MILESTONES

Milestone	2013	2014	2015	2016
I. Budget	Complete an annual budget or forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change (practices can submit their own budgets with defined domains, or build off of a template provided by the Innovation Center). This is due to the Innovation Center within 3 months of enrollment.	a. Record actual CPC expenditures and CPC revenue from program year 1. b. Complete an annotated annual budget forecast with projected new CPC Initiative practice revenue flow and plan for anticipated practice expenses associated with practice change in program year 2. This information will be due Q1 of program year 2.	a. Record actual CPC expenditures from PY 2014. b. Complete an annotated annual budget with projected CPC initiative practice revenue flow and actual revenue/expenses from PY 2014. This information will be due Q1 of PY 2015.	a. Record actual CPC expenditures from PY 2015. b. Complete an annotated annual budget with projected CPC initiative practice revenue flow and actual revenue/expenses from PY 2015. This information will be due Q1 of PY 2016.
II. Care Management for High Risk Patients	Provide information about care management of high risk patients: a. Indicate the methodology used to assign a risk status to every empanelled patient. ("Empanelled" means that all attributed patients have a designated provider/ care team within the practice and that systems are in place to produce reports based on provider/care team). *The methodology can use a global risk score or a set of risk indicators (e.g. number of medications, problems, ER/hospitalization use, or a systematic assessment of psychosocial complexity).* b. Establish and track a baseline metric for percent assignment of risk status and proportion of population in each risk category. c. Provide practice-based care	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. Provide care management to at least 80% of highest risk patients (those that are clinically unstable, in transition, and/or otherwise need active, ongoing, intensive care management). d. Implement 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 3 high risk conditions; 3. Medication management and review.	a. Maintain at least 95% empanelment to provider and care teams. b. Continue to risk stratify all patients, maintaining risk stratification of at least 75% of empanelled patients. c. Using available data on the needs of the practice population and the strengths and weaknesses of the chosen risk stratification methodology, review – and if needed, refine – the methodology being used to assign a risk status to every empanelled patient. d. Provide care management resources to the population identified as most likely to benefit from those services. Focus on patients identified by the practice's risk stratification methodology to be high risk or with rapidly rising risk (e.g. those that are clinically unstable, in transition, and/or are high utilizers of services) and likely to benefit from active, ongoing, intensive care management.	a. Maintain at least 95% empanelment to provider and care teams. b. Continue to risk stratify all patients, maintaining risk stratification of at least 75% of empanelled patients. c. Using available data on the needs of the practice population and the strengths and weaknesses of the chosen risk stratification methodology, review – and if needed, refine – the methodology being used to assign a risk status to every empanelled patient. d. Provide care management resources to the population identified as most likely to benefit from those services. Focus on patients identified by the practice's risk stratification methodology to be high risk or with rapidly rising risk (e.g. those that are clinically unstable, in transition, and/or are high utilizers of services) and likely to benefit from active, ongoing, **longitudinal care management** and

	management capabilities and indicate the following: • Who provides care management services • Process for determining who receives care management services • Examples of care management plans on request. • Be able to generate lists of patients by risk category		e. Maintain the implementation of, and further refine, one or more of the following three specific advanced care management strategies for patients in higher risk cohorts (beginning with those at highest risk): 1. Integration of behavioral health; 2. Self-management support for at least 3 high risk conditions; 3. Medication management and review.	those patients not otherwise at high risk who are identified by a triggering event (e.g. transition of care or new diagnosis) as requiring **episodic care management** for a limited period of time. e. Provide information about the care plans that are used for both longitudinal care management and episodic care management. f. Maintain the implementation of, and further refine, one of the following three specific advanced care management strategies for patients in higher risk cohorts (beginning with those at highest risk): 1. Integration of behavioral health; 2. Self-management support for at least 3 high risk conditions; 3. Medication management and review. g. Specify what changes the practice is making to implement the other two specific advanced care management strategies for patients in higher risk cohorts (beginning with those at highest risk).
III. Access and Continuity	Provide and attest to 24 hour, 7 days a week patient access to nurse or practitioner who has real-time access to practice's medical record for patient advice and to inform care by other professionals.	a. Attest that patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to the electronic medical record. b. Enhance access by implementing at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment for a timely response.	a. Attest that patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to the electronic medical record. b. Continue to implement at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment to responding to patients within a specific time. c. Measure visit continuity by empanelled patients to providers in the practice.	a. Attest that patients continue to have 24 hour/7 day a week access to a care team practitioner who has real-time access to the electronic medical record. b. Continue to implement at least one asynchronous form of communication (e.g., patient portal, email, text messaging) and make a commitment to responding to patients within a specific time. c. Measure continuity of care by measuring visit continuity quarterly for each provider and/or care team in the practice.

IV. Patient Experience	Assess and improve patient experience of care by selecting at least one of the following: a. Provide at least 2 quarters of focused survey data based on at least one CG-CAHPS domain chosen by the practice after review of results from the initial CG-CAHPS survey (https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx) results done under this Initiative; b. Provide evidence of guidance from a patient and family advisory council that meets at least quarterly, along with specific discussion of how this feedback was used to change practice workflow or policy. A description of a patient and family advisory council can be found at https://www.cahps.ahrq.gov/Quality-Improvement/Improvement-Guide/Browse-Interventions/Customer-Service/Listening-Posts/Advisory-Councils.aspx	a. Continue year 1 efforts by conducting surveys and/or meetings with a Patient and Family Advisory Council (PFAC). • **Option A:** Conduct practice-based survey monthly. • **Option B:** PFAC that meets quarterly. • **Option C:** Office based surveys administered quarterly and PFAC convened semi-annually. b. Develop communication(s) to patients about the specific changes your practice is implementing (e.g. a pamphlet or posters). The communications should explain the medical care and services at your practice (e.g. new access options, patient portals and access to health information, care management, care coordination, etc.) This is not marketing materials for CPC and should not list the CPC milestones, the change package, or contain the CMS logo. The communication should indicate how patients can help inform these changes (e.g., through surveys, the Patient and Family Advisory Council, or other mechanisms).	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 practice-based survey monthly. • **Option B:** PFAC that meets quarterly. • **Option C:** Office-based surveys administered quarterly and PFAC convened periodically. b. Specify the changes to the practice that have occurred during each reporting period as a result of, or influenced by, practice survey/PFAC activities. c. Continue to communicate to patients (either electronically, on posters, via pamphlets or similar) about the specific changes the practice is implementing as a result of the survey or PFAC.	a. Continue efforts in previous program years by conducting surveys and/or meetings with a Patient and Family Advisory Council (PFAC). • **Option A:** Conduct practice-based survey monthly. • **Option B:** PFAC that meets quarterly. • **Option C:** Office-based surveys administered quarterly and PFAC convened periodically. b. Specify the changes to the practice that have occurred during each reporting period as a result of, or influenced by, practice survey/PFAC activities. c. Continue to communicate to patients (either electronically, on posters, via pamphlets or similar) about the specific changes the practice is implementing as a result of the survey or PFAC.
V. Quality Improvement	At least quarterly, generate and review practice- or provider-based reports with a minimum of one quality measure and one utilization measure. These two measures may be derived from the list of measures that practices will be reporting to the Innovation Center for purposes of calculating a quality score for shared savings distribution, or the practice may choose any NQF endorsed measures based on clinical importance and/or improvement potential.	a. Report the EHR clinical quality measures required by CPC for your region. b. Provide panel (provider or care team) reports on at least three measures at least quarterly to support improvement in care.	a. Continue to perform continuous quality improvement using EHR CQM data on at least 3 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: 1. A high cost area 2. A practice strategy to reduce cost in this area while maintaining or	a. Continue to perform continuous quality improvement using EHR CQM data on at least 3 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: 1. A high cost or utilization area 2. A practice strategy to reduce cost or utilization in this area.

			improving quality.	
VI. Care Coordination Across the Medical Neighborhood	Demonstrate active engagement and care coordination across the medical neighborhood by creating and reporting a measurement – with numerator and denominator data – to assess impact and guide improvement in one of the following areas. a. Notification of ED visit in timely fashion. b. Practice medication reconciliation process completed within 72 hours of hospital discharge. c. Notification of admission and clinical information exchange at the time of admission. d. Notification of discharge, clinical information exchange, and care transition management at hospital discharge. e. Information exchange between primary care and specialty care related to referrals to specialty care. The milestone for Year 1 is to select and report on the measurement (this reporting is not related to the reporting required for shared savings in Year 2). In Year 2, the practice will need to describe activities they undertook to improve the results.	Select two of the three options below, building on your Year 1 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. c. Enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.	Select two of the three options below, building on your PY 2013 and 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 2 business days. c. Maintain or enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.	Select two of the three options below, building on your activities in previous program years: a. Track % of patients with ED visits who received a follow up phone call within one week. b. Contact at least 75% of patients who were hospitalized in target hospital(s), within 72 hours or 2 business days. c. Maintain or enact care compacts/collaborative agreements with at least 2 groups of high-volume specialists in different specialties to improve transitions of care.
VII. Shared Decision Making	Identify a priority condition, decision, or test that would benefit from shared decision making and the use of a decision aid. Make a decision aid available to appropriate patients and generate a metric for the proportion of patients who received the decision aid for this priority area. Information about shared decision making is available at https://www.cahps.ahrq.gov/Quality	a. Implement shared decision making tools or aids in two health conditions, decisions or tests as component of shared decision-making. b. Generate a metric for the proportion of patients who received the decision aid, OR c. Provide quarterly counts on run charts of patients receiving the decision aids and show growth in use	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	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

	-Improvement/Improvement-Guide/Browse-Interventions/Communication/Shared-Decision-Making.aspx	of the aids.	receiving individual aids.	receiving individual aids.
VIII. Participate in Learning Collaborative	Participate in the market-based learning collaborative and share knowledge, tools, and expertise with other practices in the market as indicated by: a. Attendance at three face-to-face meetings annually and in web-based meetings at least monthly. b. Sharing of materials or resources on the collaboration site. c. Reporting on the Innovation Center's on-line Collaboration Site of at least 6 key measures that are of importance to the practice and which will be used to guide active testing of changes in the practice. These may include measures required for patient experience, risk status assignment, care coordination, etc., as described above.	a. Participate in all three all-day CPC learning sessions in your region. b. Participate in one learning webinar per month. c. Contribute a minimum of one document or experiential story to the CPC Collaboration Website. d. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress towards Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty are bound by confidentiality agreements.	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, for the purposes of monitoring progress towards Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty is bound by confidentiality agreements.	a. Participate in all CPC learning sessions in your region. b. Fully engage and cooperate with the Regional Learning Faculty, including by providing regular status information as requested, for the purposes of monitoring progress towards Milestones and/or for the purposes of providing support to meet the Milestones. As a contractor for CMS, the faculty is bound by confidentiality agreements.

IX. Health Information Technology	Attest to the requirements for Stage 1 of Meaningful Use for the EHR Incentive Programs (for practitioners participating in the Medicaid EHR Incentive Program, adopting, implementing, or upgrading certified EHR technology is not sufficient, the practitioner must attest to Stage 1).	a. All eligible professionals in the practice successfully attest to Meaningful Use in accordance with the requirements of the Meaningful Use program. b. Upgrade EHR technology to the 2014 edition ONC Certification. c. Identify the care settings/providers for which the practice has the ability to exchange health information electronically.	Attest that each Eligible Professional within the practice is engaged with, and working towards, attestation for Stage II of Meaningful Use in the timelines set by the Meaningful Use program.	Attest that each Eligible Professional within the practice is engaged with, and working towards, attestation for Stage II of Meaningful Use in the timelines set by the Meaningful Use program.

Updated December 8, 2015.