2017 CPC+ IMPLEMENTATION GUIDE: GUIDING PRINCIPLES AND REPORTING

May 10, 2017

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Introduction

The *CPC+ Implementation Guide: Guiding Principles and Reporting* (referred to hereafter as the Guide) orients you to our work together in Program Year (PY) 2017, provides guidance on how you can transform your practice and report on the care delivery requirements, and describes resources to support your efforts in the coming year. This Guide supplements information provided to you previously that is summarized in Appendix A.

CPC+ Logic Model

The **Driver Diagram** (see Figure 1) illustrates how all components of the CPC+ model work together to support your practice in the delivery of comprehensive primary care. At the center is what we are striving to do: to achieve better care, to improve health outcomes, and to be smarter about how we spend money for patients and families. In the Driver Diagram, the primary driver, **Comprehensive Primary Care Functions** (in blue), are supported by three foundational drivers: **Use of Enhanced, Accountable Payment** (in green); **Continuous Improvement Driven by Data** (in orange); and **Optimal Use of Health IT** (in red). Supporting this entire primary care practice model is **Aligned Payment Reform** (in purple) in which commercial and state payers partner with the Centers for Medicare & Medicaid Services (CMS) by providing care management fees and performance-based incentive payments. For Track 2 practices, Aligned Payment Reform provides additional flexibility by shifting a portion of your fee-for-service (FFS) payment and adding an upfront Comprehensive Primary Care Payment (provided by Medicare). Partner payers have also committed to offer an alternative to FFS payment.

This Guide provides general guiding principles on practice transformation, reporting guidelines, and resources to support your work in CPC+. This work involves building capability within your practice to meet the ongoing needs of your patient population. You will report on your progress

toward fulfilling these requirements every quarter, based on the care delivery reporting guidelines.

How to Use This Guide

This Guide is organized in three sections—Care Delivery, Care Delivery Reporting Guide, and Operational Tasks—and includes Appendices with additional resources.

Section I: Care Delivery

Through your work to enhance your practice's capabilities to improve care delivery, you are building toward delivery of the five Comprehensive Primary Care Functions (Driver 1), supported by Aligned Payment Reform (Driver 5) and the following:

- Use of Enhanced, Accountable Payment (Driver 2)
- Continuous Improvement Driven by Data (Driver 3)
- Optimal Use of Health IT (Driver 4)

The Care Delivery section is organized by drivers and functions. Each driver or function is organized by key change concepts identified for that driver or function. Each change concept focuses on these key areas:

- **Defining the change.** This subsection describes the change concept and why the change concept is important to your practice, and provides guidance on how you can implement related change tactics in your practice. *Change concepts* are ideas found to be useful in developing change strategies that lead to improvement. *Change tactics* are specific examples of how your practice can implement key change concepts. Your practice is encouraged to implement high-value change tactics that are tied to the Comprehensive Primary Care Functions. These change tactics will guide your practice through the work of practice change to achieve and innovate on a set of care delivery requirements. The change tactics for each change concept are highlighted in blue call out boxes.

- **Care delivery requirements.** Care delivery requirements tied to a function or driver are highlighted in green call out boxes. You can use the "roadmap" in Appendix C as a guide for pacing change and tracking your practice's progress towards achieving these requirements. The roadmap illustrates the suggested sequencing of high-level changes that may lead to the enhanced capabilities required for PY 2017.

- **Health IT capabilities.** Key health IT capabilities related to change concepts are highlighted in pink call out boxes. Your practice can leverage these capabilities to acquire, analyze, transfer, and protect medical information vital to optimizing care delivery and meeting CPC+ requirements.

- **Resources.** Useful resources related to a given change concept or change tactic are highlighted in orange call out boxes.[1] Your practice can use these resources as references or guides to inform your tests of change. Appendix B provides a wealth of existing tools and resources your practice can reference for more details on change tactics you choose to adopt, and related evidence-based documentation.

Section II: Care Delivery Reporting Guide

You can use the Care Delivery Reporting Guide as a worksheet for care delivery reporting for PY 2017. This section includes all questions, reporting frequencies, definitions, and other notes to help you understand your practice's reporting. These questions prepare your practice to gather the information that you will report quarterly. The information you gather for the reporting guide will serve as a useful assessment tool for you to track your practice transformation progress.

Section III: Operational Tasks

The Operational Tasks section highlights important resources, timelines, and steps for quality measurement, quality reporting, practice composition, and data feedback for PY 2017.

As a CPC+ participant, your practice (Track 1 and Track 2) will report electronic clinical quality measures (eCQMs). In addition to eCQMs, CMS will assess quality using utilization measures based on the claims for your attributed patients and a patient experience of care survey conducted by and paid for by CMS. If you are a Track 2 practice, you will also participate in the development of a patient-reported, outcome-based performance measure relevant to primary care practice. Section III describes requirements and timelines, and provides helpful worksheets to assist your practice in successfully meeting these reporting goals.

Over the course of CPC+, the staff in your practice may change and your practice may even change ownership, location, and composition. The Operational Tasks section provides comprehensive guidance on the types of changes your practice may make and where you can ask questions or submit information about such changes.

Appendices

The **Appendices** include additional resources that can help support your work in CPC+.

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[1] Some of the resources listed in this Guide, including CPC Classic spotlights, reside on CPC+ Connect. To directly access these links, log in to your CPC+ Connect account first. If you are not logged in to your CPC+ Connect account and select one of these links, you will be directed to the website login page. Log in to the website, then return to this document and select the link again to open a new window.

You are also strongly encouraged to use CPC+ Connect (a collaboration and knowledge sharing platform) as a primary source of insights and tools from the CPC+ community. **CPC+ Connect is a web-based platform designed for you and your practice staff to share ideas, best practices, and resources with other CPC+ participants via National and Regional Learning Networks.** Think of this as the Facebook for primary care transformation. The website's easy-to-use features are designed to support you in your work toward the CPC+ care delivery requirements. This platform is available at CPC+ Connect. If you do not have access to CPC+ Connect, please click here to self-register for CPC+ Connect today.

Section I: Care Delivery

Driver 1: Five Comprehensive Primary Care Functions

Driver 1 includes the five Comprehensive Primary Care Functions: (1) access and continuity, (2) care management, (3) comprehensiveness and coordination, (4) patient and caregiver engagement, and (5) planned care and population health.

- **Access and Continuity**. A trusting, continuous relationship between patients, their caregivers, and the team of professionals who provide care for them is the foundation of effective primary care. Whether through expanding office hours or developing alternatives to traditional office visits, ensuring patients have access to your team enhances that relationship and increases the likelihood that patients will get the right care at the right time, potentially avoiding costly urgent and emergent care.

- **Care Management**. Care management for high-risk, high-need patients is a hallmark of comprehensive primary care. Through your work in CPC+, you will identify these patients in two ways. The first way is by systematically risk stratifying your empaneled population to identify the high-risk patients most likely to benefit from targeted, proactive, relationship-based (longitudinal) care management. The second way is by identifying patients based on event triggers (e.g., transition of care setting or a new diagnosis of major illness) for episodic or short-term care management, regardless of risk status. Your practice will provide both longitudinal and episodic care management, targeting the care management approach that best improves outcomes for these identified patients.

- **Comprehensiveness and Coordination**. Comprehensiveness in the primary care setting refers to the aim of your practice meeting the majority of your patient population's medical, behavioral, and health-related social needs in pursuit of each patient's health goals. Comprehensiveness adds both breadth and depth to the delivery of primary care services, and builds on the element of relationship that is at the heart of effective primary care. It is associated with overall lower utilization and costs, less fragmented care, and better health outcomes. By participating in CPC+, your practice will increase the comprehensiveness of care based on the needs of your practice population. Strategies to achieve comprehensiveness involve the use of data analytics to identify needs at the population level and prioritize ways to meet key needs. Primary care practices should facilitate and coordinate additional care and services that patients need to get outside of their primary care practice through closed-loop referrals and/or co-management with specialists and linkages with community and social services. Your practice will act as the hub of care for your patients, playing a central role in helping patients and caregivers navigate and coordinate care.

- **Patient and Caregiver Engagement**. Optimal care and health outcomes require patient and caregiver engagement in the management of their own care, and in the design and improvement of care delivery. Your practice will organize a Patient and Family Advisory

Council (PFAC) to help you understand the perspectives of patients and caregivers on the organization and delivery of care, and on your ongoing transformation through CPC+. You will then use the recommendations from the PFAC to help your practice improve care and ensure continued patient-centeredness and patient satisfaction.

- **Planned Care and Population Health**. Your practice will organize the care you deliver to meet the needs of the entire population of patients you serve. Using team-based care, you will proactively offer timely and appropriate preventive care, and consistent evidence-based management of chronic conditions. You will improve population health through use of evidence-based protocols in team-based care, through identification of care gaps at the population level, and through measuring and acting on the quality of care at both the practice and panel levels.

Each of the five Comprehensive Primary Care Functions is described in more detail below, including change concepts and change tactics your practice can use to transform your practice operations and care delivery.

Function 1: Access and Continuity

During the first year of CPC+ participation, your practice will enhance a core function of primary care: achieving balance between timely access and continuity of care for your patients. *Access* refers to the timely use of needed health services. *Continuity* refers to the process by which the patient and his or her care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective care, and better patient experience. Evidence suggests that improving access and continuity increases the likelihood that patients get the right care at the right time, potentially avoiding costly urgent and emergent care.

Your practice care teams will build relationships with your patients based on mutual communication and trust. To accomplish your access and continuity goals, and to achieve more patient-centered, high quality, cost effective care for patients and families, you should focus on three change concepts, which are discussed in more detail below:

Function 1 Requirements

a. Achieve and maintain at least 95 percent empanelment to practitioner and/or care teams.

b. Ensure patients have 24/7 access to a care team practitioner with real-time access to the electronic health record (EHR).

c. Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity.

d. **Track 2:** Regularly offer at least one alternative to traditional office visits and/or expanded hours.

Related Health IT Capability for Patient Empanelment (Track 2 Only)

a. Enable the practice to assign each patient to a practitioner and/or care team within the health IT and sort and review the patients by assignment.

b. Make the assigned practitioner visible in the patient record to members of the care team.

- Empanel all patients to a practitioner and/or care team.

- Ensure timely access to care.

- Optimize continuity with the practitioner and/or care team.

Empanel all patients to a practitioner and/or care team

Defining the change

Empanelment is a series of processes that assign each active patient to a practitioner and/or care team, with consideration of patient and caregiver preferences. Empanelment will allow your practice to build effective and responsive care teams to optimize patient care, and to address the preventive, chronic, and acute care needs of all

Change Tactics

1. Assign responsibility for the total population, linking each patient to a practitioner and/or care team.

patients.[2] The central goal of empanelment is to enhance relationships between patients and their practitioners and/or care teams, while shifting the team's focus towards the health of a defined panel of patients.[3] Ultimately, empanelment focuses on patient outcomes by strengthening continuity of care. A key tactic related to empanelment is outlined in the Change Tactic table.

Identify active patients. To begin empaneling your patients, you must identify the active patients in your practice. *Active patients* refers to patients who received primary care at your practice looking back over a given period. Your practice should define a look back period that is at least 18 months. The specific look back period will depend on your practice's processes to track patient encounters and your patient population. Typically, practices use a look-back period from 18 to 36 months.

Link/empanel each patient to a practitioner and/or care team. Each active patient should be assigned to a practitioner and/or care team, and the assignment should be confirmed with the patient and the practitioner and/or care team. Empanelment is a dynamic process and must be updated regularly to ensure non-active patients are removed and new patients are assigned. You can use your EHR to assign roles to practitioners and care teams, and the role of the team members should be visible on each patients' health record. You should also be able to make edits to care team assignments, and create new practitioner records in your EHR. The patient panel report by practitioner and/or care team also helps you determine which practitioner can accept new patients.

The empanelment process can help your practice answer specific questions about the patients you care for. By empaneling your population, you can answer:

- Which patients are active and inactive in our panel?

- What percent of our active patients are assigned to specific practitioners and/or care teams?

- Are we seeing patients who are not our primary care patients (e.g., patients referred to us for specialty consultation or presenting for urgent care, but who receive primary care elsewhere) and are we able to exclude them from our empanelment process?

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[2] Grumbach, K., & Olayiwola, N. J. (2015, March–April). Patient Empanelment: The Importance of Understanding Who Is at Home in the Medical Home. Retrieved from http://www.jabfm.org/content/28/2/170.full.pdf

[3] Altschuler, J., Margolius, D., Bodenheimer, T., & Grumbach, K. (2012, September/October). Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation. Retrieved from: http://www.annfammed.org/content/10/5/396.full

Ensure timely access to care

Defining the change

Improving access means working to diminish or remove appointment backlog and delay between initiation of demand and delivery of service. The gap between supply and demand not only contributes to a delay in meeting patients' needs; it can also be expensive and generate waste in the system. By promoting timely access to your practitioners and/or care teams, you can establish streamlined and accessible communication between care team members and patients, improve patient experience, reduce morbidity and mortality, and save costs.

Your practice can implement change tactics to improve timely access, such as expanding office hours, providing same-day or next-day access to the patient's care team, or initiating secure messaging for patients and their care team. Key tactics related to ensuring timely access are summarized in the Change Tactics table.

Provide 24/7 access to care. Your practice will provide patients real-time access to their assigned practitioner and/or a care team member. Patients' medical record should guide real-time access, 24 hours a day and 7 days a week. As patient needs often occur outside of traditional office hours, your practice should create pathways for continuous, reliable access. You can accomplish 24/7 access in many ways, including the use of an on-call practitioner or care team member, cross coverage by another practitioner external to your practice, and/or the use of protocol- driven nurse lines. Regardless of your practice's approach, the care team member providing 24/7 coverage must be a licensed medical practitioner—a Doctor of Medicine (MD)/Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Registered Nurse (RN) or Physician Assistant (PA)—with access to the EHR. Access to the EHR gives the practitioner vital information from the medical record that may decrease over-utilization of costly emergency department (ED) services and duplicative testing.

Change Tactics
1. Provide 24/7 access, guided by the medical record, to practitioner and/or care team for advice about urgent and emergent care; for example, through: ○ The practitioner and/or care team with real-time access to the medical record ○ Cross-coverage with access to the medical record ○ Protocol-driven nurse line with access to the medical record or ability to escalate to a practitioner with access
2. Expand office hours in early mornings, evenings, and weekends with access to the patient medical record, either directly through the practice or through coordination with other practitioners.
3. Use alternatives for care outside of the traditional office visit to increase access to the practitioner and care team, such as e-visits, phone visits, group visits, home visits, and visits in alternate locations (e.g., senior centers and assisted living centers).
4. Provide same-day or next-day access to the patient's own practitioner and/or care team for urgent care or transition management.
5. Use a patient portal and secure messaging for patient and designated caregiver access to health information in languages that align with the patient population.

Expand your office hours. By offering visits to patients outside of traditional office hours (e.g., in the early morning or evenings), your practice will support patients to access the right care at the right time. Appropriately investing in expanded office hours balances supply and demand, and reduces the delay between when the demand is initiated and when the service is delivered. In this context, you can match the "supply" or the availability of clinical resources (i.e., the practitioner and/or care team) to the "demand" (i.e., the requests for appointments on any given day). Comparing supply and demand will help your practice determine how many and what types of appointments to make available, and when to schedule those appointments to reduce access concerns.

> 📋 To learn more about how supply and demand can affect access, see IHI guidelines on measuring and understanding supply and demand

Offer alternative visits beyond traditional office visits. While all CPC+ practices are encouraged to offer alternative visits to their patients, Track 2 practices are expected to build this capability. Your practice should choose to offer the alternative visit modality that best meets the needs of your patient population. Examples include electronic or virtual visits (e-visits), phone visits, group visits, home visits, and alternate location visits (e.g., at senior centers and assisted living centers), all of which increase patients' access to care teams and sustain continuity of care for your patients.

> 📋 To learn more about how to utilize group visits to support patients with chronic conditions, see this guide:
> Putting Group Visits into Practice

> 📄 Use these templates to effectively conduct house calls: AAFP: House calls (Physician home visits)

Provide timely appointments for your patients by offering same-day or next-day access. Your practice should aim to provide timely access to the patient's own practitioner and/or care team for urgent care and transition management. Providing ample same-day and next-day appointments will better equip your practice to meet patient demand for access. A commonly used measure of the availability of timely appointments is the "third next available appointment." It is defined 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." Long patient waits for the third next available of any appointment type indicates that demand for appointments surpasses your practice's supply, and means patients do not have suitable access.

> 📋 Learn more about the Institute for Healthcare Improvement (IHI) third next available appointment

One way to balance supply with demand is to meet patients' needs at every encounter. For example, patients whose medication refill needs are assessed and met at the current visit are less likely to call back in a week with a question or a request for a refill. Same-day appointments allow your care team to do today's work today, rather than postponing patient requests for care

to a later date, thereby expanding your backlog. Furthermore, patient satisfaction increases when patients are able to get the care they need when they need it.

Improve access using patient portals and secure messaging. You can use patient portals to enhance asynchronous, bidirectional communication. Using a patient portal and secure messaging to answer patient questions, deliver test results, or collect patient information may be more efficient for your care team and your patients than telephone encounters and in-office visits. For example, instead of having a patient go to your office for routine follow-ups, that patient could report blood sugars or blood pressures via email.

Your practice can also use portal messages to point patients toward materials that may help with self-management and chronic condition management. Customizing these messages to your patient's individual needs increases the likelihood that the patient will pay attention to the content.

Any EHR with key functionalities like secure messaging, integrated scheduling, and notification can capture relevant data and display additional views that indicate coverage/access gaps. You will be able to answer specific questions about access, such as:

- How many same-day or next-day appointments can we offer patients?

- What percent of our patients send secure messages to their practitioners and/or care team? In addition, what is the average response time to patients' messages?

- How many alternative visit appointment types did we offer patients during a defined period?

Optimize continuity with the practitioner and/or care team

Defining the change

Care continuity is at the heart of comprehensive primary care. Continuity is best described through three dimensions: informational, longitudinal, and interpersonal continuity.[4]

- *Informational continuity* means that practitioners have access to information on patients' past events and personal circumstances to current care decisions (e.g., via the EHR).

Change Tactics
1. Ensure that all practitioners within the practice and all members of the care team have access to the same patient information to guide care within the electronic health record (EHR).
2. Measure and analyze care continuity between patient and practitioner and/or care teams using health IT, scheduling systems, payer reports, or a small sample of visits or other encounters.

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[4] Saultz, J.W. (2003) Defining and Measuring Interpersonal Continuity of Care. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466595/

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- *Longitudinal continuity* refers to ongoing patterns of health care visits that occur with the same practice over time.

- *Relational continuity*, a specific type of longitudinal continuity, refers to the therapeutic relationship between a patient and a practitioner and/or care team that is characterized by personal trust and accountability.

All three components of continuity improve patient outcomes and experiences of care. Key tactics related to optimizing continuity are summarized in the Change Tactics table.

Ensure the practitioner and/or care team have access to the EHR. The EHR is an essential platform for your care teams to address patient care needs during and outside of your office hours. It serves as a hub for patients' medical records and care history. The EHR should be an accessible, centralized tool that can, in real time, receive and record updates from the care team and any practitioner who contributes to your patient's care. By providing practitioners and care team members access to the EHR, you can ensure that the care provided to patients is accurate and continuous.

Measure and analyze continuity of care. Your practice should develop the capability to measure relationship continuity for empaneled patients using your EHR, practice management software, or other tracking mechanisms. Practices vary in how they measure relationship continuity. Some practices measure continuity with a practitioner (i.e., MD/DO, 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 capture non-visit-based encounters in the measurement. What's most important is that your practice applies a consistent measurement strategy and uses that measurement to guide efforts to optimize the continuity of relationships between the practitioner and/or care team and their panel of patients.

Continuity is commonly measured through *patient-centric* and *practitioner-centric* measures.[5] A *patient-centric* measure of continuity compares the number of times patients see the practitioner and/or care team to whom they are empaneled (numerator) divided by the total number of visits by empaneled patients to the practice (denominator). For example, if a practitioner's panel of patients makes 4,000 primary care visits in a year, with 3,000 of those visits to the patients' own

$$\text{Patient-Centric Continuity Rate} = \frac{\text{\# Patient visits with practitioner and/or care team}}{\text{\# Total patient visits for empaneled patients}}$$

$$\text{Practitioner-Centric Continuity Rate} = \frac{\text{\# Patient visits to a practitioner by patients empaneled to a practitioner and/or care team}}{\text{\# Total patient visits to that practitioner}}$$

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[5] Gupta, R. (2013, November 11) How Primary Care Practices can Improve Continuity of Care. Retrieved from http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/1738713

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practitioner and 1,000 to other primary care practitioners, the patient-centric continuity rate is 75 percent.

A *practitioner-centric* measure of continuity compares the number of visits to a practitioner by patients empaneled to a practitioner and/or care team (numerator) by the total number of visits to that practitioner (denominator). For example, if a practitioner provides 3,000 visits in a year and 2,000 visits are by patients in his or her panel, the practitioner-centric continuity rate is 66.6 percent. While you are not expected to report the practitioner-centric 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 practitioner and/or care team visits schedules.

Function 2: Care Management

Care management is a set of proactive activities that aims to improve health outcomes and reduce utilization, harm, and waste. Your patients with complex needs will benefit from support from their primary care team to ensure they are getting the care and treatment they need. Studies have shown that targeted care management services can decrease adverse outcomes in patients with chronic conditions.[6] Providing care management services during transitions of care is especially important for older adults with multiple chronic conditions. These patients typically receive care from many practitioners and, as a result, can experience poor communication, incomplete transfer of information, and lack of access to essential services.

In PY 2017, you will tailor care management services to patients at the highest risk for adverse, preventable outcomes. A critical first step for care management is to risk stratify your patients. Next, you will select and prioritize those patients for whom care management interventions make a meaningful difference in their health. You will build care management capability into your care team to better address the needs of: (1) those patients you identify as highest risk and who may benefit from longer-term care management, and (2) those patients at increased risk due to specific events (e.g., transition of care setting) and who need shorter term care management.

CPC+ uses two approaches to care management: episodic care management

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Function 2 Requirements

a. Risk stratify all empaneled patients.

b. **Track 2:** Use a two-step risk-stratification process for all empaneled patients:

Step 1 – Base the risk stratification on defined diagnoses, claims, or another algorithm (i.e., not care team intuition).

Step 2 – Add the care team's perception of risk to adjust the risk stratification of patients, as needed.

c. Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management.

d. Provide short-term (episodic) care management, along with medication reconciliation, to a high and increasing percentage of empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management.

e. Ensure patients with ED visits receive a follow-up interaction within one week of discharge.

f. Contact at least 75 percent of patients who were hospitalized in target hospital(s), within 2 business days.

g. **Track 2:** Use a plan of care centered on patient's actions, and support needs in management of chronic conditions for patients receiving longitudinal care management.

Related Function 2 Health IT Requirements (Track 2 Only)

a. Empanel patients to the practice site care team within the health IT.

b. Risk stratify practice site patient population; identify and flag patients with complex needs within the health IT.

c. Establish a patient-focused care plan to guide care management within the health IT.

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[6] Care Management: Implications for Medical Practice, Health Policy, and Health Services Research. (2015, April). Retrieved from https://www.ahrq.gov/sites/default/files/publications/files/caremgmt-brief.pdf

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and longitudinal care management. Short-term or *episodic care management* focuses care management activities around acute care events like ED visits, hospitalizations, and new diagnoses, and helps target opportunities to reduce costs and facilitate patient engagement. Intensive, relationship-based *longitudinal care management* focuses on patients identified as high or rising risk by your practice's risk stratification approach, who will benefit from ongoing, proactive care management. To accomplish your practice's care management goals, and improve patient-centered, high quality, cost effective care for patients and families, you should focus on three change concepts:

- Assign and adjust risk status for each patient.

- Provide longitudinal care management to patients at high risk for adverse health outcome or harm.

- Provide episodic care management, including management across transitions and referrals.

Assign and adjust risk status for each patient

Defining the change

Risk stratification is a dynamic process that includes your entire population of patients (regardless of payer or insurance status), and moves beyond solely identifying your high-risk patients. This process allows your practice to have a population view and develop strategies to address patients at high and/or rising risk (e.g., uncontrolled chronic conditions, high utilization of

Change Tactics
1. Use a consistent method to assign and adjust risk status for all empaneled patients: the first step is an algorithm-based method and the second step adds information that the clinical team has about the patient.
2. Monitor the risk stratification method and ensure accuracy of risk status identification.

hospital and/or ED, psychosocial needs), while also meeting the preventive care needs of low-risk patients. Assigning a risk status or score to each empaneled patient (i.e., risk stratification) gives you a more actionable view into the needs of your patient population, and offers you the ability to target care management resources more effectively. Key tactics related to assigning and adjusting risk status are summarized in the Change Tactics table.

Use a consistent method to assign and adjust risk. Risk stratification can occur through two strategies: (1) an algorithm-based method, which uses historical data like utilization, co-morbid conditions, EHR, and claims data; or (2) a clinical process, in which the practitioner and/or care team uses information it has about the patient (clinical intuition) to segment the population by risk.

While an algorithm-based risk stratification method has several advantages to identifying high-risk patients, it often can miss patients (up to 20 percent) who might benefit from care

management services.[7] Clinical intuition (practitioner and/or care team judgment) can ensure the identification of these patients. A blended approach using both an algorithm-based method and clinical intuition is the best method to ensure the greatest number of high-risk and high-need patients receive care management services.[8]

In PY 2017, you will be implementing risk stratification for all of your empaneled patients. Track 1 practices will implement an algorithm-based method of their choice. Track 2 practices will implement a two-step risk stratification process including both an algorithm-based method and clinical intuition by the end of PY 2017.

> **Health IT Enhancements for Risk Stratification (Track 2 Only)**
>
> *(To be available in your clinical workflows by end of PY 2017)*
>
> a. Assign risk scores based on your chosen risk stratification methodology to the entire practice population within your health IT.
> b. Identify and flag patients with complex needs as part of risk stratification within your health IT, and/or as requiring episodic care management.
> c. Update the risk scores based on clinical intuition or other factors within the health IT.
> d. Ensure the care team is able to sort patients by risk scores and generate reports or lists of patients using the risk scores and other categorizations of patients based on the risk stratification, using those labels to support clinical workflow.

- **Step 1: Algorithm-based method.** Choose a risk stratification algorithm or process for your practice. All members of your care team should understand the risk stratification methodology you select, and it should align with your care management strategy. The various risk stratification methodologies categorize patients into as few as three levels (low, medium, and high risk) and as many as seven levels. You may base your methodology on health care claims or features your EHR may have built in, or on your practice's automated risk-scoring capability using a number of specified clinical variables. Alternatively, you may apply a clinical algorithm based on a published method or create one in your practice.

  Some CPC Classic practices used the Risk-Stratified Care Management and Coordination Tool. You may want to work with your health IT vendor to identify and implement automated processes to assign and document risk levels once you have selected a method.

  > Learn more about the American Academy of Family Physicians (AAFP) Risk-Stratified Care Management and Coordination Tool

- **Step 2: Add clinical intuition/care team perception** to refine the algorithm's risk identification process. You must first implement your practice's chosen algorithm-based

[7] Hayes, S. L., & McCarthy, D. (2016, December 7). *Care Management Plus: Strengthening Primary Care for Patients with Multiple Chronic Conditions.* Retrieved from http://www.commonwealthfund.org/publications/case-studies/2016/dec/care-management-plus

[8] Hong, C. S., Siegel, A. L., & Ferris, T. G. (2014, August). *Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?* Retrieved from http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

risk stratification methodology (Step 1) and determine the distribution of your patient population in each risk level. Next, as a team, work together to review your patient risk assignments to ensure alignment with information you know about the patient (e.g., lives alone, is unable to drive, has behavioral health conditions, has cognitive impairment and/or functional disabilities). The care team should have the ability to update and edit a risk score based on professional judgment or concern. It may be helpful to start with your highest and next highest risk levels.

Monitor the risk stratification method. You will need to review and refine your methodology over time, learning from your experience and the experience of other practices on what is working to achieve better care at lower cost. Key considerations in monitoring and adjusting your chosen methodology include:

- Evaluating results to determine distribution of patients across risk levels, especially the highest and next highest risk levels.

- Defining the process and frequency of risk score review and validation. Continually re-assessing the ability of the risk stratification process to effectively manage the population should become a routine task for your practice. Regular risk stratification reviews help your care team stay current on the needs of patients and identify opportunities to improve the process.

- Monitoring the risk stratification method and refining it as necessary to improve the accuracy of risk status identification. Your practice should work on risk stratification on an ongoing basis.

Provide longitudinal care management to patients at high risk for adverse health outcome or harm

Defining the change

The goals of **longitudinal care management** are to effectively manage your patients at high risk for health complications, improve their quality of life, and lower costs of care. Five percent of patients incur nearly fifty percent of health care costs, and there is growing evidence that investing resources in these individuals can improve care while decreasing costs.[9] Many practices start by providing care management services to high-risk or

Change Tactics
1. Use the risk stratification process to identify and target care management services to patients who the team believes to be at high risk and amenable to outreach.
2. Use on-site, non-physician, practice-based, or integrated shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients, with assistance from other practice staff, as needed.
3. Use a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values, and priorities.

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[9] Hayes, S. L., Salzberg, C. A., McCarthy, D., Radley, D., Abrams, M. K., Shah, T., & Anderson, G. (2016, August 26) High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care? Retrieved from http://www.commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-meps1

complex patients identified through risk stratification. Key tactics related to longitudinal care management are summarized in the Change Tactics table. As described below, there are several essential features of ongoing, relationship-based, longitudinal care management.

Identifying which patients would benefit most from care management services based on risk. Care management is a scarce resource (including staff, funding, and time) and should be targeted to patients who are at highest or rising risk (based on assigned risk scores), and who are also amenable to care management.

Having dedicated clinically trained staff working closely with the practitioner in a team-based approach to care for individuals with complex health needs. A critical step toward integrating longitudinal care management into your practice is to determine care management job responsibilities within the care team. Many practices hire a dedicated staff member for care management functions (e.g., care manager, care coordinator, patient navigator). Care management staff members are typically in the nursing or social work disciplines and are trained to manage patients with complex health needs. Multiple team members, including physicians, non-physician practitioners, 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.[10]

Using a documented care plan. A care plan is a mutually agreed upon and documented plan of care based on the patient's goals, preferences, and values and is accessible to all team members providing care for the patient. All patients receiving care management should have a care plan developed in a joint conversation between the patient and care team. Critical elements for a care plan may include, but are not limited to: treatment goals and intervention as identified by the care team; patient's overall health goals; advance directives and patient's preferences of care; actions that the patient and his or her care team will be taking; and the most important contingencies (e.g., "if/then" for the specific patient and his or her conditions). The care plan implemented in your practice does not need to follow any

> See AAFP Patient-Centered Care Plan Template

specific template, but should be patient friendly and limit use of unfamiliar medical jargon and acronyms. It should be a tool that limits duplicative documentation within your EHR, fits within your existing workflow, and is accessible and valuable to patients and caregivers. The care team should have real-time/point of care access to a patient's care plan in the patient's medical records. It is important to maintain current and up-to-date medical records in the EHR.

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[10] Taylor, E. F., Machta, R. M., Meyers, D. S., Genevro, J., & Peikes, D. N. (2013, January/February). Enhancing the Primary Care Team to Provide Redesigned Care: The Roles of Practice Facilitators and Care Managers. Retrieved from http://www.annfammed.org/content/11/1/80.abstract

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⚕ Health IT Enhancements for Care Plans (Track 2 Only)
(To be available in your clinical workflows by the end of PY 2017)

a. CPC+ practices should use a health IT-enabled, patient-centered care-planning tool to support holistic care and a focus on beneficiary goals and preferences.

b. Care team members should be able to electronically capture the following care plan elements:
    - Advance directives and preferences for care
    - Patient health concerns, goals, and self-management plans
    - Action plans for specific conditions
    - Interventions and health status evaluations and outcomes
    - Identified care gaps

c. The practice should have the ability to customize which of these elements are included within the care plan and the care plan should display these elements.

d. Practitioners should be able to incorporate relevant triggers (e.g., a risk score or event) that indicate different care management actions.

e. The care plan tool should facilitate version control across care team members by capturing the date of the last review or change in the plan, and generating a scheduled date for reviewing and updating the plan.

f. Practices should be able to populate the care plan using data entered in the patient's record (i.e., without duplicative data entry).

g. The care plan should be available to the patient on paper and electronically, and available in electronic format to care team members outside of the practice who are involved in the patient's care. Care plan information should also be remotely accessible to practice team members delivering care outside of normal business hours.

h. To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9), within the first two years of the program.

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Making care management a structured part of the medical record, capturing critical information. A practice's EHR should clearly define and track patients in care management 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. Documentation of care management activities in the EHR should include: the nature and substance of contacts, data that reviews assessment of status, changes to care pathways or the overall care plan, unresolved questions, and next scheduled follow-up contact or review.

Providing proactive care that moves beyond traditional 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 skilled nursing facilities or hospitals to support transitional care). Practices should appropriately target these activities based on patient needs.

⊙CPC+

Finding the "Right" Size for Panel of Patients in Active Care Management

There are no prescribed "right" sizes for care management panels in CPC+. From the experience of CPC Classic practices, practices typically assign 100-250 patients in longitudinal care management per full-time employee, depending on patient acuity and care management resources available.

You will know your panel size is too big if patients you have identified as being at high risk:

- Have an ED visit or hospitalization you believe you could have prevented if you had been able to reach out to them in a timely way
- Get a test they would not have needed had you been able to obtain all the relevant clinical information available
- Did not have follow-up on an abnormal test or test value between visits
- Have not had follow-up on an important self-management goal between visits

If any of these apply to you, you should probe the following questions about your care management process:

- How much time is your care manager spending on clerical activities?
- Is the right person using his or her highest skills to provide care management services as efficiently and effectively possible?
- Do you have the right health IT in place to support timely information exchange about your patients across settings of care, as well as automated reminders for patients regarding upcoming appointments and labs, dynamic workflow capabilities, etc.?
- Are you targeting a majority of care management resources to patients who are clinically at highest risk and most likely to benefit from care management services?
- Could your patients have unmet social needs that may affect the impact of care management, such as lack of transportation, changes in caregiver support, and/or housing instability?

Provide episodic care management, including management across transitions and referrals

<u>Defining the change</u>

Those patients whom practices do not otherwise target for longitudinal care management may receive short-term (episodic) care management services. Practices initiate episodic care management during an episode of risk, such as transition from hospital, new diagnosis or injury, or exacerbation or clinical instability in a chronic condition. Focusing care management activities around acute care events helps target opportunities to reduce costs, improve patient safety, and facilitate patient engagement.

Change Tactics
1. Provide care management services to patients with recent emergency department (ED) visits or hospitalization. Services include care transition planning and follow-up, and ensuring diagnosis and discharge plans are understood by patients and families.
2. Partner with community or hospital-based transitional care services to improve care transitions and reduce readmissions.

Contact with these patients may be frequent initially, but will be short-term in nature with resolution once your practice addresses the triggering event. These patients may require more coordination services, including medication reconciliation, and less disease management. These patients will also require a plan of care addressing their immediate needs. Key tactics related to episodic care management are summarized in the Change Tactics table. As

CPC+

described below, several guiding principles exist for ED visits or hospitalization transition planning and follow-up.

Obtain complete and timely communication of information. Discuss the transition of care at discharge with your patients and their caregivers. Ideally, this discussion will occur prior to discharge, but no later than within two days of discharge from hospital admission (and within one week of discharge from the ED). You can decide on a case-by-case basis the appropriate form of contact. Some patients may require non-face-to-face outreach by phone, while the practice should see other patients in person. Essential information to review includes reason for admission, test and procedure results, medications, follow-up appointments, caregiver status, and need for other home-based or community services and support. Your practice can **partner with community or hospital-based transitional care services to improve care transitions**. Collaborative care agreements between your practice and top hospitals and EDs (i.e., those used by the majority of your patients), and community-based organizations, can facilitate better communication and coordination prior to discharge. For example, if you are in an area with multiple hospitals, list up to three hospitals that your patients most frequently use.

Conduct medication reconciliation. Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking (including drug name, dosage, frequency, and route) and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points. Medication reconciliation may reduce the number of incorrectly prescribed or adjusted medications, and may also catch potentially damaging discrepancies in dosage or duplicate therapies. Medication reconciliation is a starting point for safer, more effective medication management, but opportunities exist to more effectively and safely manage medication therapy across transitions of care. Including medication management in the care management process with these patients is key because they often receive new medications and/or experience changes to their existing medications during the transition in care.

Make a plan for regular check-in and follow-up appointments. The care team should work with patients to determine the timing and setting for regular follow-up, either by phone, email, or in-person. Some practices have initiated home visits post-discharge. Some patients will only need

> ◀ Latham Medical Group - Family Medicine
> Learn how CPC Classic practice Latham Medical Group – Family Medicine uses data around a patient's acute care episodes to tailor follow-up calls, guide care management, and fine-tune quality improvement efforts.

care management services for several weeks or months, while other patients may need to transition into longitudinal care management services. Researchers have found that patients who had one or more outpatient visits with primary care practitioners within 7 days of the hospital discharging them to their homes were 12 to 24 percent less likely to experience hospital readmission than those who did not have an outpatient visit.[11]

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[11] Kaiser Permanente Study Finds Tailored Post-Hospital Visits Lower Risk of Readmission for Medicare Advantage Patients. (2016, November 21). Retrieved from https://share.kaiserpermanente.org/article/kaiser-permanente-study-finds-tailored-post-hospital-visits-lower-risk-readmission-medicare-advantage-patients/

Function 3: Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to your practice meeting the majority of your patient population's medical and behavioral needs in pursuit of each patient's health goals. Comprehensiveness adds both breadth and depth to the delivery of primary care services, and builds on the element of relationship that is at the heart of effective primary care. It is associated with lower overall utilization and costs, less fragmented care, and better health outcomes.[12]

Your practice will also play a central *coordination* role in helping patients and caregivers navigate a complex health care system, addressing opportunities to improve transitions between different care settings, focusing on timely hospital and emergency department discharge follow-up, and communicating with specialists. Importantly, your practice will also work to understand patients' health-related social needs and community resources to meet those needs. This coordination role involves building understanding and collaborating with the network of services both within the medical neighborhood and within the community, to improve patient care.

Function 3 Requirements

a. Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payers' data.

b. Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer, using CMS/other payers' data.

c. **Track 1 CPC Classic & Track 2:** Maintain or enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payers' reports

d. **Track 1 CPC Classic & Track 2:** Choose and implement at least one option from a menu of options for integrating behavioral health into care.

e. **Track 2:** Systematically assess patients' psychosocial needs using evidence-based tools.

f. **Track 2:** Conduct an inventory of resources and supports to meet patients' psychosocial needs.

g. **Track 2:** Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and that can be tracked over time.

To begin your work to build your practice's comprehensiveness and create stronger linkages with clinical and community-based services, consider the following questions:

- Across my practice population, what are my patients' needs?
- How can my practice better meet those needs?
- How will my practice determine which needs to target first, and determine the best timing for targeting others?
- How can we better bridge the seams of care (e.g., hospitals and specialty care)?
- What meaningful role can we play in other settings of care (e.g., hospitals, skilled nursing facilities)?

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[12] CPC+ Practice Care Delivery Requirements (2017). Retrieved from https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf

As you enhance your comprehensiveness and coordination, you will begin answering these questions through a variety of strategies, including: better coordination of care for patients with complex needs, developing new capabilities to address needs commonly seen in your patient population, and assessing your patients' health-related social needs and building linkages with community services to meet those needs.

To accomplish your comprehensiveness and coordination goals and improve patient-centered, high quality, cost effective care for patients and families, you should focus on these change concepts:

- Routinely assess, link, and support patients with complex health needs.

- Integrate behavioral health services to support patients' common and complex behavioral health needs.

- Manage medications to maximize efficiency, effectiveness, and safety.

- Provide effective care coordination, navigation, and active referral management in the medical neighborhood.

- Establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs.

- Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population.

Routinely assess, link, and support patients with complex health needs

Defining the change

There are challenges and opportunities in supporting patients with complex needs. Patients with complex needs receive care from a variety of practitioners in both acute and ambulatory settings. In many cases, practitioners are unaware of prior care, prescribe incompatible or contradictory treatments, or provide conflicting advice. This lack of care coordination between practitioners and across different settings results in poor quality, fragmented care. Factors that impact the complexity of care can include multiple physical and behavioral health problems, the social vulnerability of the patient, and the large number of practitioners and settings involved in a patient's care.

Change Tactics
1. Use payer and EHR data to identify conditions and needs prevalent in the practice's patient population that add to medical complexity (e.g., multi-morbidity, end-of-life care, polypharmacy, dementia and frailty, health-related social needs).
2. Establish a process for assessing, documenting, and periodically reassessing patient health care goals, health-related social needs, as well as their choices regarding advance directives and health care surrogates.
3. Regularly assess caregiver social and emotional needs, and provide or facilitate caregiver support as a routine component of care.
4. Build a regular process to link patients with identified social needs to community-based resources for support, and consider co-locating resources.

Your practice will put into place processes to identify and address the changing needs of these patients and their caregivers. Key tactics related to supporting patients with complex health needs are summarized in the Change Tactics table.

Use data to identify conditions and needs prevalent in the practice's population. Receiving timely payer data and real-time review of EHR data can help you understand the most prevalent conditions, as well as the highest risks, needs, and costs in your patient population. These data can help you prioritize your practice resources, reorganize your workflows, and target community resources that may benefit a larger number of your patients. For example, you may learn that you have many patients with dementia, prompting you to focus on discussing and documenting patient wishes for end-of-life care, establishing a caregiver support group, and revising workflows to include caregivers on reminders and communications. Alternatively, if you find you have a cohort of patients with chronic obstructive pulmonary disease (COPD), many of whom regularly visit the ED, you might work on individualized action plans and consider establishing a collaborative care agreement with a local pulmonary rehabilitation facility.

Regularly update comprehensive needs assessments of patients. In addition to using payer and EHR data, your practice can conduct and regularly update comprehensive needs assessments of patients with complex conditions to identify additional medical, behavioral, and social supports needed to provide better care. Your comprehensive needs assessment should also identify patient preferences and goals for care, as well as advance directives and health care surrogates. In addition to collecting diagnoses and the traditional family and social history, a comprehensive assessment should address patients' ability to function in their daily life, both independently and with the support of caregivers and others. In many cases, it is important to also assess the needs of patients' caregivers to determine any additional support needed.

Build a regular process to link patients with identified social needs to community-based resources. Track 2 practices will link and coordinate care for patients with complex needs. Complex populations often have conditions and needs that require a multitude of health and long-term services and supports. For example, if patients have disabilities that prevent them from performing activities of daily living, they might need hands-on help in the form of physical therapy, personal care assistance, transportation in accessible vans to get to medical appointments or shop for groceries, and home-delivered meals.

To address patients' social needs, your practice will identify available resources and put in place referral, communication, and tracking processes that allow you to connect patients to services and follow-up. Care teams should work closely with care managers, who often take the lead on facilitating access to needed resources for patients. Care managers can spend time working with patients to identify their highest priority needs and goals, and aligning resources to those areas.

Integrate behavioral health services to support patients' common and complex behavioral health needs

Defining the change

Behavioral health care is an umbrella term for care that addresses mental health and substance use conditions, health behavior change, life stresses and crises, and stress-related physical symptoms.[13] Behavioral health conditions frequently co-exist with chronic medical conditions. Compared to patients with no behavioral health condition, health care for patients with co-existing conditions costs twice as much.[14] Integrating behavioral health in primary care can address many of these problems.

However, most practices have limited resources to support the practitioner in providing care for these conditions. While most patients with mental illness and substance abuse present in primary care, most resources for managing these conditions are built-in silos outside of the primary care practice. Key tactics related to integrating behavioral health services to support patients with behavioral health needs are summarized in the Change Tactics table.

To meet the needs of your patients with common and complex behavioral health needs, your work in CPC+ will follow a menu of options with two foundational strategies for behavioral health integration within your practice (see Figure 2 below).

Change Tactics
1. Use evidence-based treatment protocols, assess response with validated measures, and treat to goal, where appropriate.
2. Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of behavioral health services.
3. Ensure regular communication and coordinated workflows between primary care, behavioral health practitioners, and community services.
4. Establish collaborative care agreement s with mental health practitioners that set expectations for documented flow of information and practitioner expectations between settings.
5. Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment.
6. Use a registry or health IT registry functionality to support active care management and outreach to patients in treatment.
7. Facilitate integration through co-location of services (e.g., co-located social worker, psychiatric nurse practitioner, psychologist, or psychiatrist), when appropriate and feasible.
8. Implement screening with brief intervention for alcohol and other substance misuse.
9. Train clinical staff to deliver behavioral health therapies (e.g., train nurse care managers to provide problem-solving therapy).

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[13] Davis, M., Balasubramanian, B.A., Waller, E., Miller, B.F., Green, L.A., Cohen, D.J. (2013, September-October). Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together. Retrieved from http://www.jabfm.org/content/26/5/588.full.pdf

[14] The High Concentration of U.S. Health Care Expenditures. (2006, June). Retrieved from https://archive.ahrq.gov/research/findings/factsheets/costs/expriach/expendria.pdf

1. Care Management for Mental Illness

2. A Primary Care Behaviorist Model

In the first year of CPC+, your practice will choose at least one foundational strategy and begin to implement this approach to integrate behavioral health into the primary care setting. Both strategies have a whole person orientation, improve access to services, enhance communication, and support patient-engaged, planned health care. Moreover,

> Read more about the CPC+ Behavioral Health Integration Menu of Options

improving behavioral health treatments has the potential to improve mental health and general medical outcomes, and lower costs. Integrating behavioral health also improves physician self-efficacy and decreases the risk of burnout.

Over the course of CPC+, your practice will progress along a spectrum, from simple coordinated care with behavioral health practitioners to seamlessly integrated care that meets patients' behavioral health needs.

Figure 2: Overview: CPC+ Care Delivery Behavioral Health Integration Menu of Options

When choosing a behavioral health integration strategy from the two menu options, your practice may want to consider:

- Prevalence, severity, and range of mental health/substance use conditions in the population served by the practice

- Current or planned practice-based screening for mental health and substance use conditions and psychosocial stressors

- Existing resources, including care manager background/interest/training in behavioral health, physical space, teleconferencing equipment, and community resources, including behavioral health specialists

- New resources needed to achieve the integrated care goals, including capital investments, personnel, team building and diversity training activities, and technology costs

- The most financially viable strategy

Care Management for Mental Illness. Individuals with identified mental health conditions should be offered proactive, relationship-based care management, with specific attention to care management of the mental health condition. Care management for mental health/substance use conditions can be implemented in a variety of ways, but should include:

- Diagnosis using a validated questionnaire (e.g., PHQ9 for depression)

- Stepped care treatment algorithms that match treatment to patient preferences and consider response to prior treatments

- More frequent planned follow-up (often by telephone) to assess treatment response and reinforce treatment adherence, which facilitates ongoing monitoring and bringing patients back in for care prospectively

- Self-management support

- Decision support through consultation by a psychiatrist or psychiatric nurse practitioner

- In some cases, therapy (e.g., cognitive behavioral therapy [CBT]) offered in-person or telephonically by a member of the care team

Your practice can deliver care by a team that involves a primary care practitioner as the treating practitioner, a care manager (often, a behaviorally trained nurse) who provides self-management support and additional follow-up contacts, and a psychiatrist who supports the care manager and provides decision support. The psychiatrist should be connected to the team telephonically and through the EHR.

Primary care behaviorist model. The primary care behaviorist model integrates behavioral health into the primary care workflow through warm handoffs to a co-located behavioral health professional who can address mental illness in the primary care setting, implement behavioral strategies for management of chronic general medical

illnesses, and facilitate engagement of specialty care (i.e., triage) for serious mental illness and substance use conditions. This model is population-based, provides same-day access, is time-limited (e.g., usually ≤ six sessions), and can address a range of mental illness and behavioral health needs.

Team building and training to work effectively is required, regardless of the option your practice chooses to implement.

<u>Additional Targeted Tactics for Behavioral Health</u>

In the first year of CPC+, your practice should build a strong foundation by focusing on the work of the two foundational strategies: Care Management for Mental Illness and/or Primary Care Behaviorist Model. If you have previously integrated these strategies into your practice, the following targeted tactics support more robust behavioral health integration, to include alcohol misuse and management of chronic pain conditions:

- **Provide screening and brief intervention for alcohol misuse.** Adults should be screened for alcohol misuse using a validated instrument (e.g., AUDIT-C). For those who screen positive, brief interventions should follow evidence-based practice. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic substance use.

- **Provide cognitive behavioral therapy (CBT), problem-solving therapy (PST), or mindfulness-based therapies for chronic pain conditions.** Chronic pain is highly prevalent and treatment with pain medications is often only partially effective and associated with important adverse effects (e.g., opioid dependence). CBT, PST, and mindfulness-based therapies have a positive effect on pain, disability, and mood. Your practice could offer group or individual CBT, PST, and/or mindfulness-based therapy for patients with chronic pain conditions. Sessions should be offered in the primary care setting or by secure video or telephone. Identifying behavioral health practitioners trained in these therapies within your care team, or using collaborative care agreements with behavioral health practitioners outside your practice and providing space or telehealth resources to deliver these therapies, are some of the strategies for providing alternate treatments for chronic pain.

- **Support behavior change for high-risk conditions (tobacco cessation, obesity, and medications adherence).** Behavioral health specialists are trained in behavioral

therapies and collaborative communication to work effectively with patients with high-risk conditions. They can provide health coaching to patients committed to changing unhealthy behaviors, improve understanding of and adherence to agreed-upon care plans, and support patients' self-management goals. Integrate behavioral health specialists within your care teams to coordinate care and use self-management care plans to support communication of patient's goals and preferences across the care team.

Manage medications to maximize efficiency, effectiveness, and safety

Defining the change

Medication management is an evidence-based approach to improving patient outcomes. Most chronic and acute conditions are treated with medications and it is not uncommon for patients to be on several medications at a time. This creates challenges for patients and their care teams to prevent and manage medication-related problems.[15] Comprehensive medication management (CMM) ensures practices individually assess patient medications to determine that each medication is appropriate for the patient, effective for the medical condition, safe (given comorbidities and other medications taken), and able to be taken by the patient as intended. CMM includes an individualized care plan that support your patients and caregivers to achieve their intended goals of drug therapy. Goal achievement occurs because the patient understands, agrees with, and actively participates in the treatment regimen, thus optimizing each patient's medication experience and clinical outcomes. Medication management in primary care should be a comprehensive, systematic service to provide positive patient outcomes.

Change Tactics
1. Reconcile and coordinate medications and provide medication management across transitions of care settings and practitioners.
2. Provide medication self-management support to improve adherence to prescribed medication.
3. Integrate a pharmacist into the care team to provide medication management services.

4. Conduct comprehensive medication reviews with action plans, individualized therapy goals, and planned follow-up, particularly for high-risk patients who:
   o Experience a transition of care
   o Receive longitudinal care management
   o Take high-risk medication

5. Work together with pharmacists and other health care professionals to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (i.e., provide formulary management).
6. Implement robust medication reconciliation at regular, established intervals, including assessment of medication regimens for missing yet indicated medications, and those not needed or indicated.

All patients transitioning from one care setting to the next (e.g., hospital to home, ER to home, hospital to skilled nursing facility) require at least medication reconciliation, but some of your patients will also benefit from CMM.

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[15] Medication Management: Primary Care Team Guide. (2016). Retrieved from
http://www.improvingprimarycare.org/work/medication-management

CPC+

Patients who would benefit from CMM include those who were recently discharged from the hospital or are undergoing longitudinal care management, and any of the following:

- Have not reached or are not maintaining the intended therapy goal

- Are experiencing adverse effects from their medications

- Have difficulty understanding and following their medication regimen

- Need preventive therapy

- Are frequently readmitted to the hospital

Key tactics related to medication management are summarized in the Change Tactics table.

Assess the patient's medication-related needs. The assessment begins with uncovering your patient's medication experience, including the patient's beliefs, concerns, understanding, and expectations about his or her medications. The assessment includes a review of all of the patient's medications (e.g., prescription, non-prescription, alternative, traditional, supplements, vitamins, samples, medications from friends and family). This should include reconciliation and management of medications prescribed during transitions of care settings and by outside practitioners. After the assessment is completed, evaluate the appropriateness, effectiveness, and safety of medications, as well as the patient's medication adherence. Use this information to determine whether any medication-related problems are interfering with the patient achieving the intended therapy goals. If any patient support needs are identified, you should consider **providing medication [self-management support]** to improve adherence to prescribed medication.

Integrate a pharmacist into your care team. Pharmacists working with a primary care practice are able to collaborate with patients, caregivers, and health care practitioners to provide comprehensive medication management services. Pharmacists possess knowledge and skills complementary to other health care team members. CPC+ offers an opportunity for pharmacists to be part of the care team. Pharmacists may be part of the care team as an employee or clinical faculty member, or may be involved through a contractual or consulting arrangement. You may decide to include pharmacists on your care team to manage medications outside your primary care practitioners' usual scope of care, when patients do not reach clinical therapy goals, or to identify and solve complex drug related problems. You may consider empaneling patients with chronic conditions (e.g., diabetes, congestive heart failure, or patients on anticoagulants) to the pharmacist.

> [Pharmacist Integration Strategy: Working Directly with Patients to Improve Medication Adherence and Outcomes]
> This spotlight explores how Banner Health's CPC Classic practices integrated pharmacists into their team to work directly with patients who often need more support with their medication therapies, such as patients with diabetes and patients using anti-coagulation therapies.

Include individualized therapeutic goals in the patient care plan. The care plan, developed with the patient, allows the care team to intervene to solve medication-related problems, establish individualized therapy goals for all medical conditions, design personalized education to optimize each patient's medication experience, establish measurable outcome parameters that can be monitored and evaluated to determine impact of therapies, and set appropriate follow-up timeframes. The care team should conduct comprehensive medication reviews particularly for high-risk patients who experience a transition of care, receive longitudinal care management, and take high-risk medication.

Provide formulary management. Your practitioners should work together with integrated or external pharmacists and other health care professionals to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (i.e., provide formulary management). This should be an integrated patient care process focused on effective use of health care resources to minimize overall medical costs, improve patient access to more affordable care, and provide an improved quality of life.

Follow up to determine actual patient outcomes and conduct ongoing medication reconciliation. The follow-up evaluation allows the practitioner to determine the actual outcomes resulting from CMM interventions. The outcome parameters are evaluated against the intended outcomes (individualized therapy goals) and the patient is reassessed to determine if any new medication-related problems have developed that might interfere with his or her safe and effective use of the medications. Regular medication reconciliation should occur at established intervals to assure ongoing assessment of all prescribed and over-the-counter medications.

Provide effective care coordination, navigation, and active referral management in the medical neighborhood

Defining the change

Your primary care practice is at the center of your patients' health experience and coordinates care within the medical neighborhood with other practitioners who care for your patients, including those providing secondary care, ED/hospitals, and skilled nursing facilities.

Patients and both primary and secondary (specialty) care practitioners report substantial frustration with and poor outcomes from fragmented care across the medical neighborhood. Research clearly identifies communication gaps from primary care when initiating referrals and from secondary care in the referral response.[16] Patients are often unclear of their role in the referral, adding to the risk of these transitions. Tracking referrals and developing collaborative care agreement s with secondary care practices your patients use frequently and determining which are high-cost practices can improve both your practice's satisfaction with the referral

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[16] O'Malley, A.S., Reschovsky, J.D. (2011, January). Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground. Retrieved from http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/226367

process and your patients' outcomes. Key tactics related to care coordination in the medical neighborhood are summarized in the Change Tactics table.

The flow of patient information between institutional and ambulatory settings is often limited, at best.[17] Primary care physicians are often uninvolved in inpatient care and unaware when patients are discharged. Without appropriate post-discharge follow-up, patients are at risk for post-discharge complications and worsening of their condition.[18] Improving your practice's communication with institutional settings, as well as your practice's involvement in the care of patients in these settings, may help avoid unnecessary hospitalization, readmission, and care in other institutional settings. You should leverage available health IT systems to efficiently facilitate communication across the medical neighborhood and reduce unnecessary services.[19]

Change Tactics
1. Ensure routine and timely follow-up to ED visits and hospitalizations.
2. Establish collaborative care agreement s with frequently used or high-cost specialists and/or care agencies (e.g., home health agencies and skilled nursing facilities) that set expectations for documented flow of information and practitioner expectations between settings.
3. Guide, track, and follow up with patients referred to specialists.
4. Develop a process for sharing information regarding patient health care goals, as well as their choices regarding advance directives and health care surrogates, with consultants and other practitioners in the medical neighborhood (e.g., acute care facility).
5. Systematically integrate information from referrals into the plan of care and help patients understand the information provided in the referral response.

Timely follow-up after ED or hospitalizations. Timely follow-up with patients after discharge from the ED or hospital can improve patient outcomes and decrease readmissions. To ensure safe and effective transitions of care, your practice should consider the following questions:

- How do we know if our patients are seen in an ED or admitted to/discharged from a hospital?

- How will information about the ED visit or hospitalization come to my practice?

- How will that information be incorporated into the patient's medical record so that the information is available at the time of the follow-up visit or other patient contact?

- How will the patient be contacted following the ED visit or hospitalization?

[17] Carrier, E., Yee, T., Holzwart, R.A. (2011) Coordination Between Emergency and Primary Care Physicians. Retrieved from http://nihcr.org/analysis/improving-care-delivery/prevention-improving-health/ed-coordination/

[18] Ventura, T., Brown, D., Archibald, T., et al. (2010, January–February). Improving care transitions and reducing hospital readmissions: establishing the evidence for community-based implementation strategies through the care transitions theme. Retrieved from:
http://www.communitysolutions.com/assets/2012_Institute_Presentations/caretransitioninterventions051812.pdf

[19] Taylor, E.F., Lake, T., Nysenbaum, J., Peterson, G., Meyers, D. (2011, June). Coordinating care in the medical neighborhood: critical components and available mechanisms. Retrieved from:
https://pcmh.ahrq.gov/sites/default/files/attachments/Coordinating%20Care%20in%20the%20Medical%20Neighborhood.pdf

- Who will need in-person follow-up and what timeframes will be feasible and effective?

- What will happen in the follow-up visit to ensure seamless care?

To effectively answer these questions, you should use standardized processes (modified as needed for particular patients) and formalized partnerships (e.g., collaborative care agreements, which are described below) to develop an efficient workflow.

Establish collaborative care agreements. A *collaborative care agreement* is a framework for standardized communication between primary care and specialty care practitioners to improve care transitions. Collaborative care agreements can improve patients' experience of care by reducing delays, miscommunication, and gaps in care, while also lowering costs due to eliminating unnecessary and inappropriate services and improving quality and patient safety.

A collaborative care agreement lays out expectations between a primary care practice and another health care practitioner. Some core elements of a collaborative care agreement[20] include:

> Forming Successful Collaborative Care Agreements
> This spotlight explores the steps that CPC Classic practice Mayfair Internal Medicine took to establish collaborative care agreements with a high-volume specialist and behavioral health practitioner to create a medical neighborhood. This resource will foster creative thinking regarding potential collaborative care agreements, and how to monitor and continually improve the relationship within that agreement.

- Defining the types of referral, consultation, and co-management arrangements available
- Specifying who is accountable for which processes and outcomes of care within (any of) the referral, consultation, or co-management arrangements
- Specifying the content of a patient transition record or core data set

Track 2 practices (and Track 1 CPC Classic practices) are required to establish collaborative care agreements with at least two specialists that your patients frequently see and/or who are high cost.

As you target your efforts to develop collaborative care agreements with specialists, consider the following:

- Use payer (including CMS) data and other available data sources to identify specialists your patients use frequently and high-cost specialists. You may want to start with a specialist with whom you have already have a strong working relationship.

- Develop the collaborative care agreement with the specialists chosen, outlining the responsibilities of both parties, including information you can give to educate your referred

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[20] Systems of Care/PCMH Initiative Compact Facilitation Guide. (2011, May). Retrieved from http://www.improvingprimarycare.org/sites/default/files/topics/ReferralManagement-Step2-Westminster-Medical%20Neighborhood%20Implmentation%20Guide-May%202011.pdf

patients. Once you develop and refine your initial collaborative care agreement s, you can broaden your use to include other specialists.

- Ensure the timely exchange of necessary information, ideally electronically, between your practice, specialists, and patients.

Guide patient referral to specialists. Guiding patients in the referral process starts with understanding their needs. For example, patients may not have transportation, be able to afford the co-pay, or understand the significance of the referral. This process is an opportunity to set expectations for the steps of the referral. Explain the reason for the referral, discuss whether the patient or your practice will schedule the appointment, and review any tests or procedures that need to be completed before the appointment.

> 📋 Primary Care – Specialist Physician Care Coordination Guidelines
> This document provides an example of a collaborative care agreement developed for general distribution with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative.

Track and follow up with patients through the entire referral process to foster safe and effective care. A tracking system does not need to be complex, but must be able to identify gaps (in transfer of information or patient access) and close the referral loop with receipt of and any appropriate action on the referral response. Consider contacting the patient after the scheduled appointment to confirm the patient attended and explore the patient's understanding of the outcome of the visit.

Establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs

<u>Defining the change</u>

Extensive research has demonstrated the impact on health of social factors like income, education, food and housing insecurities, and employment status. Research attributes most health outcomes to social, environmental, and economic factors.[21] Interdisciplinary care teams and community linkages are key to addressing medical concerns and social needs.

In PY 2017, Track 2 practices will assess their patients' psychosocial needs and inventory resources and supports to meet those needs. Key tactics related to establishing effective linkages to support patient goals and social needs are summarized in the Change Tactics table.

Assess your patients' need for social services. Screening your patient population for those with significant unmet social needs is a vital first step to understanding many of the key factors that undermine patients' health and ability to execute their practitioners' recommendations. These social needs may pose fundamental challenges, such as food insecurity, lack of heat and

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[21] The determinants of health. (n.d.) Retrieved from http://www.who.int/hia/evidence/doh/en/

shelter, and the lack of transportation to obtain critical social and health-related items and services. However, many patients would not volunteer that they are experiencing these challenges during a brief interaction with a practitioner. Ensuring your practice is asking the right questions, in a way that elicits candid responses, will allow you to learn the prevalence and impact of unmet social needs on your unique population. Consider using a screening tool to allow for systematic assessment and determine, based on practice and community resources, the potential needs you will assess (e.g., housing, food, transportation, exposure to violence, job insecurity).

Inventory community resources. You can take advantage of local or state organizations that maintain and regularly update databases of community-based resources and support, such as "211," a free and confidential service that helps people find local resources. Staff identify community resources through previous experience, and by staying apprised of new resources that become available. Patients, caregivers, and colleagues are also valuable sources of information on how responsive and effective they find local services. After identifying available community resources, you should effectively coordinate community and social services for your patients as needed, and follow up with patients at regular intervals.

Establishing community linkages. Much in the same way you establish collaborative care agreement s with specialists, you can

Change Tactics
1. Use and integrate a health-related social need screening tool/question(s) that will identify community and social service needs among the patient population, including a universal screening for all patients and a targeted screening for patients with complex needs.
2. Inventory and maintain/access a current database of community and social services that is updated and refined regularly.
3. Provide patients with effective coordination with community and social services by following up with patients at regular intervals.
4. Build relationships and formalize coordination agreements around information sharing and linkages with culturally competent community-based initiatives and agencies/services (e.g., personal care services, homemaker services, nutrition services, home modifications, transportation, assistive technology, respite care, legal assistance, food, and other basic needs).
5. Track and measure success rates of linkages to community resources.

Health IT Capability for Managing Patient Social Needs (Track 2 Only)

a. Systematically assess and track patients' psychosocial needs within your health IT as part of your workflow.

b. Create and maintain an inventory of resources and supports to meet those needs within your health IT.

c. To support this objective, practices must adopt certified health IT that meets the 2015 Edition criterion "Social, Behavioral and Psychological Data" found at 45 CFR 170.315(a)(15), within the first two years of the program, no later than January 2019.

also develop care coordination arrangements with community-based organizations that your patients use frequently and those to which you want to refer patients. It may take time and several conversations to build relationships and develop these agreements, so consider focusing on only one or two at a time. The goal is to find common ground and focus on the structure and process of referrals, and bi-directional flow of information. Your practice should

build relationships and formalize collaborative care agreements around information sharing and linkages with culturally competent community-based initiatives and agencies/services (e.g., personal care services, homemaker services, nutrition services, home modifications, transportation, assistive technology, respite care, legal assistance, food, and other basic needs).

Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population

Defining the change

Comprehensiveness in the primary care setting refers to the availability of a wide range of services in primary care, as well as care for the depth and breadth of the health needs in the population of a primary care practice. Higher levels of comprehensive care are associated with lower overall utilization and costs, as well as better health outcomes.

Change Tactics
1. Review data from CMS and other payers to identify common health conditions seen in the population and to identify specialty use for common chronic conditions. Develop a strategy to increase knowledge and skills to address these conditions and needs in the primary care practice.
2. Expand collaboration with specialists to include strategies such as co-location and co-management for common conditions.

Because of the incentives of fee-for-service (FFS) payments, many primary care practices have referred patients outside the practice for conditions that could be managed well in primary care. To achieve the ability to care for a majority of the practice population's health care needs, many primary care practices will need to build additional practice capabilities internally. However, conditions appropriately diagnosed and treated in secondary care are best treated by others, with coordination, co-management, or co-location.

In PY 2017, Track 2 practices will identify a capability to develop that will meet the needs of their practice population, and can be tracked over time. Key tactics related to increasing capability to manage medical conditions are summarized in the Change Tactics table.

Identify common health conditions in your practice population. This work begins with an assessment that gives you an understanding of the needs of individual patients and of the population and identifies opportunities. You can use data from the CMS Feedback Report, data provided by other payers, and from your practice's health IT to help you begin to answer questions like:

- What are common diagnoses that prompt referrals that might be managed in our practice if we had different capabilities?

- What specialty referrals represent major cost centers and offer opportunities to provide that care in our practice, if we had different capabilities?

- For which referrals might a consultation with the expectation of co-management provide better and more cost-effective care than referral with the expectation of specialty management?

- When are we referring primarily for services (e.g., diabetes education) that could be provided in our practice?

Clinical and support staff can provide insight into questions like:

- Which specialty services are inconvenient for our patients, either because of long wait times for appointments or travel distance?

- Which specialists have less effective processes for communicating data and management plans and make good care coordination more challenging?

- Which specialists are especially good at communicating data and management plans, and would be amenable to a co-management model?

Some needs will be identified through the experience of practitioners providing care and informed by data from CMS, other payers, and the EHR:

- What are common problems or diagnoses that we don't have good support in our referral network? Three important examples are dementia, frailty, and palliative care.

This assessment of patient and population needs should generate a list of opportunities to expand collaboration with specialists to include strategies such as co-location and co-management for common conditions. For example, you may identify a high volume of patients with joint pain who are referred for physical therapy, or a prevalence of patients with diabetes you regularly refer for diabetic counseling, or patients you refer for palliative care. You may want to consider co-locating physical therapy services in your practice for your patients with joint pain, or consider expanding services to include diabetic counseling or palliative care services. Care provided through primary care is better integrated into the ongoing care plan, avoids hand-offs and coordination challenges, and further strengthens the primary care relationship. CPC+ is designed to give your practice flexibility to pursue opportunities to improve care that would not be feasible in a solely FFS environment. Most often, these services will include components of care that are directly reimbursable and some that are not.

Develop a strategy to increase knowledge and skills to address these health needs in your practice. You will need to assess staff skills and identify training needs once you have decided which new services you want to begin offering in your practice. For example, if you decide to begin offering counseling for diabetic patients, you may want to consider adding a certified diabetes educator to your staff or arranging education for existing staff. As you prepare your strategy, it is also critical to be explicit about your timeline, measurable outcomes, and plan for revisiting and refining the strategy.

Understand opportunities to play a more meaningful role when your patients receive care in institutional settings or at home. While many primary care practitioners no longer admit

their own patients to the hospital or other institutional settings, increasing your involvement and co-managing patients in other care settings can improve patients' experience of care and safety, decrease unnecessary services, and facilitate more seamless transitions of care when entering and leaving the institutional setting.

Your data may reveal a number of elderly, ill, or disabled patients who have difficulty coming to the office for visits and could benefit from care in the home. You may want to consider providing occasional home visits as a new service for certain populations in your practice.

Function 4: Patient and Caregiver Engagement

Patient and caregiver engagement combines both a patient's willingness and ability to manage her or his own health care, with strategies aimed at promoting and/or incentivizing healthy behaviors and achieving health goals. Patient and caregiver engagement also encompasses opportunities for patient participation in efforts to improve health care delivery. Engaged patients, armed with information about their condition and available services, make better informed choices about their own health care. Your practice will integrate appropriate recommendations from patients and caregivers into care.

Function 4 Requirements

a. Convene a PFAC at least once in PY 2017, and integrate recommendations into care, as appropriate.

b. **Track 1 CPC Classic and Track 2:** Convene a PFAC in at least two quarters in PY 2017 and integrate recommendations into care, as appropriate.

c. Assess practice capability and plan for support of patients' self-management.

d. **Track 1 CPC Classic and Track 2:** Implement self-management support for at least three high-risk conditions.

As your practice plans and implements your strategy for self-management support, and works towards improving patient-centered, high quality, cost effective care for patients and families, you will focus on these three change concepts:

- Engage patients and caregivers to guide improvement in the system of care.

- Integrate self-management support into usual care across conditions.

- Engage patients in shared decision making.

Engage patients and caregivers to guide improvement in the system of care

Defining the change

Patients and their caregivers bring a wealth of expertise based on their interactions with the health care system and their lived experiences managing chronic conditions at home, work, and in their communities. Patients are the experts in their experience: they see things you don't see, and can point out gaps you may not have identified. Your patients and their caregivers can help identify strengths of your practice, offer insights on what changes are needed, and provide ideas for solutions.

Change Tactics

1. Establish a PFAC to work on procedures, processes, and quality improvement strategies to achieve high quality, coordinated and patient- and family-centered care in the practice.

2. Ensure that patients are directly involved in the practice's transformation team.

3. Communicate to patients, families, and caregivers about the changes being implemented by the practice.

4. Regularly assess the patient care experience and engage patients as partners through surveys and/or other mechanisms.

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Key tactics exist related to engaging patients and caregivers to guide improvement in the system of care are summarized in the Change Tactics table.

Establish a Patient and Family Advisory Council (PFAC) to work on procedures, processes, and quality improvement strategies. A PFAC is an established council within a health care practice that meets regularly and consists of patients who receive care at the practice, their family members, and/or caregivers. Although patients can contribute to making improvements to the practice in a variety of ways (e.g., surveys, suggestion boxes, focus groups, interviewing potential hires), the PFAC is a strategy that many primary care practices use. The PFAC should consist of patients and/or their family members who are representative of your patient demographic. Patients and family members do not need special qualifications or expertise. An individual's experience as a patient or family member of a patient at the practice is most critical. Ask your practice staff for suggestions of patients they think would be interested in participating and who could be effective in working with the practice on improvements. Outline expectations of participation including responsibilities of the patient advisor role, term limits, frequency and location of meetings, and anticipated time commitment outside of in-person meetings.

> 📄 This resource, created for CPC Classic practices by the National Partnership for Women and Families, outlines detailed steps for creating a PFAC, including roles and responsibilities for patients.

> 🔊 Learn how CPC Classic practices Batesville Family Practice Clinic and Capital Care Medical Group developed their PFACs.

Identify discrete tasks that the PFAC can undertake, such as providing advice on patient orientation tools or assessments. Examples of PFAC recommendations from CPC Classic practices include: requiring all staff to wear nametags; installing a diaper changing station in restrooms; communicating with patients when the appointment time is 15 minutes late; and implementing user-friendly changes to the phone system, such as not signing out to answering services at lunchtime.

Acknowledge the advice of patient advisors and report back on how these recommendations were used or why not. Communication is important in building confidence that patient and caregiver input is valued and incorporated into practice improvement efforts.

Ensure that patients are directly involved in the practice's transformation team. Consider inviting two to three of your PFAC patient advisors to serve on your quality improvement team. Some patient advisors might be willing to increase their involvement in practice improvement efforts; for example, attend standing meetings with the quality improvement team (e.g., weekly or bimonthly), take a turn at leading the meetings, or provide feedback on improvement activities in real time. Collaborate with your quality improvement team to determine what improvements to prioritize.

Communicate to patients, families, and caregivers about the changes being implemented by the practice. Inform patients and families on how input from patients has spurred specific efforts for improvement in your practice. Multiple

> ▶ CPC On Demand Video: Using Patient Feedback to Drive Practice Change. Hear how one CPC Classic practice partners with its PFAC on patient education.

methods can effectively convey this information, such as a practice newsletter, website, patient portal, posters in the waiting room, social media, or updated hold messages on phone lines. You may want to ask your PFAC for recommendations on which method is best to convey information to your patients.

Use feedback from patient surveys, PFACs, and other mechanisms to regularly assess your patients' experience of care. Surveys are a common way to measure patient experience, because you can use the resulting quantitative feedback to learn what your patients perceive as areas that need improvement and what works well for your patients. Different types of patient surveys can be inexpensive and efficient methods of gathering patient input. For example, practices can do the following:

- Give paper-and-pencil surveys to patients at the clinic or via mail to patients.
- Make online surveys via the patient portal for patients to fill out at their own convenience.

You can also test use of patient focus groups, suggestion boxes, interviews, and other sources of feedback to better understand patients' experience of care at your practice.

Similarly, a high-functioning PFAC delivers valuable qualitative input that can help shape your practice's improvement efforts. When a cross section of your practice population is represented in the PFAC, your practice can dig into the "how" and "why" with patient advisors and explore solutions to address patient concerns.

Integrate self-management support into usual care across conditions

Defining the change

Self-management support (SMS) gives your patients with chronic conditions tools to manage their health on a day-to-day basis and take an active role in their health care. SMS goes beyond supplying patients with information. It develops patient confidence by collaborating with patients to set goals and make plans to live a healthier life.

The California Healthcare Foundation[22] cites seven essential activities in self-management support:

- Encouraging active participation in the management of the disease

- Collaboratively sharing information between the practice team and patient

- Teaching disease-specific skills

- Supporting healthy behavior change, including setting goals, making action plans, and linking patients with community resources

- Providing training in problem-solving skills

- Assisting with the emotional impact of having a chronic condition

- Ensuring regular and sustained follow-up

Change Tactics
1. Incorporate evidence-based approaches to promote collaborative self-management into usual care using techniques such as goal setting with structured follow-up, Teach Back, action planning, and motivational interviewing.
2. Use tools to assist patients in assessing their need for and receptivity to SMS (e.g., the Patient Activation Measure or How's My Health).
3. Use group visits for common chronic conditions (e.g., diabetes).
4. Provide condition-specific chronic disease self-management support programs or coaching, or link patients to those programs in the community.
5. Provide self-management materials at an appropriate literacy level and in an appropriate language.
6. Use a shared agenda for the visit and provide heath coaching between visits.

Although not required, conducting a practice needs assessment for self-management support is a great way to understand current gaps in resources, services and supports, or staff training needs. By assessing your practices' current capabilities and opportunities for improvement, you can focus on actions the team can take to support self-management.

Key tactics related to integrated self-management support are summarized in the Change Tactics table.

Incorporate evidence-based approaches to promote collaborative self-management. Most primary care team members have limited or no training in patient activation, goal setting, or motivation techniques. By developing these skillsets, your practice can provide patients with greater support in self-management, which is believed to have a long-term impact on utilization patterns. Two useful tools you may want to consider are:

- **Motivational interviewing.** A technique specifically designed to gain understanding from your patients' perspective, learn more about their underlying motivation, develop goals, create a plan, and determine the level of follow-up.

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[22] Helping Patients Help Themselves: How to Implement Self-Management Support. (2010, December). Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HelpingPtsHelpThemselvesImplementSelfMgtSupport.pdf

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- **The Teach-back Method.** A communication confirmation method used by health care practitioners to confirm whether a patient (or caregiver) understands what practitioners are explaining to them. If patients understand, they are able to "teach-back" the information accurately. This is a communication method intended to improve health literacy.

Use tools to assist patients in assessing their need for and receptivity to SMS. Patients are partners in SMS. If they are not activated (ready) to engage to make the necessary changes and follow the shared plan of care, their self-management may not be effective.

There are a number of helpful tools you can use to assess the level of patients' receptivity to SMS, such as the "Patient Activation Measure (PAM)" and the "How's Your Health" assessment tools.

> The Patient Activation Measure (PAM)
> This tool helps you gauge how much patients feel in charge of their healthcare, which can then guide the care team in the planning of care with the patient.

> How's Your Health
> This is a tool patients can use as a personal guide to test how confident they are with controlling and managing their health conditions.

Use group visits for common chronic conditions, support programs, or coaching or link patients to those programs in the community. Several options are available to provide such support, including group office visits, self-management support classes in the community, and peer-led groups. Peer-to-peer sharing offers peer support and social interaction that increase a patient's comfort in discussing the topic. In peer-led support groups or group educational classes, patients can hear and share real life examples that have been working or not working for others.

Provide self-management materials at an appropriate literacy level and in an appropriate language. Effective self-management hinges on patient engagement. A frequent barrier to patients' participation is not being able to understand the educational materials provided to them. Patients are often reluctant to admit they struggle with written documents. Accordingly, you will want to consider incorporating tools to assess patients' literacy levels, preferred language, and preferred teaching modality. You may want to use or create materials that are appropriate for lower literacy levels. You may find visual aids, photos, and illustrations helpful (e.g., recommended portion size for weight control programs).

> CHAMPS provides a library of condition-specific self-management tools and links to online patient self-management resources to facilitate patients having a central role in determining their care and to foster a sense of self-responsibility for health and wellbeing.

Use a shared agenda for the visit and provide heath coaching between visits.
Asking patients about their priorities for the visit can help both practitioners and patients decide together what to cover during the visit.

Setting the agenda together conveys to patients that they are active partners. Health coaching between visits allows practitioners opportunity to ask about any needs or barriers patients may have, provide education, link to additional resources, and help patients achieve their goals.

Engage patients in shared decision making

<u>Defining the change</u>

Shared decision making is a process in which practitioners and patients work together to make decisions, and to select tests and treatment plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values. When patients participate in shared decision

Change Tactics
1. Engage patients in shared decision making about risk and benefits of testing and treatments, where guidelines identify the decision as preference-sensitive
2. Use evidence-based decision aids to support shared decision making.

making, they have the information needed to evaluate their options, understand what they need to do, and are more likely to follow through. Practitioners who use shared decision making say patients are more knowledgeable and better prepared for dialogue, are helped in their understanding of what practitioners are trying to do, and can more readily build a lasting and trusting relationship.

In many situations, there is no single "right" health care decision because choices about treatment, medical tests, and health issues come with pros and cons. Shared decision making is especially important in these types of situations. While shared decision making is not a CPC+ care delivery requirement, it is a key strategy to engage patients. Key tactics related to shared decision making are summarized in the Change Tactics table.

Engage patients in shared decision making about risk and benefits of testing and treatments. Preference-sensitive care comprises treatments for conditions where the evidence does not support one, but rather several, options for treatment, which in turn involve significant tradeoffs among the different possible outcomes of each treatment.[23] Decisions about whether and which of these interventions to use should reflect the patients' personal values and preferences and should be made only after patients have enough information to make an informed choice, in partnerships with their practitioner.

It is important to gauge your practitioners' and patients' knowledge of preference-sensitive conditions and shared decision making. Assessing the current knowledge level among

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[23] Preference-Sensitive Care. (n.d.). Retrieved from:
http://www.dartmouthatlas.org/downloads/reports/preference_sensitive.pdf

practitioners and patients about different preference-sensitive treatments and shared decision making in general is a good place to start. Investigate whether there is variation in approach among practitioners within your practice. For example, do patients seeing Dr. X for lower back pain tend to have surgery while Dr. Y's patients almost always receive referrals to physical therapy? This information may indicate that physician preference is influencing patients more than it should.

List of Common Preference-Sensitive Conditions

- Management of COPD
- Management of asthma
- Management of coronary heart disease
- Management of congestive heart failure
- Management of peripheral artery disease (PAD)
- Management of hypertension

- Hyperlipidemia/high cholesterol
- Medications in diabetes
- Opioid misuse
- Tobacco cessation
- Management of anxiety or depression
- Chronic pain

Use evidence-based decision aids to support shared decision making. Patient decision aids are tools, such as pamphlets, videos, and podcasts, or a combination of media that help patients become involved in health care decisions. These decision aids present unbiased information to help your patients understand their health conditions, available treatment/screening options, and the possible outcomes of those options. Decision aids go beyond traditional patient education materials to draw out the patients' health preferences and values and help them visualize how their decision may affect their daily lives.

> AHRQ's SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient.

Your staff should determine who is responsible for providing and discussing decision aids with patients. Providing a decision aid alone is usually not sufficient, so staff may need additional training on how to converse with patients in shared decision making, along with training on the tools you choose.

> Learn how CPC Classic practices Primary Care Partners, P.C. and Hicken Medical Clinic implemented shared decision making.

Function 5: Planned Care and Population Health

Planned care and population health refers to organizing care delivery to meet the needs of the entire population. Evidence suggests that Americans receive only half of their needed preventive and chronic disease services and that a team-based approach can provide proactive and timely access to appropriate preventive care, evidence-based management of chronic conditions, and improve patients' experience of care.[24]

Effective team-based care incorporates:

> **Function 5 Requirements**
>
> a. Use feedback reports provided by CMS and other payers at least quarterly on at least two utilization measures at the practice level and at least three eCQMs (derived from the EHR) at both the practice and panel level to inform strategies to improve population health management.
>
> b. **Track 2:** Conduct care team meetings at least weekly to review practice and panel level data from payers and internal monitoring, and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.

- **Organized team structure**

    o Link patients to a care team.

    o Define roles and responsibilities, making sure that each care team member is using his or her highest skills and abilities.

    o Reserve workspace and time to facilitate team interaction.

- **Collaborative team functions**

    o Establish huddles, protocols, and standing orders to create workflows to improve efficiencies in care.

    o Provide training opportunities for staff members to learn new tasks and improve coordination.

- **Team culture that centers on quality improvement:**

    o Discuss your practice data with your team to inform improvements in quality, utilization, and patient experience of care.

Through a team-based approach, your practice will develop an understanding of the patient population, develop capabilities to measure, and act on the quality of care at both the practice and panel level. To accomplish your population's health goals, and to improve patient-centered, high quality, cost effective for patients and families, you should focus on two change concepts:

- Use team-based care to meet patient needs efficiently.

- Proactively manage chronic and preventive care for empaneled patients.

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[24] Centers for Disease Control and Prevention (2012). Nearly half of U.S. adults were not receiving key preventive health services before 2010 [Press release]. Retrieved from https://www.cdc.gov/media/releases/2012/p0614_preventive_health.html

![CPC+ logo]

Defining the change

Effective teams meet patient needs by using the skills and abilities of everyone on the team, rather than relying on a single practitioner to deliver care. When you develop a team-based structure, your patients will have greater continuity with a practitioner and/or care team, have more direct access to care when they need it, and experience greater satisfaction with the care received at your practice.

For many practices, the shift from the traditional practice culture to a team-based care approach can be challenging. By clearly defining roles and responsibilities of care team members, fostering effective communication, and establishing protocols and support tools, practices can overcome these challenges and embrace this model of care. Key tactics related to team-based care are summarized in the Change Tactics table.

Change Tactics
1. Define roles and distribute tasks among care team members consistent with their skills, abilities, and credentials, to better meet patient needs effectively and efficiently.
2. Use pre-visit planning and huddling inclusive of all key roles on the care team to optimize preventive care and care team management of patients with chronic conditions, including medical and health-related social needs.
3. Use decision-support tools and protocols to manage workflow in the team to meet patient needs.
4. Analyze and manage workflow to address chronic and preventive care, including health-related social needs (e.g., through pre-visit planning and/or huddles).
5. Enhance team resources with staff – such as a health coach, nutritionist, behavioral health specialist, pharmacist, physical therapist, community resource specialist, social worker, patient navigator, and/or health educator – as feasible to meet the needs of the population.

Define roles and distribute tasks among care team members consistent with skills and abilities to better meet patient needs. Care teams consist of clinical and non-clinical staff who work together and take responsibility for delivering care to a specific panel of patients. In your team, each member plays an important role and works to the top of his or her skills and abilities, appropriately delegating tasks and communicating. For example, medical assistants can play a major role in critical functions like self-management support, population management, and identification of gaps in treatment. The goal is to maximize the time practitioners have available for diagnosis, treatment, and building relationships with patients, while at the same time increasing job satisfaction and decreasing stress.[25] To clearly delineate team roles and responsibilities, your practice should take the time to evaluate your current distribution of tasks and establish standard work procedures for optimal efficiency and effectiveness. It is also important for you to identify and add security and restriction points in your EHR, based on the role of the care team member.

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[25] Primary Care Team Guide: Build the Team (2016). Retrieved from http://www.improvingprimarycare.org/team/pcp

Utilize team pre-visit planning and communication to meet patient needs. There are many strategies to plan your patients' care, including huddles and pre-visit planning. Huddles can be used to plan for the day and typically last 10 to 20 minutes, depending on the structure of your practice. During huddles, your care teams can complete pre-visit prep work, identify gaps in care, psychosocial needs, chronic disease management needs, screening alerts for preventative conditions, and patients with recent hospitalizations. You can employ the EHR and other health IT data to identify the patients scheduled for the day, active diagnosis, risk stratification scores, and due and overdue services. You may find it productive to regularly schedule team meetings, setting aside designated time to review practice processes, workflows, key data, and improvement activities.

Use decision-support tools and protocols to help manage workflow and patient needs. Protocols and standing orders allow patient care to be shared among members of your care team, particularly aspects of the visit that may have previously been performed solely by the practitioner. Standing orders typically are based on national clinical guidelines, but could be customized based on the needs of the population. Standing orders and protocols can be used to **manage preventive and chronic care** without first consulting a practitioner. For example, using these tools, your team's medical assistant or non-practitioner staff can identify patients due for colorectal cancer screening and provide these patients with a home testing kit before their next visit.

Enhance team resources with staff, as feasible, to meet the needs of your patient population. Enhanced team members can include a health coach, nutritionist, behavioral health specialist, pharmacist, physical therapist, community resources specialist, social worker, patient navigator, and health educator. Your practice does not necessarily need to hire each of these potential enhanced team members; rather, you can consider augmenting staff who can help you effectively meet the needs of your patient population. As you build your team, it is crucial that your patients are introduced to each team member through warm handoffs and understand what role these staff play in their care.

Proactively manage chronic and preventive care for empaneled patients

<u>Defining the change</u>

Regular use of data to identify populations or groups of patients with similar needs will allow your practice and care teams to use streamlined strategies, including setting goals with measurable outcomes, to positively impact populations of patients. Proactive management of care for your patient population is supported by building a team-based care structure and a culture of improvement driven by data. Developing this culture of improvement will empower and prepare your staff to take on new roles and act independently, and will encourage practitioners to delegate tasks done better or more efficiently by others, to provide better care for your empaneled patients. Key tactics related to proactively managing chronic and preventive care for empaneled patients are summarized in the Change Tactics table.

Use data to proactively manage population health. Your practice can identify populations or groups of patients with similar needs and challenges for which you can obtain data (e.g., from registries, electronic clinical quality measures (eCQMs), payer feedback reports, or other sources) to select high-priority areas for improvement. You can systematically use data to identify gaps in care for your practice population. Your practice can meet regularly to review and track your key data sources, which you can track over time to identify opportunities for your practice to improve on quality measures and cost and utilization indicators.[26] You can begin by testing improvement strategies on a limited set of relevant measures, rather than working on all your performance measures at once.

Use condition-specific pathways of care. Interventions targeting specific populations of patients often require a planned, proactive approach. Your practice care teams can establish disease-specific processes that incorporate evidence-based protocols and standing orders to guide treatment. By creating these processes, you can involve additional team members in the delivery of chronic and preventive care, which has been shown to improve performance measures. Having established pathways of care for common chronic conditions (e.g., hypertension, diabetes, depression, asthma, and heart failure) allows practitioners and staff to work together, which helps increase your practice's ability to meet patient needs.

Use panel tools and outreach. Registries, the registry functionality of the EHR, or other tracking mechanisms can serve as tools for managing patient population health, including identifying patients due and overdue for care. Quality measures and payer data reports may help inform the use of existing data in these tools. Some registries also include tools that facilitate disease management and allow care team members to identify and proactively manage patients with multiple morbidities, including chronic conditions and/or behavioral and mental health needs. Your practice can identify, alert, and educate patients about chronic and preventive routine care. Your practice can conduct outreach using automated tools in a registry

Change Tactics
1. Use data (e.g., from registry and payers) to identify populations or groups of patients with similar needs and challenges to select high-priority areas for improvement.
2. Use condition-specific pathways of care for common chronic conditions in the practice population (e.g., hypertension, diabetes, depression, asthma, and heart failure) with evidence-based protocols to guide treatment, and measure key quality indicators (e.g., eCQMs and utilization metrics) for those conditions.
3. Use panel support tools (e.g., registry functionality, reminders, phone calls, emails, post cards, text messaging, and community health workers where available) to identify, alert, and educate patients about regular services due and overdue, while also identifying patients for whom services otherwise due are inapplicable and why.
4. Meet with care teams regularly to review performance on the available metrics, including quality and costs that define value for patient subgroups.

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[26] Taylor, E. F., Genevro, J., Peikes, D., Geonnotti, K., Wang, W., & Meyers, D. (2013, April). Building Quality Improvement Capacity in Primary Care: Supports and Resources. Retrieved from https://www.ahrq.gov/sites/default/files/publications/files/pcmhqi2.pdf

or through a patient portal, phone, email, text messaging, and post cards. Your practice should create workflows that identify the appropriate team members for tracking and outreach activites.

Create a culture of improvement. Your practice can strive to build a culture that emphasizes improving patient outcomes and using population health data to monitor improvement over time. To accomplish this, it is crucial to include leadership and foster staff commitment and participation.[27] Practice care teams should meet regularly to review performance on available practice and panel level data, set goals with measurable outcomes, and use performance data to guide improvement. All members of the care team need not be at every meeting; rather, all team members should be included and acknowledged for their unique contributions. For more information on creating a culture of improvement, please reference Driver 3: Continuous Improvement Driven by Data.

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[27] Porter, M. E., Pabo, E. A., & Lee, T. H. (2013, March). Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs. Retrieved from http://content.healthaffairs.org/content/32/3/516.full

Driver 2: Use of Enhanced, Accountable Payment

The CPC+ enhanced payment structure will help support your practice's efforts to change how you deliver care and improve outcomes for your patients. This year, you should begin to understand what resources you need to make and sustain change. You will also need to think and plan carefully about how you will track these new funds,[28] and how you will strategically use these alternative payments to build or increase your capability to deliver comprehensive primary care in your practice. Using reports and data from payers, claims, EHR, and health information exchanges (HIEs) will help you build analytic capability to prioritize changes.

> **Driver 2 Requirements**
> a. Document use of funds and care delivery work under CPC+
> b. Appropriate use of funds:
>   • CMFs for implementation of care delivery requirements
>   • **Track 2:** CPCPs to increase the comprehensiveness and flexibility of care delivered

During the first year of CPC+, your practice will develop processes to determine where to budget funds, and to track and document the use of funds and your care delivery work. To accomplish your practice's goals using enhanced payment and to improve patient-centered, high quality, cost effective care for patients and families, you should focus on three change concepts:

- Use forecasting and accounting processes effectively to transform care and build capability to deliver comprehensive primary care.

- Align practice productivity metrics and compensation strategies with comprehensive primary care.

- Build the analytic capability required to improve care and lower costs for the practice population.

Use forecasting and accounting processes effectively to transform care and build capability to deliver comprehensive primary care

Defining the change

To ensure your practice allocates revenue to the highest priority areas, you will need to use past and present data to forecast the payments you will receive under CPC+ for the year. You will map and prioritize this year's required practice changes and allocate revenue toward those changes. Your practice should think carefully about your new revenue and how best to target your investments.

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[28] Read details about CPC+ payments in the CPC+ Payment Methodology Paper.

Practices will project revenue, perform budgeting exercises, and use the care management fee (CMF) to support delivery of comprehensive care, using these data to identify opportunities for improvement. Track 2 practices will further use data to identify opportunities to enhance comprehensiveness of care, coordination of services, and better meet the complex needs of their patient population. The comprehensive primary care payment (CPCP) can be used to support these additional opportunities and capabilities.

The intensity and breadth of care delivery requirements increase from Track 1 to Track 2 and the accompanying payments provide practices with commensurately increased resources. The supplemental requirements for Track 2 practices are directly tied to their enhanced payment structure, including a particular emphasis on supporting care for patients with complex needs.

Change Tactics
1. Invest revenue in priority areas for practice transformation.
2. Use standardized accounting and budgeting tools and processes to allocate revenue.
3. Use care management fee (CMF) payments to support staffing and training needed to provide historically non-billable and non-visit-based services, in a way that aligns with patient needs. These services include risk stratification, care management, patient outreach and education, and coordination with other care settings.
4. **Track 2:** Use Comprehensive Primary Care Payment (CPCP) to support practitioner (MD, DO, PA, NP) time spent on the five Comprehensive Primary Care Functions delivered either face-to-face or in alternative visits for covered services.

Key tactics related to properly allocating your CPC+ payments to build your practice's capability are summarized in the Change Tactics table.

Use standardized accounting and budgeting tools and processes to allocate revenue. It is important that your practice establish a budgeting process and monitor it regularly. Different practices use different tools and processes to gather historical data and make projections. Multiple options exist to building these capabilities. For example, you might use specific accounting tools or software for practice budgeting, or you could outsource this task to a financial consultant or institution. Alternatively, you might use an electronic spreadsheet. Whatever option you choose, it is important to involve those responsible for making changes in your practice's care delivery in the budget process. Even if the finance department of an affiliated health system is responsible for your practice's budget, leadership in your practice should still be involved and kept informed about your budget process. Furthermore, budget data should be part of your practice's regular data review, along with cost and utilization data, as well as quality and patient experience data. This broad capture of data is necessary to ensure allocated revenue is having the anticipated effect.

> **Practice Management Toolkit**
>
> Provides a toolkit to assist practices in 1) building financial reports; 2) evaluating payers, including payer profitability and collections monitoring; 3) fee schedule tracking; and 4) cost-benefit analysis for adding new services.

Invest revenue in priority areas for practice transformation. Your practice can strategically plan on how you will use the revenue for your care delivery transformation. Allocating revenue to high-priority areas can help to ensure long-term change. You may want to focus your initial **CMF payments** to augment staffing and training for historically non-billable and/or non-visit-based services, such as targeted care management to high-risk patients, self-management support training, patient outreach and education, and coordination with other care settings. Prioritizing these areas early on may provide a stronger foundation for your ongoing work in CPC+, better positioning your practice to build and enhance your care delivery capabilities over the course of the next five years. The Performance-Based Improvement Payments (PBIP) have no restrictions and can be used to fund needed care delivery resources. Track 2 practices can use the **Comprehensive Primary Care Payment** (CPCP) to support the time practitioners spend on the Comprehensive Primary Care Functions, with a particular focus on addressing patients' needs through enhanced comprehensiveness and delivering care outside of the traditional office visit. If you are a Track 2 practice, it will be critical to carefully plan how you will leverage the flexibility offered by this hybrid payment. Consider questions such as, "How will you use the additional support for the more complex patients?"

Align practice productivity metrics and compensation strategies with comprehensive primary care

Defining the change

CMS and CPC+ payer partners have aligned their payment structures to support and incentivize your practice to deliver the Comprehensive Primary Care Functions. Changing the way you deliver care means that you will be enhancing your staff and developing new workflows, routines, and

Change Tactics
1. Use productivity measures that include non-visit-based related care.
2. Develop compensation strategies that reward value and team-based care.

responsibilities. Because you are providing care in new ways and being paid through alternative approaches, your strategy for incentivizing your staff can be commensurately altered. Aligning the measures and goals you set for your practice through an innovative compensation strategy can encourage change and lead to improved outcomes. Key tactics related to aligning practice productivity metrics and compensation strategies are summarized in the Change Tactics table.

Use productivity measures that include non-visit-based related care. As payment becomes more focused around your patient population, you will need to measure different processes that affect population health. A focus on population health requires shifting from a practitioner-based model to a team-based approach. Accordingly, you will want to consider changing your practice's measures from a focus on a single practitioner's performance to the entire care team's performance. You can supplement your measures to include non-visit-based care that reflects the changes your practice is making in CPC+, such as measures of asynchronous communication (via email, text messages, or patient portal), care team huddles, pre-visit planning, and completing outreach during transitions of care. Consider tracking the amount of

time teams spend providing non-visit-based care, the frequency with which these activities occur, or the percentage of gaps in care.

Develop compensation strategies that reward value and team-based care. Even as your practice engages in payment models rewarding value, volume most often defines practitioner and team productivity and success. To achieve the aims of CPC+, you can test new approaches to compensate your team that better recognize and reward your care redesign. Diverse strategies exist depending on your practice structure, ownership, and resources.[29] Your practice can use various tactics when aligning compensation for practitioners and staff with your practice transformation efforts. You can start to increase motivation and buy-in by including your full team as you set common goals and benchmarks for clinical quality outcomes or process measures. You could also consider paying for process improvement work, sharing in profits and/or performance-based incentive payment earnings where everyone on the team receives a percentage, or awarding bonuses for meeting certain metrics. Non-revenue incentives can also motivate your team, such as training and education to develop skills or obtain certifications, flexible scheduling, work-from-home arrangements for certain tasks, or staff lunches to recognize and celebrate successes on meeting goals.

Build the analytic capability required to improve care and lower costs for the practice population

Defining the change

Analytic capability is the process of examining data sets to draw conclusions about the information they contain. This capability will help you track and respond to patterns in cost of care and health outcomes for your practice's patient population, and use these data to make more informed decisions and drive change.

Change Tactics
1. Regularly use available data to analyze opportunities to reduce cost through improved care.
2. Use available data to identify services which can be provided at lower cost and/or improved quality within the practice.
3. Use available data to identify value in referral, diagnostic, and community-based resources.

There are multiple sources of data you can use, such as clinical quality data from your EHR, cost/utilization data from payers, and patient experience data. You may have these data available within your practice or from external sources (e.g., payers). You may also have agreements with hospitals for admission and discharge data. Once you identify a trend in your data, you will still need to drill down into patient level data to pinpoint the specific populations and characteristics of patients that are using services in similar patterns. You may need to work with payers and your health IT vendor to create reports that allow you to see this level of detail, and run and review these reports on a regular basis to identify trends in cost and outcomes. Key

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[29] Blumenthal, D. M., Song, Z., Jena, A. B., & Ferris, T. (2014, April 13). Guidance for Structuring Team-Based Incentives in Health Care. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3984877/

tactics related to building your practice's analytic capability are summarized in the Change Tactics table.

Identify opportunities to reduce cost through improved care. Use your practice performance reports and other payer data to identify trends in cost of care. Data structure and analysis may differ slightly from payer to payer, but should still provide your practice with information on total cost and utilization of care for attributed members. Identify potentially avoidable high-cost services that you can manage through primary care and community-based resources. Review your practice data to answer questions like:

- What are the leading diagnoses for hospital admission, readmission, and emergency use among our patient population?
- Are there gaps in care transitions leading us to revise or create new processes to help prevent unnecessary readmission or ED use?

Identify services you can provide at lower cost and/ or improved quality within the practice. To maximize your revenue, identify services that you can provide at a lower cost and improve quality of care. Example of services to consider include the following:

- Are there patients who commonly seek care at the ED that our practice can manage in an outpatient setting?
- Does my practice leverage non-visit-based care to substitute traditional office visits?

Identify value in referral, diagnostic, and community-based resources. Your practice should access available data to identify opportunities for increased value referrals and other resources. Data can help change patterns and decisions made in your practice to optimize value for your patients. Review your practice data to answer questions like:

- To which clinical specialties are we referring our patients? Are there certain specialists in our community who offer higher value care than others?
- What are the leading diagnostic and imaging studies among my patient population?

Driver 3: Continuous Improvement Driven by Data

Continuous improvement driven by data refers to reliably and systematically measuring quality at the practice level, as well as at the panel/care team level. Your practice can also develop skills and capabilities to manage the changes necessary to improve quality by creating a culture of change that supports data-driven improvement. By measuring at the practice level, your practice is able to understand how you compare with similar practices. By measuring at the panel or care team level, your team can fine-tune your workflows.

During PY 2017, your practice will work with your health IT vendor to ensure the nine eCQMs you select are tracked at the practice level. Although not required, your practice is strongly encouraged to configure all 14 CPC+ eCQMs in its system in the event of the removal of one or more eCQMs for various reasons. To assess quality performance and eligibility for the CPC+ performance-based incentive payment, CPC+ requires your practice to report eCQMs annually at the practice site level. You will report on eCQMs and generate quality measure reports, both at the practice and panel/care team level. In addition to your eCQM data, your practice will use payer-reported utilization and cost data to begin building your capability for internal measurement and review and to create a culture of improvement.

> **Driver 3 Requirements**
> a. Select at least nine of the CPC+ eCQMs and work with your certified health IT vendors to ensure you track your measures at the practice level.
> b. Perform annual CPC+ practice-level eCQM reporting. For specific quality reporting requirements, refer to the Quality Reporting Requirements Guide.

> **Health IT Capability for Reporting**
> a. Practices should work with their EHR vendors now to confirm reporting capability by practice-site location and CPC+ Tax Identification Number (TIN)/National Provider Identifier(s) (NPI).

To create a practice culture of improvement driven by data, and improve patient-centered, high quality, cost effective care for patients and families, you should focus on four change concepts:

- Measure and improve quality at the practice and panel level.

- Ensure full engagement of clinical and administrative leadership in practice improvement.

- Adopt a formal model for quality improvement and create a culture in which all staff members actively participate in improvement activities.

- Actively participate in shared learning.

Measure and improve quality at the practice and panel level

Defining the change

Collecting the right data will allow you to quantify the problem you are trying to address. You can use data to describe how big, how much, how often, how many, and what type of issues your practice and patient population is facing. Gathering data for analysis is only the first step in improvement. Making progress involves evaluating these data against practice, panel, and/or care team goals, and developing a plan of action to make changes. Key tactics related to measuring and improving quality at the practice and panel level are summarized in the Change Tactics table.

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

Identify a set of EHR-derived measures. The EHR is a good source of data when you are deciding where to begin and what to measure and improve. Evaluating clinical quality measures and utilization measures will help you identify those areas that need improvement, as well as those that will be most meaningful for the practice and most beneficial for the patients. Keep in mind that the EHR may have many more reports available than are useful to your practice. Focus on reports that address your needs.

◖Ξ Following Data in the Long Term Aids in Maintaining Improvement
This CPC Practice spotlight highlights the work of Central Oregon Family Medicine on tracking referral-related metrics and using the data for improvement by looking for patterns and changes.

Regularly review measures. Determine how frequently your team will review data. Some measures are actionable on a monthly basis. Others may take longer to demonstrate change, so it will be more effective to monitor every quarter. For example, patient experience data are more sensitive when reviewed every quarter as it takes multiple months to collect sufficient data. Seasonal care (e.g., flu vaccination) may only require monthly review during specific times of the year. Set aside dedicated times for both your team and practice leadership to review data.

Consider displaying your data in graphs to allow everyone to have a visual representation of the data. Including your goals and benchmarks in the graph will help everyone readily see progress towards these marks. Run charts are one useful tool to consider for displaying your data.

◖Ξ Taking a Second Look at Medicare Utilization Data for Improvement Opportunities in Admissions and ED Use
This CPC Practice spotlight highlights the work of Family Physicians of Greeley Colorado using run charts to monitor improvement efforts.

![CPC+ logo]

Use relevant data sources to create benchmarks and goals. Consider using internal (e.g., information from on an ongoing test of change), and external (e.g., payer reports) data to create benchmarks and set goals to guide improvement. Data from within your practice will assist you in establishing a baseline and monitoring progress toward goals. Internal goals may be set at the panel level. Panel-level data showing progress towards your practice goals, helps your team understand how they each affect the overall practice goal on any given measure.

External data allows you to compare your practice against similar practices in the community, state, or region. External data may include reports from payers or quarterly reports from CMS. Consider the data's source when developing data benchmarks. Benchmarks are most meaningful when derived from similar practices or environments.

Ensure full engagement of clinical and administrative leadership in practice improvement

Defining the change

Practice transformation is challenging work. Engaged and visible leaders can inspire commitment and interest in practice improvement, whereas unengaged leaders may hinder progress. Leaders are responsible for effectively implementing improvement, and ensuring that your practice achieves its desired outcomes and sustains its results. Engaged

Change Tactics
1. Make responsibility for guidance of practice change a component of clinical and administrative leadership roles.
2. Allocate time among clinical and administrative leadership for improvement efforts, including participating in regular team meetings.

leaders can remove barriers to change and provide support for meeting improvement goals. Leading by example will help create a positive work environment for the entire team. Key tactics related to ensuring full engagement of clinical and administrative leadership in practice improvement are summarized in the Change Tactics table.

Make practice change a component of clinical and administrative leadership roles. Creating a comprehensive primary care practice is a paradigm shift requiring strong leadership support to meet the CPC+ aims of more patient-centered, high-quality, and cost-effective care. Everyone from leadership to administrative and clinical staff must be onboard to effect change. It is the

> 📧 [Building a Transformation Culture to Sustain Change](#)
> This CPC Practice spotlight highlights the work of Providence Medical Group in Dayton, Ohio on creating a culture of improvement that includes a standard approach to change, staff engagement and learning opportunities, and the use of data.

primary responsibility of leaders to build the will to change. Leaders provide the vision and champion the change. They provide guidance, training, insight, mentoring, coaching, and inspiration. Quality, utilization, patient experience, and cost metrics can be included as evaluative tools for leaders to increase accountability for practice goals.

Allocate time among clinical and administrative leadership for improvement efforts.
Leaders in your practice have many demands on their schedule. Blocking time so they may
participate in practice improvement efforts is essential to achieving practice goals. This includes
actively participating in planning and implementing change, as well as regularly attending team
meetings. Active, continued involvement in your practice's change efforts communicates the
leader's commitment to the team's efforts. For example, a physician leader may nominate his or
her practice panel for a test of change, or a front desk manager may work with his or her team
to develop a change related to the check-in process.

*Adopt a formal model for quality improvement and create a culture in which all staff members
actively participate in improvement activities*

Defining the change

A quality improvement model provides a
framework to systematically improve the way care
is delivered to patients.[30] By identifying a formal
model for quality improvement, your practice will
have a process for using data to identify
opportunities for change and assessing whether
the changes you are making in your practice
results in improvement in care and cost. As you
research the various models, think about what will
work best for your practice. There are several
models to choose from; examples include:

Change Tactics
1. Integrate practice change/quality improvement into staff duties.
2. Engage all staff in identifying and testing practice changes.
3. Designate regular team meetings to review data and plan improvement cycles.
4. Promote transparency and accelerate improvement by sharing practice- and panel-level quality of care, patient experience, and utilization data with staff.
5. Promote transparency and engage patients and families by sharing practice-level quality of care, patient experience, population health, and utilization data with patients and families.

- The Model for Improvement
  ("Plan-Do-Study-Act" [PDSA])

- Six Sigma

- LEAN

- Analytics Adoption Model

All these models listed above have one thing in common: they promote series of improvement
phases that involve planning, evaluation, and implementation. Regardless of the model you
choose, it is critical to ensure active participation from leadership, as well as administrative and
clinical staff who work most closely with the processes you are changing. Key tactics exist
related to adopting a formal model for quality improvement and creating a participatory culture
are summarized in the Change Tactics table.

Integrate practice change/quality improvement into staff duties. Successful improvement
strategies leverage the knowledge, expertise, and skills of the people in your practice. Quality

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[30] Module 4. Approaches to Quality Improvement. (2013, May). Retrieved from
https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod4.html

improvement is not just another task to accomplish, it is everyone's job and every member of the team is important.

Engage all staff in identifying and testing practice changes. Every member of your practice plays a critical role in identifying areas for improvement. The practice team, especially the members identifying the potential change, should take part in planning for change and documenting the progress and outcomes.

Promote transparency and accelerate improvement by sharing data with staff. When your teams participate in improvement projects, they are able to see the results of their work. Sharing the data with the entire team will show how team members' actions affect the results and will increase their ownership of the work. Shared data will also stimulate additional ideas for the team to plan improvement cycles. You should **designate regular team meetings to review data and plan improvement cycles.** Consider scheduling meetings to occur on a pre-determined schedule at a time that allows as many staff as possible to attend (e.g., over lunch, before the day begins) and send out any data in advance of the meeting to allow staff time to review.

Actively participate in shared learning

Defining the change

CPC+ practices are breaking new ground as you learn what it takes to make changes in your practice to deliver comprehensive primary care. New knowledge about how to achieve care delivery improvement comes from the practices engaged in the work. Connecting with other practices in this work helps you gain new ideas and maintain the energy for change. Opportunities to share and learn from each other include national webinars, action groups, affinity groups,

Change Tactics
1. Share lessons learned from practice changes (both successful and unsuccessful) and useful tools and resource materials with other practices.
2. Engage with other practices through transparent sharing of common measures used to guide practice change.
3. Access available expertise to assist in practice changes of strategic importance to the practice.

and regional virtual and in-person learning sessions, as well as on the CPC+ Connect site, through Spotlight articles, and through informal exchanges in the regions. Key tactics related to actively participating in shared learning are summarized in the Change Tactics table.

Practices are encouraged to provide time for multi-disciplinary staff to engage in shared learning opportunities. You might find it helpful to explore all learning activities offered and as a team determine what topics and which staff member(s) are best suited as subject matter experts or active learners who will be responsible for conveying lessons learned to the rest of your team. In particular, we recommend identifying a Practice Lead and Clinical Champion for each improvement effort. The Practice Lead will evaluate needs and determine priorities, and will ultimately be responsible for the effort. The Clinical Champion will lead change efforts, provide

feedback, and communicate changes to clinical teams and care managers who are implementing them. Always consider those directly involved in implementing the change, and whose work processes will change.

Share lessons learned from practice changes and useful resources with other practices. Sharing and learning from other practices enhances your progress and helps your colleagues. Learning the challenges other practices experience, as well as what worked and what did not work for them, will help you understand how to overcome common barriers to change. Sharing tools and resources saves time in locating or creating resources from scratch. Instead, you can use what others have created and adapt it for your practice's use.

Engage with other practices by sharing common measures of practice change. Data tell the objective story of the practice transformation journey. Data helps you decide where to make changes and tells you if the changes you made achieved the results you expected. Sharing your practice's results through data stimulates others to ask, "How did you do that?"

Access available expertise to assist in practice changes. Practices need knowledge about what to do and how to do it to make process improvements. The *CPC+ National Learning Community (NLC)* facilitates learning by bringing practices and subject matter experts together to share best practices. The *CPC+ Regional Learning Network (RLN)* provides support for all practices and helps to facilitate the exchange of ideas and strategies between practices in each region and across regions. Active participation in the RLN promotes the exchange of ideas with your peers in other practices, including Practice Leads, Clinical Champions, and Care Managers, regarding improvement approaches, progress tracking, results obtained, successes, and lessons learned. Engagement with other CPC+ practices can help you avoid barriers, address challenges sooner, and accelerate the pace of change in your practice.

Driver 4: Optimal Use of Health IT

CPC+ incorporates the use of health IT to deliver comprehensive primary care and improve patient-centered, high quality, cost effective care for patients and families. Seamlessly integrating health IT into your administrative workflow and clinical care delivery supports the comprehensive care functions central to implementing CPC+. Your practice will use Certified Electronic Health Record Technology (CEHRT) and other health IT tools to meet your CPC+ care delivery requirements.

While the health IT requirements provide technical guidelines and certification criteria to meet specific care functions, CMS also provides health IT objectives and corresponding technical enhancements for Track 2 practices to meet those objectives (see Appendix D: Health IT Requirements). These objectives allow flexibility and creativity in designing, developing, and implementing the health IT functionality appropriate to your practice's unique needs. As long as your health IT supports you in meeting the stated objectives, you can work with your vendor to identify the most suitable approach for your practice.

	Driver 4 Requirements		
	By January 1, 2017	**By January 1, 2018**	**By January 1, 2019**
Certified Health IT	Maintain 2014 or 2015 Edition health IT certification criteria Ensure health IT is capable of reporting CPC+ eCQMs at the practice site level	Adopt or maintain 2015 Edition health IT certification criteria	Track 2 only Adopt 2015 Edition health IT certification criteria for Care Plan criterion Adopt 2015 Edition health IT certification criteria for Social, Behavioral, and Psychological Data criterion
Quality Reporting	For 2017 reporting period, practices must use the latest eCQM specifications contained in the 2016 annual update, released in April 2016 Adopt technology that allows filtering of data by at least the practice site location and TIN/NPI	Ensure EHR is certified to the 2015 Edition (c)(1)-(3) criteria using the 2017 annual update for CPC+ eCQMs Ensure the eCQM Practice Site Report is made using health IT meeting 2015 Edition (c)(4) criterion, filtered by Practice Site and TIN/NPI	No changes

Know the Certified Health IT requirements for your track. Practices can check their CMS EHR Certification ID. You can find detailed information on all 2015 Edition certification criteria,

companion guides, and test procedures on the Testing and Test Methods page of the Office of the National Coordinator (ONC) HealthIT.gov website. The (c)(1)-(4) criterion are listed below.

- § 170.315(c)(1): Clinical quality measures (CQMs) – record and export (Companion Guide)
- § 170.315(c)(2); CQMs – Import and calculate (Companion Guide)
- § 170.315(c)(3): CQMs – report (Companion Guide)
- § 170.315(c)(4): CQMS – filter (Companion Guide)

As you build your practice's health IT infrastructure to meet requirements and support the delivery of comprehensive primary care, you will focus on these four change concepts:

- Use Office of the National Coordinator (ONC) Certified Health IT.
- Develop practice capacity for the optimal use of health IT.
- Enable the exchange of patient information to support care.
- Measure and report practice- and panel-level eCQMs from Certified Health IT.

Use Office of the National Coordinator (ONC) Certified Health IT

Defining the change

CPC+ requires the use of certified health IT in both Track 1 and Track 2 to perform specific functions throughout all five CPC+ program years. You need to know your certified health IT version to determine need for updates. All certified health IT vendors are listed on the Certified Health IT Product List (CHPL) website. Vendors work with

Change Tactics
1. Implement updates of certified health IT so that practice meets current year certification requirements for CPC+.
2. Align practice changes for comprehensive primary care with the CPC+ health IT requirements.

approved testing bodies for their certification testing. The CHPL website is updated almost daily to reflect the most up-to-date list of Certified Health IT vendors. You can search by developer, product, or testing body, with filters for certification status, certification edition, and certification criteria. Details for each product include the specific certification criteria each vendor product is certified to and the vendor CMS Certification ID, as well as the eCQM version and to which criteria it has been certified. Key tactics related to use of ONC-certified health IT are summarized in the Change Tactics table.

Implement updates of certified health IT. To ensure your practice is compliant with the CPC+ health IT requirements, you should develop an ongoing relationship with a representative from your certified health IT vendor, and be sure to always upgrade to the latest version of ONC-certified health IT offered by your vendor.

Align your practice changes with the CPC+ health IT requirements. To initiate alignment of changes to your business process and your health IT, you need to establish a strong vendor relationship. You should set up regular meetings—at least once every three months—to review health IT requirements together and ensure that you are in agreement about expected CPC+ functionalities, and to stay up to date on your vendor's planned schedule for certification- and CPC+-related releases. The meetings also provide a forum for you to express and/or escalate any concerns you have if their release plans seem to be in conflict with CPC+. All vendors partnering with CMS to support CPC+ Track 2 practices have signed letters of support and memoranda of understanding (MOUs), and as CPC+ partners, are invited to attend CPC+ learning events and to collaborate on CPC+ Connect.

As stated in the CPC+ Health IT Policies and Procedures (Appendix F), practices in Track 2 may switch to a different vendor if a vendor withdraws support for a specific health IT function, or if the practice decides it wants to work with a different vendor. However, the new vendor will also need to commit to supporting the practice for one or more of the specific health IT functions originally listed in the CPC+ Request for Applications and will be asked to sign a memorandum of understanding (MOU) with CMS. Practices must have vendor support for all health IT functions listed to remain in CPC+.

Actively participate in CPC+ affinity groups. You are encouraged to join the CPC+ affinity groups on CPC+ Connect, which include vendor representatives. CPC+ affinity groups provide a forum to share your change experiences, ideas, challenges, and solutions with each other and with the vendor as a group. A subset of online groups will also have live web meetings to further support the community. There are two types of Affinity Groups that will have live meetings: **Collaborative Affinity Groups** and **Capability Affinity Groups**. Vendors are invited to be part of these groups. The two types of affinity groups will serve different purposes.

- **Collaboration Affinity Groups** – Practices collaborate to share experiences, resources, and solutions in utilizing health IT for comprehensive primary care, focusing on Track 1 needs (although Track 2 practices are allowed to participate).
- **Capability Affinity Groups** – Practices work with health IT vendors in identifying gaps and eliciting business requirements for health IT capabilities for meeting the Track 2 enhanced health IT requirements. Affinity groups provide direct access to vendor representatives, and can serve as a forum to resolve issues that many CPC+ participants may be having.

Develop practice capacity for the optimal use of health IT

Defining the Change

Optimal use of health IT means making it an integral part of the day-to-day functioning of your practice. Capacity building within your practice includes commitment from the staff and a good relationship with your health IT vendor(s). Key tactics related to developing practice capacity for health IT are summarized in the Change Tactics table.

Identify health IT champion(s). Change is hard. Even the most enthusiastic supporters struggle with change from time to time, so it is helpful to have one or more health IT champions in your practice to support changes and help with messaging to other staff members. Your health IT champion(s) can support your practice by **teaching and training the staff,** establishing effective workflows, communicating with your vendor representatives, and creating documentation where relevant.

Change Tactics
1. Cross-train staff in key skills in the use of health IT to improve care.
2. Convene regularly to discuss and improve workflows to optimize use of health IT.
3. Engage regularly with health IT vendors about health IT requirements to deliver efficiently the five Comprehensive Primary Care Functions and on eCQM reporting.
4. Identify a health IT champion to work on improving health IT used in practice, teach the team, and establish workflows for required documentation.

The champion(s) need to have direct access to the health IT vendor representative, be included in regular meetings with the vendor, and serve as a clinical subject matter expert when new workflows are being developed. This helps your health IT vendor to develop the functional and IT requirements you need to support your practice changes. It is important to create open communication with the vendor to understand timeframes for delivery and the change request process, as well as how best to request enhancements for new functionality. Being included in the development process gives champions the background and context to explain to their peers why certain decisions were made in workflow changes.

Convene workgroups to optimize health IT use. You may want to also consider creating workgroups that includes end-users to optimize health IT for specific workflows. Practices can convene workgroups in a rapid-cycle manner to address required workflows. For example, a practice may have consistent workflows for screening for tobacco use, but no place to document cessation intervention. A workgroup can help identify if that should be done as part of physician or advanced practice nurse practitioner documentation, nursing documentation, or some other workflow. Based on how your practice wants to manage this change, the workgroup can help shape requirements for the health IT vendor on what the expected functionality should be.

Track 2 practices will implement advanced health IT functionality. Track 2 practices, in conjunction with their health IT vendors, are required to implement additional health IT functionality that supports the Comprehensive Primary Care Functions as noted in Appendix D: Health IT

> **◀▤ Risk Stratification**
> Read about how CPC Classic practice, SAMA Healthcare from El Dorado, AR, used the risk stratification capability of its EHR and blended it with care management to improve preventive care services.

Requirements. CMS expects that all health IT enhancements will be completed no later than 24 months after the first PY (i.e., January 1, 2019). Of these health IT enhancements, the highest priorities are using risk stratification to identify and flag patients with complex needs within your health IT system, using eCQM results for continuous feedback, and empaneling patients to the

practice site care teams within your health IT system. Your practice should implement these health IT enhancements within the first 6 to 12 months of CPC+.

Enable the exchange of patient information to support care

Defining the change

Practitioners and/or care teams should have real-time access to patient information to provide quality care. Your health IT system should have interoperable capabilities to facilitate seamless flow of patient data. Key tactics related to enabling patient information exchange are summarized in the Change Tactics table.

Change Tactics
1. Connect to local health information exchanges (HIE), if available.
2. Develop information exchange processes with other service practitioners with which the practice shares patients.
3. Use standard documents created in your health IT to routinely share information (e.g., medications, problems, allergies, goals of care) at times of referral and transition between settings of care.
4. Use non-clinical workflows to systematically enter structured clinical data from external (e.g., paper and e-fax) sources into health IT.

Connect to local HIE. The emergence and development of health information exchanges (HIEs) in CPC+ regions will improve the quality and timeliness of the data available to practices to better manage patient care (especially high-risk patients), and enhance care coordination across the medical neighborhood. You should investigate if you have a local, state, or regional level HIE in which you can participate. If you have a local HIE, talk with its representatives about whether your health IT's current health information service provider (HISP) for secure messaging is able to work with the HIE's HISP.

Develop information exchange processes with other service practitioners. HIE can allow you to more easily exchange information with other providers in your medical neighborhood. **Using referral or care transition templates with standard elements** also facilitates reliable exchange of information among practitioners and care teams. Consider reaching out to referring practitioners, both those who refer patients to your practice and those to whom you refer patients. Assess what health IT they have in place, if it is similar to yours, and what patient data you can share with each other, to facilitate care coordination and continuity of care. You may need to have collaborative care agreements in place.

Use non-clinical workflows to enter external structured clinical data into health IT.

Work with your health IT vendor on clinical document architecture (CDA) content. The CDA is a document standard developed by the HL7 organization that specifies the structure and semantics of clinical documents for health care data exchange. Numerous guides have been released, including those for clinical notes, medication therapy management, and personal advance care plans. Practices should work with their health IT vendors on CDA content to ensure it contains content of value to the practice and your referring practitioners, including details for ONC required data standards (e.g., Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT), Logical Observation Identifiers Names and Codes (LOINC)).

Measure and report practice- and panel-level eCQMs from Certified Health IT

Defining the change

Quality measurement and improvement is a key component of practice transformation under CPC+. Practices are expected to select and successfully report 9 of the 14 measures from the CPC+ eCQM measure set. Though you are required to report only nine measures, we suggest you obtain the technology and necessary configuration to

Change Tactics
1. Implement practice-level reporting of eCQMs derived from certified health IT.
2. Implement panel-level reporting of eCQMs derived from the certified health IT.
3. Develop capability for electronic transmission of eCQM reporting.

consistently and accurately report more than nine measures. Optimizing the use of health IT in collecting and reporting quality data will help you understand how your practice performance is calculated for all measures selected and ensure that the measures are calculated correctly in your certified health IT. Key tactics related to measuring and reporting eCQMs are summarized in the Change Tactics table.

For details on quality reporting requirements, refer to Quality Measurement and Reporting in Section III of this Guide.

Driver 5: Aligned Payment Reform

Multi-payer involvement is essential to CPC+ as it ensures adequate financial support for practices to make fundamental changes to their care delivery. When payers share cost, utilization, and quality data with practices at regular intervals, it facilitates practices' ability to manage their patient population's health, leading to improved patient-centered, high quality, cost effective care for patients and families. CMS selected payers based on regional payer density and alignment with CMS' approach to payment, care delivery, data sharing, and quality measurement.

The intensity and breadth of care delivery requirements increase from Track 1 to Track 2. Accompanying payments provide practices with appropriately increasing resources structured to align with the requirements and focus of each track. Practices are required to document use of funds and care delivery work under CPC+.

The payment flows consist of three elements:
1) care management fee (CMF);
2) performance-based incentive payment (PBIP); and 3) payment under the Medicare Physician Fee Schedule (regular payment for Track 1 and hybrid payment for Track 2). Details on CPC+ payment types can be found in the CPC+ methodology paper.

> 📋 CPC+ Methodology Paper
> This Executive Summary provides an overview of the methodologies that the Centers for Medicare & Medicaid Services (CMS) will use for the Comprehensive Primary Care Plus (CPC+) payment model being tested in Medicare fee-for-service (FFS).

Payers will support practices in both tracks. All payers (including CMS) will enter into separate agreements with the participating practices. Payers may consider focusing on these four change concepts:

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

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

- Reward practice actions to reduce total cost of care through a PBIP.

- Align quality measures.

Use population-based payment to purchase comprehensive primary care services

Defining the change

CPC+ payers will attribute their beneficiaries to a primary care practitioner and share their attribution methodology with CMS. Attribution results in greater concentration of costs for attributed patients within the practices, increasing the practices' ability to reduce costs. Payers will pay practices a monthly supplemental per-member per-beneficiary (PMPB) fee, based on a chosen risk adjustment methodology that should be shared with practices. Risk methodologies may vary from payer to payer, but should align with the CPC+ payment model and support purchase of comprehensive primary care services. Key tactics related to using population-based payment are summarized in the Change Tactics table.

Change Tactics
1. Prospectively align every member or beneficiary with a primary care practitioner, care team, or practice.
2. Provide a per-member or per-beneficiary per-month supplement to FFS payment for primary care services.
3. Use a methodology to risk adjust per member/beneficiary per month payment, and share methodology with practices.
4. Align standards for comprehensive primary care services across CPC+ payers.
5. **Track 2:** Shift payment from FFS to alternative forms of payment to compensate the care team for proactive, efficient, and comprehensive care that would otherwise be furnished in a traditional office visit.

Provide actionable and timely cost and utilization data to practices

Defining the change

CPC+ payers should provide participating practices with practice- and patient-level data about cost and utilization for their attributed patients at regular intervals (e.g., quarterly), through reports or other data sharing methods. As already described in Driver 2, practices will review cost and utilization trends in payer reports to inform decisions on what improvements they need to make to improve health outcomes. Key tactics related to providing actionable and timely data are summarized in the Change Tactics table.

Change Tactics
1. Provide at least quarterly reports of timely data, by practitioner and practice, of services received by members/beneficiaries outside of the primary care practice.
2. Notify practitioners and practices of ED visits and admissions and discharges as soon as possible.
3. Engage with practices to improve the usability and functionality of data reports.
4. Aggregate or align cost, utilization, and quality reports with other payers engaged in CPC+.

Reward practice actions to reduce total cost of care through a PBIP

Defining the change

CMS will prospectively pay and retrospectively reconcile a PBIP based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. Similarly, other CPC+ payers should use alternative financial incentives to reward practices' achievement

Change Tactics
1. Use alternative financial incentives to reward achievement of more patient centered, high quality, and cost effective care.
2. Seek alignment between payment incentives, contract terms, and the five Comprehensive Primary Care Functions.

of improved health outcomes. Key tactics related to rewarding practice actions to reduce total cost of care through a PBIP are summarized in the Change Tactics table.

Align quality measures

Defining the change

To the greatest extent possible, CPC+ payers should align practice quality and performance measures with those under CPC+. CPC+ uses eCQMs, patient experience of care measures, utilization measures, and patient-reported outcome measures (PROMs) to track experience and quality of care, identify gaps in care, and focus quality improvement

Change Tactics
1. Align with CMS and other CPC+ payer partners in a region on all three types of performance-based quality measures (i.e., eCQMs, patient experience (CAHPS) measures, and utilization measures), as appropriate across varying lines of business.

activities. CPC+ payers will provide CMS with practice- and patient-level data to be used for monitoring and evaluation purposes. A key tactic related to aligning quality measures are summarized in the Change Tactics table.

The remainder of Section I of this Guide summarizes the CPC+ Change Package; i.e., the key drivers, change concepts, and change tactics which are described in greater detail in Section I. As a reminder, these are meant to help guide you through care delivery redesign. While many of the change concepts and tactics are optional, they can all contribute to the model's overall aims of more patient centered, high quality, and cost effective care.

CPC+ Change Package

DRIVER 1: Five Comprehensive Primary Care Functions

FUNCTION 1: Access and Continuity

A trusting, continuous relationship between patients, their caregivers, and your team of professionals who provide care for them is the foundation of effective primary care. Whether through expanded hours or developing alternatives to traditional office visits, ensuring patients have access to your team will enhance that relationship and increase the likelihood that patients will get the right care at the right time, potentially avoiding costly urgent and emergent care.

Table 1: Access and Continuity Change Concepts and Tactics

Function	Change Concept	Change Tactic
1 Access and Continuity	**A. Empanel all patients to a practitioner and/or care team**	1. Assign responsibility for the total population, linking each patient to a practitioner and/or care team
	B. Ensure timely access to care	1. Provide 24/7 access, guided by the medical record, to practitioner and/or care team for advice about urgent and emergent care; for example, through: o The practitioner and/or care team with real-time access to medical record o Cross-coverage with access to medical record o Protocol-driven nurse line with access to medical record or ability to escalate to a practitioner with access
		2. Expand office hours in early mornings, evenings, and weekends with access to the patient medical record, either directly through the practice or through coordination with other practitioners
		3. Use alternatives for care outside of the traditional office visit to increase access to care team and practitioner, such as e-visits, phone visits, group visits, home visits, and visits in alternate locations (e.g., senior centers and assisted living centers) captured in the medical record
		4. Provide same-day or next-day access to the patient's own practitioner and/or care team for urgent care or transition management
		5. Use a patient portal and secure messaging for patient and designated caregiver access to health information in languages that align with the patient population

Function	Change Concept	Change Tactic
	C. Optimize continuity with practitioner and/or care team	1. Ensure that all practitioners within the practice and all members of the care team have access to the same patient information to guide care within the electronic health record (EHR)
		2. Measure and analyze care continuity between patient and practitioner and/or care team using health IT, scheduling systems, payer reports, or a small sample of visits or other encounters
Access and Continuity Requirements	https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf	

FUNCTION 2: Care Management

Care management for high-risk, high-need patients is a hallmark of comprehensive primary care. Through your work in CPC+, you will identify those patients in two ways. First, you will systematically risk stratify your empaneled population to identify the high-risk patients most likely to benefit from targeted, proactive, relationship-based (longitudinal) care management. Second, you will identify patients based on event triggers (e.g., transition of care setting or new diagnosis of major illness) for episodic (short-term) care management regardless of risk status.

Your practice will provide both longitudinal and episodic care management, targeting the care management to best improve outcomes for these identified patients. You will guide your care management efforts by analyzing internal monitoring and payer data, and by using care plans focused on goals and strategies congruent with patient choices and values.

Table 2: Care Management Change Concepts and Tactics

Function	Change Concept	Change Tactic
2 **Care Management**	**A. Assign and adjust risk status for each patient**	1. Use a consistent method to assign and adjust risk status for all empaneled patients: the first step is an algorithm-based method and the second step adds information that the clinical team has about the patient
		2. Monitor the risk stratification method and ensure accuracy of risk status identification
	B. Provide longitudinal care management to patients at high risk for adverse health outcome or harm	1. Use the risk stratification process to identify and target care management services to patients who the team believes to be at high risk and amenable to outreach
		2. Use on-site, non-physician, practice-based, or integrated shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients, with assistance from other practice staff, as needed
		3. Use a personalized care plan for patients at high risk for adverse health outcome or harm, integrating patient goals, values, and priorities
	C. Provide episodic care management, including management across transitions and referrals	1. Provide care management services to patients with recent emergency department (ED) visits or hospitalization. Services include care transition planning and follow-up, and ensuring diagnosis and discharge plans are understood by patients and families
		2. Partner with community or hospital-based transitional care services to improve care transitions and reduce readmissions
Care Management Requirements	https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf	

![CPC+ logo]

FUNCTION 3: Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to your practice meeting the majority of your patient population's medical, behavioral, and health-related social needs in pursuit of each patient's health goals. Comprehensiveness adds both breadth and depth to the delivery of primary care services; builds on the element of relationship that is at the heart of effective primary care; and is associated with overall lower utilization and costs, less fragmented care, and better health outcomes.

By participating in CPC+, your practice will increase the comprehensiveness of care based on the needs of your practice population. Strategies to achieve comprehensiveness involve the use of analytics to identify needs at the population level and prioritize strategies for meeting key needs. For some aspects of care, your practice can best achieve comprehensiveness by ensuring patients receive offered services within the practice (rather than elsewhere) and by adding additional services within the practice that might have previously required a referral. Primary care practices should facilitate additional care and services that patients need to get outside of their primary care practice through closed-loop referrals and/or co-management with specialists and linkages with community and social services.

Your practice will act as the hub of care for your patients, playing a central role in helping patients and caregivers navigate and coordinate care. Your practice will address opportunities to improve transitions of care, focusing on hospital and ED discharges, as well as post-acute care facility usage and interactions with specialists. Moreover, this work involves building the capability and network of services, both within the medical neighborhood and the community, to improve patient care. You will work to understand where your patients receive care and organize your practice to deliver or coordinate care in the way that achieves the best outcomes.

Table 3: Comprehensiveness and Coordination Change Concepts and Tactics

Function	Change Concept	Change Tactic
3 Comprehensiveness and Coordination	**A. Routinely assess, link, and support patients' complex health needs**	1. Use payer and EHR data to identify conditions and needs prevalent in the practice's patient population that add to medical complexity (e.g., multi-morbidity, end-of-life care, polypharmacy, dementia and frailty, and health-related social needs)
		2. Establish a process for assessing, documenting, and periodically reassessing patient health care goals, health-related social needs, as well as their choices regarding advance directives and health care surrogates
		3. Regularly assess caregiver social and emotional needs and provide or facilitate caregiver support as a routine component of care

Function	Change Concept	Change Tactic
		4. Build a regular process to link patients with identified social needs to community-based resources for support and consider co-locating resources
	B. Integrate behavioral health services to support patients' common and complex behavioral health needs	1. Use evidence-based treatment protocols, assess response with validated measures, and treat to goal, where appropriate
		2. Use evidence-based screening and case-finding strategies to identify individuals at risk and in need of behavioral health services
		3. Ensure regular communication and coordinated workflows between primary care, behavioral health practitioners, and community services
		4. Establish collaborative care agreement s with mental health practitioners that set expectations for documented flow of information and practitioner expectations between settings
		5. Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment
		6. Use a registry or health IT registry functionality to support active care management and outreach to patients in treatment
		7. Facilitate integration through co-location of services (e.g., co-located social worker, psychiatric nurse practitioner, psychologist, or psychiatrist), when appropriate and feasible
		8. Implement screening with brief intervention for alcohol and other substance misuse
		9. Train clinical staff to deliver behavioral health therapies (e.g., train nurse care managers to provide problem-solving therapy)
	C. Manage medications to maximize efficiency, effectiveness, and safety	1. Reconcile and coordinate medications and provide medication management across transitions of care settings and practitioners
		2. Provide medication self-management support to improve adherence to prescribed medication

Function	Change Concept	Change Tactic
		3. Integrate a pharmacist into the care team to provide medication management services
		4. Conduct comprehensive medication reviews with action plans, individualized therapy goals, and planned follow-up, particularly for high-risk patients who: ○ Experience a transition of care ○ Receive longitudinal care management ○ Take high-risk medication
		5. Work together with pharmacists and other health care professionals to promote clinically sound, cost-effective medication therapy and therapeutic outcomes (i.e., provide formulary management)
		6. Implement robust medication reconciliation at regular, established intervals, including assessment of medication regimens for missing yet indicated medications, and those not needed or indicated
	D. Provide effective care coordination, navigation, and active referral management in the medical neighborhood	1. Ensure routine and timely follow-up to ED visits and hospitalizations
		2. Establish collaborative care agreement s with frequently used or high-cost specialists and/or care agencies (e.g., home health agencies and skilled nursing facilities) that set expectations for documented flow of information and practitioner expectations between settings
		3. Guide, track, and follow up with patients referred to specialists
		4. Develop a process for sharing information regarding patient health care goals, as well as their choices regarding advance directives and health care surrogates, with consultants and other practitioners in the medical neighborhood (e.g., acute care facility)
		5. Systematically integrate information from referrals into the plan of care and help patients understand the information provided in the referral response

Function	Change Concept	Change Tactic
	E. Establish effective linkages with neighborhood/ community-based resources to support patient health goals and health-related social needs	1. Use and integrate a health-related social need screening tool/question(s) that will identify community and social service needs among the patient population, including a universal screening for all patients and a targeted screening for patients with complex needs
		2. Inventory and maintain/access a current database of community and social services that is updated and refined regularly
		3. Provide patients with effective coordination with community and social services by following up with patients at regular intervals
		4. Build relationships and formalize coordination agreements around information sharing and linkages with culturally competent community-based initiatives and agencies/services (e.g., personal care services, homemaker services, nutrition services, home modifications, transportation, assistive technology, respite care, legal assistance, food, and other basic needs)
		5. Track and measure success rates of linkages to community resources
	F. Increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population	1. Review data from CMS and other payers to identify common health conditions seen in the population and to identify specialty use for common chronic conditions. Develop a strategy to increase knowledge and skills to address these conditions and needs in the primary care practices
		2. Expand collaboration with specialists to include strategies such as co-location and co-management for common conditions
Comprehensiveness and Coordination Requirements	https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf	

FUNCTION 4: Patient and Caregiver Engagement

Optimal care and health outcomes require patients and caregivers to be engaged in the management of their own care and in the design and improvement of care delivery. Your practice will organize a Patient and Family Advisory Council (PFAC) to help you understand the perspective of patients and caregivers on the organization and delivery of care, as well as its ongoing transformation through CPC+. You will then use the recommendations from the PFAC to improve care and ensure its continued patient-centeredness.

Table 4: Patient and Caregiver Engagement Change Concepts and Tactics

Function	Change Concept	Change Tactic
4 **Patient and Caregiver Engagement**	**A. Engage patients and caregivers to guide improvement in the system of care**	1. Establish a PFAC to work on procedures, processes, and quality improvement strategies to achieve high quality coordinated and patient- and family-centered care in the practice
		2. Ensure that patients are directly involved in the practice's transformation team
		3. Communicate to patients and caregivers about the changes being implemented by the practice
		4. Regularly assess the patient care experience and engage patients as partners through surveys and/or other mechanisms
	B. Integrate self-management support into usual care across conditions	1. Incorporate evidence-based approaches to promote collaborative self-management into usual care using techniques such as goal setting with structured follow-up, Teach Back, action planning, and motivational interviewing
		2. Use tools to assist patients in assessing their need for and receptivity to self-management support (e.g., the Patient Activation Measure (PAM) or How's My Health)
		3. Use group visits for common chronic conditions (e.g., diabetes)
		4. Provide condition-specific chronic disease self-management support programs or coaching, or link patients to those programs in the community
		5. Provide self-management materials at an appropriate literacy level and in an appropriate language
		6. Use a shared agenda for the visit and provide heath coaching between visits

Function	Change Concept	Change Tactic
	C. Engage patients in shared decision making	1. Engage patients in shared decision making about risk and benefits of testing and treatments, where guidelines identify the decision as preference-sensitive
		2. Use evidence-based decision aids to support shared decision making
Patient and Caregiver Requirements	https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf	

Your practice will organize your care to meet the needs of the entire population of patients you serve. Using team-based care, you will proactively offer timely and appropriate preventive care, and consistent evidence-based management of chronic conditions. You will improve population health through use of evidence-based protocols in team-based care and identification of care gaps at the population level, as well as measure and act on the quality of care at both the practice and panel levels.

Table 5: Planned Care and Population Health Change Concepts and Tactics

Function	Change Concept	Change Tactic
5 **Planned Care and Population Health**	**A. Use team-based care to meet patient needs efficiently**	1. Define roles and distribute tasks among care team members, consistent with their skills, abilities, and credentials, to better meet patient needs effectively and efficiently
		2. Use pre-visit planning and huddling inclusive of all key roles on the care team to optimize preventive care and care team management of patients with chronic conditions, including medical and health-related social needs
		3. Use decision-support tools and protocols to manage workflow in the team to meet patient needs
		4. Analyze and manage workflow to address chronic and preventive care, including health-related social needs (e.g., through pre-visit planning and/or huddles)
		5. Enhance team resources with staff— such as a health coach, nutritionist, behavioral health specialist, pharmacist, physical therapist, community resource specialist, social worker, patient navigator, and/or health educator—as feasible to meet the needs of the population
	B. Proactively manage chronic and preventive care for empaneled patients	1. Use data (e.g., from registry and payers) to identify populations or groups of patients with similar needs and challenges to select high-priority areas for improvement
		2. Use condition-specific pathways of care for common chronic conditions in the practice population (e.g., hypertension, diabetes, depression, asthma, and heart failure) with evidence-based protocols to

Function	Change Concept	Change Tactic
		guide treatment, and measure key quality indicators (e.g., eCQMs and utilization metrics) for those conditions
		3. Use panel support tools (e.g., registry functionality, reminders, phone calls, emails, post cards, text messaging, and community health workers where available) to identify, alert, and educate patients about regular services due and overdue, while also identifying patients for whom services otherwise due are inapplicable and why
		4. Meet with care teams regularly to review performance on the available metrics including quality and costs that define value for patient subgroups
Planned Care and Population Health Requirements	https://innovation.cms.gov/Files/x/cpcplus-practicecaredlvreqs.pdf	

DRIVER 2: Use of Enhanced, Accountable Payment

Table 6: Enhanced, Accountable Payment Change Concepts and Tactics

Secondary Driver	Change Concept	Change Tactic
2.1 Strategic Use of Practice Revenue	**A. Use forecasting and accounting processes effectively to transform care and build capability to deliver comprehensive primary care**	1. Invest revenue in priority areas for practice transformation
		2. Use standardized accounting and budgeting tools and processes to allocate revenue
		3. Use care management fee (CMF) payments to support staffing and training needed to provide historically non-billable and non-visit-based services, in a way that aligns with patient needs. These services include risk stratification, care management, patient outreach and education, and coordination with other care settings
		4. **Track 2:** Use Comprehensive Primary Care Payment (CPCP) to support practitioner (MD, DO, PA, NP) time spent on the five Comprehensive Primary Care Functions delivered either face-to-face or in alternative visits for covered services
	B. Align practice productivity metrics and compensation strategies with comprehensive primary care	1. Use productivity measures that include non-visit-based related care
		2. Develop compensation strategies that reward value and team-based care
2.2 Analytic Capability	**C. Build the analytic capability required to improve care and lower costs for the practice population**	1. Regularly use available data to analyze opportunities to reduce cost through improved care
		2. Use available data to identify services which can be provided at lower cost and/or improved quality within the practice
		3. Use available data to identify value in referral, diagnostic, and community-based resources

DRIVER 3: Continuous Improvement Driven by Data

Table 7: Continuous Improvement Change Concepts and Tactics

Secondary Driver	Change Concept	Change Tactic
3.1 Internal Measurement and Review	**A. Measure and improve quality at the practice and panel level**	1. Identify a set of EHR-derived clinical quality and utilization measures that are meaningful to the practice team
		2. Regularly review quality, utilization, patient satisfaction, and other measures that may be useful at the practice level and at the level of the care team or practitioner (panel)
		3. Use relevant data sources to create benchmarks and goals for performance at the practice and panel level
3.2 Culture of Improvement	**B. Ensure full engagement of clinical and administrative leadership in practice improvement**	1. Make responsibility for guidance of practice change a component of clinical and administrative leadership roles
		2. Allocate time among clinical and administrative leadership for improvement efforts, including participating in regular team meetings
	C. Adopt a formal model for quality improvement and create a culture in which all staff members actively participate in improvement activities	1. Integrate practice change/quality improvement into staff duties
		2. Engage all staff in identifying and testing practice changes
		3. Designate regular team meetings to review data and plan improvement cycles
		4. Promote transparency and accelerate improvement by sharing practice- and panel-level quality of care, patient experience, and utilization data with staff
		5. Promote transparency and engage patients and families by sharing practice-level quality of care, patient experience, population health, and utilization data with patients and families
	D. Actively participate in shared learning	1. Share lessons learned from practice changes (both successful and unsuccessful) and useful tools and resource materials with other practices
		2. Engage with other practices through transparent sharing of common measures used to guide practice change
		3. Access available expertise to assist in practice changes of strategic importance to the practice

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DRIVER 4: Optimal Use of Health IT

Table 8: Health IT Change Concepts and Tactics

Secondary Driver	Change Concept	Change Tactic
4.1 Continuous Improvement of Health IT	**A. Use Office of the National Coordinator (ONC) Certified Health IT**	1. Implement updates of certified health IT so the practice meets current-year certification requirements for CPC+
		2. Align practice changes for comprehensive primary care with the CPC+ health IT requirements
	B. Develop practice capacity for optimal use of health IT	1. Cross-train staff in key skills in the use of health IT to improve care
		2. Convene regularly to discuss and improve workflows to optimize use of health IT
		3. Engage regularly with health IT vendors about health IT requirements to deliver efficiently the five Comprehensive Primary Care Functions and on electronic clinical quality measure (eCQM) reporting
		4. Identify a health IT champion to work on improving health IT used in practice, teach team, and establish workflows for required documentation
4.2 Data Exchange	**C. Enable the exchange of patient information to support care**	1. Connect to local health information exchanges, if available
		2. Develop information exchange processes with other service practitioners with which the practice shares patients
		3. Use standard documents created in your health IT to routinely share information (e.g., medications, problems, allergies, goals of care) at time of referral and transition between settings of care
		4. Use non-clinical workflows to systematically enter structured clinical data from external (e.g., paper and e-fax) sources into health IT
4.3 Certified Health IT Based Quality Reporting	**D. Measure and report practice- and panel-level eCQMs from certified health IT**	1. Implement practice-level reporting of eCQMs derived from certified health IT
		2. Implement panel-level reporting of eCQMs derived from the certified health IT
		3. Develop capability for electronic transmission of eCQM reporting

DRIVER 5: Aligned Payment Reform

Table 9: Aligned Payment Reform Change Concepts and Tactics for CPC+ Payer Partners

Secondary Driver	Change Concept	Change Tactic
5.1 Aligned Payment Reform	**A. Use population-based payment to purchase comprehensive primary care services**	1. Prospectively align every member or beneficiary with a primary care practitioner, care team, or practice
		2. Provide a per-member or per-beneficiary per month supplement to FFS payment for primary care services
		3. Use a methodology to risk adjust per member/beneficiary per month payment, and share methodology with practices
		4. Align standards for comprehensive primary care services across the CPC+ payers
		5. **Track 2:** Shift payment from FFS to alternative forms of payment to compensate the care team for proactive, efficient, and comprehensive care that would otherwise be furnished in a traditional office visit
	B. Provide actionable and timely cost and utilization data to practices	1. Provide at least quarterly reports of timely data, by practitioner and practice, of services received by members/beneficiaries outside of the primary care practice
		2. Notify practitioners and practices of ED visits and admissions and discharges as soon as possible
		3. Engage with practices to improve the usability and functionality of data reports
		4. Aggregate or align cost, utilization, and quality reports with other payers engaged in CPC+
	C. Reward practice actions to reduce total cost of care through a PBIP	1. Use alternative financial incentives to reward achievement of more patient centered, high quality, and cost effective care
		2. Seek alignment between payment incentives, contract terms, and the five Comprehensive Primary Care Functions
	D. Align quality measures	1. Align with CMS and other CPC+ payer partners in a region on all three types of performance-based quality measures (i.e., eCQMs, patient experience (CAHPS) measures, and utilization measures), as appropriate across varying lines of business

Section II: Care Delivery Reporting Guide

Introduction

This section guides you through the 2017 CPC+ Care Delivery Reporting. Your practice should use this Guide to prepare for reporting in each quarter, and identify what information you will need to collect and track. This Guide includes questions and answers (Q&As), reporting frequency, definitions, and other notes to help you understand the reporting requirements. We recommend reading the Q&As ahead of time and using them as a way to meet with your practice team in facilitating the reporting process and identifying the best person for reporting data by each section. Some questions require input from different staff members in your practice, and data acquired in your EHR or other data applications.

The information you collect and provide is incredibly valuable because it allows you to track your progress and direct efforts to implement the CPC+ care delivery requirements in accordance with the five Comprehensive Primary Care Functions. Your answers allow us to learn about your practice's capabilities and strategies for delivery of high-value, comprehensive primary care. This will help us better understand the changes occurring in your practice, and improve learning activities to support your practice in providing comprehensive primary care as defined in CPC+.

Table 10 shows the quarterly reporting periods. You will complete your reporting in the CPC+ Practice Portal.[31] You can begin your reporting, save it, exit the CPC+ Practice Portal, and return later to continue and finish. The Practice Portal will save your answers. Later in the year, you will be able to look back to previous quarter reports and print them for reference. We encourage you to start your reporting as early in the reporting period as possible.

Table 10: CPC+ 2017 Reporting Submission Periods

Quarter	Submission Periods
Quarter 1	3/27/17 through 4/14/17
Quarter 2	6/26/17 through 7/14/17
Quarter 3	9/25/17 through 10/13/17
Quarter 4	12/25/17 through 1/19/18

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[31] The CPC+ Practice Portal is a secure website hosted in the CMS Enterprise Portal (https://portal.cms.gov/). You can find detailed instructions on how to access the CPC+ Practice Portal in Appendix G.

Table 11 cross-references each reporting domain with the quarter in which responses are required for Year 1.

Table 11: PY 2017 Reporting by Quarter

Care Delivery Change Title		Q1	Q2	Q3	Q4
Function 1: Access and Continuity		Q1	Q2	Q3	Q4
1.1	24/7 Access	●		●	
1.2	Enhanced Access and Communication		●		●
1.3	Empanelment	●	●	●	●
1.4	Continuity of Care	●		●	
Function 2: Targeted Care Management		Q1	Q2	Q3	Q4
2.1	Risk Stratification		●		●
2.2	Identifying Patients for Care Management	●	●	●	●
2.3	Care Management Staffing	●		●	
2.4	Care Plans		●		●
2.5	Coordinating with the Hospital and EDs Your Patients Use	●	●	●	●
2.6	Medication Management	●		●	
Function 3: Comprehensiveness and Coordination		Q1	Q2	Q3	Q4
3.1	Identifying and Communicating with Hospitals and EDs Your Patients Use	●		●	
3.2	Care Compacts/Agreements with High Volume Specialists/ Practitioners	●	(●)	(●)	(●)
3.3	Linkages with Social Services		●		●
3.4	Comprehensiveness			●	
3.5	Behavioral Health Integration		●		●
Function 4: Patient and Caregiver Engagement		Q1	Q2	Q3	Q4
4.1	Patient and Family Advisory Council	●	●	●	●
4.2	Engaging Patients and Caregivers in Your Practice		●		●
4.3	Support for Self-Management Across Conditions		●		●
4.4	Self-Management Support for Selected Conditions	●	(●)	(●)	(●)
4.5	Shared Decision Making				●
Function 5: Planned Care and Population Health		Q1	Q2	Q3	Q4
5.1	Team-Based Care	●		●	
5.2	Use of Data to Plan Care		●		●
5.3	Continuous Quality Improvement		●		●
5.4	Culture of Improvement at Your Practice		●		●
General	Reporting Point of Contact, CPC+ Payer Partners, Patient Demographics	●	(●)	(●)	(●)
When denoted by (●), prior responses for that reporting domain are only required to be updated.					

Care Delivery Questions[32]

Function 1: Access and Continuity

1.1 24/7 Access	Notes
Reporting Periods: Quarters 1 and 3	
Does a clinician or care team member **from your practice site** usually provide 24/7 coverage? ○ No, we do not provide 24/7 coverage ○ Yes ○ No, we have a centralized call-center for our health system (after-hours coverage for all practices in the system) ○ No, we have a formal coverage arrangement with another practice/ organization	*A **care team** is a group of individuals at your practice who work together to care for a specific panel of patients. The members on your care team providing 24/7 coverage must include only licensed medical practitioners (i.e., MD/DO, NP, PA).* *Note: If you answer "No, we do not provide 24/7 coverage," the next question is automatically skipped.*
Is 24/7 coverage provided **with real-time access** to your practice's EHR? ○ Yes ○ No	*__Real time__ refers to having access to current, up-to-date medical records in the EHR during off hours.*

1.2 Enhanced Access and Communication	Notes
Reporting Periods: Quarters 2 and 4	

When patients need it, my practice is able to provide…

	Never	Rarely	Some-times	Often	Always
… same or next-day appointments					
… office visits **during expanded hours** on the weekend, evening, or early morning					
… telephone advice on clinical issues **during office hours**					
… telephone advice on clinical issues **on weekends and/or after regular office hours**					
… email or portal advice on clinical issues					

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[32] Note: Some changes have been made to the care delivery questions since they were published in March 2017.

What functions can patients perform through your practice's secure patient portal? (Select all that apply)	*Note: If you select "My practice does not have a secure patient portal available for patients," you will be unable to select the other options for this question.*
☐ My practice does not have a secure patient portal available for patients ☐ Communicate with the care team ☐ Access lab/test results and clinical notes ☐ Schedule appointments ☐ Other, please specify: (textbox)	

Does your practice provide any of the following types of alternative visits (billable under traditional fee-for-service)?

	Total number of this type of visit provided in the last two quarters	Who primarily provided this service? (Select all that apply)						
		MD/ DO	NP/ PA	RN	MA	LPN	RD	Other: (textbox)
Home visits (i.e. primary care home visits)		☐	☐	☐	☐	☐	☐	☐
Medical group visits (e.g., shared medical appointments)		☐	☐	☐	☐	☐	☐	☐
Group education classes (e.g. DSME Diabetes Self-Management Education)		☐	☐	☐	☐	☐	☐	☐
Preventive counsel-ing services (e.g., reimbursable counseling for obesity, alcohol misuse, tobacco cessation)		☐	☐	☐	☐	☐	☐	☐
Medical nutrition consultation visits		☐	☐	☐	☐	☐	☐	☐
Visits in alternative locations (e.g., nursing facilities, hospitals, senior centers)		☐	☐	☐	☐	☐	☐	☐
Telehealth (or tele-medicine) and e-Visits		☐	☐	☐	☐	☐	☐	☐
Remote monitoring		☐	☐	☐	☐	☐	☐	☐
(textbox)		☐	☐	☐	☐	☐	☐	☐

This question refers to medical services that go beyond traditional face-to-face office-based visits that are currently reimbursable services through traditional fee-for-service (FFS) billing.

You will only have to provide information for the type of visits your practice is providing. You can use billing data or schedul-ing to provide an accurate number of billable visits.

Note: Track 2 practices are required to develop the capacity for alternative visits in 2017, and your practice may have used or plan to use the CPCP for this work, in addition to or instead of FFS billing.

Find more information about alternative office visits (page 15) under the change concept "ensure timely access to care" in Section I of this Guide.

(Optional) In addition to the alternative visit types described in the table above, what ways has your practice used Comprehensive Primary Care Payments to increase access outside of the traditional office visit? (textbox)	*Note: This question is for Track 2 CPC+ practices only. The CPCP is intended to support the flexible delivery of care to promote population health beyond traditional office visits.* *Find more information about the CPCP (page 58) under the change concept "use forecasting and accounting processes effectively to transform care and build capability to deliver comprehensive primary care" in Section I of this Guide.*

1.3 Empanelment

Notes

Reporting Periods: Quarterly

Do you <u>primarily</u> empanel patients by practitioner (i.e., each MD, DO, PA, or NP) or by care team (i.e., practitioner-led teams)? ○ Practitioner ○ Care Team	*A **care team** is a group of individuals at your practice who work together to care for a specific panel of patients.* *Note: Prior responses to this question are shown, and only need to be updated.*

Empanelment Status	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of panels at your practice:				
Total number of patients empaneled with a practitioner or care team at your practice:				
Total number of active patients at your practice:				
% of patients empaneled				

What is your active patient look-back period?
- ○ Less than one year
- ○ 1-2 years
- ○ More than two years

*Active patients for purposes of this table are patients who received care at your practice recently. A typical **look-back period** to identify active patients is at least a year, and usually 18 to 36 months, depending on your practice.*

Note: Prior responses to the question "What is your active patient look-back period?" are shown, and only need to be updated. Table cells with a diagonal pattern indicate content that is auto-calculated.

Find more information about empanelment (page 13) under the change concept "empanel all patients to a practitioner and/or care team" in Section I of this Guide.

1.4 Continuity of Care	Notes
Reporting Periods: Quarters 1 and 3	

Do you track continuity of care (in terms of how often patients see the practitioner or care team to which they are empaneled) for your patients?
 	
○ Yes
 	
    What system(s) do you primarily use to track continuity of care? (Select all that apply)
      ☐ EHR
      ☐ Electronic practice management systems (e.g., appointment scheduling system)
      ☐ Other, please specify: (text box)
 	
○ No
	Continuity of care refers to an ongoing relationship between a patient and the practitioner(s) or care team to which they are empaneled for the delivery of care.
	
	Find more information about <u>continuity of care</u> *(page 17) under the change concept "optimize continuity with practitioner and/or care team" in Section I of this Guide.*
	
	Note: If you answer "'Yes," the question asks for further details. If you answer "'No," the next question is automatically skipped.

What scheduling strategies do you use to optimize continuity of care? (Select all that apply) ☐ We do not use any strategies to optimize continuity of care ☐ Open scheduling ☐ Same day scheduling for urgent/acute care ☐ Tools to help patients identify their practitioner or care team (e.g., practitioner and care team photos on practice website) ☐ Other, please specify: (textbox)	*Note: If you select "We do not use any strategies," you will be unable to select the other options for this question.* *Find more information about* <u>open scheduling</u> *(page 15) under the change concept "ensure timely access to care" in Section I of this Guide.*

Function 2: Targeted Care Management

2.1 Risk Stratification	Notes
Reporting Periods: Quarters 2 and 4	
What type of **data-driven algorithm** do you use for risk stratifying your patients? (Select all that apply) ☐ We do not use a data-driven algorithm as part of our risk stratification ☐ Algorithm based on claims variables ☐ Algorithm based on clinical variables from the EHR ☐ Published clinical algorithm (e.g., AAFP risk tool) ☐ Other, please specify: (textbox)	*All practices must identify and prioritize a methodology to risk stratify all empaneled patients. Track 2 practices must further use a two-step risk stratification process:* *• Step 1 – Base risk stratification on defined diagnoses, claims, or another algorithm (i.e., not care team intuition)* *• Step 2 – Adds the care team's perception of risk (care team/ clinical intuition) to adjust the risk stratification of patients, on an as-needed basis*
What other factors do you consider when using **care team/clinical intuition** to stratify your patients? (Select all that apply) ☐ We do not use the care team's perception as part of our risk stratification ☐ Social needs ☐ Behavioral health needs ☐ Clinical factors that are not included in the algorithm ☐ Other, please specify: (textbox)	***Clinical intuition/care team perception** is a practitioner's and/or care team's knowledge of a patient and a global assessment of the patient's risk, which may include clinical, social, and behavioral risk. This is the second step in the risk-stratification process required of Track 2 practices.* *Find more information about <u>risk stratification and clinical intuition</u> (page 20) under the change concept "assign and adjust risk status for each patient" in Section I of this Guide.* *Note: If you select "We do not use the care team's perception," you will be unable to select the other options for this question.*

What prompts reassessment of a patient's risk stratification assignment?
 	
○ N/A
○ Ad hoc, or only as needed
○ Pre-specified clinical events (e.g., new diagnosis, hospitalization)
○ Automatically updated when new information is in the health IT or EHR platform
○ Schedule-driven protocol
    ○ At each patient visit
    ○ Every three to six months
    ○ Annually
    ○ Other, please specify: (textbox)
○ Other, please specify: (textbox)
	Note: If you select "Schedule-driven protocol," you will be prompted to indicate the frequency.

What system do you use for risk stratification? ☐ EHR-based platform ☐ Health IT or analytic platform that **is integrated** with the EHR ☐ Health IT or analytic platform that **does not integrate** with the EHR ☐ Other, please specify: (textbox)	

2.2 Identifying Patients for Care Management	Notes
Reporting Periods: Quarterly	

In the table below, please tell us how your patient population is risk stratified, using your practice's chosen risk stratification method.

Level of Risk *(highest risk at the top)*	Total number of patients in this tier	Number of patients in this tier under longitudinal care management	% of total empaneled patients in this risk tier	% of patients in this risk tier under longitudinal care management	This tier is used to target patients for care management
Not assigned					
Total empaneled patients					

Longitudinal care management is intensive, ongoing, relationship-based care for patients at highest risk for adverse, preventable outcomes. For this table, report your patient counts based on a convenient day or moment, as close as possible to the last day of the reporting quarter:

• Level of Risk: Generate a row for each risk tier in your risk-stratification method, and label the rows using the terminology your practice uses to define risk. Place risk tiers in descending order, with the highest risk tier at the top and the lowest at the bottom.

• Total number of patients in this tier: Indicate the number of patients in each risk tier using your practice's chosen risk stratification method.

• Number of patients under longitudinal care: Indicate the number of patients in each risk tier who were targeted for and received ongoing, longitudinal care management.

• Percent of total empaneled patients: This column will auto-calculate the percentage of empaneled patients in the risk tier.

• Percent of patients under longitudinal care management: This column will auto-calculate the percentage of active patients who are under care management.

• Target patients for care management: Mark the tier(s) used to target patients for longitudinal care management. For example, your practice may target patients for care management based on the highest risk tier.

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

Note: Table cells with a diagonal pattern indicate content that is auto-populated. These data are intended to help you track rates over time. For example, in Quarter 2, your Quarter 1 rates will be auto-populated and included in this column.

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., anticoagulants)
- ☐ Other, please specify: (text box)

***Episodic care management** is short-term, goal-directed care for patients whom your practice has not already targeted for longitudinal care management.*

Note: Prior responses to this question are shown, and only need to be updated.

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2.3 Care Management Staffing								**Notes**
Reporting Periods: Quarter 1								

What type of clinician and staff at your practice is/are **primarily responsible** for each of the following care management and coordination activities? **(Select all that apply)**

Activities	None	MD/DO	NP/PA	RN	MA	SW	Other: (textbox)
Developing and monitoring care plans	☐	☐	☐	☐	☐	☐	☐
Assessing and reassessing patient risk status	☐	☐	☐	☐	☐	☐	☐
Providing patient education and self-management support	☐	☐	☐	☐	☐	☐	☐
Coordinating care transitions (Hospital, ED discharges)	☐	☐	☐	☐	☐	☐	☐
Coordinating and communicating with specialty care	☐	☐	☐	☐	☐	☐	☐
Navigating patients to community and social services	☐	☐	☐	☐	☐	☐	☐
Clinical monitoring and following up with specific patients	☐	☐	☐	☐	☐	☐	☐
Scheduling needed appointments and tests	☐	☐	☐	☐	☐	☐	☐

Notes (for 2.3):

Please limit your reporting of data to the staff at your practice who spend the most amount of time on these activities, even if these activities are not among the staff's primary duties. If no one at your practice is performing these activities, then select "None'" the leftmost column of the table.

For example, if Medical Assistants (MAs) at your practice do the bulk of follow-up calls to patients, but a Registered Nurse (RN) sometimes fills in, the MA is the person primarily responsible for this activity. If an MA and an RN equally split the coordination, then select both.

2.4 Care Plans	**Notes**
Reporting Periods: Quarters 2 and 4	

Does your practice use care plans for patients under longitudinal care management?

- ○ No, we **do not use** care plans in our care management process.
- ○ We use care plans for **some** patients, on an ad hoc basis.
- ○ We use care plans for **some** patients, targeted based on conditions or other factors.
- ○ We systematically implement care plans for **all or most** patients under care management

Notes (for 2.4):

A __care plan__ is a mutually agreed upon and documented plan of care based on the patient's goals and available medical evidence, and is accessible to all team members providing care for the patient.

For purposes of CPC+, "care plans" and "plans of care" are used synonymously.

Note: If you answer "No, we do not use care plans," the following questions are skipped and you will move on to Section 2.5.

Do you have a routine process for monitoring, updating, and reviewing care plans?
 	
○ Yes
 	
    When are care plans reviewed and updated?
        ☐ Pre-specified changes in clinical status (e.g., new diagnoses, injuries, and exacerbations of illness)
        ☐ Routinely on a time-based schedule (e.g., monthly or at every visit)
        ☐ Other, please specify: (textbox)
○ No
	Note: If you answer "Yes," the question asks for further details.

Do you document and store care plans?
 	
○ No
○ Yes, care plans are **integrated** with the EHR
    They are included in the:
        ☐ Structured field
        ☐ Unstructured note
        ☐ Other, please specify: (textbox)
○ Yes, care plans are documented and stored but **not integrated** with the EHR
    They are included in the:
        ☐ Patient portal
        ☐ After-visit summary
        ☐ Standalone system or module in EHR not integrated with patient records
        ☐ Other, please specify: (textbox)
	Note: If you answer "Yes," the question asks for further details.

What type(s) of information are typically included in care plans? (Select all that apply) ☐ Treatment goals and interventions as identified by the care team ☐ Medication adjustments for changes in condition ☐ Patient's overall health goals ☐ Patient/caregiver's plans for self-management ☐ Patient/caregiver's plans for acute changes in condition ☐ Advance directives and preferences of care ☐ Plan for next update or review of care plan with patient and care team ☐ Contact information for practitioners and services involved in the patient's care, including contact options for after-hours coverage ☐ Other, please specify: (textbox)	

Who has real-time/point of care access to a patient's care plan? (Select all that apply) ☐ Members of the care team within the practice ☐ Clinicians outside of the practice (i.e. other specialists who care for the patient) ☐ Community and/or social service agencies and practitioners ☐ Patient and his/her caregiver(s) ☐ Other, please specify: (textbox)	*Real time* *refers to having access to current, up-to-date medical records in the EHR.*
How are care plans shared with clinicians outside of the practice (i.e. other specialists who care for the patient)? (Select all that apply) ☐ Care plans are not shared with other clinicians in a systematic way ☐ Shared through the EHR ☐ A local or regional health information exchange ☐ Electronic portal ☐ Fax/eFax ☐ Phone ☐ Secure email ☐ Other, please specify: (textbox)	*Note: If you select "Care plans are not shared with other clinicians in a systematic way," you will be unable to select any other options.*
How are care plans shared with patients and caregivers? (Select all that apply) ☐ Care plans are not shared with patients in a systematic way ☐ Patient portal ☐ At the time of a face-to-face visit ☐ Incorporated in the after-visit summary ☐ Other, please specify: (textbox)	*Note: If you select "Care plans are not shared with patients in a systematic way," you will be unable to select any other options.*

2.5 Coordinating with the Hospitals and EDs Your Patients Use

Notes

Reporting Periods: Quarterly

Identify the top hospital(s) and emergency departments (EDs) that your patients **generally** used the most over the last quarter.

Name of Hospital/ED	Hospital only	ED only	Both hospital and ED
A			
B			
C			

*Top hospital(s) and EDs are those hospital/EDs **used by the majority** of your patients. For example, if you are in an area with multiple hospitals, list up to three hospitals that are used most frequently by your patients.*

Indicate if each site you list here is used for just hospital admissions, ED visits, or both.

Note: Prior responses to this question are shown, and only need to be updated.

CPC+

2.5.1 Patient Follow-up

In the table below, provide the counts of your patients discharged from the emergency department (ED) in the last quarter and those who received follow-up contact within one week after visiting the ED. This table auto populates based on which ED(s) you indicated in 2.5.

Name of ED (Generated from the table above)	Number of patient discharges from this ED	Number of patient discharges from this ED with follow-up within one week	% of discharges with follow-up within one week	We do not track discharges from this ED
A				
B				
C				
Overall discharges and follow-ups				

Overall Rate	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Overall ED follow-up rate				

*In the table, provide the counts of your **empaneled patients** discharged from the **ED** during the reporting quarter and those who received follow-up contact within one week after visiting the ED. Note that an individual patient may have more than one discharge, and we are counting the number of discharges, not patients.*

This table asks you to report on total numbers for the reporting quarter. For example, the Quarter 1 date range is 1/1/17-3/31/17.

*• **Name of ED:** A row is generated for each ED you listed in the previous question.*

*• **Number of patient discharges:** Indicate the number of empaneled patient discharges during the reporting quarter.*

*• **Number of patient discharges with follow-up:** Indicate the number during the reporting quarter.*

*• **Percent of discharges with follow-up:** This column will auto-calculate.*

*• **We do not track discharges:** If you select this, you will not be able to enter discharge or follow-up numbers for those ED(s).*

Note: The overall rates for discharges and follow-ups are auto-calculated once all of your data have been entered. Table cells with a diagonal pattern indicate content that is auto-calculated.

2.5.1 Patient Follow-up

In the table below, provide the counts of your patients discharged from the hospital in the last quarter and those who received follow-up contact within two business days after hospital discharge. This table auto populates based on which Hospital(s) you indicated in 2.5.

Name of Hospital	Number of patient discharges from this hospital	Number of patient discharges followed by contact within 72 hours or 2 business days	% of discharges with follow-up within 72 hours or 2 business days	We do not track discharges from this hospital (checkbox)
A				
B				
C				
Overall discharges and follow-ups				

Overall Rate	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Overall Hospital follow-up rate				

*In the table, provide the counts of your **empaneled patients** discharged from the **hospital** during this quarter and those who received follow-up contact within 72 hours or 2 business days after visiting the hospital. Note that an individual patient may have more than one discharge, and we are counting the number of discharges, not patients.*

This table asks you to report on total numbers for the reporting quarter. For example, the Quarter 1 date range is 1/1/17-3/31/17.

*• **Name of hospital:** A row is generated for each hospital you listed in the previous question.*

*• **Number of patient discharges:** Indicate the number during the reporting quarter.*

*• **Number of patient discharges with follow-up:** Indicate the number during the reporting quarter.*

*• **Percent of discharges with follow-up:** This column will auto-calculate.*

*• **We do not track discharges:** If you select this, you will not be able to enter discharge or follow-up numbers for those ED(s).*

Note: The overall rates for discharges and follow-ups are auto-calculated once all of your data have been entered. Table cells with a diagonal pattern indicate content that is auto-calculated.

2.6 Medication Management	Notes
Reporting Periods: Quarters 1	

The intent of this section is to learn more about your practice's medication management strategies and activities of your practice. More information about underlined medication management (page 34), can be found under the change concept: manage medications to maximize efficiency, effectiveness, and safety in Section I of this Guide.

What type of clinician and staff at your practice is/are primarily responsible for each of the following medication management activities? **(Select all that apply)**

Services	None	MD/DO	RN	Care Manager	Pharm.D	Pharmacy Tech.	Other: (textbox)
Routine medication reconciliation at scheduled visits	☐	☐	☐	☐	☐	☐	☐
Coordination and reconciliation of medication during transitions of care	☐	☐	☐	☐	☐	☐	☐
Comprehensive medication reviews	☐	☐	☐	☐	☐	☐	☐
Formulary management	☐	☐	☐	☐	☐	☐	☐
Patient support for medication use and self-management	☐	☐	☐	☐	☐	☐	☐
Collaborative drug therapy management	☐	☐	☐	☐	☐	☐	☐

Please limit this to the staff at your practice that spend the most amount of time on these activities, even if these activities are not the staff's primary duty. If no one at your practice is performing these activities, then select "None" at the bottom of the table.

For example, if RNs at your practice do the bulk of medication management activities, but an NP sometimes fills in, the RN is the person primarily responsible for this activity. If an NP and an RN equally split the coordination, then select both.

Note: If you select "None," you will be unable to select any other options. If you use credentialed staff not listed in the table (e.g., NP/PA), check "Other," and use the textbox. Also, "Pharm.D" in column five is an abbreviation for Pharmacist.

Does your practice use a specific model of care or strategy for medication management services?
- ☐ No, we do not use a specific model of care or strategy
- ☐ AMA's STEPS*forward* /SafeMed Model
- ☐ Medications at Transitions and Clinical Handoffs (MATCH) Model
- ☐ Practice developed protocol
- ☐ Other, please specify: (text box)

Note: If you select "No," for this question, you will be unable to select the other options. If you are not familiar with a specific model of care or strategy, then do not indicate that your practice is using this approach.

How does the practice engage pharmacist(s) as part of the care team? (Select all that apply) ☐ We do not formally engage pharmacists ☐ Direct hire ☐ Shared resource for practices in our health system ☐ Contract ☐ Relationship with a teaching facility ☐ We use a non-pharmacist with prescribing authority for medication management Specify practitioner type: (textbox) ☐ Other agreement, please specify: (textbox)	*Note: If you select "We do not formally engage pharmacists," the next two questions will be automatically skipped.*
How many pharmacists work at the practice? (textbox)	*Please include all pharmacists who are engaged with your care team, including those who are not physically located at your practice full-time.* *Note: If you select "We do not formally engage pharmacists," this question is automatically skipped.*
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. (textbox)	*Please include the hours worked by pharmacists engaged with your care team, whether or not pharmacists' services were physically provided at your practice.* *Note: If you select "We do not formally engage pharmacists," this question is automatically skipped.*
How do you identify patients for medication management services with a pharmacist (beyond routine medication reconciliation)? (Select all that apply) ☐ We do not systematically select patients for medication management services ☐ High risk tier based on risk stratification ☐ Not achieving a therapeutic goal for a chronic condition ☐ Experiencing a care transition(s) ☐ Direct practitioner referral ☐ Number of medications taken (poly-pharmacy) ☐ Use of high risk medication(s) ☐ Use of high cost medications(s) ☐ Other, please specify: (textbox)	*Note: If you select "We do not systematically select patients for medication management services," you will be unable to select the other options for this question.*

Function 3: Comprehensiveness and Coordination

3.1 Identifying and Communicating with Hospitals and EDs Your Patients Use	Notes
Reporting Periods: Quarters 1 and 3	

Tell us how you coordinate and communicate about admission/ discharge/transfer (ADT) information with the hospitals and EDs where your patients seek care. This table auto-populates based on which hospitals/EDs you indicated in 2.5.	*These questions assess the extent to which your practice communicates and coordinates with hospitals and EDs.*

Hospital/ ED	How promptly do you receive ADT information about your patients seen at this hospital/ED?	How do you receive ADT information from this hospital/ED?
Name of hospital/ED auto-populated (textbox)	○ We do not receive this information ○ At time of event ○ Within 1 day ○ Within 1 week ○ Within 2 weeks ○ More than 2 weeks	○ Practice pulls information: We periodically seek updates from hospital. ○ Hospital pushes information: Hospital sends a periodic (e.g., daily or weekly) report for all admitted or discharged patients. ○ Hospital pushes information: Hospital sends patient-specific alerts to the practice.

Find more information about admission/discharge/transfer (ADT) between practices/ hospitals/EDs (page 37) under the change concept "provide effective care coordination, navigation, and active referral management in the medical neighborhood" in Section I of this Guide.

"Patient-specific alerts" are sent in real time, versus in periodic reports.

Note: If you select "We do not receive this information," you will be unable to select any other options.

What communication vehicle do you use to obtain ADT information? (Select all that apply)
- ☐ Phone
- ☐ Fax
- ☐ Email
- ☐ Health Information Exchange (HIE)
- ☐ Access to hospital EHR/hospital portal Access
- ☐ Other, please specify: (textbox)

Our method of care coordination…

	Never	Rarely	Some-times	Often	Always
…ensures all practitioners in the practice have access to information about patient care conducted outside of our practice.					
…effectively tracks patients after referral.					

CPC+

3.2 Care Compacts/Agreements with High Volume Specialists/ Practitioners	Notes
Reporting Periods: Quarterly	

Note: For auditing purposes, you are required to retain a copy of your signed care compacts/collaborative agreements for 10 years per CMS policy.

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

☐ We have not established care compacts/collaborative agreements.

Specialists

☐ Allergy/Infectious disease   ☐ Ophthalmology
☐ Cardiology   ☐ Optometry
☐ Dermatology   ☐ Orthopedic surgery
☐ Emergency medicine   ☐ Palliative care
☐ Endocrinology   ☐ Pain management
☐ ENT/Otolaryngology   ☐ Podiatry
☐ Gastroenterology   ☐ Psychiatry
☐ Hospitalist care   ☐ Radiology
☐ Nephrology   ☐ Rheumatology
☐ Neurology   ☐ Surgery
☐ Obstetrics/Gynecology   ☐ Urology
☐ Oncology/Hematology

Other Specialty Care

☐ Behavioral Health   ☐ Pharmacist
☐ Physical Therapy   ☐ Nutritionist/Dietician services
☐ Podiatry

Other

☐ Urgent care or after hours care
☐ Home health agency
☐ Other, please specify: (textbox)

Collaborative care agreements (care compacts/collaborative agreements) are established with other practitioners or health care organizations to create formal working relationships and common expectations around roles, flow of information, and shared plans for management.

For purposes of CPC+, "care compacts," "collaborative care agreements," and "collaborative care agreement s" are synonymous.

Note: If you select "We have not established care compacts/collaborative agreements," you will be unable to select the other options for this question. Prior responses to this question are shown, and only need to be updated.

Find more information about care compacts and collaborative care agreements (page 38) under the change concept "establish collaborative care agreement s" in Section I of this Guide.

Please indicate the source(s) of the care compact(s) you use.

☐ American Academy of Pediatrics
☐ American College of Physicians
☐ American Academy of Family Physicians
☐ We use a practice-developed or customized care compact template
☐ Other, please specify: (textbox)

Note: If you select "We have not established care compacts/collaborative agreements" in the previous question, this question is automatically skipped. Prior responses to this question are shown, and only need to be updated.

What components are typically included in your care compacts? (Select all that apply) ☐ We have not established care compacts/collaborative agreements ☐ Sharing data: accurate and up-to-date clinical records ☐ Sharing data: practice-level quality and performance measures ☐ Requirements related to content, timing, and method of communication ☐ Defined responsibilities for patient care and communication throughout the referral process ☐ Defined responsibilities for clinical co-management of specific conditions ☐ Protocols for requesting and conducting referrals ☐ Other, please specify: (textbox)	*Note: If you select "We have not established care compacts/ collaborative agreements," you will be unable to select the other options for this question. Prior responses to this question are shown, and only need to be updated.*

3.3 Linkages with Social Services	**Notes**
Reporting Periods: Quarters 2 and 4	
What social need domains are **most prevalent** in your patient population? (Select all that apply) ☐ We have not identified prevalent social needs in our population ☐ **Food insecurity:** limited or uncertain access to adequate and nutritious food ☐ **Housing instability**: homelessness, unsafe housing quality, inability to pay mortgage/rent, eviction ☐ **Utility needs:** difficulty paying utility bills, shut off notices, disconnected phone ☐ **Financial resource strain:** inability to pay for basics such as food and medical care ☐ **Transportation:** difficulty accessing/affording transportation (medical or public) ☐ **Employment:** under-employment/unemployment ☐ **Social isolation**: lack of family and/or friend networks, minimal community contacts, absence of social engagement ☐ **Safety:** intimate partner violence, elder abuse, community violence ☐ **Other**, please specify**:** (textbox)	*Prevalent* refers to social needs that are frequently found in your patient population. Only check the social needs that impact a significant portion of your patients. *Note: If you select "We have not identified prevalent social needs in our population," you will be unable to select the other options for this question.*
Do you track demographics from your patients? (e.g., race/ethnicity, educational attainment, family income level, employment status) ○ No ○ Yes, outside of the EHR or health IT platform ○ Yes, in the EHR or other health IT platform	

Do you screen your patients for unmet social needs? ○ We **do not screen** patients for unmet social needs ○ We screen **targeted patients** with high risk that are more likely to suffer from unmet social needs (e.g., depression, hypertension and diabetes) ○ We universally screen **all patients** for unmet social needs	*Note: If you select "We do not screen patients for unmet social needs," the next two questions are automatically skipped.*
Which screening tool(s) or question(s) do you use to capture unmet social needs in your patient population? (Select all that apply) We do not regularly use any standard screening tools ☐ HealthLeads screening tool ☐ Institute of Medicine (IOM) recommendations for social and behavioral domains ☐ HealthBegins screening tool ☐ WeCARE screening tool ☐ Accountable Health Communities (AHC) screening tool ☐ Other, please specify: (textbox)	*The intent of this question is to understand what screening questions or tools you are using to assess the unmet social needs of your patient population.* *Note: If you select "We do not screen patients for unmet social needs" in the previous question, this question is automatically skipped.* *Find more information about social needs screening (page 39) under the change concept "establish effective linkages with neighborhood/ community-based resources to support patient health goals and health-related social needs" in Section I of this Guide.*
Are these screening tools integrated with your EHR? ○ Yes ○ No	*Note: If you select "We do not screen patients for unmet social needs" in the previous question, this question is automatically skipped.*

3.3.1 Coordinating with Social Service Resources	*In CPC+, the **inventory** is a catalog or a listing of social service resources available in your community that your practice uses to meet your patients' social needs. Your practice may create your own or use an existing inventory.*
How frequently is the inventory of social service resources your practice uses updated?	
○ We do not maintain or have access to an inventory of these resources	*Find more information about social service inventories (page 40) under the change concept "establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs" in Section I of this Guide.*
○ Ad hoc basis only	
○ At least monthly	
○ Every 2-6 months	
○ Every 6-12 months	
○ Less than annually	*Note: If you select "We do not maintain or have access to an inventory of these resources," you will be unable to select the other options.*
Is the inventory of social service resources integrated with your EHR? ○ Yes ○ No	*Note: If you select "We do not maintain or have access to an inventory of these resources," in the previous question, this question is automatically skipped.*

How available and accessible are community and government social service resources in your community?

	Unknown	Inadequate	Moderate	Adequate
State programs (e.g., Area Agency on Aging (AAA), Aging and Disability Resource Centers (ADRC))				
Long-term services and supports (for patients needing assistance with daily self-care tasks)				
Home and Community-Based Services (through Medicaid waiver)				
Financial services (e.g., TANF, SSDI/SSI)				
Government nutrition assistance (e.g., SNAP, WIC)				
Information and access services (e.g., 211, eldercare.gov)				
Temporary and permanent housing resources				
Food resources (e.g., food pantries, Meals on Wheels)				
Transportation resources				
Other: (textbox)				

The intent of this question is to understand which social service resources are available, and to what extent these services are available in your community, based on information you have gathered or accessed.

Inadequate could mean that this resource does not exist at all in your community, or that an organization exists, but your patients are unable to access those services for any reason, such as a long waiting list, transportation, and/or financial barriers.

Adequate means that the resource or organization exists in the community, and the services provided are accessible to your patients when they need them.

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

Our method of coordinating with social services…

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
…integrates with clinical workflow.					
…uses designated staff to coordinate referrals.					
…creates structured referrals.					
…helps patients identify resources in the community.					

3.4 Comprehensiveness	Notes
Reporting Periods: Quarter 3	

Based on your population needs, identify 1-3 services your practice plans to further develop in the upcoming year. We will ask you the following questions for each of the following types of service**:** ○ Behavioral health care ○ Chronic pain management ○ Gynecological services ○ Palliative care ○ Medication therapy management (MTM) ○ Other, please specify: (textbox) **Why are you choosing this service?** (Select all that apply) ☐ Common need in my patient population ☐ Not available for my patients in community ☐ More cost-efficient to deliver this service at the primary care setting (e.g., high-cost referral) ☐ Improve convenience and access for patients ☐ Other, please specify: (textbox) **How is the service currently provided?** ○ Referral to specialist ○ Co-management: relationship with a specialist via a care compact ○ Co-location: specialist care at the primary care practice ○ In our practice, by primary care clinicians **How do you plan to develop this service for your patients?** ○ Co-management: relationship with a specialist via a care compact ○ Co-location: specialist care at the primary care practice ○ In our practice, by primary care practitioners ○ Other, please specify: (textbox)	*Comprehensiveness refers to your practice's ability to meet the majority of your patient population's medical, behavioral, and health-related social needs in pursuit of each patient's health goals.* *Find more information about medical, behavioral, and health-related social needs (page 30) under the change concept "increase capability to manage medical conditions in the primary care setting that meet the needs of the practice population" in Section I of this Guide.* *In this question, you are sharing information on your practice's initial considerations and decision making as you begin to enhance comprehensiveness to meet your patients' needs.*

3.5 Behavioral Health Integration	Notes
Reporting Periods: Quarters 2 and 4	

Tell us about your behavioral health integration strategies.

☐ We are not integrating or planning to integrate behavioral health at our practice.

	Primary Strategy	Secondary Strategy	In planning (not yet implemented)	We use telemedicine to support this strategy
Primary care practitioner delivers behavioral health care				
Specialty referral				
Established care compact/referral agreement with behavioral health practitioners				
Co-management between primary care and behavioral health care				
Care Management (proactive, relationship-based care management for mental health condition)				
Primary Care Behaviorist Model (behavioral health professional co-located and integrated into workflow)				

Are behavioral health and medical practitioners involved in care in a standard way across all of your practice's practitioners and patients who need behavioral health services?

○ Yes

○ No

Does this type of behavioral health staff support your behavioral health strategy at your practice site?				*Please list all the staff that support your behavioral health strategy at your practice, even if supporting this strategy is not the staff's primary duty.*
Staff Type	No	Yes, less than half a day per week	Yes, more than half a day per week	
Practitioner (MD/DO/NP/PA)				
Health Educator				
Care Manager (specify)				
Nurse (RN/LPN)				
Psychologist				
Psychiatrist				
Psychiatric NP				
Substance Abuse Counselor				
Social Worker (LCSW)				
Other: (textbox)				

What mental health conditions are you targeting with your behavioral health strategy? (Select all that apply)

- ☐ Anxiety Disorders
- ☐ Dementia
- ☐ Depressive Disorders
- ☐ Chronic Pain
- ☐ Complex/chronic disease and comorbidities (e.g., major depressive disorder and poorly controlled diabetes)
- ☐ High risk behaviors (e.g., tobacco use, obesity, and medication adherence)
- ☐ Insomnia
- ☐ Substance Abuse
- ☐ Other, please specify: (textbox)

3.5.1 Behavioral Health Capabilities and Supports

Do you have the following capabilities currently in place to support behavioral health at your practice?

	Yes	No	In plan-ning	N/A
Screening for behavioral health conditions as standard practice				
Registries and/or EHR functionality to track care of patients with behavioral health conditions				
Ability to monitor and assess treatment response and behavioral health outcomes at your practice (e.g., using validated scales such as PHQ-9)				
Method to share medical records between behavioral health and primary care clinicians				

What payment mechanisms do you use to support behavioral health integration? (Select all that apply)	Note: We are asking about all types of payment mechanisms your practice is using to support BHI, not limited to Medicare or CPC+ related funding.
☐ Fee-for-service (FFS) reimbursement ☐ CPC+ care management fee ☐ CPC+ CPCP ☐ Payer funding specifically for behavioral health services ☐ Grant funding ☐ Quality incentives or bonus payments from your health system ☐ Quality incentives or bonus payments from payers ☐ Other, please specify: (textbox)	

What types of targeted tactics are available for your patients?

	Provided within the practice	Available outside of the practice with external practitioners	Not available or in planning
SBIRT (e.g., alcohol misuse)			
Evidence-based psychotherapy (e.g., CBT, PST)			
Self-management support for behavioral health conditions			
Counseling for behavior change (e.g., smoking cessation, weight loss)			
Other: (textbox)			

SBIRT – Screening, Brief Intervention, Referral to Treatment

CBT – Cognitive behavioral therapy

PST – Problem-solving therapy

Find more information about BHI tactics (page 33) under the change concept "integrate behavioral health services to support patients' common and complex behavioral health needs" in Section I of this Guide.

Function 4: Patient and Caregiver Engagement

4.1 Patient and Family Advisory Council (PFAC)	Notes
Reporting Periods: Quarterly	
How integrated is the PFAC is at your practice? ○ 1 – PFAC is still in planning or in development ○ 2 ○ 3 – PFAC ideas and recommendations are occasionally integrated into practice improvement processes ○ 4 ○ 5 – PFAC ideas and recommendations are fully integrated into our practice improvement processes	*The intent of this question is to understand where your practice is in the development of PFACs.* *Find more information about* PFACs *(page 45) under the change concept "engage patients and caregivers to guide improvement in the system of care" in Section I of this Guide.* *Note: Options "2" and "4" are midpoints on the scale from 1-5 for where your practice is in the development of PFACs.*
Which of the following steps has your practice achieved to integrate the PFAC in your practice? (Select all that apply) ☐ Identified staff participants ☐ Recruited patient participants ☐ Defined mission and vision of PFAC ☐ Determined structure of PFAC (e.g., number of patients or family advisors, frequency of meetings, term lengths, and other meeting logistics) ☐ Developed a sustainability plan for the PFAC ☐ We haven't taken any of these steps yet	*The steps listed here for PFAC integration are not necessarily sequential.*
Identify the number of meetings held by your practice's PFAC in the past quarter: (textbox)	*Note: For audit purposes, you are required to retain all meeting minutes for 10 years per CMS policy. Track 1 practices are required to convene a PFAC at least once in 2017, and Track 2/CPC Classic practices are required to convene a PFAC in at least two quarters during 2017.*
Who typically meets with or is a part of your PFAC?	*The intent of this question is to better understand who is participating in your PFAC. Please estimate the average make-up of your PFAC. Exact numbers are not necessary.*

Role	Number of Individuals
Practitioners (MD/DO, NP, PA)	
Clinical staff (RN, LPN, MA, care manager)	
Patients and family/caregivers	
Non-clinical staff (e.g., administration, front office, IT)	
Other: (textbox)	

Rate how well your PFAC reflects your practice's overall patient population (i.e., based on factors such as age, gender, race, socioeconomic status, language, or medical conditions) ○ Not applicable, or PFAC is still in development ○ Not at all representative ○ Slightly representative ○ Moderately representative ○ Very representative ○ Completely representative	*Find more information about* *Patient and Family Advisory Councils (PFAC) (page 45) under the change concept "engage patients and caregivers to guide improvement in the system of care" in Section I of this Guide.*

4.2 Engaging Patients and Caregivers in Your Practice

Reporting Periods: Quarters 2 and 4

Notes

We engage patients and caregivers as equal partners in…

	Never	Rarely	Some-times	Often	Always
…developing agendas for PFAC meetings.					
…establishing improvement projects.					
…communicating results of improvement projects.					

Equal partners in care refers to the care team actively listening to and involving patients and caregivers in setting health goals and making decisions in an environment of mutual respect.

Besides your PFAC, how do you engage patients and caregivers in practice improvement processes? (Select all that apply)
- ☐ Patient surveys
- ☐ Community meetings
- ☐ Facebook page or other social media site
- ☐ Website/portal
- ☐ Suggestion box
- ☐ Focus groups
- ☐ Other, please specify: (textbox)

What areas of practice changes <u>were influenced by patient and caregiver input</u> in the last two quarters? (Select all that apply) ☐ We did not implement changes based on patient and caregiver input ☐ Governance policies and procedures ☐ Patient education and outreach ☐ Communication and customer service ☐ Patient portal/Patient Health Record changes ☐ Practice capabilities to serve unmet medical needs in the population ☐ Working with high-risk patients (e.g., risk stratification methodology, care plan development, medication management, self-management support) ☐ Patient access and flow (e.g., scheduling, office hours, front office staffing, wait times, forms, etc.) ☐ Linkages to community-based social services ☐ Coordination with medical neighborhood (e.g., tracking and follow-up from hospital/ED/diagnostic studies, coordination with specialists, etc.) ☐ Other, please specify: (textbox)	*Input includes all forms of patient and caregiver engagement, including PFACs and other strategies.* *Note: If you select "We did not implement changes based on patient and caregiver input," you will be unable to select the other options for this question.*
How did your practice communicate about practice changes to your patients in the last two quarters? (Select all that apply) ☐ We did not communicate changes to our patients ☐ Materials distributed at the office (e.g., brochures, posters, written notice on visit summary) ☐ Materials distributed outside of the office (e.g., newsletters, mailings, social media) ☐ Website or patient portal/Patient Health Record ☐ Public reporting through local/regional collaboratives or press releases ☐ Other, please specify: (textbox)	*Note: If you select "We did not communicate changes to our patients," you will be unable to select the other options for this question.*

4.3 Support for Self-Management Across Conditions	Notes
Reporting Periods: Quarters 2 and 4	

How frequently does your practice implement each of the following aspects of self-management support to patients and caregivers?

	Never	Rarely	Some-times	Very often	Always
We encourage patients to choose goals that are meaningful to them					
We include family/caregivers in goal-setting and care plan development					
We connect patients and caregivers with self-management support programs that help them maintain wellness at home					
We measure patients' skills and progress (e.g., How's My Health, Patient Activation Measure)					

Self-management support refers to help given to people with chronic conditions that enables them to manage their health on a day-to-day basis.

Find more information about self-management support (page 47) under the change concept "integrate self-management support into usual care across conditions" in Section I of this Guide.

Which self-management support techniques are staff trained in at your practice? (Select all that apply)

☐ Staff are not trained in self-management support techniques
☐ Motivational interviewing
☐ 5 A's (Ask, Advise, Assess, Assist, Arrange)
☐ Teachback
☐ Reflective listening
☐ Other, please specify: (textbox)

If you are currently training your staff in any of the listed options for self-management support (SMS) techniques, please select these options.

Note: Track 1 practices are required to assess practice capability and plan for support of patients' self-management during 2017.

Note: If you select "Staff are not trained in self-management support techniques," you will be unable to select the other options for this question.

4.4 Self-Management Support for Selected Conditions	Notes
Reporting Periods: Quarterly	

For which conditions did your practice provide self-management support in the last quarter? (Select all that apply) ☐ We did not select any conditions for self-management support. Cardiovascular ☐ Congestive Heart Failure (CHF) ☐ Hyperlipidemia/high ☐ Coronary Artery Disease (CAD) cholesterol Respiratory/Pulmonary ☐ Asthma ☐ COPD Mental Health ☐ Depression Substance misuse ☐ Alcohol misuse ☐ Tobacco cessation ☐ Opioid misuse Other ☐ Chronic pain ☐ Diabetes ☐ Hypertension ☐ **Other**, please specify: (textbox) ☐ Obesity/weight Loss	*CPC Classic practices and Track 2 practices are required to pick 3 conditions for SMS in 2017.* *Note: If you select "We did not select any conditions for self-management support," you will be unable to select the other options for this question. Prior responses to this question are shown, and only need to be updated.*
How do you identify patients for self-management support? (Select all that apply) ☐ We do not systematically identify patients for self-management support ☐ All patients with targeted condition ☐ General risk status (using the practice's risk stratification methodology) ☐ Poorly controlled disease ☐ Data from a formal self-management assessment tool ☐ Patient expression of interest ☐ Clinician referral/identification ☐ Other, please specify: (textbox)	*Note: If you select "We do not systematically identify patients for self-management support," you will be unable to select the other options for this question.*

4.5 Shared Decision Making	Notes
Reporting Periods: Quarter 4	

The intent of this section is to assess the capability of your care teams for shared decision making.

How do clinicians and staff at your practice involve patients with preference-sensitive conditions in shared decision making? (Select all that apply)

☐ We do not implement shared decision making for specific conditions

☐ Discuss preferences for care with patients with targeted preference-sensitive conditions

☐ Distribute decision aids to patients with targeted preference-sensitive conditions

☐ Document patients' decisions after shared-decision making

For which preference-sensitive health conditions, decisions, or tests of focus is your practice implementing shared decision making? (Select all that apply)

☐ We did not select any preference-sensitive health conditions, decisions, or tests of focus for shared decision making.

Therapeutic options in management

☐ Low back pain (acute or chronic)

☐ Insomnia

☐ Chronic pain

☐ Adult sinusitis

☐ Depressive disorders

☐ Osteoarthritis of the hip or knee

☐ Chronic stable angina

☐ Tobacco cessation choices in approach (e.g., classes, medication)

☐ Osteoporosis management and medication choices

☐ Care preferences over the life continuum (e.g., end-of-life decisions and advance care planning)

Medication choices

☐ Asthma management

☐ Congestive heart failure management

☐ COPD management

☐ Diabetes management

☐ Anticoagulation for atrial fibrillation

☐ Hypertension management

☐ Statin use

☐ Antibiotic use for acute infections

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.

Preference-sensitive conditions are conditions where multiple treatment options exist and there is not a consensus supporting a single recommended pathway of care.

Decision aids are tools designed to support patient decision making in preference-sensitive care.

Note: If you select "We do not implement shared decision making for specific conditions," you will be unable to select the other options for this question.

Find more information about shared decision making (page 49) under the change concept "engaging patients in shared decision making" in Section I of this Guide.

Screenings
    ☐ Prostate cancer screening
    ☐ Mammography for patients age 40 – 49 or over the age of 75
    ☐ Lung cancer screening
    ☐ Colon cancer screening
    ☐ Other, please specify: (textbox)	

How do you identify patients for shared decision making? (Select all that apply)
    ☐ We do not systematically identify patients for shared decision making
    ☐ Ad hoc basis only, no established process or protocol
    ☐ Clinician or care team referral, based on clinical intuition
    ☐ Clinician or care team identification, based on routine established protocols
    ☐ Automatic flags built into EHR or health IT platform
    ☐ Other, please specify: (textbox)
	Note: If you select "We do not systematically identify patients for shared decision making," you will be unable to select the other options for this question.

Function 5: Planned Care and Population Health

5.1 Team-Based Care	Notes
Reporting Periods: Quarters 1 and 3	

Please select the member roles found on your typical care team and estimate average number of hours spent by each on a single care team per week.

Role	Average number of hours per week spent with each care team
Physician	
Nurse Practitioner (NP)	
Physician Assistant (PA)	
Registered Nurse (RN)	
Medical Assistant (MA)	
Licensed Practice Nurse (LPN)	
Care Manager	
Behavioral Health Specialist	
Pharmacist	
Dietician or Nutritionist	
Administrative Staff	
Other: (text box)	

Notes:

*A **care team** is a group of individuals at your practice who work together to care for a specific panel of patients.*

*The intent of the question is to understand the composition of your **established care teams**. For example, if you have four full-time physicians at your practice in four care teams, the average number of hours for a physician would be 40 hours. If you have one care manager who splits his or her time between two care teams, then the average number of hours per week would be 20 hours. Approximations are fine.*

Team-based care hours can include activities like pre-visit huddles and scheduled care team meetings.

Find more information about team-based care (page 52) under the change concept "engaging patients in shared decision making" in Section I of this Guide.

Note: Prior responses to this question are shown, and only need to be updated.

How often are the following clinical activities delegated to members of the care team besides the physician/practitioner (e.g., RN, MAs, front desk staff, other care managers)?

	Never	Rarely	Some-times	Often	Always
Direct patient care activities (e.g., patient education, self-management support activities)					
Patient assessments (e.g., assessing lifestyle factors, screening)					
Communicating with patients (e.g., answering messages from patients)					

What communication structures and processes do care teams use and how often? (Select all that apply)	*Note: When you select "Structured pre-visit huddles," "Scheduled care team meetings," or "Other," you will be prompted to indicate the frequency.*

☐ Structured pre-visit huddles
    ○ Not routinely, or ad hoc
    ○ Daily
    ○ Every 1-2 weeks
    ○ Monthly
    ○ Other, please specify: (textbox)
☐ Scheduled care team meetings to discuss high-risk patients and planned care
    ○ Not routinely, or ad hoc
    ○ Daily
    ○ Every 1-2 weeks
    ○ Monthly
    ○ Other, please specify: (textbox)
☐ Other, please specify: (textbox)
    ○ Not routinely, or ad hoc
    ○ Daily
    ○ Every 1-2 weeks
    ○ Monthly
    ○ Other, please specify: (textbox)	

5.2 Use of Data to Plan Care	Notes
Reporting Periods: Quarters 2 and 4	

The intent of these questions is to understand how your practice is using your data, and how valuable the data are to your quality improvement work.

Tell us about how you use data on quality, utilization, patient experience and other measures. We will ask you the following three questions for each type of data (listed below the questions). **At what level is it available?** ○ Not available ○ Practice level ○ Care team or panel level ○ Both the practice and the care team/panel level **How frequently do care teams review this data?** ○ Weekly ○ Monthly ○ Quarterly ○ Annually **How helpful is this data** (list below) **in quality improvement or population health work at your practice?** (Rate from 1-5, with 5 being the most helpful and 1 being not helpful at all) List of data sources: • Electronic Clinical Quality Measures (eCQMs); • Claims feedback from CMS; • Claims feedback from other payers; • Patient experience data; • Patient Reported Outcome Measures (PROM); • Multi-payer data from health information exchange (HIE), all payer claims databases (APCD), or other data aggregator; • Public health data from county or state government; • Other, please specify: (textbox)	*Find more information about using data to improve care (page 60) under the change concept "build the analytic capability required to improve care and lower costs for the practice population" in Section I of this Guide.*

How does your practice use available data (e.g., quality metrics, utilization data, payer reports) to inform quality improvement? □ Identify specific patients with gaps or high risk □ Identify groups or specific conditions to focus on □ Identify opportunities for improvement in existing services at the practice □ Identify new services to provide within the practice □ Identify practitioners outside of the practice with to coordinate with □ Other, please specify: (textbox)	

5.3 Continuous Quality Improvement	Notes
Reporting Periods: Quarters 2 and 4	

Identify the CPC+ measures on which your practice **focused its quality improvement efforts** <u>during the past two quarters</u>. (Select all that apply) <u>eCQMs</u> ☐ Depression Remission at Twelve Months ☐ Controlling High Blood Pressure ☐ Diabetes: Eye Exam ☐ Dementia: Cognitive Assessment ☐ Pneumococcal Vaccination Status for Older Adults ☐ Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ☐ Breast Cancer Screening ☐ Cervical Cancer Screening ☐ Colorectal Cancer Screening ☐ Use of High-Risk Medications in the Elderly ☐ Falls: Screening for Future Falls Risk ☐ Documentation of Current Medications in the Medical Record ☐ Preventive Care and Screening: Screening for Depression and Follow-Up Plan ☐ Diabetes: Hemoglobin HbA1c Poor Control (>9%) ☐ Use of Imaging Studies for Low Back Pain ☐ Closing the Referral Loop: Receipt of Specialist Report ☐ Other, please specify: (textbox) <u>Utilization and cost</u> ☐ ED ☐ Inpatient ☐ Specialty care ☐ Imaging/labs ☐ Post-acute care ☐ Other, please specify: (textbox) <u>Patient Experience (CAHPS domains)</u> ☐ Getting timely appointments, care, and information ☐ How well practitioners communicate with patients ☐ Overall practitioner ratings ☐ Attention to care from other practitioners ☐ Practitioners support patients in taking care of own health ☐ Other, please specify: (textbox)	*Note: Pick at least three quality improvement measures from the nine eCQMs you have selected to report on in your EHR. The intent here is not to choose all of your selected eCQMs, but to tell us those you have focused quality improvement efforts on in the last two quarters.* *Find more information about continuous quality improvement (page 62) under the change concept "measure and improve quality at the practice and panel level" in Section I of this Guide.*

What quality improvement approach are you using to improve these measures? (Select all that apply) □ Root cause analysis □ Plan, Do, Study, Act □ FADE model □ Six Sigma □ Clinical practice improvement method □ Other, please specify: (textbox)	*The intent of this question is to learn about the quality improvement approaches your practice uses to improve measures. If your approach is not included on this list, please add or state "None," under "Other," in the textbox.*
Why are these measures high priority areas? (Select all that apply) □ High volume of patients □ High risk population □ Poor performance or outcomes □ High cost or utilization in this area □ Patient feedback □ Payment incentive from payers □ Other, please specify: (textbox)	

5.4 Culture of Improvement at Your Practice

Reporting Periods: Quarters 2 and 4	**Notes**

Over the last two quarters, who in your practice…

*A **quality improvement team** is a group of people within the practice who meet on a regular basis and are devoted to quality improvement efforts.*

	Did not occur	Clinical and administrative leadership	Designated quality improve-ment team	Care teams and clinical staff	Non-clinical staff	Patients/care-givers
…primarily generated improve-ment ideas and opportun-ities?						
…imple-mented improve-ment projects or tests of change?						
…had access to practice-level results?						
…had access to results identified to the applicable practitioner or care team?						

How frequently do care teams at your practice track and measure progress on quality improvement projects?

- ○ We do not routinely track and measure progress on quality improvement projects
- ○ At least weekly
- ○ At least monthly
- ○ At least quarterly
- ○ Only as needed or ad hoc

Note: If you select "We do not routinely track and measure progress on quality improvement projects," you will be unable to select the other options for this question.

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

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Our staff is trained in quality improvement methods.					
We allocate time for **practitioners and 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.					
We have open communication and a blame-free environment when working on quality improvement.					

![CPC+ logo]

General Practice Questions

Reporting Point of Contact	Notes
Reporting Periods: Quarterly	
Please provide the name and role of the primary person who completed this reporting. ○ **Name:** (textbox) ○ **Practice role** 　○ Practice/office manager or administrator 　○ Physician/clinical leader 　○ Care manager or clinical staff (RN, LPN, MA) 　○ Health system point of contact 　○ Other, please specify: (textbox)	

CPC+ Payer Partners	Notes
Reporting Periods: Quarterly	
Below are the CPC+ payer partners in your region. Please indicate with which payer(s) your practice has a contractual agreement to receive CPC+ payments and other supports for caring for your patients.	*Note: When you are in the practice portal, you will only see payers for your region. Prior responses are shown, and only need to be updated.*

Patient Demographics	Notes
Reporting Periods: Quarter 4	

Tell us about the demographic makeup of your patient population. Please answer these questions to the best of your ability.

Percentage of patients of Hispanic, Latino, or Spanish origin (including Mexican, Mexican American, Chicano, Puerto Rican, Cuban, Argentinian, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, etc.) _____%

Percentage of patients by race	%
Alaska Native or Native American (*e.g., Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.*)	
Asian (*e.g., Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, Hmong, Laotian, Thai, Pakistani, Cambodian, etc.*)	
Black or African American (*e.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somalian, etc.*)	
Native Hawaiian or other Pacific Islander (*e.g., Samoan, Guamanian or Chamorro, Tongan, Fijian, Marshallese, etc.*)	
White	
Other: (textbox)	
Unknown	

We are asking you to fill this out to update our records to better understand the demographics of CPC+. Exact counts for patient demographics are not necessary. You can use your best estimates for the following questions on patient demographics, if automated data are not available.

Note: You will be required to use any numerical value between 0-100, and the percentages must add up to 100 percent. Prior responses to this question are shown, and only need to be updated.

Is this based on collected data or best estimate? ○ Collected ○ Best estimate	*Note: This question refers to the previous table on patient demographics.*
Percentage of patients by preferred language: a. English ____% b. Non-English ____% What are the most common non-English languages spoken among your patient population? (Select all that apply) ☐ Arabic ☐ Chinese (Cantonese and Mandarin) ☐ Dutch ☐ Japanese ☐ Russian ☐ Spanish ☐ Vietnamese ☐ Other, please specify: (textbox)	*If your practice has patients who have a non-English preferred language, you will be prompted to tell us what the most common non-English language is.* *Note: You will be required to use any numerical value between 0-100, and the percentages must add up to 100 percent.*
Is this based on collected data or best estimate? ○ Collected ○ Best estimate	*Note: This question refers to the previous question on preferred languages.*
Percentage of patients by insurance type: a. Commercial or private __% b. Medicare __% c. Medicare Advantage __% d. Medicaid __% e. Uninsured __% f. Other __%	*Note: You will be required to use any numerical value between 0-100, and the percentages must add up to 100 percent.*
Is this based on collected data or best estimate? ○ Collected ○ Best estimate	*Note: This question refers to the previous question on preferred languages.*

Section III: Operational Tasks

Quarterly Reporting Schedule

As shown in Figure 3, the submission period opens the last week of each quarter (though you will have to wait until the quarter ends to report many of the data). Directly after the submission period, you have the option to request a one-week extension to correct previously submitted data. Following approval of your request, you should complete your data submission in the week directly following the submission period for the quarter.

Should your practice fail to complete reporting per the deadlines indicated below, CMS will terminate your CPC+ Participation Agreement and recoup all funds paid for participation in CPC+, in accordance with Section XIV.B and Section XIV.D of the CPC+ Practice Participation Agreement.

Figure 3: Quarterly Reporting Timeline

Table 12 contains the actual dates for all CPC+ care delivery reporting in Program Year 2017 (January 1, 2017 to December 31, 2017). You must submit all reporting in accordance with this schedule. Below are instructions for requesting an extension to submit data and requesting approval to correct previously submitted data.

Table 12: Program Year 2017: Submission Schedule

	Quarter 1	Quarter 2*	Quarter 3	Quarter 4*
Submission Period	3/27/17 to 4/14/17	6/26/17 to 7/14/17	9/25/17 to 10/13/17	12/25/17 to 1/19/18
Extension Request Window	3/27/17 to 3/31/17	6/26/17 to 6/30/17	9/25/17 to 9/29/2017	12/25/17 to 1/5/18
Late Submission Period	4/17/17 to 4/21/17	7/17/17 to 7/21/17	10/16/17 to 10/20/17	1/22/18 to 1/26/18
Correction Request Window	4/24/17 to 6/12/17	7/24/17 to 9/11/17	10/23/17 to 12/4/17	1/29/18 to 03/12/18
Data Correction Period	6/19/17 to 6/23/17	9/18/17 to 9/22/17	12/11/17 to 12/22/17	3/19/18 to 3/23/18

*Financial reporting will also follow these submission periods in Q2 and Q4.

Extension Requests

You should plan ahead for the submission period to ensure there is coverage at your practice to access and report in the CPC+ Practice Portal. However, you may request a one-week extension if you foresee an extenuating circumstance that will prevent your practice from completing your report within the submission period, such as travel plans or scheduled health IT maintenance. You must submit requests for an extension to submit your data during the Late submission period by the end of the first week of the initial submission period. You must submit all requests via the CPC+ Practice Portal.

Correction Requests

If you discover an error in data you previously submitted, due to a system malfunction or other issue, you may submit corrections to your data prior to the opening of the next quarterly submission period. Requests to correct submitted data will be available after the Late submission period closes and you must submit them no later than one week prior to the beginning of the data correction period. You must submit all requests via the CPC+ Practice Portal. CMS will not accept any data correction requests after each data correction period.

Requesting an Extension or Correction

To request approval for an extension or to correct data:

1. Log into the CPC+ Practice Portal.
2. Click on the "Practice Reporting" tab and scroll to the bottom of the page.
3. Click the "Request" button and complete the form.
4. Click on the "Save" button to submit the request.

CMS will grant approval to submit data during the late submission period or data correction period on a case-by-case basis. You can view the status of your data submission requests by clicking the "Request History" tab in the My Practice Info section of the CPC+ Practice Portal.

If you have not submitted your data by the end of the Late Submission Period, your practice may be subject to remedial action by CMS. Please contact CPC+ Support at 1-888-372-3280 or CPCPlus@telligen.com as soon as you can if you have any questions or concerns about submitting your data.

CMS may send a CPC+ Performance Alert if your data report raises any concerns about the progress of your transformation work in CPC+. Please note that data corrections may not impact any learning or remedial actions taken as a result of the data originally submitted.

Financial Forecast and Reconciliation

You will submit your CPC+ financial reporting in late 2017 and early 2018, which will include CPC+ revenues and expenditures from CMFs and hybrid payments, including those from all payer partners. You are not required to report on the PBIP payments you received or how you spent them. There are two components to financial reporting: (1) a forecast and (2) a retrospective reconciliation.

- In the forecast, you will tell us what funding you expect to receive in 2018, and how you plan to spend it to support CPC+ activities. Forecasting is intended to help you understand and optimally plan your use of these alternative payments, and will not be subject to auditing or monitoring.

- You will also provide a retrospective report of actual program year 2017 revenues and expenditures. We will use this information to understand how you allocate new streams of revenue and prioritize resources to different aspects of CPC+ practice transformation.

This summer, CMS will provide you with the reporting template and guidance to help you prepare for reporting and track your CPC+ financial activities.

We recommend you track CMF and CPCP revenues, and related expenditures, from all payer partners throughout the year to prepare for reporting. Please note that you must retain documentation of revenues in the event of an audit.

Quality Measurement and Reporting

Overview

The success of CPC+ depends on how well CPC+ practices improve and maintain improvements in quality of care throughout the five years of the model. To track quality of care, identify gaps in care, and focus quality improvement activities, the model will use electronic clinical quality measures (eCQMs), utilization measures, and a patient experience of care

survey. CMS will reward practices that demonstrate a high quality of care reflected by these measures with a Performance-Based Incentive Payment (PBIP) that matches their performance as discussed in the CPC+ Payment Methodology Paper.

In addition to these three types of measures, CMS will work with Track 2 practices throughout the model to develop a patient-reported, outcome-based performance measure (PRO-PM). Development of the PRO-PM is a unique innovation for this model that will aid in practices' better understanding of how to use patient-reported outcomes to capture quality performance. The PRO-PM is not connected to the PBIP.

This section of the Guide reviews the quality measures required for CPC+, the reporting requirements for these measures, and how CPC+ requirements align with other CMS quality reporting requirements, namely those of the Quality Payment Program and Medicare Shared Savings Program.

Table 13 shows the quality measurement strategy for each track and the quality measures that affect the amount of PBIP you will receive (the PRO-PM will not affect the amount of PBIP you will receive). Definitions and explanations of key quality measurement terms follow the table.

Table 13: CPC+ Quality Measurement Strategy by Track

Quality Measures	Track 1	Track 2	Affects PBIP
eCQMs	●	●	●
Utilization Measures	●	●	●
Patient Experience of Care Survey – Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey	●	●	●
PRO-PM (to be developed; details forthcoming in latter part of 2017)		●	

Definitions/Explanation of Quality Terms and Acronyms

eCQM. An electronic clinical quality measure assesses a particular aspect of quality of care provided to patients. eCQMs pull the information needed to evaluate performance directly from the EHR, which can be far more efficient than traditional approaches of extracting data from paper charts or claims databases.

Performance Period. The performance period in CPC+ is the calendar year during which CPC+ practices collect data for reporting eCQMs. The first performance period for CPC+ is calendar year 2017, which is January 1, 2017 through December 31, 2017.

Submission Period. The Submission Period is the time period in which CPC+ practices report their eCQM results to CMS. For the 2017 Performance Period, the Submission Period is January 1, 2018 through February 28, 2018.

QRDA III electronic submission of eCQM results. If you choose QRDA III as your means of submitting eCQM results to CMS, you can either submit an electronic file directly from your EHR or have a third-party intermediary submit an electronic file on your behalf. The electronic file format is called "QRDA III," which stands for *Quality Reporting Document Architecture, Category III.* CMS provides guidance each year on how to submit files using this method. CMS will provide detailed instructions regarding this submission method to practices in program year 2017. You should talk with your health IT vendor as soon as possible about QRDA III submission if you are considering this method. You can find Information on reporting eCQMs using the QRDA III file at 2017 CPC+ QRDA III Implementation Guide for Eligible Clinicians Reporting v0.1.

Attestation of eCQM results. You must choose either attestation or QRDA III (see below) as your means of submitting eCQM results to CMS. If you choose attestation, you will use the CPC+ Practice Portal to enter (attest to) the quality measure data results in 2018. We will provide detailed instructions regarding this submission method in program year 2017.

Third-party intermediary. For the purposes of reporting CPC+ quality measures, a third-party intermediary refers to a qualified registry, a QCDR, or a health IT vendor that obtains data from a CPC+ practice site's CEHRT and/or certified health IT. A third-party intermediary may submit a QRDA III electronic file on behalf of a practice.

CAHPS. The family of Consumer Assessment of Healthcare Providers and Systems surveys are widely used instruments that measure patient experience of care. One of the instruments from the CAHPS family—the CAHPS Clinician and Group Patient-Centered Medical Home Survey—will be used for CPC+. For brevity, throughout this Guide, we simply refer to this specific instrument as CAHPS.

Practice Site Level Reporting of eCQMs. CMS requires practices to report eCQMs at the CPC+ Practice Site level. Practice Site-level reporting reflects the quality of care provided by the CPC+ practice and should include all patients (from all payers, as well as the uninsured) who were seen one or more times at the Practice Site location during the 2017 Performance Period by one or more CPC+ clinicians (identified by Tax ID number and National Provider Identifier [NPI]), and who met the inclusion criteria for the eCQM's initial patient population (IPP)/denominator.

Timeline

The quality measurement and reporting information in this section relates to the 2017 Performance Period. Figure 4 displays the timeline of key quality-related events for the 2017 Performance Period. The details in the paragraphs below Figure 4 walk you through this timeline.

Figure 4: Timeline of Key Quality-Related Events for the 2017 Performance and Submission Periods

January – February 2017

Select nine eCQMs for your practice to report for the 2017 Performance Period. Your practice must select 9 of the 14 measures from the CPC eCQM measure set (see Table 14). If your practice has not yet selected measures, you should do so immediately to meet the requirements of the CPC+ participation agreement. This Guide provides useful resources regarding the selection of eCQMs. See the Quality Measurement in CPC+ section below for more details on selecting the appropriate eCQMs for your practice.

Choosing eCQM Submission Method. You and other members of your practice should decide as early as possible if you are going to report your eCQMs through attestation using the CPC+ Practice Portal or electronically submit them via QRDA III to the Merit-Based Incentive Payment System (MIPS) Portal. If your practice plans to report eCQMs using QRDA III, you should talk with your health IT vendor(s) to ensure that their health IT can successfully calculate and submit your selected eCQMs via QRDA III. For more information, see the Quality Measurement in CPC+: Electronic Clinical Quality Measures section below.

Quarterly or More Often throughout 2017

Check your quality performance. Your practice should check its eCQM performance throughout 2017 to assess progress during the year. This is not a requirement of CPC+, but is something we strongly recommend so that your practice understands how it is performing on these measures. Figure 6 in the Quality Measurement in CPC+: Electronic Clinical Quality Measures section below provides a worksheet that you can use for tracking eCQM performance

each quarter. Use of this worksheet is also not required, but it is a useful template your practice can use to develop an approach that works best for you.

Quarterly throughout 2017, Beginning at the End of the First Quarter

Quality Improvement (QI). Your practice will report information to CMS through the CPC+ Practice Portal regarding the CPC+ Comprehensive Primary Care Functions. Among other topics, you will answer questions about your practice's quality improvement efforts. You are required to focus your QI efforts on at least three of the eCQMs you select. Each quarter, you will report information on what you are doing to improve those eCQMs. CMS will use this information to help CPC+ practices engage in more successful quality improvement efforts during the five years of the model.

Spring 2017

Patient Roster. CMS will ask your practice to provide a roster of patients for the patient experience of care survey (CAHPS) that CMS will conduct.

Spring/Summer 2017

Patient Experience of Care Survey: CMS will conduct a CAHPS survey on a sample of patients from the roster that you provided in the spring of the Program Year. This sample will be the basis of your practice's patient experience of care score (CAHPS score). The CAHPS score is an important factor that affects whether you receive the full PBIP. For more information, see the Quality Measurement in CPC+: Patient Experience of Care section below.

Summer/Fall 2017

Development of a Patient-reported, Outcome-based Performance Measure (PRO-PM). As shown in Table 13 above, **the PRO-PM requirement applies only to Track 2 practices**. CMS will develop a measure during the five years of the model with significant input from Track 2 practices. As the 2017 Performance Period progresses, CMS will provide more information to Track 2 practices on its efforts to develop a PRO-PM. This measure is not included in the PBIP calculation.

November/December 2017

List of 2018 Performance Period eCQMs. CMS will share the final list of eCQMs for the 2018 Performance Period so you can decide which eCQMs you plan to select and report for the 2018 Performance Period. The eCQM list may change each year, due to various factors like updates to clinical guidelines that affect measures.

January 1 – February 28, 2018

Report eCQMs to CMS. Your practice must report the nine eCQMs selected at the beginning of 2017 and monitored throughout 2017 to CMS via attestation using the CPC+ Practice Portal or

electronically using a QRDA III file submitted through the MIPS Portal. We will provide more instructions on how to report the measures in the Practice Portal at the end of 2017, before the January 1, 2018 – February 28, 2018 Submission Period. You can find information on reporting eCQMs using the QRDA III file at 2017 CPC+ QRDA III Implementation Guide for Eligible Clinicians Reporting v0.1.

Quality Measurement in CPC+

> **What does your practice need to do for eCQMs?**
> - Choose 9 of the 14 eCQMs in the measure set for 2017 Performance Period. (Table 13)
> - Check with your EHR vendor to ensure it can report the nine selected CPC+ eCQMs at the Practice Site level.
> - Select at least three eCQMs for your quality improvement efforts as discussed in Section I: Care Delivery of this guide. This is a CPC+ requirement.
> - Monitor your eCQM performance at least quarterly for the nine selected measures. This is not required for CPC+, but is strongly recommended.
> - Report eCQMs during the Submission Period of January 1 – February 28, 2018.
> - Include all required data elements (i.e., numerators, denominators, exclusions, exceptions, and performance rates) for eCQMs when reporting them.

Your practice must choose and successfully report 9 of the 14 measures from the CPC+ eCQM measure set for the 2017 Performance Period that began on January 1, 2017 and ends on December 31, 2017. **You must select the measures using a three-step process as described in Table 13 and as follows:**

- Step 1: Select at least two of the three outcome measures from Group 1.

- Step 2: Select at least two of the four complex care measures from Group 2.

- Step 3: Select any five of the remaining measures from Groups 1, 2, or 3.

We also strongly encourage you to include all 14 CPC+ measures in your EHR. This comprehensive scope will allow you to report at least nine required measures in the event that one or more eCQMs are removed from the list due to changes in clinical practice guidelines or some other unpredictable problem with the measure.

Table 14 contains the CPC+ eCQM measure set for the 2017 Performance Period. All of these eCQMs are also in the eCQM measure set finalized for MIPS that is a part of the new Quality Payment Program (QPP). You can find more details on what is required (specifications) for each of these eCQMs in the CMS eCQM Library listed below in the Useful Resources section. The latest change to the measure set included updates to the domain names and was incorporated in Table 14.

Table 14: CPC+ eCQM Measure Set for the 2017 Performance Period

		Group 1: Outcome Measures – Select at least two of the three outcome measures			
CMS ID#	**NQF#**	**Measure Title**	**Measure Type/ Data Source**	**Domain**	**Check All the Measures Your Practice Is Selecting**
CMS159v5	0710	Depression Remission at 12 Months	Outcome/eCQM	Effective Clinical Care	☐
CMS165v5	0018	Controlling High Blood Pressure	Outcome/eCQM	Effective Clinical Care	☐
CMS122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Outcome/eCQM	Effective Clinical Care	☐

		Group 2: Complex Care Measures – Select at least two of the four complex care measures			
CMS ID#	**NQF#**	**Measure Title**	**Measure Type/ Data Source**	**Domain**	**Check All the Measures Your Practice Is Selecting**
CMS156v5	0022	Use of High-Risk Medications in the Elderly	Process/eCQM	Patient Safety	☐
CMS149v5	N/A	Dementia: Cognitive Assessment	Process/eCQM	Effective Clinical Care	☐
CMS139v5	0101	Falls: Screening for Future Fall Risk	Process/eCQM	Patient Safety	☐
CMS137v5	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Effective Clinical Care	☐

Group 3: Select five of the remaining measures from Groups 1 or 2 (above) or Group 3 (below)					
CMS ID#	NQF#	Measure Title	Measure Type/ Data Source	Domain	Check All the Measures Your Practice Is Selecting
CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/eCQM	Communication and Care Coordination	☐
CMS124v5	0032	Cervical Cancer Screening	Process/eCQM	Effective Clinical Care	☐
CMS130v5	0034	Colorectal Cancer Screening	Process/eCQM	Effective Clinical Care	☐
CMS131v5	0055	Diabetes: Eye Exam	Process/eCQM	Effective Clinical Care	☐
CMS138v5	0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process/eCQM	Community/Population Health	☐
CMD166v6	0052	Use of Imaging Studies for Low Back Pain	Process/eCQM	Efficiency and Cost Reduction	☐
CMS125v5	2372	Breast Cancer Screening	Process/eCQM	Effective Clinical Care	☐

Impact of ICD-10 Code Changes

ICD-10 is the 10th version of a medical classification list called the International Statistical Classification of Diseases and Related Health Problems (ICD). eCQMs, including those in CPC+, use ICD-10 codes to capture data needed to calculate performance rates. ICD-10 updates are currently scheduled to occur every October. CMS will assess the impact, if any, of these code changes each year on the eCQMs that CPC+ practices are required to report. If CMS decides the CPC+ quality reporting requirements need adjusting, based on the ICD-10 updates, CMS will inform your practice of these modifications.

Our current analysis indicates that the changes that occurred in October 2016 have a low impact on the eCQM set for CPC+. Thus, currently, CMS is not making any changes to the CPC+ quality reporting requirements because of the October 2016 ICD-10 updates. You can find more information on these updates in the CMS eCQM Library in a section labeled **"Addendum to eCQMs for eReporting for the 2017 Performance Period."**

Each reported eCQM must include all data elements (i.e., the numerator, denominator, exclusions, exceptions [if applicable], and performance rates) to meet the requirements. For measures with multiple data elements, practices must report all elements (e.g., two performance rates, two numerators). The performance rate formula is illustrated in Figure 5.

$$\text{Performance Rate} = \frac{\text{Numerator} - \text{Numerator Exclusions}}{\text{Denominator} - \text{Denominator Exclusions} - \text{Denominator Exceptions}}$$

Figure 5: Example of a Performance Rate Formula

The Performance Rate calculation is documented in the 2017 CPC+ QRDA III Implementation Guide for Eligible Clinicians Reporting v0.1.

You must meet eCQM reporting requirements to be eligible to earn the PBIP. Figure 6 is a worksheet you can use to select and monitor your progress on CPC+ eCQM measures on a quarterly basis. This worksheet also explains what your practice must do to attain a portion or all of the PBIP.

You are not required to use this tracking sheet, but it is a useful tool for developing a tracking sheet that fits your practice. This tracking sheet may also be a useful way to help team members understand how their quality improvement work relates to the PBIP. We recommend that you display this or a similar type of tracking sheet in your practice so practice staff can see how the practice is performing over time.

If your practice has any questions about how to use this sheet, contact CPC+ Support (CPCPlus@telligen.com or 1-888-372-3280) or the practice facilitators in your region.

How to keep the Quality Component of your PBIP and qualify for the Utilization Component

Your performance on Clinical Quality Measures (eCQMs) will determine the largest share of your CPC+ Performance-Based Incentive Payment (PBIP). To qualify for the PBIP, your practice must report 9 of 14 eCQMs in the CPC+ eCQM Measurement Set.

1 Select 9 of 14 eCQMs in the CPC+ eCQM Measurement Set

2 Track Your Progress

If you reach this benchmark | 50th: 63.60% | 80th percentile: 75.34%

Then you keep this percent of the PBIP allotted to this measure | 100%

3 Record Your Actual Quarterly Progress

| Q1 | Q2 | Q3 | Q4 |

eCQM	Measure	50th	80th
☐ CMS159v5	Depression Remission at 12 Months (370)	Not Available	
☐ CMS165v5	Controlling High Blood Pressure (236)	63.60%	75.34%
☐ CMS122v5	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) (001)*	19.33%	3.33%
☐ CMS156v5	Use of High-Risk Medications in the Elderly (238)*	9.39%	0.01%
☐ CMS149v5	Dementia: Cognitive Assessment (281)	56.26%	95.56%
☐ CMS139v5	Falls: Screening for Future Fall Risk (318)	47.87%	90.21%
☐ CMS137v5	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (305)	2.11%	6.99%
☐ CMS50v5	Closing the Referral Loop: Receipt of Specialist Report (374)	18.16%	51.18%
☐ CMS124v5	Cervical Cancer Screening (309)	28.84%	54.78%
☐ CMS130v5	Colorectal Cancer Screening (113)	33.46%	67.92%
☐ CMS131v5	Diabetes: Eye Exam (117)	94.12%	99.99%
☐ CMS138v5	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (226)	90.16%	96.59%
☐ CMS166v6	Use of Imaging Studies for Low Back Pain (312)	100.00%	100.00%
☐ CMS125v5	Breast Cancer Screening (112)	40.87%	63.07%

*This measure is reverse-scored.

The amount of PBIP your practice can keep increases as you achieve more of the quality and reporting benchmarks listed below.

	No Payment		Quality			Utilization	
			Partial Payment	Full Payment	Full Payment	Partial Payment	Full Payment
	Not eligible to retain your PBIP	Qualify to retain your PBIP	Receive a portion of incentive payment for performance above 50th percentile on eCQMs and 30th percentile on CAHPS	Receive a portion of incentive payment for performance above 50th percentile on eCQMs and 30th percentile on CAHPS Qualify to retain Utilization Component	Automatically keep 100% of the Quality Component	Receive some portion of the incentive payment for any performance above the 50th percentile	Automatically keep 100% of the Utilization Component
You don't report all nine eCQMs (and CAHPS)	✗						
You report all nine eCQMs (and CAHPS)		✗	✗	✗	✗	✗	✗
You achieve 50th percentile on some of the eCQMs and 30th percentile on CAHPS			✗	✗			
You achieve 50th percentile on all nine of the eCQMs and 30th percentile on CAHPS				✗	✗	✗	✗
You achieve 80th percentile or better on six measures (eCQMs or CAHPS)					✗		
You achieve 50th percentile or better on one Utilization measure						✗	
You achieve 80th percentile or better on each Utilization measure							✗

Figure 6: eCQM and PBIP Worksheet

Utilization Measures

> **What does your practice need to do for utilization measures?**
> - Your practice does not need to report anything for these measures. CMS calculates these measures.
> - Your practice should engage in the primary care functions that can improve the quality of care reflected in these measures (e.g., care management and care coordination) as described in Section 1: Care Delivery of this guide.

CMS will assess practice performance on utilization measures. For the 2017 Performance Period, we will focus on the following two utilization measures from the Healthcare Effectiveness Data and Information Set (HEDIS):[33]

1. Inpatient hospitalization utilization per 1,000 attributed beneficiaries
2. Emergency department utilization per 1,000 attributed beneficiaries

There is no reporting requirement for these two measures. CMS and its contractor will calculate these measures at the end of each program year using claims data. Additional information related to how the results of the utilization measures impact the PBIP are described in CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule (Version 2) (February 17, 2017). (Appendix G of the methodology paper lists the technical specifications for the two utilization measures.)

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[33] Disclaimer: The Inpatient Hospital Utilization and Emergency Department Utilization measures and specifications were developed by the National Committee for Quality Assurance (NCQA) under the Performance Measurements contract (HHSM-500-2006-00060C) with CMS and are included in HEDIS® with permission of CMS. The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. HEDIS measures cannot be modified without the permission of NCQA. Any use of HEDIS measures for commercial purposes requires a license from NCQA.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

The American Medical Association holds a copyright to the Current Procedural Terminology (CPT®) codes contained in the measures specifications.

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> **What does your practice need to do for the patient experience of care measure?**
> - CMS will ask your practice to provide a roster of all patients that we can use to identify survey participants. CMS will pay for this survey.
> - Your practice should review the domains of the survey and engage in efforts to improve patient experience of care in each of the domains.

Why is measuring patient experience of primary care important? For patients, good experience—particularly with care continuity—is positively associated with patients' engagement with and adherence to medication and other care regimens.[34,35] Better experience in primary care is associated with lower utilization of inpatient and ED services.[35,36] For the practice, measures of patient experience correlate with measures for clinical care processes to prevent and manage disease. Thus, patient experience can serve as a proxy of quality care delivery.[34,37] You can only know some features of care delivery by asking your patients questions like whether they readily understand the information that your practice is providing, their ease of obtaining after-hours medical advice, or their ability to see practitioners at the appointed time for an office visit.[38] Feedback about patient experience can also help set priorities for patient-centered quality improvement initiatives.

While some primary care practitioners may be concerned about whether efforts to transform quality of care conflict with patient experience, there is no evidence that this is the case.[39] Furthermore, routine monitoring of measures for both quality processes and patient experience will ensure that if such conflicts arise, your practice can detect and correct them. Research shows the business case for improved patient experience, as it is positively correlated with patient loyalty and retention, reduced medical malpractice risk, and increased employee satisfaction.[34]

CMS will perform patient experience of care surveys annually using CAHPS, as described above, on a sample of your patient population. Table 15 describes the composite measures of patient experience that CMS will review.

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[34] Browne, K., et al., Analysis & commentary. (2010). Measuring patient experience as a strategy for improving primary care. Retrieved from http://content.healthaffairs.org/content/29/5/921.full.pdf

[35] Saultz, J.W., Defining and Measuring Interpersonal Continuity of Care. (2003, September-October). Retrieved from http://www.hpm.org/Downloads/Bellagio/Articles/Evaluation_and_measurement/Saultz_2003_Defining_Measuring.pdf

[36] Anhang Price, R., et al. (2014, October 1) Examining the role of patient experience surveys in measuring health care quality. Retrieved from http://escholarship.org/uc/item/8746s9d2

[37] Cook, N., et al. (2015, December). Patient Experience in Health Center Medical Homes. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26026275

[38] Anhang Price, R., et al., Should health care providers be accountable for patients' care experiences? (2015), Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25416601

[39] Sequist, T.D., et al., Quality monitoring of physicians: linking patients' experiences of care to clinical quality and outcomes. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18752026

Table 15: Measures of Patient Experience

CAHPS Measure	Survey items in this measure asks patients whether…
Getting timely appointments, care, and information	They got an appointment for urgent and non-urgent care as soon as needed, and answers to medical questions the same day they contacted your office.
How well providers communicate	You explained things in a way that was easy to understand, listened carefully to them, showed respect for what they had to say, and spent enough time with them.
Use of information to coordinate care	You knew important information about their medical history and followed up with them in giving them their test results.
Shared decision making	You talked to them about their reasons they might or might not want to take medications, or asked them what they thought was best for them.
Providers support patients in taking care of their own health	You talked to them about the stressful aspects of their lives, personal or family problems, alcohol or drug use, or mental illness.
Provider rating	You were poor to excellent in the provision of care (scale of 1 to 10).

You can find additional information about this survey in the Useful Resources section below.

CMS will pay for fielding this survey. Your practice will be required to provide a patient roster that CMS will use to sample your patient population. Additional information related to how the results of the CAHPS survey will impact the PBIP is available in CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-based Incentive Payment, and Payment Under the Medicare Physician Fee Schedule. (Appendix E of CPC+ Payment Methodologies paper further discusses CAHPS measures and describes the benchmarking methodology.)

Development of Patient-reported Outcome-based Performance Measure (PRO-PM) with Track 2 Practices Only

> **What does your Track 2 practice need to do for development of the PRO-PM measure?**
>
> For Track 2 practices only:
> - Your practice does not need to do anything initially.
> - CMS will inform Track 2 practices of what is required for the development of the PRO-PM throughout CPC+.

What is a patient-reported outcome measure? A patient-reported outcome measure (PROM) is an instrument, scale, or single item measure that assesses outcomes of interest (Patient-reported Outcomes or PROs) as perceived by the patient and obtained directly from patient self-reporting. PROMs can screen for and capture a patient's reported clinical outcomes for some common, disease agnostic, and medical/social problems, such as depression, problems with

physical functioning, social isolation, and pain. The Patient Health Questionnaire (PHQ-9) is an example of a patient self-reported screening tool for depression.

Are PROMs and CAHPS the same? No, PROMs are distinct from CAHPS in that they ask what patients are able to do or how they feel as opposed to their perception or experience of the care received. This section addresses PROMs. For further information on CAHPS, refer to the Quality Measurement in CPC+: Patient Experience of Care section above.

What is a PRO-PM and how is it different from a PROM? A PRO-PM is a performance measure *based on PROM data* that CMS aggregates for an accountable health care entity.

How will PRO-PMs be rolled out to Track 2 practices? The ultimate goal is to use one or more PRO-PMs to assess performance of Track 2 practices in the later years of CPC+. However, initially, CMS will focus on PROMs to:

- Guide medical care and care management for patients with complex needs

- Gain a better understanding of how and what PROM data CMS can use to develop appropriate PRO-PMs for primary care clinicians

To that end, CMS will select one or more PROMs that practices can use later in 2017. We will keep you informed of this requirement.

PRO-PMs will not be included in the data used to calculate PBIP in the 2017 Performance Period.

Health IT Requirements

Certified EHR Technology (CEHRT)

CPC+ practices must use technology that meets the CEHRT definition finalized for the Quality Payment Program at 42 CFR 414.1305. This is the CEHRT definition required for Advanced Alternative Payment Models (APMs) and the MIPS program. As of January 1, 2017, practices must adopt technology certified to at least the 2014 Edition. By no later than January 1, 2018, practices must adopt technology certified to the 2015 Edition. This is a certified health IT requirement for both tracks of CPC+, and practices must maintain continuous use of CEHRT throughout the model. Your practices can view health IT vendor materials and a list of all health IT requirements for Track 1 and Track 2 practices on the CPC+ website.

Know your CMS EHR Certification ID. The CMS Certification ID is required for CPC+ data submission, and can be found on the CHPL website using the following steps (Note: Vendor names and complete Certification IDs are intentionally blurred):

1. Search for your health IT product and, once you identify it, select the yellow +Cert ID box.

Figure 7: Cert ID Selection Box

2. After selecting the +Cert ID box, a second pop-up box will open with the option to "Get EHR Certification ID."

Figure 8: Get Certification ID Selection Box

3. After selecting the "Get Certification ID" button, the pop-up box will expand and display the CMS EHR Certification ID required for CPC+ data submission. You can download a PDF document that includes the ID.

Figure 9: CMS EHR Certification ID Pop-up Box

Certified Health IT for Quality Reporting

CPC+ practices in both tracks of the model must ensure they can generate an eCQM report using certified health IT that filters the quality measure data at the CPC+ Practice Site location and CPC+ Tax Identification Number (TIN)/National Provider Identifier(s)(NPI) level. In many cases, this reporting is performed by the CEHRT that a practice already uses; however, some practices may adopt additional certified health IT to meet these requirements, such as a registry that is certified to the criteria at 45 CFR 170.315 (c)(1)-(c)(3) for each quality measure. Starting on January 1, 2018, practices must ensure the eCQM performance results and Practice Site reports are generated using health IT meeting the 2015 Edition (c)(4) criterion, filtered by CPC+ Practice Site location and CPC+ TIN/NPI.

Know the CPC+ Health IT Policies, Procedures, and Guidelines

Appendix E details the CPC+ Health IT Definitions, and Appendix F includes the CPC+ Health IT Policies and Procedures for participating practices. All practices should become familiar with these requirements. This section highlights aspects from the policies and links to corresponding details in the Appendices. As outlined in Table 16, practices must use technology that meets the certified health IT definition defined in the Quality Payment Program, and must maintain its use throughout all five CPC+ years or risk removal from the program.

Table 16: Summary of CPC+ Certified Health IT Requirements

	By January 1, 2017	By January 1, 2018	By January 1, 2019
Certified Health IT	Maintain 2014 or 2015 Edition health IT certification criteria Ensure health IT is capable of reporting CPC+ eCQMs at the Practice Site level	Adopt or maintain 2015 Edition health IT certification criteria	<u>Track 2 only</u> Adopt 2015 Edition health IT certification criteria for Care Plan criterion Adopt 2015 Edition health IT certification criteria for Social, Behavioral, and Psychological Data criterion
Quality Reporting	For 2017 reporting period, use the latest eCQM specifications contained in the 2016 annual update, released in April 2016 Adopt technology that allows filtering of data by at least practice site location and TIN/NPI	Ensure EHR is certified to the 2015 Edition (c)(1)-(3) criteria using the 2017 annual update for CPC+ eCQMs Ensure eCQM Practice Site Report is made using health IT meeting 2015 Edition (c)(4) criterion, filtered by CPC+ Practice Site and TIN/NPI	No changes

Practices must also ensure that they can generate an eCQM report using certified health IT that is filterable by Practice Site location and CPC+ TIN/NPI. Although not required, practices are strongly encouraged to configure all 14 CPC+ eCQMS in their system in the event one or more eCQMS is removed for various reasons.

Track 2 practices have additional Track 2 health IT requirements, including items like risk stratification, patient empanelment, and patient-reported outcomes. Practices have the option of using multiple health IT vendors to meet these requirements, and all vendors being used to support Track 2 requirements must sign a Memorandum of Understanding (MOU) with CMS. Practices are responsible for ensuring that their vendors sign the MOUs, and practices with missing MOUs risk removal from the program. Of note, other health IT being used in the practice for non-Track 2 purposes (e.g., billing) does not need to be documented with CMS.

If your practice opts to switch health IT systems during CPC+, you must notify CMS at CPCPlus@Telligen.com as early as possible, but at least three months prior to the switch, with a plan for meeting all of the eCQM reporting requirements throughout. If the switch will result in the inability to report 12 months of data from the new system, CMS may approve an alternative submission plan.

Note: If a practice fails to give notice in a timely manner and is not able to report the required eCQM data, it risks removal from continued participation in CPC+. Please carefully review the policy outlined in Appendix F.

Quality Reporting in CPC+

> **What does your practice need to do to prepare for CPC+ quality reporting?**
> - Your practice should understand Practice Site level reporting.
> - Talk to your health IT vendor to ensure they can report on your selected eCQMs and provide you with a report of your eCQM results.
> - Periodically pull test reports from your CEHRT and Certified Health IT vendor to ensure that calculated performance rates are correct.

Practice Site Level Reporting

Both Track 1 and Track 2 practices will be required to report eCQMs annually at the CPC+ Practice Site level. Each practice accepted into CPC+ has a separate geographic location with a unique CPC+ ID. Larger organizations with multiple practice sites and locations should have a unique CPC+ ID for each physical location, unless they are a satellite office. CPC+ defines the practice location as the physical address (i.e., street address, suite number, city, state, and ZIP Code) of the CPC+ Practice Site. See Figure 10 for an example of practice site-level reporting.

Figure 10: Practice Site-level Reporting

Practice site-level reporting should include all patients (for all payers and the uninsured) who were seen one or more times at the practice site location during the performance period by one or more CPC+ practitioners (CPC+ TIN/NPIs) and who met the inclusion criteria for the IPP denominator. Your practice's health IT champion should talk with your health IT vendor representatives to ensure your eCQMs can be reported at the practice site level, and that your health IT vendor can provide you a copy of your annual eCQM report that reflects all of the eCQM results (numerator, denominator, exclusions and exceptions [if applicable], and performance rate[s]) for each eCQM that you report. You should retain a hard copy the eCQM report with the annual results you submit to CMS for six years in case of a potential eCQM audit. A sample of CPC+ practices will undergo an eCQM audit annually after each eCQM reporting period.

eCQM Reporting

You should obtain an eCQM report from your health IT vendor. The report should include at a minimum the following information:

✓	eCQM Report Checklist
Practice and Practitioner Information	
☐	Practice Site Location: CPC+ ID, Practice Name and Address
☐	Date of report
☐	Time period the report covers (it should cover the entire performance period)
☐	CPC+ Tax Identification Number (TIN) – optional
☐	CPC+ National Provider Identifier(s) (NPIs) – optional
For Each Submitted eCQM	
☐	CMS ID and Version
☐	Numerator(s)
☐	Denominator(s)
☐	Exclusions (if applicable)
☐	Exceptions (if applicable)
☐	Performance Rate(s)

The report may be one or more pages, and you may need to generate information from different areas of your EHR or health IT to provide all the information required. We recommend that all practices keep a hard copy of the eCQM report for a potential eCQM audit. In addition, if your practice attests to eCQMs, you will be required to upload the eCQM report into the CPC+ Practice Portal.

CMS also recommends that practices periodically pull test reports from their CEHRT and certified health IT to ensure calculated performance rates are correct.

Can you report on more than 9 of the 14 eCQMs and what happens if you do? Yes, you can report more than nine of the measures in the CPC+ eCQM measure set during the January 1 – February 28, 2018 Submission Period, but you are only required to report nine. If you report more than nine, you must still meet the stated selection requirements (two outcome measures, two complex care measures, and five selected from any remaining measures on the three lists). Note that all the eCQMs you submit (whether nine or more) must all be from the CPC+ eCQM measure set. The CPC+ Practice Portal will not allow you to enter an eCQM that is not from the CPC+ eCQM measure set. Furthermore, CMS will filter out any eCQM in a QRDA III submission that is not from the CPC+ eCQM measure set.

Should you submit more than nine eCQMs, the top nine conforming to reporting requirements (i.e., the top two from Group 1 – Outcome Measures, the top two from Group 2 – Complex Care

Measures, and the top five from the remaining measures you submit) will be used towards your PBIP.

What happens if you do not have nine eCQMs to report? You must report at least nine eCQMs to be compliant with CPC+ requirements. If you attempt to enter (attest to) fewer than nine eCQMs in the CPC+ Practice Portal, an error message will notify you of the deficiency, and the system will hold your measures until you report nine measures. Similarly, should you report fewer than nine eCQMs in your QRDA III submission, the system will return a notification to you, and the system will hold your measures. We encourage you to report at least nine measures during the Submission Period. Doing otherwise will affect the eCQM component of your PBIP.

CPC+ Alignment with Other CMS Quality Programs

Quality Payment Program (QPP) and CPC+

On October 14, 2016, HHS issued its final rule with comment period implementing the Quality Payment Program (QPP) as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (see QPP educational resources). The QPP aims to improve Medicare through achieving better care and better health at a lower cost. It provides new tools and resources to help you give your patients the best possible, highest value care. You can find more information on the QPP at https://qpp.cms.gov.

The QPP has two paths practitioners can choose from: Advanced Alternative Payment Models (APMs) and MIPS. You can find more information about CPC+ participants' interaction with QPP on CPC+ Connect in the recorded webinar[40] and fact sheet.[41] Figure 11 describes how CPC+ acts as both a MIPS APM and Advanced APM under the QPP.

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[40] Understanding CPC+ and the Quality Payment Program in 2017. (2017, April). Retrieved from https://www.youtube.com/watch?v=vwT8wwGtYcI&feature=youtu.be

[41] Quality Payment Program Overview Fact Sheet. (n.d.). Retrieved from https://app.innovation.cms.gov/CPCPlusConnect/sfc/#version?selectedVersionId=068t0000000u4ll

Figure 11: CPC+ Is a MIPS APM and an Advanced APM

Additional questions/comments regarding the overlap between QPP and CPC+ should be sent to either the QPP Help Desk (QPP@cms.hhs.gov or 1-866-288-8292) or CPC+ Support (CPCPlus@telligen.com or 1-888-372-3280).

Medicare Shared Savings Program and CPC+

CPC+ primary care practices that are Medicare Shared Savings Program (SSP) Accountable Care Organizations (ACOs) may also participate in CPC+. CMS identifies these practices as "dual participants." Key questions and answer for dual participants relevant to quality reporting are listed below.

Do dual participants have to report quality measures required by SSP? Yes, the ACO in which the dual participant is participating must meet all quality reporting requirements of the SSP.

Are dual participants' Medicare fee-for-service (FFS) patients subject to the CAHPS for ACOs Survey required by the SSP? Yes, CMS may ask Medicare beneficiaries attributed to ACOs that include dual participants through the SSP to participate in the annual CAHPS for ACOs survey that is part of the SSP quality standard.

CPC+ will also conduct CAHPS surveys on a sample of all dual participants' patients (associated with Medicare and other payers). CPC+ and the SSP will work together to prevent FFS Medicare beneficiaries from receiving both the CAHPS for ACOs and the CPC+ CAHPS surveys, thereby limiting the survey burden of any individual beneficiary.

Do dual participants have to report eCQMs to CPC+? Yes, dual participants must meet all quality reporting requirements of CPC+, including reporting 9 of the 14 eCQMs in the CPC+ eCQM measure set for the 2017 Performance Period.

Are dual participants in SSP Track 1 ACOs excluded from MIPS reporting? No, dual participants in Track 1 ACOs are subject to MIPS and will be assessed under the MIPS APM scoring standard. For the 2017 Performance Period, the requirements of the MIPS APM scoring standard for eligible clinicians in Track 1 ACOs are as shown in Table 17.[42]

Table 17: Reporting Requirement and Performance Score

	Reporting Requirement	**Performance Score**	**Weight**
Quality	SSP ACOs submit quality measures to the CMS Web Interface on behalf of their participating MIPS eligible clinicians.	The MIPS quality performance category requirements and benchmarks will be used to score quality at the ACO level.	50%
Cost	MIPS eligible clinicians will not be assessed on cost.	N/A	0%
Improvement Activities	ACOs only need to report if the CMS-assigned improvement activities scores is below the maximum improvement activities score.	CMS will assign the same improvement activities score to each APM Entity group based on the activities required of participants in the SSP. The minimum score is one-half of the total possible points. If the assigned score does not represent the maximum improvement activities score, ACOs will have the opportunity to report additional improvement activities to add points to the APM Entity group score	20%
Advancing Care Information	All ACO participant TINs in the ACO submit under this category according to the MIPS group reporting requirements.	CMS will aggregate all of the ACO participant TIN scores as a weighted average based on the number of MIPS eligible clinicians in each TIN to yield one APM Entity group score.	30%

Eligible clinicians participating in the ACO will receive the same MIPS score, which will lead to either a positive, neutral, or negative payment adjustment in 2019. Because the 2018 Performance Period may not follow the same APM scoring standards, dual participant practices

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[42] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, Table 11—APM Scoring Standard for the Shared Savings Program—2017 Performance Period for the 2019 Payment Adjustment. Retrieved from https://www.federalregister.gov/documents/2016/11/04/2016-25240/medicare-program-merit-based-incentive-payment-system-mips-and-alternative-payment-model-apm

should review future communications from CMS and also monitor the Quality Payment Program website for changes these standards.

Are dual participants in SSP Track 2 or 3 ACOs excluded from MIPS? SSP Tracks 2 and 3 are Advanced APMs and eligible clinicians in dual participant practices may receive the 5 percent lump sum bonus and a MIPS exemption if their ACO meets the required standards of the QPP.

Is a dual participant eligible to receive shared savings payments under the SSP? Dual participants may be eligible for shared savings payments based on the ACO's performance as assessed by the SSP and the terms and conditions of the ACO participant agreement the dual participant's practice signed with the ACO.

Does a dual participant receive the CPC+ PBIP? No, but instead of receiving the CPC+ PBIP, dual participants are included in their ACO's shared savings/loss arrangement. Dual participants will receive CPC+ care management fees and, if in CPC+ Track 2, will receive Comprehensive Primary Care Payments. Both of these payments will be included in their ACO's expenditure calculation.

Additional questions/comments regarding the overlap between the Medicare SSP and CPC+ should be sent to CPC+ Support (CPCPlus@telligen.com or 1-888-372-3280).

Useful Resources

Agency for Healthcare Research and Quality – Selecting Quality Measures.

CAHPS Clinician and Group Survey Measures: https://www.ahrq.gov/cahps/surveys-guidance/cg/about/survey-measures.html.

CMS eCQM Library – This is a general resource with details on all eCQMs and QRDA III submission.

https://ecqi.healthit.gov/ – The one-stop-shop for the most current Electronic Clinical Quality Improvement resources.

Developing a CAHPS® Clinician & Group Survey to Measure the Medical Home: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/item-sets/PCMH/PCMHFactSheet.pdf.

eMeasures Blueprint – A deep dive into CMS measure development and conceptualization.

Health IT-Enabled Quality Measurement Strategic Implementation Guide – Provides a framework for multi-stakeholder engagement, 10 key activities, and a series of tools states can use to assess readiness, technical decisions, and tactics to set up a health IT-enabled quality measurement system.

Health Resources and Services Administration – Quality Improvement Methodology – The section on Performance Management and Measurement is useful for selecting measures.

JIRA CQM Feedback System – A collaboration platform for stakeholders to submit issues with eCQM implementation and tools and receive feedback. Users with technical questions use JIRA to ask questions and report issues rather than submitting email, telephone, or paper issues.

National Quality Forum – ABCs of Measurement – NQF provides measures that have undergone rigorous scientific and evidence-based review, input from patients and their families, and the perspectives of people throughout the healthcare industry.

Value Set Authority Center (VSAC) – Provides downloadable access to all official versions of vocabulary value sets included in the eCQMs (link to VSAC is also available on the eCQI Resource Center).

Updated CPC+ Payment Methodologies Paper – Performance Thresholds to Retain Performance-Based Incentive Payment

On February 23, 2017, we released an updated CPC+ Payment Methodologies paper. In addition to details about how we calculate and pay the CPC+ care management fees, PBIP, and Comprehensive Primary Care Payments, we released the benchmarks that practices are required to attain for the PBIP. You can access the updated CPC+ Payment Methodologies paper here.

Practice Composition Policy

Overview

We know that over the course of CPC+, the practitioners and staff in your practice may change, and your practice may change ownership, location, and billing information. As part of the Participation Agreement, each practice has agreed to keep its practice, practitioner, and staff information up-to-date. Current and accurate information will assure correct payment calculations, assist CMS in monitoring your practice's performance, and ensure your practice receives accurate and timely program information.

You can quickly and easily submit some changes through the CPC+ Practice Portal. Other changes, in particular those with impact on your CPC+ payments, are more complex and require approval after you submit the change in the CPC+ Practice Portal. Above all, it is imperative that your practice be mindful of notifying CPC+ immediately of any changes to staffing, ownership, or location.

Composition Change Request Process

Your practice will submit requests to update your Practitioner Roster, Staff Roster, TIN, and organizational affiliation through the CPC+ Practice Portal. The CPC+ team will review each submitted request and provide a response via the CPC+ Practice Portal. These responses will inform you if we need additional information, or if we approved or rejected your request. Step-by-step instructions, as well as screen shots for each of these composition changes, are included in Appendix H.

More complex changes in composition, such as practice mergers, practice splits, and satellite site additions, require more information and need to be submitted to CPC+ Support at CPCPlus@telligen.com or 1-888-372-3280.

Practitioner Roster Changes: Practitioner Adds/Withdraws

Your practice may add or withdraw practitioners at any time during your CPC+ participation. CMS will only use practitioners who are formally part of your practice's Practitioner Roster in beneficiary attribution and for payments to your practice site. For CMS to consider practitioners part of your CPC+ Practitioner Roster, they must:

- Be a physician (MD or DO), nurse practitioner, physician assistant, or clinical nurse specialist
  - o Your practice does not need a physician on your roster to remain in CPC+.
  - o Residents and fellows may participate in CPC+.
  - o No minimum number or percentage of hours is required for a practitioner to be included on your roster.
- Have a primary specialty of internal medicine, general medicine, geriatric medicine, or family medicine (applicable to physicians only)
- Provide predominantly, though not exclusively, primary care services[43] at the CPC+ practice
- Be paid according to the Medicare Physician Fee schedule for routine office visits and submit claims on a Medicare Physician/Supplier claim form[44]
- Pass a CMS-initiated CMS Center for Program Integrity (CPI) Screening, which is processed on a monthly basis
  - o All practitioners' effective date for CPC+ purposes is the date when CMS receives acceptable CPI screening results.

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[43] Defined as the following Current Procedural Terminology (CPT) codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99354, and 99355.
[44] CMS 1500, formerly HCFA 1500.

- o The CPC+ effective date for new practitioners is contingent on CMS' receipt of acceptable CPI screening results. Depending on the timing of these results, a practitioner's effective date with CPC+ may be later than the date the practitioner joins the practice. To ensure CPI checks can be completed prior to the start date of the practitioner, please submit your practitioner add requests via the CPC+ Practice Portal upon confirmation of the practitioner joining your practice.

  - o Practitioners moving from one CPC+ practice to another have already received CPI screenings, and do not need to repeat screening.

- Be associated with only one CPC+ Practitioner Roster at a time for the purposes of attribution/payment

  - o In the event the practitioner moves from one CPC+ practice to another, both practices must submit the applicable practitioner add or withdraw requests (as applicable) for each site. CPC+ Support will assist in coordination of practitioner assignment in these situations. CMS will not add practitioners to a different CPC+ practice until a withdrawal has been processed from the initial CPC+ practice.

- Plan to be at the practice for more than three months

  - o CMS will not add *locum tenens* practitioners covering temporarily for other practitioners in the practice if they are covering for less than three months.

- Not charge beneficiaries concierge fees

  - o Practitioners charging concierge fees for patients not attributed to CPC+ must: (1) use a TIN separate from your practice; (2) must keep their funds separate from your practice; and (3) notify CPC+ Support of the concierge services they are offering.

- Not be engaged in any fraudulent or illegal activity

Please refer to Appendix G for a step-by-step guide for getting access to the CPC+ Practice Portal.

Changing a Practice Name

Practices may have updates to their name for a variety of reasons. Practice name changes should be reported to CPC+ Support by phone or email and must be accompanied by a copy of a legal document effecting the name change, authenticated by the appropriate state official (if applicable). Upon processing, CMS will amend your Participation Agreement to reflect the change of your CPC+ Practice's name.

Changing a Practice TIN

CMS recognizes that during the course of CPC+, business changes may occur, including changes to your practice TIN. At the beginning of your participation, you will verify that the TIN listed in the CPC+ Practice Portal is correct. If the CPC+ Practice Portal lists an incorrect TIN, or

if you have changed your TIN since the submission of the application to CPC+, you must update this information in the CPC+ Practice Portal.

In certain circumstances, a TIN change may require additional follow-up. For example, if a TIN is changed due to a change in ownership, the CPC+ Composition team will ask you for additional details. In addition, practices may need to update banking information as the result of a TIN change to ensure CMS deposits CPC+ payments into the appropriate account.

Please refer to Appendix H for a step-by-step guide for updating your practice TIN in the CPC+ Practice Portal.

Joining the Shared Savings Program

If your practice intends to join the SSP while participating in CPC+, you will need to notify CPC+ Support within 30 days of becoming an ACO participant. To facilitate a smooth transition to participation in both programs, CMS requests that you provide this notification by September 30 of the year prior to the potential effective date.

Additionally, you will need to notify CPC+ Support when you receive notice of your acceptance/denial in the SSP. If accepted, you will need to submit a written statement signed by a representative of the leadership of the SSP ACO to CMS. This statement needs to acknowledge that the CPC+ Practice's participation in CPC+ may impact the ACO's total expenditures and, if applicable, acknowledge that any CPC+ payments made to the ACO will be segregated from all other funds of the ACO and will be used solely by the CPC+ Practice.

If your practice plans to join the SSP, please be sure to read the sections of the CPC+ Participation Agreement and comply with all terms relevant to practices participating in both SSP and CPC+.

Withdrawing a Practice

Practices may voluntarily withdraw from CPC+ at any time. If your practice decides to withdraw, you must take the following actions:

- Notify CPC+ Support of intent to withdraw 30 calendar days in advance[45]

- Complete the applicable CPC+ Practice Withdrawal form, including obtaining signatures from all CPC+ practitioners[46]

- Identify any practitioners who are moving to another CPC+ practice

- Submit progress to date on care delivery requirements in the CPC+ Practice Portal

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[45] Requests for practice withdraw in the first quarter of 2017 are exempt from this requirement and should provide notification as soon as the decision to withdraw is made.

[46] This form will be provided to practices by CPC+ Support.

- Submit partial or full year forecasts and financial reports depending on the effective withdrawal date

- Submit eCQM results if the withdrawal is effective on 12/31

- Submit a beneficiary notification letter that notifies your beneficiaries that your practice participation in CPC+ has ended for CMS review and approval. Upon approval, your practice will distribute to your beneficiaries.

In some circumstances, CMS may terminate a practice from CPC+ for cause. Termination can occur for a variety of reasons, including a practice's inability or unwillingness to meet the requirements of their participation agreement, or a practice's involvement in fraudulent or illegal activity. A practice must still complete the required actions associated with a withdrawal regardless whether the withdrawal if voluntary or involuntary.

> **For information regarding your Quality Payment Program (QPP) status,**
> **please refer to the following source at qpp.cms.gov.**

Adding a Practice Site

There are two allowable circumstances for a practice site to add a second location: (1) opening a satellite site, or (2) the splitting of a practice site into two practice sites. Table 18 describes the requirements for each circumstance.

Table 18: Allowable Circumstances to Add Another Site to a Practice Site

Topic	Satellite Site[47]	Practice Split
Description	An additional site opened to accommodate a patient panel that is geographically dispersed	A geographic extension of the original practice site as a result of natural growth of the patient panel/volume and physical space limitations at the current practice location
Notice required	30 days	30 days
Notification Method	Contact CPC+ Support	Contact CPC+ Support

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[47] Being in the same medical group or health system does not constitute being a satellite practice.

Topic	Satellite Site[47]	Practice Split
Shared Resources	All or a subset of practitioners from the initial CPC+ practice need to work at the satellite location. CMS cannot add new practitioners only to the satellite location. The exception to this is for specialists who do not meet the definition of a CPC+ practitioner. Both sites share the same personnel, management, practitioners, EHR, beneficiaries, and other resources. Note: Each site can have separate administrative staff.	Both sites share the same management, health IT, and EHR, but may have different personnel and practitioners. Some original CPC+ practitioners will need to be at the existing practice location and the new practice for purposes of continuity and likelihood of success. CMS will not approve a new practice site without practitioners with CPC+ experience.
Clinical Requirements	Practitioners must practice at each practice site; therefore, any given practitioner must not work exclusively at one of the sites. Note: CMS may allow specialty practitioners to work only at the satellite site with CMS approval.	Practitioners may work at both of the practice sites, or only one. If a practitioner was not part of the original practice, practices must submit a practitioner add request.
CPC+ Payments	CMS considers the satellite site part of the CPC+ Practice Site and payments from CPC+ will not be split between the original practice site and satellite location.	CMS will make payments to the new practice per the payment schedule.
Effective date of change	Upon completion of processing request	The effective date will be the first of the following calendar year (if appropriate notice is given).

Important Information about Practice Splits

- Requests received <u>on or before September 30, 2017</u> that CMS approves will be effective <u>January 1, 2018.</u>
- Requests received <u>after September 30, 2017</u> that CMS approves will be effective <u>January 1, 2019.</u>

Practice Mergers and Acquisitions

You have the freedom to make the right decisions for your practice. If your practice merges with another practice, acquires another practice, or if another practice acquires your practice, your practice should take the steps detailed in Table 19.

Mergers

Table 19: Practice Mergers

Topic	Same Track Mergers	Different Track Mergers
Description	Merger of two CPC+ practices that are in the same track or a merger of an existing CPC+ practice with a non-participating CPC+ practice	A merger where both practices participate in CPC+ but in different tracks
Notice required	30 days	30 days
Notification Method	Contact CPC+ Support	Contact CPC+ Support
Track assignment	The current track assignment will not be changed.	CMS will determine the appropriate track for merged practice sites based on a review of practice performance and the ability of the Track 1 practice to meet Track 2 requirements.
Reporting Timeline	Merged practices will begin to report as one site for the quarterly reporting period in which the merger effective date occurred.	Merged practices will begin to report as one site for the quarterly reporting period in which the merger effective date occurred.
CPC+ Payments	Payment will be consolidated to the one CPC+ practice.	Payment will be consolidated to the one CPC+ practice. If the merged practice is Track 1, the practice will stop receiving CPCP as of the effective date of the change. If the merged practice is Track 2, they will start receiving CPCP as of the effective date of the change.
Effective date of change	The first day of the quarter following completion of processing of the request	The first day of the quarter following completion of processing of the request

> **CMS will determine the appropriate track for merged practice sites that are operating in two different tracks**

Acquisitions

Table 20: Practice Acquisitions

Topic	New Owner
Description	A CPC+ practice is acquired by a new parent owner
Notice required	30 days
Notification Method	Contact CPC+ Support

Topic	New Owner
Track assignment	The current track assignment will not be changed.
Reporting Timeline	Reporting requirements and timeline are not impacted.
CPC+ Payments	Banking information is often updated when a practice obtains a new parent owner. The amount of payments will not be impacted. Owner will need to sign a segregation letter that commits all funds received for CPC+ for the said practice will be only used by the practice and not at the larger organizational level.
Effective date of change	The day in which the new parent owner legally has ownership of the practice

> **CMS will contact the new parent owner to orient the organization to the CPC+ model requirements. CMS wants to ensure a smooth transition and increase the likelihood of practice success when new parent organizations acquire existing CPC+ practices.**

Additional Practice Changes to Report

As noted in your Participation Agreement, you will need to notify CPC+ Support if there are changes in your practice's business ownership structure that makes your practice ineligible for participation in CPC+. These situations include the following:

- Changes that result in your practice no longer providing primary care services
- Designation as a Rural Health Clinic or Federally Qualified Health Center
- Changes that result in participation in a CMS program with a no-overlaps policy with CPC+, such as the Next Generation ACO Model and the Independence at Home Demonstration

Understanding the Impact of Composition Changes

Beneficiary Attribution

The Practice Site, along with the TIN or CMS Certification Number (CCN) for CAHs, and the National Provider Identifiers (NPIs) for each practitioner at a practice site are used by CMS for beneficiary attribution calculations[48] and the calculation of the care management fee. CMS uses these data to identify Medicare primary care services provided by your CPC+ practice.

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[48] For additional information on beneficiary attribution and CPC+ payment methodologies, please refer to the CPC+ Payment Methodologies: *Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment under the Medicare Physician Fee Schedule.*

Your practice's CPC+ Practitioner Roster determines the TINs, NPIs, and CPC+ effective dates. Any change made to your practitioner roster may impact the beneficiaries that are attributed to your practice, which may affect your practice's CPC+ payments.

Different types of composition changes have different processing times from when a practice submits the change to the effective date in the CPC+ Practitioner Roster, as noted in Table 21.

Table 21: Composition Change Impacts: Beneficiary Attribution and Joining the SSP

Composition Change Impacts: Beneficiary Attribution	
Practitioner Updates	When CPC+ practitioners leave a practice, their NPIs remain on the CPC+ roster and are marked with a termination date.
	In this way, CMS will count past visits to those practitioners (i.e., visits during the look back period) toward the practice when beneficiary attribution is calculated.
	When practices add CPC+ practitioners, CMS adds their NPIs to the CPC+ Practitioner Roster and includes them in the next quarter's beneficiary attribution methodology. CMS will use the date the practitioner joined the practice for attribution purposes, not the CPC+ practitioner effective date, which CMS bases on the CPI validation check being completed.
TIN Change	TIN changes are incorporated into the attribution methodology when the update has been approved.
	Historical TINs continue to be used in the attribution methodology to capture eligible visits in the look back period.
	A new TIN will not impact your attribution calculations until claims billed under the new TIN are included in the look back period used for attribution.
Joining the Shared Savings Program (SSP)	**Participation in the SSP will not affect beneficiary attribution.**
Practice Withdrawal (voluntary or involuntary)	CMS will remove the practice from the beneficiary attribution calculations.
Adding a Practice Site	CMS will add the practice to the first beneficiary attribution calculations for the Program Year that it became a CPC+ participant.
Practice Mergers and Acquisitions	CMS will add practices that merge to the applicable quarterly beneficiary attribution calculation that aligns with the quarter that the practice is effective as a CPC+ participant.
	Practice acquisitions do not impact the beneficiary attribution, however practices need to report TIN changes, which are often part of an acquisition, to have any new TIN included in beneficiary attribution calculations.

Care Management Fee

CMS pays the care management fee (CMF) quarterly, based on a per-beneficiary per-month (PBPM) calculated amount. The number of beneficiaries attributed to a given practice per

month, the HCC scores relative to the other practices, and the CPC+ track to which the practice belongs determines the CMF.

Composition changes affecting the attributed beneficiary calculation will affect the PBPM through changes to the distribution of beneficiaries in each of the risk tiers, as shown in Table 22.

Table 22: Composition Change Impacts: Care Management Fee

Composition Change Impacts: Care Management Fee	
Practitioner Roster Updates	Changes in the NPIs used in attribution may yield a different pool of attributed beneficiaries. A different attributed population may affect the total CMF through changes in the attributed population's case mix. The CMF total amount for each quarter also depends on the number of attributed beneficiaries.
TIN Change	A new TIN will not impact your attribution calculations until claims with dates of service in the look back period used for beneficiary attribution have been processed.
Joining the SSP	Participation in the SSP will not affect your care management fee.
Practice Withdrawal (voluntary or involuntary)	Depending on the timing of your practice withdrawal effective date, CMS may recoup CMFs paid to your practice. CMS may also recoup any debits identified for past beneficiary attribution cycles.
Adding a Practice Site	The practice will receive its first CMF for the quarter in which it joins CPC+.
Practice Mergers and Acquisitions	Practices that merge will see the impact to their CMF in the quarter in which the practice is effective as a CPC+ participant.

Performance-Based Incentive Payment

CMS determines the amount of PBIP by: (1) the number of beneficiaries attributed to a given practice in the first quarter of each year, (2) the CPC+ track to which the practice belongs, and (3) the practice's performance on the measures.[49]

Because CMS pays the PBIP prospectively and then reconciles it at the end of the performance period, composition changes will not significantly affect this payment unless your practice performance on measures is greatly impacted. Additional information on how this payment is impacted is provided in subsequent specific composition changes.

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[49] For additional information on beneficiary attribution and CPC+ payment methodologies, please refer to the *CPC+ Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance-Based Incentive Payment, and Payment under the Medicare Physician Fee Schedule.*

Table 23: Composition Change Impacts: Performance-based Incentive Payment

Composition Change Impacts: Performance-based Incentive Payment	
Practitioner Roster Updates	Practitioner changes will not significantly affect the PBIP reconciliation unless such changes greatly impact your practice's performance on measures.
	If a practice has a dramatic increase or decrease in the number of practitioners, the next Program Year's PBIP will be impacted accordingly.
	The PBIP also depends on the number of attributed beneficiaries.
TIN Change	TIN changes have no direct impact on the PBIP. However, practices should update banking information, when applicable.
Joining the SSP	Practices that join the SSP are not eligible to receive a PBIP.
Practice Withdrawal (voluntary or involuntary)	CMS may recoup the PBIP paid to your practice based on the effective date of your practice's withdrawal.
Adding a Practice Site	The practice will be eligible for PBIP on January 1 of the year that it joins CPC+.
Practice Mergers and Acquisitions	These impacts will be determined by CMS on a case-by-case basis.

Comprehensive Primary Care Payments (Track 2 only)

As shown in Table 24, Track 2 practices will receive a hybrid payment, meaning CMS will prospectively pay them Comprehensive Primary Care Payments (CPCPs) with commensurately reduced FFS payments. The CPCP is a lump sum quarterly payment based on historical Office Visit Evaluation and Management (E&M) FFS payment amounts. Track 2 practices will continue to bill as usual, but CMS will reduce the FFS payment amount to account for the CPCP.

Table 24: Composition Change Impacts: Comprehensive Primary Care Payments

Composition Change Impacts: Comprehensive Primary Care Payments	
Practitioner Roster Updates	Any new practitioners added to the CPC+ roster will be included in the practice's CPCP calculation for the payment quarter and have its FFS payment reduced by the amount the practice selected for the respective year. Practitioners who withdraw will not carry the reduced FFS amount forward to their new practice location unless they join a CPC+ practice that is in Track 2. In these cases, the practitioner would have a reduced FFS determined by the CPCP selection made by the new practice.
TIN Change	TIN changes may have an impact on the Medicare FFS claim reduction from the CPCP. Please be aware that the CMS claims system applies the FFS claim reduction when a Track 2 attributed beneficiary has an Office Visit E&M to the TIN/NPI combination on the roster for the quarter. This means that the claim system will apply the FFS claims reduction to a claim submitted by a CPC+ Tract 2 practitioner billing an Office Visit E&M for an attributed beneficiary at a Track 1 practice or a non-CPC+ participating practice location sharing the same TIN as Track 2 CPC+ practice. If this will be a concern, a potential solution is for CPC+ Track 2 practices to bill under a separate TIN.

Composition Change Impacts: Comprehensive Primary Care Payments	
Joining the SSP	Participation in the SSP will not affect your CPCPs.
Practice Withdrawal (voluntary or involuntary)	The FFS payment will revert to 100 percent after practices update the withdrawal information, which occurs on a monthly basis. CMS will perform partial reconciliation of the CPCP based on the effective date of the practice withdrawal.
Adding a Practice Site	If the practice is in Track 2, they will need to identify their upfront CPCP percentage.
Practice Mergers and Acquisitions	CMS will determine these impacts on a case-by-case basis.

Quality Reporting

CMS requires your CPC+ practice to report a full year of eCQM data. Certain composition changes, such as practice additions, practice splits, practice mergers, or practice acquisitions may impact your ability to meet this requirement, as shown in Table 25.

Furthermore, for CMS to consider your practitioners an Advanced Alternative Payment Model (APM) participant for Quality Payment Program (QPP) purposes, the APM/TIN/NPI combination must be present on one of three CPC+ Practitioner Roster "snapshots." CMS will take these snapshots in March, June, and August. Thus, any practice or practitioner withdrawing from CPC+ prior to March 30 will be subject to MIPS requirements.

Additional information regarding the Quality Payment Program is available at qpp.cms.gov.

Table 25: Composition Change Impacts: Quality Reporting

Composition Change Impacts: Quality Reporting	
Practitioner Updates	Quality reporting is at a practice level; therefore, individual practitioner changes should not impact them. Practices may need to update their EHR to reflect updated practitioner information to create their practice-level reports.
TIN Change	A TIN does not affect the quality reporting requirements. The new TIN will be included in the practitioner roster, which CMS will communicate to the QPP.
Joining the SSP	Practices participating in the SSP are still required to complete quality reporting for CPC+.
Practice Withdrawal (voluntary or involuntary)	CPC+ will provide data on participating practitioners to the QPP on a quarterly basis. Once a practice withdraws from CPC+, the practice will need to identify how they plan to report to the QPP.
Adding a Practice Site	New practice sites will need to be able to meet the quality reporting requirements and will report eCQM data during the reporting period immediately following their acceptance to CPC+.
Practice Mergers and Acquisitions	Practice mergers and acquisitions do not negate the practice's responsibility to fulfill all the eCQM reporting requirements.

Reporting of Care Delivery Requirements

Composition changes may affect reporting of care delivery requirements, as shown in Table 26. The impact on reporting requirements varies depending on type change that practice is making.

Table 26: Composition Change Impacts: Care Delivery Requirements

Composition Change Impacts: Care Delivery Requirements	
Practitioner Updates	Practitioner updates may impact the information captured in the care delivery requirements. Practitioner changes will need to be evaluated for impact on reporting of these data and incorporated to ensure the applicable information is reported in the practice data.
TIN Change	A TIN does not affect the reporting of care delivery requirements
Joining the SSP	Participation in the SSP will not affect reporting of your care delivery requirements.
Practice Withdrawal (voluntary or involuntary)	CMS may require partial submission of care delivery requirements. Upon final submission of all required data, CMS will terminate all user accounts affiliated with the practice. Such accounts include the CPC+ Practice Portal, the CPC+ Connect Site, and any other CPC+ related programs.
Adding a Practice Site	A new practice will need to start reporting care delivery requirements starting at the end of the first quarter in which it is effective as a CPC+ participant.
Practice Mergers and Acquisitions	Practice mergers and acquisitions do not negate the practice's responsibility to meet care delivery requirements.

Distribution List Updates

Composition changes may affect staff access to the CPC+ Practice Portal, CPC+ Connect, and the distribution list for program information. If your composition change requires updates, please submit those changes to CPC+ Support.

When In Doubt—Reach Out

If you have questions regarding how to perform composition changes in the CPC+ Practice Portal, or need to report a change that you cannot process in the CPC+ Practice Portal, contact CPC+ Support at CPCPlus@telligen.com or 1-888-372-3280. Please have your CPC+ ID ready and include it in the subject line of your email.

Use of Data Feedback Reports

Data comprise a foundational tool to help practices measure progress, track change, and identify areas for quality improvement and shared learning. In CPC+, practices can expect to receive timely and actionable data feedback in the form of quarterly reports from Medicare and all payer partners. CMS will release the first report for your attributed Medicare FFS beneficiaries in spring 2017 and will focus on key cost and utilization measures, based on claims data. Thereafter, CMS will provide reports on a quarterly basis.

Future Medicare FFS reports will build on this initial report, integrating new measures, data sources, and a more interactive format as the project progresses.

If you are interested in helping give regular feedback on these reports and providing details on how your practice uses these data, CMS will provide information on how to give feedback at a later date.

Other CPC+ payer partners will send you data feedback specific to their attributed patients separately, and may use different methods, timelines, and formats for their data feedback reports. In some regions, CPC+ payers may collaborate to create a unified report that includes information for all of your CPC+ attributed patients.

In addition to the reports, CMS is exploring ways to deliver regular claims and claims-line feed files to practices that have the technical ability to receive and analyze these data files. We will provide more details on how to request and receive these data in winter 2017.

Appendices

Appendix A. Key CPC+ Resources

Table 27 summarizes key resources available to practices, some of which are included in this Guide.

Table 27: CPC+ Key Resources

Resource	Description
CPC+ Change Package	The CPC+ Change Package, distributed by CMS in January 2017, provides a summary of key drivers, change concepts, and change tactics that contribute to the model's overall aims of more patient centered, high-quality, and cost effective care. This resource includes a diverse set of ideas that can be helpful in guiding care delivery work in practices.
CPC+ Payment Methodologies	This document, distributed by CMS in March 2017, explains the CPC+ payment methodology.
CPC+ Electronic Clinical Quality Measure (eCQM) Fact Sheet	This fact sheet, distributed by CMS in March 2017, reviews what eCQMs are and how they work in the context of CPC+.
Care Delivery Reporting Guide	This document, distributed by CMS in March 2017, guides practices through 2017 CPC+ Care Delivery Reporting. Practices should use this guide to prepare for reporting in each quarter, and to identify what information they will need to collect and track. *Note*: a*ll components of the Care Delivery Reporting Guide are now included in Section II of this Guide.*
Getting Started with CPC+ Connect	This quick guide, distributed in January 2017, walks users through the steps required to successfully access CPC+ Connect. *Note: For more information about how to access CPC+ Connect, please see the Introduction section of this Guide.*
CPC+ National Curriculum	This resource outlines upcoming learning events, including national webinars, action groups, and regional events in 2017. *Note: The National Curriculum is updated monthly, so please check CPC+ Connect for the most recent version.*
Frequently Asked Questions (FAQs)	The FAQs are a compilation of questions and answers addressing key change concepts and tactics of the CPC+ model and related inquiries about payment.
On The Plus Side weekly newsletter	*On The Plus Side* is a weekly newsletter emailed to all practices that includes CPC+ program updates, resources, answers to frequently asked questions, and upcoming CPC+ events. *Note: Please check CPC+ Connect for the most recent version.*
CPC+ Practice Portal	The Practice Portal is your source of current practice information: demographics, Practitioner and Staff Roster, TIN, organizational affiliation, and health IT vendor information

Appendix B. Useful Tools and Resources

Tools and resources exist that your practice can reference for more details on change tactics you choose to adopt, and related evidence-based documentation.[50] As referenced below, we categorized resources to help you easily identify the resource types.

🗋	**Templates** include documents that practices can modify for their use. Templates include policies, letters to patients, care agreements, confidentiality agreements, training module, etc.
◖⋮	**Spotlight examples** from CPC Classic practices describing how they implemented a change concept or tactic
▶	**Movie shorts** (most of which are five minutes or less in length) or **recorded webinars** that describe a change concept or tactic. Many include interviews with subject matter experts and/or practice representatives who have implemented a change.
🗐	**Articles or case studies** providing a deeper-dive into the evidence or expert thinking behind a change concept or tactic
☑	**Guidelines, toolkits, and/or checklists** that provide a detailed, step-by-step process for how to implement or test a change concept or tactic

Function 1: Access and Continuity Resources

Type	Title	Description
🗐	Patient Empanelment: The Importance of Understanding Who Is at Home in the Medical Home,	This article discusses the importance of identifying active patients and measuring panel sizes as well as the benefits of reforms that support and promote universal registration of patients with primary care practitioners.
🗐	"Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation"	This article explains factors used to determine panel size, and how practices can optimize efforts by organizing their care teams by skill set and task.
☑	The Safety Net Medical Home Initiative Empanelment Implementation Guide	This implementation guide is a step-by-step tool that provides key steps to successful empanelment. It describes the approach used in the Safety Net Medical Home initiative. You can find more information on tools and webinars on the Safety Net Medical Home web page.
☑	AHRQ Primary Care Practice Curriculum on Facilitating Panel Management	This module will guide learners in identifying steps involved in training a practice on key concepts of panel management. The module references panel training management by Bodenheimer and Ghorob to train key practice staff on panel management.
☑	IHI Third Next Available Appointment	This IHI web page provides guidelines on the use and collection process for the "third next available appointment" measure of access.

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[50] You must have an active CPC+ Connect account to access these spotlights. See page 8 of this Guide for more information on other features of the CPC+ Connect website and a self-registration link.

Type	Title	Description
	Group Visit Toolkit	This popular family practice management (FPM) article collection features content on the subject of group visits; includes tools such as documentation forms, and problem-solving worksheet.
	AAFP: House calls (Physician home visits)	This article provides an overview of house calls, and suggests strategies to facilitate incorporation of this service into busy practices. It also includes a template.
	IHI: Measure and Understand Supply and Demand	This web page provides guidelines on measuring demand for all services, measuring supply for all practitioners and staff, and comparing supply and demand to ensure patients receive timely access to care.
	Putting Group Visits Into Practice	This is an implementation guide for practitioners who want to utilize group visits in order to support their patients with chronic conditions. It outlines challenges, benefits for group visits, and a step-by-step guide for implementation.
	Spotlight 59: Home Visits Help Brittle and High-Risk Patients Stay in the Continuum of Care	This CPC Classic Spotlight highlights how Providence Medical Group offers home visits from a nurse practitioner to increase support and expand access for patients whose struggles to come to the office could compromise their health. Providence Medical Group refreshed an old idea to support timely continuity of care and patient engagement for high-risk patients.
	How Primary Care Practices Can Improve Continuity of Care	This article provides suggestions for how to improve continuity of care and examples of patient- and practitioner-centric continuity approaches.
	Spotlight 85: Expanding Access to Care through E-visit Technology	This spotlight highlights how the St. Elizabeth Physicians team decided to offer patients the option of virtual treatment for non-urgent medical issues. This spotlight describes how St. Elizabeth's early adopters, Karl Schmitt, MD, and Bradley Gray, DO, embraced the innovation and led efforts to convince their colleagues to do so too.
	Patient Empanelment: The Importance of Understanding Who Is at Home in the Medical Home	This article highlights the importance of identifying active patients and measuring panel sizes, even in the face of imperfect data, as well as knowing "who is at home in the medical home" and how it is critical to achieving high-performing primary care.
	Estimating a Reasonable Patient Panel Size for Primary Care Physicians With Team-Based Task Delegation	This article describes how portions of preventive and chronic care services can be delegated to nonphysician team members and how primary care practices can provide recommended preventive and chronic care with panel sizes that are achievable with the available primary care workforce.
	Defining and Measuring Interpersonal Continuity of Care	This article discusses how continuity can be best described through three dimensions: informational, longitudinal, and interpersonal continuity.

Type	Title	Description
📝	How Primary Care Practices Can Improve Continuity of Care	This article explains how primary care practices can improve continuity of care and how continuity can be measured through patient-centric and practitioner-centric measures.

Function 2: Care Management Resources

Type	Title	Description
☑	Risk-Stratified Care Management and Coordination Tool	This AAFP tool provides a systematic process to developing a risk stratification model using available data.
☑	Complex Care Management Toolkit	The California Quality Collaborative provides a step-by-step process to developing a risk stratification model using available data. Each step is supported by additional tools to help the practice work through each stage of development.
📄	AAFP Patient-Centered Care Plan Template	This AAFP template outlines the elements to include in a patient-centered care plan
☑	Organized, Evidence-Based Care: Planning Care for Individual Patients and Whole Populations	This resource provides guidance for implementing a care management program and considerations to address through this effort. Page 8 summarizes care management and links to an implementation guide.
🔦	Spotlight 64: Toolkit for End-of-Life Care Helps Care Teams with Effective Conversations	At the request of physicians seeking help with end-of-life planning and conversations, CPC Classic practice Hunterdon Healthcare Partners of New Jersey created "Care Planning for Serious Illness," a toolkit for use across its system in both hospital and clinic settings. As described in this Spotlight, Hunterdon tapped internal resources—including its patients and families—to build a comprehensive set of resources and tools that better prepare physicians and care teams to help patients with advanced care planning.
☑	Improving Medication Safety in High Risk Medicare Beneficiaries Toolkit	This AHRQ toolkit provides interview questions for medication reconciliation and guidance for addressing adverse drug interaction. The Appendix of this toolkit provides sample tools for documenting the medication reconciliation process, patient charting, as well as a medication list template for patients.
☑	Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation	This toolkit provides a step-by-step guide to improving the medication reconciliation process. It will help your care team evaluate the effectiveness of your medication reconciliation process, as well as identify and respond to any gaps. It promotes a successful approach to medication management and reconciliation that emphasizes standardization of the medication reconciliation process.

Type	Title	Description
◖⦂	Spotlight 36: Look to CPC Change Package for Strategies as You Expand Your Comprehensive Primary Care Services	This CPC Classic spotlight details how Andaraj Subramanium, MD, shaped his practice's care management capability from scratch. Dr. Andy chose to apply intensive care management to patients with a high-risk score who had also been diagnosed with COPD. He hired and trained a care manager who would call patients within 48 hours of discharge or treatment to effectively close gaps for all patients.
◖⦂	Spotlight 54: Use Your ED and Hospitalization Follow-Up Data for New Insight on When, How and Why Patients Use Urgent and Emergency Care	This CPC Classic Spotlight describes how Latham Medical Group gathers more than 10 data points around a patient's acute care episodes and uses the data to tailor follow-up calls, guide care management, and fine-tune quality improvement efforts.
📝	Care Management Plus: Strengthening Primary Care for Patients with Multiple Chronic Conditions	This case study is one in a series examining programs that aim to improve outcomes and reduce costs of care for patients with complex needs, who account for a large share of U.S. health care spending.
📝	Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?	This study from the Commonwealth Fund compares the operational approaches of 18 successful complex care management programs in order to offer guidance to providers, payers, and policymakers on best practices for complex care management.
📝	High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?	This article examines demographics, health care spending, and use of services among adults with high needs to identify ways to improve outcomes and reduce spending for patients with complex and costly care needs.
📝	Enhancing the Primary Care Team to Provide Redesigned Care: The Roles of Practice Facilitators and Care Managers	This article describes how practice facilitators and care managers can help primary care practices deliver coordinated, accessible, comprehensive, and patient-centered care.
📝	Care Management: Implications for Medical Practice, Health Policy, and Health Services Research	This article discusses the implications of care management and how targeted care management services can decrease adverse outcomes in patients with chronic conditions.
📝	Kaiser Permanente Study Finds Tailored Post-Hospital Visits Lower Risk of Readmission for Medicare Advantage Patients	This article highlights how patients who had one or more outpatient visits with primary care practitioners within 7 days of the hospital discharge were 12 to 24 percent less likely to experience hospital readmission than those who did not have an outpatient visit.

Function 3: Comprehensiveness and Coordination Resources

Type	Title	Description
	The Geriatric Assessment	The geriatric assessment is a multidimensional, multidisciplinary assessment designed to evaluate an older person's functional ability, physical health, cognition and mental health, and socio-environmental circumstances.
	Practice Spotlight 7: Oregon Medical Group BHI	This CPC Classic spotlight demonstrates integration of behavioral health services to support patients' common and complex behavioral health needs by ensuring regular communication and coordinated workflows between primary care, behavioral health practitioners, and community services.
	Practice Spotlight 77: Latham Medical Group BHI	Learn how Latham Medical Group, a CPC Classic practice, found the right practitioners, located helpful resources to support transformation work, refined workflows, and measured effectiveness to fully integrate behavioral health (BH) services.
	A Guidebook of Professional Practices for Behavioral Health and Primary Care	This AHRQ-funded guidebook was developed to assist the field of primary care and behavioral health in identifying professional practices for developing a workforce for integrated care.
	The Administrative Readiness Tool (ART)	The ART is a self-assessment tool designed to help practices assess and improve the core administrative processes needed most to support primary and behavioral health care integration.
	Practice Spotlight 60: Pharmacist Integration Strategy: Working Directly with Patients to Improve Medication Adherence and Outcomes	This spotlight explores how Banner Health's CPC Classic practices integrated pharmacists into their team to work directly with patients who often need more support with their medication therapies, such as patients with diabetes and patients using anti-coagulation therapies.
	Integrating Comprehensive Medication Management to Optimize Patient Outcomes	The goal of this resource guide, developed by the PCPCC's Medication Management Task Force, is to provide information that facilitates the appropriate use of medications in order to control illness and promote health, which are critical elements to the PCMH's success.
	Medication Management	This Primary Care Team website provides guidance on how practices can help patients overcome the challenges of multiple prescriptions through medication management that assesses medication use and adherence in a non-judgmental way.
	AMCP Formulary Management	This Academy of Managed Care (AMCP) guide on formulary management describes formulary development and how formularies complement other health care management tools.

Type	Title	Description
	[AMA STEPS Forward: Module on Project ECHO](#)	The American Medical Association's STEPS Forward Module on Project ECHO provides numerous tools and resources for primary care practices to establish access to a wide variety of medical and behavioral health specialists via structured telemedicine interactions.
	[Primary Care—Specialist Physician Collaborative Guidelines](#)	This document provides an example of a care coordination agreement from Colorado. This physician compact has been developed for general distribution with the support of the Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation.
	[Spotlight 35: Timely ED and Admissions Follow-Up Still Closes Gaps Even When Patient Mix Changes](#)	This spotlight explores how the CPC Classic practice First Street Family Health of Salida, Colorado ensured timely follow-up and held ED visits steady, despite a dramatic increase in Medicaid patients.
	[Spotlight 19: Forming Successful Care Coordination Agreements with a High-Volume Specialist and a Behavioral Health Practitioner](#)	This spotlight explores the steps that Mayfair Internal Medicine, a CPC Classic practice, took to establish care coordination agreements with a high-volume specialist and behavioral health practitioner to create a medical neighborhood. This resource will foster creative thinking regarding potential collaborative care agreements, and how to monitor and continually improve the relationship within that agreement.
	[Health Leads Screening Toolkit](#)	This Social Needs Screening Toolkit shares the latest research on how to develop an effective social need screening tool and how to screen patients for social needs. Also provides list of other useful screening tools.
	[PRAPARE Implementation and Action Toolkit](#)	The sections in this toolkit provides practices with guidance and resources on how to better understand patients' social determinants of health, transform care to meet the needs of patients, and identify and act on social determinants of health.
	[PRAPARE Toolkit, Chapter 9: Respond to Social Determinants Data with Interventions](#)	This chapter of the PRAPARE Toolkit provides practices with guidance and examples on ways to address or ameliorate risks for social determinants of health.
	[We-Care Screening Tool](#)	This document is a parent-completed screening tool that focuses on well-child visit, evaluation, community resources, advocacy, referral, and ED.
	[HealthBegins Screening Tool](#)	This tool provides practices with a way to screen patient risk and social needs.
	[CPC+ Behavioral Health Integration Menu of Options](#)	To meet the needs of your patients with common and complex behavioral health needs, your work in CPC+ will follow a menu of options with two foundational strategies for behavioral health integration within your practice: Care Management for Mental Illness and the Primary Care Behaviorist Model.

Type	Title	Description
☑	Advancing Integrated Mental Health Solutions (AIMS Center)	This web page offers an implementation guide and other resources for collaborative care. It provides an approach that uses care management and a "stepped care" approach to enhance behavioral health services. The approach is based primarily on the IMPACT trial. AIMS Center also offers care manager training.
📝	Core Competencies for Behavioral Health Practitioners Working in Primary Care	The scope of this document is the desired competencies tailored for licensed behavioral health practitioners. The goal for all members of the primary care team is to acquire and demonstrate competencies specific to their roles in integrated primary care. This document was primarily sponsored by the University of Colorado, School of Medicine.
☑	SBIRT: Screening, Brief Intervention, and Referral to Treatment	SBIRT is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. This site introduces SBIRT, resources, guides, and webinars.
📝	Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together	This research article research article identifies common challenges that manifest in integrating behavioral and physical health care.
☑	Medication Management	This resource provides steps and tools necessary to achieve efficient medication management.
📝	Referral and Consultation Communication Between Primary Care and Specialist Physicians: Finding Common Ground	This article examines PCPs' and specialists' perceptions of communication regarding referrals and consultations and how enhancing communication can inform efforts to improve care coordination.
📝	Coordination Between Emergency and Primary Care Physicians	This research article by the Center for Studying Health System Change (HSC) examines emergency and primary care physicians' ability—and willingness—to communicate and coordinate care, finds that haphazard communication and poor coordination often exist, and provides possible steps to correct these discontinuities.
☑	Improving care transitions and reducing hospital readmissions: establishing the evidence for community-based implementation strategies through the care transitions theme	This resource provides best practices and strategies on improving care transitions.
📝	Coordinating care in the medical neighborhood: critical components and available mechanisms	This article describes the importance of care coordination for patients treated in hospital emergency departments (EDs) and how primary care providers also can be involved in the coordination process.
☑	CPC+ Care Delivery Requirements	The CPC+ Care Delivery Requirements will guide practices through the comprehensive primary care functions as markers for regular, measureable progress to the CPC+ model aims.

Type	Title	Description
📝	The High Concentration of U.S. Health Care Expenditures	This AHRQ report provides analyses on health care spending patterns in the United States.
📝	The Determinants of Health	This AHRQ report provides analyses on health care spending patterns in the United States.
☑	Systems of Care/PCMH Initiative Compact Facilitation Guide	This guide provides tools to support practice changes to implement care coordination guidelines within their medical neighborhood by developing tools, key questions, and other resources that aid in collaborative care agreement adoption.

Function 4: Patient and Caregiver Engagement Resources

Type	Title	Description
☑	National Partnership for Women and Families. Key Steps for Creating Patient and Families Advisory Councils in CPC Practices	This how-to document developed by the National Partnership for Women and Families for CPC Classic practices outlines detailed steps for creating a PFAC, including roles and responsibilities for patient advisors, interview questions for potential advisors, and a health care glossary for patients.
☑	AMA STEPS Forward: Forming a Patient and Family Advisory Council	AMA's open-access, on-line module describes steps in forming a PFAC. This resource includes downloadable tools including PowerPoint presentations, candidate applications, council compacts, meeting agendas, welcome letters, and more.
🗋	Patient Advisor Application (pg. 30–33)	Pages 30–33 of this document describe a template application from IPFCC that practices can use to think through questions they might ask potential patient advisors.
◀≡	Spotlight 51: Developing a Highly Effective PFAC over Time: How Structure and Transparency Foster Useful and Actionable Feedback	This CPC Classic spotlight describes the Batesville Family Practice Clinic implementation of its PFAC. Read this spotlight to learn about how Batesville Family Practice Clinic revised their recruitment efforts, cultivated a structured environment for PFAC meetings, and boosted participation and actionable feedback.
◀≡	Spotlight 9 & 10: CapitalCare Shares How It Operationalized 10 PFACs in 2013	This CPC Classic spotlight describes the CapitalCare Medical Group's implementation of its PFAC. CapitalCare's 10 CPC Classic practices collectively decided the PFAC approach would provide up-close and actionable feedback that was specific to their sites, staff, and workflow.
▶	Using Patient Feedback to Drive Practice Change	In this CPC On Demand Video, hear how one CPC Classic practice partners with its PFAC on patient education.
☑	IHI Partnering in Self-Management Support: A Toolkit for Clinicians	This toolkit and other resources help support self-management from both the practitioner and the patient side, and include diagrams, action plans, and presentations.

Type	Title	Description
	[AHRQ Self-Management Support Toolkit](#)	AHRQ provides a plethora of tools and resources for self-management support including evidence-based guidelines, training materials, and patient education materials.
	[Self-Management Toolkit: A Resource for Health Care Providers](#)	This toolkit offers tutorials for practitioners to quickly learn self-management techniques and tools.
	[Community Health Association of Mountain Plain States (CHAMPS) Patient Self-Management Tools](#)	CHAMPS provides a library of condition specific self-management tools and links to online patient self-management resources to facilitate patients having a central role in determining their care and to foster a sense of self-responsibility for health and wellbeing.
	[Patient-Centered Interactions: Engaging Patients in Health and Healthcare](#)	This implementation guide to improving patient-centered interactions includes use of surveys, self-management support, and organizing patient-centered visits.
	[Spotlight 27: RN Care Coordinators as Diabetes Educators: Expanding Patient-Centered Disease Management Support](#)	This spotlight describes CPC Classic practice Corvallis Clinic's implementation of self-management support and expansion of patient-centered disease management support.
	[Spotlight 33: Check for Literacy When Evaluating Patient Self-Management Skills – Warren Clinic](#)	This CPC Classic spotlight describes the Warren Clinic's implementation of self-management support and evaluation of patient literacy and self-management skills.
	[The Effective Physician: Motivational Interviewing Demonstration](#)	This video provides a demonstration of the motivational interviewing approach in a brief medical encounter.
	[Always Use Teach-back Training Toolkit](#)	This toolkit includes videos and tools using teach-back to confirm understanding, with behavior change principles of coaching to new habits and adapting systems to promote consistent use of key practices.
	[The Patient Activation Measure (PAM)](#)	This tool identifies the patient's level of activation, which can then guide the care team in the planning of care with the patient. Any team member can quickly use this tool with a patient. Note: This tool is a commercial product with a licensing fee associated with its usage.
	[How's Your Health](#)	This assessment tool can be completed by the patient. It measures his or her level of confidence in managing a chronic condition, and provides guidance in building a plan that improves confidence.
	[The AHRQ SHARE Approach to Shared Decision Making](#)	AHRQ's SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient. This web-based resource includes curriculum on the SHARE approach, patient decision aids, case studies, and guidelines.

Type	Title	Description
	[Mayo Clinic Shared Decision Making National Resource Center](#)	The Mayo Clinic Shared Decision Making National Resource Center advances patient-centered medical care by promoting shared decision making through the development, implementation, and assessment of patient decision aids and shared decision-making techniques. This web-based resource includes decision aids, training materials, case studies, presentations, and videos.
	[Center for Shared Decision Making](#)	The Center for Shared Decision Making at Dartmouth Institute offers training modules, toolkits, and resources for integrating decision support into primary care, specialty care, and clinical skills.
	[Choosing Wisely](#)	*Choosing Wisely* centers on conversations between practitioners and patients informed by the evidence-based recommendations of "[Things Providers and Patients Should Question](#)." More than 70 [specialty society partners](#) have released recommendations with the intention of facilitating wise decisions about the most appropriate care based on a patients' individual situation.
	[Shared Decision Making—Finding the Sweet Spot](#)	This New England Journal of Medicine article describes the importance of shared decision making in health care.
	[Value of shared decision making](#)	This four-minute educational video by St. John Health System explores the concept of shared decision making using the SHARE approach.
	[Minnesota Shared Decision Making Collaborative Toolkit](#)	This toolkit is roadmap of how to establish a shared decision-making collaborative.
	[Spotlight 14: Hicken Medical Clinic](#)	This CPC Classic spotlight describes the Hicken Medical Clinic's shared decision-making approach and workflow for shared decision making for patients with behavioral-health-related conditions.
	[Spotlight 3: Primary Care Partners](#)	This CPC Classic spotlight features Dr. Pramenko, who discusses how Primary Care Partners' journey with shared decision making began and what work still lies ahead to fully integrate shared decision making in primary care.
	[Helping Patients Help Themselves: How to Implement Self-Management Support](#)	This guide from the California Healthcare Foundation cites seven essential activities in self-management support.
	[Preference-Sensitive Care](#)	This resource from Dartmouth provides information on preference-sensitive conditions and engaging patients in shared decision making.

Function 5: Planned Care and Population Health Resources

Type	Title	Description
📝	Building Quality Improvement Capacity in Primary Care: Supports and Resources	These articles focus on developing QI capacity to its fullest to enhance primary care. Promising models, such as the patient-centered medical home (PCMH), are discussed, along with their potential to transform the delivery of primary care and achieve the triple aim of improved patient experience, improved population health, and reduced costs.
📝	Redesigning Primary Care: A Strategic Vision to Improve Value By Organizing Around Patients' Needs	This article addresses the absence of an overall strategy and vision for primary care. It offers a framework based on value for patients to sustain and improve primary care practice.
📋	Implementing a point-of-care registry	This guideline provides how-to steps for brainstorming point of care registries, as well as templates and examples of completed registries.
📋	The Primary Care Team: Conceptual Diagram	The Primary Care Team Conceptual Diagram helps practices think about how to effectively organize a care team around the patient.
📋	Team-based relationship resource	This resource provides a team-based planning worksheet to guide you in your patient care evaluation.
📋	An Organized Approach to Chronic Disease Care	This article highlights a practice that implemented the chronic care model. The article outlines the baseline data, team-based roles and responsibilities, and outcome measures for improving chronic care for high-risk diabetic patients.
📋	IHI: Optimize the Care Team	This resource guide provides guiding steps for a practice to understand the types of services it provides, and then decide who should be involved in the work and how practices should divide the work among the care team.
📋	AMA STEPS Forward: Conducting Effective Team Meetings	This online module answers the question "How will this module help me successfully conduct effective team meetings in my practice?" The module includes: (1) 10 steps to help successfully conduct regular team meetings, (2) answers to common questions and concerns about team meetings, (3) case vignettes describing how practices are successfully using team meetings, and (4) provides implementation tools, such as a sample agenda.
📝	Can Health Care Teams Improve Primary Care Practice?	This article focuses on the question "how do team members work together?" and provides steps toward team development that may improve the work environment in primary care practices.

Type	Title	Description
	Spotlight 58: Setting Your Improvement Project in Motion: Get a Quick Start with Pre-Planning, Guidelines, Communication and Tools	This CPC Classic spotlight describes how Colorado's Family Physicians of Greeley created a package of materials, information, and measures to clearly articulate the need and expectations for their short-term improvement project on early identification and preventative treatment for COPD. Read on to find ideas about how your practice could follow the same strategies to earn buy-in and support for your improvement efforts.
	Spotlight 65: Social Worker Contributes to Collaborative, Team-based Care Management	This CPC Classic spotlight highlights how the care management team at Stillwater Medical Physicians Clinic in Oklahoma added a part-time social worker to its team to complement their clinical expertise in caring for patients. Learn how they identified the need, created the position, and recruited a person with the right skillset for their team.
	Spotlight 86: Pre-visit Planning Helps Eliminate Gaps in Patient Care	This CPC Classic spotlight highlights how Upper Valley Family Care in Ohio uses a well-coordinated system of pre-visit planning to eliminate gaps in patient care.
	Primary Care Team Guide: Build the Team	The Improving Primary Care web site outlines how to structure team-based care to be successful by building PCPs' trust, and collaborate with their staff to figure out the best ways to organize work, communicate, and identify tasks other members of the team can accomplish.
	Spotlight 39: Care Team as a Partner in Wellness	This CPC Classic spotlight explores Dr. Borghini's approach to help patients set attainable goals and make a measurable difference in their health.
	Nearly half of U.S. adults were not receiving key preventive health services before 2010	This article highlights how Americans receive only half of their needed preventive and chronic disease services and that increased use of clinical preventive services could save tens of thousands of lives.
	Primary Care Team Guide: Build the Team	This site provides an overview of the role of the primary care practitioner, action steps to build a team-based approach to care, and tools for transforming primary care.
	Building Quality Improvement Capacity in Primary Care: Supports and Resources	This resource provides frameworks and resources for engaging in quality improvement and developing quality improvement capacity.
	A Strategic Vision To Improve Value By Organizing Around Patients' Needs	This article describes how redesigning primary care using a framework centered around patients' needs can improve the ability of primary care to play its essential role in the health care system.

Driver 2: Use of Enhanced, Accountable Payment Resources

Type	Title	Description
📝	Guidance for Structuring Team-Based Incentives in Health Care	This article provides some guidelines on structuring team-based incentives in health care.
🗒	Practice Management Toolkit	This toolkit assists practices in 1) building financial reports; 2) evaluating payers, including payer profitability and collections monitoring; 3) fee schedule tracking; and 4) cost-benefit analysis for adding new services.
◐≡	Practice Spotlight 1 & 2: SAMA Healthcare	This CPC Classic spotlight highlights how SAMA Healthcare Services leveraged CPC dollars to re-configure their clinic into four care teams, each led by a physician and supported by a nurse practitioner, three additional nurses, and a care coordinator. The funding allowed them to hire the needed nurse practitioners, including one who is a certified diabetes educator and another with a pediatrics specialty certification.
◐≡	Practice Spotlight 31: Building a Transformative Culture to Sustain Change	This CPC Classic spotlight explores how this 39-site practice group has sought ways to stave off "change fatigue" by cultivating engagement and incorporating compensation strategies that reward value and team-based care. Find out how their patients are responding to a staff of empowered and knowledgeable practitioners.
◐≡	Spotlight 44: Teamwork, Transparency and Rewards Drive Improvement in Quality Measures	This CPC Classic spotlight describes how PriMed pursued three strategies to help physicians and their teams adapt and embrace integrating the CPC CQMs: teamwork, data transparency, and rewards for performance. PriMed developed compensation strategies that recognized high performers at meetings and practice events, as well as through financial incentives.
◐≡	Spotlight 37: Taking a Second Look at Medicare Utilization Data for Improvement Opportunities in Admissions and ED Use	This CPC Classic spotlight highlights how Family Physicians of Greeley, Colorado, is focusing on Medicare utilization data to track hospitalizations and ED visits. Learn how their strategy is informing improvement efforts that span the CPC change drivers as well as their patient population.
◐≡	Spotlight 61: Practice Credits 63% Drop in ACSC Admissions to 'Going All In'	This CPC Classic spotlight highlights how UC Health – Timberline credits four tactics for decreasing its ASCS admissions by 63 percent and its risk-adjusted expenditures 2.5 percent. Timberline uses "show and tell" tactics to keep data clearly present at all times. This ensures everyone understands their individual performance directly contributes to patient satisfaction and outcomes, as well as the practice's overall performance.
📝	Guidance for Structuring Team-Based Incentives in Health Care	This article describes the importance of provider payment reform and the need to design and implement compensation systems that provide incentives for team-based care.

Driver 3: Continuous Improvement Driven by Data Resources

Type	Title	Description
◖≣	Spotlight 37: Taking a Second Look at Medicare Utilization Data for Improvement Opportunities in Admissions and ED Use	This CPC Practice spotlight highlights the work of Family Physicians of Greeley, Colorado using run charts to monitor improvement efforts.
◖≣	Spotlight 41: Following Data Over the Long Term Aids in Maintaining Improvement	This CPC Practice spotlight highlights the work of Central Oregon Family Medicine on tracking referral related metrics and using the data for improvement by looking for patterns and changes.
◖≣	Spotlight 70: Practice 'Re-attacks' ED Visits Following Changes in the Medical Neighborhood	Despite sustained improvements in several key Medicare outcomes, Harrison Family Practice was puzzled to see its patients' ED visits start to climb around Q5. Read this CPC Classic spotlight to find out how they searched for root causes and how they are "re-attacking" ED visits.
◖≣	Spotlight 71: Practice Credits Culture for Sustained Improvements	This CPC Classic spotlight features Scotia-Glenville Family Medicine, which consistently ranks among the practices with the lowest expenditures in the New York region. Practice leaders credit a culture of putting patients' needs first for their gains in their transformational efforts. A deeper look reveals data help identify those patient needs, which autonomous care teams then support. A full complement of care management services then back up those teams. The result is responsive, timely care for a range of patient needs.
◖≣	Spotlight 73: Utica Park Clinic: CPC from the Leader's Perspective	This CPC Classic spotlight describes Utica Park Clinic's approach to improving care by teambuilding and spreading and embracing change.
◖≣	Spotlight 31: Building a Transformative Culture to Sustain Change	This CPC Classic spotlight explores how Providence Medical Group, a 39-site practice group, sought ways to stave off "change fatigue" by cultivating engagement and building a culture focused on continual improvement. Find out how their patients are responding to a staff of empowered and knowledgeable practitioners.
◖≣	Spotlight 62: Marrying Actionable Data with Better Operations to Improve Care	Eugene Heslin, MD, describes how his CPC Classic practice has tackled the challenges of transformation, leveraging data to build better operations. This CPC Classic spotlight discusses how Bridge Street Family Medicine marries utilization and improvement with quality care and patient satisfaction.
☑	Approaches to Quality Improvement	This guide describes how the model for improvement and Plan-Do-Study-Act cycle provides a framework to systematically improve the way care is delivered to patients.

Driver 4: Optimal Use of Health IT Resources

Type	Title	Description
	Spotlight 1: SAMA Healthcare	Read about how CPC Classic practice, SAMA Healthcare from El Dorado, AR, used the risk stratification capability of its EHR and blended it with care management to improve preventive care services.
	Certified Health IT Product List (CHPL)	This website lists all certified health IT vendors and versions.
	Testing and Test Methods	The Office of the National Coordinator (ONC) HealthIT.gov website provides detailed information on all 2015 Edition certification criteria, companion guides, and test procedures.
	Common Clinical Data Set (CCDS) Reference Document	This resource is a complete list of the 2015 Edition of the Common Clinical Data Set (CCDS) and their associated standards
	CDA® Release 2	This document standard developed by the HL7 organization specifies the structure and semantics of clinical documents for health care data exchange.

Driver 5: Aligned Payment Reform Resources

Type	Title	Description
	CPC+ Methodology Paper	This Executive Summary provides an overview of the methodologies that the Centers for Medicare & Medicaid Services (CMS) will use for the Comprehensive Primary Care Plus (CPC+) payment model being tested in Medicare fee-for-service (FFS).

Appendix C. CPC+ 2017 Roadmap

The figure below illustrates a "roadmap" for the first year of care delivery redesign. The roadmap illustrates the suggested sequencing of high-level changes that may lead to the enhanced capabilities required in CPC+. Practices may be at different stages of readiness at the start of CPC+, and should look to this roadmap as a guide for pacing change. Depending on the specific corridor of work, your practice may be more advanced in one domain than in another. Your practice can start at the stage appropriate to its own needs and resources. By the end of 2017, you should have fulfilled—and even moved beyond—the 2017 care delivery requirements and be ready to advance to the next steps of redesign. We expect to release the 2018 Program Year requirements in fall 2017.

Note: In the roadmap, care delivery requirements are noted in light blue. Track 2 requirements are outlined in red. The incremental steps your practice may take to achieve requirements are noted in green.

Figure 12: Roadmap for First Year of Care Delivery Redesign

Access and Continuity

Q1	Q2	Q3	Q4
Ensure patients have 24/7 access to a care team practitioner with real-time access to the Electronic Health Record (EHR).			
Identify roles and responsibilities of care teams.	Organize care by practice-identified teams responsible for a specific, identifiable panel of panelists to optimize continuity.		
Identify active patient population.	Begin to empanel patients to clinicians and/or care teams.	Achieve 95% empanelment to practitioner and/or care teams.	Maintain 95% empanelment to practitioner and/or care teams.

TRACK 2 ONLY

Q1	Q2	Q3	Q4
Identify at least one alternative office strategy.	Plan and test at least one alternative office strategy.	Implement at least one alternative office strategy.	Regularly offer at least one alternative office strategy.

Care Management

	Q1	Q2	Q3	Q4
	Plan and test risk stratification strategies.	Refine and implement risk stratification strategies.	Initiate risk stratification of all empaneled patients.	Complete and maintain risk stratification of all empaneled patients.
	Based on a defined risk stratification process, identify patients likely to benefit from intensive care management.		Target care management services for patients identified as at increased risk and most likely to benefit from care management.	
	Assess ideal workflow for follow-up of ED and hospitalizations.	Plan and test workflow to ensure practices contact patients with ED visits and hospitalizations within a timely manner.	Ensure patients with ED visits receive a follow-up interaction within one week of discharge.	
			Contact hospitalized patients in target hospital(s), within two business days after discharge.	Contact at least 75% of hospitalized patients in target hospital(s) within two business days.
				Provide short-term care management with medication reconciliation to patients who have hospital admission, discharge, and/or transfer.

TRACK 2 ONLY

	Q1	Q2	Q3	Q4
	Plan and test two-step risk stratification process that uses identified strategy and adds the care team's perception of risk to adjust risk-stratification of patients.	Implement two-step process.	Use and refine two-step process.	Use two-step risk stratification process.
	Identify components of care plan for a longitudinal care management (see Health IT Requirements for care plan core elements).	Plan and test a strategy for care plan workflow and process.	Implement care plans with patients receiving longitudinal care management.	Use care plans for patients receiving longitudinal care management.

Comprehensiveness & Coordination

Q1	Q2	Q3	Q4
Identify hospital(s) & ED(s) responsible for the majority of patients' hospitalizations & ED visits.	Assess timeliness of notification and information transfer with these hospitals and EDs.	Improve timeliness of notification and information transfer with hospitals and EDs.	
		Systemically identify high-volume and/or high-cost specialists serving the patient population using CMS and/or other payer's data.	

TRACK 2 ONLY

Q1	Q2	Q3	Q4
	Identify at least two specialist groups based on CMS/other payer/practice data to enact a collaborative care agreement.	Define and negotiate collaborative care agreements with at least two specialist groups.	Enact collaborative care agreements with at least two specialist groups, identified as high-volume and/or high-cost.
Plan at least one option from the CPC+ menu of options for integrating behavioral health into care.	Test at least one option from the CPC+ menu of options for integrating behavioral health into care.	Refine at least one option from a menu of options for integrating behavioral health into care.	Implement at least one option from a menu of options for integrating behavioral health into care.
Conduct an inventory and/or access a database of services to meet patients' psychosocial needs.	Identify and plan use of tools/ questions to assess patients' psychosocial needs.	Test tools/questions to assess patients' psychosocial needs.	Refine and implement tools/questions to assess patients' psychosocial needs.
		Identify a practice capability that can provide better care and lower cost for high-risk patients.	Plan and begin to develop the new practice capability targeted to high-risk patients.

Patient & Family Engagement

	Q1	Q2	Q3	Q4
	Define and develop PFAC structure and goals.	Recruit patients and caregivers for PFAC.		Convene PFAC meeting(s) and integrate recommendations into care, as appropriate.
	Conduct practice needs assessment for self-management support.	Begin training for self-management support.	Plan processes for integrating self-management support.	

TRACK 2 ONLY

	Q1	Q2	Q3	Q4
	Identify at least three high-risk conditions for self-management support & develop necessary workflows.	Train staff for self-management support for selected conditions.	Test implementation of self-management support for at least three high-risk conditions.	Implement self-management support for at least three high-risk conditions.

Planned Care & Population Health

	Q1	Q2	Q3	Q4

Identify sources of internal practice and external data.

Develop workflow to disseminate data in an actionable format to care teams.

Identify opportunities for improvement in quality, utilization, and patient experience of care.

Organize and train staff to review and understand practice and feedback data.

Use feedback reports provided by CMS/other payers at least quarterly on at least two utilization measures at the practice-level and practice data on at least three eCQMs (derived from the EHR) at both practice- and panel-level to inform strategies to improve population health management.

Use practice and feedback data to guide iterative tests of change to improve population health.

TRACK 2 ONLY

Plan and test a team-based approach to practice improvement, with time for regular review of data on quality and utilization.

Conduct care team meetings at least weekly to review practice- and panel-level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.

Continue to develop and test strategies to improve population health management.

Appendix D. Health IT Requirements

Overall Certified Health IT Adoption Requirement

Requirement	Date	Notes
Adopt, at a minimum, the certified health IT needed to meet the certified EHR technology (CEHRT) definition required by the Quality Payment Program at 42 CFR 414.1305.	Practices must adopt the health IT meeting this requirement. All practices must upgrade to 2015 Edition technology by January 1, 2018.	Practices must adopt and maintain use of certified health IT modules, which meet the definition of CEHRT required by the Quality Payment Program at 42 CFR 414.1305.

Certified Health IT Requirements for Reporting

Requirement	Date	Notes
Adopt health IT meeting 2015 Edition certification criteria found at 45 CFR 170.315(c)(1) - (3), using the 2017 annual update, for all of the electronic clinical quality measures in the CPC+ measure set.	By January 1, 2018	For the 2018 Performance Period, practices must use the latest eCQM specifications included in the 2017 annual update, released in April 2017.
Adopt health IT meeting the 2015 Edition eCQM certification criterion at 45 CFR 170.315(c)(4).	By January 1, 2018	Practices will demonstrate their ability to filter their eCQM data by CPC+ Practice Site location and CPC+ TIN/NPI using this certification criterion.

Track 2 Enhanced Health IT Function Requirements

Requirement	Date	Notes
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9).	By January 1, 2019	Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.
TRACK 2 ONLY: Adopt health IT certified to the 2015 Edition "Social, Behavioral, and Psychological Data" criterion found at 45 CFR 170.315(a)(15).	By January 1, 2019	Adoption of this capability will support enhanced health IT functionality for Track 2 practices, as described below.

Health IT Functionalities/Enhancements for Track 2

CMS will ask practices in Track 2, supported by participating vendors, to develop the following health IT functions/enhancements. CMS will not prescribe how the health IT enhancement is accomplished, rather only that the health IT solution meets the CPC objective for use of the health IT by the CPC+ Practice Site team. CMS anticipates that practices will complete some of these requirements in the first 6-12 months of model start-up, while others will take longer. CMS

expects that practices will complete all health IT enhancements listed below no later than 24 months after practices start their first Program Year (e.g., January 1, 2019).

Health IT Technical Enhancement	Timeline	CPC+ Objective for Use of Health IT
Risk stratify practice site patient population; identify and flag "Patients with Complex Needs"	Within the first six months of the model, if not already in place	1. Enable the CPC+ Practice Site to assign a risk score/label that reflects assignment based on the practice's risk stratification methodology. 2. The methodology used to stratify practices should be clear and meet basic guidelines established by CMS. 3. The CPC+ Practice Site practice team should be able to sort patients by score and update risk scores as needed. 4. Based on stratification results, the practice site should be able to flag patients they identify as "complex patients" and/or as requiring episodic, short-term care management, and generate reports or lists of patients using those labels to support clinic workflow.
Produce and display eCQM results at the practice level to support continuous feedback	Within the first six months of the model, if not already in place	1. Enable the entire practice team to view eCQMs results at the CPC+ Practice Site level to support continuous feedback on quality improvement efforts. 2. Practices should update measured results as frequently as possible so that measures reflect current progress. 3. This capability should present results in a usable, actionable manner that the care team can use to effectively manage population health.
Empanel patients to the practice site care team	Within the first six months of the model, if not already in place	1. Enable the practice to assign each patient to a care team or practitioner and sort and review the patients by assignment. 2. The assigned practitioner should be visible in the patient record to members of the care team.
Systematically assess patients' psychosocial needs and inventory resources and supports to meet those needs	Within the first 24 months of the model, or no later than January 1, 2019	1. Enable primary care practices to electronically assess patients' psychosocial needs. 2. Enable primary care practices to capture or electronically access an inventory of resources and supports to meet patients' identified psychosocial needs. 3. To support this objective, practices must adopt certified health IT that meets the 2015 Edition criterion "Social, Behavioral, and Psychological Data" found at 45 CFR 170.315(a)(15), within the first two years of the program.

Health IT Technical Enhancement	Timeline	CPC+ Objective for Use of Health IT

Establish a patient focused care plan to guide care management	Within the first 24 months of the model, or no later than January 1, 2019	CPC+ practices should use an IT-enabled, patient-centered care planning tool in order to support holistic care and a focus on beneficiary goals and preferences.
		
		1. Enable practitioners to electronically capture the following care plan elements:
		  o Advance directives and preferences for care
		  o Patient health concerns, goals, and self-management plans
		  o Action plans for specific conditions
		  o Interventions and health status evaluations and outcomes
		  o Identified care gaps
		
		2. The practice should have the ability to customize which of these elements are included within the care plan and how they display these elements.
		3. Practitioners should be able to incorporate relevant triggers (e.g., a risk score or event) that indicate different care management actions.
		4. The care plan tool should facilitate version control across care team members by capturing the date of the last review or change in plan and generating a scheduled date for reviewing and updating the plan.
		5. Practices should be able to populate the care plan using data entered in the patient's record (e.g., without duplicative data entry).
		6. The care plan should be available to the patient on paper and electronically, and available in electronic format to care team members outside of the practice that are involved in the patient's care. Care plan information should also be remotely accessible to practice team members delivering care outside of normal business hours.
		7. To support this objective, practices must adopt certified health IT that meets the 2015 Edition "Care Plan" criterion found at 45 CFR 170.315(b)(9), within the first two years of the program

Health IT Technical Enhancement	Timeline	CPC+ Objective for Use of Health IT
Document and track patient-reported outcomes	CMS will provide guidance later in 2017	CMS is evaluating a patient-reported outcome survey instrument that CMS will send to CPC+ Track 2 patients to identify specific care needs requiring intervention/ management by the CPC+ Practice Site team. CMS plans to use the data collected from the patient-reported outcome survey to develop a patient-reported outcome performance measure that may be included in the CPC+ measure set in the later years of the model. The modes of administration are yet to be determined. 1. The health IT tool should provide the care team with the ability to administer the survey, store and track patient responses, and score results longitudinally for each patient surveyed. 2. The practice should be able to review the patient responses/results in their EHR or other health IT tool and, as appropriate, establish care plans /interventions for positive findings.

Appendix E. CPC+ Health IT Definitions

1. Certified EHR Technology (CEHRT)

CPC+ practices must use technology that meets the CEHRT definition finalized for the Quality Payment Program at 42 CFR 414.1305. This is the CEHRT definition required for Advanced Alternative Payment Models (APM) and the MIPS program. As of January 1, 2017, practices must have adopted technology certified to at least the 2014 Edition. By no later than January 1, 2018, practices must adopt technology certified to the 2015 Edition. This is a certified health IT requirement for both tracks of CPC+, and practices must maintain continuous use of CEHRT throughout the model.

2. Certified Health IT for Quality Reporting

CPC+ practices in both Tracks of the model must ensure that they can generate an electronic clinical quality measure (eCQM) report using certified health IT that filters the quality measure data at the CPC+ Practice Site location and CPC+ Tax Identification Number (TIN)/National Provider Identifier(s)(NPI) level. In many cases, this reporting is performed by the CEHRT that a practice already uses; however, some practices may adopt additional certified health IT to meet these requirements, such as a registry that is certified to the criteria at 45 CFR 170.315 (c)(1)-(c)(3) for each quality measure. Starting on January 1, 2018, practices must ensure the eCQM performance results and Practice Site report are generated using health IT meeting the 2015 Edition (c)(4) criterion, filtered by CPC+ Practice Site location and CPC+ TIN/NPI.

While not required, practices are encouraged to configure all 14 CPC+ eCQMs in their certified health IT. This will ensure that the practice is able to report the required nine measures in the event of the removal of one or more eCQMs from the list due to changes to clinical guidelines or a problem with the measure specifications. The Quality Reporting requirements are available here.

3. Track 2 Required Health IT

Track 2 practices have additional health IT requirements beyond the requirements for all practices discussed in section 2 above. Track 2 practices applied with a Letter of Support from their health IT vendor(s), attesting that the vendor(s) will support the practice in developing and implementing enhanced health IT functions. Those functions include the following:

- Empanel patients to the practice site care team.
- Risk stratify practice site patient population; identify and flag patients with complex needs.
- Produce and display eCQM results at the practice level to support continuous feedback.
- Document and track patient-reported outcomes.

- Systematically assess patients' psychosocial needs and inventory resources and support to meet those needs. (Note: Starting in 2019, practices must adopt health IT certified to the 2015 Edition "Social, Behavioral, and Psychological Data" criterion found at 45 CFR 170.315(a)(15).)

- Establish a patient-focused care plan to guide care management. (Note: Starting in 2019, practices must adopt health IT certified to the 2015 Edition "Care Plan" criterion found at 45 CFR 170(b)(9).)

It is possible that the Track 2 required health IT vendor(s) will be the same as the CEHRT vendor, but this is not required. Some practices will have different vendors for the Track 2 functionality. *The Vendor Letter of Support is **only** required for the vendor(s) that is providing the Track 2 required health IT functionality.* CMS will sign a Memorandum of Understanding (MOU) with the Track 2 required health IT vendors only. If CMS is unable to procure an MOU with the vendor, practices will need to find a new vendor with which CMS can sign an MOU. Please refer to the Vendor MOU policy for more information. Some vendors have already signed Global Vendor Letters of Support for CPC+ practices and have signed MOUs with CMS, and these apply to all practices using these vendors' technology.

4. Other Health IT

CPC+ practices may use other health IT in their practices that they do not need to document in the CPC+ Practice Portal. This health IT might include billing software, or IT that performs functions not required in the CPC+ Care Delivery Model. There is no need to document or include the names of this health IT in the CPC+ Practice Portal or provide vendor Letters of Support or MOUs from these health IT vendors.

Appendix F. CPC+ Health IT Policies and Procedures

1. ALL PRACTICES: Maintaining Use of Certified Health IT

All CPC+ practices must use health IT meeting the CEHRT definition finalized for the Quality Payment Program at 42 CFR 414.1305 throughout all five CPC+ years. Starting January 1, 2017, practices are required to use 2014 or 2015 Edition Technology, or a combination of the two. Starting January 1, 2018, practices are required to exclusively use 2015 Edition Technology.

If at any time during the model the practice stops using certified health IT and does not replace the certified health IT via the designated process for switching health IT vendors, the practice will be out of compliance with the CPC+ health IT requirements. In this case, CMS and its contractors will do the following:

1. Day 0: CPC+ Support will send a courtesy email to the practice as soon as the certified health IT deficiency is determined, which is "day 0." The email will ask practices to remediate the situation by adopting new certified health IT, or the practice will be at risk for termination from CPC+. The practice must submit new certified health IT information (vendor name, product name, version number, and CMS EHR Certification ID) to CPCPlus@telligen.com and through the Practice Portal.

2. Day 30: If the practice has not yet adopted new certified health IT, CMS will issue a CPC+ Performance Alert to the practice. This notice will stipulate that the practice will have 90 calendar days to address the lack of certified health IT.

3. Day 90: CMS will issue a Request for Corrective Action Plan to practices that have failed to adopt new certified health IT. CMS will ask the practice to submit a Corrective Action Plan addressing the steps the practice plans to take to ensure compliance with CPC+ within 30 days from the letter's issuance. The Corrective Action Plan may include a freeze on CPC+ payments until the issue is resolved.

4. Day 120: CMS may remove practices failing to adopt new certified health IT from the CPC+ program. Once CMS terminates a practice, it is no longer eligible to participate in CPC+.

2. ALL PRACTICES: Switching required Health IT Systems for Quality Reporting

Practices may switch their certified health IT systems during CPC+ participation, however switching these systems while participating in CPC+ may affect a practice's ability to meet the quality reporting and health IT requirements. Practices must ensure that they can continue to meet these requirements after implementation of a new certified health IT system. This may involve working with both old and new vendors to do the following:

- Arrange for data transfer between the two certified health IT systems.
- Confirm the capability to generate a CPC+ Practice Site level eCQM report for the entire 12-month period.

Manually compiling reports from two certified health IT systems is not acceptable without pre-approval from CMS.

Practices must notify CMS via email at CPCPlus@Telligen.com of any plan to switch health IT systems. Such notice must occur at least three months prior the switch and include the practice's plan for meeting all of the eCQM reporting requirements despite the switch. If the switch will result in the practice's inability to report 12 months of data from the new health IT system, they must do one of the following, with CMS' pre-approval only:

1. If a practice cannot report 12 months of eCQM data, then CMS may accept as few as 9 consecutive months of eCQM data. Practices in this situation will be required to submit attested eCQM results to the CPC+ Practice Portal during the subsequent Submission Period. Due to the shorter period of time being reported, eCQM performance results may be lower than expected, and practices may be required to return a greater portion of the PBIP to CMS than expected.

2. If a practice cannot report at least nine consecutive months of eCQM data for the performance period, manual compilation of eCQM data from a combination of different health IT systems may be possible with the advance approval by CMS. To obtain approval, a practice must submit a plan to CMS that describes how it plans to combine the data to yield accurate practice-level eCQM reporting. CMS will audit the manually compiled data.

CMS and its contractors will review switching plans and provide a formal response to CPC+ practices via email.

If the practice fails to give notice in a timely manner and is not able to report the required eCQM data, the practice may become ineligible for continued participation in CPC+. As noted previously, it is the responsibility of CPC+ practices to maintain continuous usage of CEHRT throughout CPC+, and to adopt 2015 Edition technology no later than January 1, 2018.

3. TRACK 2 PRACTICES ONLY: Missing Vendor MOU

Participating Track 2 practices are responsible for ensuring that their vendors sign MOUs with CMS. The Participation Agreement states in Section III.F.2(b), "The CPC+ Practice acknowledges that as part of its application to participate in CPC+, it submitted a letter of support from each health IT vendor listed on the cover letter described in Section III.F.2(a) above. This letter expressed the health IT vendor's intention to sign a Memorandum of Understanding with CMS, outlining the health IT vendor's commitment to support the development of the required Track 2 enhanced health IT functions."

CMS will reach out to the health IT vendors in the letters of support that CPC+ practices indicated in their applications, and attempt to obtain a signed MOU. However, if the vendor does not respond within 30 days, CMS will require Track 2 practices to procure a response and a signature from the vendor. If the practice is unable to procure the response and the vendor is unable to sign the MOU with CMS, CMS will consider the practice out of compliance with the CPC+ health IT requirements. CMS and its contractors will do the following:

1. Day 0: CPC+ Support will send a courtesy email to the practice notifying them that the health IT vendor has not responded to a request for a signed MOU, which is "day 0." The email will ask practices to contact their health IT vendor(s) and inform them that CMS requires receipt of the missing signed MOU within 30 calendar days or the practice will be at risk for termination from CPC+. Additionally, CMS will ask them to provide vendor contact information in the event that the contact(s) details on record are not accurate.

   If the practice does not have a Letter of Support from the health IT vendor(s) that they plan to use to meet the advanced health IT requirements of CPC+, or if there is no Global Vendor Letter of Support on file for the vendor, they must obtain one from the vendor(s), and send to CMS immediately at CPCPlus@Telligen.com.

   The practice should inform their health IT vendor(s) that they must sign the MOU as a follow-up to their Letter of Support. The vendor will sign the MOU with CMS, and submit it to CPC+ Support. In the case that the vendor declines to sign the MOU within 30 calendar days, practices must identify a new vendor(s), who must then provide a new Letter of Support and signed MOU.

2. Day 30: If no MOU is obtained for each of the Track 2 vendors supporting the health IT requirements, CMS will issue a CPC+ Performance Alert to the practice. This notice will stipulate that the practice will have 90 calendar days to address the lack of Letter of Support and/or unsigned MOUs. Two options are available:

   - Have existing vendors submit the Letter of Support (if applicable) and sign the MOU.

   - Select and onboard new vendors, and receive signed Letters of Support and MOUs.

3. Day 90: CMS will issue a Request for Corrective Action Plan to practices that have failed to secure a signed MOU. CMS will ask the practices to submit a Corrective Action Plan addressing the steps they plan to take to ensure compliance with CPC+ within 30 days from the letter's issuance. The Corrective Action Plan may include a freeze on CPC+ payments until the issue is resolved.

4. Day 120: CMS may remove practices failing to secure a signed MOU from the CPC+ program. Once CMS terminates a practice, it is no longer eligible to participate in CPC+.

Appendix G. Getting CPC+ Practice Portal Access

Note: This Appendix references the *CPC+ Web Practice User Manual*, which is available for download on the CPC+ Connect site. You can access the *CPC+ Web Practice User Manual* once you receive access to CPC+ Connect.

Your application contact or your practice contact (as noted on your CPC+ application) must submit a list of individuals at the practice who will receive access to the CPC+ Practice Portal. Please submit your list to CPC+ Support by phone or email. We encourage you to ensure that multiple people at each practice site have CPC+ Practice Portal access. This will allow your practice to complete requirements and access your CPC+ information even in the event of staff changes or unexpected absences.

For each Practice Portal user at your practice, you must send CPC+ Support the following information:

- First Name
- Last Name
- Email
- Phone
- Practice Role
- CPC+ Practice Site ID(s)
- CMS ePortal/EIDM User ID

Step 1: New User Registration for the CMS Enterprise Portal (ePortal)

1. Navigate to https://portal.cms.gov/.
2. Select **New User Registration** in the CMS Secure Portal box.

Figure 13: Portal Home – Begin Registration

3. Read the **Terms and Conditions**.

4. Select **I agree to the terms and conditions**.

5. Select **Next**.

Figure 14: New Registration – Terms and Conditions

6. Fill out Your Information.

   Note: Required fields are marked with an asterisk. Tool tips are provided for all fields.

7. Select **Next** once all fields are complete.

Figure 15: Your Information

8. Choose your User ID and Password.

9. Select and answer three challenge questions.

   Note: All fields are required and contain tool tips.

10. Select **Next** once all fields are complete.

Figure 16: Choose User ID and Password and Challenge Questions

11. Once you have completed the required fields, you will be prompted with an "Account Successfully Created" screen.

12. Select **OK**.

Figure 17: Account Successfully Created

Step 2: Requesting IC Access

After you receive a user account for the CMS ePortal, you must request access to the Innovation Center (IC) application within the CMS ePortal (https://portal.cms.gov/).

1. Select **Login to CMS Secure Portal**

Figure 18: Portal Home – Log In

2. Select **I Accept** on the Terms and Conditions screen.

Figure 19: Terms and Conditions

3. Enter existing User ID information.

4. Select **Next**.

Figure 20: User ID Log-in Screen

5. Enter existing Password information.

6. Select **Log In**.

Figure 21: Password Log-in Screen

Note: After successful log-in, you will be directed to the Portal main page.

7. Select **Request Access Now**.

Figure 22: Request Access Now

8. Enter "IC" in the Search box and **search**.

9. Select **Request Access**.

Figure 23: Access Catalog

Note: The Innovation Center system description will be pre-populated.

10. Select the "Innovation Center Privileged User" role.

11. Enter an appropriate note to the approver to ensure application access is approved.

Note: In the "Notes to Approver" field, CPC+ Practices should enter "CPC+ Practice Site requesting access to CPC Web."

12. Select **Submit**.

Figure 24: Request New System Access

13. Select **Next** to proceed to Identity Verification.

Figure 25: Identity Verification

14. Read the **Terms and Conditions**.

15. Select **I agree to the terms and conditions**.

16. Select **Next**.

Figure 26: Terms and Conditions

17. Complete the required fields on the Your Information screen.

18. Select **Next.**

Figure 27: Your Information

19. Enter the required information on the **Verify Identity** page for the Remote Identity Proofing (RIDP) check.

20. Select **Next**.

Figure 28: Verify Identity

Note: Upon successful completion of the "Verify Identity" page, you will be prompted with a success message.

21. Select **Next.**

Figure 29: Complete Step Up

Note: After completing the RIDP process, you will be directed to the "Multi-Factor Authentication Information" page

22. Select **Next**.

Figure 30: MFA Information Confirmation

23. Register your phone, computer, or email for Multi-Factor Authentication Information. The Symantec software must be downloaded first.

    Note: Users will likely have to return to this screen after downloading the software.

24. Enter the credential ID and description once the software is downloaded and launched.

25. Select **Next**.

Figure 31: Secure Registration Screen

Note: Upon successful completion of the "Register Your Phone, Computer, or Email" page, you will be prompted with a success message.

26. Select **OK**.

Figure 32: Secure Registration Confirmation

27. Select **OK** on the Request Acknowledgment screen to view your pending request.

Figure 33: Request Acknowledgement

Once the request has been approved by the IC Application Approver, you will be informed via email. When you return to https://portal.cms.gov/ and log in, the Innovation Center will display as one of the menu options. From here you will be able to request access to the CPC+ Practice Portal.

Figure 34: CMS ePortal After Log-in – IC Mega Menu

Step 3: Requesting Access to the CPC+ Practice Portal

Once you have successfully created a CMS ePortal account and have been approved for an IC role, you must request access to launch the CPC+ Practice Portal. You will request access from the CMMI Request Access page.

1. Select **Application Console** from the Innovation Center drop-down list.

Figure 35: Portal After Log-in – IC Mega Menu

2. Select **Request New Access** to put in a request.

   Note: The Request Access section consists of a Request New Access button, a Search text field and button, and Filter buttons that allow the user to see the status of applications that have had requests submitted and are Pending, Approved, Rejected, or all.

Figure 36: Request Access Screen

3. Upon selection of "Request New Access," you will be prompted to complete a form requesting the Application Name, desired User Role, and Comments about your request.

Figure 37: Application and Role Selection – Request Access Screen

4. Select Comprehensive Primary Care (CPC) from the Application Name drop-down list.

Figure 38: Application Name Selection – Request Access Screen

5. Select the appropriate User Role from the "User Role" drop-down list.

Figure 39: User Role Selection – Request Access Screen

Note: If an application and role have custom attributes, then the attribute label and text box will display for the user to complete. Selecting the "Cancel" button will return the user to the "Request Access" screen.

6. Select **Submit Request** to complete your request once all of the required fields are completed.

Figure 40: Application and Role Selection with Attribute Label – Request Access Screen

Note: If the requested application and role has already been made, the system will notify the requestor with an error message at the top of the screen.

Figure 41: Application and Role Selection with Error Message – Request Access Screen

7. Once the CPC Web request has been submitted, you will return to the Request Access screen, where you will see the Pending application request.

Figure 42: Pending Request – Request Access Screen

Note: You will receive an email notification indicating that the request has been submitted. You will also receive an email notification when the request has been approved or rejected.

Step 4: Accessing the CPC+ Practice Portal

This section describes the process to log into the CPC+ Practice Portal.

1. Access https://portal.cms.gov/.

2. Select **Login to CMS Secure Portal**.

Figure 43: ePortal Home – Log In

3. Select **I Accept** on the Terms and Conditions screen.

Figure 44: Terms and Conditions – Log In

4. Enter existing User ID information.

5. Select **Next.**

Figure 45: User ID Log-in Screen

6. Enter existing password information, select multi-factor authentication (MFA) device type and enter security code.

7. Select **Log In.**

Figure 46: Password Log-in Screen

Upon successful ePortal log-in, you will be directed to the CMS ePortal Home Page where Innovation Center will be one of your menu items at the top of the page.

Figure 47: CMS Enterprise Portal Home

8. Select Application Console from the Innovation Center drop-down list.

Figure 48: Innovation Center Menu

9. The Innovation Center landing page will display.

Figure 49: Launching the CPC+ Practice Portal

10. Select **Launch CPC App** to be directed to the CPC+ Practice Portal.

Figure 50: CPC+ Home

Appendix H. Updating Practice Information

1 Updating Demographic Information

The Demographic Information page displays your practice's demographic information, points of contact, and health IT information. To edit these fields:

1. Select **Update Information**.

2. Make changes to desired fields.

3. Select **Save**.

Note: If you choose to enter Secondary Contact information, all fields in this section are required unless otherwise noted.

Figure 51: Demographic Information

2 Updating Practice Information

The Practice Information page enables you to view your Health Information Technology Details and Organization Details (including TIN). This page is read-only by default.

If you want to edit:

1. Select **Update Information.**
2. Make changes to desired fields.
3. Select **Save**.

If you want to initiate a TIN and/or an Organizational Detail Change:

1. Select **TIN/Org Change** (available only when the Practice Information page is read-only).
2. The system navigates to the **TIN/Organizational Change** page.

3 Updating TIN/Organizational Detail

The TIN/Organizational Change page displays the details necessary to request a TIN and/or an Organizational Detail Change for a practice.

If you want to request a change:

1. Complete the **TIN/Organizational Details Change.**
2. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.
3. Attest the accuracy of the information provided by completing the **Confirmation.**
4. Select **Save** to submit the request.

Figure 52: TIN/Organizational Change

Appendix I. Adding and Withdrawing Practitioners

Note: This Appendix references the *CPC+ Web Practice User Manual*, which is available for download on the CPC+ Connect site. You can access the *CPC+ Web Practice User Manual* once you receive access to CPC+ Connect.

1 Updating Rosters

The Composition page enables you to view and maintain your practice's Practitioner and Staff Rosters. This information ensures the practices receive accurate CMF, PBIP, and CPCP (Track 2) payments.

If you want to complete your practice's composition information:

1. Complete the **Practice Composition.**
2. Verify **Practitioner Roster** and **Staff Roster** information.
3. Attest the accuracy of the information provided by completing the **Confirmation.**
4. Select **Save.**

If you want to edit your practice's previously saved composition information:

1. Select **Update Information.**
2. Make changes to desired fields.
3. Verify **Practitioner Roster** and **Staff Roster** information.
4. Attest the accuracy of the information provided by completing the **Confirmation.**
5. Select **Save.**

If you want to export your roster(s):

1. Select **Export Roster.**
2. Open or save the **PracticeID_ClinicianRoster** or **PracticeID_NonClinicianStaffRoster** in Excel file format.

   Note: The file should reflect the content from the respective roster's table.

Figure 53: Composition

1A Practitioner Roster

The Practitioner Roster displays the details of each practitioner associated with a practice, including the Practitioner Name, Primary Specialty, NPI, Status, Employment Status, and Estimated Weekly Hours.

Table 28 illustrates actions you can initiate from the **Practitioner Roster** section.

Table 28: Practitioner Roster Actions

If you want to…	Then…
Submit a request to add a New Practitioner	• Select **Add** from the Practitioner Roster o Selecting **Add** navigates you to the **Add New Practitioner** page • Refer to the Add New Practitioner section for actions you can execute
Submit a request to withdraw an Active Practitioner	• Select the check box in the far-right column of the table for the related practitioner • Select **Withdraw** o Selecting Withdraw navigates you to the **Withdraw Practitioner** page • Refer to the Withdraw Practitioner section for actions you can execute
View Practitioner Information for a practitioner in Active or Withdrawn status	• Select the related **Practitioner Name** o Selecting the Practitioner Name will navigate you to the **Practitioner Information** page • Refer to the Practitioner Information section for actions you can execute
Edit Practitioner Information for Practitioner in Active status	• Select the related **Practitioner Name** o Selecting the Practitioner Name will navigate you to the **Practitioner Information** page • Refer to the Practitioner Information section for actions you can execute
View request details or add remark to a request in Pending Add, Pending Withdraw, Incomplete Add, or Incomplete Withdraw status	• Select the related **Practitioner Name** o Selecting the Practitioner Name will navigate you to the Add New Practitioner Request or Withdraw Practitioner Request page • Refer to the Add New Practitioner and Withdraw Practitioner sections for actions you can execute
Edit request details for a practitioner in Incomplete Add or Incomplete Withdraw status	• Select the related **Practitioner Name** o Selecting the Practitioner Name will navigate you to the **Add New Practitioner Request** or **Withdraw Practitioner Request** page • Refer to the Add New Practitioner and Withdraw Practitioner sections for actions you can execute

Figure 54: Practitioner Roster

1B Staff Roster

The Staff Roster displays the details of the associated staff by including the Staff Name, Title/Position, if the individual works in direct patient care, Employment Status, and Estimated Weekly Hours. The Staff Roster excludes practitioners, and is separate from the Practitioner Roster. This should be anyone in the practice including those who doing any work related to CPC+ but is not a practitioner, and consultants.

Table 13 illustrates actions you can initiate in the Staff Roster section of the Composition tab.

Table 29: Staff Roster Actions

If You Want To …	Then …
View Staff Information	• Select Staff Name • Selecting the Staff Name will navigate you to the Staff Information page • Refer to the Updating Staff Information section for actions you can execute
Edit Staff Information	• Select Staff Name. • Selecting the Staff Name will navigate you to the Staff Information page • Refer to the Updating Staff Information section for actions you can execute
Add a New Staff member	• Select Add • Selecting Add navigates you to the Add New Staff page • Refer to the Updating Staff Roster section for actions you can execute.
Delete an existing Staff member	• Select the box displayed beside the Estimated Weekly Hours • Select Delete • Select Yes on the Confirm Staff Deletion pop-up

Figure 55: Staff Roster

2 Adding a New Practitioner

The Add New Practitioner page displays the details necessary to request to add a new practitioner.

If you want to submit an Add New Practitioner request:

1. Complete the **Practitioner Details.**

2. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.

3. Attest the accuracy of the information provided by completing the **Confirmation.**

4. Select **Save** to submit the request.

If you want to add a remark to an Add New Practitioner Request in Pending status:

1. Add a **Remark**, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding a remark.

2. Select **Save.**

If you want to edit an Add New Practitioner Request in Incomplete status:

1. Select **Update Information**.

2. Make desired changes.

3. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.

4. Add a **Remark**, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding remarks.

5. Attest the accuracy of the information provided by completing the **Confirmation**.

6. Select **Save**.

Figure 56: Add New Practitioner

3 Updating Practitioner Information

The Practitioner Information page displays the details for an Active or Withdrawn Practitioner.

If you want to edit Practitioner Information for an Active Practitioner:

1. Select **Update Information**.
2. Make desired changes.
3. Select **Save**.

Figure 57: Practitioner Information

4 Withdrawing a Practitioner

The Withdraw Practitioner page displays request details necessary for withdrawing an existing Active Practitioner from your practice.

If you want to submit a Withdraw Practitioner Request:

1. Complete the **Withdrawal Information**.
2. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.
3. Attest the accuracy of the information provided by completing the **Confirmation**.
4. Select **Save** to submit the request.

If you want to add a remark to a Withdraw Practitioner Request in Pending status:

1. Add a **Remark**, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding a remark.
2. Select **Save**.

If you want to edit a Withdraw Practitioner Request in Incomplete status:

1. Select **Update Information**.
2. Make desired changes to **Withdrawal Information**.
3. Upload **Supporting Documentation**, if any. Refer to Section 3.4.3 of the *CPC+ Web Practice User Manual* for instructions on uploading a file.
4. Add a Remark, if applicable. Refer to Section 3.4.4 of the *CPC+ Web Practice User Manual* for instructions on adding a remark.
5. Attest the accuracy of the information provided by completing the **Confirmation**.
6. Select **Save**.

Figure 58: Withdraw Practitioner

5 Updating Staff Roster

The Add New Non-Practitioner Staff page displays details necessary for adding a new Non-Practitioner Staff member to your practice.

If you want to update your Staff Roster:

1. Complete the **Non-Practitioner Staff Details.**

2. Attest the accuracy of the information provided by completing the **Confirmation.**

3. Select **Save.**

Figure 59: Add New Non-Practitioner Staff

6 Updating Staff Information

The Staff Information page displays the details for non-practitioner staff at your practice.

If you want to edit Non-Practitioner Staff Information:

1. Select **Update Information**.

2. Make desired changes to **Non-Practitioner Staff Details**.

3. Select **Save**.

Figure 60: Non-Practitioner Staff Information

Appendix J. List of Acronyms

Acronym	Definition
AAA	Agency on Aging
ADRC	Aging and Disability Resource Centers
ADT	About Admission/Discharge/Transfer
AHC	Accountable Health Communities
APCD	All Payer Claims Databases
APM	Alternative Payment Model
ART	Administrative Readiness Tool
BH	Behavioral Health
BHI	Behavioral Health Integration
CAD	Coronary Artery Disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBT	Cognitive Behavioral Therapy
CCN	CMS Certification Number
CDA	Clinical Document Architecture
CEHRT	Certified Electronic Health Record Technology
CHAMPS	Community Health Association of Mountain Plain States
CHF	Congestive Heart Failure
CHPL	Certified Health IT Product List
CMF	Care Management Fee
CMM	Comprehensive Medication Management
CMS	Center for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPCP	Comprehensive Primary Care Payment
CPI	Center for Program Integrity
DO	Doctor of Osteopathic Medicine
E&M	Evaluation and Management
eCQM	Electronic Clinical Quality Measures
ED	Emergency Department
FFS	Fee-For-Service
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HISP	Health Information Service Provider
ICD	International Statistical Classification of Diseases and Related Health Problems
IOM	Institute of Medicine
IPP	Initial Patient Population
LCSW	Licensed Clinical Social Worker
LOINC	Logical Observation Identifiers Names and Codes
LPN	Licensed Practice Nurse
MA	Medical Assistant

Acronym	Definition
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MATCH	Medications at Transitions and Clinical Handoffs
MD	Doctor of Medicine
MIPS	Merit-Based Incentive Payment System
MOU	Memorandum of Understanding
MTM	Medication Therapy Management
NP	Nurse Practitioner
NPI	National Provider Identifier
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PAM	Patient Activation Measure
PBIP	Performance-Based Incentive Payment
PBPM	Per-Beneficiary Per-Month
PCMH	Patient-Centered Medical Home
PCRS	Chronic Disease Self-Management
PDSA	Plan-Do-Study-Act
PFAC	Patient and Family Advisory Council
PMPB	Per-Member Per-Beneficiary
PROM	Patient-Reported Outcome Measure
PRO-PM	Patient-Reported, Outcome-Based Performance Measure
PST	Problem-Solving Therapy
PY	Program Year
QI	Quality Improvement
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
RLN	Regional Learning Network
RN	Registered Nurse
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SMS	Self-Management Support
SNOMED	Systematized Nomenclature of Medicine Clinical Terms
SSP	Shared Savings Program
TIN	Tax Identification Number
VSAC	Value Set Authority Center