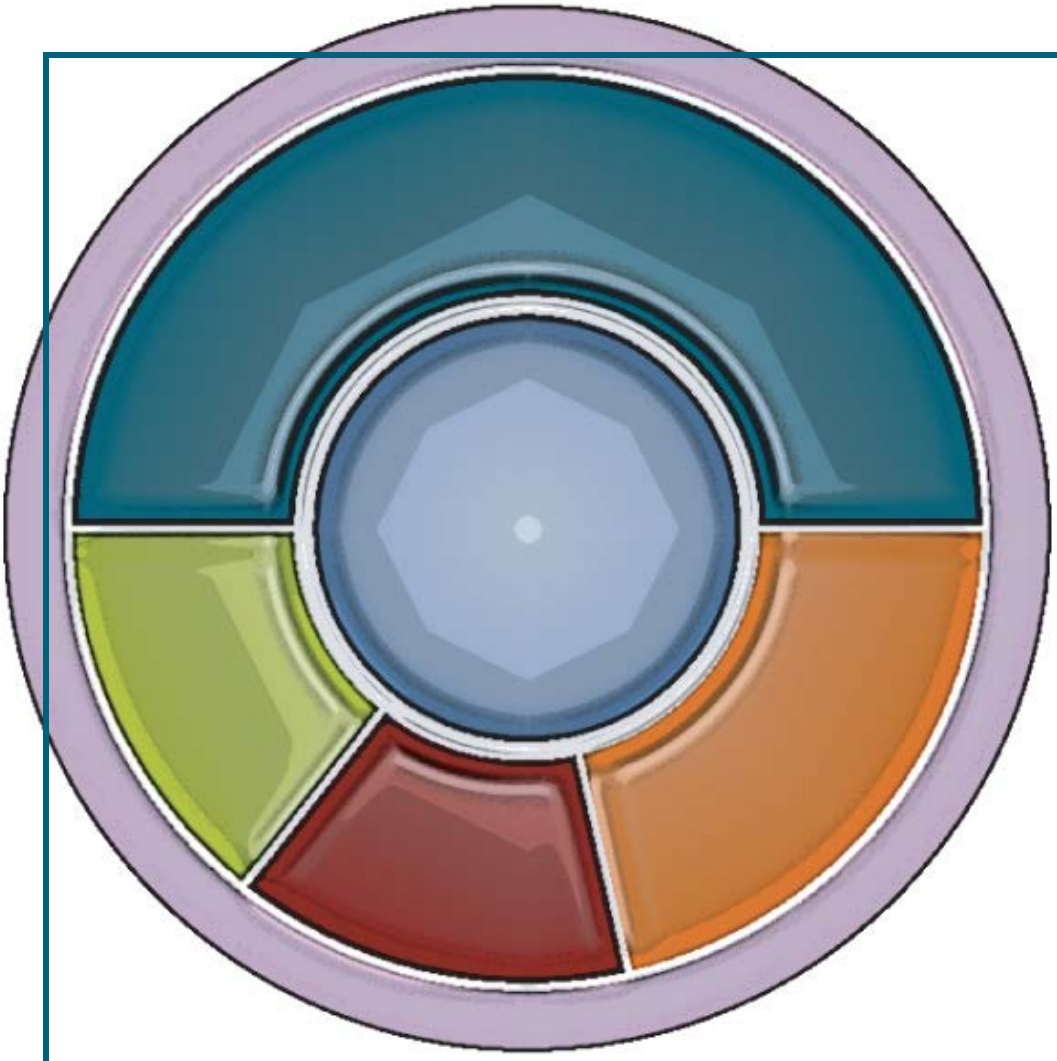


CPC Program Year 2015 Implementation and Milestone Reporting Summary Guide

December 2014

CPC
Comprehensive Primary Care

An Initiative of the Center for
Medicare & Medicaid Innovation

Table of Contents

TMF Health Quality Institute

This material is presented by TMF Health Quality Institute under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

Introduction

Welcome to the Comprehensive Primary Care (CPC) Program Year 2015.

This Program Year (PY) 2015 Implementation Guide will provide you with an orientation to our work together in this next program year, guidance for reporting on the Milestones on the CPC Web Application and key resources available to support your efforts in the coming year. It is our hope that you will find this Guide helpful as you work on delivering the five primary care functions supported by enhanced payment, better data and optimal use of health information technology to improve care, achieve better health outcomes and reduce the total cost of care.

How to Use This Guide

Similar to the last year, the PY 2015 Guide is divided into three sections: Milestones, Reporting and an Appendix.

Section 1: Milestones

This section is organized into three parts around three key questions:

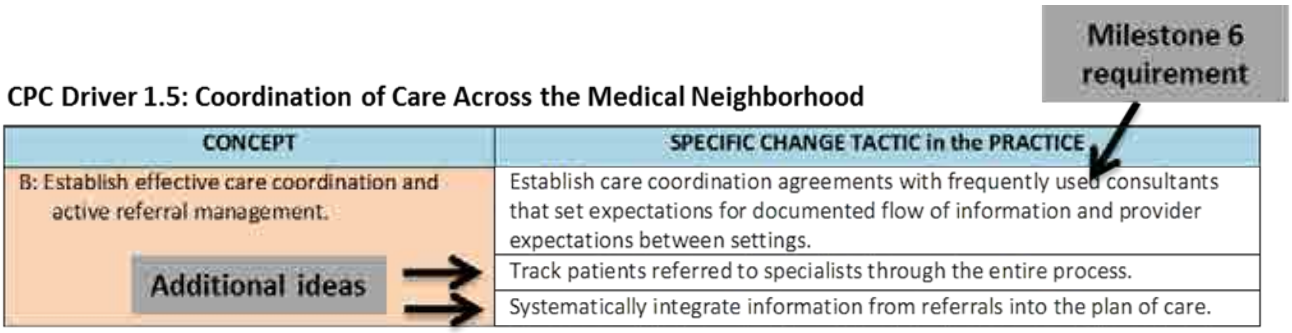
1. The Goal of the Milestone: *What is the aim of the work in this Milestone?*
We review the intent of each Milestone and any important differences in the work from previous years. The PY 2015 Milestone requirements are included for your reference.

2. The Milestone and the Work of Comprehensive Primary Care: *What changes are we testing and implementing in our practice through our work in this Milestone?*
To answer this question we look beyond the details of the Milestone to the ultimate aims of CPC (improve care, achieve better health outcomes and reduce the total cost of care through improvement in care) and the factors that drive achievement of those aims, known as the CPC "Drivers." Through your work in each Milestone you have been building toward the five Comprehensive Primary Care Functions (Driver 1), supported by:

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

As your practice worked through the Milestones in the first two years of CPC, you have built or enhanced your capability in all five key drivers of Comprehensive Primary Care.

Each of these CPC Drivers has underlying **Change Concepts** that provide further details about the Driver. In turn, Change Tactics provide concrete implementation ideas for how practices might implement the Change Concept. Though the Change Tactics provide ideas you will recognize from the Milestones, they contain additional ideas beyond the Milestone requirements. The following is an example from Milestone 6:



Your practice can consider whether these Change Concepts – beyond the Milestone requirements themselves – might be useful to implement to further your work to achieve the CPC aims for your population.

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

Over the first two years of CPC, you have used the Milestones as a way of marking transformation of your practice. In the final two years of the initiative, you will rely much more heavily on data, developed through your work in the Milestones and received from CMS and other payer sources, to guide your work. These data, reflecting processes of care, important health and utilization outcomes and unexpected consequences of your practice changes, link your work to the CPC aims. In this section, you will find a series of questions and suggestions for data that are meant to stimulate your thinking about how you can obtain and use data to inform further testing and refinement in your delivery of comprehensive primary care.

Section 2: The PY 2015 Milestone Reporting Summary

The PY 2015 Milestone Reporting Summary walks through the Milestone reporting process. Guided by your feedback and the insights of your faculty, we have simplified and reduced the reporting for this year.

Section 3: Appendix

The Appendix contains an extensive list of Collaboration site and online resources to support your work as well as the CPC Key Drivers and Changes.

Section 1 — The Milestones

Milestone 1: Budget

The Goal of Milestone 1

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

Milestone 1 Requirements

a. Record actual CPC funding and expenditures from PY 2014.
b. Complete an annotated annual budget with anticipated changes in revenue and spending for PY 2015.

Milestone 1 and the Work of Comprehensive Primary Care

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

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

CPC Driver 2.1: Strategic Use of Practice Revenue

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	Develop a process for prioritizing practice changes necessary to improve patient outcomes and population health.
	Invest revenue in priority areas for practice transformation.
	Use accounting and budgeting tools and processes to allocate revenue.
B: Align practice productivity metrics and compensation strategies with comprehensive primary care.	Use productivity measures that include non-visit related care.
	Incent effective team-based care.

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices. Practice reporting for Milestone 1 will capture key data on revenue from participation in CPC in PY 2014 and costs associated with the changes in your practice. You will estimate the number of patients attributed to your practice and the percentage of your total practice revenue represented by the enhanced payment from all CPC payers. You can use these data to support your practice budget planning and prioritizing for PY 2015.

Payer reports, practice CQM data, and results from your patient satisfaction surveys or PFACs can provide helpful information to guide your practice in deciding on top clinical priorities for the upcoming year. In reviewing payer reports, are you surprised by any areas of high cost or utilization? Do you see opportunities to lower these costs? Is your practice achieving internal benchmarks on your CQMs? How might you use your financial resources to target such priorities?

In review of your revenue and expenses for PY 2014, do you find that you allocated your financial resources in a way that is consistent with your clinical priorities? Do you see opportunities to reallocate resources to achieve your practice goals in a more cost-effective manner?

How is your practice measuring and rewarding staff productivity? You can track the amount of time providers and other staff members spend in regular non-visit activities such as asynchronous communication, care team huddles, care management or behavioral health reviews, participation in PFACs and working on practice improvement. How does your practice reward these activities and are the rewards commensurate with the value of the activity for your practice and patients? Does your practice reward other activities or outcomes and have you considered whether those are aligned with your overall goals for your practice and patients?

Milestone 2: Care Management for High-Risk Patients

The Goal of Milestone 2

The work in Milestone 2 addresses population health, with a focus on those at highest risk for poor outcomes and preventable harm.

In PY 2015, the foundation of this work remains empanelment of every active patient to a provider or care team, and risk stratification of every empanelled patient. As before, you can use your practice definition of "active patient."[1]

Care management is targeted to those patients who are at high (or rapidly rising) risk and likely to benefit from intensive care management services. This year, you will need to review your stratification methodology in light of your clinical quality and utilization data as well as your care management resources. Then, refine the methodology as needed to achieve the best possible match between your patients' needs and your care management resources.

In PY 2015, you will continue to develop the advanced primary care management strategy or strategies you began in the previous year: integration of behavioral health, self-management support and medication management and review. This year you will have the opportunity to show your work in more than one of these strategies to build additional capability to care for patients at high and rising risk.

Milestone 2 and the Work of Comprehensive Primary Care

Empanelment and Risk Stratification

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

Empanelment identifies the patients and population for whom the provider and/or care team is responsible and is the foundation for the relationship continuity between patient and provider/care team that is at the heart of comprehensive

Milestone 2 Requirements

a. Maintain at least 95% empanelment to provider and care teams.
b. Continue to risk stratify all patients, achieving risk stratification of at least 75% of empanelled patients.
c. Using available data on the needs of the practice population and the strengths and weaknesses of the chosen risk stratification methodology review – and if needed refine – the methodology being used to assign a risk status to every empanelled patient.
d. Provide care management resources to the population identified as most likely to benefit from these services. Focus on patients identified by the practice's risk stratification methodology to be high risk or with rapidly rising risk (e.g., those that are clinically unstable, in transition and/or are high utilizers of services) and likely to benefit from active, ongoing, intensive care management.
e. Maintain the implementation, and further refine, one or more of the following three specific care management strategies for patients in higher risk cohorts (beginning with those at highest risk):
    1. Integration of behavioral health
    2. Self-management support for at least three high-risk conditions
    3. Medication management and review

[1] **Active patient** — Most practices include patients seen the in the last two or three years.

primary care. Effective empanelment requires identification of the "active population" of the practices: those patients who identify and use your practice as a source for primary care. There are many ways to define "active patients" operationally, and CPC does not impose a single definition on practices. Generally, the definition of "active patients" includes patients who have sought care within the last 24 to 36 months, allowing inclusion of younger patients who have minimal preventive health care needs.

CPC Driver 1.1: Access and Continuity

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
B: Empanel all patients to a care team or provider.	Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.

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

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

CPC Driver 1.3: Risk-Stratified Care Management

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Assign and adjust risk status to each patient.	Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts.

Care Management

Care management is a primary care function tailored to patients at highest risk for adverse, preventable outcomes, including iatrogenic harm. Effective care management results from a complex exercise of clinical judgment and is proactive, flexible, longitudinal and relationship-based and addresses the patient's self-identified health care goals.

These are the essential features of care management:

- **A mutually agreed upon and documented plan of care.** The plan of care is based on the patient's goals and the best available medical evidence; it is accessible to all team members providing care for the patient and is up to date, addressing all major and significant ongoing health problems and risks.
- **Ongoing assessment and monitoring with interventions as appropriate and using an EHR or registry for tracking.** Patients in care management should be clearly identified in the EHR and tracked with the aid of the EHR registry functionality or through a stand-alone registry. Care management of these patients occurs with data monitoring and other interventions triggered by regularly scheduled and ad hoc reviews.

- **Proactive care that does not require waiting for office visits or crises (e.g., ED care or hospitalization) and is not primarily visit-based.** While office visits are opportunities to define goals, plan patient care, engage in shared decision making and build a trusting relationship, most care management activities take place by phone, patient portal, email or home visits (as well as visits to SNFs or hospitals to support transitional care). These activities are appropriately targeted based on patient needs.
- **Dedicated, clinically trained staff working closely with the provider in a team-based approach to care for individuals with complex health needs.** Care management staff members are typically in the nursing or social work disciplines and trained to manage patients with complex health needs. Multiple team members, including physicians, non-physician providers and other disciplines, may engage in care management, but each patient at high risk should have a clinically trained individual in the practice accountable for his or her active, ongoing care management that goes beyond office-based clinical diagnosing and treatment.
- **Care management is documented as a structured part of the medical record, capturing critical information.** These include the nature and substance of contacts, data reviewed, assessment of current status, changes to care pathway or overall care plan, unresolved questions and next scheduled follow-up contact or review.

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

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

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

CPC Driver 1.3: Risk-Stratified Care Management

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
B: Use care management pathways appropriate to the risk status of the patient.	Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.
	Use panel management and registry capabilities to support management of patients at low and intermediate risk.
C: Manage care across transitions.	Routine and timely follow-up to hospitalizations.
	Routine and timely follow-up to ED visits.

Care management is a “team sport” and requires a mutually agreed-upon plan of care. The Medicare Annual Wellness Visit provides an opportunity for development and refinement of that plan of care.

CPC Driver 1.2: Planned Care for Chronic Conditions and Preventive Care

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Use a personalized plan of care for patients at high risk for adverse health outcome or harm.	Engage patients at highest risk in ongoing development and refinement of their care management plan, to include integration of patient goals, values and priorities.
	Use the Medicare *Annual Wellness Visit with Personalized Prevention Plan Services* (AWV with PPPS) for Medicare patients.

While the first two years of CPC has emphasized identifying addressing the needs of those patients at highest risk, many practices have begun to focus attention on *rising* risk patients, often patients with a combination of chronic disease, challenging social situations and inconsistent attention to health care and prevention. Interventions targeting this cohort of patients often require a planned, proactive approach, with use of systematic interventions such as evidence-based protocols for care, registries or the registry functionality of the EHR, reminders and outreach.

CPC Driver 1.2: Planned Care for Chronic Conditions and Preventive Care

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

Effective team-based care is essential for both intensive care management of those at highest risk as well as proactive, planned care and outreach to those at rising risk.

CPC Driver 1.2: Planned Care for Chronic Conditions and Preventive Care

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
D: Use team-based care to meet patient needs efficiently.	Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs.
	Use decision support and protocols to manage workflow in the team to meet patient needs.
	Manage workflow to address chronic and preventive care, for example through pre-visit planning or huddles.
	Enhance team resources with staff such as health coach, nutritionist, behavioral health, pharmacy and physical therapy as feasible to meet patient needs.

Risk Stratified Care Management at Warren Clinic

The **Warren Clinic in Jenks, Oklahoma,** is one of several Warren Clinic CPC sites. The Warren Clinic system uses the Epic EHR and employs a centralized data analyst who provides the Warren Jenks care manager with a care management report every Monday. The report includes every active patient at the Warren Jenks site of which 95% are empanelled and 75% are currently risk stratified using the AAFP 6-tier method. This Excel report includes the risk tier (1 – 6), diagnostic codes indicating if the patient has CHF, COPD, or diabetes, along with the date of their last office visit, date of most recent care management encounter and date of the last care planning encounter.

Care Management Tracking

The care manager filters the report by AAFP risk tier and merges her notes with the previous week's Excel report. These notes might indicate important characteristics that she will use in subsequent contacts but are not necessarily ready yet for documentation in the EHR (e.g., patient is blind, patient in Florida for winter, patient in SNF, etc.).

When the care manager receives the report, she first checks for changes in risk tier and documents when patients were hospitalized or had ED visits since the last report. Approximately 115 patients are classified as AAFP-5 at this clinic, and the care manager tries to have active contact with each throughout each month. She will also check on patients at AAFP-6 and some at AAFP-4 who have CHF, COPD and/or diabetes. These active contacts may be in-person in conjunction with a scheduled office visit or through a phone call or email. If a high-risk patient hasn't had a visit in the current quarter, the care manager calls to check in with the patient.

The care manager also reviews the clinic's next day schedule, which notes the patient's AAFP risk score. During the all-staff morning huddle, she will note specific patients she would like to see during their visit.

The care manager documents each care management encounter in the EHR as a "care planning encounter." The care planning encounter documentation includes the patient's care goals and all documentation of contact by the care managers.

Quarterly Reporting to CPC

For the quarterly reporting to CPC in the web application, the data analyst from the central office runs a report that counts the patients classified as high risk (AAFP 5s and 6s) who had a type of care planning encounter in the current quarter. Because the care manager aims to have active contact (e.g., in person, phone or email) with each AAFP-5 and 6 each month, the practice's quarterly care management hovers around 85% and 80% overall.

The table shown is one that the Care Manager uses with the physicians every week to review their own goals and look for process improvements as well as improvement opportunities. The data analyst creates the report from data in the EHR.

Advanced Primary Care Strategies

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

These three strategies overlap in significant ways and must also integrate into the risk stratification and care management capability you have already built. All practices have begun incorporating one of these strategies into their practice and many already use a combination. Over the next two years, practices will learn more about and integrate elements of each strategy into their team-based care to best meet the needs of their patients and population.

Behavioral Health Integration

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

CPC Implementation Framework for Behavioral Health Integration

1. The practice is able to identify and meet the behavioral health (BH) care needs of each patient and situation, either directly or through co-management or coordinated referral.
    - The practice has an available range of skills in BH in the practice for primary care management of BH issues.
    - There is a training strategy (formal or on-the-job) to develop capacity for primary care management of BH.
    - The practice identifies and collaborates with appropriate specialty referral resources in the health system (as applicable) and the medical neighborhood.
2. The practice has a systematic clinical approach that:
    - Identifies patients who need or may benefit from BH services
    - Engages patients and families in identifying their need for care and in the decisions about care (shared decision making)
    - Uses standardized instruments and tools to assess patients and measure treatment to target or goal
    - Uses evidence-based treatment counseling and treatment
    - Addresses the psychological, cultural and social aspects of the patient's health, along with his or her physical health, in the overall plan of care
    - Provides systematic assessment, follow up and adjustment of treatment as needed, reflected in the care plan
3. The practice measures how integrated behavioral health services affect patients, families and caregivers receiving these services and on target conditions or diseases and adapts and improves upon these services to improve care outcomes.

CPC Driver 1.2: Planned Care for Chronic Conditions and Preventive Care

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
E: Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions.	Ensure PCPs and other clinical staff have been trained in principles of behavioral health care and are able to handle routine behavioral health care needs.
	Include use of non-clinical staff to provide screening and assessment of behavioral health care needs.
	Ensure regular communication and coordinated workflows between primary care and behavioral health providers.
	Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment.
	Use the registry function of the EHR or a shared registry to support active care management and outreach to patients in treatment.
	Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
E: Manage referral networks to meet behavioral health needs not available in the practice.	Develop formal referral relationships with mental health and substance abuse services in the community.

Medication Management

The use of medications for primary and secondary prevention and for treatment of chronic conditions is a mainstay of medical practice. The potential for medication-related harm increases in aged individuals with multiple comorbidities and those receiving care from multiple providers and settings. Many medications require scheduled monitoring for safe use. Protocol-guided medication management can improve outcomes in many chronic conditions. Medication reconciliation is a starting point for safer, more effective medication management, but great opportunities exist to more effectively and safely manage medication therapy across transitions of care. Practices implementing medication management and review as a core strategy include a pharmacist on their care team.

CPC Implementation Framework for Medication Management

1. The practice integrates a clinical pharmacist or pharmacists into the care team. The pharmacist is considered a member of the care team and:
   - Is involved in patient care, either directly or through chart review and recommendations, and documents care in the EHR
   - Participates in the identification of high-risk patients who would benefit from medication management
   - Participates in care team meetings
   - Participates in development of processes to improve medication effectiveness and safety

2. The practice delivers comprehensive medication management services, including:
   - Medication reconciliation
   - Coordination of medications across transitions of care settings and providers
   - Medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
   - Development of a medication action plan and integration of that plan into a global care plan
   - Medication monitoring
   - Support for medication adherence and self-management
   - Collaborative drug therapy management (when within the state's scope of practice)
3. The practice has a systematic approach to the identification of patients in need of medication management services, including some or all of the following:
   - Patients in high-risk cohorts already defined under Milestone 2
   - Patients who have not achieved a therapeutic goal for a chronic condition
   - Patients in care transition
   - Patients with multiple ED visits or hospitalizations
   - Patients with high-risk medications or complex medication regimens
4. The practice measures key processes and outcomes to improve medication effectiveness and safety.

CPC Driver 1.2: Planned Care for Chronic Conditions and Preventive Care

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
C: Manage medications to maximize efficiency, effectiveness and safety.	Periodic medication reconciliation.
	Coordinate medications across transitions of care settings and providers.
	Integrate a clinical pharmacist as part of the care team.
	Conduct periodic, structured medication reviews.
	Develop a medication action plan for high-risk patients.
	Provide collaborative drug therapy management for selected conditions or medications.
	Provide support for medication self-management.

Self-Management Support

Support for self-management of chronic conditions requires a collaborative relationship: a health partnership between health care providers and teams and patients and their families. The partnership should support patients in building the skills and confidence they need to reach their health goals.[2]

CPC Implementation Framework for Support of Self-Management

1. The practice team embeds self-management support tactics and tools into care of all patients and has intensive strategies available for patients at increased risk.
   - All members of the care team have basic communication skills to support patient self-management.

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

- The practice routinely uses tools and techniques that reinforce patient self-management skills.
- The practice routinely and systematically assesses the self-management skills and needs of patients with chronic conditions and uses this information to guide support for self-management.
- The practice has a systematic approach to identifying patients with need for additional support in self-management.
- The practice has a training strategy (formal or on-the job) to develop staff/care team capacity to support self-management.

2. The practice uses tactics and tools that support self-management across conditions and supports patient acquisition of specific skills for management of target conditions or diseases.
   - Routine interval follow up with patients about their goals and plans is a critical tactic for supporting patient self-management.
3. The practice is able to measure how self-management support strategies affect target conditions or diseases and adapts and improves these strategies to improve care outcomes.
4. The practice develops and maintains formal and informal linkages to external resources to support self-management.

CPC Driver 1.4: Patient and Caregiver Engagement

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

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

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

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices. In no part of your work in CPC is a focus on using data to understand and guide changes in your practice more important than in your work in Milestone 2.

Empanelment and Risk Stratification

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

Care Management

- What is the percent of patients in each risk tier that are under care management?
  - How well do your care management resources "match" your risk stratification methodology?
  - What is your practice definition of the activities that result in a patient being "under care management?" How efficient and effective are these activities addressing the needs of patients? This will be an area of active learning in the next year in CPC.
- What is the percent of all patients and/or of patients in high-risk tiers with care plans?
- Can you track key utilization measures (hospitalization, ambulatory sensitive care hospitalizations, re-admissions, ED visits, total cost of care) or quality measures for patients under care management?

Advanced Primary Care Strategies

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

Behavioral Health Integration

Process measures:

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

Outcome measures:

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

Medication Management

Process measures:

- You may already be using a measure for medication reconciliation and review as part of your work for Meaningful Use; if so, this will be helpful to you.
- Percent of patients with a transition of care who had medication reconciliation
- Number of patients with medication review each month.
- Patients seen in collaborative drug therapy management.

Outcome measures:

- The CPC clinical quality measures of lipid management in diabetes (NQF#0064), diabetes control (NQF#0059), hypertension control (NQF#0018), and heart failure therapy (NQF#0083) will all be responsive to improved medication management, but there may be other measures that you are following that may also be indicators of the impact of mediation management.
- Improved medication management should also result in changes in utilization among your high-risk patients.
- For those practices engaging pharmacists in tobacco cessation efforts, percent of patients using tobacco products could be a useful measure.

Self-Management Support

Process measures:

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

Outcome measures:

- Quality metrics related to your target conditions will give you important insight into the impact of support for self-management.
- Utilization measures for patients in your high-risk tier or with target conditions will also provide insight into impact.

Milestone 3: 24/7 Access and Continuity

The Goal of Milestone 3

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

In PY 2015, your practice will measure relationship continuity between patients and the providers or care team to whom they are empanelled. This builds on the work you began in PY 2013 and PY 2014 to increase access through opportunities for asynchronous communication and 24/7 access to care guided by the electronic health record.

Milestone 3 and the Work of Comprehensive Primary Care

CPC practices are working in Milestone 3 to increase access to care by broadening access beyond the traditional face-to-face office visit.

Milestone 3 Requirements

a. Attest that patients have 24/7 access to care team practitioner with real-time access EHR
b. Continue at least one form of asynchronous communication and make a commitment of timely response.
c. Measure visit continuity of patients with the provider to whom they are empanelled.

Relationship continuity — An ongoing therapeutic relationship between a patient and one or more providers (made up of longitudinal continuity with one provider or team continuity with a team)

While the emphasis of the work in this Milestone is on non-visit/non-reimbursed access, there are also strategies for increasing access and continuity identified in the CPC Change Package. Included are strategies that are reimbursable by some payers (e.g., group visits, visits in alternate locations, alternate hours and potentially even e-visits). Similarly, same day or next day access is generally reimbursable and can increase continuity and reduce need for ED or urgent care.

CPC Driver 1.1: Access and Continuity

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

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

CPC Driver 1.1: Access and Continuity

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
B: Empanel all patients to a care team or provider.	Empanel (assign responsibility for) the total population, linking each patient to a provider or care team.

Continuity can be thought of as occurring in three dimensions[3]:

- **Interpersonal/Relationship** – continuity with a provider/care team
- **Management** – there are no conflicts or inconsistency between providers in the management plan for a patient (this is also addressed in the work of Milestone 6)
- **Information** – all providers and teams caring for the patient have access to the patient's electronic health record

CPC Driver 1.1: Access and Continuity

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
C: Optimize continuity with provider and care team.	Measure continuity between patient and provider and/or care team.
	Use scheduling strategies that optimize continuity while accounting for needs for urgent access.
	Use a shared care plan to ensure continuity of management between within the practice and with consultants.
	Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.

Using Data to Understand the Changes in Your Practice

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

Continuity

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

- The provider-centric measure divides the number of visits to a clinician by patients empanelled to a clinician or clinician team (numerator) by the total number of visits for that clinician (denominator). For example: If a clinician provides 3,000 visits in a year and 2,000 visits are by patients in his or her panel, the provider-centric continuity rate is 66.6%.
- A patient-centric measure of continuity would measure the number of times patients see the provider to whom they are empanelled (numerator) divided by the total number of visits in the practice.

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

- Continuity measures can be adapted to answer additional specific questions asked by the clinic. For example:
  - What percent of same-day visits are with the provider to whom the patient is empanelled?
  - What percent of routine appointments are scheduled with the provider to whom the patient is empanelled?

Access

A commonly used measure for access is the "Third next available appointment." This 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." Information about the use and collection process for this measure can be found at: http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx.

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

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

- How many non-emergent visits to the ED or urgent care were made during regular practice business hours?
- How many patients seen in emergency department or admitted to hospital were for ambulatory care sensitive conditions?
- What is the rate of missed appointments and/or no-shows?
- What is the ratio of ED visits to hospitalization in the practice?

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

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

Milestone 4: Patient Experience

The Goal of Milestone 4

The work in Milestone 4 puts the patient and family at the center of care, utilizing their critical input to improve processes and accelerate practice transformation. In PY 2015, your practice will continue the efforts you made in PY 2013 and PY 2014: you will use a Patient and Family Advisory Council (PFAC) and/or brief, in-office surveys to understand the patient perspective and use the voice of the patient to guide efforts to improve care. These activities are intended to engage patients and families as valuable partners in improving care as well as communicate improvements.

In PY 2014, the option of creating a hybrid approach using both office-based surveys and PFAC was added. This hybrid approach allowed practices to benefit from the advantages of both the data-driven survey process as well as the more qualitative PFAC approach. In Quarter 1 reporting for PY 2015, your practice will be prompted either to continue with your PY 2014 selection (PFAC or survey) or to shift to the hybrid approach[4].

Milestone 4 and the Work of Comprehensive Primary Care

Your work in this Milestone builds practice capabilities in several key areas of Comprehensive Primary Care (see the CPC Change Package). You may find other strategies, such as focus groups, comment boxes and use of Facebook or other social media, helpful for obtaining the perspectives of patients and families on the care they receive. You might consider bringing your Milestone 7 (shared decision making) approach to the PFAC for discussion. Remember – engaging them is not just a nice thing to do; it is also an extremely efficient process for understanding gaps in your practice and generating ideas to improve them.

Milestone 4 Requirements

a. Continue PY 2013 and PY 2014 efforts by conducting surveys and/or meetings with a Patient and Family Advisory Council (PFAC).
   - **Option A:** Conduct a practice-based survey monthly
   - **Option B:** PFAC that meets quarterly
   - **Option C:** Office-based surveys administered regularly and PFAC convened periodically

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

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

In Quarter 1 reporting for PY 2015, your practice will be able to make the change from doing just surveys or PFAC to doing the hybrid combination if you wish. You may also continue your current selection.

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

[4] Pathways to Patient and Family Engagement in CPC Practices, CPC Collaboration website

CPC Driver 1.4: Patient and Caregiver Engagement

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
C: Engage patients and families to guide improvement in the system of care.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
	Communicate to patients the changes being implemented by the practice.

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

CPC Driver 2.1: Strategic Use of Practice Revenue

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	Develop a process for prioritizing practice changes necessary to improve patient outcomes and population health.
	Invest revenue in priority areas for practice transformation.
	Use accounting and budgeting tools and processes to allocate revenue.

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

CPC Driver 3.2: Culture of Improvement

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.	Promote transparency and engage patients and families by sharing practice-level quality of care, patient experience and utilization data with patients and families.

Using Data to Understand the Changes in Your Practice

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

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

You may find it helpful to capture and review data that tells you about the implementation of these strategies in your practice (process measures).

The questions below are examples of the kind of data that can help you gain a greater understanding of your process:

- What is your attendance rate at your PFAC meetings?
- How many ideas for change are emerging from PFAC meetings? Of these ideas, how many have been implemented or tested? Of those implemented, is there a measure of impact?
- What tangible products have been created as a result of your PFAC?
- How many patients are requesting to participate in your PFAC?
- What is your response rate to vendor-administered surveys?
- How many patients are surveyed each month or quarter on vendor-/practice-administered surveys?
- How many survey responses were taken to the PFAC to review?
- How many changes in the practices were initiated by survey data?
- What is the number of "likes" on your practice's Facebook page?
- How many suggestions are submitted in your drop box at the office each month?

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

- How much staff time is involved in the PFAC or survey activities?
- What is the cost to the practice of the PFAC or survey process?

Subsequent to PFAC and survey data, some opportunities that may arise for increasing patient engagement include:

- Review and re-design existing care plan templates with patients and family caregivers
- Identify existing challenges within the practice (e.g., phone call volume, wait times, medication refill process) and ask a small group of patients and family caregivers to meet to discuss solutions
- Patients and family caregivers can provide feedback on the current methods of communication used by patients for getting in touch with members of a care team
- Review the design, function and uses of the practice's electronic patient portals and get input from patients and family caregivers on how it could be improved so it generates efficiencies for patients and the practice
- Discuss with patients and family caregivers the practice's existing care transitions processes and ask for their feedback on ways to improve

Milestone 5: Quality Improvement

The Goal of Milestone 5

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

In PY 2015, your practice will continue to use data from your Electronic Health Record (EHR) to guide improvement in at least three areas of care measured by the electronic clinical quality measures (eCQMs). By measuring at both the practice level and at the provider (or care team) level (where the patient actually receives care), your practice gains perspectives that help guide your changes to improve that care.

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

Milestone 5 Requirements

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

For PY 2015, two new measures were included in the eCQM set:

- NQF#0043 – Pneumonia Vaccination for Older Adults
- NQF#0419 – Documentation of Current Medications in the Medical Record

Milestone 5 and the Work of Comprehensive Primary Care

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

CPC Driver 3.1: Internal Measurement and Review

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

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

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

CPC Driver 3.2: Culture of Improvement

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Adopt a formal model for Quality Improvement and create a culture in which all staff actively participates in improvement activities.	Train all staff in quality improvement methods.
	Integrate practice change/quality improvement into staff duties.
	Engage all staff in identifying and testing practices changes.
	Designate regular team meetings to review data and plan improvement cycles.
	Promote transparency and accelerate improvement by sharing practice level and panel level quality of care, patient experience and utilization data with staff.

As identified in CPC Driver 2, the work in this Milestone should lead to new capabilities to understand opportunities to manage total cost of care by reducing harm and waste, including redundant or unnecessary tests and care. The intent of the CMS quarterly Practice Feedback Report is to support this work, as are the reports generated by other payers. To use these reports effectively requires analytic capability that may be new to your practice.[5]

CPC Driver 2.2: Analytic Capability

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Build the analytic capability required to manage total cost of care for the practice population.	Train appropriate staff on interpretation of cost and utilization information.
	Use available data regularly to analyze opportunities to reduce cost through improved care.

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

[5] For more information about how to find these reports see "How to Find Your CMS CPC Reports," which is posted on the CPC Collaboration site.

CPC Driver 4.1: Continuous Improvement of HIT

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

As you know, CPC requires annual practice-level reporting of eCQMs from the EHR. Panel-level reporting should already be a function of all ONC-certified EHRs, since measurement of the panel will generally be the same as measurement of care provided by a MU Eligible Professional (EP). In PY 2014, most CPC practices could report eCQMs at the practice level; practice-level reporting is a requirement for eligibility to participate in any shared savings generated by the CPC practices in your region in PY 2015.

CPC Driver 4.3: EHR-Based Quality Reporting

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Develop the capability for practice and panel level quality measurement and reporting from the EHR.	Develop capability for practice-level reporting of Clinical Quality Measures derived from the EHR.
	Develop capability for panel-level reporting of Clinical Quality Measures derived from the EHR.
	Develop capability for electronic transmission of quality reports.

Using Data to Understand Quality Improvement Changes in Your Practice

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

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

- Have you identified quality and utilization benchmarks and goals for performance at the practice and panel level?
    - How often do you review these goals with practice staff and patients?
- Do you have a set of key quality and utilization measures (a dashboard) so that all staff in the practice can see whether the practice is meeting its goals?

- Do you have a way to assess the quality of the data entered into your EHR?
    - Do you have confidence in your eCQM data?
    - How do you monitor data quality deficiencies (e.g., “misfiled notes or tests, missing data”)?
- Does your staff have the basic skills in practice improvement (e.g., rapid cycle testing, using process maps, etc.)?
    - How many of your staff members are actively participating in testing changes in the practice?
    - Do you have meeting time set aside to plan and prioritize changes and to assess the results of testing?
    - Do staff members feel responsible for testing changes? How deep and wide is the involvement in improvement in your practice?
- How are you using practice-level and panel-level data?
- Do staff members understand the data?
    - How do you train the appropriate staff in interpretation of cost and utilization measures?
    - Are they using the data to identify changes to test in the practice?
- How much time spent is allocated to and/or spent on managing change in the practice?
    - Do you keep track of the number of projects and personnel that working on making changes in your practice?
- How are you assessing workflow for data retrieval and reporting?
    - Would process maps help you see and improve your workflows?
- What is the process for review and analysis of payer reports?
    - Do you have a strategy for identifying high-cost and/or low-value areas of care, developing a plan for change and measuring the results?
- Are you tracking your progress toward reporting eCQMs and your eligibility to participate in any Shared Savings?

Milestone 6: Care Coordination Across the Medical Neighborhood

The Goal of Milestone 6

The purpose of the work in Milestone 6 is to develop systematic coordination of care across the medical neighborhood. In PY 2015, your practice will continue to build on the implementation of at least two of the three options for this Milestone. In PY 2014, you worked with hospitals, emergency departments (EDs) and/or specialists to bridge seams of care for your patients as they transition between settings and providers. The three care coordination strategies in this Milestone all have the potential to improve care and reduce harm and cost. Depending on the characteristics of your medical neighborhood and your practice demographics, some strategies may offer more promise than others, though all three strategies will be valuable for practices working toward the CPC aims of better care, better health and lower total cost of care.

Milestone 6 Requirements

Implement two of the three options below, building on your PY 2013 and PY 2014 activities:

a. Track % of patients with ED visits who received a follow up phone call within one week.

b. Contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours or two business days.

c. Enact care compacts/ collaborative agreements with at least two groups of high-volume specialists in different specialties to improve transitions.

Milestone 6 and the Work of Comprehensive Primary Care

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

Optimizing Continuity

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

CPC Driver 1.1: Access and Continuity

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
C: Optimize continuity with provider and care team.	Measure continuity between patient and provider and/or care team.
	Use scheduling strategies that optimize continuity while accounting for needs for urgent access.
	Use a shared care plan to ensure continuity of management between and within the practice and with consultants.
	Ensure that all providers within the practice and all members of the care team have access to the same patient information to guide care.

Managing Care Transitions

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

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Establish standard operations to manage transitions of care.	Formalize lines of communication with local care settings in which empanelled patients receive care to ensure documented flow of information and clear transitions in care.

CPC Driver 1.3: Risk-Stratified Care Management

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
C: Manage care across transitions.	Routine and timely follow-up to hospitalizations.
	Routine and timely follow-up to ED visits.

Referral Management

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

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
B: Establish effective care coordination and active referral management.	Establish care coordination agreements with frequently used consultants that set expectations for documented flow of information and provider expectations between settings.
	Track patients referred to specialists through the entire process.
	Systematically integrate information from referrals into the plan of care.

Medical Neighborhood

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

Think also about the use of care compacts or agreements with community-based services that your patients use, such as senior centers, chronic disease self-management programs and exercise/wellness programs. CPC

practices are also using this approach to build stronger, more integrated behavioral health and pharmacy services for their patients.

CPC Driver 1.5: Coordination of Care Across the Medical Neighborhood

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

Using Data to Understand the Changes in Your Practice

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

- **30-day readmission rate** is an outcome measure that may be affected by your efforts to coordinate care across the medical neighborhood more effectively. You may be able to derive this data from the patient-specific report you receive as part of your CMS Feedback Report, from other payer reports and from hospital data. Plotting the 30-day readmission rate data on a simple run chart or control chart[6] will help you identify trends in that data. You may also see possible associations if you plot 30-day readmissions and your Milestone 6 measures for hospital follow-up on the same chart.
- **Hospital admission and ED visit rates** may be sensitive to your efforts to follow-up on all ED visits. Following this data on run charts or control charts will similarly help you to see trends in the data that may be affected by your ED follow-up efforts.
    - **Tracking frequency.** Milestone 6 only requires quarterly reporting of follow-up after hospitalization and ED visits, but practices seeking to make that follow-up systematic and reliable will want to track these important process measures internally on a weekly or monthly basis. Plotting this data in a run chart format will show trends in performance. Annotating the run chart with changes that you are testing in your process will help you understand whether those changes are associated with an improvement in performance.
    - **Setting internal benchmarks.** CPC provides a benchmark of 75% follow-up of patient discharges from target hospitals, but your practice may set a higher goal. There is no benchmark set for follow-up contacts from the ED; your practice may decide to set an explicit internal goal for ED follow-up.

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

    - **Targeting hospitals.** The hospital discharge measure identifies the population for intervention (the denominator for the measure) as patients discharged from "target hospitals." This is an acknowledgement that practices may not have timely discharge data for all hospitals that their patients may use. Can you use the CMS and other payer data to understand what percentage of discharges you are capturing in your "target hospitals?" If you are missing a significant number of discharges, you may consider targeting those "missing" hospitals as well. Similarly, you may find in review of the CMS Practice Feedback Report or other payer reports that you are missing ED visits; this may represent an opportunity for further outreach. Practices whose patients use multiple hospitals, EDs or urgent care clinics may want to track the use of the major settings for care to inform priorities for outreach.
- **Data on specialist referrals,** such as monthly counts of patients referred to specialists or the cost of care by the specialists your patients see, will give you an idea of where your efforts to coordinate care will have the most impact (perhaps the top 5 or 10 most-referred specialists).
    - A run chart in which you plot the count of all patients referred to specialists with whom you have a care compact is a simple way to see how your work towards systematically coordinating care is affecting your patients. A run chart can also help you communicate your work in this area to your patients. Consider, also, how you can use your PFAC or patient survey to help identify issues to address in your compacts.

Milestone 7: Shared Decision Making

The Goal of Milestone 7

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

Milestone 7 Requirements

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

In PY 2014, you built on the work begun in PY 2013 as you increased the number of decision aid(s) to support shared decision making in preference-sensitive care in your practice. This has been an area of intensive learning in CPC, and PY 2015 presents a good opportunity to reassess the topics and the associated decision aids you have selected in prior years. Are the aids you have been using helping patients to make choices that reflect their values and preferences? Are they making these challenging discussions easier? Have you chosen a preference-sensitive condition that affects a large number of your patients or an area with utilization of high cost care? If not, in Quarter 1 of 2015, you may select up to three new areas of priority and decision aids that your practice will implement. (You may also choose to continue with the SDM selections from PY 2014 while adding at least one new condition.) As you review your data you may determine that the aids or conditions you have selected are not having the desired effect. Perhaps they are not reaching the target audience, not impacting care or cost, or not meeting the needs of the practice. In such cases, you will have the opportunity to select a different priority condition and decision aid in subsequent quarters (see Milestone 7 reporting section). As you make your SDM selections, consider the sample questions and process measures listed below to avoid having to make quarterly changes to your SDM selections. It will be valuable to your practice to track your progress over time and selecting a high-impact condition and/or aid that meet the needs of your patients and practice from the onset will allow you to see the effect of SDM on your practice over time.

You can measure the use of the aid either as a rate (the proportion of patients eligible who actually received each decision aid) or as a quarterly count of patients receiving each aid.

Milestone 7 and the Work of Comprehensive Primary Care

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

CPC Driver 1.4: Patient and Caregiver Engagement

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
B: Shared decision making.	Use evidence-based decision aids to provide information about risks and benefits of care options in preference-sensitive conditions.
	Routinely share test results, along with appropriate education about the implications of those results, with patients.

These are the three key components to this work:

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

These are among the ongoing challenges of Milestone 7:

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

In PY 2014, the CPC program published a Shared Decision Making Implementation Guide that includes definitions for shared decision-making, preference-sensitive care and decision aids. Brief definitions are included here, and the full guide is located at this link: Shared Decision Making Implementation Guide.

- **Shared decision making** is an approach to care that seeks to fully inform patients about the risks and benefits of available treatments for preference-sensitive conditions and engage them as participants in decisions about the treatments.

  Source: Veroff, Marr and Wennberg: http://content.healthaffairs.org/content/32/2/285.full.html

- **Preference-sensitive care** comprises treatments for conditions where legitimate treatment options exist — options involving significant tradeoffs among different possible outcomes of each treatment (some people will prefer to accept a small risk of death to improve their function; others won't). Decisions about these interventions — whether to have them, and which ones to have — should thus reflect patients' personal values and preferences and should be made only after patients have enough information to make an informed choice, in partnership with their provider.

  Source: The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2938

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

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

- **Decision Aids** are interventions designed to support patient decision making in preference-sensitive care by making explicit the decision, providing information about treatment or screening options and their associated outcomes, compared to usual care and/or alternative interventions. Source: Cochrane Database of Systematic Review 2014

Using Data to Understand the Changes in Your Practice

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

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

Milestone 8: Participation in the CPC Learning Collaborative

The Goal of Milestone 8

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

The Advanced Primary Care strategies in Milestone 2 involve major new workflows in most practices, and for this reason all practices are asked participate in the collective learning of the Action Groups for this work.

Milestone 8 Requirements

a. Participate in all CPC learning sessions in your region.
b. Participate in at least one of the following Advanced Primary Care Action Groups:
   - Integration of behavioral health
   - Medication management
   - Self-management support
c. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested.

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

Milestone 8 and the Work of Comprehensive Primary Care

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

Practices also need ideas for change. Practices will test and implement home-grown innovative ideas, promising ideas based on anecdotal evidence and evidence-based practices. The best solutions come from other practices that have shown that these ideas can work.

Practices need to be able to put the ideas into the daily workflow. Learning from other practices about how they implemented a new idea, and what the challenges and successes were in that implementation, can provide valuable shortcuts in executing changes. In addition, individualized assistance from practice coaches (the RLF) have proven to be a valuable asset for practices engaged in making significant changes in their care processes.

Driver 3.2 Culture of Improvement

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

Using Data to Understand the Changes in Your Practice

In this section, we'll explore how you might use data to help you understand the changes that you are making in your practices. Participation in the regional and national webinars, face-to-face sessions and other learning activities supports your practice transformation efforts. Note the level of your practice's engagement and the correlation with your practice's changes as well as changes undertaken by other CPC practices, both regionally and nationally.

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, responsible for conveying lessons learned to the rest of your team. Below are some questions that can help you determine how to maximize learning through engagement with the CPC community:

- Are there CPC topics or areas of work that your practice has successfully implemented? Have you found other practices that could use your help as they work on similar changes? Which staff member is most skilled at sharing your successful experiences? Can presenting in a shared learning environment be a growth opportunity for your staff members?
- What is the expectation for your practice representatives when they attend an event? What processes will help your practice assimilate ideas gathered at learning events?
- Who is most appropriate to participate in the Action Group forum and live Web sessions for selected topics?
- In what areas of practice change do you need to invest the most time?
- If you are confronting barriers to a particular change in your practice, have you sought out ideas and solutions from others on the Action Groups, through the Collaboration site or in a regional meeting?
- How do you measure the value of participation in shared learning activities?

Milestone 9: Health Information Technology

The Goal of Milestone 9

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

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

Milestone 9 Requirement

Attest that your providers are engaged with, and working toward, attestation for Stage 2 of Meaningful Use in the timelines set by the Meaningful Use program.

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

Milestone 9 and the Work of Comprehensive Primary Care

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

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

CPC Driver 4.1: Continuous Improvement of HIT

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

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

CPC Driver 4.2: Data Exchange

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

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

CPC Driver 2.2: Analytic Capability

CONCEPT	SPECIFIC CHANGE TACTIC in the PRACTICE
A: Build the analytic capability required to manage total cost of care for the practice population.	Train all appropriate staff on interpretation of cost and utilization information.
	Use available data regularly to analyze opportunities to reduce cost through improved care.

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

CPC Driver 3.1: Internal Measurement and Review

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

Using Data to Understand the Changes in Your Practice

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

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

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

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

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

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

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

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

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

Section 2 — The PY 2015 Milestone Reporting Summary

Introduction to Reporting in PY 2015

This section is your guide to PY 2015 CPC Reporting. It includes each of the questions asked on the CPC Web Application. We heard from many of you that reporting in PY 2014 was much more efficient when you used the PY 2014 Milestone Reporting Summary to prepare your answers before actually signing on to the Web Application. With that in mind, we designed this section to allow you to prepare your reporting for PY 2015 before you sign on to the Web Application.

With the exception of Milestone 1, all practice reporting on the CPC Milestones will be done through the CPC Web Application. Reporting on Milestone 1 (Budget) will be accomplished through an Excel spreadsheet returned by secure email to CPC Support.

PY 2015 Milestone Reporting by Quarter

The table below cross-references each reporting item and the quarter in which a response is required.

Question and Milestone Title	Q1	Q2	Q3	Q4
2.0.1 Empanelment Status	x	x	x	x
2.0.2.1 Risk Stratification Methodology	x	(x)	(x)	(x)
2.0.2.2 Explaining the Risk Stratification Process*	x	(x)	(x)	(x)
2.0.2.3 Changes to the Risk Stratification Methodology		x	x	x
2.2.0.4 Risk Stratification Care Management Statistics	x	x	x	x
2.0.2.5 Tracking High Risk Patients		x		
2.0.3 Description of Care Management		x		
2.0.4.1 Staff Providing Care Management	x			x
2.0.4.2 Time Spent Providing Care Management	x			x
2.0.5 Selection of Care Management Strategies	x			
2.1.1 Identification of Patients for Behavioral Health Services	x			x
2.1.2 Organization of Behavioral Health Care in Your Practice	x			x
2.1.3 Integration of Behavioral Health Specialists	x			x
2.1.4 Care Coordinated with Behavioral Health Services External to the Practice	x			x
2.1.5 Evidence-based Management of Behavioral Health Conditions	x			x
2.1.6 Care Management and Treatment to Goal	x			x
2.1.7 Measurement and Sustainability	x			x
2.2.1 Condition-Specific Self-Management Support	x			x
2.2.2 Skills for Self-Management	x			x
2.2.3 Support for Self-Management Across Conditions	x			x
2.2.4.1 Tools Used to Assist Patients	x			x
2.2.4.2 Evidence-based Counseling Approaches	x			x
2.2.5 Use of Community-based Resources for Self-Management Support				x
2.2.6.1 New Capacity for Support of Self-Management				x
2.2.6.2 Identifying Measures and Understanding the Impact				x
2.3.1 Medication Management Services	x			x
2.3.2.1 Engaging Pharmacists as Part of the Care Team	x			x
2.3.2.2 Pharmacists Engaging in Patient Care	x			x
2.3.3 Patient Selection for Medication Management	x			x
2.3.4 Collaborative Drug Therapy Management	x			x
2.3.5 Medication Process Measures	x			x
3.1 Continuity of Care	x			x
3.2 24/7 Access by Patients	x	x	x	x
3.3 Enhanced Access Outside of Office Visits	x			x
3.4 Communication about Enhanced Access	x			x
3.5 Commitment to a Timely Response	x			x

Table continues on next page.

Question and Milestone Title	Q1	Q2	Q3	Q4
4.1 Patient Experience Option Selection	x			
4.2 Survey		x		x
4.3.1 PFAC Meetings		x		x
4.4 Improvement Based on Feedback	x	x	x	x
4.5 Communicating the Changes		x		x
5.1 Continuous Quality Improvement using CQM Data	x	x	x	x
5.2 Monitoring CQM Data	x	x	x	x
5.3 Testing Changes to Improve Quality	x	x	x	x
5.4 Review of Payer Feedback Reports	x	x	x	x
5.5 Improving Quality and Reducing Cost	x	x	x	x
6.1 Identify Area of Improvement	x			
6.2 Follow-up Contact with Patient within One Week of ED Discharge	x	x	x	x
6.2.1 Methods of Obtaining ED Information	x	x	x	x
6.3 Follow-up Contact within 72 hours or Two days of Hospital Discharge	x	x	x	x
6.3.1 Methods for Obtaining Hospital Discharge Information	x	x	x	x
6.4 Care Compacts/Agreements with High Volume Specialists	x	x	x	x
7.1 Area of Priority	x	(x)	(x)	(x)
7.2 Source of Decision Aid		x	x	x
7.3 Rate of Use		x	x	x
9.1 Meaningful Use				x

Milestone 1: Budget

Milestone 1 reporting is due by February 20, 2015. Practices will use a CMS-provided Excel template (one for each region) to report on Milestone 1. CMS will post the Excel template to the Collaboration Site in mid-December. Practices will return the completed templates to CPC Support via secure transmission using Barracuda. CPC Support will send several email reminders for submission that will include a link and instructions for practices to follow when returning their completed Milestone 1 template by February 20, 2015.

For PY 2015, Milestone 1 includes reporting the practice site's final funding and costs for PY 2014 and a description of any changes in revenue and costs anticipated for PY 2015. In a change from previous years, **no** detailed PY 2015 forecast is required.

Please bear in mind that under CPC Terms and Conditions for PY 2015, all information submitted is subject to audit. If audited, we will ask your practice to provide supporting evidence of revenues or expenditures. Please keep all supporting documentation. Regional participating payers will see each practice's aggregate CPC revenue and expense information.

CMS has reduced Milestone 1 reporting requirements for PY 2015. The following are the changes to the Milestone 1 requirements:

- Consolidated categories of staff to simplify their expenditure allocation
- Use percentages rather than exact figures to allocate expenses across the Milestones
- Eliminated the comparisons between PY 2014 forecast and PY 2014 actual revenue and costs
- Eliminated the detailed PY 2015 forecast
- Added a question about anticipated changes in revenue and your allocation of revenue to practice direct costs for PY 2015
- Added a question about practice site revenue (repeated from the 2012 practice application)

Milestone 1 for PY 2015 includes 4 sections (tabs):

1. About
2. Revenues
3. Expenses
4. Summary

Section 1. About

The first tab collects important contact information about your practice.

Section 2. Revenues

This section collects the same information your practice has provided in past years. You will provide the total amount of care management fees for each CPC payer with whom you contract. We also ask you to tell us the average number of patients covered by those payments (CPC attributed lives). Payers contribute with varying frequency so we ask that you provide an average number of patients across the year so that we can calculate an average per member per month figure from the year's total. We have found that some commercial payers don't contribute care management fees for all their patients because some of their clients don't participate with the CPC program. These may be self-insured employers or for employers who declined to contribute to CPC. If you are unsure about the attributed lives for any payer, please contact the payer for more detailed information.

We also ask if you received bonus or shared savings amounts based on quality and/or utilization targets. Please **do not** include shared savings or bonus amounts in the care management fee totals.

In the revenue section, we also ask for total revenue for the practice site. We first asked this question in 2012 during the practice application phase and we need to update our records. We also ask for the number of active patients at the site. While we also ask this in Milestone 2 every quarter, we need to link the practice site revenue to a current active patient figure. Often the person completing the budget is different than who answers Milestone 2 so we want to ensure that these two figures are linked as much as possible.

In addition to care management fees from all payers, some practices contribute other funding to the CPC work. This may include grant funding or revenue from other sources that is used for direct costs or to support salaries for care managers or other staff used to support CPC activities. If your practice makes such contributions, please estimate this in the revenue section on the line labeled, "Fiscal Contributions from Your Organization."

The revenue section also includes a question asking whether you expect to see notable changes in care management revenue in PY 2015 (other than the drop in Medicare average PMPM). This is a new question in lieu of asking for detailed forecasts as we did in the previous two years.

2.1 Total Practice Revenue: Indicate how much total revenue your practice received in 2014, *including* fee-for-service revenue and all CPC care management fees.

Total Practice Revenue in 2014	$	
Total Number of Active Lives (As Of 12/31/14)		
Comments (Optional)		

2.2 Revenue from CPC Care Management Fees
(do not include bonuses or shared savings)

Payer	**Annual Total CPC Care Management Fees (2014)**	**CPC Attributed Lives**
Medicare	$	
Payer 2	$	
Payer 3	$	
Payer 4	$	
Payer 5	$	
Fiscal Contributions by Your Organization (optional)	$	
Total Revenue from Care Management Fees	$	

2.3 Do you expect significant changes in your CPC payer revenue in 2015 **(other than the drop in CMS average PMPM to $15)?** If yes, please explain.	

Section 3. CPC Expenses

For this year, we have tried to lighten the burden of reporting how your practice allocates its CPC revenues to CPC expenses. We ask for a total cost for each type of labor category and then how those staff allocate their time across the nine Milestones. We hope that this is a much easier way for you to tell us how you applied your CPC funding and how they spend their CPC time across the milestones. By asking for percentages of time in Milestones, we acknowledge that these are estimates for which your practice can't held accountable for in an audit, but which helps us characterize the relative burden the Milestones require. These estimates are helpful for CMS policy making and financial analysis.

Specifically, we ask you how many staff are working within each category — these are actual people, "belly buttons," not hours or percentage of FTE. For instance, if your practice site has two part-time care managers, then you would enter "2." If you have three physicians, one of which is the CPC lead and perhaps spends 25% of her time on CPC and the others spend only 5% on CPC, you would enter "3."

3. Program Year 2014 Expenditures

3.1 Labor Costs and Allocation to CPC Work: In the cells below, please provide estimated percentage of time spent on individual CPC Milestones.

Labor			Percent of Labor Distributed by Milestone
Clinician/Staff Role	**Number of Staff**	**Total CPC Cost**	**MS2, MS3, MS4…**
Providers (MD, DO, PA, NP)		$	%s for each MS
Clinical Staff (RN, LPN, APRN)		$	
Care Managers		$	
Pharmacists		$	
Health Educators/ Social Workers		$	
Behavioral Health Professional		$	
Administrative Staff		$	
Executive Management		$	
IT/Data/Quality Improvement Staff		$	
Other: <<ENTER TEXT TO SPECIFY>>		$	
Other: <<ENTER TEXT TO SPECIFY>>		$	
TOTAL LABOR COSTS		$	
Comments (Optional)			

3.2 Non Labor Program Costs

Direct Cost Category	Total Annual Cost
EHR/IT/Portals	
Consulting/Vendors	
Training/Travel	
Office space	
Equipment (NON-IT)	
Other: <<ENTER TEXT HERE TO SPECIFY>>	
Other: <<ENTER TEXT HERE TO SPECIFY>>	

Section 4. Summary

4.1 Net CPC Care Management Budget for 2014

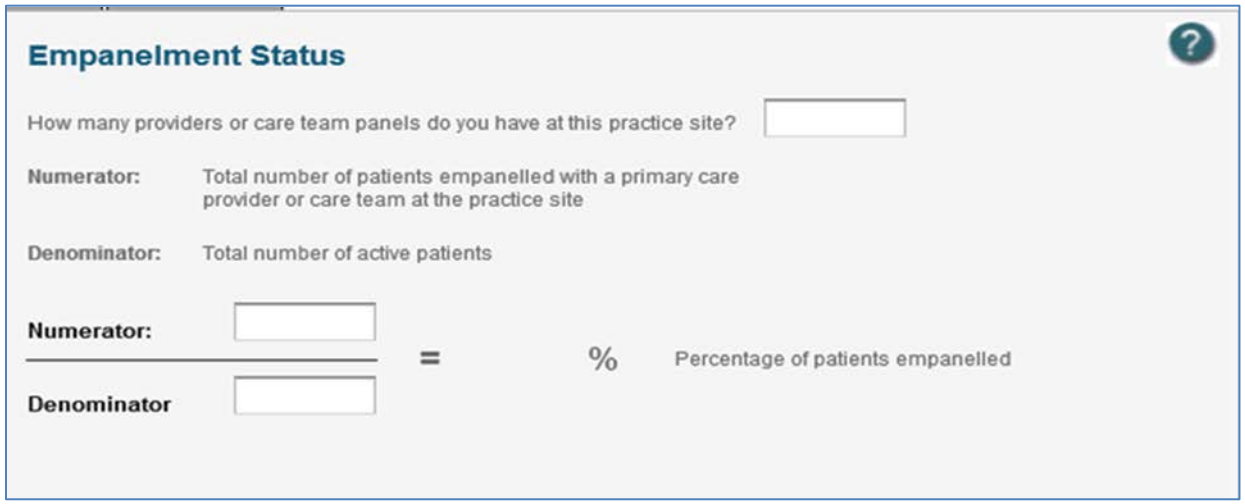
Total Care Management Fee Revenue (from tab 2)	$
Total Labor + Non Labor Expenses (from tab 3)	$
Total Unspent/Overspent Care Management Funds	
Alert:	Explain in comments box why your care management expenses exceeded care management funding or what your practice plans to do with the excess funding
Comments (Optional)	

Milestone 2: Care Management for High-Risk Patients

The work in Milestone 2 addresses population health, targeting initially those at highest risk for poor outcomes and preventable harm. In PY 2013 you began to risk stratify your patients and provide intensive care management for those at highest risk. In PY 2014 you continued this process and applied additional strategies to support patients struggling to achieve their health goals or at risk for poor health outcomes.

2.0.1 Empanelment Status [Quarters 1 – 4]

Enter the data in the provided fields as shown below.



2.0.1.1 Empanelment Look Back Period [Quarter 1]

What is your empanelment look back period?

- ○ One year
- ○ Two years
- ○ Three years
- ○ Other (specify)

2.0.2 Risk Stratification

2.0.2.1 Risk Stratification Methodology [Quarter 1 and as needed to answer question 2.0.2.3]

The goal of risk stratification is to get a prioritized list of patients, ordered both by their riskiness and the reason for their risk. A patient's risk can be defined in many ways; for the purposes of CPC, you are encouraged to think about the risk of hospitalization, readmission and patient morbidity. There are many methodologies used to help risk stratify the population of patients in your practice, and therefore, CMS want to understand your process at your practice.

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

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

2.0.2.2 Explaining the Risk Stratification Process (Optional) [Quarter 1 and as needed based on answer to question 2.0.2.3]

Please use the space below to provide any further details about your risk stratification process. Text box will be provided.

2.0.2.3 Changes to the Risk Stratification Methodology [Quarters 2 – 4]

We recognize that risk stratification is a dynamic process and may change to better enable you to achieve the goal of identifying those at risk in your patient population.

Did you make any changes to your risk stratification methodology from the previous quarter?

- ◯ Yes
- ◯ No

  If yes, update your risk stratification methodology above [2.0.2.1] and explain the changes below. *Text box will be provided.*

2.0.2.4 Risk-Stratified Care Management Statistics [Quarters 1 – 4]

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

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

Level of Patient Risk	Total number of patients in each tier at the time of this report	Number of patients within each tier under care management at the time of this report	% of patients under care management
			%
			%
			%
			%
			%
Not assigned			%
Total empanelled	[will autopopulate from response to 2.0.1]		

2.0.2.5 Tracking High Risk Patients [Quarter 2]

Based on the CPC Milestone 2 definition of care management, describe how your practice reviews and tracks the panel of patients at high or escalating risk. Briefly describe the range of services your care management staff perform for patients under care management. Include a description of how care management differs for patients at different levels of risk. *(Text box and a document upload option will be provided.)*

2.0.3 Description of Care Management [Quarter 2]

Now, to help CMS categorize the types of care management work occurring in CPC practices, indicate which best correspond with the description of care management your practice provides:

- ○ Patient coaching
- ○ Education and skill building for specific chronic conditions
- ○ Referral or connection to community resources
- ○ Care plan development and documentation
- ○ Planned telephonic or electronic follow up or check in
- ○ Planned monitoring of medical data collected at home (e.g., blood pressure, weight)
- ○ Regular (at least quarterly) chart review and monitoring based on plan of care
- ○ Home visits for transition management
- ○ Home visits for chronic disease management
- ○ Hospital visits for care coordination and transition management
- ○ Post-hospital discharge follow-up
- ○ Post ED follow-up
- ○ Referral tracking and follow-up
- ○ Test tracking and follow-up
- ○ Transition management (between both sites of care and providers of care)
- ○ Post-discharge contact
- ○ Other (specify)

2.0.4 Care Management Staffing [Quarters 1 and 4]

2.0.4.1 Staff Providing Care Management

Indicate who in your practice is responsible for the care management of the patients you identified above as being under active care management. Select all that apply:

- ○ Physician
- ○ PA
- ○ APRN/NP
- ○ RN
- ○ LPN
- ○ MA
- ○ Social Worker
- ○ Other Care Manager (specify)
- ○ Other (don't specify)

2.0.4.2 Time Spent Providing Care Management

For each role selected above, provide an estimate on the time spent on a weekly basis. Do not include time spent on billable patient visits. If there is more than one person in any given role, total those individuals' hours together. *Text box will be provided.*

2.0.5 Selection of Care Management Strategies [Quarter 1]

In PY 2014, you selected one or more of the following advanced primary care strategies for patients at risk. In PY 2015, you will build on the same strategy or strategies you selected in PY 2014. You are not required to add an additional strategy or strategies but are encouraged to do so below.

Below are the selection(s) you made in PY 2014. Review the information and identify whether you will continue building on the work that you started in PY 2014 or will be making changes to your strategy or strategies in PY 2015.

- ○ Integration of behavioral health (BH)
- ○ Self-management support (SMS) for at least three high-risk conditions
- ○ Integration of pharmacists for medication management and review (MM)

2.1 Behavioral Health Integration Services

2.1.1 Identification of patients for behavioral health services [Quarters 1 and 4]

Practices use a variety of methods to identify patients for behavioral health services. Indicate how your practice identifies patients using each of three different criteria: condition, chronic illness indicators and health risks. If your practice doesn't use any of these criteria, use the text box below to describe your method for identifying patients.

1. Our practice focuses on specific conditions to identify patients, either through routine screening or other strategies. Select all that apply:
   - ○ Depression
   - ○ Anxiety
   - ○ Substance abuse
   - ○ Intimate partner violence
   - ○ Cognitive impairment
   - ○ Pain
   - ○ Other (specify)
   - ○ We don't use specific conditions to identify patients for behavioral health services.

2. Our practice uses chronic illness indicators to identify patients. Select all that apply:
   - ○ Not reaching goals of therapy for specific conditions or diagnoses (specify)
   - ○ Caregivers for persons with dementia
   - ○ At increased risk according to the practice risk stratification methodology
   - ○ Other (specify)
   - ○ We don't use chronic illness indicators to identify patients for behavioral health services.

3. Our practices uses health risks to identify patients. Select all that apply:
   - ○ Tobacco use
   - ○ Sleep disorder
   - ○ Obesity
   - ○ Social risk factors
   - ○ Other (specify)
   - ○ We don't use health risks to identify patients for behavioral health services. *If this is selected, the following question will appear:*

     If your practice's response for the three above questions is "We don't use health risks to identify patients for behavioral health services," the following question will appear:

4. Describe your practice's method for identifying patients for behavioral health services. Text box will be provided.

2.1.2 Organization of behavioral health care in your practice [Quarters 1 and 4]

5. Our practice provides the following options for behavioral health care. Select all that apply:
   - ○ Referral for specialty mental health care
   - ○ Co-management between primary care and behavioral health specialists
   - ○ Primary care management with behavioral health specialist consultation and case review
   - ○ Behavioral health specialists integrated into primary care workflow (primary care behavioral health clinicians)
   - ○ Other (specify)

2.1.3 Integration of behavioral health specialists [Quarters 1 and 4]

6. Does your practice have behavioral health specialists co-located within your CPC practice?
   - ○ Yes (go to 7)
   - ○ No (go to 10)

7. Indicate the types of behavioral health specialists working in your practice. Select all that apply:
   - ○ Psychologist
   - ○ Psychiatrist
   - ○ Licensed clinical social worker
   - ○ Behavioral health care manager
   - ○ Psychiatric NP
   - ○ Psychiatric PA
   - ○ Other (specify)

For each of the behavioral health specialists selected above, you will be required to indicate the number of hours per week that the specialist works. If more than one person performs the role, you should provide the total hours worked in a typical week. Text box will be provided.

8. Indicate the type of care provided by your behavioral health specialists. Select all that apply:
   - ○ Mental health care
   - ○ Substance abuse care
   - ○ Support for self-management of chronic conditions
   - ○ Care for stress and related physical symptoms
   - ○ Modification of behaviors affecting health
   - ○ Social assistance (e.g., help with housing, employment, social services)
   - ○ Counseling for grief/other stressors

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

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

2.1.4 Care coordinated with behavioral health services external to the practice (including system resources located external to the CPC practice) [Quarters 1 and 4]

10. Indicate the types of care offered to patients through external behavioral health providers with whom your practice has care compacts or referral agreements. Select all that apply:
    - ○ Mental health care
    - ○ Substance abuse care
    - ○ Support for self-management of chronic conditions
    - ○ Care for stress and related physical symptoms
    - ○ Modification of behaviors affecting health
    - ○ Social assistance (e.g., help with housing, employment, social services)
    - ○ Other (specify)

11. Does your practice have a process in place for regular medication reconciliation and medication coordination for your patients who receive behavioral health care through referral?
    - ○ Yes, for all patients
    - ○ Yes, for most patients
    - ○ Yes, for some patients
    - ○ No, we don't have a process in place

2.1.5 Evidence-based management of behavioral health conditions [Quarters 1 and 4]

12. Indicate the type of capabilities your practice provides. Select all that apply:
    - ○ Cognitive Behavioral Therapy
    - ○ Problem Solving Treatment
    - ○ Behavioral Activation
    - ○ Motivational Interviewing
    - ○ Interpersonal Therapy
    - ○ Other (specify)

13. Indicate the types of tools and instruments for screening, assessment, monitoring and treatment to goal that your practice uses. Select all that apply:
    - ○ Broad Measure
        - o Brief Psychiatric Rating Scale (BSRS)
    - ○ Depression/mood disorders:
        - o Patient Health Questionnaire for Depression PHQ 2
        - o PHQ-9
        - o Mood Disorder Questionnaire (MDQ)
        - o Composite International Diagnostic Interview (CIDI) for depression
        - o Other (specify)
    - ○ Anxiety:
        - o Generalized Anxiety Disorder subscale (GAD-7)
        - o Other (specify)

- ○ Pain:
  - o Brief Pain Inventory (BPI)
  - o Other (specify)
- ○ Alcohol use disorder:
  - o The Alcohol Use Disorders Identification Test (AUDIT-C)
  - o Drug Abuse Screen Test (DAST)
  - o Other (specify)
- ○ Cognitive function:
  - o Montreal Cognitive Assessment (MoCA)
  - o Mini Mental Status Examination (MMSE)
  - o Mini-COG
  - o Other (specify)
- ○ PTSD
  - o PTSD Checklist (PCL-C)
  - o Primary Care PTSD Screener (PC-PTSD)
- ○ ADHD
  - o Adult ADHD Self-Report Scale (ASRSv1.1)
- ○ OCD
  - o Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

2.1.6 Care management and Treatment to Goal [Quarters 1 and 4]

14. We use the following to track and manage treatment to goal for patients receiving behavioral health services:
    - ○ EHR registry functionality
    - ○ Stand-alone registry
    - ○ Other (specify)

15. Behavioral Health care management and outreach as needed is provided by:
    - ○ The same care manager(s) who provides care management for other high-risk patients
    - ○ Specialized behavioral health care manager
    - ○ Behavioral health specialist
    - ○ Other (specify)

16. We systematically review the following. Select all that apply:
    - ○ Patients not achieving goal for therapy
    - ○ Patients who have relapses following therapy
    - ○ Patients identified as at risk by providers
    - ○ Patients with specific diagnoses or severity scores (specify)
    - ○ Other (specify)

17. What is the frequency of reviews?
    - ○ Weekly
    - ○ Biweekly (every other week)
    - ○ Monthly
    - ○ Quarterly
    - ○ Other (specify)

18. Who is typically on the review team? Select all that apply:
    - ○ Psychologist
    - ○ Psychiatrist
    - ○ Social worker
    - ○ Primary care provider
    - ○ Care manager
    - ○ Psychiatric NP
    - ○ Psychiatric PA
    - ○ Other (specify)

2.1.7 Measurement and sustainability [Quarters 1 and 4]

19. What quality measures, population health indicators, or utilization metrics are you using to understand the effects of integrated behavioral health in your practice? (Five text boxes will be provided.)

20. In addition to our CPC revenue resources, we use the following resources to support integration of behavioral health. Select all that apply:
    - ○ Allocation of general practice revenue
    - ○ Fee-for-service billing
    - ○ Capitation contracts for which we are at financial risk
    - ○ Capitation payments as special payer initiatives (no financial risk)
    - ○ Pay for performance funding
    - ○ Time-limited grant funding
    - ○ State, regional, community or foundation support on an ongoing basis (not time limited)
    - ○ Other (specify)

2.2 Self-Management Support

2.2.1 Condition-Specific Self-Management Support [Quarters 1 and 4]

Identify at least three high-risk conditions that are the focus for self-management support in your practice and the number of patients in the practice who have that condition.

Condition 1: (100-character limit text box)

Number of eligible patients: (text box with 4-digit limit)

List the triggers to support SMS of condition 1. Select all that apply:
- ○ All patients with the 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
- ○ Other (specify)

Condition 2: (100-character limit text box)

Number of eligible patients: (text box with 4-digit limit)

List the triggers to support SMS of condition 1. Select all that apply:

- ○ All patients with the 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
- ○ Other (specify)

Condition 3: (100-character limit text box)

Number of eligible patients: (text box with 4-digit limit)

List the triggers to support SMS of condition 1. Select all that apply:

- ○ All patients with the 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
- ○ Other (specify)

OPTIONAL (additional reporting for practices selecting more than three conditions)

Condition 4: (100-character limit text box)

Number of eligible patients: (text box with 4-digit limit)

List the triggers to support SMS of condition 1. Select all that apply:

- ○ All patients with the 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
- ○ Other (specify)

Condition 5: (100-character limit text box)

Number of eligible patients: (text box with 4-digit limit)

List the triggers to support SMS of condition 1. Select all that apply:

- ○ All patients with the 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
- ○ Other (specify)

2.2.2 Skills for Self-Management [Quarters 1 – 4]

Indicate how you provide your patients with disease or condition-specific skills for your target conditions (beyond patient education in the E/M visits with a physician, NP or PA) and the training or credentials of the person working with patients on disease or condition-specific skills.

For each condition, also identify how many patients received training in managing their disease or condition this quarter. If your practice is still planning how you will provide training for a condition, select the "In Planning" checkbox for that condition.

Condition 1: *(prepopulated from previous response)*

- ○ **Provided by** (select all that apply):
  - o Internal staff

  Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

  - o External staff

  Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

  Cumulative number of patients that received this intervention this quarter: (text box)

- ○ **In planning**

Condition 2: *(prepopulated from previous response)*

- ○ **Provided by** (select all that apply):
  - o Internal staff

  Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

  - o External staff

  Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

  Cumulative number of patients that received this intervention this quarter: (text box)

- ○ **In planning**

Condition 3: *(prepopulated from previous response)*

- ○ **Provided by** (select all that apply):
  - o Internal staff

  Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

  - o External staff

  Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

  Cumulative number of patients that received this intervention this quarter: (text box)

- ○ **In planning**

OPTIONAL (additional reporting for practices selecting more than three conditions)

Condition 4: *(prepopulated from previous response)*

○ **Provided by** (select all that apply):

- o Internal staff

Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

- o External staff

Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

Cumulative number of patients that received this intervention this quarter: (text box)

○ **In planning**

Condition 5: *(prepopulated from previous response)*

○ **Provided by** (select all that apply):

- o Internal staff

Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

- o External staff

Training or credentials of that person (i.e., MD/DO, APRN/NP, PA, RN, MA, CDE): (text box)

Cumulative number of patients that received this intervention this quarter: (text box)

○ **In planning**

2.2.3 Support for Self-Management Across Conditions [Quarters 1 and 4]

Select the tactics your practice uses to support self-management across conditions. Select all that apply:

Between-visit planning and coaching

○ **Team preparation for the patient (huddle).** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

○ **Pre-visit development of a draft visit agenda to share with the patient.** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

○ **Coaching between visits and follow-up on care plan and goals.** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

Goal setting and Care Plan/Action Plan development

○ **Identify patient goals and document in EHR.** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

○ **Develop care plan/action plan and document plan in the EHR.** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

Peer support and counseling

○ **Peer-led support for self-management.** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

○ **Group visits.** Team members responsible (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

2.2.4 Methods Used in Support of Self-Management [Quarters 1 and 4]

2.2.4.1 Tools Used to Assist Patients

Identify the tools you are using to assist patients in assessing their need for support for self-management. Select all that apply:

- ○ Patient Activation Measure (PAM)
- ○ How's My Health
- ○ Other (specify)
- ○ None

2.2.4.2 Evidence-Based Counseling Approaches

Identify the evidence-based counseling approaches you are using in self-management support (select all that apply). Upon selecting Save Data, the page will reload with additional fields for you to identify who on the care team has had training and is using each of the selected approaches.

- ○ **Motivational Interviewing.** Team members who are using these skills/methods (select all that apply):
  - o Physician
  - o APRN/NP
  - o PA
  - o RN
  - o LPN
  - o MA
  - o Other Care Manager
  - o Behaviorist
  - o Health Educator
  - o Community Resource
  - o Pharmacist
  - o Community Health Worker
  - o Other (specify)

- ○ **5 As (Ask, Advise, Assess, Assist, Arrange).** Team member who is using these skills/methods (select all that apply):
  - o Physician
  - o APRN/NP
  - o PA
  - o RN
  - o LPN
  - o MA
  - o Other Care Manager
  - o Behaviorist
  - o Health Educator
  - o Community Resource
  - o Pharmacist
  - o Community Health Worker
  - o Other (specify)

- ○ **Reflective Listening.** Team member who is using these skills/methods (select all that apply):
  - o Physician
  - o APRN/NP
  - o PA
  - o RN
  - o LPN
  - o MA
  - o Other Care Manager
  - o Behaviorist
  - o Health Educator
  - o Community Resource
  - o Pharmacist
  - o Community Health Worker
  - o Other (specify)

- ○ **Teach Back.** Team member who is using these skills/methods (select all that apply):
  - o Physician
  - o APRN/NP
  - o PA
  - o RN
  - o LPN
  - o MA
  - o Other Care Manager
  - o Behaviorist
  - o Health Educator
  - o Community Resource
  - o Pharmacist
  - o Community Health Worker
  - o Other (specify)

○ **Other (specify).** Team member who is using these skills/methods (select all that apply):

- o Physician
- o APRN/NP
- o PA
- o RN
- o LPN
- o MA
- o Other Care Manager
- o Behaviorist
- o Health Educator
- o Community Resource
- o Pharmacist
- o Community Health Worker
- o Other (specify)

2.2.5 Use of Community-Based Resources for Self-Management [Quarter 4]

In the fields below, identify up to five community-based resources that you make available to your patients for support for self-management. Select the "In planning" option if you are still in the planning phase.

○ In planning

Community-Based Resource 1: (text box)

Indicate how the link between the patient and this resource is made:

○ Information provided
○ Formal referral or prescription, without feedback
○ Formal referral or prescription with feedback report expected and tracked
○ Other (specify)

Community-Based Resource 2: (text box)

Indicate how the link between the patient and this resource is made:

○ Information provided
○ Formal referral or prescription, without feedback
○ Formal referral or prescription with feedback report expected and tracked
○ Other (specify)

Community-Based Resource 3: (text box)

Indicate how the link between the patient and this resource is made:

○ Information provided
○ Formal referral or prescription, without feedback
○ Formal referral or prescription with feedback report expected and tracked
○ Other (specify)

Community-Based Resource 4: (text box)

Indicate how the link between the patient and this resource is made:

○ Information provided
○ Formal referral or prescription, without feedback
○ Formal referral or prescription with feedback report expected and tracked
○ Other (specify)

Community-Based Resource 5: (text box)

Indicate how the link between the patient and this resource is made:

- ○ Information provided
- ○ Formal referral or prescription, without feedback
- ○ Formal referral or prescription with feedback report expected and tracked
- ○ Other (specify)

2.2.6 Building Capacity for Support of Self-Management [Quarter 4]

2.2.6.1 New Capacity for Support of Self-Management

Identify any new capacity for support of self-management you have added to your practice since you last reported on this in January 2015 (for PY 2014 Q4 reporting).

Five text boxes will be provided. For each text box provided, the following question will appear.

How have you added this capacity?

- ○ Training (specify)
- ○ Hire or contract for new staff with specific training or skills (e.g., CDE) (specify)
- ○ Formal relationship with external resources
- ○ Other (specify)
- ○ None in this quarter

2.2.6.2 Identifying Measures and Understanding the Impact

Identify the measures that your practice uses to understand the implementation of support for self-management or the impact of this support on care processes, health outcomes or costs. *Five text boxes will be provided.*

2.3 Medication Management

2.3.1 Medication Management Services [Quarters 1 and 4]

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

- ○ Routine medication reconciliation
- ○ Coordination of medications at the time of transitions of care
- ○ Comprehensive medication review and assessment aimed at providing the safest and most cost-effective medication regimen possible to meet the patient's health goals
- ○ Development of a medication action plan or contribution to a global care plan
- ○ Medication monitoring
- ○ Support for medication use and self-management
- ○ Collaborative drug therapy management

2.3.2 Pharmacist as a Member of the Care Team [Quarters 1 and 4]

2.3.2.1 Engaging Pharmacists as Part of the Care Team

Identify how your practice engages pharmacists as part of the care team:

- ○ Direct hire
- ○ System resource
- ○ Contract
- ○ Agreement with teaching facility
- ○ Other agreement (specify)
- ○ A non-pharmacist with prescribing authority for medication management (specify)
- ○ In planning

How many pharmacists work at the practice? (Text box provided.)

How many hours per week, on average, does the pharmacist work at the practice? If more than one pharmacist, please total the hours. (Text box provided.)

2.3.2.2 Pharmacists Engaging in Patient Care

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

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

2.3.3 Patient Selection for Medication Management [Quarters 1 and 4]

Identify how patients are selected for medication management services beyond routine medication reconciliation. These indications may be overlapping. Select all that apply:

- ○ Based on risk cohorts (specify the cohorts)
- ○ Patients who have not achieved a therapeutic goal for a chronic condition (specify the eligible conditions)
- ○ Direct provider referrals
- ○ Poly pharmacy
- ○ High-risk medications
- ○ Patients with care transition(s)

If "Patients with care transition(s)" is selected, the following two questions will appear:

Identify which transitions trigger these services. Select all that apply:

- ○ ED visit
- ○ Hospital admission
- ○ Hospital discharge
- ○ NF or SNF admission
- ○ NF or SNF discharge

Identify who receives these services:

- ○ All patients
- ○ Patients with specific risk factors (specify)
- ○ Patients with multiple ED visits or hospitalizations
- ○ High-risk medications
- ○ Complex medication regimens (specify)
- ○ Other (specify)

2.3.4 Collaborative Drug Therapy Management [Quarters 1 and 4]

Does your practice provide collaborative drug therapy management?

- ○ Yes
- ○ No
- ○ In planning

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

- ○ Diabetes
- ○ Hypertension
- ○ Hyperlipidemia
- ○ Anticoagulation
- ○ Asthma
- ○ Heart Failure
- ○ Hyper/Hypothyroidism
- ○ COPD
- ○ Other (specify)

2.3.5 Medication Process Measures [Quarters 1 and 4]

Identify the measures that your practice uses to understand the implementation of Medication Management or the impact of these services on care processes, health outcomes or costs. *(Five text boxes will be provided.)*

Milestone 3: 24/7 Access and Continuity

3.1: Continuity of Care [Quarters 1 and 4]

Do you use your EHR to track continuity of care for each patient in your empanelled population?

- ○ **Yes.** *If selected, the following three questions will appear:*

1. ***How does your practice define continuity of care?*** Select all that apply:
   - o Number of office visits to empanelled provider/number of office visits to practice
   - o Number of office visits to care team/number of office visits to practice
   - o Number of office visits + non-visit communication with empanelled provider/number with practice
   - o Number of office visits + non-visit communication with care team/number with practice
   - o Other [text box will be provided]
2. ***How does the EHR calculate continuity?*** Select all that apply:
   - o Number of office visits to empanelled provider/number of office visits to practice
   - o Number of office visits to care team/number of office visits to practice
   - o Number of office visits + non-visit communication with empanelled provider/number with practice
   - o Number of office visits + non-visit communication with care team/number with practice
   - o Other (specify)
3. ***How do you use the calculations made by your EHR?*** Text box will be provided.

- ○ **No.** Our EHR is capable of tracking continuity, but we do not use this function.
- ○ **No.** Our EHR is not capable of tracking continuity.

*If either **No** response is selected, the following question will appear:*

Identify the main barriers to tracking continuity of care for your empanelled patients and when you expect to begin tracking continuity of care. Text box will be provided.

3.2 24/7 Access by Patients [Quarters 1 – 4]

In PY 2014, all practices were asked to ensure that patients had 24/7 access to a care team practitioner who had real-time access to their electronic medical record. This could be provided by a care team member from your practice or through various coverage arrangements.

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

- ○ Yes
- ○ No

*If the **No** response is selected this question will appear:*

When does your practice expect to have 24/7 access to your EHR for all practitioners covering calls after patient hours?

- o Within three months
- o Between three and six months
- o More than six months

3.3: Enhanced Access Outside of Office Visits [Quarters 1 and 4]

Identify how your practice is providing enhanced patient access (non-urgent care provided to patients outside of office visits). Select all that apply:

- ○ Patients send and receive messages through a patient portal (as defined by MU)
- ○ Web-enabled visits other than through a patient portal
- ○ Secure email
- ○ Text messaging
- ○ Telemedicine/Remote monitoring
- ○ Other (specify)
- ○ In progress/we are currently building this capacity

Identify if your practice also provides any of the following (billable) types of alternative visits:

- ○ Home visits
- ○ Group visits
- ○ Our practice does not provide other types of alternative visits

3.4: Communication about Enhanced Access [Quarters 1 and 4]

Indicate how your practice communicates the availability of care provided to patients outside of office visits. Select all that apply:

- ○ Waiting room communication (e.g., poster, video)
- ○ Hand-out/brochure given to patient in office
- ○ Website/Patient portal
- ○ Social Media
- ○ Phone hold messages
- ○ Written reminder on visit summary or care plan
- ○ Mailing to patients
- ○ Other (specify)

3.5: Commitment to a Timely Response [Quarters 1 and 4]

Does your practice have a standard turnaround time for patient responses that you communicate to patients?

- ○ Yes
- ○ No

If yes, provide the language you use to communicate the turnaround time to your patients. Text box will be provided.

Milestone 4: Patient Experience

4.1 Patient Experience Option Selection [Quarter 1]

Identify the methods you are using to engage patients in improving care:

- ○ Practice-Based Survey (Option A)
- ○ Patient and Family Advisory Council (Option B)
- ○ Both Survey Patient and Family Advisory Council (Option C)

4.2 Survey (Options A, C) [Quarters 2 and 4]

Method of Survey (select one):

- ○ 1. Our practice used a survey developed or adapted to address our specific questions
- ○ 2. Our practice used a commercially available survey administered by a vendor.

*If answer is **1**, the following two questions will appear:*

We administered the survey in the following way(s). Select all that apply:

- o Distributed and collected during office visit
- o Mailed to patients
- o Telephone survey of patients
- o Use of online survey tool
- o Distributed via Patient Portal
- o Other (specify)

Frequency of surveys:

- o Weekly
- o Monthly
- o Every other month
- o Quarterly

4.3: PFAC (Options B, C)

4.3.1 PFAC Meetings [Quarters 2 and 4]

Over the past two quarters, our PFAC met on the following days (please retain all meeting minutes for the purposes of auditing and monitoring): (text box will be provided)

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

Role	Number of Individuals
Physician	
APRN/NP	
PA	
RN	
LPN	
MA	
Other Care Manager	
Behavioral Health Professional	
Health Educator	
Pharmacist	
Patient	
Family/Caregiver	
Hospital Representative	
Administrative	
Other: (5 user-defined rows can be added each quarter)	

4.4 Improvement Based on Feedback [Quarters 1 – 4]

Identify the types of practice changes in the last quarter were influenced by the survey or PFAC, either because they were initiated based on what you learned through survey or PFAC or because you used survey or PFAC data to assess improvement. Select all that apply:

- ○ Changes to scheduling, hours, appointment types
- ○ Changes to front office staffing and waiting areas
- ○ Refinements to risk stratification methodology
- ○ Changes in the development or use of the plan of care for patients at high risk
- ○ Changes to medication management strategies
- ○ Changes to self-management support strategies
- ○ Coordination of care with mental health and behavioral health providers
- ○ Using community-based self-management support and wellness resources
- ○ Strategies to improve continuity of care and relationship between patients and providers/care team
- ○ Tracking and follow-up from hospitals and diagnostic studies
- ○ Transition of care from hospitals and subacute care
- ○ Follow-up from ED visits
- ○ Coordination of care with specialists
- ○ Other: (specify)
- ○ Other: (specify)

4.5: Communicating the Changes [Quarters 2 and 4]

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

- ○ Waiting room communication (e.g., poster, video)
- ○ Hand-out/brochure given to patient in office
- ○ Website/Patient portal
- ○ Social media (e.g., Facebook, Twitter)
- ○ Phone hold messages
- ○ Written reminder on visit summary or care plan
- ○ Mailing to patient
- ○ Public reporting through local or regional collaboratives/press releases
- ○ Newsletter or other communication distributed to patients outside of office visits
- ○ Other (specify)

Milestone 5: Quality Improvement

5.1 Continuous Quality Improvement Using CQM Data [Quarters 1 – 4]

In this past quarter, we focused quality improvement on the following areas that are addressed in the quality measure set for CPC. Select all that apply:

- ○ Controlling High Blood Pressure [NQF 0018]
- ○ Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents [NQF 0024] *(Regional measure for Colorado, Oklahoma, Oregon only)*
- ○ Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention [NQF 0028]
- ○ Breast Cancer Screening [NQF N/A]
- ○ Use of Appropriate Medications for Asthma [NQF 0036]*(Regional measure not applicable to Arkansas)*
- ○ Colorectal Cancer Screening [NQF 0034]
- ○ Preventive Care and Screening: Influenza Immunization [NQF 0041]
- ○ Pneumonia Vaccination Status for Older Adults [NQF 0043]
- ○ Diabetes: Hemoglobin A1c Poor Control [NQF 0059]
- ○ Diabetes: Low Density Lipoprotein (LDL) Management [NQF 0064]
- ○ Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control [NQF 0075]
- ○ Heart Failure (HF): Beta-blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) [NQF 0083]
- ○ Falls: Screening for Future Fall Risk [NQF 0101]
- ○ Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan [NQF 0418]
- ○ Documentation of Current Medications in the Medical Record [NQF 0419]

5.2 Monitoring CQM Data [Quarters 1 – 4]

During the past quarter, we reviewed CQM data:

- ○ At the panel level
- ○ At the practice level
- ○ We were unable to review the CQM data. If selected, a text box for explanation will be provided.

5.3 Testing Changes to Improve Quality [Quarters 1 – 4]

Select the types of practice change in the last quarter that were influenced by your CQM review activities. Select all that apply:

- ○ Plans of care for patients at high risk
- ○ Pre-visit planning
- ○ Huddles
- ○ Training
- ○ Health education
- ○ Medication management
- ○ Risk stratification
- ○ Care transitions workflows
- ○ Self-management support protocols
- ○ Condition-specific support for self-management of common conditions
- ○ Shared decision-making protocols
- ○ Coordination of care with specialists
- ○ Using community-based self-management support and wellness resources.
- ○ Coordination of care with mental health and behavioral health providers in the community
- ○ Other (specify)

5.4 Review of Payer Feedback Reports [Quarters 1 – 4]

Select the payer data feedback report(s) your practice reviewed this quarter. Select all that apply:

- ○ [Selection of payers will be auto-populated by region]
- ○ My practice reviewed an aggregate report from another source. *If selected, a text box will be provided to identify the source.*

5.5 Improving Quality and Reducing Cost [Quarters 1 – 4]

Using the selected feedback report, identify the areas of high cost for your practice that you worked to reduce while maintaining or improving quality. Select all that apply:

- ○ Professional services provided by primary care providers at your practice
- ○ Professional services provided by primary care providers at other practices
- ○ Professional services provided by specialty care providers
- ○ Inpatient hospital services, any cause
- ○ Inpatient hospital services for ambulatory care sensitive conditions (ACSCs)
- ○ Outpatient hospital services
- ○ Laboratory services
- ○ Imaging services
- ○ Skilled nursing facilities
- ○ Home health
- ○ ED visits for any cause
- ○ Potentially preventable ED visits
- ○ Other: (specify)

Briefly list or describe the changes your practices tested: (text box will be provided)

Milestone 6: Care Coordination Across the Medical Neighborhood

6.1 Identify Areas of Improvement [Quarter 1]

Building on your Program Year 2014 activities, select TWO of the care coordination options below.

- ○ **Option A:** Track the percentage (%) of patients with ED visits who received a follow-up contact
- ○ within one week of discharge.
- ○ **Option B:** Contact at least 75% of patients who were hospitalized in target hospital(s) within 72 hours or two business days of discharge.
- ○ **Option C:** Enact care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve coordination and transitions of care. (These may be the same groups selected in PY 2014.)

6.2 Follow-Up Contact with Patient Within One Week of ED Discharge (Option A) [Quarters 1 – 4]

Your practice tracks the number of patients seen in a target emergency department (ED) who received follow-up contact from your practice within one week. A target ED is defined as a facility for which your practice can receive regular and timely information about your patient's ED discharges.

In the table below, identify your target ED(s) and provide the counts of your patients' ED discharges and your follow-up contacts within one week of discharge.

Name of ED [text box provided; saving opens new row, up to five rows max. per quarter.]	**Number of patient discharges from this ED in the past quarter (an individual patient may have more than one discharge)**	**Number of patient discharges followed by contact within one week in the past quarter**	**Percentage of follow-up within one week** [percentage will be calculated in the web app]

The names of the EDs entered in previous quarters will be pulled forward and displayed each quarter, and they will not be editable. A maximum of five user-defined rows can be added each quarter, with no ability to delete or modify the rows once the quarter is submitted.

Below you can see the trend in the percentage of your patients who received follow-up within one week of discharge from target EDs:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
ED name to be pre-populated by web application				

[This table will be pre-populated by the web app so that practices can see their quarterly trend. This is a read-only table. This table will be updated on all tabs as data is entered for each quarter (i.e., the table on the Quarter 1 tab will show quarter 1 and quarter 2 data once quarter 2 is entered).]

6.2.1: Methods for Obtaining ED Information [Quarters 1 – 4]

Select how your practice received ED discharge information in the last quarter. Select all that apply:

- ○ Practice pulls information: practice periodically seeks updates from hospital on discharges.
- ○ Hospital pushes information: hospital notifies the practice about discharges. *If this option is selected, the selections below will appear:*
  - o Hospital sends a periodic (e.g., daily or weekly) reports for all patients discharged from the hospital in that timeframe.
  - o Hospital sends patient-specific alerts to the practice when a hospital discharge occurs.

Identify the communication vehicle through which your practice obtained ED discharge information. Select all that apply:

- ○ Phone
- ○ Fax
- ○ Email
- ○ Health Information Exchange (HIE)
- ○ Access to hospital EHR/Hospital portal access
- ○ Other (specify)

6.3 Follow-up Contact within 72 Hours or Two Business Days of Hospital Discharge (Option B) [Quarters 1 – 4]

Your practice contacts at least 75% of patients within 72 hours or two business days of discharge from one or more target hospital(s). A target hospital is defined as a facility from which your practice can receive regular and timely information about your patient population's hospitalizations.

In the table below, identify the target hospital(s) and provide the counts of your patients discharged from the target hospital during this quarter and those who received follow-up contact within 72 hours or two business days after hospital discharge.

Name of Hospital [text box provided; saving opens new row, up to five rows max. per quarter.]	**Number of patient discharges from this hospital in the past quarter (an individual patient may have more than one discharge)**	**Number of patient discharges followed by contact within 72 hours or two business days in the past quarter**	**Percentage of patients discharged from the hospital with follow-up within 72 hours or two business days** [percentage will be calculated in the web app]

The names of the hospitals entered in previous quarters will be pulled forward and displayed each quarter. A maximum of five user-defined rows can be added each quarter, with no ability to delete or modify the rows once the quarter is submitted.

Below you can see the trend in the percentage of patients who received follow-up contact within 72 hours or two business days of hospital discharge:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Hospital names to be pre-populated by web application				

[This table will be pre-populated by the web app so that practices can see their quarterly trend. This is a read-only table. This table will be updated on all tabs as data is entered for each quarter (i.e., the table on the Quarter 1 tab will show quarter 1 and quarter 2 data once quarter 2 is entered).]

6.3.1 Methods for Obtaining Hospital Discharge Information (Option B) [Quarters 1 – 4]

Select how your practice received hospital discharge information in the last quarter. Select all that apply:

- ○ Practice pulls information: practice periodically seeks updates from hospital on discharges.
- ○ Hospital pushes information: hospital notifies the practice about discharges. *If this option is selected, the selections below will appear:*
  - o Hospital sends a periodic (e.g., daily or weekly) reports for all patients discharged from the hospital in that timeframe.
  - o Hospital sends patient-specific alerts to the practice when a hospital discharge occurs.

Identify the communications vehicle through which your practice obtained hospital discharge information. Select all that apply:

- ○ Phone
- ○ Fax
- ○ Email
- ○ Health Information Exchange (HIE)
- ○ Access to hospital EHR/Hospital portal access
- ○ Other (specify)

6.4 Care Compacts/Agreements with High Volume Specialists (Option C) [Quarters 1 – 4]

You indicated that your practice has enacted care compacts/collaborative agreements with at least two groups of high-volume specialists in different specialties to improve the coordination and transitions of care for your patient population.

Identify the specialist types with whom you have arranged these care compacts/collaborative agreements. Select all that apply and select at least two. *Note: Please retain a copy of the signed care compacts/collaborative agreements that your practice has with the high-volume specialists in your community.*

- ○ Allergy
- ○ Anesthesiology
- ○ Cardiology
- ○ Dermatology
- ○ Endocrinology
- ○ Gastroenterology
- ○ Hematology
- ○ Infectious Disease
- ○ Nephrology
- ○ Neurology
- ○ Obstetrics/Gynecology
- ○ Oncology
- ○ Ophthalmology
- ○ Orthopedic Surgery
- ○ Otolaryngology
- ○ Pain Management
- ○ Pathology
- ○ Physical Medicine
- ○ Physical Therapy
- ○ Podiatry
- ○ Pulmonology
- ○ Psychiatry
- ○ Radiology & Imaging
- ○ Rheumatology
- ○ Urology
- ○ Other (specify)

Milestone 7: Shared Decision Making

7.1 Area of Priority [Quarter 1, Quarters 2 – 4 as needed]

Identify health conditions, decisions or tests of focus for which your practice is implementing shared decision making (select at least three). This list contains some common preference-sensitive conditions for you to consider. Ideally, you are focusing on an area that is important to the patients in your practice and for which you can acquire an aid/tool. **It is important that your practice is able to track your progress over time and selecting a high-impact condition and/or aid that meet the needs of your patients and practice from the onset could avoid having to make quarterly changes to your selection and would allow you to see the effect of SDM on your practice over time.** *Please do not include immunization for influenza, pneumococcus or cancer screening for which consensus is supporting a single recommended pathway of care.*

- ○ Diagnostic and therapeutic management of acute low back pain without high risk indicators
- ○ Therapeutic options in management of chronic back pain
- ○ Therapeutic options in management of insomnia
- ○ Therapeutic options in management of chronic pain
- ○ Therapeutic options in management of menopausal symptoms
- ○ Therapeutic options in management of adult sinusitis
- ○ Therapeutic options in management of mild anxiety
- ○ Therapeutic options in management of mild depression
- ○ Therapeutic options in management of urinary incontinence
- ○ Therapeutic options in management of functionally significant osteoarthritis of the hip or knee
- ○ Therapeutic options in management of chronic stable angina
- ○ Therapeutic options in management of claudication
- ○ Medication choices in management of asthma
- ○ Medication choices in management of congestive heart failure
- ○ Medication choices in management of COPD
- ○ Medication choices in management of diabetes
- ○ Anticoagulation in atrial fibrillation
- ○ Prostate cancer screening
- ○ Screening mammography age 40 – 49
- ○ Colon cancer screening strategies
- ○ Care preferences over the life continuum
- ○ Other 1 (specify)
- ○ Other 2 (specify)
- ○ Other 3 (specify)
- ○ Other 4 (specify)
- ○ Other 5 (specify)
- ○ Other 5 (specify)

7.2 Source of Decision Aid [Quarters 2 – 4]

For each selected area of priority below, please identify the source(s) of the decision aid(s) that your practice will use. You may select more than one option under each area of priority.

- ○ Agency for Health Care Research and Quality (AHRQ)
- ○ Center for Disease Control (CDC)
- ○ Emmi Solutions
- ○ Food and Drug Administration (FDA)
- ○ Health Dialog/Informed Medical Decisions Foundation
- ○ Healthwise Decision Points
- ○ Mayo Clinic
- ○ Other (specify)

7.3: Rate of Use [Quarters 2 – 4]

Select whether your practice will report your decision aid data as a count or as a rate. Upon selecting Save Data, the page will reload with additional fields for you to complete.

- ○ Report as a count
- ○ Report as a rate

For each area of priority selected:

Selected Area of Priority: [Web application will prepopulate and show a unique entry for each selected area]

Indicate the counts or percentage of eligible patients who received a decision aid for the selected area of focus. We would expect this rate to increase over time as you implement this decision aid. *(Additional tables provided to accommodate additional selections.)*

For practices who select to report as a COUNT:

Selected Area of Priority 1: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 2: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 3: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 4: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 5: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of patients who received a decision aid	[Practice reports selection of decision aid]			

For practices who select to report as a RATE:

Note: The previous quarter's data will display in the table as read-only. You may only edit the current quarter.

Selected Area of Priority 1: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of eligible patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 2: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of eligible patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 3: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of eligible patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 4: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of eligible patients who received a decision aid	[Practice reports selection of decision aid]			

Selected Area of Priority 5: [Area of Priority prepopulated from earlier response]

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Percentage of eligible patients who received a decision aid	[Practice reports selection of decision aid]			

Milestone 8: Participation in the Learning Collaborative

No web application reporting requirements.

Milestone 9: Health Information Technology

9.1 Meaningful Use [Quarter 4]

The expectation for Milestone 9 is that the eligible professionals (EPs) at your practice site are working toward meeting the Stage 2 requirements of Meaningful Use (MU) per the timelines established by the EHR Incentive Program. EPs are not required to have successfully met all of the Stage 2 requirements by end of PY 2015 but should be actively engaged with meeting those requirements.

Select one of the options below:

- ○ Yes, our practice site attests that all our EPs are currently working toward meeting the Stage 2 requirements for MU.
- ○ No, our practice site attests that not all of our EPs are working toward meeting the Stage 2 requirements for MU. *If "No" is selected, a text box for explanation will be provided.*

Section 3 — Appendix

Resources

The Resource list is updated quarterly with the most up-to-date version posted on the Collaboration site here: https://collaboration.cms.gov/?q=content/py-2014-comprehensive-tools-and-resources. The content below is up to date as of Dec. 18, 2014.

General Program Information

CPC 2014 Continuing the Journey – Advancing Primary Care, National Resource, April 7, 2014
Meeting materials from the April 7, 2014, National meeting in Baltimore. The presentations include:

1. Mathematica Policy Research: The CPC Initiative: Evaluation Design, Description of Participants and Early Practice Transformation: This presentation reviews the evaluation and what we know so far about payers, patients, practices and cost, use and quality of care. (45-page PDF)
2. PY 2014 Milestones – Faculty Perspective: This presentation describes the regional learning faculty roles and how it supports practice transformation by regional approach. Notable achievements for PY 2013 are listed as well as anticipated challenges and strategies for PY 2014. (21-page PDF)
3. The CPC Journey: Practice Transformation: This presentation traces the progress of CPC since inception. Major achievements are included as well as a review of Milestones. (22-page PDF)

CPC Orientation, Colorado Regional Webinar, Aug. 14, 2014 (34-page PDF, transcript and video)
This webinar provides an overview of the CPC project and aims. It is a great resource for anyone new to the CPC project.

CPC Patient Survey – Patient Roster, Patient Roster Documents, April 10, 2014
This posting provides information around the second round of MPR patient roster surveys that were conducted in summer 2014. Resources include:

1. Sample email sent to patients (2-page PDF)
2. FAQ (2-page PDF)
3. Secure email instructions (5-page PDF)
4. Patient roster template (Excel template)

CPC PY 2014 Implementation and Reporting Summary Guide, Jan. 28, 2014 (69-page PDF)
This Implementation Guide outlines each Milestone by intent, work and reporting requirements. The first part of this Guide covers the Milestone intent and the work you will need to do to achieve the Milestones. We describe what is different from PY 2013 and map out the new capabilities your practice will develop through your work in Milestones 2, 3 and 6. The second part of the Guide walks through the Milestone reporting process. *(Note: Document updated June 10, 2014.)*

CPC PY 2015 Milestones, Sept. 18, 2015 (6-page PDF)
This document contains a description of the PY 2015 Milestones for CPC. In general, these Milestones represent a shift from an emphasis on building practice capacity to deliver comprehensive primary care to an emphasis on

deepening and refining the changes that you have already made. As such, there are very few new requirements. They provide a floor, not a ceiling, for your practice's continued efforts to provide comprehensive primary care and allow your practice to take ownership of its path forward.

FAQ for Action Groups, Sept. 15, 2014
This posting contains two resource documents that may be helpful as you prepare for participation in CPC Action Groups.

1. FAQ Action Groups (2-page PDF): FAQ will assist you to put these activities to use to enhance your comprehensive primary care work.
2. 2014-2015 Learning Support_Action Groups (3-page PDF): Provides a general overview of the purpose and set up of the seven CPC Action Groups.

Fast Facts Preview from Friends of CPC Meeting, Sept. 22, 2014 (10-page PDF)
These slides include a substantive preview of the forthcoming Mid-Year 2014 Fast Facts.

Friends of CPC Slides, Sept. 22, 2014 (46-page PDF)
This is the presentation from the "Friends of CPC" meeting that provides an overview of the CPC program to-date. The Friends of CPC is an occasional meeting bringing together representatives from the primary care and health policy communities and partners within the federal government to discuss progress within CPC and how outside stakeholders might help CPC succeed.

National Payer Call, Sept. 10, 2014 (43-page PDF)
This is the presentation from the national payer call and provides an overview of the CPC project to-date.

PY 2013 CPC Regional Quality Reports, National Resource, June 27, 2014 (seven 40-page PDFs)
This posting contains the seven CPC regional quality reports. These reports compare your CPC region to other CPC regions for quality measures in PY 2013. These reports include claims-derived utilization measures, CAHPS and eCQM data for each region.

PY 2013 Fast Facts by Region, National Resource, June 27, 2014 (6-page PDF)
Have you wondered how practices in other regions approached last year's Milestones? Which region has the largest practice size on average? How many Patient and Family Advisory Councils did we have in Colorado? Find out in the "Fast Facts."

PY 2014 Comprehensive Milestone FAQ, updated monthly
Frequently asked questions for the CPC program and all Milestones.

PY 2014 Practice Milestone Selections (M2, 4, 6), National Resource, June 4, 2014 (7-slide PowerPoint)
Are you curious about how many CPC practices selected the option to work on Medication Management or Behavioral Health in PY 2014? Wondering what CPC region has the highest number of practices that decided to work on Care Compact Agreements? How about Patient Engagement? How many CPC practices do you think have taken the plunge and selected PFAC and Office-Based Surveys? Explore this PowerPoint document to find out the answers to these questions and review the summary of CPC Practice selections for Milestones 2, 4 and 6 for PY 2014.

Q5 Regional Feedback Report, National Resource, June 4, 2014 (seven 33-page PDFs)
This posting contains the seven region feedback report bundles for CPC Quarter 5. The feedback report contains data related to patient characteristics, Medicare expenditures and use of Medicare services for Medicare fee-for-service (FFS) patients attributed to your practice during a quarter based on the attribution algorithm for the CPC initiative.

Q6 Regional Feedback Report, National Resource, Sept. 4, 2014 (seven 36-page PDFs)
This posting contains the seven region feedback report bundles for CPC Quarter 6. The feedback report contains data related to patient characteristics, Medicare expenditures, and use of Medicare services for Medicare fee-for-service (FFS) patients attributed to your practice during a quarter based on the attribution algorithm for the CPC initiative.

Resources for Milestone 1: Budget

Tools and Resources

Compensation Strategies Implementation Guide, Aug. 6, 2014 (14-page PDF)
Payment in addition to any fee-for-service payment makes it possible for CPC practices to develop strategies that align productivity metrics and compensation strategies with comprehensive primary care delivery. The Compensation Strategies Implementation Guide explores strategies CPC practices have employed to move compensation in this direction.

FAQs and Guidance for Creating a Budget for CPC Revenue (7-page PDF)
Questions gathered from the CPC community forums and answered by CMS staff.

Guide to Creating a Budget for CPC Revenue: Q&A, Jan. 9, 2014 (2-page PDF)
This document contains frequently asked questions related to Milestone 1: Budget.

Webinars

Annual Budget Preparation and Completion, Arkansas Learning Session, Nov. 16, 2012 (38-page PDF)
Presentation slides describe how to prepare the practice's CPC budget and how it should apply across the Milestones.

Effectively Using a Budget to Meet PY 2014 Milestones, New Jersey Regional Webinar, March 26, 2014 (29-page PDF, transcript and video)
This presentation shows budgetary impact from each Milestone, summarizes budget considerations and walks through PY 2014 Milestone 1 submissions.

Milestone 1: Budget as a Planning Tool, Oklahoma Regional Webinar, Jan. 10, 2014 (34-page PDF, transcript, video and two additional resource documents)
This presentation describes how to develop a CPC budget and prepare for PY 2014 Milestone 1 submissions.

Projecting New Revenue and Investing in Change, National Webinar, Oct. 17, 2012 (24-page PDF)
CMS CMMI staff describe enhanced payment and the budget, how to project new revenue, how to identify priorities for your practice and what tasks are at hand in this process.

Resources for Milestone 2: Care Management for High-Risk Patients

Care Management Tools and Resources

Care Management Central, Website

Care Management Central (CMC) is an easy-to-use interactive website. CMC can help you create a care management program that addresses specific health care goals across multiple disease states. Browse their library of more than 1,000 programs and tools to create your own customized program. *(Note: Links to external site.)*

Care Management in CPC

Definition, essential features of and distinction between care management and care coordination. This is a critical document for educating team members and framing how to do the work of care management.

Care Plan Document, May 16, 2014 (1-page PDF)

Sample form used by practice to help patients identify their goals and encourage them in their progress.

CPC PY 2014 Care Management Implementation Guide, June 6, 2014 (33-page PDF)

This Guide reflects on how CPC practices across the country have approached the care management component of Milestone 2. These practice strategies represent samples of the work and are not representative of every strategy for implementing robust care management in a practice. This Guide captures the energy, innovative ideas and rigorous and determined execution of the CPC practices as they test and implement care management in their practice. Through this Guide we hope you find in your colleagues' work the support for implementing Comprehensive Primary Care.

CPC Practice Spotlight 15: Ensure High-Risk Patients Carry Up-to-Date Medical Information with a Digital Personal Health Record, Aug. 1, 2014 (1-page PDF)

Timely and complete access to medical information is essential for high-risk patients who often seek emergency medical care or treatment by multiple providers. To help his high-risk patients in these critical situations, solo practitioner Marc Feingold, MD, asks them to carry a digital health record stored on a password-protected USB drive. Read CPC Practice Spotlight 15 for more information about how this New Jersey physician is closing gaps in his medical neighborhood.

CPC Practice Spotlight 23: Blending Care Coordination with Wellness Counseling: Low-Cost, Low-Intensity Intervention Supports Preventive Care, Sept. 26, 2014 (1-page PDF)

Telluride Medical Center of Telluride, Colorado, provides wellness counseling as an additional care management strategy to better support patients seeking to improve their health. Learn more about their implementation and process steps in this Spotlight.

CPC Practice Spotlight 6: TriHealth, Feb. 21, 2014 (3-page PDF)

Article features TriHealth, a Cincinnati-based, not-for-profit health system's approach to care management.

Explanation of Risk, June 10, 2014 (1-page handout)

Patient education tool/discussion starter for education on risk level.

Huddles, April 15, 2014
Two resource documents on team huddles

1. How to Huddle – Simple guide purpose and structuring huddles (1-page document)
2. Huddle Form – Same huddle worksheet/agenda (1-page document)

IHI: Chronic Care Management
This web page lists several tools, articles, models and assessments available at the Institute for Healthcare Improvement Knowledge Center. The resources available include identification of six fundamental areas forming a system that encourages high-quality chronic disease management. Also see a survey to assess your organization's current levels of care with respect to the six components of the Chronic Care Model.

Million Hearts® initiative resources that support CPC practices' work in Milestones 2, 5 and 7, June 4, 2014
Million Hearts® offers a multitude of resources available to CPC practices and health systems and includes standardized treatment protocols for improving blood pressure control, tool kits, videos, publications, articles and action guides. The following resources have been uploaded to the CPC Collaboration Site:

1. A customizable Hypertension protocol (2-page PDF; editable form)
2. Protocol Implementation guidance gleaned from our stakeholder panels, also on website (2-page PDF)
3. JAMA Viewpoint in support of protocol-driven care (2-page PDF)
4. ACC/AHA/CDC Scientific Advisory on protocol (27-page PDF)
5. Three guides regarding HTN control: one for people to help in self-management (40-page PDF); one for employers (2-page PDF); one for clinicians (8-page PDF)

Million Hearts® is a national initiative that was launched by the Department of Health and Human Services in September 2011 to prevent 1 million heart attacks and strokes by 2017.

Resources to support your work in Milestones 2, 5 and 7 are available through the Million Hearts® website.

- http://millionhearts.hhs.gov/resources.html
- http://millionhearts.hhs.gov/resources/protocols.html

Million Hearts® resources, Sept. 25, 2014
This posting contains two resources available to CPC practices around the Million Hearts® campaign

1. Can We Save a Million Hearts®?: Two-minute video presented by Tom Frieden, MD, MPH, describing the Million Hearts® campaign *(Note: external link)*
2. Medscape's companion article describing strategies used and lessons learned from the 2013 champions (Note: external link; will need to log in to access content)

Sample Care Plan Templates, Colorado Regional Webinar resource (10 sample care plans)
This posting includes 10 sample care plan templates and assessments referred to in the Colorado regional webinar on March 20, 2014, on patient engagement and care plans.

Care Management Webinars

Care Management, Oregon Regional Webinar, Dec. 20, 2012 (40-page PDF)
An overview of care management strategies, starting with who will provide the service and working through issues practices need to address as they operationalize.

Complex Care Management, Colorado Regional Webinar, March 8, 2013
This webinar describes high-risk care management, how it works and how practices can get started.

Coordinated Systems of Care, New York Regional Webinar, Jan. 24, 2013 (50-page PDF)
This webinar summarizes the common perspectives of coordinated care, strategies for formation of a comprehensive care team and strategy for delivery of case/care management.

Health Disparities – Equity and Care Management, National Webinar, Feb. 26, 2014 (30-page PDF, transcript and video)
This presentation focuses on care management and equity, patient coaching, proactive care delivery, identifying a care manager and stories from the field: Duke University. The one-page resource document includes websites and other resources with further information on health issues among minority populations.

Introduction to New Primary Care Strategies for Milestone 2, National Webinar, Jan. 28, 2014 (32-page PDF, transcript and video)
Webinar focuses on three primary care strategies for PY 2014: Self-Management Support, Integrated Behavioral Health and Comprehensive Medication Management.

Million Hearts® Presentation, July 30, 2014, National Webinar (58-page PDF, transcript and video)
This presentation provides a review of the Million Hearts® campaign and its valuable resources for shared decision making, self-management support and patient experience tools available for CPC practices.

Empanelment Tools

Empanelment Implementation Guide (5-page PDF)
This Implementation Guide explains empanelment within the context of CPC Program Year 2013 Milestones. It serves as a road map for empaneling patients in your practice.

Risk Stratification Tools and Resources

AAFP Risk-Stratified Care Management
This web page explains what risk-stratified care management is, in that it begins with a periodic and systematic assessment of each patient's health risk status, using criteria from multiple sources to develop a personalized care plan.

AAFP Risk-Stratified Care Management and Coordination Table (1-page PDF)
This table shows examples of potentially significant risk factors, as well as risk categories and levels. It provides guidance to identifying disease burden and determining health risk status.

Assessment of Risk Stratification Methods Identifying Patients for Care Coordination within a Medical Home (27-page PDF)
This Mayo Clinic presentation at the Academy Health Conference in June 2012 focuses on identifying patients with care coordination needs who are part of a Medical Home.

Care Management Central, website
Care Management Central is an easy-to-use interactive Web site. CMC can help you create a care management program that addresses specific health care goals across multiple disease states. Choose from our library of over 1,000 existing programs and tools to create your own customized program. Many practices have used the Health Coaching Module for staff coaching. *(Note: Links to an external site)*

Care Management in CPC: Definition
Care management is a tailored primary care function. In CPC, specific dynamics of the initiative will shape how and when your practice initiates this care. This document describes how care management supports the drivers for comprehensive primary care.

Care Management of High-Risk Patients by Washington Regional Clinic for Senior Health
Washington Regional Clinic for Senior Health provided this resource as their approach to Milestone 2: Care Management of High-Risk Patients. Attached is a description of their approach, their care management workflow and definitions of their risk.

Coding for Group Visits, article
This article from the American Academy of Family Physicians provides information on how to code for group visits. *(Note: Links to an external site)*

CPC Practice Spotlight 2: SAMA Healthcare, Dec. 6, 2013 (2-page PDF)
SAMA Healthcare Services in Arkansas describes the practice's approach to risk stratification.

CPC Practice Spotlight 22: Heeding the Signs – Know When It's Time to Modify Your Risk Stratification Methodology, Sept. 19, 2014 (1-page PDF)
Nearly a year after Freeman Family Medicine of Conway, Arkansas, completed risk stratifying its patients, the staff spotted some troubling trends that indicated the practice's methodology may need tweaking. Read this Spotlight to see how they added flexibility to their workflow that better addressed patient needs and improved overall workflow.

Group Visit Billing Information, article
This article from the American College of Physicians provides some guidance and resources on billing for group visits. *(Note: Links to an external site)*

NIHCR High Intensity Primary Care
The National Institute for Health Care Reform offers this article outlining approaches and models for "high-intensity primary care," which could prevent costly emergency department visits and hospitalizations. High intensity primary care could be offered to a handful of patients with complex or multiple chronic conditions, such as diabetes, congestive heart failure, obesity and depression.

An Overview of Risk Stratification and Care Management, CPC National Learning Community, Feb. 27, 2013
Outlines the basics of risk stratification and how it underpins successful care management.

PCPCC: Successful Examples of Integrated Models
The Patient-Centered Primary Care Collaborative presents successful examples of integrated models of care in primary care from around the world, including links to project websites.

Risk Stratification Implementation Guide, July 31, 2014 (23-page PDF)
Implementing a risk stratification methodology has fundamentally shifted how many CPC practices examined care opportunities in targeted populations. This Guide explores how CPC practices have approached this component of Milestone 2, from identifying a process, testing and implementation approaches along with strategies for further refinement.

Risk Stratification Process (2-page PDF)
Risk stratification method using four levels, which correspond to primary, secondary and tertiary prevention as levels 1, 2 and 3. The fourth level is the patient who is a vastly complicated and high-risk individual.

Risk Stratification Webinars

Care Plans, New Jersey Regional Webinar, Nov. 6, 2013 (17-page PDF)
Learn to design workflows with a focus on care plans; navigate workflow issues within the process.

Risk Stratification, National Webinar, April 9, 2014 (38-page PDF, transcript and video)
This presentation focuses on different risk stratification approaches and provides stories from the field.

Risk Stratification, Ohio/Kentucky Regional Webinar, Jan. 22, 2013 (40-page PDF)
A review of risk stratification, a care management overview and practice stories.

Risk-Stratified Care Management, Arkansas/Oklahoma Regional Webinar, Dec. 11, 2012
This presentation provides steps toward starting a risk stratification care management plan as well as what to avoid. Comprehensive notes for this session are provided here as well.

Behavioral Health Integration Tools and Resources

Advancing Integrated Mental Health Solutions (AIMS)
The AIMS Center, housed within the University of Washington's Division of Integrated Care & Public Health, Department of Psychiatry and Behavioral Sciences, seeks to improve the health and mental health of populations through patient-centered, integrated mental health services for individuals across the age span. The site provides information on integrated mental health care including principles and tasks for integrating care.

Approaches to Integrating Physical Health Services into Behavioral Health Organizations, External Resource (31-page PDF)
This guide from Resources for Integrated Care lays out a continuum of primary care and behavioral health integration, beginning with engaging individuals with severe mental illness in discussions about their physical health to full integration. (*Note: Links to an external site.)*

Behavioral Health Care Compact (2-page PDF)
Sample behavioral health care compact agreement from The Leslie Clinic in Arkansas.

Behavioral Health Integration Resources from AHRQ, Website
The AHRQ Academy web portal offers you resources to advance the integration of behavioral health and primary care and fosters a collaborative environment for dialogue and discussion among relevant thought leaders. (*Note: Links to an external site.)*

Billing for Mental Health Services, External Resources
Two resources that provide information around billing for mental health services:

1. Mental Health Services, Department of Health and Human Services, Center for Medicare & Medicaid Services, September 2013 (24-page PDF) – This booklet discusses billing for mental health services
2. Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting, Suicide Prevention Resource Center (5-page PDF) – Tip sheet for billing for mental health services

Care Compacts for Behavioral Health

Several sample care compact documents created by Mayfair Internal Medicine from Denver, Colorado. Documents include:

1. Mayfair_MariaDroste_Care_Compact_2014 (3-page Word Doc): Behavioral Health Care Compact Example
2. 2014 Mayfair Intermal_Maria Droste two-way release of information (2-page Word Doc): Example Two Way Release Form
3. Mariadroste_paperwork_201408251505 (3-page PDF): Example Communication Templates

CPC Practice Spotlight 7: Oregon Medical Group, March 7, 2014 (3-page PDF)

Article features a Eugene, Oregon, practice with embedded behavioral health specialists.

Organized, Evidence-Based Care: Behavioral Health Integration, website

This webpage from the Safety Net Medical Home Initiative provides implementation guides, tools, resources and other materials to help primary care practices integrate behavioral health care. Some of the resources include:

- An Executive Summary that provides a concise description of behavioral health integration, its role in PCMH transformation, and key implementation activities and actions described in plain language for a wide variety of readers.
- The Implementation Guide provides clear guidance and concrete strategies on behavioral health integration: creating a vision for integrated care, identifying resources to support integration, building integrated care teams, monitoring progress and spreading and sustaining successes.
- The GROW Pathway Planning Worksheet — an interactive tool a practice can use to develop a customized implementation plan reflective of its goals for integration and its current resources.
- Case examples from diverse primary care practices

(Note: Links to external site)

PHQ-9 Resources, Aug. 13, 2014 (two 1-page PDFs)

These documents provide descriptions of how the PHQ-9 tool is used for diagnosing and monitoring.

Behavioral Health Integration Webinars

Advanced Primary Care: The Role of Behavioral Health on the Primary Care Team, National Webinar, March 18, 2014 (30-page PDF, transcript and video)

This presentation focuses on Milestone 2, the role of behavioral health on the primary care team.

Behavioral Health Action Group, National Webinar, Aug. 12, 2014 (20-page PDF, transcript and video)

This presentation is the initial meeting for the Behavioral Integration Action Group. It provides an overview of the action group objectives and different approaches for integrating Behavioral Health into your practice.

Behavioral Health Integration with Virtual Site Visits, National Webinar, May 13, 2014 (16-page PDF, transcript and video)

This presentation focuses on practices' approaches for implementing behavioral health services in their clinics.

Medication Management Tools and Resources

Approach to Medication Management, June 1, 2014

Provides resources on medication management used by employed pharmacists at a NJ practice

1. Medication Management Plan (2-page document) – Describes practice's approach to medication management
2. Announcing a new service for our patients on multiple medications (1-page document) – Flyer announcing new medication management services
3. Medication Action Plan (1-page document) – Sample action plan for patients

CPC Practice Spotlight 8: OU Physicians and Associates in Family Medicine, March 21, 2014 (3-page PDF)

This article features Associates in Family Medicine in Colorado and OU Physicians in Oklahoma sharing how their pharmacists contribute not only to medication management but also to quality improvement, patient satisfaction and timely care.

CPC Practice Spotlight 21: Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes, Sept. 12, 2014 (1-page PDF)

Blending the work from three CPC Milestones (medication management, data-driven improvement and shared decision making), Cherokee Nation's Mankiller clinic made significant gains toward a population health target within three months. Read this Spotlight to find out how integrating a pharmacist in the intervention was a key aspect to making these gains.

Gallery Walk, Oregon Learning Session, March 12, 2014 (11-page PDF)

The presentation titled "MS 2 OHSU General Internal Medicine Medication Management" focuses on a practice's approach for integrating medication management into their clinic.

Medication Management: CMS Clarify 'Incident to' Rules Relating to Pharmacists' Services, article in AAFP News, April 16, 2014

Update from American Academy of Family Physicians providing clarification on Medicare's rules for billing "incident to" services.

Medication Management Resource, Website

This website from the Community Pharmacy Foundation has multiple articles and resources relative to Milestone 2 (Medication Management). *(Note: No official endorsement by CMS for the information in this resource is intended or should be inferred.)*

PCPCC: Guidelines for the Practice and Documentation of Comprehensive Medication Management in the Patient-Centered Medical Home (5-page PDF)

The Patient-Centered Primary Care Collaborative (PCPCC) provides an open forum for the full range of health care stakeholders seeking to advance the quality of care for all Americans through the implementation of the patient-centered medical home (PCMH) as the principal platform for a reformed system for the delivery of primary care health services. This document highlights the suggested guidelines for the practice and documentation of CMM services.

Resources for Medication Management (1-page PDF)
This document contains links to resources on Medication Management. Reviewing this information may be beneficial to enhance your knowledge of the subject and better prepare you to participate in the Medication Management Action Group.

Medication Management Webinars

Medication Management, National Webinar, May 7, 2014 (37-page PDF, transcript, video and 3-page Q&A PDF)
This presentation focuses on integrating medication management services in the primary care setting.

Medication Management Action Group, National Webinar, Aug. 26, 2014 (39-page PDF, transcript and video)
This presentation provides an overview of the action group objectives and practice sharing on how they have integrated medication management into their practices.

Self-Management Tools and Resources

Partnering in Self-Management Support: A Toolkit for Clinicians, website
This toolkit from the Institute of Healthcare Improvement provides concepts and tools to give practices an introduction to a set of activities and changes that support patient and families in the day-to-day management of chronic conditions and may be of benefit as practices work together toward meeting Milestone 2. *(Note: Links to an external site)*

Personalized Digital Coaching (20:37 video)
Vic Strecher at TEDMED 2009 discusses how to inspire healthy behavior change through digital coaching.

Self-Management Goal Sheet and Stages of Change, June 26, 2014
Goal sheets and tools developed by an Ohio practice for integrating effective self-management support as part of its Milestone 2 work. The stages of change presentation materials are informative and include practical strategies for determining and tracking a patient's readiness and stages of change.

1. SMG tool – Sample patient self-management action plan (1-page PDF)
2. Stages of change handout – Resource document outlining the stages of change (9-page PDF)
3. Stages of Change Model and Self-Management – Presentation focusing on self-management support and practical strategies for determining and tracking a patient's readiness and stages of change (27-page PDF)

Self-Management Strategies for Vulnerable Populations
AMA video for physicians on self-management strategies and steps to support self-management in vulnerable populations. This video is not captioned.

Self-Management Support Action Group Preparation Materials, Aug. 19, 2014
These documents review Self-Management Support, which will be helpful prior to the Action Group meeting. The attachments include:

- SMS Pre-Work Slides (18-page PDF) – General review of Self-Management Support
- Prework One Team Matrix_Updates_508 (3-page PDF) – Matrix of roles in Self-Management Support

Stanford Chronic Disease Self-Management Resources
This page links to the Stanford Chronic Disease Self-Management information. This site provides links to local offerings of the classes, staff training programs and other courses for patients. *(Note: Links to external website.)*

Self-Management Webinars

Milestone 2: Self-Management Support, National Webinar, June 10, 2014 (13-page PDF, transcript, video and resource links)
This presentation focuses on defining and integrating self-management support and provides two stories from the field. A few additional resources are also provided:

- http://www.insigniahealth.com/
- http://patienteducation.stanford.edu/programs/cdsmp.html
- http://www.howsyourhealth.org/

Self-Management Support Action Group, National Webinar, Aug. 12, 2014 (36-page PDF, transcript and video)
This presentation is the initial meeting for the Self-Management Support Action Group. It provides an overview of the action group objectives and the cycle of self-management support.

Resources for Milestone 3: Access and Continuity

Tools and Resources

Coordination Between Emergency and Primary Care Physicians (11-page PDF)
This article from the National Institute for Health Care Reform includes examples of workflow, guidelines and protocol resources practices can use to coordinate care with emergency physicians and other after-hours providers.

CPC Practice Spotlight 11: DTC Family Health and Walk-In, May 2, 2014 (2-page PDF)
Article features DTC Family Health and Walk-In, a three-physician group in Colorado that tackles ever-evolving and emerging changes in health care by following one simple principle. Could their mantra help your practice with change fatigue?

CPC Practice Spotlight 12: DTC Family Health and Walk-In, May 15, 2014 (2-page PDF)
This article takes a deep-dive look at DTC Family Health and Walk-In of Greenwood Village's approach toward asynchronous access. “The email sent to new patients at DTC Family Health and Walk-In of Greenwood Village, Colorado, has the usual welcome message along with one key piece of information. Read the attached Spotlight to see if this tactic will increase your patients’ use of your portal.”

Expanded Access to Primary Care in Colorado, Colorado Regional Webinar, Sept. 12, 2013 (31-page PDF)
In this presentation, practices share how they provided expanded access to services for their patients.

Pilot Study of Providing Online Care in a Primary Care Setting (7-page PDF)
How e-visits can supplement traditional patient encounters in the primary care setting.

Webinars

Milestone 3 Action Group, National Webinar, Sept. 9, 2014 (25-page PDF, transcript and video)
This presentation is the initial meeting for the Access to Care Outside Office Visits Action Group. It provides an overview of the action group objectives and practice sharing on how they have leveraged technology to engage with patients between visits.

Milestone 3: 24/7 Access by Patients and Enhanced Access, Oregon Regional Webinar, July 17, 2014 (17-page PDF, transcript and video)
This webinar focuses on 24/7 access from a supply and demand approach and provides practices sharing on how they approached Milestone 3 in their clinics.

Milestone 3: Enhanced Access to Care, National Webinar, March 4, 2014 (45-page PDF, transcript and video)
This presentation focuses on Milestone 3 requirements and intent and provides guidance on evaluating options for choosing communication strategies. The presentation also touched on Stage 2 Meaningful Use as it relates to Milestone 3.

Milestone 3: Non-Visit Based Care, Arkansas Regional Webinar, May 23, 2014 (14-page PDF, transcript and video)
This presentation highlights the work done at three practices toward providing asynchronous access.

Resources for Milestone 4: Patient Experience

Tools and Resources

AHRQ CAHPS Survey Information
The Agency for Healthcare Research and Quality describes its role in CAHPS surveys and provides guidance and instructions for requesting data from the database.

CAHPS-Related Items

- Format example (2-page PDF)
- Item Bank: Reliable questions from CAHPS item bank (14-page PDF)
- Survey guidance and tips (3-page PDF)

CAHPS Survey, Cover Letter and Talking Points for Practices
The invitation letter (in English and Spanish) along with the survey that was sent to patients of CPC practices in May 2013. Talking points for practices are also posted on this page.

CPC Practice Spotlight 10: CapitalCare Medical Group – PFACs, April 11, 2014 (3-page PDF)
New York's CapitalCare Medical Group chose PFACs for all 10 CPC sites because the staff wanted up-close and actionable feedback. They got it and much more. Find out how they made their PFACs a "light lift" with a big return in this Spotlight article.

CPC Practice Spotlight 17: Patient-Centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity, Aug. 15, 2014 (1-page PDF)
Understanding patients' needs and how to better communicate with them has helped care management staff at Clopton Clinic in Arkansas guide their patients toward better outcomes. This Spotlight explores how patient-centered communication and coaching has helped Clopton's patients make a 14-point improvement in one clinical quality measure. What worked for them could easily be part of your practice.

Creating a Patient and Family Advisory Council in Your Practice (5-page PDF)
Step-by-step guidelines to creating your PFAC, including logistical considerations for your meetings as well as a sample phone script your practice could use to invite participants.

Engaging Patients In Improving Ambulatory Care: A Compendium of Tools from Maine, Oregon and Humboldt County, California, March 2013 (262-page PDF)
This document developed by Aligning Forces for Quality provides a variety of tools used for patient engagement. *(Note: Links to an external site)*

Guides to Developing Patient and Family Councils (PFAC)
This posting contains two resources developed by the National Partnership for Women & Families that may be helpful in establishing Patient and Family Advisory Councils. The two documents include:

1. Key Steps for Creating Patient and Family Advisory Councils in CPC Practices (30-page PDF) – Outlines key steps for establishing Patient and Family Advisory Councils in a primary care office
2. Pathways to Patient and Family Engagement in CPC Practices (5-page PDF) – Discusses ways to engage patients and families in primary care

Here to Stay: What Health Care Leaders Say About Patient Engagement, Sept. 22, 2014 (170-page PDF)
Published by the Center for Advancing Health (CFAH), this paper provides key health care stakeholder perspective on patient engagement from a year-long study conducted by the CFAH.

Improved Patient Satisfaction and Better Organizational Performance, Agency for Healthcare Research and Quality Video (2-minute video)
This video and webpage provides the value of patient's participation in a PFAC from the perspective of Georgia Regents Medical Center. Current and former patients and family members of the Georgia Regents Medical Center participate in a variety of patient advisory councils and on every clinic, department and hospital committee, providing their perspectives on potential improvements and their input into key operational and strategic decisions. The program has contributed to improvements in patient satisfaction and in key metrics of organization-wide performance and has received positive reviews from medical students.

Improving Patient Experience of Care Resources
Links to two Robert Wood Johnson Foundation resources on improving patient experience of care resources. Resources were addressed during the National Webinar on CAHPS on March 11, 2014. The first resource is an inventory and lists a variety of free resources—including toolkits, guides, reports and webcasts—that are available to support health care organizations in determining what they need to do to improve patient experience and how to implement those improvements. The second link is a list for Improving Patient Experience of Care.

Interview on Importance of Patient and Family Engagement, IHI Blog Post
This IHI Faculty interview focuses on why it is important to work with patient and family advisors and how to address common challenges to successfully using them to aid your improvement efforts.
External Link: "Constructively Disgruntled": Finding the Most Effective Patient and Family Advisory

Webinars

Health Disparities – Equity and Patient Experience, National Webinar, Feb. 18, 2014 (45-page PDF, transcript and video)
This presentation focuses on how race and ethnicity shape patient experience, ensuring race and ethnicity minority groups are represented in data, identifying race and ethnicity disparities in experience, designing and disseminating a targeted improvement plan and stories from the field.

Implementation of PFAC, Ohio/Kentucky Regional Webinar, March 12, 2014 (50-page PDF, transcript and video)
This presentation features several practices sharing their experience with implementing PFACs.

Improvement Plans, Oklahoma Learning Session, Nov. 8, 2013 (14-page PDF and video)
This video presentation provides three practices' experiences in implementing improvement plans to achieve the aims of Milestones 4, 5 and 6.

Key Steps in Building an Effective PFAC, Oregon Regional Webinar, March 6, 2014 (21-page PDF, transcript and video)
This presentation outlines preparing for a PFAC meeting, defines patients' roles and discusses how to sustain a PFAC.

Milestone 4: Analyzing Feedback and Taking Action, Arkansas Learning Session, April 16, 2014 (49-page PDF)
The presentation titled "2014-04-16 AR LS 3 M4 Feedback_508" discusses using CAHPs survey data to drive improvements in the patient experience through the use of PFACs. The presentation features practice sharing from two Arkansas practices.

National Partnership for Women & Families Webinar Series
NPWF presented a four-part national webinar series addressing Patient and Family Engagement, which the CPC program coordinated. Each session dives deeper into strategies and methods for engaging patients and families in your efforts to improve care and build a comprehensive primary care. Slides, transcript and audio are provided within each series.

- Part 1: Patient and Family Centered Care and Engagement Best Practices, May 2, 2013
- Part 2: Building a Patient & Family Engagement Infrastructure and Selecting and Orienting Patient and Family Advisors, May 9, 2013
- Part 3: Evaluating Impact: Continuous Assessment of Patient & Family Engagement Efforts, May 16, 2013
- Part 4: Sustaining Your Patient and Family Advisory Council, May 23, 2013

Patient Advisory Boards, Colorado Learning Session, March 14, 2014 (23-page PDF)
The presentation titled "2014-03-14 CO LS3. Track1A_Nicole_Deaner_Marie_Henderson_Patient Advisory_508" provides a high-level overview of the benefits of patient advisory boards and some suggestions on how to start one in your practice.

PFACs and Improving Access, Oklahoma Learning Session, April 9, 2014 (26-page PDF)
The presentation titled "2014-04-09_OK_PFAC_RegionalMtg_508" shares a practice's experience with improving patient access to the urgent care process, using patient surveys and their PFAC.

PFACs and Surveys, Oregon Learning Session, March 12, 2014 (two 9-page PDFs)
Two presentations highlight a practice's experience with Milestone 4. The Hicken Medical gallery walk presentation focuses on implementing and using patient surveys, and the PIMS CPC Gallery presentation focuses on implementing PFACs.

Understanding and CG Using CAHPS Data for Quality Improvement, Oregon Regional Webinar, Nov. 21, 2013 (60-minute video and transcript)
This presentation provides an overview on using CAHPS data to guide improvement.

Virtual Site Visit on Milestone 4: Improving the Patient Experience, National Learning Session, Aug. 25, 2013
Practices share their approaches to surveying and creating a Patient and Family Advisory Council. Includes slides, transcript and recording.

Resources for Milestone 5: Quality Improvement

Tools and Resources

AHRQ: Practice Facilitation Handbook

The Practice Facilitation Handbook is designed to assist in the training of new practice facilitators as they begin to develop the knowledge and skills needed to support meaningful improvement in primary care practices. It evolved from the Agency for Healthcare Research and Quality's Integrating Chronic Care and Business Strategies in the Safety Net toolkit. That toolkit was developed to aid safety net practices in implementing the Chronic Care Model, now commonly referred to as the Care Model, in their practices. *(Note: Links to external website.)*

AHRQ: Uses of Quality Measures

AHRQ is the lead Federal agency charged with improving the quality, safety, efficiency and effectiveness of health care for all Americans. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision making. This site discusses quality improvement, accountability and research. *(Note: Links to external website.)*

CPC Practice Spotlight 16: Lower A1c Among Patients with Diabetes Through Standardized Team Approach, Aug. 8, 2014 (1-page PDF)

Warren Clinic in Oklahoma developed a team approach for helping patients with diabetes lower their A1c values. Called the "INCOGNITO" approach, it leverages data to identify patients, uses the consistency of the team approach to reach those patients, addresses each patient's needs and provides a follow-up mechanism for patients who remain at high risk.

EHR Utilization and Patient Shared Decision Aid Help Increase Colorectal Cancer Screening Rates, Colorado Practice Story, July 24, 2014 (2-page PDF)

This document walks through how Hinman Family Practice was able to use its EHR system and shared decision aids to help increase colorectal cancer screening rates.

IHI Open School Run Chart Tool

The Institute for Healthcare Improvement offers this run chart template tool for download as well as an instruction sheet.

Milestone 5, Oregon Learning Session, March 12, 2014 (9-page PDF)

The presentation titled "MS5 Grande Ronde Hospital" outlines a practice's challenges, solutions, successes and next steps with Milestone 5.

Million Hearts® Resources, Sept. 25, 2014
This posting contains two resources available to CPC practices around the Million Hearts® campaign

1. Can We Save a Million Hearts®?: Two-minute video presented by Tom Frieden, MD, MPH, describing the Million Hearts® campaign *(Note: external link)*
2. Medscape's companion article describing strategies used and lessons learned from the 2013 champions *(Note: external link; will need to log in to access content)*

Resources from Million Hearts® initiative that supports CPC practices work in Milestones 2, 5 and 7, June 4, 2014
Million Hearts® offers a multitude of resources available to CPC practices and health systems and include standardized treatment protocols for improving blood pressure control, tool kits, videos, publications, articles and action guides. The following resources have been uploaded to the CPC Collaboration Site:

1. A customizable Hypertension protocol (2-page PDF; editable form)
2. Protocol Implementation guidance gleaned from our stakeholder panels, also on website (2-page PDF)
3. JAMA Viewpoint in support of protocol-driven care (2-page PDF)
4. ACC/AHA/CDC Scientific Advisory on protocol (27-page PDF)
5. Three guides regarding HTN control: one for people to help in self-management (40-page PDF); one for employers (2-page PDF); one for clinicians (8-page PDF)

Million Hearts® is a national initiative that was launched by the Department of Health and Human Services in September 2011 to prevent 1 million heart attacks and strokes by 2017.

Resources to support your work in Milestones 2, 5 and 7 are available through the Million Hearts® website.
http://millionhearts.hhs.gov/resources.html
http://millionhearts.hhs.gov/resources/protocols.html

STEADI Tool Kit for Health Care Providers
Practices focusing on reducing falls risk among their patients should access this toolkit from the CDC Injury Center. It provides resources to incorporate fall risk assessment and fall prevention into your clinical practice. Resources include fall risk assessment tool with the patient checklist, patient handouts, validated TUG, Chair Stand and 4-Stage Balance screens, patient referral forms, posters and training videos as well as provider pocket guide and workflow algorithm. (*Note: Links to external site)*

Webinars

CPC Vital Signs – Knowing the Pulse of Your Practice, National Webinar, Sept. 3, 2014 (53-page PDF, transcript and video)
Four practices showcase their proven data-driven improvement strategies with Q&A from participants. Learn how these practices have used data from their EHRs, the CMS feedback report and payer reports among other sources to pinpoint areas for improvement and identify quantitative gains that make a difference in the delivery of care.

Creating Improvement Plans Based on Data, New Jersey Learning Session, Nov. 6, 2013 (19-page PDF)
This webinar focuses on using baseline data to guide improvement and defines steps for creating an improvement plan. The information presented helps practices with establishing new processes and practice transformation.

Leadership In Quality Improvement, Colorado Learning Session, Dec. 20, 2012 (mp3 audio)
This webinar focuses on the goals of practice transformation and the important elements needed for successful transformation.

Milestone 5: Practice Experience, Arkansas Learning Session, Sept. 12, 2012 (23-page PDF)
This presentation demonstrates how a practice used data to guide improvement.

Million Hearts®, National Webinar, July 30, 2014 (58-page PDF, transcript and video)
This presentation provides a review of the Million Hearts® campaign and its valuable resources for shared decision making, self-management support and patient experience tools available for CPC practices.

Overcoming Barriers and Challenges to Improve Utilization Metrics, New Jersey Learning Session, Nov. 6, 2013 (14-page PDF)
This webinar focuses on how to identify barriers associated with utilization measures and tactics to overcome identified barriers to improving utilization measures.

Run Charts: A Tool to Monitor Rapid Cycle Improvement, Improvement Basics National Learning Session, Nov. 20, 2013 (33-page PDF)
This presentation offers methods for creating and using run charts to monitor rapid cycle improvements activities.

Skills for Practice Improvement, Ohio/Kentucky Regional Webinar, Feb. 13, 2013
This webinar focuses on how to develop a quality improvement infrastructure and features practice examples of using data to drive improvement. Tools and materials included on this page are a sample of a completed PDSA tool as well as a worksheet to start your PDSA.

Using Data to Guide Improvement, Colorado Regional Webinar, Feb. 28, 2013 (37-page PDF)
This webinar recording focuses on selecting quality measures for improvement.

Using Practice Feedback Reports, Colorado Learning Session, March 7, 2014 (22-page PDF, transcript and video)
The presentation titled "2014-03-07 CO 1_RMHP MPR Practice Feedback Reports_508" provides an overview of the practice-level feedback reports and how to leverage them to guide work in your practice.

Resources for Milestone 6: Care Coordination Across the Medical Neighborhood

Tools and Resources

Care Compact Agreement for Specialty Care, Sept. 25, 2014 (2-page PDF)
Sample specialty care compact agreement from The Leslie Clinic in Arkansas.

Care Compact and Communications Templates for Behavioral Health, Sept. 22, 2014
Mayfair Internal Medicine of Denver shares its care compact documents that apply to a collaborative agreement with a behavioral health specialist:

1. Mayfair_MariaDroste_Care_Compact_2014 (3-page Word doc.): Behavioral Health Care Compact Example
2. 2014 Mayfair Internal_Maria Droste two-way release of information (2-page Word doc.): Example Two-Way Release Form
3. Mariadroste_paperwork_201408251505 (3-page PDF): Example Communication Templates

Care Compact for Behavioral Health, Sept. 23, 2014 (2-page PDF)
Sample behavioral health care compact agreement from The Leslie Clinic in Arkansas.

Care Compact Template, Aug. 25, 2014 (2-page PDF)
This document is a care compact template created by Mayfair Internal Medicine of Denver.

Care Coordination Agreements: Barriers, Facilitators and Lessons Learned
This American Journal of Managed Care article describes how CCAs are formed and explores facilitators and barriers to adoption of effective CCAs and the implications for policies and programs that aim to improve the coordination of care. *(Note: Links to external site)*

Care Coordination Implementation Guide, Aug. 28, 2014 (34-page PDF)
Have you ever wondered how other CPC practices are tracking ED admissions and follow-up to reduce ED utilization? How are others tracking hospital admissions and reducing readmissions? Can a Care Compact really increase the communication between a health care partner and our practice? This guide will provide you with case studies for all of these and more. Care Coordination is central to improving patient flow and bridging the seams of care through our complicated health care system.

Collaboration/Compact Agreement Resources
Sample care compact agreements for various specialties, including:

1. Primary Care-Specialist Physician Collaborative Guidelines (10-page PDF) – A framework for better communication and safe transition of care between primary care and specialty care providers
2. Service Agreement Template (2-page PDF) – A fill-in-the-blank style template for a service agreement
3. Example of a Specialty Care Compact (12-page PDF) – Example of a care compact with a specialist
4. Primary Care-Specialty Care Master Service Agreement (4-page PDF) – Example of a master service agreement with a specialist
5. Primary Care/Cardiology Service Agreement (2-page PDF) – Example of a service agreement between primary care and cardiology
6. Professional Services Agreement for Sub-Acute Services (8-page PDF) – Example of a professional services agreement for sub-acute services between a health system and a Skilled Nursing Facility (SNF)
7. Collaborative Care Agreement for PCP and Specialty Care Coordination (2-page PDF) – Example of a collaborative care agreement for PCP and specialty care coordination
8. Cardiology Service Agreement (4-page PDF) – Example of a service agreement with cardiology
9. Primary Care/Orthopedics Service Agreement (2-page PDF) – Example of a service agreement between primary care and orthopedics
10. Service Agreement Between Specialty and Primary Care Medicine (3-page PDF) – Example of a service agreement between specialty services and primary care
11. Gastroenterology Service Agreement (2-page PDF) – Example of a service agreement between primary care and gastroenterology

Compilation: Care Coordinator Job Descriptions
Examples of care coordinator job descriptions.

Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms (45-page PDF)
From AHRQ's PCMH Resource Center, this article describes mechanisms of communication between PCP and other providers. PDF download available on the webpage.

CPC Practice Spotlight 19: Forming Successful Care Compacts with a High-Volume Specialist and a Behavioral Health Provider, Aug. 29, 2014 (1-page PDF)
Mayfair Internal Medicine of Denver, Colorado, has started strengthening its medical neighborhood by establishing care compacts with two high-volume specialists, one of which is a counseling center. Read this week's Spotlight to see how Mayfair accomplished this and is shoring up its referral processes. Sample care compacts and communications forms are provided as well.

CPC Practice Spotlight 20: Focused Care Management and Coordination Reduced Emergency Room Visits for Patient, Sept. 9, 2014 (1-page PDF)
Find out how this Ohio practice helped one patient spend more time at home rather than in the emergency room. Group Health Associates' well-rounded approach demonstrates how care management and coordination are interdependent functions for improving care, improving health and decreasing cost of care in a comprehensive primary care setting.

CPC Practice Spotlight 23: Blending Care Coordination with Wellness Counseling: Low-Cost, Low-Intensity Intervention Supports Preventive Care, Sept. 26, 2014 (1-page PDF)
Telluride Medical Center of Telluride, Colorado, provides wellness counseling as an additional care management strategy to better support patients seeking to improve their health. Learn more about their implementation and process steps in this week's Spotlight.

Diabetic Workflow and Care Coordination Referral Form (two 1-page documents)
This posting includes a workflow on caring for patients with diabetes and a care coordination consultation form from Summit Family Physicians in Middletown, Ohio. These have been very instrumental in outlining and tracking new processes that have been integrated into the care team workflow.

High Value Care Coordination Toolkit, American College of Physicians
From the American College of Physicians, the High Value Care Coordination (HVCC) Toolkit provides resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors. Particularly noteworthy materials on this site are the care plans and sample specialist PCP referral agreements. *(Note: Links to external site)*

Hospital Discharge Assessment form (2-page MS Word document)
Care managers may find this template useful when contacting patients recently discharged from the hospital and assessing their acute and long-term needs following the hospitalization.

How to Avoid Being Readmitted to the Hospital (1-page PDF)
This simple, one-page handout would be helpful to share with patients recently discharged from the hospital or who have a pending hospitalization.

Kaiser Permanente: Care Coordination Resources and Training
Regional Health Education online portal from the Permanente Medical Group. Offers training for clinicians in several topics including care coordination, medication adherence and disease self-management. The site requires you to create an account.

Medication Management and Behavioral Health Integration, Colorado Regional Webinar, April 16, 2014
Examples of Care Compact, Referral Form and Information Release shared by Dr. Susan Roach of Longs Peak Family Practice. The resources include three sample care compacts:

1. Example Behavioral Health Care Compact (2-page document)
2. Example Referral Communication Form (1-page document)
3. Example Two-Way Release of Information (1-page document)

Milestone 6, Oregon Learning Session, March 12, 2014 (9-page PDF)
The presentation titled "MS6 Springfield Family Physicians" outlines a practice's challenges, solutions, successes and next steps with Milestone 6.

New York Region Ambulatory and Acute Care TOC Guidelines, July 22, 2014 (14-page PDF)
Guideline template to be used between ambulatory and acute care facilities to coordinate transition of care.

New York Region PCMN PCP – Specialty Agreement, May 20, 2014 (10-page word document)
This document is a compact care agreement between a PCP and Specialty Office.

NIH Components of Care Coordination
Table excerpted from the AHRQ Technical Review, "Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)" shows the components to care coordination and how NQF domains and principles apply.

Optimizing Referrals and Consults with a Standardized Process, article
Referrals and consultations present numerous challenges for the primary care practitioner. This article from AAFP discusses how to make them run smoothly for everyone involved. *(Note: Links to external site)*

The Patient-Centered Medical Home Neighbor: The Interface of the PCMH with Specialty/Subspecialty Practices, paper (35-page PDF)
From the American College of Physicians, this 2010 position paper highlights three years of deliberations and feedback through a designated workgroup to address the interface between the PCMH and specialty/subspecialty practices. *(Note: Links to external site)*

Practice Story: Care Coordination with Hospital, Aug. 12, 2014 (6-page PDF)
This presentation walks through Arkansas' Burchfield Family Medicine's approach to following up and scheduling a visit with patients after hospital discharge.

Practice Story: Continuity of Care Model, July 28, 2014 (2-page PDF)
This story describes the continuity of care model at Colorado's Provident Healthcare and how it applies to patients with a high-risk score and those with recent hospitalizations or ER visits.

Practice Story: Developing Workflows for Transitions of Care, Aug. 14, 2014 (6-page PDF)
Learn how Arkansas' Little Rock Family Practice-Central clinic initiated a seamless process congruent with transition of care criteria to improve care across a continuum of services.

Practice Story: Following Patients Discharged from the Hospital, July 28, 2014 (2-page PDF)
This story highlights how The University of Colorado Health-Sterling clinic's collaboration with hospital discharge planners allows the care manager to contact patients while they are hospitalized and start their follow-up care.

Practice Story: Process for ER Discharge Alert and Follow-up, Aug. 12, 2014 (9-page PDF)
This presentation describes Arkansas' Washington Regional Clinic for Senior Health's process for developing alerts and follow-ups after inpatient or ED hospital discharge.

Practice Story: Tracking Inpatient Hospital Stays and Emergency Room Visits, July 25, 2014 (4-page PDF)
This document walks through Colorado's First Street Family Health's systematic approach to coordinating care services across the medical neighborhood.

Primary – Specialty Care Transition of Care Guidelines (14-page PDF)
This guide developed by the New York Leadership Engagement Team provides information and templates to help two (or more) health care organizations that seek to engage in advanced patient care transitions. The document is guideline meant to be modified as needed to suit the needs of the health care organizations, while optimizing patient care. Several templates are provided.

Reducing Care Fragmentation: A Toolkit for Coordinating Care
This website from Improving Chronic Illness Care was designed for clinics, practices and health systems focused on improving care coordination by transforming the way they manage patient referrals and transitions. Providing coordinated care is an essential feature of any patient-centered medical home (PCMH) — and one that can be challenging to implement. This toolkit was created to make it easier. *(Note: Links to external site)*

Sample Policy and Procedure on Transitional Care Management (3-page PDF)
This document provides an example of policy and procedures for transitional care management, which includes coordinating with facilities and managing all transitions of care.

Transitional Care Management FAQ from CMS, Aug. 31, 2013 (3-page PDF)
Frequently Asked Questions about Billing Medicare for Transitional Care Management Services (2013)

Transitional Care Management (TCM) Process Infographic (1-page PDF)
This workflow map summarizes a practice's transitional care management process, outlining the process following a patient's hospital discharge. It includes the documentation process and lists responsibilities by role.

Webinars

Care Collaboration/Compacts, National Webinar, May 27, 2014 (22-page PDF, Transcript and video)
This presentation focuses on strategies for implementing care compacts.

Care Coordination Across the Medical Neighborhood, Ohio/Kentucky Regional Webinar, May 15, 2013 (51-page PDF)
This presentation highlights resources to help develop the best practices of primary care coordination and to understand the challenges of care coordination from the consumer perspective. (Listed are the recording of the presentation and the presentation slides.)

Care Coordination – Preparing for Submission for Milestone 6, Arkansas Regional Webinar, Nov. 15, 2013 (15-page PDF)
Preparing for Milestone 6 reporting; tips on how to focus the work and identifies barriers and solutions.

Collaborative Agreements, Oregon Learning Session, May 21, 2014 (57-page PDF)
Dr. Carol Greenlee from the Council of Subspecialty Societies, American College of Physicians, provides the why, what and how for implementing collaborative agreements in the presentation titled "2014-05-21 Oregon_4a. Track 1 – MS6_CCA."

Co-Management Agreements, New Jersey Regional Webinar, May 14, 2014 (39-page PDF)
This presentation provides an overview on creating co-management agreements and their benefits.

Developing and Utilizing Care Compacts, Colorado Learning Session, June 13, 2014 (17-page PDF)
The presentation titled "20140613_CO_LS_3.Track4A_Developing_and_Utilizing_Care_Compacts" discusses key components of care compacts, how to implement those strategies and features a practice sharing their experience with developing and using care compacts.

Hospital to Home Care Management, Arkansas Regional Webinar, Aug. 15, 2014 (20-page PDF, transcript, video and four handouts)
This presentation discusses how to define a process for an effective hospital-to-home care management program, with several practice sharing examples and useful handouts. Practices may find the TCM workflow and STAAR1 tools particularly useful. These handouts are posted with the webinar materials:

1. Duncan_TCM Workflow Map (2)_508.pdf (1-page PDF): Sample transitional care management workflow map
2. Make the Right Call Primary Care Practice Toolkit_508.pdf (8-page PDF): This document provides simple, low-tech ideas your practice can implement to reduce emergency department use for primary care physician (PCP) treatable conditions
3. ReadmissionsDiagnosticTool_STAAR1_508.pdf (5-page PDF): This tool developed by the Institute for Healthcare Improvement helps perform an in-depth review of the last five re-hospitalizations to identify opportunities for improvement. This includes conducting chart reviews of the last five readmissions as well as interviews with recently readmitted patients and their family members
4. Shipley and Sills TOC_508.pdf (3-page PDF): Sample transition of care process

Improving Care Transitions, Ohio/Kentucky Regional Webinar, July 9, 2014 (37-page PDF, transcript, video and two handouts)
This presentation reviews helpful resources from "Making the Right Call" and provides practice sharing on approaches to Milestone 6. These handouts are discussed:

1. Primary Care Practice Toolkit FINAL_508_version 2.pdf (8-page PDF): This document provides simple, low-tech ideas your practice can implement to reduce emergency department use for primary care physician (PCP) treatable conditions.
2. YHM_Your Guide To MTRC_508.pdf (1-page PDF): Handout to help patients make appropriate choices about emergency room utilization

Improving Specialist Relationships and Collaboration Agreements, Arkansas Regional Webinar, May 9, 2014 (19-page PDF, transcript and video)
This presentation features practice's sharing their strategies for improving the specialty referral process.
Milestone 6 and 9: HIE – Imagining the Possibilities with Arkansas SHARE, Arkansas Regional Webinar, June 13, 2014 (18-page PDF, transcript and video)
This presentation describes Arkansas' State Health Alliance for Record Exchange (SHARE) program and how it can help accomplish the objectives of Milestone 6.

Milestone 6 Best Practices, Arkansas Learning Session, April 16, 2014 (21-page PDF)
In the presentation titled "2014-04-16 AR LS 3 M6 Best Practices," two practices share their transitional care management program for hospital discharge follow-up process and workflow.

Milestone 6: Care Compacts and Collaborative Agreements, Ohio/Kentucky Regional Webinar, May 14, 2014 (40-page PDF)
This presentation provides an overview on collaborative agreements and practice's sharing on their experiences in implementing collaborative agreements.

Milestone 6: Improving Care Coordination with ED and Hospitals, Colorado Regional Webinar, Feb. 4, 2014 (44-page PDF)
This presentation describes the value of enhanced care coordination between primary care and hospitals and ED; discusses how to develop a strategy to educate patients in their role in facilitating communication between hospitals and ED and how to construct a plan to proactively find out about a patient's admission or discharge from a hospital or ED.

Milestone 6: Smoothing Cross-Provider Care Coordination, Oklahoma Regional Webinar, May 2, 2014 (35-page PDF, transcript and video)
This presentation features practices sharing their strategies toward coordinating care across the medical neighborhood.

Reducing Avoidable ED Visits, New Jersey Learning Session, April 29, 2014 (36-page PDF)
In the presentation titled "2014-04-29 FINAL 5A Reducing Avoidable ED Visits," three practices provide strategies for reducing avoidable emergency department visits and preventable inpatient admissions.

Transitional Care Management, Arkansas Learning Session, Nov. 15, 2013 (6-page PDF)
Workflow example from system-level primary care; includes info graphic for workflow as well as documentation examples.

Resources for Milestone 7: Shared Decision Making

Tools and Resources

Colonoscopy Shared Decision Aid, (2-page PDF)
Colonoscopy Shared Decision Aid from Vital Signs 2013 and USPSTF

Colorectal Cancer Screening Shared Decision Aid, April 4, 2014 (3-page document)
Shared decision aid provided to patients to assist with the decision making process surrounding colorectal cancer screening. Developed by a nurse manager of Grant Pass Clinic, Oregon.

Common List of Preference-Sensitive Conditions, Implementation Guide (1-page)
A list of common preference sensitive conditions can be found on page 62 in the Milestone summary section of the CPC PY 2014 Implementation Guide.

Common Preference Sensitive Conditions, July 9, 2014 (1-page PDF)
This one-page document is a high-level overview of common preference-sensitive conditions (PSCs) along with a list of resources such as websites for SDMAs, articles about PSCs or SDMAs, etc. It is not intended to be a comprehensive list of all PSCs but does list many of the more common ones.

CPC Practice Spotlight 4: Primary Care Partners, Jan. 10, 2014 (2-page PDF)
Article features Colorado-based Primary Care Partners' approach to Shared Decision Making. Includes a sample workflow.

CPC Practice Spotlight 13: Grants Pass Clinic on Shared Decision Making (2-page PDF)
This article features Grants Pass Clinic in Oregon and how they are making progress with shared decision making by tracking data and emphasizing a standardized approach. Read this article to see if your practice can borrow their strategies to improve your SDM rates.

CPC Practice Spotlight 18: Shared Decision Making Helps Patients Make Cost-Efficient, Safe Choices for Lower Back Pain Radiological Assessments, Aug. 22, 2014 (1-page PDF and video)
Patients with lower back pain and no indication of nerve damage (red flags) often request unnecessary and expensive radiology services. James Aram, MD, of Brunswick Family Practice (Brunswick, New York) used shared decision making to help patients weigh their options. Data to date shows a 4 percentage point drop in radiological assessments and no adverse outcomes.

CPC Practice Spotlight 21: Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes, Sept. 12, 2014 (1-page PDF)
Blending the work from three CPC Milestones (medication management, data-driven improvement and shared decision making), Cherokee Nation's Mankiller clinic made significant gains toward a population health target within three months. Read this Spotlight to find out how integrating a pharmacist in the intervention was a key aspect to making these gains.

Decision Aids to Help People Who Are Facing Health Treatment or Screening Decisions, article from the Cochrane Summaries, Jan. 28, 2014
This academic article highlights the positive effects of using shared decision aids in the clinic setting. *(Note: Links to external site.)*

End of Life/Advance Care Planning Resources, Ottawa Hospital Research Institute website
This searchable website provides an index for several shared decision aids. *(Note: Links to external site.)*

The Informed Medical Decision Foundation, Website
This website provides a wealth of resources to help practices advance evidence-based shared decision making. *(Note: Links to external site.)*

Integrating Patient Decision Aids into Primary Care Practice (71-page PDF)
Oregon Rural Practice-Based Research Network produced this Shared Decision Making toolkit, which focuses on implementation in primary care. It is designed for use by quality improvement teams.

Milestone 7: Shared Decision Making, May 14, 2014
Two shared decision making tools used by Branchburg Family Health Center in New Jersey:

1. Diabetic SDM tool (2-page PDF)
2. Prostate Screening tool (2-page PDF)

Million Hearts® initiative resources that support CPC practices work in Milestones 2, 5 and 7, June 4, 2014
Million Hearts® offers a multitude of resources available to CPC practices and health systems and include standardized treatment protocols for improving blood pressure control, tool kits, videos, publications, articles and action guides. The following resources have been uploaded to the CPC Collaboration Site:

1. A customizable Hypertension protocol (2-page PDF; editable form)
2. Protocol Implementation guidance gleaned from our stakeholder panels, also on website (2-page PDF)
3. JAMA Viewpoint in support of protocol-driven care (2-page PDF)
4. ACC/AHA/CDC Scientific Advisory on protocol (27-page PDF)
5. Three guides regarding HTN control: one for people to help in self-management (40-page PDF); one for employers (2-page PDF); one for clinicians (8-page PDF)

Million Hearts® is a national initiative that was launched by the Department of Health and Human Services in September 2011 to prevent 1 million heart attacks and strokes by 2017.

Ottawa Hospital Research Institute Decision Aids
Extensive resources available online, including an index of decision aids, guides for discussing health decisions with patients and families and implementation toolkits for practices seeking to integrate SDM in their workflow.

Patient-Provide Partnership – Shared Decision-Making Low Back Pain Patient Available Tools, resource from Maine Quality Counts (5-page PDF)
"Patient-Provider Partnership (P3) Pilots – Shared Decision-Making: Low Back Pain Decisions Application" provides a summary of low-back pain shared decision making tools. *(Note: Links to external site.)*

Preference-Sensitive Conditions, Article from Dartmouth Atlas, Jan. 15, 2007 (6-page PDF)
This article describes the importance of preference-sensitive care in increasing quality and reducing variation in care. *(Note: Links to external site.)*

Presenting Risk Information — Helping Your Patients with Health Numeracy (5-page PDF)
An important aspect of decision support is helping patients weigh the pros and cons of the options. This document details strategies and questions to ask when helping a patient work through challenging decisions.

The SHARE Approach — Putting Shared Decision Making Into Practice: A User's Guide for Clinical Teams (16-page PDF)
The SHARE Approach is a one-day training program developed by the Agency for Healthcare Research and Quality (AHRQ) to help health care professionals work with patients to make the best possible health care decisions. This guide highlights a number of "how to" strategies for starting, maintaining, and evaluating a shared decision-making program in clinical practice settings of all sizes. It is supplemented with numerous case examples from a number of organizations that have implemented shared decision making in varied ways to improve the quality of care that they provide to their patients. *(Note: Links to external site.)*

Shared Decision Making Aid: Low-Back Pain Diagnosis and Treatment Options, Aug. 19, 2014 (mp4)
Brunswick Family Practice of Troy, New York, created this 5-minute video to support its shared decision making effort around choosing appropriate radiological assessments for low back pain. Patients often request MRIs to confirm diagnosis of lower back pain when other appropriate and less expensive diagnosis and treatment options are available.

Shared Decision Making Aid: Prostate Cancer Screening with PSA Testing (12-page PDF)
Shared decision aid for prostate cancer screening developed by the American Society of Clinical Oncology. *(Note: Links to external site)*

Shared Decision Making: Engaging the Patient's Experience, article from Healthleaders Media, June 18, 2014
This article highlights how a team at Carolinas Medical Center-Mercy adopted Shared Decision Making tactics with their $2 million research grant, experiencing quantitative success with asthma patients resulting in dropping ED admissions and use of oral steroids. Dr. Hazel Tapp's research defines SDM as believing the patient is the expert on his or herself while the provider brings the medical expertise; they meet in the middle with a conversation about what the patient will decide to do.
Link to the original article: http://www.healthleadersmedia.com/print/QUA-305622/Engaging-the-Patients

Shared Decision Making Implementation Guide, Aug. 5, 2014 (27-page PDF)
This implementation guide presents stories from your fellow CPC practices on shared decision making.

Shared Decision Making Resources, website
Shared Decision Aids for Preference-Sensitive Care that are clear, unbiased from United Kingdom-National Health Service. Despite some descriptive and treatment differences, they are worth considering. Website Link: http://sdm.rightcare.nhs.uk/shared-decision-making-sheets/.

Shared Decision Making: Sign of the Times (Part II), Society of General Internal Medicine Article, June 5, 2014 (12-page PDF)
In this article, Drs. Simmons and Sepucha, Health Decision Sciences Center, Massachusetts General Hospital, offer four of their most useful shared decision aids in the transition to a patient-centered medical home. To show the usefulness of Shared Decision Making, Drs. Simmons and Sepucha provide testimonies of two almost identical cardiovascular risk profiles and the patients' opposite opinions on statin use.

Six Steps to Shared Decision Making, April 1, 2014
Two resources from the Informed Medical Decisions Foundation that outline the six steps of shared decision making, along with sample language that may be helpful in working with patients to make decisions together.

1. Six Steps SDM Card (1-page PDF)
2. Six Steps SDM Language (2-page PDF)

Webinars

Health Disparities Series: Equity and Shared Decision Making, National Webinar, Feb. 13, 2014 (40-page PDF, transcript and video)
This presentation focuses on linking equity and Shared Decision Making, considering equity issues when implementing Shared Decision Making and stories from the field.

Improve Patient Shared Decision-Making Capacity, Oregon Regional Webinar, Jan. 17, 2013 (25-page PDF)
Covers the fundamentals of SDM: definition, why it is a hot topic, lists conditions where it is likely to be of use, points to where to find tools and resources. Also describes models for implementation and discusses costs for implementation.

Integrating Shared Decision Making into Primary Care Practice, Part 2, Oregon Learning Session, Sept. 5, 2013
Content focuses on these objectives: criteria for achieving CPC Milestone 7, reviewing SDM principles and decision aids, implementation strategies, workflow importance, examples of workflow, status report from a sample of Oregon CPC practices. Slides, transcript and video posted.

Milestone 7: Shared Decision Making, Oklahoma Learning Session, Nov. 8, 2014 (23-page PDF, transcript, video and two handouts)
This presentation reviews the process of vetting a shared decision aid how to integrate the use of shared decision tools into your practice workflow. The two handouts include:

1. Colon cancer screening handout (1-page PDF)
2. Colon Cancer Screening Process (1-page PDF)

Milestone 7: Using Decision Aids to Improve Shared Decision Making, Oregon Regional Webinar, April 3, 2014 (26-page PDF, transcript and video)
This presentation reviews the purpose of Milestone 7, shared decision making implementation approaches and provides helpful tools and resources and answers to practices frequently asked questions around implementing shared decision making aids.

Overview of Shared Decision Making, National Webinar, July 25, 2013
This presentation provides an overview of shared decision making, defines decision aids and describes models of implementing SDM. Slides, video and transcript from the presentation are posted.

An Overview of Shared Decision Making, Oregon Learning Session, Oct. 29, 2013
This presentation provides an overview of shared decision making, explains the purpose of Milestone 7 and reviews some foundational principles.

Overview of Shared Decision Making, Virtual Site Visit, National Webinar, July 31, 2013 (17-page PDF)
This presentation reviews Shared Decision Making, including participation from two practices that share their approaches to selecting and implementing SDM tools.

Shared Decision Making, Arkansas Regional Webinar, Dec. 12, 2013 (10-page PDF, transcript and video)
This regional presentation focuses on preparing for PY 2013 web app submission for Milestone 7: Shared Decision Making.

Shared Decision Making, Colorado Learning Session, June 6, 2014 (16-page PDF)
The presentation titled “20140606 CO LS_Session5_M7 Shared Decision Making” was presented by Richard Wexler, MD, CMO, from The Informed Medical Decisions Foundation. The presentation outlines the difference between shared decision making, self-management support and motivational interviewing. It also provides strategies for effectively implementing shared decision making into a practice and lists helpful resources.

Shared Decision Making, New York Regional Webinar, June 17, 2014 (42-page PDF, transcript and slides)
This presentation helps practices understand the intent of Milestone 7 and provides practice-to-practice sharing on lessons learned, ideas, tips and tools. In addition, a portion of the presentation provides key steps for effectively implementing shared decision making, presented by the VP for content from Healthwise, Inc.

Shared Decision Making, Ohio/Kentucky Regional Webinar, April 10, 2013 (40-page PDF)
This webinar defines decision aids, highlights barriers and describes the steps toward Shared Decision Making.

Shared Decision Making, Ohio/Kentucky Regional Webinar, April 9, 2014 (54-page PDF, transcript and video)
This presentation reviews the Milestone 7 Web Application reporting requirements, understanding shared decision making and using SDM to improve patient experience. The presentation ends with four practices sharing their experiences with implementing shared decision making in their clinics.

Shared Decision Making, Oklahoma Regional Learning Session, April 9, 2014 (15-page PDF)
The presentation titled "2014-04-09 OK Shared Decision Making" helps practices identify patterns in their patients' utilization to inform the identification of priority preference-sensitive conditions, provides steps for vetting shared decision making aids and provides an overview for incorporating shared decision making into practice's self-management work plan.

Shared Decision Making and Decision Aids, New York Regional Webinar, March 21, 2013
Presentation provides a common understanding of Shared Decision Making and describes how to initiate informed decisions in the primary care practice.

Shared Decision Making Part 3, Colorado Regional Webinar, Dec. 5, 2014 (42-page PDF, transcript and video)
This presentation focuses on measuring and tracking decision aid distribution to meet CPC requirement and modifying workflows to accommodate decision aid distribution and measurement.

Shared Decision Making Skills for Providers, Colorado Regional Webinar, Oct. 30, 2013 (43-page PDF)
Presentation from the Informed Medical Decisions Foundation featuring CMO Richard Wexler, MD, and Julie Riley, MS, Learning Specialist.

Shared Decision Making Tools, Arkansas Regional Webinar, April 11, 2014 (21-page PDF, transcript and video)
This presentation reviews the process of selecting and validating shared decision aids.

Resources for Milestone 9: Health Information Technology

Tools and Resources

AHRQ: Practice Facilitation Handbook

The Practice Facilitation Handbook is designed to assist in the training of new practice facilitators as they begin to develop the knowledge and skills needed to support meaningful improvement in primary care practices. It evolved from the Agency for Healthcare Research and Quality's Integrating Chronic Care and Business Strategies in the Safety Net toolkit. That toolkit was developed to aid safety net practices in implementing the Chronic Care Model, now commonly referred to as the Care Model, in their practices. *(Note: Links to external website.)*

Attestation User Guide for Medicare Eligible Professionals (75-page PDF)
The Attestation User Guide for Medicare Eligible Professionals provides step-by-step guidance for EPs participating in the Medicare EHR Incentive Program on navigating the Meaningful Use attestation system.

Attestation Worksheet (8-page PDF)
Attestation Worksheet for Eligible Professionals: allows eligible professionals to document their attestation data on paper before they attest in the Meaningful Use attestation system.

CMS' PQRS Information
Overview of PQRS, a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

HRSA Resources
This site describes Meaningful Use, the Stage 1 CQMs, how they are calculated, reported and attested and additional Meaningful Use Clinical Quality Measures resources and information.

Meaningful Use Attestation Calculator
This tool allows EPs and eligible hospitals to determine if they have met the Stage 1 Meaningful Use guidelines before they attest in the system.

Registration & Attestation Page
This site includes information on registration and attestation to Meaningful Use and links to additional resources.

Meaningful Use Resources on the Collaboration Site
CMS has several resources located on the EHR Incentive Programs website to help EPs properly meet Meaningful Use and attest. The consolidated information helps eligible hospitals and professionals reduce the time and resources needed to implement validated and endorsed health quality measures. Select to access additional information. Data is made publicly available in USHIK by a federal partnership of AHRQ, CMS, NIH/National Library of Medicine and the Office of the National Coordinator for Health Information Technology.

Regulations and Guidance/Legislation for EHR Incentive Programs Section
This site provides information about the Medicare and Medicaid EHR Incentive Programs. These programs provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate Meaningful Use of certified EHR technology.

Webinars

Meaningful Use Stage 2, Ohio/Kentucky Regional Webinar, Dec. 11, 2013 (33-page PDF, transcript and video)
This presentation summarizes the components of Stage 2 Meaningful Use.

CMS Collaboration Website

Tools and Resources

Collaboration Site Action Group Instructions, Aug. 18, 2014 (6-page PDF)
This presentation provides helpful instructions for using the Collaboration Website Action Group forums and library folders.

Collaboration Site Demo, September 2012 (35-minute video)
Video on how to use the CPC Collaboration Site. Instructions include the following:

Introduction for member:

1. Password Rests (00:53)
2. Navigating the site (06:19)
3. Library (09:36)
4. Forums (12:41)
5. Events (16:31)

Administration:

1. Adding/Managing Members (24:38)
2. Sharing content (28:13)
3. Help/Support (36:33)

CPC Collaboration Site How-To, Aug. 13, 2014 (3-page PDF)
This step-by-step how-to guide will help you set up your access for the Action Group forums and library. This will enhance your experience with your chosen Action Group(s).

Collaboration Website Quick Reference – How to create a library document, July 11, 2014 (3-page PDF)
Step-by-step instructions for uploading a document to the CPC Library.

Culture of Improvement

Resources and Tools

Addressing Common Inefficiencies in Office Practice, article
This 2010 article from AAFP discusses common inefficiencies in practice office flow and provides some practical tips and tricks to kicking off a revisit of your office's work and patient flow.

Webinars

Change Fatigue, New Jersey Regional Webinar, June 18, 2014 (8-page PDF, transcript and video)
The presentation features tips and techniques on overcoming change fatigue.

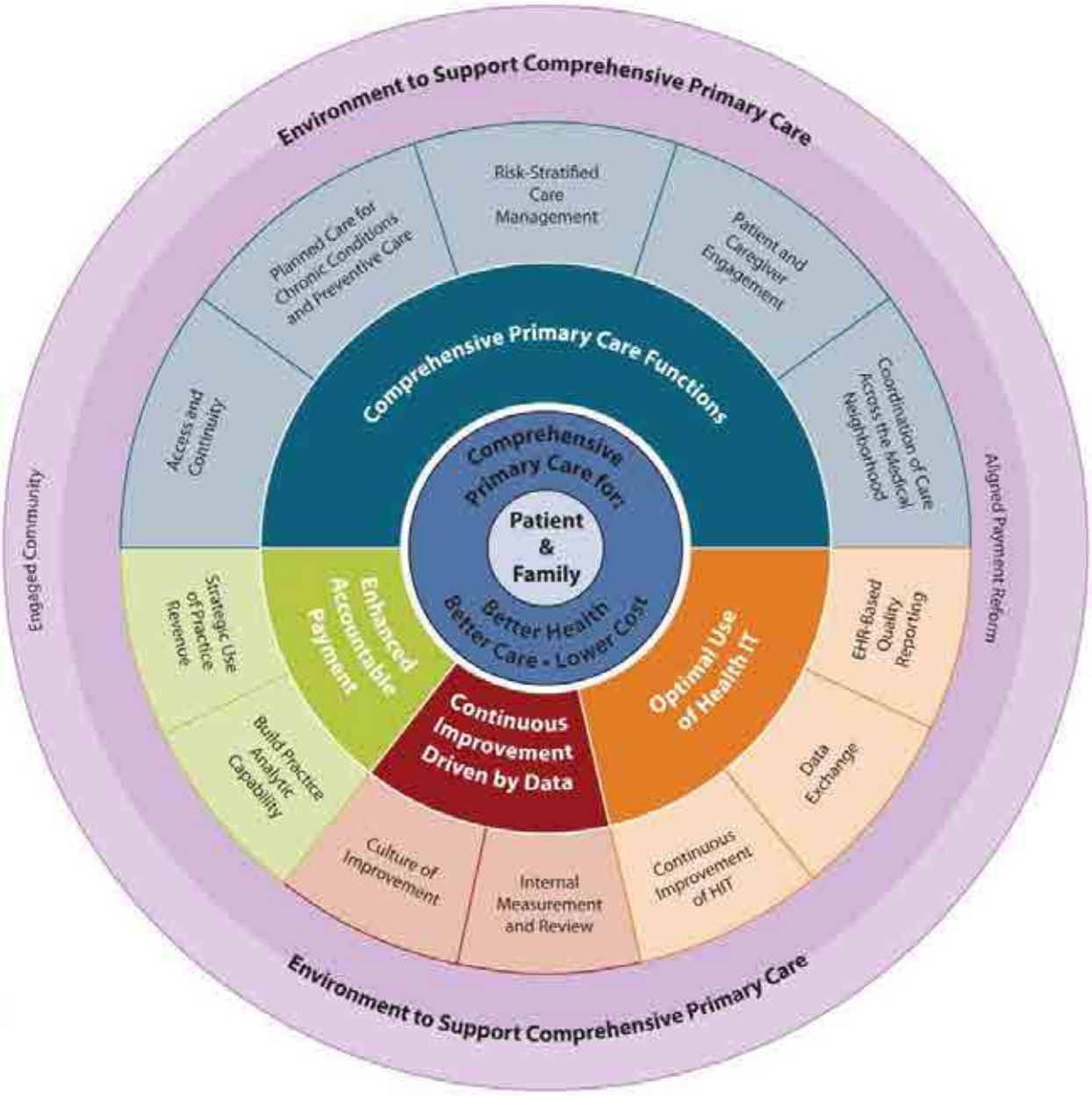
Leadership Series – Part 3, Colorado Regional Webinar, Feb. 5, 2014 (17-page PDF, transcript and video)
This presentation provides strategies for sustaining change during competing priorities.

CPC Change Package and Key Drivers

The Driver Diagram

Below is the updated "logic model" for the CPC initiative, and following it is the updated Change Package, delineating the concepts and tactics that support the aim of CPC: better health, better care and lower cost.

Revision: The main change in the CPC "logic model" is in the outer ring representing the new fifth driver to achieve the aims of CPC: the Environment to Support Comprehensive Primary Care. This driver includes both the payment changes in CPC and the multi-stakeholder efforts to create a more integrated medical neighborhood. There are also revisions to the Change Package that capture the work actually being done by CPC practices.



Primary Driver – 1.0 Comprehensive Primary Care Functions

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

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.2 **Planned Care for Chronic Conditions and Preventive Care**	A: Use a personalized plan of care for patients at high risk for adverse health outcome or harm.	Engage patients at highest risk in ongoing development and refinement of their care management plan, to include integration of patient goals, values and priorities.
		Use the Medicare *Annual Wellness Visit with Personalized Prevention Plan Services* (AWV with PPPS) for Medicare patients.
	B: Proactively manage chronic and preventive care for empanelled patients.	Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care, including health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning.
		Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target.
		Use pre-visit planning to optimize team management of patients with chronic conditions.
		Use panel support tools (registry functionality) to identify services due.
		Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due.
	C: Manage medications to maximize efficiency, effectiveness and safety.	Periodic medication reconciliation.
		Coordinate medications across transitions of care settings and providers.
		Integrate a clinical pharmacist as part of the care team.
		Conduct periodic, structured medication reviews.
		Develop a medication action plan for high-risk patients.
		Provide collaborative drug therapy management for selected conditions or medications.
		Provide support for medication self-management.

	D: Use team-based care to meet patient needs efficiently.	Define roles and distribute tasks among care team members, consistent with the skills, abilities and credentials of team members to better meet patient needs.
		Use decision support and protocols to manage workflow in the team to meet patient needs.
		Manage workflow to address chronic and preventive care, for example through pre-visit planning or huddles.
		Enhance team resources with staff such as health coach, nutritionist, behavioral health, pharmacy and physical therapy as feasible to meet patient needs.
	E: Offer integrated behavioral health services to support patients with behavioral health needs, dementia and poorly controlled chronic conditions.	Ensure PCPs and other clinical staff have been trained in principles of behavioral health care and are able to handle routine behavioral health care needs.
		Include use of non-clinical staff to provide screening and assessment of behavioral health care needs.
		Ensure regular communication and coordinated workflows between primary care and behavioral health providers.
		Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment.
		Use the registry function of the EHR or a shared registry to support active care management and outreach to patients in treatment.
		Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.3 Risk-Stratified Care Management	A: Assign and adjust risk status to each patient.	Use a consistent method to assign and adjust global risk status for all empanelled patients to allow risk stratification into actionable risk cohorts.
	B: Use care management pathways appropriate to the risk status of the patient.	Use on-site practice-based or shared care managers to proactively monitor and coordinate care for the highest risk cohort of patients.
		Use panel management and registry capabilities to support management of patients at low and intermediate risk.
	C: Manage care across transitions.	Routine and timely follow-up to hospitalizations.
		Routine and timely follow-up to ED visits.

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
1.4 Patient and Caregiver Engagement	A: Integrate culturally competent self-management support into usual care across conditions and provide condition-specific support for self-management of common conditions.	Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR.
		Incorporate evidence-based techniques to promote self-management into usual care, using techniques such as goal setting with structured follow-up, Teach Back, action planning or Motivational Interviewing.
		Use tools to assist patients in assessing their need for support for self-management (e.g., the Patient Activation Measure or How's My Health).
		Provide a pre-visit development of a shared visit agenda with the patient.
		Provide coaching between visits with follow-up on care plan and goals.
		Provide peer-led support for self-management.
		Provide group visits for common chronic conditions (e.g., diabetes).
		Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community.
		Provide self-management materials at an appropriate literacy level and in an appropriate language.
	B: Shared decision making.	Use evidence-based decision aids to provide information about risks and benefits of care options in preference-sensitive conditions.
		Routinely share test results, along with appropriate education about the implications of those results, with patients.
	C: Engage patients and families to guide improvement in the system of care.	Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
		Communicate to patients the changes being implemented by the practice.

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

Primary Driver – 2.0 Enhanced Accountable Payment

SECONDARY DRIVER	CHANGE CONCEPT	CHANGE TACTICS
2.1 Strategic Use of Practice Revenue	A: Use budgeting and accounting processes effectively to transform care processes and build capability to deliver comprehensive primary care.	Develop a process for prioritizing practice changes necessary to improve patient outcomes and population health.
		Invest revenue in priority areas for practice transformation.
		Use accounting and budgeting tools and processes to allocate revenue.
	B: Align practice productivity metrics and compensation strategies with comprehensive primary care.	Use productivity measures that include non-visit related care.
		Incent effective team-based care.
2.2 Analytic Capability	A: Build the analytic capability required to manage total cost of care for the practice population.	Train appropriate staff on interpretation of cost and utilization information.
		Use available data regularly to analyze opportunities to reduce cost through improved care.

Primary Driver – 3.0 Continuous Improvement Driven by Data

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

Primary Driver – 4.0 Optimal Use of Health IT

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

Primary Driver – 5.0 Environment to Support Comprehensive Primary Care

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