to participate in the Rapid Cycle Action Groups, both on CPC Connect and during live Web sessions for selected topics? Have you enrolled in a Rapid Cycle Action Group(s) as a team to work on a specific topic?
- Are members of your practice team enrolled on CPC Connect? Have they joined groups that relate to their role in your practice? Do they actively share ideas or seek information from their peers using this tool?
- If you have challenges using your EHR to help you meet this Milestone and others have you participated in the EHR Affinity Groups for your EHR both on CPC Connect and in live sessions?

Milestone 9: Health Information Technology

The Goal of Milestone 9

Milestone 9 optimizes use of your EHR to achieve better care, better health outcomes and lower total cost of care with the CMS EHR Incentive Programs (Meaningful Use).

CPC practices attested that all Eligible Professionals (EPs) were successful in meeting the requirements of Stage 1 Meaningful Use (MU) in PY 2014. In PY 2015, all EPs in CPC practices were expected to be working toward Stage 2 MU, within the timelines set by the Meaningful Use program. This continues in PY 2016.

Milestone 9 Requirement

Attest that each eligible professional within the practice is engaged with, and working toward, attestation for Stage II of Meaningful Use in the timelines set by the Meaningful Use program.

Meaningful Use requires attestation at the level of the EP, while CPC requirements are at the level of the practice site. All EPs in the CPC practices are expected to be engaged in the MU program. However, if a provider does not meet criteria as an EP for the purposes of MU, then that provider is exempt from the requirements of this Milestone. For the purposes of Milestone 9, the Meaningful Use timelines and requirements prevail.

Milestone 9 and the Work of Comprehensive Primary Care

The key to success in the work of Milestone 9 is to integrate practice efforts in Meaningful Use with the work in the practice to deliver Comprehensive Primary Care.

Health Information Technology (HIT) offers powerful tools that are essential to providing comprehensive primary care. Practices that invest in the changes in workflow necessary to use the EHR effectively can realize the promise of this technology. Automated reminders, alerts and prompts help care teams proactively plan for preventive care and for care of chronic conditions. Use of the registry functionality in the EHR enables population health management. Templates in the EHR embed decision support into care and help capture key clinical data as structured data. The work in this Milestone provides a foundation for the work of the other CPC Milestones.

CPC Driver 4.1: Continuous Improvement of HIT

Concept	Change Tactics (examples)
A: Align with the Meaningful Use (MU) program to improve EHR function and capability.	Use an ONC-certified EHR.
	Align practice changes for Comprehensive Primary Care with MU requirements
B: Develop practice capacity for optimal use of EHR.	Identify staff with responsibility for management of EHR capability and function.
	Cross-train staff members in key skills in the use of HIT to improve care.
	Convene regularly to discuss and improve workflows to optimize use of the EHR.
	Engage regularly with EHR vendors about EHR requirements to deliver efficiently the five CPC functions and for EHR-based quality reporting.

The emergence of health information exchange (HIE) in CPC regions will improve the quality and timeliness of the data available in primary care to manage care of the patient and enhance coordination of care across the medical neighborhood as well as care management of high risk patients. Using referral or care transition templates with standard elements facilitates reliable exchange of information among providers and care teams.

CPC Driver 4.2: Data Exchange

Concept	Change Tactics (examples)
A: Enable the exchange of patient information to support care.	Connect to local health information exchanges, if available.
	Develop information exchange processes and care compacts with other service providers with which the practice shares patients.
	Use standard documents created by the EHR to routinely share information (e.g., medications, problem, allergies, goals of care, etc.) at time of referral and transition between settings of care.
	Use non-clinician workflows to systematically enter structured clinical data from external (e.g., paper and e-fax) sources into the EHR.

Some CPC practices have added modules to their EHR/HIT that facilitate risk stratification and population health management. This is a way of adding analytic capability to the practice through your EHR.

CPC Driver 2.2: Analytic Capability

Concept	Change Tactics (examples)
A: Build the analytic capability required to manage total cost of care for the practice population.	Train appropriate staff on interpretation of cost and utilization information.
	Use available data regularly to analyze opportunities to reduce cost through improved care.

The use of clinical data for quality measurement creates a virtuous cycle: Inaccurate data in your quality reports should prompt improvement in the entry of clinical data. Improvements in the entry of clinical data will result in more accurate quality measurements and better care.

CPC Driver 3.1: Internal Measurement and Review

Concept	Change Tactics (examples)
A: Measure and improve quality at the practice and panel level.	Identify a set of EHR-derived clinical quality and utilization measures that are meaningful to the practice team.
	Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or provider (panel).
	Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices. The practice changes in Driver 4 involve building and maintaining the HIT/HIE infrastructure necessary for achieving the aims of CPC. These are reflected in Milestone 9 as alignment with the CMS Meaningful Use program. You will want to integrate your practice work plan for Meaningful Use attestation into your CPC work plan.

- You can track progress toward MU attestation as a measure of progress in the work of this Milestone.

Health information exchange is a valuable tool in the coordination of care across the medical neighborhood as the information flow necessary to provide seamless care for individuals is increasingly hardwired.

- Manual work-arounds for health information exchange, including entering paper reports into the EHR and tracking down consults, tests and labs not already electronically exchanged are costly. Understanding the cost of managing this information can help the practice make decisions about investing in health information exchange.

Internal reporting and feedback give providers and care teams information they can use to manage their panel of patients.

- How much time is allocated to generating, formatting and disseminating this information?
- How useful do your providers and teams find your reports; do they know what to do with this data?
- How much time is allocated to the practice care team to plan interventions for specific patients or to test new ideas in management of the panel based on EHR-derived reports?

Your practice now has patient data in electronic form that can be used to answer specific questions for your care teams and transferred efficiently to others caring for your patients.

- How well are you using this relatively new capability to track and analyze patient care, utilization and cost?

- Can you use this data to help understand patterns of care and of utilization and develop testable hypotheses to influence them?
- How does your data compare with payer data; can you use your own data measurement and analysis to help you design and run tests (PDSA cycles) that address patterns in CMS and payer reports that you want to improve?
- What new tracking, analytic or data exchange capabilities might help you understand the needs of your patients and opportunities to improve a particular aspect of care delivery?

The practice investment in HIT/HIE clearly does not end with the purchase of a system. Think about the data that you need to understand the workforce requirements, training and ongoing investment, as well as the potential for improvement in quality of care and population health that may result from these investments. Invest the time to improve the effectiveness and usefulness of your HIT.

- Are you capturing in your budget the investment required to 1) optimize the configuration of your EHR to provide comprehensive primary care most efficiently, and 2) regularly obtaining and using data from your EHR to guide your continuous improvement in the cost and quality of care reduction in unnecessary utilization, and in patient experience of care?

Section 2 — PY 2016 Milestone Reporting Worksheets

Introduction to Reporting in PY 2016

This section is your guide to PY 2016 CPC Reporting. Because many of you use this section to help you prepare for reporting, we've designed this section as worksheets to help you gather and record the information you will need for reporting. Each section closely mirrors the content you will find in the actual Web-based application.

All practice reporting on the CPC Milestones will be done through the CPC Web Application. Reporting on Milestone 1 (PY 2015 Budget) will be accomplished through a custom Excel spreadsheet downloaded and submitted through the Web Application.

PY 2016 Milestone Reporting by Quarter

The table below cross-references each reporting item and the quarter in which a response is required. Frequency of reporting is also noted in the worksheets in the following pages in bold red text in the right margin. When denoted by (x), a response is required for that reporting domain only on an as-needed basis.

Milestone Reporting Domain	Q1	Q2	Q3	Q4
Milestone 1 — See page 51 for information on how to report.	Feb. 26			
Milestone 2				
2.0.1 Empanelment Status	x	x	x	x
2.0.2.1 Risk Stratification Methodology	x	(x)	(x)	(x)
2.0.2.2 Explaining the Risk Stratification Process (optional)	(x)	(x)	(x)	(x)
2.0.2.3 Risk Stratified Care Management Statistics	x	x	x	x
2.0.3 Identifying Patients for Care Management	x	(x)	(x)	(x)
2.0.4 Care Plans		x		x
2.0.5 Care Management Staffing	x	(x)	(x)	(x)
2.1.1 Identification of Patients for Behavioral Health Services	x		x	
2.1.2 Organization of Behavioral Health Care in Your Practice	x		x	
2.1.3 Integration of Behavioral Health Specialists at Your Practice	x		x	
2.1.4 Care Coordinated with Behavioral Health Services External to the Practice	x		x	
2.1.5 Evidence-Based Management of Behavioral Health Conditions	x		x	
2.2.1 Condition-Specific Self-Management Support	x		x	
2.2.2 Skills for Self-Management	x		x	
2.2.3 Support for Self-Management Across Conditions	x		x	
2.3.1 Medication Management Services	x		x	
2.3.2 Pharmacists as Member of the Care Team	x		x	
2.3.3 Patient Selection for Medication Management	x		x	
2.3.4 Collaborative Drug Therapy Management	x		x	
Milestone 3				
3.1 Continuity of Care	x	x	x	x
3.2 24/7 Access by Patients	x	(x)	(x)	(x)
3.3 Enhanced Access During Office Hours and Outside of Office Visits		x		x
Milestone 4				
4.1 Patient Experience Option Selection	x	(x)	(x)	(x)
4.2 Patient and Family Advisory Council		x		x
4.3 Improvement Based on Feedback	x	x	x	x
4.4 Communicating the Changes	x	x	x	x
4.5 Engaging Patients and Caregivers in Your Practice	x			x

Milestone Reporting Domain	Q1	Q2	Q3	Q4
Milestone 5				
5.1 Continuous Quality Improvement Using CQM Data	x	(x)	(x)	(x)
5.2 Monitoring Quality and Utilization Data	x		x	
5.3 Review of Payer Feedback Reports	x	x	x	x
5.4 Culture of Improvement at Your Practice Site	x			x
Milestone 6				
6.1 Identifying and Communicating with Hospitals and EDs Your Patients Use	x	(x)	(x)	(x)
6.2 Patient Follow-up within One Week of ED Discharge	x	x	x	x
6.3 Patient Follow-up within 72 hours or Two Business Days of Hospital Discharge	x	x	x	x
6.4 Care Compacts/Agreements with High Volume Specialists	x	x	x	x
6.5 Effectiveness of Care Coordination at Your Practice	x			x
Milestone 7				
7.1 Area of Priority	x	(x)	(x)	(x)
7.2 Source of Decision Aid	x	(x)	(x)	(x)
7.3 Rate of Decision Aid Use and Shared Decision Aid Making Conversations	x	x	x	x
7.4 Shared Decision Making Processes		x		x
Milestone 8 — No reporting requirements				
Milestone 9				
9.1 Meaningful Use				x

Milestone 1: The Budget

Milestone 1 reporting is due by February 26, 2016. Practices will use a CMS-provided Excel template (one for each practice) to report on Milestone 1. CMS will post the Excel template to the CPC Web Application in early February 2016. Practices will return the completed templates by uploading them to the CPC Web Application. CPC Support will send several email reminders for submission that will include a link and instructions for practices to follow when returning their completed Milestone 1 template by February 26, 2016.

For PY 2016, Milestone 1 includes reporting the practice site's final revenue and costs for PY 2015 and a description of any changes in revenue and costs anticipated for PY 2016. A detailed PY 2016 forecast is not required.

Please bear in mind that under CPC Terms and Conditions for PY 2016, all information submitted is subject to audit. If audited, we will ask your practice to provide supporting evidence of revenues and expenditures. Please keep all supporting documentation. Regional participating payers will see each practice's aggregate CPC revenue and expense information.

CMS has revised Milestone 1 reporting requirements for PY 2016. The following are the changes to the Milestone 1 requirements:

- Added pre-populated expenditure categories, along with the ability to record expenditures in the same terminology and fashion that your practice uses internally
- Added pre-populated information about Medicare FFS care management fees received in 2015 and other practice specific information.
- The use of percentages rather than exact figures to allocate expenditures across the Milestones
- Maintained a question about anticipated changes in revenue for PY 2016
- Expanded the definition of about practice site revenue

Milestone 1 for PY 2016 includes four sections (tabs):

1. Basic Information
2. Revenues
3. Expenditures
4. Summary

Section 1. Basic Information

The first tab collects important contact information about your practice, including the practice site name, site ID, the name of the person who completed the revenue and expenditure template, and contact information for the practice site. Your practice's revenues and expenditures information from prior years is pre-populated.

Section 2. Revenues

This section collects the same information your practice has provided in past years. You will provide the total amount of care management fees for each CPC payer with whom you contract. We also ask for the

average number of patients covered by those payments (CPC attributed lives). This information will be pre-populated for your Medicare FFS care management fees and attributed lives. Payers contribute with varying frequency so you will need to provide an average number of patients across the year so that we can calculate an average per member per month figure from the annual total. We have found that some commercial payers don't contribute care management fees for all their patients because some of their clients don't participate with the CPC program. These may be self-insured employers or for employers who declined to contribute to CPC. If you are unsure about the attributed lives for any payer, please contact the payer for more detailed information.

You will also report any information regarding any received bonus or shared savings based on quality and/or utilization targets. Please do not include shared savings or bonus amounts in the care management fee totals.

In the revenue section, we ask for total revenue for the practice site. Total practice revenue consists of payments received for clinical services (e.g., Fee-for-Service, per member per year/month/episode, shared savings, care management fees, etc.) This amount should exclude revenues not related to clinical services (e.g. rent, investment, etc.). We also ask for the number of active patients at the site. While we ask this in Milestone 2 every quarter, we need to link the practice site revenue to a current active patient figure. Often the person completing the budget is different from the one who completes Milestone 2, and we want to ensure that these two figures are linked as much as possible. A PMPM calculation is included. This will populate based on revenue and active lives data as reported by your practice for each payer. This calculated data provides a blueprint of the PMPM care management fees that your practice receives from each payer. Additionally, this can be used to identify potential input errors before submission of the final revenue/active lives information.

In addition to care management fees received from payers, some practices contribute other funding to the CPC work. This may include grant funding or revenue from other sources that is used for direct costs or to support salaries for care managers or other staff used to support CPC activities. If your practice makes such contributions, please include this on a separate line as a "payer" in the revenue section. The revenue section also includes a question asking whether you expect to see notable changes in care management revenue in PY 2016. This is the same question that was asked for PY 2014, in lieu of asking for detailed forecasts as we did in the previous years.

In this tab, please report your practice site revenues in PY 2015. This includes both total practice revenue (Table 2.1) and the CPC care management fees from all participating payers (Table 2.2). For question 2.3, we ask you to describe any expected significant changes to your CPC payer revenue in the upcoming year (2016). Please make sure that you complete all the required sections (blue cells).

2.1 Total Practice Revenue

	Enter Information Here	Instructions
Total Practice Revenue in PY 2015		*Enter your total practice revenue for PY 2015. Total practice revenue consists of payments received for clinical services at your practice site,* ***including payments for fee-for-service, care management fees, shared savings or quality bonuses, and other*** *per member per year/month/episode payments. Exclude revenues not related to clinical services (e.g. rent, investment).*
Total # of Active Lives		*Enter the total active lives served by the practice. "Active lives" means all the patients you actively serve, irrespective of insurance coverage.*
Comments (optional)		*Enter any comments that may be applicable to the information entered above.*

2.2 Revenue from CPCi Care Management Fees

PMPMs will auto calculate.

CPCi Payers	Annual Total CPCi Care Management Fees (PY 2015)	CPCi Attributed Lives	Per Member Per Month (PMPM) Amount	Alerts	Did you receive shared savings or other bonus payments from this payer in PY 2015?	Comments (Optional)
	Enter the total care management fees you received in PY 2015, excluding shared savings or bonus payments.	*Enter the number of patients attributed to your practiec as CPCi patients by each payer.*	*Auto-calculates based on what you entered in columns B and C*	*if an alert in red text appears, please explain any discrepancies in Column G.*	*Indicate "Yes" or "No".*	
Medicare	Medicare care management fees and average attribution will be pre-populated.					
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
<insert payer name>			-			
PY 2015 Total	$ -	0				

Regional payers will be pre-populated.

Totals for care management fees and attributed lives will auto calculate.

2.3 Forecasting Revenue Changes in PY 2016

Do you expect significant changes in your CPCi payer revenue in 2016? If yes, please explain. If none, write "NONE".
<< DELETE THIS TEXT AND TYPE IN YOUR RESPONSE>>

Section 3. CPC Expenditures

We have simplified how your practice records CPC revenue and expenditures. Additionally, we ask that you estimate the percentage of each expenditure that can be attributed to completing each Milestone. We hope that this is a much easier way for you to tell us how you applied your CPC funding and how practitioners and staff spend their CPC time across the Milestones. By asking for percentages of time in Milestones, we acknowledge that these are estimates for which your practice will not be held accountable for in an audit, but which helps us characterize the relative resource use each Milestone requires. These estimates are helpful for CMS policy making and financial analysis.

We have provided four main cost classifications to categorize each type of expenditure that your practice is likely to have incurred for PY 2015. Two of the cost categories are related to staff costs (medical staff and support staff), while the other two categories relate to information technology and operating expenses.

Within each category we have provided examples of common costs that are incurred by most CPC practices; as well as the ability to record expenditures on a new line that will reflect the manner in which they are recorded in your practice's records.

Example 1: OK000001 incurred $90,000 in expenditures for 3 Care Coordinators during PY 2015. They would report $90,000 in the Medical Staff Category – Care Coordinators (line item) and leave a note in the Memo/Description Column that explained the expenditure.

3.1 PY 2015 Expenditures

For each CPCi expenditure that your practice incurred for PY 2015, please report the actual amounts in the table below. The table has been organized with 4 broad categories: Medical Staff, Support Staff, Information Technologies, and Operating Expenses. Please report your expenditures in the blue cells within the category that best matches the nature of each expenditure. We have included several common cost subcategories (Care Coordinator, Physician, Administrative, EHR Upgrades, etc.) that practices would likely incur in each of the 4 aforementioned categories to assist your practice in organizing these costs. You may also insert cost subcategories unique to your practice in each of the 4 primary categories. If this option is utilized, please include the title of the expenditure, the amount, and a short description that may define the nature of each expenditure in the table below.

Categories	Amount	Memo/Description
Medical Staff		
Physician		
RN		
MA		
Care Coordinator	$ 90,000.00	Salaries for John Doe, Joe Smith, and Janet Thomas for Care Coordination.
<insert title/role>		
<insert title/role>		
<insert title/role>		
<insert title/role>		
<insert title/role>		

Example 2: OK000001 also incurred $55,000 in expenditures for a Clinical Pharmacist for PY 2015. Since a clinical pharmacist is not an expense that most practices incur, we have not included a dedicated space for the practice to report this cost. The practice would need to add "Clinical Pharmacist" to the expenditure report in one of the line items original titled <insert title/role>.

3.1 PY 2015 Expenditures

For each CPCi expenditure that your practice incurred for PY 2015, please report the actual amounts in the table below. The table has been organized with 4 broad categories: Medical Staff, Support Staff, Information Technologies, and Operating Expenses. Please report your expenditures in the blue cells within the category that best matches the nature of each expenditure. We have included several common cost subcategories (Care Coordinator, Physician, Administrative, EHR Upgrades, etc.) that practices would likely incur in each of the 4 aforementioned categories to assist your practice in organizing these costs. You may also insert cost subcategories unique to your practice in each of the 4 primary categories. If this option is utilized, please include the title of the expenditure, the amount, and a short description that may define the nature of each expenditure in the table below.

Categories	Amount	Memo/Description
Medical Staff		
Physician		
RN		
MA		
Care Coordinator	$ 90,000.00	Salaries for John Doe, Joe Smith, and Janet Thomas for Care Coordination.
Clinical Pharmacist	$ 55,000.00	Salary for Heather Johnson for clincial pharmacy role for the CPCi program.
<insert title/role>		
<insert title/role>		
<insert title/role>		
<insert title/role>		

In this tab, please provide detail on how your practice site spent your CPC revenue in PY 2015. Please report actual expenditures, organized by four broad categories: Clinical Staff, Non-Clinical Staff, Non-Labor IT and Operating Expenses. For each item or staff role, consider the percentage of costs that were allocated to each Milestone in PY 2015. These estimates should add up to 100%. We recognize the amount of spent in each Milestone will be approximate, therefore please use your best judgment to estimate how the costs relate to the completion of each Milestone. For the non-labor expenditure categories, only account for expenses that are clearly related to the CPC milestones; please refer to the CPC policy on Allowable Uses of Care Management Funds in the Appendix tab for further explanation.

In the "Alerts" column, you may see prompts in red text based on the values that you enter for each Expense Category. If an alert appears, please read the alert and either explain the discrepancy in the comments box (on the right), or correct any typos.

3.1 PY 2015 Labor Costs and Percent on Each Milestone

Expenditure Categories				Percent of Total Time Spent on Each Milestone						
	Number of Staff Working on CPC	Total Cost (PY 2015)	Memo/ Description (Please describe what types of CPC-related work this staff type/role performs.)	MS2: Risk-stratified Care Management	MS3: Access & Continuity	MS4: Patient Engagement	MS5: Quality Improvement	MS6: Coordination w/ Medical Neighborhood	Other CPCi Planning & Operations	ALERT
Clinical Staff										
Physician										
PA										
APRN/NP										
RN										
LPN										
MA										
Care Manager										
<insert title/role>										
<insert title/role>										
TOTAL	0	$ -								
Non-Clinical Staff										
Administrative Staff										
IT Staff										
Accountant										
<insert title/role>										
<insert title/role>										
<insert title/role>										
<insert title/role>										
<insert title/role>										
TOTAL	0	$ -								

3.2 PY 2015 Non-Labor Expenditures

Expenditure Categories	Total Cost (PY 2015)	Memo/ Description
Non-Labor Information Technology		
EHR Upgrades		
IT Equipment		
IT Maintenance		
Consulting		
<insert name/type>		
<insert name/type>		
<insert name/type>		
<insert name/type>		
TOTAL	$ -	
Operating Expenses		
Expenses (e.g., rent,		
Travel Expenses (e.g., printing,		
<insert name/type>		
<insert name/type>		
<insert name/type>		
<insert name/type>		
<insert name/type>		
TOTAL	$ -	

3.3 Forecasting Expenditure Changes in PY 2016

Do you expect significant changes in how you spend your CPCi care management funding in PY 2016? If yes, please explain changes in the blue box. If none, please write "NONE".
<< DELETE THIS TEXT AND TYPE IN YOUR RESPONSE>>

Section 4. Summary of PY 2015 and Surplus/Deficit Report

The summary tab provides a prepopulated summary of your practice's PY 2015 revenues, PY 2015 expenditures, surplus/deficit for PY 2015, as well as total cumulative surplus/deficit including all program years for your practice. Please use the comments box to describe any large cumulative surpluses or deficits, to give a better indication on why your practice has significant variances between the level of funding (revenues) and spending (expenditures) over the course of the program.

4. Summary of PY 2015 CPCi Revenue and Expenditures

Total PY 2015 Care Management Revenues	$	-
Total PY2015 Expenditures	$	-
		-
Surplus/(Deficit) for PY 2015	$	-
Prior Program Year Surplus (+) / Deficit (-)	$	-
Cumulative CPCi Surplus/(Deficit) as of the End of PY 2015	$	-

4.1 Please explain any surpluses/deficits that are present as of the end of PY 2015, including how your practice intends to address the situation.
<<DELETE THESE TEXT AND TYPE YOUR RESPONSE>>

Milestone 2: Care Management for High Risk Patients

2.0 Risk-Stratified Care Management

2.0.1 Empanelment Status

Quarterly

Do you empanel patients by provider (MD/DO, NP/APRN and PA) or by care team?

- ◯ Provider
- ◯ Care Team

What is your active patient look-back period?

- ◯ One year
- ◯ 18 months
- ◯ Two years
- ◯ More than two years
- ◯ Other: (text box)

How many care providers or care team panels do you have at this practice? (text box)

Total number of patients empanelled with primary care provider or care team at the practice site:	
Total number of active patients:	
% of patients empanelled: *[percent is auto calculated from above responses]*	

	Number of providers or care team panels *[auto populated]*	**Number of patients empanelled to primary care provider(s) or care team(s)** [*auto filled from response above]*	**Total number of active patients** [*auto filled from response above]*	**Percent of patients empanelled** [*auto calculated*]
Quarter 1				
Quarter 2				
Quarter 3				
Quarter 4				

Note: Each quarter, a new row will populate for your updates. The previous quarter's data will then be read-only.

2.0.2 Risk Stratification

2.0.2.1 Risk Stratification Methodology

Quarter 1

Identify and prioritize the methodology (or types of methods) used by your practice to risk stratify your population. Indicate which strategy is most closely aligned to your method. If you use a combination of methods, enter a "1" next to the main method, and a "2" next to the secondary method. *(See table on the next page.)*

Quarters 2 – 4

We recognize that risk stratification is a dynamic process and may change as you improve how you identify those at risk in your patient population. **Did you make any changes to your risk stratification methodology from the previous quarter?**

- ◯ Yes *(If yes, fields below will open for editing.)*
- ◯ No

Risk Stratification Methodology	Risk Strategy (1 = main method, 2 = secondary)
Claims (payer data generated risk scores, for example HCC scores)	
Electronic Health Records (EHR program that identifies and generates risk score using a number of specified clinical variables)	
Clinical algorithm – Based on published algorithm (practice risk stratifies patients based on this published algorithm) *Please select from the following:* ◯ American Academy of Family Practice risk tool ◯ Other (text box)	
Clinical algorithm – Practice developed (practice risk stratifies patients based on algorithm constructed by the practice)	
Clinical intuition (practice risk stratifies patients based on provider's knowledge of patient and their global assessment of that patient's risk)	

2.0.2.2 Explaining the Risk Stratification Process (Optional) Quarterly

Briefly describe additional details about your risk stratification process. (text box)

2.0.2.3 Risk-Stratified Care Management Statistics Quarterly

The table below allows your practice to show how you break down your patient population into risk tiers. Generate a row for each risk tier, as defined by your practice. Label the rows using the terminology your practice uses to define risk, **but place the highest risk tier at the top of the table.** There is no set number of tiers required.

- The first column should show how the entire empanelled population identified in question 2.0.1 is currently broken down by risk strata.
- The second column should report numbers of patients in each risk tier **at the time of this report**. You may pick a convenient date this quarter (today or another single point in time).
- The third column should record how many patients in each risk tier are under care management.

Level of Patient Risk *(start with **highest** risk in top row and then list by descending risk)*	Total number of patients in each tier at the time of this report.	How many patients within each risk tier are under care management	% of patients under care management *[auto calculated]*
Not assigned			
Total empanelled	*[auto calculated from prior responses]*	*[sum is auto calculated from above rows]*	*[auto calculated]*

	Q1	Q2	Q3	Q4
% of patients under care management out of total empanelled				
% of patients risk-stratified out of total empanelled				

Note: Table will auto populate with data reported from previous quarter.

2.0.3 Identifying Patients for Care Management

Quarter 1

In 2016, you are to refine how you track and describe your care management process. CPC practices use risk stratification to identify a prioritized list of patients who are considered high risk or with rapidly rising risk requiring active, ongoing relationship based care management (longitudinal care management). There are also patients not otherwise at high risk identified by a triggering event requiring short-term, goal-directed care managed (episodic care management).

Quarters 2 – 4

Did you make any changes to how you identify patients for care management in the last quarter?

- ◯ Yes (*If you selected "yes," the fields below will open for editing.)*
- ◯ No

Indicate how your practice differentiates between longitudinal and episodic care management.
(Select all that apply)

- ◯ In designing care plans
- ◯ In assigning workload and staffing for care management
- ◯ For standard workflow processes and algorithms
- ◯ In identifying patients for care management *(If selected, additional question will appear below.)*
- ◯ We do not differentiate between longitudinal and episodic care management. (*If selected, additional question will appear below.)*

If you selected "In identifying patients for care management," please answer the questions below:

In the risk-stratification table from 2.0.2.3, indicate which risk tiers serve as triggers for longitudinal care management based on high or rising risk. This refers to patients considered high risk or with rapidly rising risk who require active, ongoing relationship-based care management.

Level of Patient Risk *(start with **highest** risk in top row and then list by descending risk)*	**Total number of patients in each tier at the time of this report.**	**How many patients within each risk tier are under care management**	**% of patients under care management** *[auto calculated]*	**Indicate if this risk level is used to identify patients for care management based on high or rising risk.**
				◯
				◯
				◯
				◯
				◯
Not assigned				◯
Total empanelled	*[auto calculated]*	*[auto calculated]*		

Indicate how you identify patients for episodic care management. This refers to short-term, goal-directed care management for patients who are not already in longitudinal care management as a result of their risk status. (Select all that apply)

- ◯ Hospital admission
- ◯ ED visit
- ◯ New health condition (e.g., cancer diagnosis, accident, chronic condition)
- ◯ New clinical instability in a chronic condition, including change in medications
- ◯ Life event (e.g., death of spouse, financial loss)
- ◯ Initiation or stabilization on a high risk medication (e.g., warfarin)
- ◯ Other: (text box)

If you selected "We do not differentiate between longitudinal and episodic care management," please answer the questions below:

In the risk-stratification table from 2.0.2.3, indicate which risk tiers serve as triggers for care management based on high or rising risk.

Please identify other triggers you use to identify patients for care management <u>in addition to a patient's risk status.</u>

- ◯ Hospital admission
- ◯ ED visit
- ◯ New health condition (e.g., cancer diagnosis, accident, chronic condition)
- ◯ New clinical instability in a chronic condition, including change in medications
- ◯ Life event (e.g., death of spouse, financial loss)
- ◯ Initiation or stabilization on a high risk medication (e.g., warfarin)
- ◯ Other: (text box)

2.0.4 Care Plans

Quarters 2 and 4

Does your practice create care plans for patients under care management?

- ◯ No, we do not use care plans in our care management process. *(If this is selected, you will move forward to 2.0.5 Care Management Staffing.)*
- ◯ We use only informal care plans or have one that is only used occasionally.
- ◯ We use care plans for some patients but do not implement this routinely.
- ◯ We have a care plan that is used and implemented routinely for all or most patients under care management.

Do you have a routine process for monitoring, updating and reviewing care plans?

- ◯ Yes

  When are care plans reviewed and updated?
  - o Pre-specified changes in clinical status
  - o Routinely on a time-based schedule (e.g., monthly or at every visit)
  - o Other: (text box)

- ◯ No

Identify how you document, store, and share care plans:

- ◯ Within the EHR
  - o Structured field
  - o Unstructured note
  - o Other: (text box)

- ◯ Outside of the EHR
  - o Patient portal
  - o After-visit summary
  - o Other: (text box)

Identify the type(s) of information typically included in your care plan: (Select all that apply)

- ◯ Treatment goals and interventions as identified by the care team
- ◯ Patient/caregiver's plans for acute changes in condition
- ◯ Patient's goals and plans for self-management
- ◯ Advance directives and goals of care
- ◯ Plan for next update
- ◯ Providers and services involved in the patient's care and how the patient/caregiver can reach them

Identify who has access to the care plan: (Select all that apply)

- ◯ Members of the care team within the practice
- ◯ Clinicians outside of the practice
- ◯ Social service agencies or providers
- ◯ Patients and caregivers

If "patients and caregivers" is selected above, please answer the following question.

Identify how patients and caregivers access their care plan(s): (Select all that apply)

- o Patient portal
- o At the time of a face-to-face visit
- o Incorporated in the after-visit summary
- o Care plans are not shared with patients in a systematic way
- o Other: (text box)

2.0.5 Care Management Staffing

Quarter 1

Indicate who in your practice is responsible for care management of the patients under active care management: (Select all that apply in table below)

Were there any changes to the staffing for care management this quarter? **Quarters 2 – 4**

- ◯ Yes *(If yes, the fields in the table below will open for editing.)*
- ◯ No

Person Responsible for Care Management	Provide an estimate of the time spent on a weekly basis. Do not include time spent on billable patient visits. Indicate total hours for all staff in each given role.
◯ Physician	(text box) **Hrs**
◯ APRN/NP	(text box) **Hrs**
◯ PA	(text box) **Hrs**
◯ RN	(text box) **Hrs**
◯ LPN	(text box) **Hrs**
◯ MA	(text box) **Hrs**
◯ Social Worker	(text box) **Hrs**
◯ Other Care Manager: (text box)	(text box) **Hrs**
◯ Other: (text box)	(text box) **Hrs**

2.1. Behavioral Health Integration Services

2.1.1 Identification of Patients for Behavioral Health Services

Quarters 1 and 3

Indicate how you identify patients for behavioral health services: (Select all that apply)

- ◯ We do not systematically identify patients for behavioral health services
- ◯ Screening tools, such as for depression, dementia or domestic violence
- ◯ Clinical indicators, such as patient not reaching goals
- ◯ Health risk assessment
- ◯ Self-referral by patient
- ◯ Referral by staff or provider
- ◯ Other: (text box)

2.1.2 Organization of Behavioral Health Care at Your Practice

Quarters 1 and 3

Our practice provides the following options for behavioral health care: (Select all that apply)

- ◯ Referral for specialty mental health care
- ◯ Primary care management with referral as needed to specialty mental health care
- ◯ Co-management between primary care and behavioral health specialists
- ◯ Primary care management with behavioral health specialist consultation and case review
- ◯ Behavioral health specialists integrated into primary care workflow (primary care behavioral health clinicians)
- ◯ Other: (text box)
- ◯ None of the above

In the table below, indicate whether your practice provides the following types of behavioral health care either within the practice or through referral.

	Provided within the practice	Available through external providers with whom you have a care compact or referral agreement	Not available or in planning
Brief, targeted counseling or therapy	◯	◯	◯
Substance use disorder care	◯	◯	◯
Social assistance (e.g., help with housing, employment, other social services)	◯	◯	◯
Ongoing, medium to long-term counseling or therapy	◯	◯	◯
Support groups	◯	◯	◯

2.1.3 Integration of Behavioral Health Specialists at Your Practice **Quarters 1 and 3**

Does your practice have behavioral health specialists co-located within your CPC practice?

- ◯ Yes *(If you select "yes," three questions about rating your behavioral health integration will appear below.)*
- ◯ No *(If you select "no," you will move forward to 2.2 Self-Management Support.)*

Indicate the types of behavioral health specialists working in your practice. (Select all that apply).

Person Responsible for Behavioral Health	About how many hours does this person(s) work? If more than one person performs the role, please provide total hours worked in a typical week.
◯ Psychologist	(text box) **Hrs**
◯ Psychiatrist	(text box) **Hrs**
◯ Social Worker	(text box) **Hrs**
◯ Primary Care Provider	(text box) **Hrs**
◯ Care Manager	(text box) **Hrs**
◯ Psychiatric NP	(text box) **Hrs**
◯ Substance Abuse Counselor	(text box) **Hrs**
◯ Other: (text box)	(text box) **Hrs**

On a scale of 1 to 5 where 1 is low integration and 5 is the highest level of integration, how would you rate the integration of your on-site behavioral health specialist(s) into the primary care workflow?

- ◯ **1** – Functionally separate with totally separate workflow and separate patient records
- ◯ **2** –
- ◯ **3** – Separate workflow and shared patient records
- ◯ **4** –
- ◯ **5** – Fully integrated workflow and shared patient records; functionally integrated with availability for warm hand-offs and for acute visits in primary care

How often does the behavioral health care team meet and review patients?

- ◯ Weekly
- ◯ Biweekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Other: (text box)
- ◯ Not regularly or only on an ad hoc basis

Quarters 1 and 3

2.1.4 Care Coordinated with Behavioral Health Services External to the Practice

Indicate whether your practice has a process in place for regular medication reconciliation and medication coordination for your patients who receive behavioral health care through referral:

- ◯ Yes, for all patients
- ◯ Yes, for most patients
- ◯ Yes, for some patients
- ◯ No, we don't have a process in place.

2.1.5 Evidence-based Management of Behavioral Health Conditions

Quarters 1 and 3

Do you use standard tools and instruments for screening, assessment, monitoring and treatment?

- ◯ Yes *(If you select "yes," the series of questions about types and tools used will appear.)*
- ◯ No

Indicate the types of tools and instruments for screening, assessment, monitoring and treatment to goal that your practice uses: (Select all that apply)

- ◯ **Broad measure**
  - o Brief Psychiatric Rating Scale (BPRS)
  - o Other: (text box)

- ◯ **Depression/mood disorders**
  - o Patient Health Questionnaire for Depression PHQ 2
  - o PHQ-9
  - o Mood Disorder Questionnaire (MDQ)
  - o Composite International Diagnostic Interview (CIDI) for depression
  - o Other: (text box)

- ◯ **Anxiety**
  - o Generalized Anxiety Disorder subscale (GAD-7)
  - o Other: (text box)

- ◯ **Pain**
  - o Brief Pain Inventory (BPI)
  - o Other: (text box)

- ◯ **Alcohol use disorder**
  - o The Alcohol Use Disorders Identification Test (AUDIT-C)
  - o Drug Abuse Screen Test (DAST)
  - o Other: (text box)

- ◯ **Cognitive function**
  - o Montreal Cognitive Assessment (MoCA)
  - o Mini Mental Status Examination (MMSE)
  - o Mini-COG
  - o Other: (text box)

- ◯ **PTSD**
  - o PTSD Checklist (PCL-C)
  - o Primary Care PTSD Screener (PC-PTSD)
  - o Other: (text box)

- ◯ **ADHD**
  - o Adult ADHD Self-Report Scale (ASRSv1.1)
  - o Other: (text box)

- ◯ **OCD**
  - o Yale-Brown Obsessive Compulsive Scale (Y-BOCS)
  - o Other: (text box)

- ◯ **Other:** (text box)
  Which tool? (text box)

2.2 Self-Management Support

2.2.1 Condition-Specific Self-Management Support **Quarters 1 and 3**

Identify at least three high-risk conditions that are the focus for condition-specific self-management support in your practice.

◯ We do not focus on high-risk conditions for self-management support at our practice.

Note: If you select "We do not focus on high-risk conditions for self-management support at our practice," the following selections will not appear.

Condition 1	
Condition 2	
Condition 3	
Condition 4	
Condition 5	

These conditions will appear in drop-down lists in the fields above:

- Asthma
- Atrial fibrillation
- Depression
- Diabetes
- Diabetes with hypertension
- Diabetes with hyperlipidemia
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Hyperlipidemia/high cholesterol
- Hypertension
- Obesity and weight loss
- Tobacco cessation
- Other: (text box)

How do you identify patients for self-management support? (Select all that apply)

◯ All patients with targeted condition
◯ Risk status (using the practice's risk stratification methodology)
◯ Poorly controlled disease
◯ Data from a formal self-management assessment tool
◯ Patient expression of interest
◯ Referral by physician or other care team member
◯ Hospital discharge or other care transition
◯ Newly diagnosed
◯ Other: (text box)
◯ We do not systematically identify patients for self-management support.

2.2.2 Skills for Self-Management

Quarters 1 and 3

Beyond your staff's participation in the CPC learning system, describe what additional training is available in evidence-based counseling approaches. (text box)

	Do you provide staff training in this area? o Yes o No	*(If you selected "yes" in the left column, this question will appear.)* **After initial training, do you provide additional ongoing training?** o Yes o No	**Do you assess core competencies in this area?** o Yes o No
5 A's			
Teachback			
Motivational interviewing			
Reflective listening			
Health literacy			
Other: (text box)			

2.2.3 Support for Self-Management Across Conditions

Quarters 1 and 3

Below is a list of tactics that your practice may use to support self-management. Please use the table to rate your practice's level of use for each tactic.

	Never	**Rarely**	**Sometimes**	**Very often**	**Always, when applicable**
Encourage patients to choose goals that are meaningful to them	○	○	○	○	○
Document patient's confidence areas and potential barriers	○	○	○	○	○
Family/caregivers are included in goal-setting and plan development	○	○	○	○	○
Follow-up on goals at scheduled intervals	○	○	○	○	○
Proactive planning for visit	○	○	○	○	○
Team huddles before visit	○	○	○	○	○
Between-visit coaching	○	○	○	○	○
Peer support and counseling	○	○	○	○	○
Work with community outreach workers (e.g., patient navigators, community health workers, promotores). Please describe: (textbox)	○	○	○	○	○

Note: A "describe" text box will appear for all responses above except "never."

2.3 Medication Management

2.3.1 Medication Management Services **Quarters 1 and 3**

Select the comprehensive medication management services your practice provides:
(Select all that apply)

- ◯ Routine medication reconciliation
- ◯ Coordination and reconciliation of medications at the time of transitions of care
- ◯ Comprehensive medication review and assessment of medication safety and cost-effectiveness
- ◯ Development of a medication action plan or contribution to a global care plan
- ◯ Medication monitoring
- ◯ Support for medication use and self-management
- ◯ We do not provide medication management services at our practice

2.3.2 Pharmacist as Member of the Care Team **Quarters 1 and 3**

2.3.2.1 Engaging Pharmacists as Part of the Care Team

Identify how your practice engages pharmacists as part of the care team. (Select all that apply)

- ◯ Direct Hire
- ◯ System resource
- ◯ Contract
- ◯ Agreement with teaching facility
- ◯ A non-pharmacist with prescribing authority for medication management.
- ◯ Specify: (text box)
- ◯ Other agreement: (text box)
- ◯ We do not formally engage pharmacists. *(If selected, you will skip question 2.3.2.2.)*

How many pharmacists work at the practice? (text box)

How many hours a week, on average, do the pharmacist(s) work at the practice? If more than one pharmacist, please add up the hours. (text box)

(Practices who do not formally engage pharmacists will skip this question.)

2.3.2.2 Pharmacists Engaging in Patient Care

Identify how the pharmacist(s) on your team engage in patient care. (Select all that apply)

- ◯ Pre-appointment review and planning without patient present
- ◯ Pre-appointment consultation and planning with patient
- ◯ Coincident referral (“warm hand-off”) for consultation
- ◯ Follow-up referral from provider for appointment
- ◯ Medication review and recommendations in the EHR (asynchronous with visit)
- ◯ Specified medication management appointment or clinic (e.g., warfarin management or lipid management)
- ◯ E-consultations with patients through patient portal or other asynchronous communication
- ◯ Other: (text box)

2.3.3 Patient Selection for Medication Management **Quarters 1 and 3**

Identify how patients are selected for medication management services beyond routine medication reconciliation: (Select all that apply)

- ◯ Based on risk cohorts using your practice risk stratification
- ◯ Patients who have not achieved a therapeutic goal for a chronic condition
- ◯ Direct provider referrals
- ◯ Poly-pharmacy
- ◯ High risk medications
- ◯ Patients with care transition(s)
- ◯ We do not routinely select patients for medication management services

2.3.4 Collaborative Drug Therapy Management **Quarters 1 and 3**

Does your practice currently provide collaborative drug therapy management?

- ◯ Yes

  If yes, indicate for which conditions your practice uses collaborative drug therapy management: (Select all that apply)

  - o Anticoagulation
  - o Asthma
  - o Chronic Kidney Disease
  - o COPD
  - o Diabetes
  - o Heart Failure
  - o Hyper/hypothyroidism
  - o Hyperlipidemia
  - o Hypertension
  - o Other: (text box)

- ◯ No

  If no, identify the reason your practice does not provide this service:

  - o Our state does not allow it
  - o Not enough resources
  - o Other: (text box)

Milestone 3: 24/7 Access and Continuity

3.1 Continuity of Care

Quarterly

Does your practice track continuity of care for your empanelled patients?

- ◯ Yes
- ◯ No *(If no, you will move forward to section 3.2)*

In the table below, identify the continuity metrics by panel for the last quarter. If your practice has only one provider or care team, complete the table for your whole practice.

- ◯ We do not track continuity.
- ◯ Our EHR only allows us to report rates of continuity and not numerators and denominators. (*If this response is selected, you will only report a rate of continuity in the fifth [right] column below.)*

Panel (based on number reported in Milestone 2)*	Name of panel/provider (text boxes)**	Number of visits by empanelled patients to their care team or provider	Number of visits by empanelled patients to the practice	Rate of continuity* *[auto calculated]*
1				
2				
3				
4				
5				
Overall		*[auto populated]*	*[auto populated]*	

*****Some of the columns and rows above will auto populate based on your reporting for Milestone 2.*

***For your reference only. Intended to help you track which rate corresponds with each panel.*

	Q1	Q2	Q3	Q4
Overall continuity of care rate				

Note: This table will auto populate with previously reported quarterly data.

In tracking and measuring continuity, we include visits to the following members of the care team:

- ◯ Physician
- ◯ PA
- ◯ APRN/NP
- ◯ RN
- ◯ LPN
- ◯ MA
- ◯ Social Worker
- ◯ Other Care Manager: (text box)
- ◯ Other: (text box)

Our practice includes non-visit communications in our continuity measurement.

- ◯ Yes
- ◯ No

What do you use to calculate continuity of care?

- ◯ EHR
- ◯ Practice management systems, such as appointment scheduling system
- ◯ We use a small sample of patients to estimate continuity.
- ◯ Other: (text box)

3.2 24/7 Access by Patients

Quarter 1

Please confirm that your practice's patients continue to have 24-hour/7-day-a-week access to a care team practitioner who has real-time access to their electronic medical record.

- ◯ Yes
- ◯ No *(If you select "no," the question below will appear.)*

Briefly explain the barriers for supporting 24/7 access, and indicate when your practice expects to have 24/7 access to your EHR for all practitioners covering calls after patient hours. (text box)

If your practice selected "No" for the first question in this section in Quarter 1, the question below will appear in reporting for Quarters 2 – 4.

You indicated last quarter that you did not have 24 hour/7 day a week access to a care team practitioner who has real-time access to their electronic medical record. Have you implemented this in the last quarter?

- ◯ Yes
- ◯ No *(If you select "no," the question below will appear.)*

Briefly explain the barriers for supporting 24/7 access, and indicate when your practice expects to have 24/7 access to your EHR for all practitioners covering calls after patient hours. (text box)

3.3 Enhanced Access During Office Hours and Outside of Office Visits

Quarters 2 and 4

Identify how your practice provides enhanced office access. (Select all that apply)

- ◯ Availability of same or next day appointments
- ◯ Flexible appointment scheduling system
- ◯ Extended hours on weekend, evening or early morning
- ◯ After-hour coverage via a formal arrangement or care compact with urgent care centers or other providers
- ◯ Other: (text box)
- ◯ We do not provide enhanced office access.

Identify how your practice is providing enhanced access to patients outside of office visits.

(Select all that apply)

- ◯ Patients send and receive messages through a patient portal (as defined by Meaningful Use)
- ◯ Web-enabled visits other than through a patient portal
- ◯ Secure email
- ◯ Text messaging
- ◯ Telemedicine/Remote monitoring
- ◯ Other: (text box)
- ◯ None of the above

Identify if your practice <u>also</u> provides any of the following (billable) types of alternative visits.

(Select all that apply)

- ◯ Home visits
- ◯ Group visits
- ◯ Group education classes
- ◯ Preventive counseling services
- ◯ Medical nutrition consultation visits
- ◯ Other: (text box)
- ◯ Our practice does not provide these types of alternative visits.

Milestone 4: Patient Experience

4.1 Patient Experience Option Selection

Quarter 1

Identify the methods you are using to engage patients in improving care: (Select all that apply)

- ◯ Practice-based Survey
- ◯ Patient and Family Advisory Council

Would you like to add to or change your selections? **Quarters 2 – 4**

- ◯ Yes *(If you select "yes," the options above will be editable.)*
- ◯ No
- ◯ Quarterly

Are there other ways besides PFACs and surveys through which you engage patients in the design of how care is delivered in your practice? For example, this could include focus groups, Facebook pages or community meetings.

- ◯ Yes **Please describe:** (text box)
- ◯ No

Note: If your practice selected PFACs in 4.1, the questions below will appear.

4.2 Patient and Family Advisory Council

Quarters 2 and 4

Identify the number of meetings held by the PFAC in Quarter 1 and Quarter 2 (January–June)*: (text box)

**For Quarter 4 reporting, this will read "Identify the number of meetings held by the PFAC in Quarter 3 and Quarter 4 (July – December)."*

Note: For audit purposes, you are required to retain all meeting minutes for six years per CMS policy.

The following individuals typically meet with or are a part of our PFAC (include patients and family members, staff and others who may be in attendance).

Role	Number of Individuals
◯ Physician	
◯ PA	
◯ APRN/NP	
◯ RN	
◯ LPN	
◯ MA	
◯ Other Care Manager	
◯ Behavioral Health Professional	
◯ Health Educator	
◯ Pharmacist	
◯ Patient	
◯ Family/Caregiver	
◯ Hospital Representative	
◯ Administrative	
◯ Other	

Identify the characteristics of your PFAC composition that reflect(s) the patient population served by your practice. (Select all that apply)

- ◯ Age
- ◯ Gender
- ◯ Ethnicity/Race
- ◯ Socioeconomic status
- ◯ Language
- ◯ Medical conditions or risk level
- ◯ Unknown or we do not track demographic composition of the PFAC
- ◯ Other: (text box)

4.3 Improvement Based on Feedback

Quarterly

Identify the types of practice changes in the last quarter that were influenced by the survey or PFAC. (Select all that apply)

- ◯ Changes to scheduling, hours, appointment types
- ◯ Changes to front office staffing and waiting areas
- ◯ Improving communication with patients (e.g., newsletters, signage)
- ◯ Improving patient portal access and usability
- ◯ Improving customer service
- ◯ Reducing wait times
- ◯ Streamlining forms to reduce patient burden
- ◯ Refinements to risk stratification methodology
- ◯ Changes in the development or use of the plan of care for patients at high risk
- ◯ Changes to medication management strategies
- ◯ Changes to self-management support strategies
- ◯ Coordination of care with mental health and behavioral health providers
- ◯ Using community-based self-management support and wellness resources
- ◯ Strategies to improve continuity of care and relationship between patients and providers/care team
- ◯ Tracking and follow-up from hospitals and diagnostic studies
- ◯ Transition of care from hospitals and subacute care
- ◯ Follow-up from ED visits
- ◯ Coordination of care with specialists
- ◯ Other: (text box)
- ◯ Other: (text box)

4.4 Communicating the Changes

Quarterly

Indicate how your practice is communicating the changes that you are making based on patient and caregiver feedback. (Select all that apply)

- ◯ Waiting room communication (e.g., poster, video)
- ◯ Hand-out/brochure given to patient in office
- ◯ Website/Patient portal
- ◯ Social media (e.g., Facebook, Twitter)
- ◯ Phone hold messages
- ◯ Written reminder on visit summary or care plan
- ◯ Mailing to patient
- ◯ Public reporting through local or regional collaboratives/press releases
- ◯ Newsletter or other communication distributed to patients outside of office visits
- ◯ Other: (text box)
- ◯ We do not routinely communicate changes to our patients.

4.5 Engaging Patients and Caregivers in Your Practice

Quarters 1 and 4

Indicate how much you agree or disagree with the following statements:

We engage patients and families as equal partners in…

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
…developing agendas for PFAC meetings.*	◯	◯	◯	◯	◯
…establishing improvement projects as a result of PFAC and/or survey guidance.	◯	◯	◯	◯	◯
…communicating results of improvement projects.	◯	◯	◯	◯	◯

**This will option will only appear if your practice uses a PFAC for outreach.*

Milestone 5: Quality Improvement

5.1 Continuous Quality Improvement Using eCQM Data

Quarter 1

Identify the CPC measures on which you focused quality improvement efforts during the past quarter. (Select all that apply)

- ◯ Controlling High Blood Pressure [CMS 165 v4.0.000/NQF 0018]
- ◯ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* [NQF 0024]*
- ◯ Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention [CMS 138 v4.0.000/NQF 0028]
- ◯ Breast Cancer Screening [CMS 125 v4.0.000/NQF N/A]
- ◯ *Use of Appropriate Medications for Asthma* [NQF 0036]*
- ◯ Colorectal Cancer Screening [CMS 125 v4.0.000/NQF 0034]
- ◯ Preventive Care and Screening: Influenza Immunization [CMS 147 v5.0.000/NQF 0041]
- ◯ Pneumonia Vaccination Status for Older Adults [CMS 127 v4.0.000/NQF 0043]
- ◯ Diabetes: Hemoglobin A1c Poor Control [CMS 122 v4.0.000/NQF 0059]
- ◯ Diabetes: Low Density Lipoprotein (LDL) Management [CMS 163 v4.1.000/NQF N/A]
- ◯ Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control [CMS 163 v4.1.000/NQF N/A]
- ◯ Heart Failure (HF): Beta-blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) [CMS 144 v4.0.000/NQF 0083]
- ◯ Falls: Screening for Future Fall Risk [CMS 139 v4.0.000/NQF 0101]
- ◯ Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan [CMS 2 v5.0.000/NQF 0418]
- ◯ Documentation of Current Medications in the Medical Record [CMS 68 v5.0.000/NQF 0419]

*Regional measure; not required by CMS for annual eCQM reporting.

Quarters 2 – 4

In Quarter 1, you selected the following areas of priority from the CPC CQM measure set. Indicate whether you have modified your selections in the last quarter.

- ◯ Yes *(If yes, you will be able to edit the selection fields for the areas of priority shown above.)*
- ◯ No

5.2 Monitoring Quality and Utilization Data

Quarters 1 and 3

At what level do you review data on quality, utilization, patient satisfaction and other measures?

	We do not review	Care team/ panel level	Practice level
EHR clinical quality measures (eCQMs)	◯	◯	◯
Utilization and cost	◯	◯	◯
Patient experience data	◯	◯	◯
Other: (text box)	◯	◯	◯

Note: If you select "We do not review"' in the table, the following question will appear for each response:

Briefly explain why your practice does not review this data. (text box)

5.3 Review of Payer Feedback Reports

Quarterly

Identify the payer data feedback report(s) your practice received this quarter:

Payer *[Application will pre-populate rows with payers from your region.]*	**Did your practice receive a data feedback report from this payer in the past quarter?** o Yes o No	**Does your practice review and use this report?** o Yes o No	*(If you select "no" in the previous column, the question below will appear.)* **Please indicate why you do not use this report.** (Select all that apply) o Not available o No staff designated to review o Difficult to understand o Not helpful to us o Other:

○ **My practice received an aggregate report from another source (e.g., a health information exchange or data aggregator such as MyHealth, Stratus, or The Health Collaborative)**

Identify the source: (text box)

5.4 Culture of Improvement at Your Practice Site

Quarters 1 and 4

In thinking about quality improvement activities supported by infrastructure in your practice, indicate how much you agree or disagree with each statement below.

	Strongly disagree	**Disagree**	**Neither agree or disagree**	**Agree**	**Strongly agree**
All of our staff are trained in quality improvement methods.	○	○	○	○	○
We integrate practice change and improvement activities into staff roles and duties.	○	○	○	○	○
We allocate time for staff to implement improvement projects or attend practice performance meetings.	○	○	○	○	○
We allocate time for clinical and administrative leadership to implement improvement projects or attend practice performance meetings.	○	○	○	○	○

Who at the practice primarily generates improvement ideas and opportunities? (Select all that apply)

- ◯ Clinical and administrative leadership at the system level
- ◯ Clinical and administrative leadership at the practice level
- ◯ Designated quality improvement team
- ◯ Staff members
- ◯ Patients/caregivers
- ◯ N/A or in planning

Over the last two quarters, who at the practice has implemented improvement projects or tests of change? (Select all that apply)

- ◯ Clinical and administrative leadership
- ◯ Designated quality improvement team
- ◯ Staff members
- ◯ Patients/caregivers
- ◯ N/A for the last two quarters

How are quality improvement data and results shared? (Select one)

- ◯ Results are reviewed by a designated QI team or staff member but not shared with individual providers or care teams.
- ◯ Results are provided to care teams or providers without identification of the applicable provider or care team.
- ◯ Panel-level results with the care teams or providers identified are shared openly within the clinic for providers and staff only.
- ◯ Panel-level results with the care teams or providers identified are shared openly within the clinic for providers and staff, as well as patients and families.
- ◯ We do not routinely review or share quality improvement data and results.

Does your practice routinely track and measure progress on quality improvement projects? (Select one)

- ◯ Yes, at least monthly
- ◯ Yes, at least quarterly
- ◯ Only as needed or ad hoc
- ◯ We do not routinely track and measure progress on quality improvement projects.

Milestone 6: Care Coordination Across the Medical Neighborhood

6.1 Identifying and Communicating with Hospitals and EDs Your Patients Use

Quarter 1

Identify the hospital(s)/EDs that your patients generally used most frequently over the last quarter.
(Enter your responses in the table below)

Quarters 2 – 4

In Q1, you listed the identified hospitals and/or EDs where your patients were seen for inpatient and emergency care. For this quarter, indicate whether you are adding or removing hospitals/EDs from this list.

- ◯ Yes *(If you select "yes," the table below will open for editing.)*
- ◯ No

		If you respond "yes" to the previous question, these two columns will appear with the following drop-down lists.	
Name of hospital/ ED (text boxes)	**Do you receive timely admission/ discharge/ transfer information about patients seen at this hospital/ED?** o Yes o No	**Identify the communication vehicle through which your practice obtained hospital and/or ED discharge information:** (Select all that apply) o Phone o Fax o Email o Health Information Exchange (HIE) o Access to hospital EHR/Hospital Portal Access o Other: (text box)	**Select how your practice receives timely discharge information from your hospital(s)/target ED(s):** (Select one) o Practice pulls information: practice periodically seeks updates from hospital on discharges. o Hospital pushes information: hospital sends a periodic (e.g., daily or weekly) report for all discharged patients. o Hospital pushes information: hospital sends patient-specific alerts to the practice when a hospital discharge occurs.

6.2 Patient Follow-Up within One Week of ED Discharge

Quarterly

In the table below, provide the counts of your patients' ED discharges and the patients with whom you have contacted within one week of discharge. A target ED is defined as a facility for which your practice can receive regular and timely information about your patients' ED discharges.

○ Our practice does not track or follow-up on ED discharges.

Name of ED *[Will auto populate from responses to 6.1]*	**Number of patient discharges from this ED in the past quarter** (an individual patient may have more than one discharge)	**Number of patient discharges followed by contact within one week in the past quarter**	**Percentage of patients with follow-up within one week** *[Will auto populate from responses in second and third columns.]*	**We do not track discharges from this ED.** *[Completion of second and third columns not required if this is selected.]*
				○
				○
				○
				○
				○
Overall discharges and follow-ups *[This row will auto calculate based on above responses.]*				

	Q1	**Q2**	**Q3**	**Q4**
Overall ED follow-up rate				

Note: This table will auto populate with previously reported quarterly data.

6.3 Patient Follow-up within 72 Hours or Two Business Days of Hospital Discharge

In the table below, provide the counts of your patients discharged from the hospital during this quarter and those who received follow-up contact within 72 hours or two business days after hospital discharge. A target hospital is defined as a facility from which your practice can receive regular and timely information about your patient population's hospitalizations.

○ Our practice does not track or follow-up on any hospital discharges.

Name of Hospital *[Will auto-populate from responses to 6.1]*	**Number of patient discharges from this hospital in the past quarter** (an individual patient may have more than one discharge)	**Number of patient discharges followed by contact within 72 hours or two business days in the past quarter**	**Percentage of patients discharged from the hospital with follow-up within 72 hours or two business days** *[Will auto populate from responses in second and third columns.]*	**We do not track discharges from this hospital.** *[Completion of second and third columns not required if this is selected.]*
				○
				○
				○
				○
				○
Overall discharges and follow-ups *[This row will auto calculate based on above responses]*				

	Q1	**Q2**	**Q3**	**Q4**
Overall hospital follow-up rate				

Note: This table will auto populate with previously reported quarterly data.

6.4 Care Compacts/Agreements with High Volume Specialists Quarterly

Identify the high-volume specialists or health care organizations with whom you have arranged care compacts/collaborative agreements. (Select all that apply)

NOTE: For auditing purposes, you are required to retain a copy of your signed care compacts/ collaborative agreements for six years per CMS policy.

- ◯ We have not established any care compacts/collaborative agreements.

Specialists:

- ◯ Allergy/Infectious disease
- ◯ Cardiology
- ◯ Dermatology
- ◯ Endocrinology
- ◯ ENT/Otolaryngology
- ◯ Gastroenterology
- ◯ Nephrology
- ◯ Neurology
- ◯ Obstetrics/Gynecology
- ◯ Oncology
- ◯ Ophthalmology
- ◯ Optometry
- ◯ Orthopedic surgery
- ◯ Podiatry
- ◯ Psychiatry
- ◯ Radiology
- ◯ Rheumatology
- ◯ Surgery
- ◯ Urology

Other specialty care:

- ◯ Behavior health
- ◯ Physical therapy
- ◯ Pain management
- ◯ Palliative care
- ◯ Pharmacist
- ◯ Nutrition Services

Other:

- ◯ Skilled Nursing Facility
- ◯ Long-term care facility
- ◯ Home health agency
- ◯ Urgent care or after hours care
- ◯ Community resources and social services: Please describe (text box)
- ◯ Other: (text box)

Please indicate the source(s) of the care compact(s) you use. *(This question will not appear if you selected "We have not established care compacts" from above.)*

- ◯ American Academy of Pediatrics
- ◯ American College of Physicians
- ◯ American Academy of Family Physicians
- ◯ We use a practice-developed or customized care compact template
- ◯ *Please describe what is included in your care compact:* (text box)
- ◯ Other: (text box)

6.5 Effectiveness of Care Coordination at Your Practice

Quarters 1 and 4

Indicate how much you agree or disagree with the following statement:

Our method of care coordination is effective at…

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
…tracking patients after discharge from ED or hospital.	◯	◯	◯	◯	◯
…helping patients identify resources in the community.	◯	◯	◯	◯	◯
…ensuring all providers in the practice have access to information about patient care outside of our practice to guide further care.	◯	◯	◯	◯	◯
…tracking patients after referral and documenting bidirectional communication with providers outside of our practice.	◯	◯	◯	◯	◯

Milestone 7: Shared Decision Making

7.1 Area of Priority

Quarter 1

Identify health conditions, decisions, or tests of focus for which your practice is implementing shared decision making (select at least three but not more than five).

This list contains some common preference-sensitive conditions for you to consider. Please do not include conditions for which there is consensus supporting a single recommended pathway of care, such as immunization for influenza, pneumococcus or certain cancer screenings.

Quarters 2 – 4

In Q1, you indicated the source of decision aids that your practice uses. Would you like to change your answers from a previous quarter?

- ◯ Yes *(If you select "yes," you will be able to identify the changes below.)*
- ◯ No, we are working on the same areas of priority as identified in Q1.

Therapeutic options in management:

- ◯ Adult sinusitis
- ◯ Care preferences over the life continuum (e.g., end-of-life decisions and advance care planning)
- ◯ Chronic pain
- ◯ Chronic stable angina
- ◯ Insomnia
- ◯ Low back pain (acute or chronic)
- ◯ Mild depression
- ◯ Osteoarthritis of the hip or knee
- ◯ Osteoporosis management and medication choices
- ◯ Tobacco cessation choices in approach (e.g., classes, medication)

Medication choices:

- ◯ Antibiotic use
- ◯ Anticoagulation for atrial fibrillation
- ◯ Asthma management
- ◯ Congestive heart failure management
- ◯ COPD management
- ◯ Diabetes management
- ◯ Hypertension management
- ◯ Statin us

Screenings:

- ◯ Colon cancer screening strategies
- ◯ Lung cancer screening
- ◯ Mammography for patients age 40 – 49 or over the age of 75
- ◯ Prostate cancer screening

Other:

- ◯ Other 1: (text box)
- ◯ Other 2: (text box)
- ◯ Other 3: (text box)
- ◯ Other 4: (text box)

What is the primary reason you selected these areas of priority for shared decision making? (Select all that apply)

- ◯ Large number of patients with condition (high volume)
- ◯ Potential for significant cost associated with care (low-volume, high-cost area)
- ◯ Impact on quality
- ◯ Significant impact on cost for patient
- ◯ Other: (text box)

7.2 Source of Decision Aid

Quarter 1 and as needed Quarters 2 – 4

Note: If you select "yes" in 7.1 in Quarters 2 – 4, you will be able to edit this section with updated information.

Do you use established and validated decision aids from accredited sources?

- ◯ Yes

  Identify the source(s) of the decision aids and tools that your practice uses:

  - o Agency for Health Care Research and Quality (AHRQ)
  - o Center for Disease Control (CDC)
  - o Health Dialog/Informed Medical Decisions Foundation
  - o Healthwise Decision Points
  - o Mayo Clinic
  - o Ottawa Hospital Research Institute
  - o Option Grid
  - o Other: (text box)
- ◯ No, we use an ad hoc or practice-created tool. *Describe:* (text box)

7.3 Rate of Decision Aid Use and Shared Decision Making Conversations

Quarterly

Indicate the counts of eligible patients who received a decision aid in the past quarter (numerator), as well as the total number of eligible patients for each decision aid (denominator).

Selected area of priority *[Will auto fill from responses to 7.1.]*	**Patients who received a decision aid**	**Total eligible patients with condition** (optional)	**Rate of use** *[Will auto fill if both numerator and denominator are provided.]*

7.4 Shared Decision Making Processes

Quarters 2 and 4

Indicate how patients are identified as eligible for preference sensitive care: (Select all that apply)

- ◯ Ad hoc basis or referral-based only, no established process or protocol
- ◯ Provider or care team referral, based on clinical intuition
- ◯ Automatic flags built into EHR
- ◯ Routinely identified based on established protocols for each preference sensitive condition
- ◯ Other: (text box)

Indicate whether providers and staff members receive formal training in shared decision making.

- ◯ Yes

  (Optional) **Please describe the training, including the source (e.g., AHRQ, SHARE):**
  (text box)
- ◯ No, staff members do not receive training on shared decision making skills

Where do you document the distribution of decision aids?

- ◯ EHR
- ◯ Care plan
- ◯ After visit summary
- ◯ Other: (textbox)

Do you routinely document outcomes of shared decision making?

- ◯ Yes
  - o We routinely document this in the EHR.
  - o We routinely document this outside of the EHR.

    Identify where this is documented:
    - o Care plan
    - o After-visit summary
    - o Patient portal
    - o Other: (text box)
- ◯ We do not routinely document outcomes of shared decision making.

Milestone 8: Participation in the Learning Collaborative

No web application reporting requirements.

Milestone 9: Health Information Technology

9.1 Meaningful Use

Quarter 4

The expectation for Milestone 9 is that the eligible professionals (EPs) at your practice site are working toward meeting the Stage 2 requirements of Meaningful Use (MU) per the timelines established by the EHR Incentive Program. EPs are not required to have successfully met all of the Stage 2 requirements by end of PY 2016 but should be actively engaged with meeting those requirements.

Select one of the options below:

- ◯ Yes, our practice site attests that all our EPs are currently working toward meeting the Stage 2 requirements for MU.
- ◯ No, our practice site attests that not all of our EPs are working toward meeting the Stage 2 requirements for MU. (*If you select "no," a text box for explanation will be provided.)*

Section 3 — Appendix

Resources

CPC Connect

CPC practices use this online collaboration platform for collaboration, conversation and sharing as they explore and implement change in their delivery of care. The Chatter feed chronicles ongoing practice activities stemming from regional and national learning opportunities, and the Library section is a searchable index of other materials and resources produced from CPC learning activities. Please note that access to CPC Connect is restricted to the CPC community.

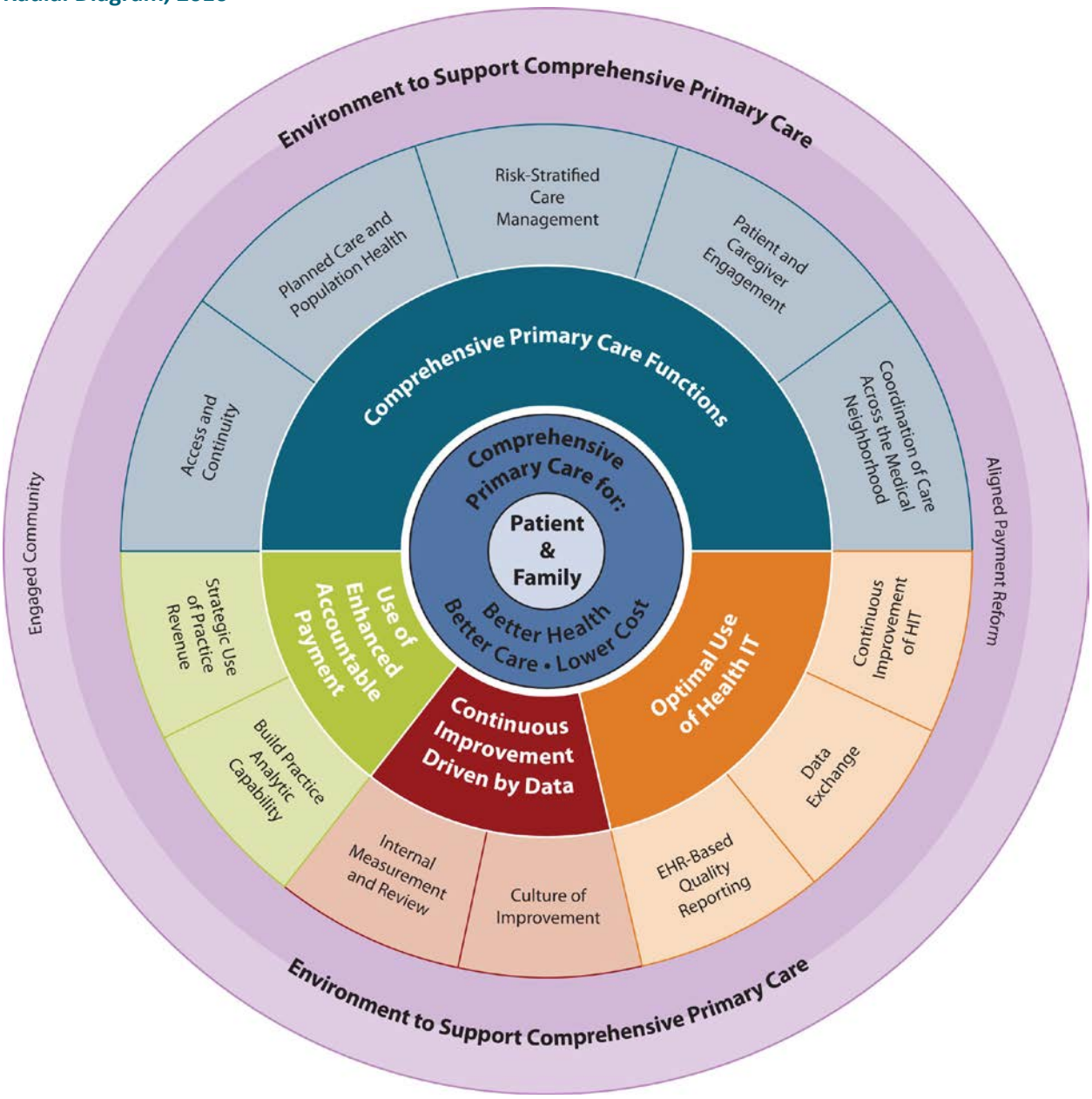
The CPC Pathways Portfolio

Practices are encouraged to seek out additional resources as needed through the **CPC Pathways** (32MB PDF download). This online portfolio contains the artifacts of real practice learning and change. They include selected web-based presentations through which practices shared their work with each other, miniature case studies (Spotlights) through which practice changes are explored, video discussions, and a variety of tools and resources practices have used as they iteratively test and implement changes in the way they deliver care. You will see a diverse set of examples, representing the heterogeneity of practices engaged in CPC. In addition, a summary document outlines the work going on in each region to build the environment to support primary care in each CPC region.

CPC Key Drivers and Changes

In the following pages are a high-level view of the actions required to achieve the CPC aims of improved care, better health for populations and lower cost. Use the key drivers and changes as a navigational aid to understand how CPC practices are delivering care and how CMS, our payer partners, and regional stakeholders are supporting this care delivery.

Radial Diagram, 2016



Primary Driver – 1.0 Comprehensive Primary Care Functions

Secondary Driver	Change Concept	Change Tactics (Examples)
1.1 Access and Continuity	A: Ensure timely access to care guided by the medical record.	Provide 24/7 access to provider or care team for advice about urgent and emergent care, for example: ○ Provider/care team with access to medical record ○ Cross-coverage with access to medical record ○ Protocol-driven nurse line with access to medical record
		Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate small practices to provide alternate hours office visits and urgent care).
		Use alternatives to increase access to care-team and provider, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers).
		Provide same-day or next-day access to a consistent provider or care team when needed for urgent care or transition management.
		Provide a patient portal for patient-controlled access to health information.
	B: Empanel all patients to a care team or provider.	Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.
	C: Optimize continuity with provider and care team.	Measure continuity between patient and provider and/or care team.
		Use scheduling strategies that optimize continuity while accounting for needs for urgent access.
		Use a shared care plan and referral management strategies to ensure continuity of management between within the practice and with consultants.
		Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.

Secondary Driver	Change Concept	Change Tactics (Examples)
1.2 Planned Care and Population Health	A: Integrate culturally competent self-management support into usual care across conditions.	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR.
		Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or Motivational Interviewing.
		Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).
		Provide peer-led support for self-management.
		Use group visits for common chronic conditions (e.g., diabetes).
		Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.
		Provide self-management materials at an appropriate literacy level and in an appropriate language.
	B: Proactively manage chronic and preventive care for empanelled patients.	Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning.
		Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target.
		Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions.
		Use panel support tools (registry functionality) to identify services due.
		Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due.
		Routine medication reconciliation.
	C: Use team-based care to meet patient needs efficiently.	Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs effectively and efficiently.
		Use decision support and protocols to manage workflow in the team to meet patient needs.
		Manage workflow to address chronic and preventive care, such as through pre-visit planning or huddles.
		Enhance team resources with staff such as a health coach, nutritionist, behavioral health specialist, pharmacist and physical therapist as feasible to meet patient needs.

Secondary Driver	Change Concept	Change Tactics (Examples)
1.3 Risk-Stratified Care Management	A: Assign and adjust risk status for each patient.	Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification.
	B: Provide longitudinal care management to patients at high risk for adverse health outcome or harm.	Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities.
		Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.
	C: Provide episodic care management, including management across transitions and referrals.	Routine and timely follow-up to hospitalizations, ED visits and stays in other institutional settings, including symptom and disease management, and medication reconciliation and management.
		Manage care intensively through new diagnoses, injuries and exacerbations of illness.
	D: Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions.	Use evidence-based treatment protocols and treatment to goal where appropriate.
		Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services.
		Ensure regular communication and coordinated workflows between primary care and behavioral health providers.
		Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment.
		Use a registry or EHR registry functionality to support active care management and outreach to patients in treatment.
		Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.
	E: Manage medications to maximize efficiency, effectiveness and safety.	Reconcile and coordinate medications and provide medication management across transitions of care settings and providers.
		Integrate a pharmacist into the care team.
		Conduct periodic, structured medication reviews.
		Provide medication self-management support and medication action plans.
		Provide collaborative drug therapy management for selected conditions or medications.
	F: Provide intensive self-management support for patients with poorly controlled chronic conditions.	Provide a pre-visit development of a shared visit agenda with the patient.
		Provide coaching between visits with follow-up on care plan and goals.
		Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.

Secondary Driver	Change Concept	Change Tactics (Examples)
1.4 **Patient and Caregiver Engagement**	A: Shared decision making.	Engage patients in shared decision-making about risk and benefits of care options in preference-sensitive conditions.
		Use evidence-based decision aids to support shared decision-making.
	B: Engage patients and families to guide improvement in the system of care.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
		Communicate to patients and families the changes being implemented by the practice.

Secondary Driver	Change Concept	Change Tactics (Examples)
1.5 Coordination of Care Across the Medical Neighborhood	A: Establish standard operations to manage transitions of care.	Formalize lines of communication with local settings in which empanelled patients receive care to ensure documented flow of information and seamless transitions in care.
		Partner with community or hospital-based transitional care services.
	B: Establish effective care coordination and active referral management	Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings. Provide patients with information that sets their expectations consistently with the care coordination agreements.
		Track patients referred to specialist through the entire process.
		Systematically integrate information from referrals into the plan of care.
	C: Ensure that there is bilateral exchange of necessary patient information to guide patient care.	Participate in a Health Information Exchange if available.
		Use structured referral notes.
	D: Develop pathways to neighborhood/ community-based resources to support patient health goals.	Maintain formal (referral) links to community-based chronic disease self-management support programs, exercise programs and other wellness resources with the potential for bidirectional flow of information.
		Provide a guide to available community resources.
	E: Manage referral networks to meet behavioral health needs not available in the practice.	Develop formal referral relationships with mental health and substance abuse services in the community.

Primary Driver – 2.0 Use of Enhanced Accountable Payment

Secondary Driver	Change Concept	Change Tactics (Examples)
2.1 Strategic Use of Practice Revenue	A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	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.
	B: Align practice productivity metrics and compensation strategies with comprehensive primary care.	Use productivity measures that include non-visit related care.
		Incentivize financially efficient and effective team-based care.
2.2 Analytic Capability	A: Build the analytic capability required to manage total cost of care for the practice population.	Train appropriate staff on interpretation of cost and utilization information.
		Use available data regularly to analyze opportunities to reduce cost through improved care.

Primary Driver – 3.0 Continuous Improvement Driven by Data

Secondary Driver	Change Concept	Change Tactics (Examples)
3.1 Internal Measurement and Review	A: Measure and improve quality at the practice and panel level.	Identify a set of EHR-derived clinical quality and utilization measures that are meaningful to the practice team.
		Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or provider (panel).
		Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level.
3.2 Culture of Improvement	A: Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.	Train all staff in quality improvement methods.
		Integrate practice change/quality improvement into staff duties.
		Engage all staff in identifying and testing practices changes.
		Designate regular team meetings to review data and plan improvement cycles.
		Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff.
		Promote transparency and engage patients and families by sharing practice level quality of care, patient experience and utilization data with patients and families.
	B: Ensure full engagement of clinical and administrative leadership in practice improvement.	Make responsibility for guidance of practice change a component of clinical and administrative leadership roles.
		Allocate time for clinical and administrative leadership for practice improvement efforts, including participation in regular team meetings.
		Incorporate population health, quality and patient experience metrics in regular reviews of practice performance.
	C: Active participation in shared learning.	Share lessons learned from practice changes (successful and unsuccessful changes) and useful tools and resource materials with other practices.
		Engage with other practices through transparent sharing of common measures used to guide practice change.
		Access available expertise to assist in practice changes of strategic importance to the practice.

Primary Driver – 4.0 Optimal Use of Health IT

Secondary Driver	Change Concept	Change Tactics (Examples)
4.1 Continuous Improvement of HIT	A: Align with the Meaningful Use (MU) program to improve EHR function and capability.	Use an ONC-certified EHR.
		Align practice changes for Comprehensive Primary Care with MU requirements
	B: Develop practice capacity for optimal use of EHR	Identify staff with responsibility for management of EHR capability and function.
		Cross-train staff members in key skills in the use of HIT to improve care.
		Convene regularly to discuss and improve workflows to optimize use of the EHR.
		Engage regularly with EHR vendors about EHR requirements to deliver efficiently the five CPC functions and for EHR-based quality reporting.
4.2 Data Exchange	A: Enable the exchange of patient information to support care.	Connect to local health information exchanges, if available.
		Develop information exchange processes and care compacts with other service providers with which the practice shares patients.
		Use standard documents created by the EHR to routinely share information (e.g., medications, problem, allergies, goals of care, etc.) at time of referral and transition between settings of care.
		Use non-clinician workflows to systematically enter structured clinical data from external (e.g., paper and e-fax) sources into the EHR.
4.3 EHR-Based Quality Reporting	A: Develop the capability for practice- and panel-level quality measurement and reporting from the EHR.	Develop capability for practice-level reporting of Clinical Quality Measures derived from the EHR.
		Develop capability for panel-level reporting of Clinical Quality Measures derived from the EHR.
		Develop capability for electronic transmission of quality reports.

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Secondary Driver	Change Concept	Change Tactics
5.1 Engaged Community	A: Engage stakeholders with an interest in better care, better health outcomes, and lower overall cost of care in support of CPC practices.	Engage consumers, employers, unions and other regional or local entities in support of CPC practices.
		Engage policy-makers at the regional or state level in the work of CPC.
		Ensure that other regional or state primary care improvement efforts are aware of and can align with CPC.
	B: Support processes that integrate care across the Medical Neighborhood.	Engage hospitals, nursing facilities, pharmacies, other ambulatory providers and community-based services in efforts to improve coordination of care.
5.2 Aligned Payment Reform	A: Use population-based payment to purchase comprehensive primary care services.	Prospectively align every member or beneficiary with a primary care provider, care team or practice.
		Provide a per-member or beneficiary per-month supplement to fee for services for comprehensive primary care services.
		Use a methodology shared with practices to risk adjust per member/beneficiary per month payment.
		Align standards for Comprehensive Primary Care services.
	B: Provide actionable and timely cost and utilization data to practices.	Provide at least quarterly reports of timely data, by provider and practice, of services received by beneficiaries from outside of the primary care practice.
		Notify providers and practices of ER visits and admissions, as soon as possible.
		Engage with practices to improve the usability and functionality of data reports.
	C: Reward practice actions to reduce total cost of care through shared savings or other mechanism.	Use shared savings or similar methodology to reward achievement of better care, better health outcomes and lower total cost of care.
		Provide regular data that practices can use to guide practice changes to create shared savings.
		Seek alignment between payment incentives and contract terms and the five Comprehensive Primary Care functions.
	D: Align quality measures.	Seek alignment on all three types of CPC quality measures (quality of care, patient experience and cost of care) with CMS and other major payers in the market.