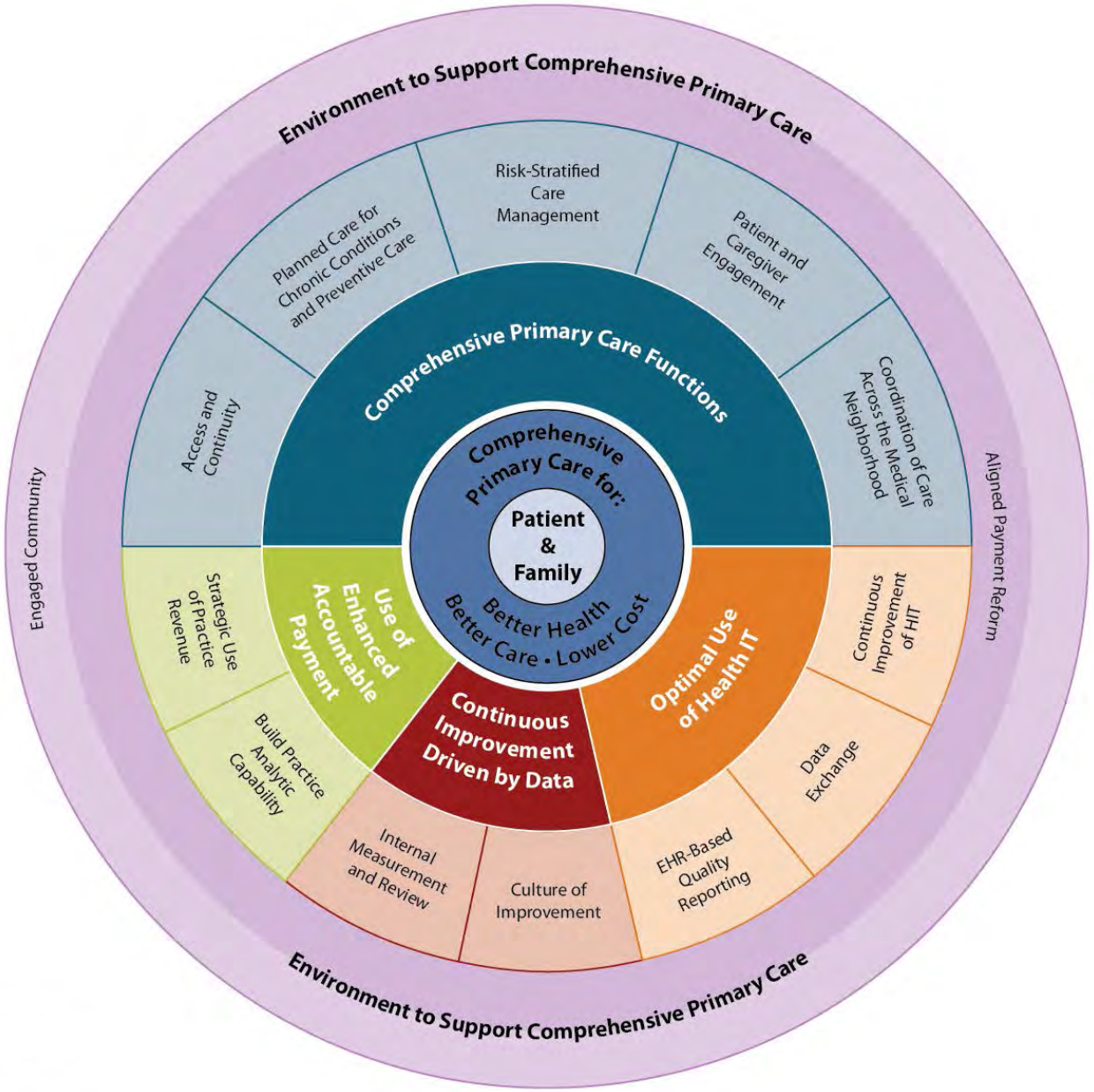
CPC Change Package and Key Drivers

The Driver Diagram

The updated "logic model" for the CPC initiative is shown here, followed by the corresponding Change Package. It delineates the concepts and tactics that support the aim of CPC: better health, better care and lower cost.

2015 Revision: The CPC "logic model" now includes a fifth driver to achieve the aims of CPC: the outer ring represents the Environment to Support Comprehensive Primary Care. This driver encompasses both the payment changes in CPC and the multi-stakeholder efforts to create a more integrated medical neighborhood. Other revisions to the Change Package can be found in the tactics, which now capture the work CPC practices are doing.



Introduction to the Pathways Guide, May 2016

The **Pathways Guide to CPC** is a resource for practices, payers, and other health care organizations who are working through change efforts similar to those in CPC. The *CPC Key Drivers and Changes* presents a high-level view of the actions required to achieve the CPC aims of improved care, better health for populations, and lower cost. CPC practices have been working through the CPC Milestones to make these changes in their practices, build this capability and deliver comprehensive primary care. CMS, CPC payers, and regional stakeholders have been working together to build the Environment to Support Comprehensive Primary Care (Driver 5).

You can use the *Key Drivers and Changes* 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. The *Key Drivers and Changes* identifies the key drivers necessary to achieve the CPC aims and the changes in practice delivery required. The radial diagram provides a visual representation of the drivers and changes. It highlights the connections among drivers, changes and change concepts. For each *Change Concept* you will find multiple search terms to explore applicable resources in this portfolio – resources that demonstrate not only "what" should be in place to do this work but also examples of change tactics (the "hows" and examples of this work). The change tactics now include work the CPC practices have undertaken to support the drivers.

Practice change is difficult and complicated. This complexity is reflected in the multiplicity of search terms for each *Change Concept* identified in the *Key Drivers and Changes.*

The resources in this Pathways portfolio are 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 how 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.

As you use this **Pathways Guide** it will be helpful to understand the relationship between the CPC Milestones and the *Key Drivers and Changes*. The Key Drivers and Changes provide the theory of action for CPC: how properly supported primary care will produce better care, smarter spending and healthier people. The *CPC Milestones* are the corridors of work through which the CPC practices have been developing the capabilities identified in the *Key Drivers and Changes*. CPC practices are accountable to CMS for the Milestones and report progress quarterly through a web portal. In this Guide you will be able to search by the CPC Milestones as well to understand the changes practices are making through each Milestone.

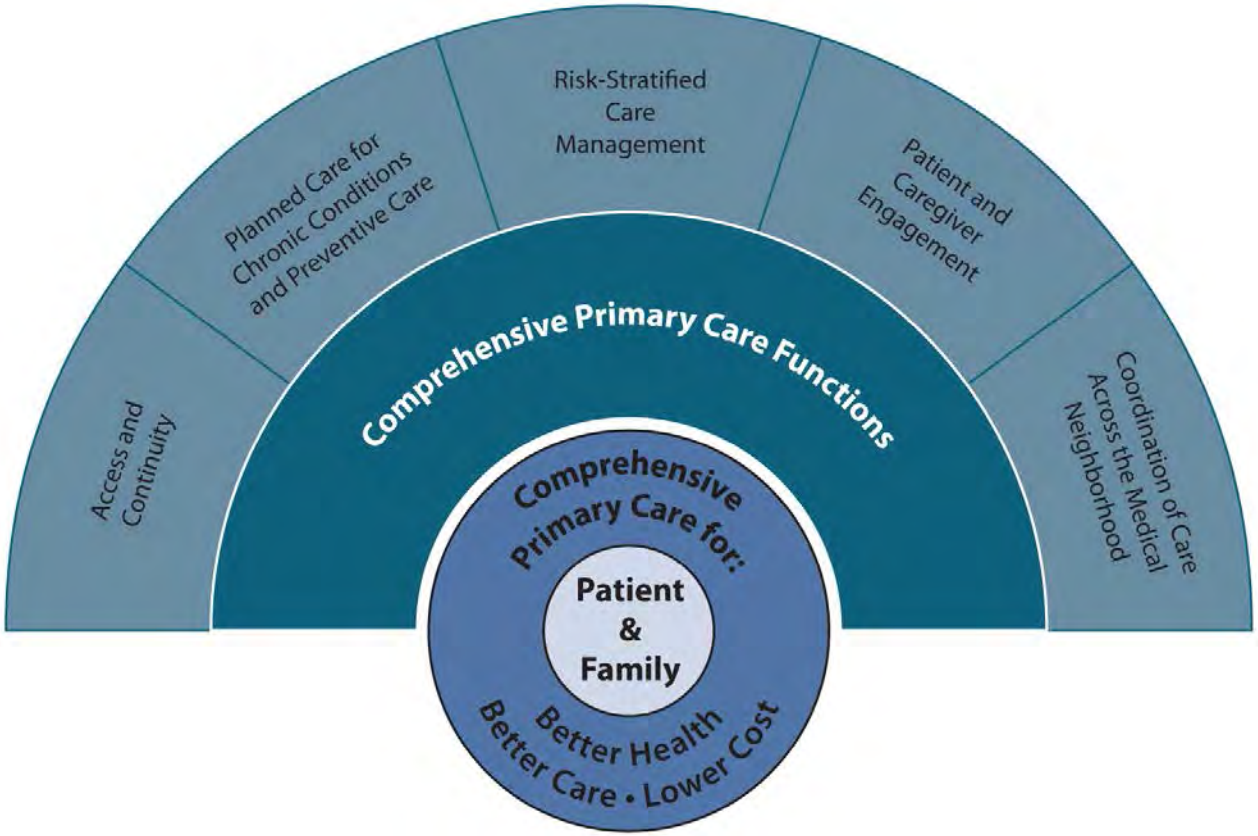
In CPC we are learning with and from the practices, payers, and regional stakeholders about the changes necessary to improve care, achieve better health outcomes, and lower the cost of care. We hope this CPC Pathway's Guide reflects that process and captures some of what has been learned.

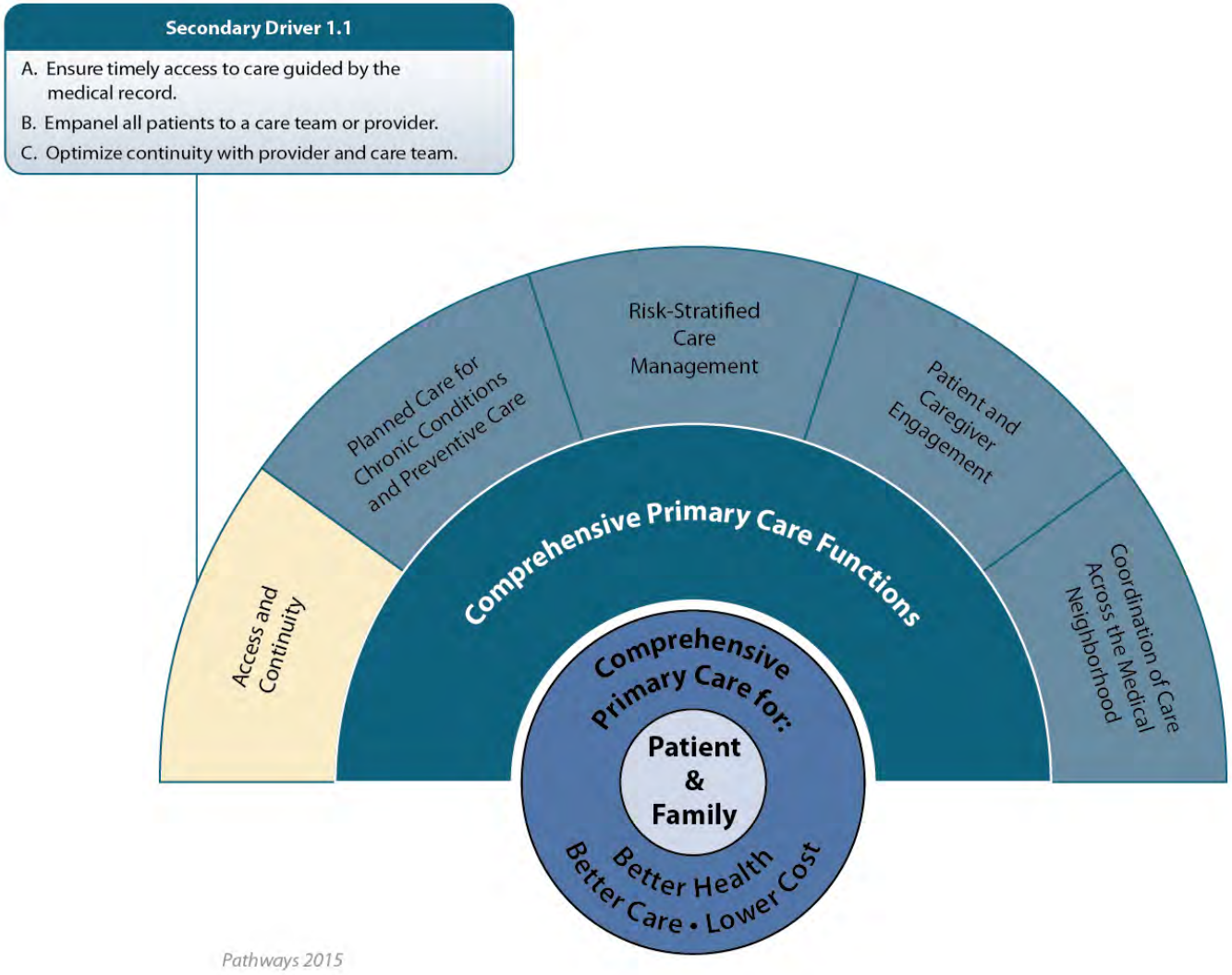
Primary Driver – 1.0 Comprehensive Primary Care Functions

Introduction to Driver 1

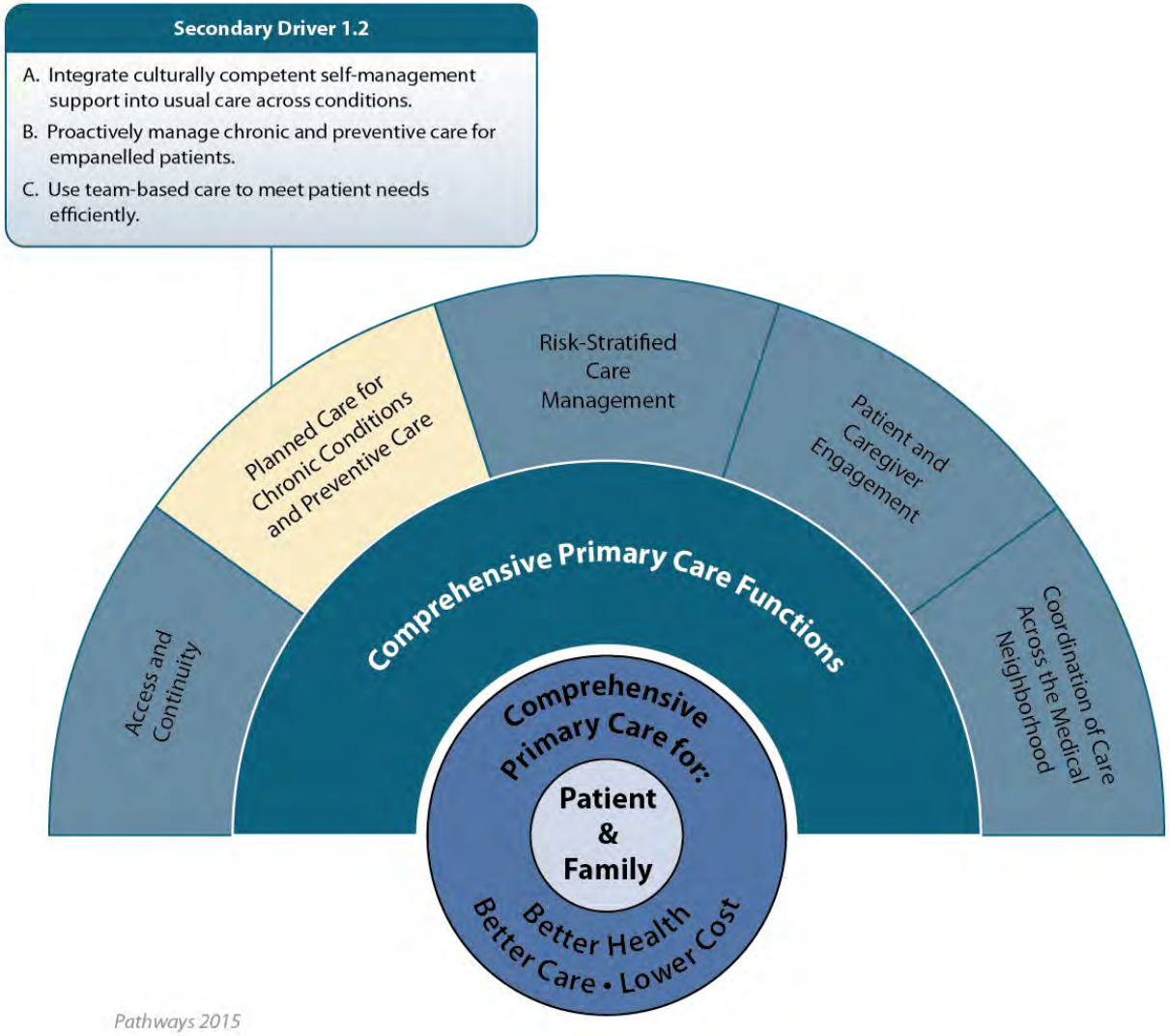
CPC practices have developed capabilities in the delivery of five comprehensive primary care functions to achieve better health outcomes and improve the experience of care, as well as reduce the cost of care through improvement in care. In the examples that follow you will see how CPC practices achieve the following:

1. **Improve access** to care fully informed by the medical record, building relationship through **continuity of care** and maintaining continuity in management of acute and chronic conditions.
2. Use teams to provide **planned, proactive care** for chronic conditions and preventive care, integrate behavioral health services, and manage medications to maximize efficiency, effectiveness and safety.
3. Address the health of both the individual and the practice population through **risk stratification** of their practice population, management of transitions in care, and practice-based care management for those at highest risk.
4. **Engage patients, families, and caregivers** in the management of their own health and health care and in the way the practice provides that care.
5. **Coordinate care across the medical neighborhood,** serving as the hub of care for their patients, systematically bridging care handoffs and transitions, and linking to community-based resources to support their patients.




Secondary Driver 1.1
A. Ensure timely access to care guided by the medical record.
B. Empanel all patients to a care team or provider.
C. Optimize continuity with provider and care team.
Access and Continuity
Planned Care for Chronic Conditions and Preventive Care
Risk-Stratified Care Management
Patient and Caregiver Engagement
Coordination of Care Across the Medical Neighborhood
Comprehensive Primary Care Functions
Comprehensive Primary Care for:
Patient & Family
Better Health
Better Care • Lower Cost
Pathways 2015

Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
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.	Milestone 3, MS 3, MS3 Milestone 6, MS 6, MS6 24/7 Asynchronous Care compacts Care coordination Community Based Resources Continuity ED visits, Emergency Department Visits Enhanced access Follow up, follow-up Home care, Home health Hospice Hospital, Hospitalization Medical Neighborhood SNF, skilled nursing facility
	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.	Milestone 2 Empanelment
	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.	Milestone 2, MS 2, MS2 Milestone 3, MS 3, MS3 Milestone 6, MS 6, MS6 24/7 Asynchronous Care compacts Care coordination Care manager, CM, care management Care plan Continuity Enhanced access Follow up, follow-up Medical Neighborhood Pre-visit planning, Previsit plan Team based care


Secondary Driver 1.2
A. Integrate culturally competent self-management support into usual care across conditions.
B. Proactively manage chronic and preventive care for empanelled patients.
C. Use team-based care to meet patient needs efficiently.
Planned Care for Chronic Conditions and Preventive Care
Risk-Stratified Care Management
Patient and Caregiver Engagement
Coordination of Care Across the Medical Neighborhood
Access and Continuity
Comprehensive Primary Care Functions
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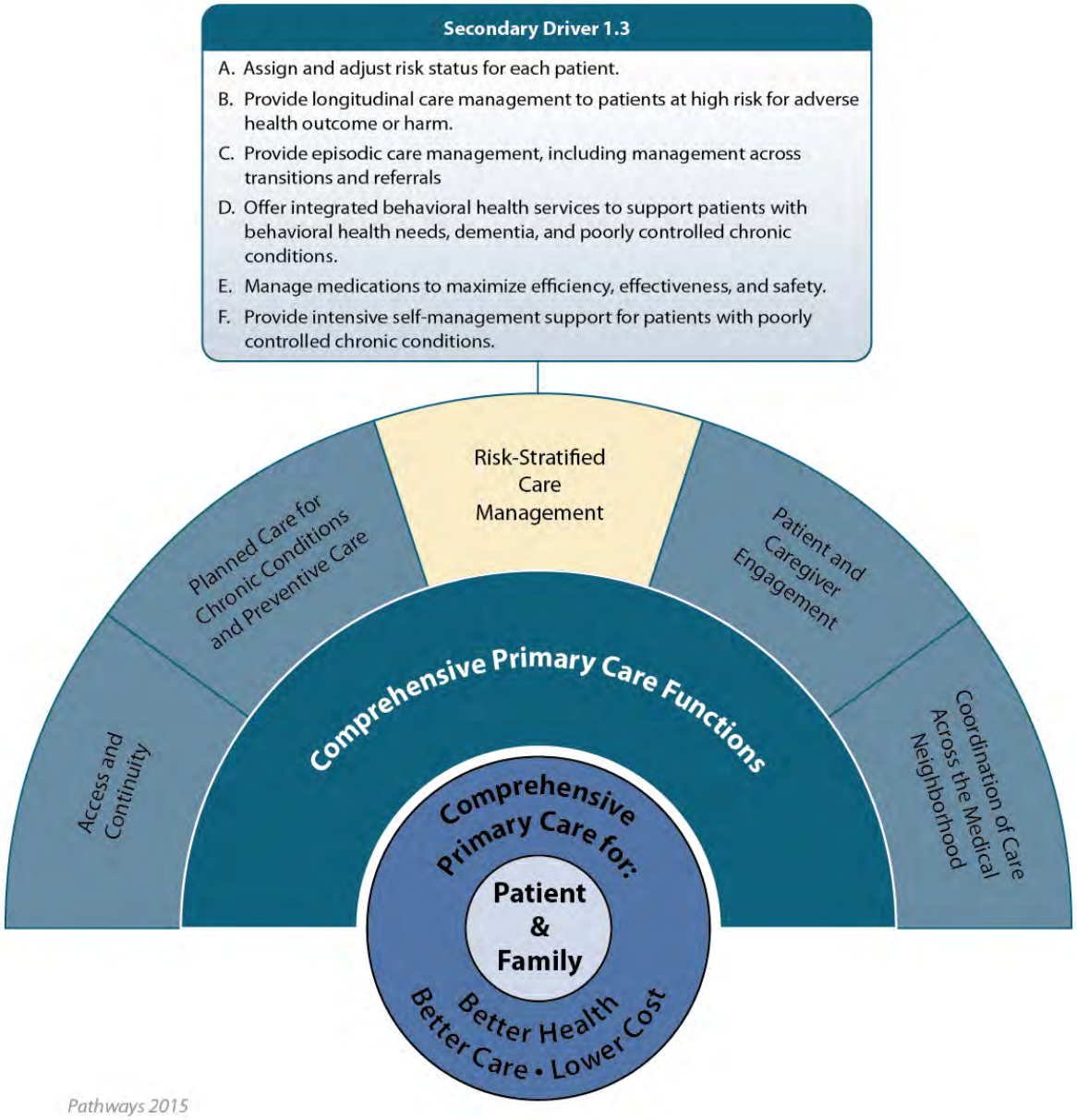
Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
1.2	A: Integrate culturally competent self-management support into usual care across conditions.	• Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR. • 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.	Milestone 2, MS 2, MS2 Milestone 4, MS 4, MS4 Milestone 6, MS 6, MS6 Care manager, CM, care management Care plan Community Based Resources Empanelment, empanel, empanelled Family Caregiver Engagement Patient Engagement Pre-visit planning, Previsit plan Self-Management Support (SMS)
Planned Care and Population Health	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.	Milestone 2, MS 2, MS2 Milestone 5, MS 5, MS5 Clinical Quality Measures, CQM, eCQM Care manager, CM, care management Care plan Empanelment, empanel, empaneled High risk, High-risk, High need Medication Management, MM Patient Portal Pre-visit planning, Previsit plan Risk Stratification Self-Management Support (SMS) Team based care

Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
	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.	Multiple Milestones Behavioral Health Integration, BHI Care coordination Care manager, CM, care management Care plan Community Based Resources Empanelment, empanel, empaneled High risk, High-risk, High need Pre-visit planning, Previsit plan Risk Stratification Self-Management Support (SMS) Team based care


Secondary Driver 1.3
A. Assign and adjust risk status for each patient.
B. Provide longitudinal care management to patients at high risk for adverse health outcome or harm.
C. Provide episodic care management, including management across transitions and referrals
D. Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions.
E. Manage medications to maximize efficiency, effectiveness, and safety.
F. Provide intensive self-management support for patients with poorly controlled chronic conditions.
Risk-Stratified Care Management
Planned Care for Chronic Conditions and Preventive Care
Patient and Caregiver Engagement
Access and Continuity
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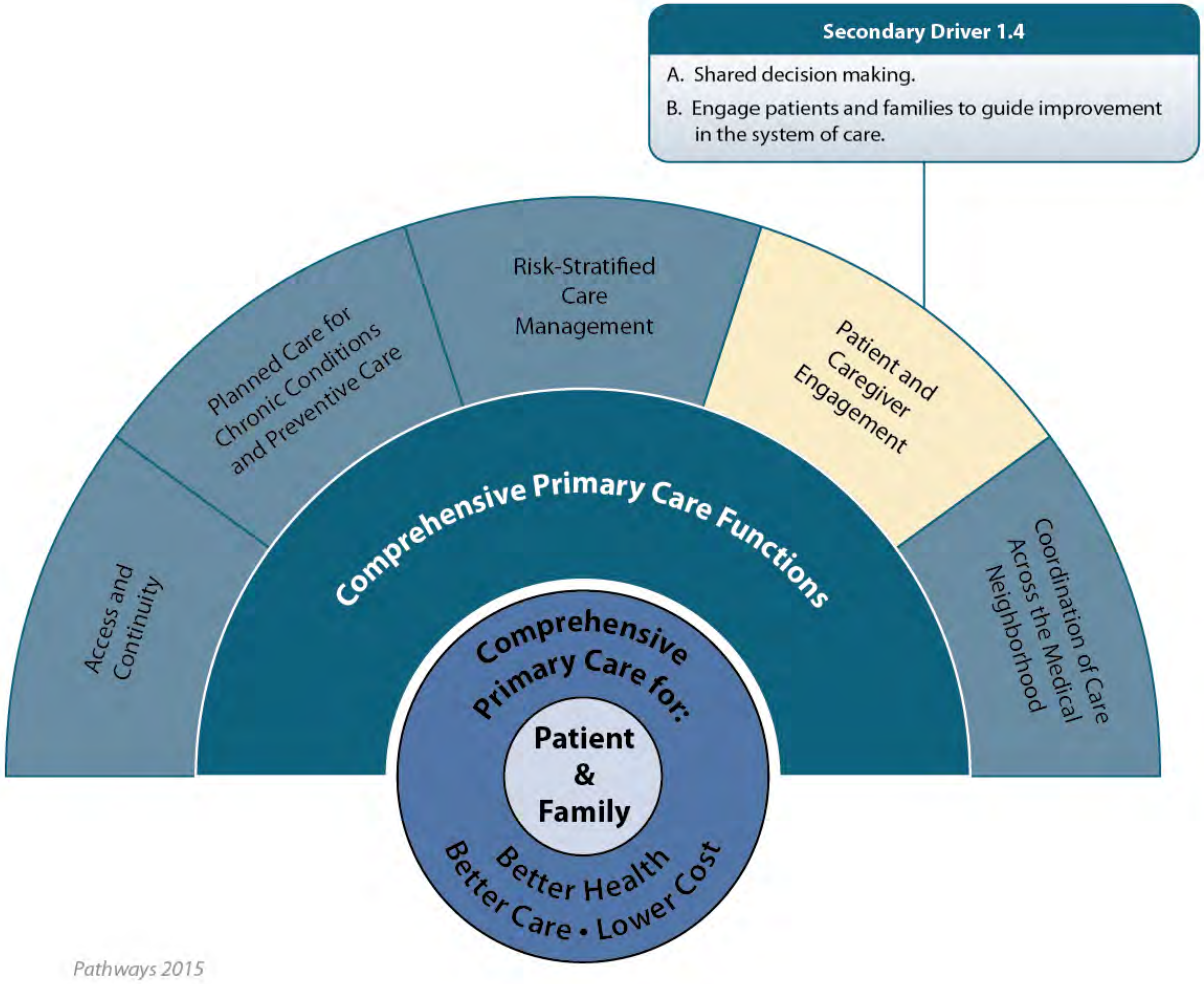
Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
1.3 Risk-Stratified Care Management	A: Assign and adjust risk status for each patient.	• Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts. Monitor the risk-stratification method and refine as necessary to improve accuracy of risk status identification.	Milestone 2, MS 2, MS2 Care manager, CM, care management Empanelment, empanel, empaneled High risk, High-risk, High need Pre-visit planning, Previsit plan Risk Stratification
	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.	Milestone 2, MS 2, MS2 Care manager, CM, care management Care plan Empanelment, empanel, empaneled High risk, High-risk, High need Pre-visit planning, Previsit plan Risk Stratification
	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.	Milestone 2, MS 2, MS2 Milestone 6, MS 6, MS6 Care coordination Care manager, CM, care management Care plan ED visits, Emergency Department Visits Empanelment, empanel, empaneled High risk, High-risk, High need Home care, Home health Hospice Hospital, Hospitalization Medical Neighborhood Pre-visit planning, Previsit plan Risk Stratification SNF, skilled nursing facility Team based care

Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
1.3 Risk-Stratified Care Management	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.	Milestone 2, MS 2, MS2 Milestone 5, MS 5, MS5 Milestone 6, MS 6, MS6 Behavioral Health Integration, BHI Care manager, CM, care management Care plan Care coordination Clinical Quality Measures, CQM, eCQM Empanelment, empanel, empaneled Feedback Reports High risk, High-risk, High need Medication Management, MM Pre-visit planning, Previsit plan Risk Stratification Self-Management Support (SMS) Team based care
	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.	Milestone 2, MS 2, MS2 Milestone 6, MS 6, MS6 Care manager, CM, care management Care plan High risk, High-risk, High need Medication Management, MM Pre-visit planning, Previsit plan Self-Management Support (SMS) Team based care Medical Neighborhood
	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.	Milestone 2, MS 2, MS2 Care manager, CM, care management Care plan High risk, High-risk, High need Pre-visit planning, Previsit plan Self-Management Support (SMS)


Secondary Driver 1.4
A. Shared decision making.
B. Engage patients and families to guide improvement in the system of care.
Access and Continuity
Planned Care for Chronic Conditions and Preventive Care
Risk-Stratified Care Management
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Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
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.	Milestone 7, MS 7, MS7 Decision Aid Patient Education Preference Sensitive Coordination Shared decision aid, SDA Shared Decision Making, SDM
	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.	Milestone 4, MS 4, MS4 CAHPS Family Caregiver Engagement Patient Engagement Patient Family Advisory Council, PFAC Surveys

Secondary Driver 1.5

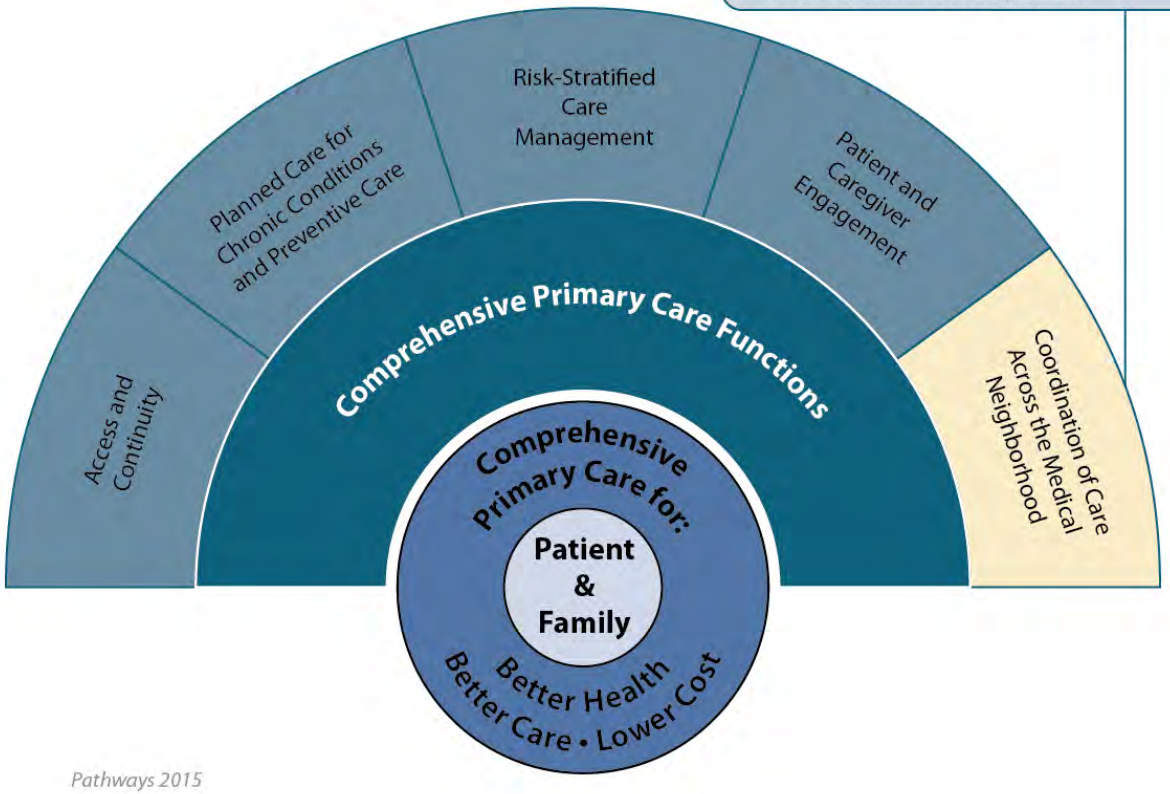
A. Establish standard operations to manage transitions of care.

B. Establish effective care coordination and active referral management.

C. Ensure that there is bilateral exchange of necessary patient information to guide patient care.

D. Develop pathways to neighborhood/community-based resources to support patient health goals.

E. Manage referral networks to meet behavioral health needs not available in the practice.



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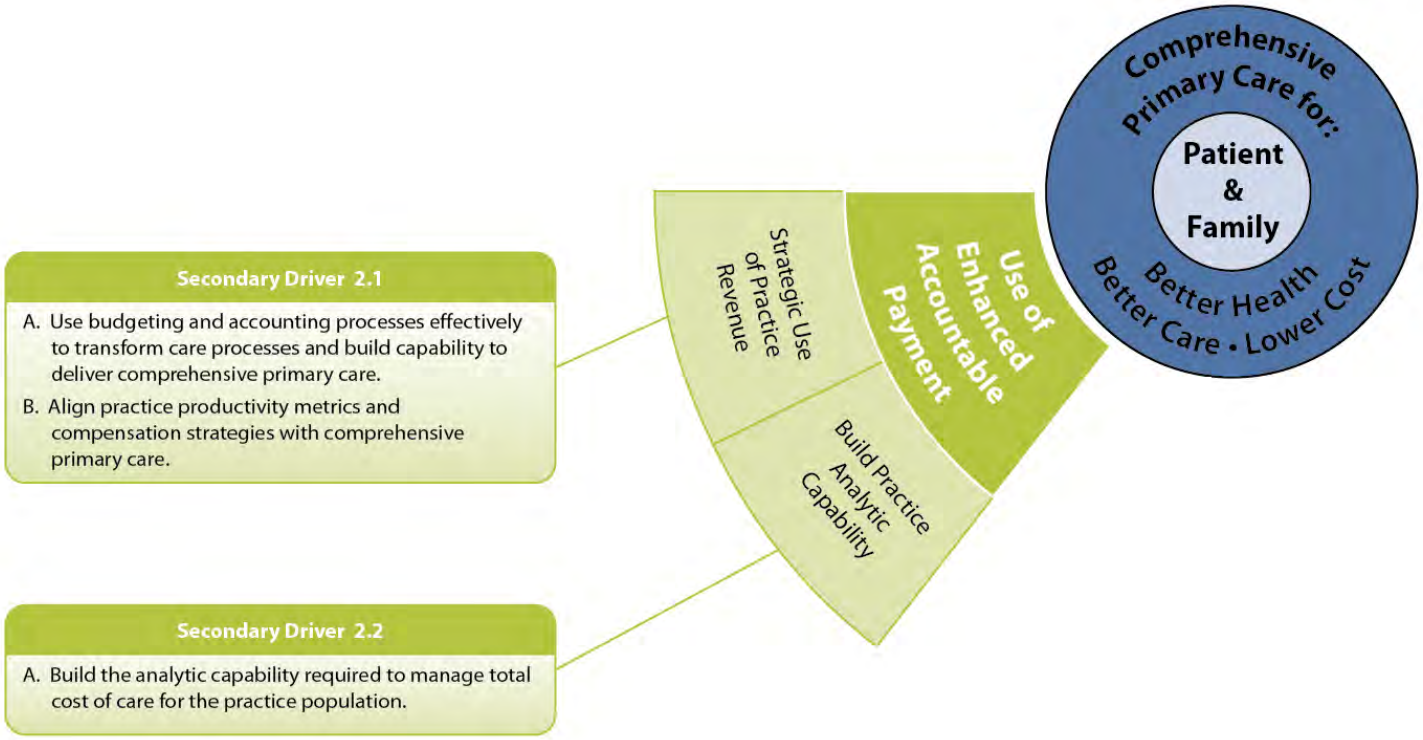
Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
1.5	A: Establish standard operations to manage transitions of care.	• Formalize lines of communication with local settings in which empanelled patients receive care to ensure documented flow of information and seamless transitions in care. • Partner with community or hospital-based transitional care services.	Milestone 2, MS 2, MS2 Milestone 6, MS 6, MS6 Care compacts Care coordination Care manager, CM, care management Community Based Resources ED visits, Emergency Department Visits Home care, Home health Hospice Hospital, Hospitalization Medical Neighborhood SNF, skilled nursing facility
Coordination of Care Across the Medical Neighborhood	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.	Milestone 2, MS 2, MS2 Milestone 3, MS 3, MS3 Milestone 6, MS 6, MS6 Care compacts Care coordination Care manager, CM, care management Care plan Continuity Follow up, follow-up Home care, Home health Hospice Hospital, Hospitalization Medical Neighborhood Pre-visit planning, Previsit plan SNF, skilled nursing facility Team based care

Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
1.5 Coordination of Care Across the Medical Neighborhood	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.	Milestone 6, MS 6, MS6 Milestone 9, MS 9, M9 Care compacts Care coordination Community Based Resources Medical Neighborhood HIE
	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.	Milestone 2, MS 2, MS2 Milestone 6, MS 6, MS6 Care manager, CM, care management Self-Management Support (SMS) Care coordination Community Based Resources Medical Neighborhood
	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.	Milestone 2, MS 2, MS2 Behavioral Health Integration, BHI Care manager, CM, care management Care plan High risk, High-risk, High need Care compacts Care coordination Community Based Resources Medical Neighborhood

Primary Driver – 2.0 Use of Enhanced Accountable Payment

Introduction to Driver 2

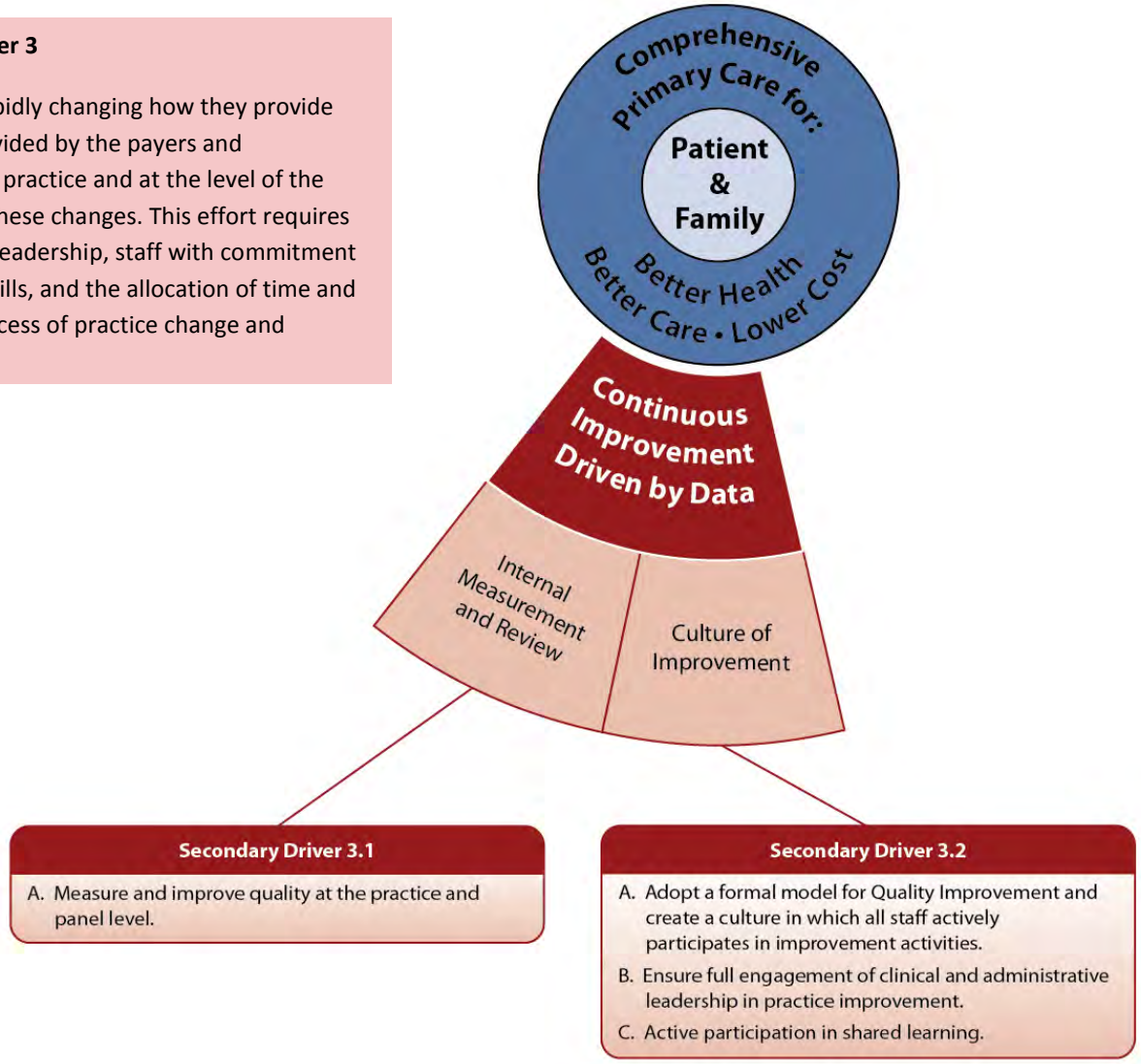
CPC practices combine the non–visit-based payments they receive from multiple commercial and public payers to deliver comprehensive primary care. They are strategic in their use of these alternate payment resources to build and sustain the capability to deliver the comprehensive primary care functions and are investing in the analytic capability they will need to meet the health care needs of their population with attention to the cost of care.



Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
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.	Milestone 1, MS 1, MS1 Billing Budget Care management fees Payers Shared Savings
	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.	Milestone 1, MS 1, MS1 Budget Care management fees Compensation strategies Payers Shared Savings
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.	Links to all Milestones Data Analytics EMR / EHR

Introduction to Driver 3

CPC practices are rapidly changing how they provide care, using data provided by the payers and measurement in the practice and at the level of the care team to guide these changes. This effort requires active and engaged leadership, staff with commitment and improvement skills, and the allocation of time and resources to the process of practice change and improvement.



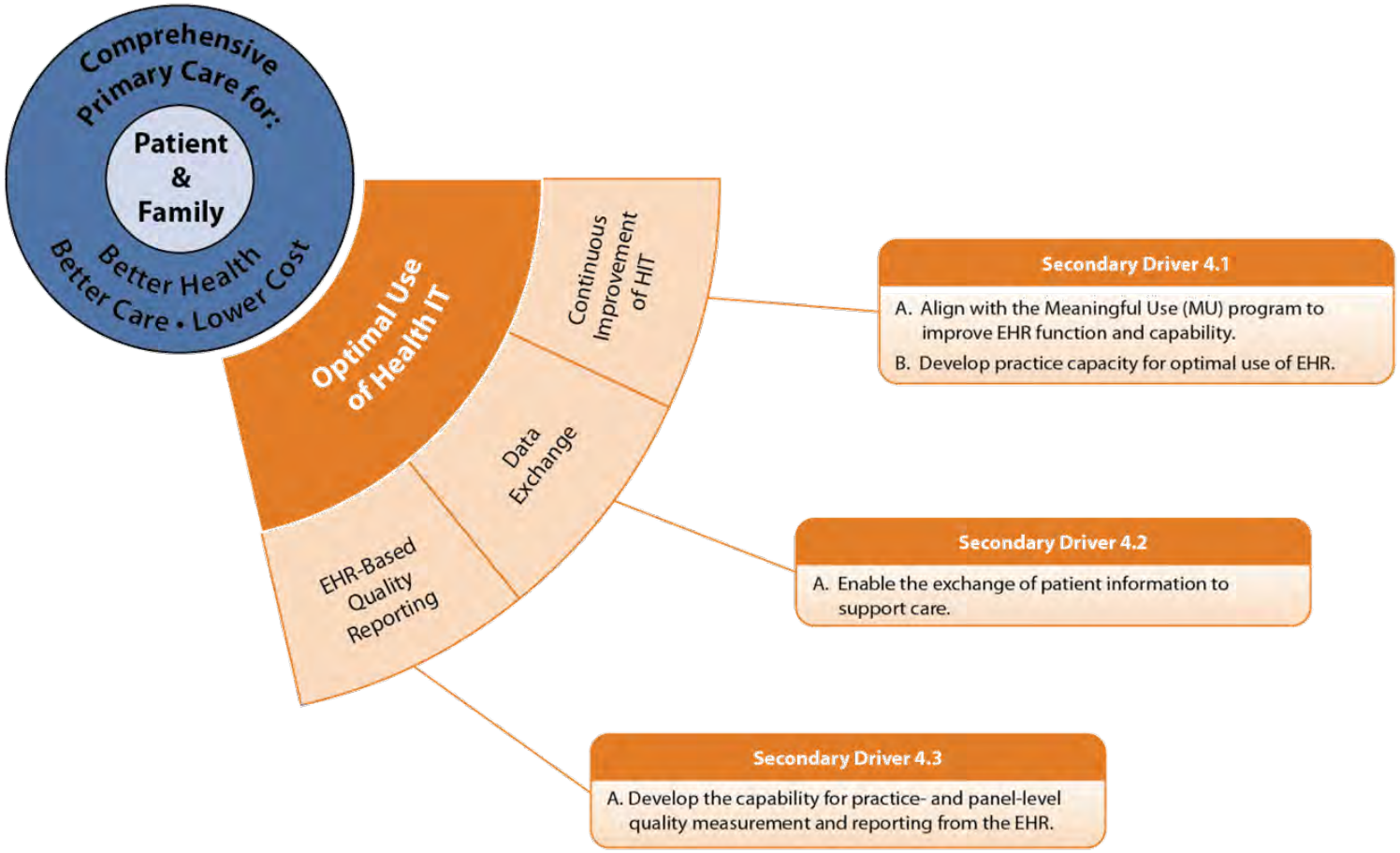
Pathways 2015

Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
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.	Milestone 5, MS 5, MS5 Clinical Quality Measures, CQM, eCQM Continuous Quality Improvement, CQI Feedback Reports PQRS
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.	Links to all Milestones Clinical Quality Measures, CQM, eCQM Continuous Quality Improvement, CQI
	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.	Links to all Milestones CAHPS Continuous Quality Improvement, CQI Feedback Reports Patient Family Advisory Council, PFAC Surveys
	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.	Milestone 8, MS 8, MS8 Action Group Implementation Guide Program Reports Spotlights Teach back Webinars

Primary Driver – 4.0 Optimal Use of Health IT

Introduction to Driver 4

CPC practices are adapting workflows to fully use the capabilities of the electronic health record (EHR) to manage patients and population. Through EHR-based quality reporting they link quality measurement and improvement to daily clinical care and documentation. Participation in regional health information exchanges, when available, helps them to more effectively bridge the seams of care in their medical neighborhood.



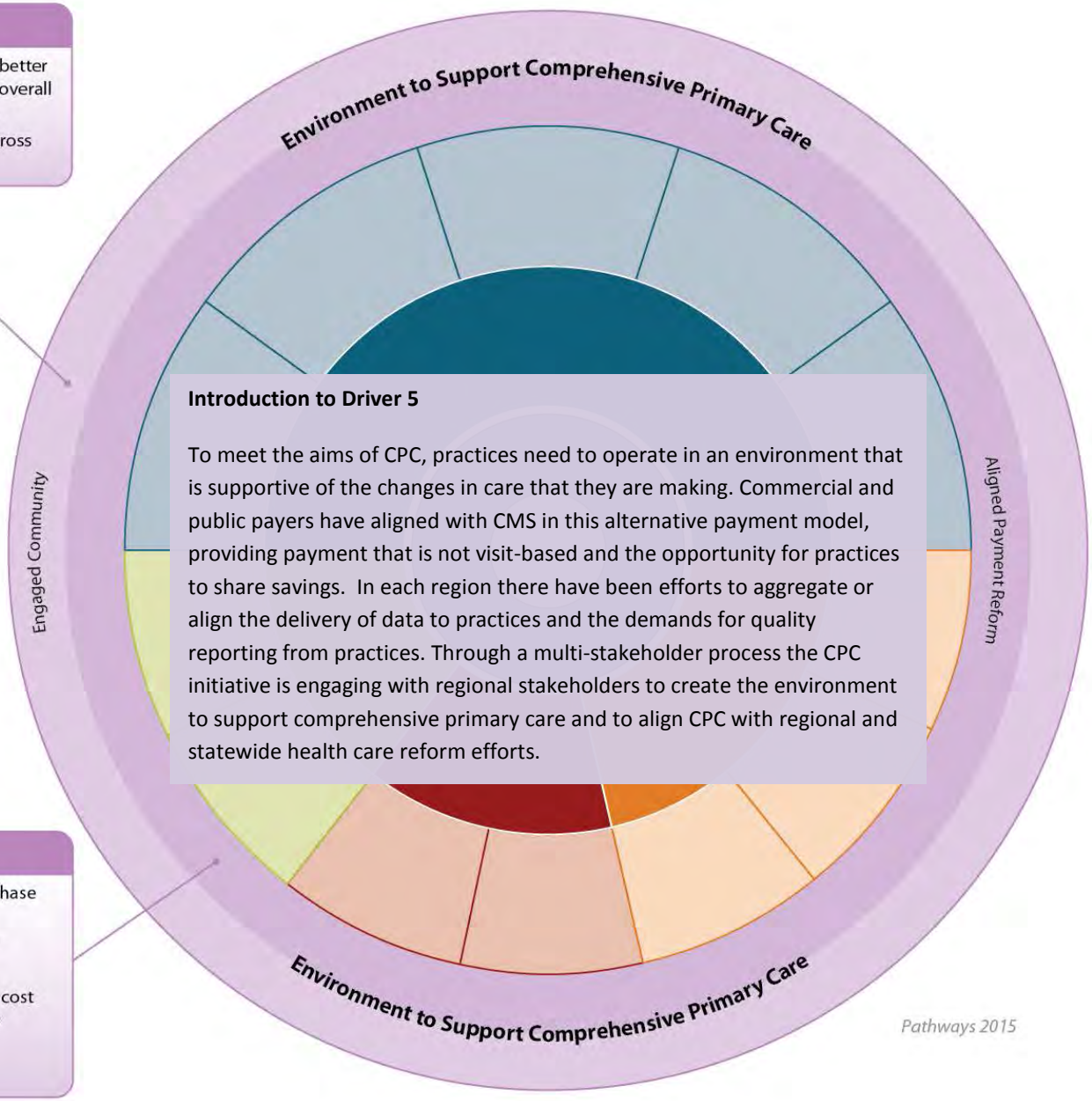
Secondary Driver	Change Concept	Change Tactics (Examples)	Search Terms
4.1 **Continuous Improvement of HIT**	A: Align with the Meaningful Use (MU) program to improve EHR function and capability.	• Use an ONC-certified EHR. • Align practice changes for Comprehensive Primary Care with MU requirements	Milestone 9, MS 9, M9 Data Analytics EMR / EHR HIE Meaningful Use, MU ONC Patient portal
	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.	Link to all Milestones Data Analytics EMR / EHR Meaningful Use, MU ONC
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.	Milestone 2, MS 2, MS2 Milestone 5, MS 5, MS5 Milestone 6, MS 6, MS6 Milestone 9, MS 9, M9 Care compacts Care coordination Care manager, CM, care management Care plan Community Based Resources ED visits, Emergency Department Visits EMR / EHR HIE Medical Neighborhood
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.	Milestone 5, MS 5, MS5 Clinical Quality Measures, CQM, eCQM Continuous Quality Improvement, CQI

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

Secondary Driver 5.1

A. Engage stakeholders with an interest in better care, better health outcomes and lower overall cost of care in support of CPC practices.

B. Support processes that integrate care across the Medical Neighborhood.



Introduction to Driver 5

To meet the aims of CPC, practices need to operate in an environment that is supportive of the changes in care that they are making. Commercial and public payers have aligned with CMS in this alternative payment model, providing payment that is not visit-based and the opportunity for practices to share savings. In each region there have been efforts to aggregate or align the delivery of data to practices and the demands for quality reporting from practices. Through a multi-stakeholder process the CPC initiative is engaging with regional stakeholders to create the environment to support comprehensive primary care and to align CPC with regional and statewide health care reform efforts.

Secondary Driver 5.2

A. Use population-based payment to purchase comprehensive primary care services.

B. Provide actionable and timely cost and utilization data to practices.

C. Reward practice actions to reduce total cost of care through shared savings or other mechanism.

D. Align quality measures.

Secondary Driver	Change Concept	Change Tactics	Search Terms
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.	Patient engagement Payers
	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.	Milestone 6, MS 6, MS6 Community Based Resources Medical Neighborhood Payers
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.	Billing Budget Empanelment, empanel, empaneled Payers Risk stratification
	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.	Data analytics ED visits, Emergency Department Visits Feedback reports HIE Medical Neighborhood
	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.	Data analytics Feedback reports Payers Shared Savings
	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.	CAHPS Clinical Quality Measures, CQM, eCQM Payers Surveys